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

MassHealth
Eligibility Letter 123
July 1, 2004

TO: MassHealth Staff

FROM: Beth Waldman, Medicaid Director BW

RE: MassHealth Essential Coverage for Certain Aliens with Special Status

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The attached regulations provide MassHealth Essential coverage to certain adult aliens with special status. These revised regulations expand the current MassHealth Essential coverage type for persons under age 65 (under Health Care Reform), and provide an additional coverage type for persons aged 65 or older (under Traditional). MassHealth Essential will be provided to aliens with special status who are under age 65, disabled, and meet all existing MassHealth Essential requirements, including long-term unemployment, and to aliens with special status who are aged 65 or older who meet all MassHealth Standard requirements except immigration status.

The Massachusetts legislature has mandated that these benefits be provided through September 30, 2004. These regulations were filed as an emergency, with a retroactive effective date of June 1, 2004.

MANUAL UPKEEP

Insert	**Remove**	**Trans. By**
501.004	501.004	E.L. 109
501.005	501.005	E.L. 114
502.007	502.007	E.L. 109

Insert	**Remove**	**Trans. By**
504.002 (1 of 3)	504.002 (1 of 3)	E.L. 104
504.002 (2 of 3)	504.002 (2 of 3)	E.L. 112
504.002 (3 of 3)	504.002 (3 of 3)	E.L. 118
505.001	505.001	E.L. 114
505.002 (1 of 6)	505.002 (1 of 6)	E.L. 120
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505.007 (1 of 4)	505.007 (1 of 3)	E.L. 109
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505.008 (1 of 2)	505.008 (1 of 2)	E.L. 118
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508.016	508.016	E.L. 119
515.001 (2 of 8)	515.001 (2 of 8)	E.L. 117
515.002	515.002	E.L. 117
515.004	--	--
515.008	515.008	E.L. 117
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518.002 (1 of 3)	518.002 (1 of 3)	E.L. 104
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519.003 (2 of 2)	519.003 (2 of 2)	E.L. 115
519.011	519.011	E.L. 98
519.013	--	--

Insert	**Remove**	**Trans. By**
520.003	520.003	E.L. 117
520.005 (1 of 2)	520.005 (1 of 2)	E.L. 63
520.026 (5 of 5)	520.026 (5 of 5)	E.L. 63
520.030	520.030	E.L. 117
520.035	520.035	E.L. 119

(2) (a) Family Assistance Premium Assistance payments for persons enrolled from the waiting list will begin in the month that the application or new determination is processed from the waiting list, or in the month that the health insurance deduction begins, whichever is later.

(b) Medical coverage for Family Assistance Purchase of Medical Benefits for persons who are enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

(3) (a) Essential Premium Assistance payments for persons enrolled from the waiting list will begin in the calendar month following verification of the member's health insurance information. Coverage before enrollment for MassHealth Essential members who are aliens with special status is described in 130 CMR 505.007(E).

(b) Medical coverage for Essential Purchase of Medical Benefits for persons enrolled from a waiting list will begin on the date specified in MassHealth's notice of enrollment in the MassHealth Primary Care Clinician (PCC) Plan. There is no coverage for Essential members before the member's effective enrollment date, except as described in 130 CMR 505.007(E) for aliens with special status eligible for MassHealth Essential with MassHealth Limited.

501.004: Administration of MassHealth

(A) MassHealth. MassHealth 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. Uninsured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for the purchase of medical benefits under MassHealth Basic upon managed-care enrollment, in accordance with the requirements of 130 CMR 508.000. Insured individuals and members of a couple receiving EAEDC cash assistance are automatically eligible for premium assistance under MassHealth Basic. Eligibility requirements for aliens with special status, as described in 130 CMR 504.002(D), who are aged 19 through 64, and receiving EAEDC, are detailed in 130 CMR 505.007(E). Families receiving EAEDC are automatically eligible for MassHealth Standard coverage and are provided choices of enrollment in a managed care plan, unless exempt in accordance with 130 CMR 508.004, except as described in 130 CMR 505.007(E).

(2) Social Security Administration (SSA). District Social Security Offices administer the SSI program and determine the eligibility of disabled individuals. Individuals receiving SSI are automatically eligible for MassHealth Standard coverage. Individuals without health insurance are provided choices of enrollment in a managed care plan.

(3) Department of Public Health (DPH). The Department of Public Health administers the Women's Health Network, which provides breast and cervical cancer screening and diagnostic services to certain low-income women. Uninsured women who are screened or receive diagnostic services through the Women's Health Network are eligible for MassHealth Standard for the duration of their cancer treatment if they:

(a) are found to be in need of treatment for breast or cervical cancer; and

(b) meet the MassHealth program requirements described in 130 CMR 505.002(H), as determined by MassHealth.

(4) Department of Employment and Training (DET). The Department of Employment and Training administers the Medical Security Plan that provides health insurance to persons who are receiving, or who are eligible to receive, state or federal unemployment benefits. Coverage is offered either through direct purchase of coverage or partial reimbursement for insurance premium payments.

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

(A) Members Who Were Not Subject to a Deductible. 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: 1) the individual or family no longer lives in Massachusetts; 2) the individual enters an institution; 3) the individual turns 65; 4) the individual or all members of the family are deceased; or 5) the individual or family is no longer categorically eligible. Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

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

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

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

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

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

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

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

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

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

(E) If the member fails to provide a written update of his or her circumstances within 30 days of MassHealth's request, MassHealth coverage is terminated. If the member subsequently submits a written update, MassHealth determines his or her eligibility as of the date the written update is received. If the applicant is determined eligible, the medical coverage date is established in accordance with the rules in 130 CMR 502.006.

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

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

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

(8) Aliens or their unmarried dependent children, as defined in federal law, who have been subjected to battery or extreme cruelty by their spouse, parent, sponsor, or a member of their family group, and who no longer live in the same family group as the batterer.

(9) Persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980.

(10) Native Americans with at least 50 percent American Indian blood who were born in Canada pursuant to section 289 of the INA or other tribal members born in territories outside of the U.S. pursuant to 25 U.S.C. 450b(e).

(11) Amerasians admitted pursuant to section 584 of Public Law 100-202.

(12) Victims of severe forms of trafficking.

(C) Protected Alien. Aliens who are not qualified aliens, but who are aliens with special status or nonqualified aliens, as described at 130 CMR 504.002(D) and (E), and who were receiving medical assistance or CommonHealth on June 30, 1997, are considered protected aliens and may continue to receive MassHealth regardless of immigration status, if they are otherwise eligible. This status continues until a determination of ineligibility due to failure to meet categorical or financial eligibility requirements has been made.

(D) Alien with Special Status. Certain aliens who are not qualified aliens are afforded eligibility for MassHealth based on provisions of state law as described in 130 CMR 504.002(D). Aliens with special status, who qualify for MassHealth under 130 CMR 504.002(F)(2)(a), (b), or (c), must be under age 19. Long-term unemployed, disabled aliens with special status aged 19 through 64 are afforded eligibility for MassHealth under 130 CMR 505.007(E).

(1) Persons permanently living in the United States under color of law (PRUCOLs) are described in 42 CFR 435.408(b)(3) through (7), (b)(10) through (14), and (b)(16), and include the following.

(a) Aliens living in the United States in accordance with an indefinite stay of deportation.

(b) Aliens living in the United States in accordance with an indefinite voluntary departure.

(c) Aliens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the United States Department of Homeland Security (DHS) does not contemplate enforcing.

(d) Aliens who have filed applications for adjustment of status that the DHS has accepted as "properly filed," and whose departure the DHS does not contemplate enforcing.

(e) Aliens granted stays of deportation by court order, statute, or regulation, by individual determination of the DHS, or relevant DHS instructions, and whose departure the DHS does not contemplate enforcing.

(f) Aliens granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing.

(g) Aliens granted deferred action status.

(h) Aliens living under orders of supervision.

(i) Aliens who have entered and continuously lived in the United States since before January 1, 1972.

(j) Aliens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing.

(k) Any other aliens living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include permanent nonimmigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.)

(2) Persons described below who are not otherwise defined as qualified aliens under 130 CMR 504.002(B) are the following.

(a) Persons admitted for legal permanent residence (LPR) under the INA.

(b) Persons granted parole for at least one year under section 212(d)(5) of the INA.

(c) Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980.

(E) Nonqualified Alien. Aliens whose status is not described in 130 CMR 504.002(B), (C), or (D) are considered nonqualified aliens.

(F) Applicable Coverage Types.

(1) Citizens, qualified aliens, and protected aliens may receive MassHealth under any coverage type if they meet the eligibility requirements described in 130 CMR 505.000 et seq.

(2) Aliens with special status may not receive coverage under MassHealth Standard. However, they may be eligible for:

(a) MassHealth CommonHealth, if they are under age 19, disabled, and meet the categorical requirements and financial standards of MassHealth Standard as described at 130 CMR 505.002(F) or MassHealth CommonHealth if they are under age 19 and meet the categorical requirements and financial standards as described at 130 CMR 505.004;

(b) MassHealth Family Assistance, if they are children under age 19, parents under age 19, or pregnant women under age 19 who meet the categorical requirements and financial standards of MassHealth Standard as described at 130 CMR 505.002(C), (D), or (E). If they meet these requirements and have health insurance, they are also eligible for MassHealth Limited;

(c) MassHealth Family Assistance, if they are children under age 19 or persons under age 19 who are HIV positive, who meet the categorical requirements and financial standards of Family Assistance, as described at 130 CMR 505.005. MassHealth does not pay the copayments, coinsurance, and deductibles described in 130 CMR 505.005(B)(6) for children who receive premium assistance;

(d) MassHealth Limited, if they are adults who are parents, pregnant, or disabled and meet the categorical requirements and financial standards of MassHealth Standard, as described in 130 CMR 505.002(D), (E), and (F); or

(e) MassHealth Essential with MassHealth Limited, if they are long-term unemployed, disabled adults aged 19 through 64, and meet the eligibility requirements of 130 CMR 505.007(E).

(3) Nonqualified aliens may only receive MassHealth Limited if otherwise eligible for MassHealth Standard. This does not include women eligible for MassHealth Standard based on 130 CMR 505.002(H).

(4) Aliens with special status are not eligible for MassHealth Basic.

(G) Verification of Immigration Status.

(1) A determination of eligibility is made as of the date the MBR and all required information, except verification of immigration status, is received by MassHealth.

(2) MassHealth submits the names of qualified aliens to the DHS for confirmation of immigration status.

(3) MassHealth requests verification of immigration status subsequent to the eligibility determination from:

(a) qualified aliens who did not submit verification of their immigration status with the MBR, and for whom the DHS has been unable to confirm their status, as described at 130 CMR 504.002(G)(2); and

(b) aliens with special status who did not submit verification of their immigration status with the MBR.

(4) Aliens who fail to submit verification of their immigration status, as described in 130 CMR 504.002(G)(3), within 60 days of MassHealth's Request for Information will subsequently be:

(a) eligible only for MassHealth Limited if they meet the categorical requirements and financial standards of MassHealth Standard; or

(b) ineligible for any MassHealth coverage type if not otherwise eligible for MassHealth Standard.

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.

(A) The MassHealth coverage types are the following:

(1) Standard – for families, pregnant women, children, disabled individuals, and women with breast or cervical cancer;

(2) Prenatal – for pregnant women;

(3) CommonHealth – for disabled adults and disabled children who are not eligible for MassHealth Standard;

(4) Family Assistance – for children, certain employed adults, and persons who are HIV positive who are not eligible for MassHealth Standard or CommonHealth;

(5) Basic – for the long-term unemployed who have income at or below 100 percent of the federal poverty level, and who are receiving services or are on a waiting list to receive services from the Department of Mental Health (DMH), as identified by the DMH to MassHealth, or for individuals or members of a couple who receive EAEDC cash assistance;

(6) Essential – for the long-term unemployed and for disabled long-term unemployed aliens with special status who have income at or below 100 percent of the federal poverty level and are not eligible for MassHealth Basic; and

(7) Limited – for nonqualified aliens and aliens with special status.

(B) The financial standards referred to in 130 CMR 505.000 et seq. depend on the family group size, which may be composed of an individual, couple, or family, as defined in 130 CMR 501.001.

505.002: MassHealth Standard

(A) Overview.

(1) 130 CMR 505.002 contains the categorical requirements and financial standards for MassHealth Standard serving families, children under 19, pregnant women, disabled individuals, parents and caretaker relatives described in 130 CMR 519.005(C)(1), and women with breast or cervical cancer.

(2) Persons eligible for Standard coverage are eligible for medical benefits as described in 130 CMR 450.105(A) and 130 CMR 508.000.

(3) 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.

(B) Extended Eligibility.

(1) Members of a family group whose cash assistance terminates continue to receive four months of MassHealth Standard coverage beginning in the month the family group became ineligible if they are:

(a) terminated from EAEDC, except for those described in 130 CMR 505.007(E), 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 family group 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 family group continues to include a child who is under age 19, or if he or she has reached age 19, is expected to complete his or her secondary level studies before his or her 20th birthday;

(b) a parent or caretaker relative continues to be employed; and

(c) the parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(3) Members of a family group who receive MassHealth Standard (whether or not they receive TAFDC) and have increased earnings that raise the family group's gross income above 133 percent of the federal-poverty level, continue to receive MassHealth Standard for a full 12-calendar-month period that begins with the date on which the increase occurred if:

(a) the family group continues to include a child who is under age 19;

(b) a parent or caretaker relative continues to be employed; and

(c) the parent or caretaker relative complies with 130 CMR 505.002(I) and 507.003.

(4) MassHealth independently reviews the continued eligibility of the family group at the end of the extended period described in 130 CMR 505.002(B)(1), (2), and (3).

(3) 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 MassHealth Disability Determination Unit (DDU).

(G) Medicare Premium Payment. MassHealth also pays the following on behalf of members who meet the requirements of 130 CMR 505.002(F) and 519.005(C). The coverage described in 130 CMR 505.002(G)(1), (2), and (3) begins on the first day of the month following the date of MassHealth's eligibility determination.

(1) The cost of the monthly Medicare Part B premiums;

(2) Where applicable, the cost of hospital insurance under Medicare Part A for members who are entitled to Medicare Part A; and

(3) Where applicable, for the deductibles and coinsurance under Medicare Parts A and B.

(H) Women with Breast or Cervical Cancer.

(1) Eligibility Requirements. A woman whose application has been received through the Department of Public Health in accordance with 130 CMR 501.005 and who is under the age of 65 is eligible for MassHealth Standard provided she meets all of the following requirements.

(a) She is a United States citizen or qualified alien as described at 130 CMR 504.002(A) and (B).

(b) She has provided a social security number in accordance with the requirements at 130 CMR 503.003.

(c) She has been screened or has received diagnostic services through the Department of Public Health (DPH) Women's Health Network and found to need treatment for breast or cervical cancer, including precancerous conditions.

(d) She has family group income less than or equal to 250 percent of the federal poverty level in accordance with DPH requirements as certified by DPH to MassHealth.

(e) She is uninsured as defined at 130 CMR 505.002(H)(2).

(f) She does not meet the requirements for MassHealth Standard described at 130 CMR 505.002(C)(2), (D), (E) or (F).

(a) They are currently unemployed and:

(i) have been unemployed for more than one year; or

(ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.

(b) They are not eligible for unemployment compensation.

(c) They have family group gross income less than or equal to 100 percent of the federal-poverty level.

(d) Their spouse is:

(i) not employed more than 100 hours a month; or

(ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage in accordance with 130 CMR 505.005(C).

(2) EAEDC Recipients. Individuals and members of couples who receive EAEDC cash assistance are eligible for premium assistance under MassHealth Basic if they have health insurance.

(3) Eligibility Date. Once MassHealth has determined eligibility, premium assistance payments begin in the calendar month following the verification of the member's health insurance information.

(4) Extended Premium Assistance. Persons who are no longer eligible for premium assistance payments under MassHealth Basic due to earnings continue to have their premiums paid for a six-calendar-month period following their date of employment if they or their spouse are not otherwise eligible for premium assistance payments, in accordance with 130 CMR 505.005(C).

505.007: MassHealth Essential

(A) Overview. 130 CMR 505.007 contains the categorical requirements and financial standards for MassHealth Essential. This coverage type is available to individuals or members of a couple who are long-term unemployed and do not meet the eligibility criteria for MassHealth Basic, as described in 130 CMR 505.006. MassHealth Essential coverage is available either through the purchase of medical benefits or through premium assistance payments. MassHealth Essential benefits afforded to aliens with special status are described in 130 CMR 505.007(E).

(1) The Purchase of Medical Benefits under MassHealth Essential.

(a) The purchase of medical benefits under MassHealth Essential is available to unemployed adults aged 19 through 64 who:

(i) do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or

(ii) have health insurance that MassHealth has determined does not cover the applicant's chronic medical condition requiring frequent treatment and medical services, or is of significant cost to the applicant.

(b) Persons eligible for the purchase of medical benefits are eligible for medical benefits, as described in 130 CMR 450.105(I) and 130 CMR 508.000.

(2) Premium Assistance under MassHealth Essential.

(a) Premium assistance under MassHealth Essential is available to unemployed adults aged 19 through 64 who have health insurance that:

(i) MassHealth has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;

(ii) is not of significant cost to the applicant;

(iii) is not available from the college or university that they attend; and

(iv) meets MassHealth's cost-effective analysis.

(b) Persons eligible for premium assistance payments are eligible for payment of part or all of their health insurance premium.

(B) The Purchase of Medical Benefits.

(1) Eligibility Requirements. Individuals and members of couples under age 65 are eligible for Essential coverage if they are uninsured, in accordance with 130 CMR 505.007(A)(1)(a), and meet all of the following conditions.

(a) They are not eligible for MassHealth Basic.

(b) They are currently unemployed and:

(i) have been unemployed for more than one year; or

(ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.

(c) They are not eligible for unemployment compensation.

(d) They have family group gross income less than or equal to 100 percent of the federal poverty level.

(e) Their spouse is:

(i) not employed more than 100 hours a month; or

(ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage, in accordance with 130 CMR 505.005(C).

(2) Medical Coverage Date. Except as provided in 130 CMR 501.003(E)(3), members, after they have received notice from MassHealth stating that they meet the eligibility requirements for the purchase of medical benefits under MassHealth Essential at 130 CMR 505.007(B) and (E), receive medical coverage effective on the date specified in MassHealth's notice of enrollment in the MassHealth Primary Care Clinician (PCC) Plan. There is no medical coverage for MassHealth Essential members before the member's effective enrollment date, except for aliens with special status, as provided under 130 CMR 505.007(E)(2).

(C) Premium Assistance.

(1) Eligibility Requirements. Individuals and members of couples under age 65 are eligible for premium assistance under MassHealth Essential if they are insured, in accordance with 130 CMR 505.007(A)(2)(a), and meet all of the following conditions.

(a) They are not eligible for MassHealth Basic.

(b) They are currently unemployed and:

(i) have been unemployed for more than one year; or

(ii) during the past 12 months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation.

(c) They are not eligible for unemployment compensation.

(d) They have family group gross income less than or equal to 100 percent of the federal poverty level.

(e) Their spouse is:

(i) not employed more than 100 hours a month; or

(ii) employed 100 hours or less a month, and not eligible for premium assistance payments that provide couple or family coverage, in accordance with 130 CMR 505.005(C).

(2) Eligibility Date. Except as provided in 130 CMR 501.003(E)(3), once MassHealth has determined eligibility, premium assistance payments under MassHealth Essential begin in the calendar month following the verification of the member's health insurance information.

(D) Funding. State legislation does not provide funding for MassHealth Essential after September 30, 2004. MassHealth Essential benefits will not be provided after this date unless a legislative extension is authorized. MassHealth Essential members who are receiving MassHealth Essential on September 30, 2004, will be provided only MassHealth Limited coverage as of October 1, 2004, if otherwise eligible for MassHealth Limited under 130 CMR 505.008.

(E) MassHealth Essential for Aliens with Special Status. MassHealth Essential for aliens with special status is available to adults aged 19 through 64 who meet the eligibility requirements of 130 CMR 505.007, except that they must be aliens with special status, as described in 130 CMR 504.002(D), and in addition to being long-term unemployed, they must be disabled, as described in 130 CMR 505.002(F)(2)(a). MassHealth Essential for aliens with special status is available either through the purchase of medical benefits or through premium assistance payments. Benefits may begin no earlier than June 1, 2004, except as described in 130 CMR 505.007(E)(2). The following provisions apply to MassHealth Essential members who are aliens with special status:

(1) Funding and Enrollment/Waiting List Restrictions. MassHealth Essential members who are aliens with special status are subject to funding restrictions described in 130 CMR 505.007(D) and enrollment/waiting list restrictions described in 130 CMR 501.003(C), (D), and (E).

(2) Eligibility for MassHealth Limited. MassHealth Essential members who meet the requirements of 130 CMR 505.007(E) are automatically eligible for MassHealth Limited coverage. Medical services are provided pursuant to 130 CMR 450.105(G). MassHealth members meeting the requirements of 130 CMR 505.007(E) are eligible for MassHealth Limited benefits as follows.

(a) For MassHealth Essential members with purchase of medical benefits, medical coverage begins in accordance with 130 CMR 505.008(B).

(b) For MassHealth Essential members with premium assistance, medical coverage begins in accordance with 130 CMR 505.008(B) and is provided on a fee-for-service basis covering only MassHealth-covered services that are not covered by the member's private health insurance.

505.008: MassHealth Limited

(A) Eligibility Requirements.

(1) MassHealth Limited is available to persons who meet the financial and categorical requirements of MassHealth Standard, except women described at 130 CMR 505.002(H), and are:

(a) nonqualified aliens described in 130 CMR 504.002(E) (nonqualified aliens are not required to furnish or apply for a social security number);

(b) aliens with special status described in 130 CMR 504.002(D) who are under age 19 and are eligible for premium assistance under MassHealth Family Assistance; or

(c) aliens with special status who are adults described in 130 CMR 504.002(F)(2)(d).

(2) Persons eligible for Limited coverage are eligible for medical benefits as described in 130 CMR 450.105(G). These aliens are eligible for medical benefits under Limited only to the extent that such benefits are not covered by their health insurance.

(3) Aliens lawfully admitted for a temporary purpose such as students, visitors, and diplomats are eligible for Limited coverage if they meet all other eligibility requirements including residence.

(4) A child born to a woman who was receiving MassHealth Limited on the date of the child's birth is automatically eligible for MassHealth Standard for one year provided the child continues to live with the mother.

(5) Aliens with special status who are eligible for MassHealth Essential in accordance with 130 CMR 505.007(E) are automatically eligible for MassHealth Limited.

(B) Medical Coverage Date.

(1) The medical coverage date for MassHealth Limited begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a MassHealth outreach worker at a designated outreach site, if all required verifications, including a completed disability supplement, have been received within 60 days of the date of the Request for Information.

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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth Standard members described in 130 CMR 505.002(B), (C), (D), (E), and (F), as well as certain MassHealth Family Assistance members described in 130 CMR 505.005(E), and Basic members described in 130 CMR 505.006(B), must enroll in one of the following managed care options unless excluded from participation in 130 CMR 508.004:

(a) Primary Care Clinician (PCC) Plan; or

(b) MassHealth-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 505.005(F) and MassHealth Standard members described at 130 CMR 505.002(H) must enroll in the PCC Plan, unless excluded from participation in 130 CMR 508.004.

(3) MassHealth Essential members who have coverage through the purchase of medical benefits described in 130 CMR 505.007(B) and (E) must enroll in the PCC Plan.

(B) Obtaining Services.

(1) Primary Care. When the member selects or is assigned to either a PCC or MCO, that MassHealth managed care provider will deliver the member's primary care, decide if the member needs medical care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (Excluding Behavioral Health Services).

(a) Service Delivery to Members Enrolled in the PCC Plan. All medical services to members enrolled in the PCC Plan, except those services listed in 130 CMR 450.118(J), require a referral or authorization from the PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(b) Service Delivery to Members Enrolled in an MCO. All medical services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the referral requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and referral requirements.

(3) Behavioral Health Services.

(a) Members Enrolled in the PCC Plan. All members who enroll in the PCC Plan receive behavioral health (mental health and substance abuse) services through MassHealth's behavioral health contractor. See 130 CMR 508.003.

(b) Members Enrolled in an MCO.

(i) Members who enroll in a MassHealth-contracted MCO that is under contract to provide behavioral health services receive behavioral health services through that MCO.

(ii) All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and authorization requirements.

(c) Members with Presumptive or Time-Limited Eligibility, or Fee-for-Service. Members with presumptive or time-limited eligibility, or fee-for-service receive behavioral health services through any qualified participating MassHealth provider.

508.002: Choosing a MassHealth Managed Care Provider

All MassHealth members, except those excluded under 130 CMR 508.004, must enroll with a MassHealth managed care provider. For MassHealth Basic members, described at 130 CMR 505.006(B), and MassHealth Essential members, described at 130 CMR 505.007(B) and (E), services are available only as of the member's enrollment effective date, as established by MassHealth in accordance with 130 CMR 508.002(I), with a MassHealth managed care provider. MassHealth Essential members described in 130 CMR 505.007(E) are also provided services under MassHealth Limited pursuant to 130 CMR 505.007(E) and 505.008.

(A) Selection of a Managed Care Provider.

(1) Procedure. MassHealth notifies the member of the availability of MassHealth managed care providers in the member's service area, and of the member's obligation to select such a provider within the time period specified by MassHealth. The member may select any provider from MassHealth's list of MassHealth managed care providers in his or her service area, if the provider is able to accept new patients.

(2) Member's Service Area. The member's service area is determined by MassHealth based on zip codes. Service area listings may be obtained from MassHealth.

(B) Assignment to a Managed Care Provider. If a member does not choose a managed care provider within the time period specified by MassHealth in a notice to the member, MassHealth assigns the member to a MassHealth managed care provider.

(C) Criteria for Assigning Members.

(1) MassHealth assigns a member eligible to enroll with a managed care provider only if the provider is:

(a) in the member's service area as described in 130 CMR 508.002(A)(2);

(b) physically accessible to the member, if the member is disabled;

(2) the travel time or distance to the requested out-of-area MassHealth managed care provider is equal to or less than the travel time to a MassHealth managed care provider in the member's service area, or the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by MassHealth, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment or Transfer of Members. MassHealth may disenroll or transfer a member from a MassHealth managed care provider if the provider demonstrates to MassHealth's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, MassHealth states the good cause basis for disenrollment or transfer in a notice to the member.

(H) Reenrollment. Any member who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled.

(I) Enrollment of MassHealth Basic and MassHealth Essential Members.

(1) After MassHealth sends members a notice of eligibility for the purchase of medical benefits, MassHealth enrolls them with a MassHealth managed care provider. MassHealth Basic members, described at 130 CMR 505.006(B), must enroll in a Primary Care Clinician Plan or with a MassHealth-contracted managed-care organization. MassHealth Essential members, described at 130 CMR 505.007(B) and (E), must enroll in the Primary Care Clinician Plan. Enrollment is accomplished in one of the following ways and within the following time frames.

(a) After MassHealth approves eligibility for the purchase of medical benefits, the member may contact MassHealth directly by telephone at the number indicated on the eligibility notice, or in person, and provide all information needed to enroll the member with a MassHealth managed care provider. If complete information is provided, MassHealth enrolls the member, in accordance with the member's selection, effective no later than 10 business days after MassHealth receives this information.

(b) After MassHealth approves eligibility for the purchase of medical benefits, MassHealth sends the member enrollment materials and a managed care provider selection form. If the member completes and returns this form to MassHealth within the time frame specified by MassHealth, and if the information provided is complete, MassHealth enrolls the member, in accordance with the member's selection, effective no later than 10 business days after MassHealth receives the completed enrollment form. MassHealth considers only such forms that the member sends to MassHealth after MassHealth has approved the member's eligibility.

(c) If the member fails to notify MassHealth of his or her enrollment selection, either by telephone, in person, or by submitting a completed enrollment form within the time frame specified by MassHealth, MassHealth selects a MassHealth managed care provider for the member. MassHealth enrolls the member effective no later than 35 days after the date MassHealth determined the member to be eligible for the purchase of medical benefits. The member is notified in writing of the enrollment selection and the effective date of enrollment.

(d) If MassHealth determines a member to be eligible for the purchase of medical benefits under MassHealth Basic or MassHealth Essential, and if that member was enrolled with a MassHealth managed care provider during an earlier period of MassHealth eligibility, MassHealth may automatically enroll that member with the same provider pursuant to 130 CMR 508.002(H).

(2) If, at any time after MassHealth enrolls the member with a MassHealth managed care provider, the member wants to transfer to or from an available managed care provider, the member may notify MassHealth, and the effective date of medical coverage with the newly selected provider will be effective no later than 10 business days after MassHealth receives notification of the requested change.

(3) The time frames for establishing an effective date of enrollment may be extended if:

(a) the member asks MassHealth to delay any action described in 130 CMR 508.002(I) or otherwise causes a delay;

(b) MassHealth needs additional time to resolve conflicting information; or

(c) MassHealth does not have sufficient information to enroll or reenroll the member.

(4) In no event will a MassHealth Basic or MassHealth Essential member who is eligible for the purchase of medical benefits be enrolled with a MassHealth managed care provider with an effective date that is before the date of MassHealth's issuance of a notice to the member stating that the member is eligible for MassHealth Basic or MassHealth Essential.

508.003: Behavioral Health Contractor

The following applies to MassHealth members who receive behavioral health services through MassHealth's behavioral health contractor. See 130 CMR 508.001(C).

(A) Nonemergency Behavioral Health Services. All behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with MassHealth's behavioral health contractor. MassHealth's behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(B) Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with MassHealth's behavioral health contractor.

508.016: Copayments Required by MassHealth

MassHealth requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 520.036 through 520.040. If the usual and customary fee for the service is less than the copayment amount, the member must pay the amount of the service. Members who are enrolled in MassHealth MCOs must make copayments in accordance with the MCO's MassHealth copayment policy. Those MCO copayment policies must:

(1) be approved by MassHealth:

(2) exclude the persons and services listed in 130 CMR 520.037;

(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 520.038; and

(4) include the calendar-year maximum set forth in 130 CMR 520.040. (See also 130 CMR 450.130.)

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

Burial Trust — a trust established by an individual solely for funeral expenses, burial expenses, or both.

Business Day — any day during which MassHealth's offices are open to serve the public.

Caretaker Relative — an adult who is the primary caregiver 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.

Community Resident — a person who lives in a noninstitutional setting in the community.

Competent Medical Authority — a physician or psychiatrist licensed by any state, a psychologist licensed by the Commonwealth of Massachusetts, or both.

Countable Income — the types of income that are considered in the determination of eligibility.

Countable-Income Amount — gross income less certain business expenses and income deductions.

Couple — two persons married to each other according to the rules of the Commonwealth of Massachusetts.

Coverage Date — the date medical coverage begins.

Coverage Types — a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. These coverage types include the following: MassHealth Standard (Standard), MassHealth Essential (Essential), MassHealth Limited (Limited), MassHealth Senior Buy-In (Senior Buy-In), and MassHealth Buy-In (Buy-In). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Curing of a Transfer — the return, following the transfer for less than fair-market value of a portion of, or the full uncompensated value of, a resource to the individual.

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

515.002: Introduction to MassHealth

(A) MassHealth administers and is responsible for the delivery of health-care services to its members.

(B) 130 CMR 515.000 through 522.000 (referred to as Volume II) provide the requirements for noninstitutionalized persons aged 65 or older, institutionalized persons of any age, persons who would be institutionalized without community-based services, as defined by Title XIX of the Social Security Act and authorized by Massachusetts General Laws (M.G.L.) c. 118E, and certain Medicare beneficiaries. These regulations are intended to conform to all applicable federal and state laws and will be interpreted accordingly.

(C) The requirements for coverage of noninstitutionalized low- and moderate-income persons under age 65, as prescribed under a 1115 Medicaid Research and Demonstration Waiver, are described in 130 CMR 501.000 through 508.000.

515.003: MassHealth Coverage Types

(A) MassHealth provides access to health care by determining eligibility for the coverage types that provide the most comprehensive benefits for a person who may be eligible. Generally, members are provided services on a fee-for-service basis as defined at 130 CMR 515.001.

(B) MassHealth offers the following types of coverage: MassHealth Standard, MassHealth Essential, MassHealth Limited, MassHealth Senior Buy-In, and MassHealth Buy-In. The type of coverage for which a person is eligible is based on the person's or the spouse's income and assets, as described in 130 CMR 519.000 and 520.000, and immigration status, as described in 130 CMR 518.000.

(C) MassHealth may limit the number of people who can be enrolled in MassHealth Essential. When MassHealth imposes such a limit, no new applicants aged 65 or older who are subject to these limitations will be added to MassHealth Essential, and current MassHealth Essential members who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until MassHealth is able to reopen enrollment for adults.

(1) Applicants who cannot be enrolled under MassHealth Essential pursuant to 130 CMR 515.003(C), will be placed on a waiting list when their eligibility has been determined. When MassHealth is able to open enrollment for adult applicants, the applications will be processed in the order they were placed on the waiting list.

(2) Medical coverage for MassHealth Essential for persons enrolled from a waiting list will begin on the date that the application or new determination is processed from the waiting list.

515.004: Administration of MassHealth

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

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA). The Department of Transitional Assistance administers the Emergency Aid for the Elderly, Disabled and Children (EAEDC) Program. Persons receiving EAEDC who are 65 or older are automatically eligible for MassHealth Standard coverage, if they meet the citizen and immigration rules for MassHealth Standard at 130 CMR 518.002. Aliens with special status described in 130 CMR 518.002(D) who are receiving EAEDC who are aged 65 or older are automatically eligible for MassHealth Essential coverage pursuant to 130 CMR 515.003(C).

(2) Social Security Administration (SSA). District Social Security offices administer the Supplemental Security Income (SSI) Program and determine the eligibility of persons aged 65 or older. Persons receiving SSI who are 65 or older are automatically eligible for MassHealth Standard coverage.

(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 515.001.

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in his or her MassHealth case file and contest the accuracy of the information.

(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 MassHealth. 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. MassHealth will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, MassHealth will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from MassHealth has limited English proficiency or sensory impairment and requests interpreter services; or

(2) MassHealth determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. MassHealth provides a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard, CommonHealth, Essential, or Basic has ended. MassHealth issues a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by private insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents are included on the Certificate.

515.008: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with MassHealth in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery.

(B) Responsibility to Report Changes. The applicant or member must report to MassHealth, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, assets, inheritances, gifts, transfers of and proceeds from the sale of real or personal property, distributions from or transfers into trusts, address, the availability of health insurance, immigration status, 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.

516.001: Overview

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

(B) All applicants must file an application for MassHealth at a MassHealth Enrollment Center or outreach site.

(C) MassHealth may request additional information or documentation, if necessary, to determine eligibility.

(1) MassHealth sends the applicant written notification requesting verifications to corroborate information necessary to determine eligibility, generally within five days of the receipt of the application.

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

(D) If the requested information, with the exception of verification of immigration status, is not provided within 30 days of the date of the request, MassHealth benefits may be denied.

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

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

(3) If a reapplication is subsequently denied and not appealed, the applicant must submit a new written application for benefits to pursue eligibility for MassHealth. The earliest date of application then becomes the date of the new written application.

516.002: Date of Application

(A) The date of application is the date that a completed application is received at a MassHealth Enrollment Center or outreach site. An application is considered complete when all financially related questions have been answered. If unsigned, the application is returned for a signature during the verification process.

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

516.003: Matching Information

MassHealth initiates matches with other agencies when an application for MassHealth is received in order to update or verify eligibility. These agencies and matches may include, but are not limited to, the following agencies: the Department of Employment and Training, Department

of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and banks and other financial institutions.

516.004: Time Standards for Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, a determination of eligibility must be made within 45 days from the date of receipt of the complete application for MassHealth.

(B) For applicants who apply for MassHealth on the basis of a disability, a determination of eligibility must be made within 90 days from the date of receipt of the complete application, including a disability supplement, if required. If MassHealth determines unusual circumstances exist, the timeframes for determining eligibility are extended.

516.005: Coverage Date

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

516.006: Eligibility Determination

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

(1) as a result of a member's reported changes in circumstances;

(2) by external matching with other agencies; and

(3) where matching is not available, through a written update of the member's circumstances on a prescribed form.

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

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

(7) (a) Veterans of the United States Armed Forces with an honorable discharge not related to their alien status.

(b) Filipino war veterans who fought under U.S. command during WWII.

(c) Hmong and Highland Lao veterans who are admitted for legal permanent residence (LPR) and who fought under U.S. command during the Vietnam War.

(d) Persons with alien status on active duty in the U.S. Armed Forces, other than active duty for training.

(e) The spouse, unremarried surviving spouse, or unmarried dependent children of the alien described in 130 CMR 518.002(B)(7)(a) through (d).

(8) Aliens or their unmarried dependent children, as defined in federal law, who have been subjected to battery or extreme cruelty by their spouse, parent, sponsor, or a member of their household, and who no longer live in the same household as the batterer.

(9) Persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980.

(10) Native Americans with at least 50 percent American Indian blood who were born in Canada pursuant to section 289 of the INA or other tribal members born in territories outside of the U.S. pursuant to 25 U.S.C. 450b(e).

(11) Amerasians admitted pursuant to section 584 of Public Law 100-202.

(12) Victims of severe forms of trafficking.

(C) Protected Alien. Aliens who are not qualified aliens but who are aliens with special status or nonqualified aliens, as described at 130 CMR 518.002(D) and (E), are considered protected aliens and may receive MassHealth regardless of immigration status, if they meet one of the following conditions and are otherwise eligible. This status continues until a determination of ineligibility due to failure to meet categorical or financial eligibility requirements has been made.

(1) They were receiving medical assistance on June 30, 1997.

(2) They had a long-term-care application pending on July 1, 1997.

(3) They lived in a long-term-care facility on June 30, 1997, but had not yet applied for MassHealth.

(D) Alien with Special Status. Certain aliens who are not qualified aliens are afforded eligibility for MassHealth based on provisions of state law as described in 130 CMR 518.002(D).

(1) Persons permanently living in the United States under color of law (PRUCOLs) are described in 42 CFR 435.408(b)(3) through (7), (b)(10) through (14), and (b)(16), and include the following.

(a) Aliens living in the United States in accordance with an indefinite stay of deportation.

(b) Aliens living in the United States in accordance with an indefinite voluntary departure.

(c) Aliens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the United States Department of Homeland Security (DHS) does not contemplate enforcing.

(d) Aliens who have filed applications for adjustment of status that the DHS has accepted as "properly filed," and whose departure the DHS does not contemplate enforcing.

(e) Aliens granted stays of deportation by court order, statute, or regulation, by individual determination of the DHS, or relevant DHS instructions, and whose departure the DHS does not contemplate enforcing.

(f) Aliens granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing.

(g) Aliens granted deferred action status.

(h) Aliens living under orders of supervision.

(i) Aliens who have entered and continuously lived in the United States since before January 1, 1972.

(j) Aliens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing.

(k) Any other aliens living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include permanent nonimmigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.)

(2) Persons described below who are not otherwise defined as qualified aliens under 130 CMR 518.002(B) are the following.

(a) Persons admitted for legal permanent residence (LPR) under the INA.

(b) Persons granted parole for at least one year under section 212(d)(5) of the INA.

(c) Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980.

(E) Nonqualified Alien. Aliens whose status is not described in 130 CMR 518.002(B), (C), or (D) are considered nonqualified aliens.

(F) Applicable Coverage Types.

(1) Citizens, qualified aliens, and protected aliens may receive MassHealth under any coverage type for which they are eligible.

(2) Aliens with special status may not receive coverage under MassHealth Standard, Buy-In, Senior Buy-In, or CommonHealth. However, they may be eligible for MassHealth Essential if they meet the eligibility requirements in 130 CMR 519.013 and MassHealth Limited if they meet the eligibility requirements of Essential at 130 CMR 519.013.

(3) Nonqualified aliens may only receive MassHealth Limited if they meet the eligibility requirements at 130 CMR 519.009.

(G) Verification of Immigration Status.

(1) A determination of eligibility is made as of the date the application and all required information, except verification of immigration status, is received by MassHealth.

(2) MassHealth submits the names of qualified aliens to the DHS for confirmation of immigration status.

(3) MassHealth requests verification of immigration status subsequent to the eligibility determination from:

(a) qualified aliens who did not submit verification of their immigration status with the application, and for whom the DHS has been unable to confirm their status as described at 130 CMR 518.002(G)(2); and

(b) aliens with special status who did not submit verification of their immigration status with the application.

(4) Aliens who fail to submit verification of their immigration status as described in 130 CMR 518.002(G)(3) within 60 days of MassHealth's information request are subsequently eligible only for MassHealth Limited if they meet the eligibility requirements of 130 CMR 519.009.

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519.001: Introduction

(A) Categorical Requirements and Financial Standards. 130 CMR 519.000 explains the categorical requirements and financial standards that must be met to qualify for a MassHealth coverage type. The rules of financial responsibility and the calculation of financial eligibility are detailed in 130 CMR 520.000.

(B) MassHealth Coverage Types. The MassHealth coverage types available to individuals aged 65 and older, institutionalized individuals, and those who would be institutionalized without community-based services are the following:

(1) MassHealth Standard;

(2) MassHealth Limited;

(3) MassHealth Senior Buy-In;

(4) MassHealth Buy-In;

(5) MassHealth CommonHealth; and

(6) MassHealth Essential.

(C) Determining Eligibility. MassHealth determines eligibility for the most comprehensive coverage available to the applicant, although the applicant has the right to choose to have eligibility determined only for Senior Buy-In or Buy-In coverage. If no choice is made by the applicant, MassHealth determines eligibility for all available coverage types.

519.002: MassHealth Standard

(A) Overview.

(1) 130 CMR 519.002 through 519.007 contain the categorical requirements and asset and income standards for MassHealth Standard, which provides coverage for individuals aged 65 and older, institutionalized individuals, and those who would be institutionalized without community-based services.

(2) Individuals eligible for MassHealth Standard are eligible for medical benefits on a fee-for-service basis as defined in 130 CMR 515.001. The medical benefits are described in 130 CMR 450.105(A).

(3) The begin date of medical coverage for MassHealth Standard is established in accordance with 130 CMR 516.005.

(4) MassHealth pays the following costs for members eligible for MassHealth Standard who meet the requirements of 130 CMR 519.010(A)(1) and (2). Coverage generally begins on the first day of the month following the date of MassHealth's eligibility determination.

(a) the cost of the Medicare Part B premiums;

(b) the cost of Medicare Part A premiums for adult members of MassHealth Standard who are entitled to Medicare Part A; and

(c) the deductibles and coinsurance under Medicare Parts A and B.

(B) Automatic Eligibility for SSI Recipients.

(1) Individuals described in 130 CMR 519.002(A)(1) who meet basic, categorical, and financial requirements under the Supplemental Security Income (SSI) program are automatically eligible to receive MassHealth Standard coverage.

(2) Eligibility for retroactive coverage must be established by MassHealth in accordance with 130 CMR 516.005.

(C) Extended Eligibility for SSI Recipients. An individual whose SSI assistance has been terminated, and who is determined to be potentially eligible for MassHealth, continues to receive MassHealth Standard coverage until a determination of ineligibility is made by MassHealth.

(D) Automatic Eligibility for EAEDC Recipients Aged 65 and Older.

(1) Individuals aged 65 and older who meet the requirements of the EAEDC program administered by DTA and who are United States citizens or qualified aliens, as described in 130 CMR 518.002, are automatically eligible for MassHealth Standard benefits.

(2) Individuals aged 65 and older who meet the requirements of the EAEDC program administered by DTA and who are aliens with special status, as described in 130 CMR 518.002(D), are automatically eligible for MassHealth Essential benefits under 130 CMR 519.013.

519.003: Pickle Amendment Cases

(A) Eligibility Requirements. Under the Pickle Amendment, former SSI recipients whose income exceeds 100 percent of the federal poverty level are eligible for MassHealth Standard provided they:

(1) or their spouse or both are receiving RSDI benefits;

(2) were eligible for and received SSI benefits after April 1977;

(3) would be currently eligible for SSI, in accordance with SSI payment standards at 130 CMR 519.003(B), if the incremental amount of RSDI cost-of-living increases paid to them since the last month subsequent to April 1977, for which they were both eligible for and receiving SSI and entitled to (but not necessarily receiving) RSDI were deducted from the current amount of RSDI benefits. Cost-of-living increases referred to in 130 CMR 519.003 include increases received both by the applicant or member or by the spouse. The spouse need not be otherwise eligible for SSI; and

(4) have countable assets that are $2,000 or less for an individual, and $3,000 or less for a married couple**.**

(B) SSI Payment Standards. The RSDI amount, as described in 130 CMR 519.003(A)(3), and any other countable-income amount, as defined in 130 CMR 520.009, of the individual or couple is compared to the SSI payment standards to determine Pickle eligibility.

MASSACHUSETTS SSI PAYMENT STANDARDS

	LIVING ARRANGEMENT CATEGORY				
	A	**B**	**C**	**E**	**G**
Individual	**Full Cost of Living Expenses**	**Shared Living Expenses**	**Household of Another**	**Licensed Rest Home**	**Assisted Living**
Aged	$692.82	603.26	480.36	857.00	1018.00
Disabled	678.39	594.40	463.58	857.00	1018.00
Blind	713.74	713.74	713.74	713.74	1018.00
Member of a Couple					
Aged	$523.86	523.86	389.90	857.00	763.50
Disabled	513.03	513.03	379.09	857.00	763.50
Blind	713.74	713.74	713.74	713.74	763.50

NOTE: The personal-needs allowance in licensed rest homes is $60. The personal-needs allowance in nursing facilities and chronic-disease hospitals is $65.

(C) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards in 130 CMR 519.003 may establish eligibility by reducing assets in accordance with 130 CMR 520.004, meeting a deductible as described in 130 CMR 520.028 et seq., or both.

(c) have a countable income amount (including the income of the spouse with whom he or she lives) that is equal to or greater than 120 percent of the federal poverty level and less than 135 percent of the federal poverty level; and

(d) have countable assets of $4,000 or less for an individual, or $6,000 or less for a married couple living together.

(2) Benefits. MassHealth pays the entire Medicare Part B premium, in accordance with section 1933 of the Social Security Act (42 U.S.C. § 1396u-3), for members who meet the requirements of 130 CMR 519.011(B) and have a countable income amount that is less than 135 percent of the federal poverty level. Such payments are made through the state Medicare Buy-In process.

(3) Eligibility Coverage Period.

(a) MassHealth Buy-In coverage, in accordance with 130 CMR 519.011(B), begins with the month of application. Coverage may be retroactive up to three months before the month of application provided:

(i) the retroactive date does not extend into a calendar year in which the expenditure cap described at 130 CMR 519.011(B)(4) has been met;

(ii) the retroactive date is not earlier than October 1, 1998; and

(iii) the applicant was not receiving MassHealth during the retroactive period.

(b) Once determined eligible, a member who continues to meet the requirements of 130 CMR 519.011(B) is eligible for the balance of the calendar year. Such members are not adversely impacted by the provisions of 130 CMR 519.011(B)(4).

(4) Cap on Expenditures.

(a) MassHealth does not extend eligibility to individuals who meet the requirements of 130 CMR 519.011(B), if MassHealth estimates the amount of assistance provided to these members during the calendar year will exceed the state's allocation, as described in section 1933 of the Social Security Act.

519.013: MassHealth Essential

(A) Eligibility Requirements. MassHealth Essential is available to community residents aged 65 and older who are aliens with special status as described in 130 CMR 518.002(D), and who meet the following requirements:

(1) the countable-income amount, as defined in 130 CMR 520.009, of the individual or married couple living together is less than or equal to 100 percent of the federal poverty level; and

(2) the countable assets of an individual are $2,000 or less, and those of a married couple living together are $3,000 or less.

(B) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.013(A) may establish eligibility for MassHealth Essential by reducing their assets in accordance with 130 CMR 520.004, meeting a deductible as described at 130 CMR 520.028 et seq., or both.

(C) Benefits. Individuals eligible for MassHealth Essential are eligible for medical benefits on a fee-for-service basis as defined in 130 CMR 515.001. These medical benefits are described in MassHealth's regulations at 130 CMR 450.105(I).

(D) Coverage Date. The begin date of medical coverage is established in accordance with 130 CMR 516.005, but no earlier than June 1, 2004. MassHealth Essential members are eligible for medical coverage under MassHealth Limited prior to June 1, 2004, if otherwise eligible for MassHealth Limited as described in 130 CMR 519.009.

(E) Funding. State legislation authorizes funding for MassHealth Essential as of June 1, 2004, but does not provide funding for MassHealth Essential after September 30, 2004. MassHealth Essential benefits will not be provided after this date unless a legislative extension is authorized. MassHealth Essential members receiving benefits under 130 CMR 519.013 on September 30, 2004, will be established as MassHealth Limited as of October 1, 2004, if otherwise eligible for MassHealth Limited.

520.003: Asset Limit

(A) The total value of countable assets owned by or available to individuals applying for or receiving MassHealth Standard, Essential, or Limited may not exceed the following limits:

(1) for an individual — $2,000; and

(2) for a couple living together in the community where there is financial responsibility according to 130 CMR 520.002(A)(1) — $3,000.

(B) The total value of countable assets owned by or available to individuals applying for or receiving MassHealth Senior Buy-In, as described in 130 CMR 519.010, or MassHealth Buy-In, as described in 130 CMR 519.011, may not exceed the following limits:

(1) for an individual — $4,000; and

(2) for a couple living together in the community where there is financial responsibility according to 130 CMR 520.002(A)(1) — $6,000.

(C) The treatment of a married couple's assets when one spouse is institutionalized is described in 130 CMR 520.016(B).

520.004: Asset Reduction

(A) Criteria.

(1) An applicant whose countable assets exceed the asset limit of MassHealth Standard, Essential, or Limited may be eligible for MassHealth:

(a) as of the date the applicant reduces his or her excess assets to the allowable asset limit without violating the transfer of resource provisions for nursing-facility residents at 130 CMR 520.019(F); or

(b) as of the date, described in 130 CMR 520.004(C), the applicant incurs medical bills that equal the amount of the excess assets and reduces the assets to the allowable asset limit within 30 days after the date of the notification of excess assets.

(2) In addition, the applicant must be otherwise eligible for MassHealth.

(B) Evaluating Medical Bills. MassHealth does not pay that portion of the medical bills equal to the amount of excess assets. Bills used to establish eligibility:

(1) cannot be incurred before the first day of the third month prior to the date of application as described at 130 CMR 516.002;

(2) must not be the same bills or the same portions of the bills that are used to meet a deductible based on income; and

(3) for MassHealth Essential, must be incurred on or after the effective date of the coverage type.

(C) Date of Eligibility. The date of eligibility for otherwise eligible individuals described at 130 CMR 520.004(A)(1)(b) is the date that his or her incurred allowable medical expenses equaled or exceeded the amount of his or her excess assets.

(1) If after eligibility has been established, an individual submits an allowable bill with a medical service date that precedes the date established under 130 CMR 520.004(C), MassHealth readjusts the date of eligibility.

(2) In no event will the first day of eligibility be earlier than the first day of the third month before the date of the application, if permitted by the coverage type.

(D) Verification. MassHealth requires the applicant to verify that he or she incurred the necessary amount of medical bills and that his or her excess assets were reduced to the allowable asset limit within required timeframes.

520.005: Ownership of Assets

(A) General. Assets owned exclusively by an applicant or member and the spouse are counted in their entirety when determining eligibility for MassHealth, except when assessing assets in accordance with 130 CMR 520.016.

(B) Joint Ownership of Assets, Other Than Bank Accounts. Any asset, other than a joint bank account, jointly owned by two or more individuals, is presumed to be owned in equal shares and counted proportionately unless a different distribution of ownership is verified or unless assets are being assessed in accordance with 130 CMR 520.016. When such a different distribution of ownership is verified, MassHealth attributes the countable value of the assets to the applicant or member or the spouse in proportion to the ownership interest.

(C) Joint Bank Accounts.

(1) Bank accounts are defined at 130 CMR 520.007(B)(1).

(2) When the applicant or member is a joint owner of a bank account, the entire amount on deposit is considered available to the applicant or member, except when assessing assets in accordance with 130 CMR 520.016.

(3) If the applicant or member claims partial ownership of the funds in the joint account, he or she must verify the amount owned by each joint depositor. When such a partial ownership is verified, the countable value of the assets is attributed to each owner in proportion to the ownership interest.

(4) The applicant or member may transfer the funds owned by him or her into an account that accurately reflects his or her ownership interest. MassHealth does not consider such a transfer of assets to make oneself eligible for MassHealth if the transfer is completed within 30 days after written notification by MassHealth of this requirement, except in the case of a community spouse as described at 130 CMR 520.016 who is allowed 90 days to make the transfer.

(f) Hardship.

(i) If exceptional circumstances exist that make the deductions allowed under 130 CMR 520.026(E) insufficient to cover the expenses required for a guardian to provide essential guardianship services needed to gain access to or consent to medical treatment, the guardian, on behalf of the member, may appeal to the Board of Hearings for an increased deduction.

(ii) A hearing officer may allow for an increased deduction for guardianship expenses only in circumstances where the issues surrounding the member's need to gain access to or consent to medical treatment are extraordinary.

(iii) Extraordinary circumstances may exist when:

1. there is a need for a guardian to consistently spend more than 24 hours per year providing guardianship services to appropriately consent to medical treatment needed by the member; or

2. the circumstances of a MassHealth member cause the guardian appointment or application process to be particularly complex and significantly more costly than the deduction allowed at 130 CMR 520.026(E)(3)(a) or (b).

(g) Guardianship Services and Expenses that are not Deductible. The following fees and costs are not allowed as a deduction under 130 CMR 520.026(E).

(i) Amounts that are also used to reduce a member's assets under 130 CMR 520.004.

(ii) Amounts that are also used to meet a deductible or any other deduction allowed under MassHealth regulations.

(iii) Expenses related to the appointment of a guardian for an applicant when the appointment is made more than six months before submission of a MassHealth application.

(iv) Expenses related to the appointment of a guardian for an applicant or member when the applicant or member does not request a deduction for the appointment within six months of the date of application or date of appointment, whichever is later. However, these expenses may be used as allowed pursuant to 130 CMR 506.009 or 520.032 to meet a deductible.

520.030: Calculating the Deductible

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

MASSHEALTH DEDUCTIBLE-INCOME STANDARDS		
Number of Persons	Monthly-Income Standard for Community Residents	Monthly-Income Standard for Long-Term-Care-Facility Residents
1	$522	$60
2	650	

520.031: Notification of Potential Eligibility

(A) MassHealth informs the applicant who has excess monthly income that he or she is currently ineligible for MassHealth Standard, Essential, or Limited but may establish eligibility for a six-month period by meeting the deductible. MassHealth informs the applicant in writing of the following:

(1) the deductible amount and the method of calculation;

(2) the start and end dates of the deductible period;

(3) the procedures for submitting medical bills;

(4) his or her responsibility to report all changes in circumstances that may affect eligibility or the deductible amount; and

(5) that the bills submitted to meet the deductible are the responsibility of the individual and cannot be submitted for MassHealth payment.

(B) A member who has established eligibility based upon meeting a deductible is only eligible for MassHealth Standard, Essential, or Limited until the end of the deductible period. At the end of the deductible period, MassHealth notifies the member in writing of a new deductible period and amount, if the countable-income amount continues to exceed applicable income standards.

520.035: Conclusion of the Deductible Process

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

520.036: Copayments Required by MassHealth

MassHealth requires MassHealth members to make the copayments described in 130 CMR 520.038, up to the calendar-year maximum described in 130 CMR 520.040, except as excluded in 130 CMR 520.037. If the usual and customary fee for the service or product is less than the copayment amount, the member must pay the amount of the service or product.

520.037: Copayment Requirement Exclusions

(A) Excluded Individuals.

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

(a) members under 19 years of age;

(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15, she is exempt from the copayment requirement until August 1);

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for Medicare-covered drugs 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 the mentally retarded or are admitted to hospitals from such facilities;

(f) members receiving hospice services; and

(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106, if they do not receive MassHealth Standard or MassHealth Essential.