

2.0 | MassHealth Eligibility

This chapter describes the rules and processes that will be used in determining the eligibility of MassHealth members. The material in this chapter addresses eligibility-related issues.

Eligibility will be effective ten (10) calendar days prior to the EOHHS's receipt of an application if certain conditions are met, except for MassHealth Basic, MassHealth Essential, MassHealth Buy-in, and premium assistance payments under the Family Assistance Plan.

Eligibility requirements for MassHealth Standard are expanded by offering coverage to children through the age of 18 and increasing the financial eligibility standards for pregnant women and newborns to 200% FPL and for children, aged one through 18, to 150% FPL, and parents and disabled adults to 133% FPL. In addition, certain women with breast or cervical cancer are also eligible for MassHealth Standard. Also MassHealth Standard eligibility is expanded to include independent foster care adolescents who age out of DSS care or custody until the age of 21 without regard to income or assets.

Children whose family's self-declared income meets the Standard income requirements will be determined presumptively eligible for Standard. Uninsured children with self-declared family income between 150-200% FPL will be determined presumptively eligible for Family Assistance.

Family Assistance offers coverage to children through either the purchase of medical benefits for uninsured children or through premium assistance for children who have, or have access to, health insurance.

Adults without dependent children who are employed by a small business employer and have income equal to or under 200% FPL are also eligible for premium assistance through the Insurance Partnership (IP) program. Effective October 1, 2006, eligibility for the IP will expand to include members with gross family income at or below 300% of the FPL.

MassHealth Family Assistance is available to persons with HIV disease whose family income is at or below 200% FPL. Individuals who do not have employer sponsored health insurance will be offered coverage through the purchase of medical benefits while those who have or choose to enroll in employer sponsored health insurance will be provided premium assistance.

MassHealth Basic and Essential are available to certain recipients of state-funded cash assistance and long-term unemployed adults to 100% FPL.

Under CommonHealth, MassHealth has retained a modified spenddown approach (referred to here as a deductible), which is a one-time spenddown rule for that portion of

the non-working disabled population (i.e. SSI-related) with incomes over 133% FPL. This rule is described in **Section 2.1.4.9**.

MassHealth may limit the number of adults (age 19 and over) who can be enrolled in MassHealth Family Assistance, and Essential. MassHealth will impose such a limit if it determines that it does not have sufficient appropriations remaining in a fiscal year to cover its expenditures. When MassHealth imposes such a limit, no new adult applicants will be added to these coverage types, and current adult members in these coverage types who lose eligibility for any reason will not be allowed to reenroll until MassHealth is able to reopen enrollment for adults in these coverage types.

Applicants, who cannot be enrolled for the reason detailed above, 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.

2.1 Description of Eligibles

This section describes the eligibility requirements that must be met to receive medical benefits under MassHealth. These requirements include:

- Universal eligibility requirements that are common to all members, (e.g., residence) (**Section 2.1.1**);
- Citizenship and immigration requirements (**Section 2.1.2**);
- Eligibility requirements by coverage type (**Section 2.1.3**); and
- Calculation of financial eligibility (**Section 2.1.4**).

2.1.1 Universal Eligibility Requirements

All Mass Health applicants and members must meet the following requirements (Sections 2.1.1.1 through 2.1.1.6) as a condition of eligibility.

2.1.1.1 Residence Requirements

As a condition of eligibility an applicant or member must:

- Live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or
- Live in the commonwealth at the time of application having entered the Commonwealth with a job commitment, whether or not currently employed, (also applicable to migrant or seasonal workers.)

Examples of applicants or members who generally do not meet the residency requirement for MassHealth are:

- Students under age 19 whose parents reside out of state; and

- Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts.

Applicants and members who are residents of non-acute medical institutions and whose placement is expected to last at least 30 days may not have eligibility for MassHealth determined under the rules of this chapter. Eligibility for these individuals must be determined under the provisions of Title XIX.

2.1.1.1.1 Individuals in Penal Institutions

Inmates of penal institutions may not receive MassHealth benefits except under one of the following conditions, if they are otherwise eligible for MassHealth:

- They are inpatients in a medical facility; or
- They are residing outside of the penal institution and are not returning to the institution for overnight stays.

2.1.1.2 Social Security Number (SSN) Requirements

As a condition of eligibility for any MassHealth coverage type with the exception of MassHealth Limited, applicants and members must furnish an SSN. Applicants who do not have an SSN will be notified of their obligation to apply for one.

MassHealth shall verify each applicant's SSN by a computer match with the Social Security Administration.

2.1.1.2.1 Right to Know Uses of Social Security Numbers

All household members will be given written notice in a booklet accompanying their MassHealth Benefit Request of the following:

- The reason the SSNs are requested;
- The computer-matching with SSNs in other personal data files within MassHealth, other government agencies, and elsewhere; and
- That failure to provide the SSN of any person receiving or applying for benefits may result in denial or termination of his or her benefits.

2.1.1.3 Utilization of Potential Health Insurance Benefits

MassHealth pays for medical benefits only when no other source of payment is available. Applicants and members are required, as a condition of eligibility to obtain or maintain health insurance when MassHealth determines it is cost effective to do so. Members of Standard or CommonHealth may participate in MassHealth Standard/CommonHealth Premium Assistance (MSCPA), where MassHealth purchases cost-effective private health insurance on behalf of the member and the member receives wrap services from MassHealth. MSCPA participants are not required to contribute more

towards the cost of their health insurance than they would pay without access to health insurance. MassHealth Standard and CommonHealth members who do not obtain or maintain available health insurance will be denied MassHealth benefits or lose MassHealth eligibility for all of those in the family group, unless the individual is under age 19 or pregnant.

Standard and CommonHealth members described in Sections 2.1.3.1.2.1.3.1.1, 2.1.3.1.4.1, 2.1.3.1.4.2, 2.1.3.1.6 if over age 18, 2.1.3.3., 2.1.3.3.1, and 2.1.3.3.2, who are otherwise eligible may receive fee for service benefits during a 60-day period while MassHealth investigates if they have or have access to cost-effective private health insurance that meets the basic benefit level (BBL). If MassHealth determines the private health insurance available to the member does not meet the requirements for MSCPA, the member is notified in writing and will continue receiving MassHealth Standard or CommonHealth benefits, but not necessarily on a fee for service basis. MassHealth does not consider insurance available to the member if he or she is unable to enroll due to open-enrollment periods for a private health insurance plan that is not subject to Massachusetts Law. If it is verified that the available private health insurance is cost effective, the members will be required to obtain and maintain the insurance and will receive premium subsidies and a wrap benefit. The member may receive an additional time-limited 60-day fee for service benefit while he or she enrolls in the private health insurance. If the member fails to enroll or to maintain the insurance at the end of the second 60-day period, the member will lose MassHealth benefits, unless he or she is under age 19 or pregnant.

Family Assistance members described in **Sections 2.1.3.4.6.1 and 2.1.3.4.6.2** who have or have access to private health insurance which meets the Basic Benefit Level generally will be required to obtain or maintain that insurance and are eligible to receive a premium assistance payment from MassHealth. They will not be provided any wrap services. Families with dependent children will be required to contribute to the cost of the health insurance premium if their family group gross income is greater than 150% of the FPL. MassHealth will also pay co-payments and deductibles in certain circumstances.

Adults without dependent children whose family group gross income is less than or equal to 200% of the FPL (effective October 1, 2006, less than or equal to 300% of the FPL) will be required to contribute to the cost of the health insurance premium if their family group gross income is greater than 100% FPL.

2.1.1.4

Assignment of Rights to Medical Support and Third Party Payments

Every legally able applicant or member must assign to MassHealth his or her own rights to medical support and third party payments for medical services

provided under MassHealth as well as the rights of those for whom he or she can legally assign medical support and third party payments.

The applicant or member must provide MassHealth with information to help pursue any medical support and source of third party payment, including support available from the absent parent, who is legally obligated to pay for care and services for the applicant/member and/or for person(s) on whose behalf benefits are requested unless he or she can show good cause not to provide this information.

2.1.1.5 Good Cause for Noncooperation

Good cause for non-cooperation in complying with **Section 2.1.1.4** is present if at least one of the following circumstances exists regarding the child of the applicant or member:

- The child was conceived as a result of incest or forcible rape;
- Legal proceedings for adoption are pending before a court;
- A public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three (3) months; or
- Cooperation would result in serious harm or emotional impairment to the child or relative with whom the child resides or to the applicant or member.

2.1.1.6 Assignment for Third Party Recoveries

As a condition of eligibility, an applicant or member must inform MassHealth when a household member is involved in an accident, or suffers from an illness or injury, which has or may result in a lawsuit or insurance claim. The applicant or member must;

- File a claim for compensation;
- Assign to MassHealth the right to recover, as allowable, an amount equal to the MassHealth benefits provided from either the member or the third party;
- Provide information about the third party claim and cooperate with MassHealth's Post Payment Recovery Unit unless MassHealth determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to the applicant or member.

2.1.2 Citizenship and Immigration Requirements

In determining eligibility, MassHealth evaluates the individual's citizenship/immigration status. In making this evaluation, individuals are determined to be citizens; qualified aliens; aliens meeting specific criteria and referred to as aliens with special status; protected aliens; and nonqualified aliens.

Those aliens whom MassHealth has defined as protected aliens and aliens with special status always receive services (except for emergency services) at full state

cost. All services and benefits to aliens that are provided at full state cost are not part of this demonstration.,

But information pertaining to these services and benefits is included herein only to provide a comprehensive overview. These state-funded services and benefits are subject to changes of state law and regulations, and such changes may be implemented without amendment of the MassHealth 1115 Demonstration Project.

2.1.2.1

Citizen

A citizen of the United States is:

- An individual born in the United States or its territories, including Puerto Rico, Guam, and the U.S. Virgin Islands;
- An individual born of a parent who is a U.S. citizen; or
- A naturalized citizen

2.1.2.1.1

Qualified Aliens

The following persons, for the purpose of MassHealth eligibility, are considered qualified aliens:

- a) Persons granted asylum under section 208 of the Immigration and Nationality Act (INA);
- b) Refugees admitted under section 207 of the INA;
- c) Persons whose deportation has been withheld under section 243(h) or 241(b)(3) of the INA, as provided by s5562 of the federal Balanced Budget Act of 1997;
- d) Veterans of the United States Armed Forces with an honorable discharge not related to their alien status;
- e) Filipino war veterans who fought under U.S. command during WWII;
- f) Hmong and Highland Lao veterans who are admitted for legal permanent residence (LPR) and who fought under U.S. command during the Vietnam war;
- g) persons with alien status on active duty in the U.S. Armed forces, other than active duty for training;
- h) The spouse, unremarried surviving spouse, or unmarried dependent children of the alien described in (a) through (d);
- i) 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 reside in the same household as the batterer;
- j) persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980;
- k) 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 USC450 (b)(e);

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The charts provided in **Attachment 2.4** summarize by coverage type and funding source, citizenship/immigration requirements, categorical requirements the corresponding MMIS category of assistance, income standards, and service delivery mechanism. The MMIS category designates whether or not an individual's services are federally reimbursable. The following sections describe requirements for an individual to be defined as a citizen, qualified alien, alien with special status, protected alien, or nonqualified alien. The term "qualified alien" is defined here for MassHealth purposes and is not identical to the definition of "qualified alien" in 8U.S.C.164(b). However, federally reimbursable benefits provided under MassHealth are in compliance with federal law.¶

- l) Amerasians admitted pursuant to section 584 of Public Law 100-202; Persons admitted for legal permanent resident (LPR) under the INA; Persons granted parole for at least one year under section 212(d)(5) of the INA; and
- m) Conditional entrants under section 203(a)(7) of the INA as in effect prior to April 1, 1980.

These optional aliens (items k – m above), if they arrived prior to 8/22/96, or if they arrived later and have had their status for five or more years, will be provided federally reimbursable benefits, if otherwise eligible. This time limitation will not apply if they are also qualified under one of the preceding categories (first eight bullets above).

2.1.2.1.2

Aliens with Special Status

Persons described in the bullets below who entered the United States on or after 8/22/96 and have not had their status for five or more year are referred to as “aliens with special status” provided they are not also described in the first eight bullets of **section 2.1.2.1.2**

Persons admitted for legal permanent residence (LPR) under the INA;
Persons granted parole for at least one year under section 212(d)(5) of the INA; and
Conditional entrants under section 203(a)(7) of the INA as in effect prior to April 1, 1980.

In addition, persons permanently residing in the United States under color of law (PRUCOLS) as described in 42 CFR 435,408(b)(3) through (b)(7), (b)(10) through (b)(14), and (b)(16) are also referred to as aliens with special status.

Benefits provided to aliens with special status shall, except for MassHealth Limited, be provided at full state cost.

2.1.2.1.3

Protected Aliens

Persons who were receiving medical assistance or CommonHealth on the date of the demonstration’s implementation and who meet one of the following immigration statuses, shall be considered protected aliens:

Aliens with Special Status (legal permanent residents, parolees, and conditional entrants) entering the United States on or after 8/22/96; and
Aliens whose immigration status met medical assistance eligibility requirements prior to July 1, 1997, and who are not considered qualified aliens. These include persons permanently residing in the United States under color of law.

2.1.2.1.4

Nonqualified Aliens

Any alien not defined as a qualified alien, an alien with special status, or a protected alien.

2.1.2.1.5

Verification of Immigration Status

For aliens, a determination of eligibility will be made once the application is complete except for documentation of immigration status. Aliens who have not submitted documentation of immigration status within sixty (60) days of the date of the eligibility determination, or whose verification cannot be confirmed by the United States Department of Homeland Security; shall subsequently;

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- Be eligible only for MassHealth Limited if otherwise eligible for MassHealth Standard except for women described in **Section 2.1.3.1.7**; or
- Be ineligible for any MassHealth benefit if not otherwise eligible for MassHealth Standard.

2.1.3 Eligibility Requirements by Coverage Type

There are seven MassHealth Coverage Types:

- MassHealth Standard for children, independent foster care adolescents who age out of DSS care or custody until the age of 21, families, pregnant women, disabled individuals and certain women with breast or cervical cancer;
- Prenatal for pregnant women;
- CommonHealth for disabled adults and disabled children who are not eligible for Standard;
- Family Assistance for children and for aliens with special status who are under age 19 who are not eligible for Standard or CommonHealth, adults who have employer-sponsored health insurance available through a qualified employer; and persons with HIV disease;
- Basic for persons receiving Emergency Aid to Elders, Disabled and Children (EAEDC) and certain Department of Mental Health (DMH) clients who are long-term or chronically unemployed;
- Essential for the long-term or chronically unemployed who do not meet the eligibility criteria for Basic; and
- Limited for nonqualified aliens, (undocumented aliens, aliens with special status, and protected aliens) if they would be eligible for Standard but for their immigration status except for nonqualified aliens with breast or cervical cancer as described in **Section 2.1.3.1.7**.

For each coverage type, this document will describe categorical requirements and financial standards for MassHealth.

2.1.3.1 **MassHealth Standard**

This section contains the categorical requirements and financial standards for MassHealth Standard serving families, children under 19, independent foster care adolescents who age out of DSS care or custody until the age of 21, pregnant women, disabled individuals and certain women with breast or cervical cancer.

MassHealth will claim enhanced federal reimbursement under Title XXI for some individuals described in this section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI. These include children described in **Sections 2.1.3.1.2.1, 2.1.3.1.2.2, and 2.1.3.1.2.3**; parents under 19 described in **Section 2.1.3.1.4**; and pregnant women under 19 described in **Section 2.1.3.1.5**.

2.1.3.1.1 Extended Eligibility

2.1.3.1.1.1 Extended Eligibility When Cash Assistance Terminates

Members of a family group whose cash assistance terminates will continue to receive four months of MassHealth Standard coverage. This coverage will begin in the month the family group became ineligible provided they are terminated from EAEDC or TAFDC and are determined to be potentially eligible for MassHealth or terminated from TAFDC because of receipt of or an increase in spousal or child support payments.

Members of a family group who become ineligible for TAFDC for employment-related reasons continue to receive MassHealth for a full 12-calendar month period beginning with the date on which they became ineligible for TAFDC, provided:

- 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; and
- a parent or caretaker relative continues to be employed.

Some family groups who receive MassHealth Standard when cash assistance ends had income at or below 133 percent of the federal-poverty level during their extended period. If during the extended period that family group has increased earnings that raise the family group's gross income above that limit, the family group is eligible for another full 12-calendar month period that begins with the date on which the increase occurred, provided:

- the family group continues to include a child who is under age 19; and
- a parent or caretaker relative continues to be employed.

2.1.3.1.1.2 Extended Eligibility When Earned Income Increases above 133% FPL

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 will continue to receive MassHealth Standard. This coverage will begin with the date on which the increase income occurred and continue for a full 12-calendar month period, provided:

- the family group continues to include a child who is under age 19; and
- a parent or caretaker relative continues to be employed.

2.1.3.1.1.3 Redetermination of Eligibility at End of Extended Period

MassHealth reviews the continued eligibility of the family group at the end of the extended period described in **2.1.3.1.1.1** and **2.1.3.1.1.2**.

2.1.3.1.2 Eligibility Requirements for Children

Children under the age of 19 may establish eligibility for Standard Coverage subject to the requirements below.

Children Under Age 1

Eligibility of a child under age 1 is established under the following conditions:

- Eligibility for a child under age 1 born to a woman who was not receiving MassHealth Standard on the date of the child's birth is established if the gross income of the family group is less than or equal to 200 percent of the FPL; or
- Eligibility for a child born to a woman who was receiving MassHealth Standard or MassHealth Limited on the date of the child's birth is automatic for 1 year provided the child continues to live with the mother.
- A MassHealth Standard eligible child who is receiving inpatient hospital services on the date of his or her first birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Children Aged 1 through 18

Eligibility of a child aged 1 through 18 is established if the gross income of the family group is less than or equal to 150 percent of the FPL.

A MassHealth eligible child who is receiving inpatient hospital services on the date of his or her 19th birthday shall remain eligible until the end of the stay for which the inpatient services are furnished.

Independent Foster Care Adolescents

Independent foster care adolescents who age out of DSS care or custody are eligible for MassHealth Standard until the age of 21 without regard to income or assets.

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Presumptive Eligibility for Standard

A child shall be determined presumptively eligible for Standard based on the family group's self declaration of gross income on the Medical Benefit Request (MBR), if that income meets the financial requirements of MassHealth Standard described in Section 2.1.3.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

2.1.3.1.3 Reserved

2.1.3.1.4 Eligibility Requirements for Parents and Caretaker Relatives

2.1.3.1.4.1 Eligibility Requirements for Parents

A natural, step or adoptive parent shall be eligible for Standard coverage provided:

- The gross income of the family group is less than or equal to 133% of the FPL; and
- The parent resides with his or her children or has children who are absent from home to attend school.

2.1.3.1.4.2 Eligibility Requirements for Caretaker Relatives

A caretaker relative shall be eligible for Standard coverage provided:

- The caretaker relative chooses to be part of the family group;
- The gross income of the family group is less than or equal to 133% of the FPL; and
- The caretaker relative lives with children to whom he or she is related by blood, adoption or marriage, or is a spouse or former spouse of one of those relative provided neither parent lives in the home.

2.1.3.1.5 Eligibility Requirements for Pregnant Women

A pregnant woman whose gross family group income is less than or equal to 200% of the FPL is eligible for Standard Coverage. In determining the family group size, the unborn child or children are counted as if born and living with the mother.

Eligibility, once established, shall continue for the duration of the pregnancy and for the two- (2) calendar months following the month in which the pregnancy ends regardless of any subsequent changes in family group income.

2.1.3.1.6 **Disabled Individuals**

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Extended MassHealth Eligibility When SSI Benefits End

Any disabled persons whose SSI-Disability benefits have been terminated shall continue to receive MassHealth coverage until MassHealth makes a determination of ineligibility.

Disabled Individuals

Disabled individuals may establish eligibility for Standard coverage if;

- They are permanently and totally disabled
- The family group gross income is less than or equal to 133% of FPL

Disability Determination

Disability shall be established by one of the following:

Certification of legal blindness from MCB;

A determination of disability by the Social Security Administration; or

- A determination of disability by MassHealth's Disability Evaluation service.

Medicare Premium Payment

For MassHealth Standard members described in section **2.1.3.1.6.1.1** who are also eligible for Medicare, MassHealth will (1) pay the cost of the monthly Medicare Part B premiums, (2) hospital insurance under Medicare Part A; and, (3) the cost of deductibles and co-insurance under Medicare Part A and B. Coverage shall begin on the first day of the month following the date of the MassHealth eligibility determination.

2.1.3.1.7 **Eligibility Requirements for Women with Breast or Cervical Cancer**

A woman with breast or cervical cancer shall be eligible for Standard coverage provided she:

- Is under the age of 65;
- Is uninsured;
- Is not otherwise eligible for Standard;
- Has family income at or below 250% of the FPL (as determined by the Department of Public Health [DPH] on behalf of MassHealth;

- Was screened through the Center for Disease Control's (CDC's) National Breast and Cervical Cancer Early Detection Program (administered in Massachusetts by the DPH's Women's Health Network) and found to be in need of cancer treatment services (including precancerous conditions).

MassHealth will receive 65% FFP for women described at Section 2.1.3.1.7 who have breast or cervical cancer with the following exception. MassHealth will receive only 50% FFP for women who are eligible for this benefit and also appear to be otherwise eligible for Standard as a person under 19, a parent, pregnant woman, or disabled person. MassHealth will receive this lower level of FFP until such time as it is able to make a final eligibility determination under these provisions

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Women described at Section 2.1.3.1.7 with family group income greater than 150% FPL will be assessed a monthly premium in accordance with the provisions of section 2.1.4.10.

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Adults and children age 6 and older (with the exception of individuals described in section 2.1.3.1.1.2) who meet the requirements described above may be assessed a monthly (health insurance) premium in accordance with the provisions of section 2.1.4.10.¶

Medical Coverage Date

The begin date of medical coverage for MassHealth Standard shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center (MEC) or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within 60 calendar days of the information request.

If required verifications are received after the sixty (60) day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received with one (1) year of receipt of the MBR.

MassHealth Prenatal

This section contains the categorical requirements and financial standards for Prenatal Coverage.

MassHealth will claim enhanced federal reimbursement under Title XXI for some of the individuals covered under the section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI.

2.1.3.2.1 Eligibility Requirements

A pregnant woman whose self declared family group gross income is less than or equal to 200% of the FPL shall be eligible for Prenatal coverage.

2.1.3.2.2 Medical Coverage Date

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at any MEC or MassHealth outreach site and lasts until MassHealth makes an

eligibility determination. If information necessary to make the eligibility determination is not submitted with 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end.

2.1.3.3 MassHealth CommonHealth

This section contains the categorical requirements and financial standards for CommonHealth coverage available to disabled children, disabled adults and disabled working adults. The requirements differ depending on whether or not the disabled adult is considered working.

Generally, MassHealth treats 18 year olds as children when making eligibility determinations. However, in determining whether a person who is 18 is disabled for purposes of eligibility for CommonHealth, MassHealth follows the disability requirements of Title XVI, which treats 18 years olds as adults.

MassHealth will claim enhanced federal reimbursement for disabled individuals described in this section provided they are uninsured, under the age of 19, and meet other criteria described in Title XXI. Children under age 19 who are aliens with special status and who are otherwise eligible will receive CommonHealth at full state cost. (For immigrant children who are also eligible for Limited, federal reimbursement is provided for emergency services only).

2.1.3.3.1 Disabled Working Adults

Disabled working adults must meet the following requirements:

- Be age 19 to 64 (inclusive);
- Be employed at least forty (40) hours per month; or if employed less than forty (40) hours per month have been employed at least 240 hours in the six- (6) month period immediately preceding the month of application;
- Be permanently and totally disabled except for the requirement of not being engaged in substantial gainful activity as determined by MassHealth's disability evaluation service; and
- Be ineligible for MassHealth Standard.
- CommonHealth members who terminate their employment shall continue to be eligible for CommonHealth for up to three calendar months after termination of their earned income provided they continue to make timely payment of monthly premiums.

2.1.3.3.2 Disabled Adults (Non-working)

Disabled adults must meet the following requirements:

Be age 19 to 64 (inclusive);

- Not be employed or, if employed, not engaged in substantial gainful activity as determined by MassHealth's disability determination service;
- Be permanently and totally disabled;
- Be ineligible for MassHealth Standard; and

- Meet a one-time only deductible (spenddown) in accordance with **Sections 2.1.4.8 and 2.1.4.9.**

2.1.3.3.3 Disabled Children

Disabled children under age 18 must meet the following requirements:

- Be totally and permanently disabled; and
- Be ineligible for MassHealth Standard;

Disabled 18 year olds must meet the following requirements:

- Be ineligible for MassHealth Standard; and
- If not working, be permanently and totally disabled based on the disability criteria for adults and 18 year olds, as described in Attachment 1.2; or
- If working, be permanently and totally disabled based on the disability criteria for adults and 18 year-olds, as described in attachment 1.2 (except for engagement in substantial gainful activity).

2.1.3.3.4 Determination of Disability

Disability shall be established by one of the following:

- Certification of legal blindness from MCB; or
- A determination of disability by the Social Security Administration; or
- A determination of disability by MassHealth's disability evaluation service.

2.1.3.3.5 CommonHealth Premium

Disabled adults and disabled children who meet the requirements described above may be assessed a monthly (health insurance) premium in accordance with the provisions of **Section 2.1.4.10.**

2.1.3.3.6 Medical Coverage Date

- The begin date of medical coverage for CommonHealth for all children (age 18 and under), and for adults (age 19 and over) shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within sixty (60) calendar days of the date of the information request. If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

2.1.3.4 MassHealth Family Assistance

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Children under the age of 19 who are aliens with special status, as described in **Section 2.1.2.1.3**, may be eligible for CommonHealth provided they meet all of the requirements of **Section 2.1.3.3.3**. They may also be eligible for CommonHealth if they meet the requirements for MassHealth Standard at **Section 2.1.3.1.6.1.1** but for their immigration status.¶

This section contains the categorical requirements and financial standards for MassHealth Family Assistance. This coverage type provides coverage either through the purchase of medical benefits or through premium assistance payment.

2.1.3.4.1 Eligibility Requirements for the Purchase of Medical Benefits

MassHealth will claim enhanced federal reimbursement under Title XXI for the children described in this section who were uninsured at the time of application, with the exception of aliens with special status (described in **Section 2.1.3.4.1.1, 2.1.3.4.1.2, and 2.1.3.4.1.3**) who will receive these services at full state cost.

2.1.3.4.1.1 Children Under the Age of 19

Children under the age of 19, including aliens with special status as described in Section 2.1.2.1.3, may establish eligibility for the purchase of medical benefits provided:

- The gross income of the family group is between 150% and 200% FPL;
- The child is ineligible for MassHealth Standard and MassHealth CommonHealth;
and
- The child does not have or have access to health insurance.

2.1.3.4.1.2 Persons with HIV Disease

Persons with HIV disease may establish eligibility for the purchase of medical benefits provided they:

- Are under the age of 65 (unless the person is an alien with special status, in which case the person must be under the age of 19);
- Have family group gross income that is less than or equal to 200% FPL;
- Are ineligible for MassHealth Standard or MassHealth CommonHealth; and
- Do not have employer-sponsored health insurance or choose not to accept employer sponsored insurance.

2.1.3.4.1.3 Medicare Premium Payment

MassHealth will pay the cost of the monthly Medicare Part B premiums for MassHealth Family Assistance members described in **Section 2.1.3.4.1.2**, who are also eligible for Medicare. Payment will begin in the calendar month following MassHealth's eligibility determination.

2.1.3.4.2 Family Assistance Premium

Individuals who meet the requirements in **Section 2.1.3.4.1.1** or **2.1.3.4.1.2** may be assessed a monthly health insurance premium in accordance with the provisions of **Section 2.1.4. 10**.

2.1.3.4.3 Presumptive Eligibility for Family Assistance

An uninsured child whose self-declared family group income is greater than 150% FPL and less than or equal to 200% FPL shall be determined presumptively eligible for Family Assistance. Presumptively eligible children shall not be assessed a monthly health insurance premium. A child may only be presumptively eligible for Family Assistance if the applicant states he or she has no health insurance coverage.

Presumptive eligibility begins 10 calendar days prior to the date the MBR is received at the MEC and lasts until MassHealth makes an eligibility determination. If information necessary to make the eligibility determination is not submitted within 60 days of the begin date, the MBR will be deactivated and presumptive eligibility will end. A child may receive presumptive eligibility only once in a twelve-month period.

2.1.3.4.5 Medical Coverage Date

The begin date of medical coverage for all children (ages 18 and under), and for adults (ages 19 and over) who have not been placed on a waiting list pursuant to Section 2.0 of this Chapter, for the purchase of medical benefits under MassHealth Family Assistance shall be ten (10) calendar days prior to the date a Medical Benefit Request (MBR) is received at any MassHealth Enrollment Center (MEC) or outreach site, provided all required verifications with the exception of documentation of immigration status and/or verification of HIV status have been submitted within sixty (60) calendar days of the date of the information request. If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

The begin date of medical coverage for MassHealth Family Assistance applicants enrolled from the waiting list will be the date the application was processed from the waiting list.

2.1.3.4.5.1 Verification of HIV Disease

For persons who indicate on the MBR that they have HIV disease, a determination of eligibility will be made once family group income has been verified. Persons who have not submitted verification of HIV diagnosis within sixty days of the eligibility determination shall subsequently have their eligibility redetermined as if they did not have the HIV disease.

2.1.3.4.6 Eligibility Requirements for Premium Assistance

Premium assistance subsidizes payment of the member's health insurance premium in accordance with the formula and process described in **Section 3.6**, for members described in **Sections 2.1.3.4.6.1** and **2.1.3.4.6.2**. MassHealth will provide premium assistance equal to the policy holder's total premium, less the applicable MassHealth premium as described in **Section 2.1.4.10** and **Section 2.1.3.4.6.1**.

Persons with HIV disease described in **Section 2.1.3.4.6.3** may also receive premium assistance. MassHealth will provide premium assistance equal to the policy holder's total premium, less the applicable MassHealth premium as described in **Section**

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2.1.4.10 to members with family group gross income less than or equal to 200% FPL. MassHealth will claim enhanced federal reimbursement under Title XXI for some of the children described in Section 2.1.3.4.6.1, provided they were uninsured at the time of application for MassHealth and meet other criteria described in Title XXI.

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The premium assistance payment is described in **Section 3.6**.

2.1.3.4.6.1 Families with Children Under Age 19

Children under the age of 19 may be eligible for Family Assistance premium assistance payments provided they have, or have access to, employer sponsored health insurance that meets the Basic Benefit Level as described in **Section 3.6**, and meet the following additional requirements;

Deleted: , including aliens with special status as described in **Section 2.1.2.1.3**,

- The family group gross income is between 150% and 200% FPL;
- The child is ineligible for MassHealth Standard or CommonHealth; and
- The child is enrolled in, and retains coverage under, the employer sponsored health insurance plan, (NOTE; the employer does not need to be a qualified employer for the child to be eligible under this section. For example, the employer may be a large employer or a non-participating small employer).
- MassHealth will also pay certain co-payments and deductibles for the children described in this Section provided they:
 - are citizens or qualified aliens as described in **Sections 2.1.2.1.1 and 2.1.2.1.2**;
 - were uninsured at the time of application, and enrolled in employer-sponsored health insurance due to MassHealth action; and
 - are not employed by the Commonwealth of Massachusetts.

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MassHealth payment is limited to co-payments and deductibles incurred by eligible children for well child visits as well as any other co-payments and deductibles incurred in a 12 month period that exceed five percent of the family's gross annual income.

2.1.3.4.6.2 Adults

Adults who are under age 65 may establish eligibility for Family Assistance premium assistance provided:

- The family group gross income is less than or equal to 300% of the FPL. The adult is not eligible for MassHealth Standard or CommonHealth;
- The individual is employed by a small business employer who meets the requirements of **Section 2.1.3.4.7**; and
- The individual enrolls in, and retains coverage under, the employer's health insurance plan.

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Individuals whose spouse and/or noncustodial children are receiving MassHealth must enroll in a health plan that provides coverage to the dependents provided

MassHealth determines it is cost effective to do so and the employer contributes at least 50% of the premium cost.

The employer must also be a qualified employer as described in **Section 2.1.3.4.8**.

2.1.3.4.6.3 Persons With HIV Disease

Persons with HIV disease may establish eligibility for premium assistance provided they:

- Are under the age of 65;
- Have family group gross income that is less than or equal to 200% FPL;
- Are ineligible for MassHealth Standard or CommonHealth; and
- either have or have available employer-sponsored health insurance in which they choose to participate.

MassHealth will also pay for all services covered under the purchase of medical benefits that are not covered by the individual's employer-sponsored health insurance.

Persons eligible under this section who also meet the requirements of **Sections 2.1.3.4.6.1** or **2.1.3.4.6.2** will receive premium assistance under the provisions of this section.

2.1.3.4.7 Small Employer

An employer will be considered a small employer if it meets the following requirements;

- Has 50 or fewer full-time employees;
- Offers health insurance to its employees that meets the basic benefit level;
- Contributes at least 50% of the cost of the employee's health insurance premium.

2.1.3.4.8 Qualified Employer

An employer who meets all of the requirements of a small employer shall be considered qualified if the employer;

- Purchases health insurance through a billing and enrollment intermediary (BEI) or directly through an insurance company; and
- Has completed an Insurance Partnership Employer application and been approved by MassHealth as a qualified employer.

MassHealth will make insurance partnership payments as described in **Section 11.5** to qualified employers.

2.1.3.4.9 Access to Employer Sponsored Health Insurance

MassHealth may waive its requirement for children described in **Section 2.1.3.4.6.1**, to access employer sponsored health insurance if MassHealth determines it is more cost effective to purchase medical benefits under MassHealth Family Assistance than to assist the family with payments of health insurance premiums.

2.1.3.4.10 Eligibility Date

Once MassHealth has determined eligibility, premium assistance payments shall begin in the month of the MassHealth eligibility determination or the month in which the insurance deduction begins, whichever is later. Premium assistance payments are for the following month's coverage.

Persons described in Section 2.1.3.4.6.3 shall also be eligible for services provided under the purchase of medical benefits that are not covered by the individual's employer sponsored health insurance. The medical coverage date for these services shall be established in accordance with Section 2.1.3.4.5.

2.1.3.5 MassHealth Basic

This section contains the categorical requirements and financial standards for MassHealth Basic. This coverage type is available to individuals or members of a couple, who are under the age of 65, who either receive EAEDC cash assistance or who are eligible to receive services from the Department of Mental Health (DMH) and are long-term or chronically unemployed. MassHealth Basic coverage is available either through the purchase of medical benefits or through premium assistance payments.

2.1.3.5.1 Purchase of Medical Benefits for Basic Members Defined

The purchase of medical benefits under MassHealth Basic is available to unemployed adults aged 19 through 64 who:

- do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or
- 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.

2.1.3.5.2 Premium Assistance for Basic Members

Premium assistance under MassHealth Basic is available to unemployed adults aged 19 through 64 who have health insurance that:

- MassHealth has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;
- is not of significant cost to the applicant;
- is not available from the college or university that they attend; and
- meets the MassHealth cost effective analysis

2.1.3.5.3 Eligibility Requirements for the Purchase of Medical Benefits

2.1.3.5.3.1 Long-term Unemployed DMH Clients

Individuals and members of a couple, who are under age 65 are eligible for the purchase of medical benefits provided they have no health insurance as defined in **Section 2.1.3.5.1** and they:

- Are not eligible for unemployment compensation;
- Have been unemployed for more than one year; or during the past twelve months have earned less than the minimum amount of earnings necessary to qualify for Unemployment Compensation;
- Have been identified by the Department of Mental Health (DMH) as getting services or as being on a waiting list to get services from the DMH;
- Have gross income less than or equal to 100% of the FPL;
- Are not eligible for MassHealth Standard or CommonHealth

A member of a couple who is under age 65 is eligible for the purchase of medical benefits provided he or she meets the above requirements and his or her spouse is not employed more than 100 hours per month or the spouse is not eligible for premium assistance payments as described in **Section 2.1.3.4.6.2**.

2.1.3.5.3.2 EAEDC Recipients

Individuals and members of a couple, who receive EAEDC cash assistance are eligible for the purchase of medical benefits provided they have no health insurance and are not otherwise eligible for MassHealth Standard.

Generally, this population is comprised of chronically unemployed, disabled adults aged 19 through 64 who are pending an eligibility determination from SSI or whose disability does not meet the SSI criteria. The EAEDC cash payment provides income of approximately 50% of the federal poverty level.

2.1.3.5.3.3 Extended Eligibility When EAEDC Terminates

Individuals or members of a couple whose EAEDC terminates and who are determined to be potentially eligible for MassHealth shall continue to receive medical benefits under MassHealth Basic until MassHealth makes an eligibility determination.

2.1.3.5.3.4 Extended Coverage for the Purchase of Medical Benefits

Members who would have become ineligible for Basic coverage due to employment shall continue to receive medical benefits under MassHealth Basic for up to six calendar months after their date of employment provided health insurance is not available (i.e. not offered or subject to a waiting period) to them from their employer or their spouse's employer.

2.1.3.5.3.5 Medical Coverage Date

Persons who meet the requirements of this section shall have medical coverage established as of the date of enrollment in a MassHealth contracted health plan.

2.1.3.5.4 Premium Assistance

Premium assistance is available to persons who would be eligible for Basic coverage as defined in **Section 2.1.3.5.3.1**, but have health insurance. Premium assistance is limited to payment of all or part of the person's health insurance premium.

2.1.3.5.4.1 Eligibility Date

Once MassHealth has determined eligibility, premium assistance shall be effective on the first day of the calendar month following MassHealth's receipt of the member's health insurance information.

2.1.3.5.4.2 Extended Eligibility for Premium Assistance

Persons who become ineligible for premium assistance due to earnings^s will continue to have all or part of their premiums paid for a six calendar month period following their date of employment provided neither they nor their spouse are eligible for premium assistance payments as described in **Section 2.1.3.4.6.2**.

2.1.3.6 MassHealth Essential

This section contains the categorical requirements and financial standards for MassHealth Essential. This coverage type is available to individuals who are under the age of 65 who are long-term or chronically unemployed and do not meet the eligibility criteria for MassHealth Basic. MassHealth Essential coverage is available either through the purchase of medical benefits or through premium assistance payments.

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2.1.3.6.1 Purchase of Medical Benefits for Essential Members Defined

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

- do not have, or have access to, health insurance, including health insurance offered by the college or university that they attend; or
- 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.

2.1.3.6.2 Premium Assistance for Essential Members

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

- has determined covers the applicant's chronic medical condition requiring frequent treatment and medical services and for which they must pay a premium;
- is not of significant cost to the applicant;
- is not available from the college or university that they attend; and

- meets the MassHealth cost effective analysis

2.1.3.6.3 Eligibility Requirements for the Purchase of Medical Benefits

Individuals ~~under age 65 are eligible for Essential Coverage provided they are~~ uninsured as described in **Section 2.1.3.6.1** and:

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- are not eligible for unemployment compensation;
- have been unemployed for more than one year, or during the past twelve months have earned less than the minimum amount of earnings necessary to qualify for unemployment compensation;
- have gross income less than or equal to 100% of the FPL; and
- are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or Basic.

A member of a couple who is under age 65 is eligible for Essential coverage provided he, or she meets the above requirements and his or her spouse ~~is not employed more than~~ 100 hours per month or the spouse ~~is not eligible for premium assistance payments as~~ described in **Section 2.1.3.4.6.2**

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2.1.3.6.3.1 Medical Coverage Date

Persons who meet the requirements of this section shall have medical coverage established as of the date of enrollment in a MassHealth contracted Primary Care Clinician (PCC) Plan.

2.1.3.6.4 Eligibility Requirements for Premium Assistance

Premium Assistance is available to persons who would be eligible for Essential coverage as defined in **Section 2.1.3.6.3**, but have health insurance as described at **Section 2.1.3.6.2**. Premium Assistance is limited to payment of all or part of the person's health insurance premium.

2.1.3.6.4.1 Eligibility Date

Once MassHealth has determined eligibility, premium assistance shall be effective on the first day of the calendar month following MassHealth's receipt of the member's health insurance information.

2.1.3.6.5 Enrollment Cap

MassHealth, at its discretion, shall freeze enrollment upon determination that further enrollment of MassHealth Essential members would result in expenditures in excess of allotted funding.

2.1.3.7 MassHealth Limited

This section contains the eligibility requirements for MassHealth Limited. This coverage type is available to aliens with special status and non-qualified aliens under the age of 65 who would receive Standard but for their immigration status except for women described in **Section 2.1.3.1.7**.

Persons receiving Limited coverage are eligible only for emergency services as described in **Section 2.1.3.7.1.**

2.1.3.7.1 Eligibility Requirements

MassHealth Limited is available to persons who meet the financial and categorical requirements for Standard coverage and who are aliens with special status as defined in Section 2.1.2.1.3, or nonqualified aliens as defined in Section 2.1.2.1.5 This does not include women described in **Section 2.1.3.1.7**

Limited provides for the care and services necessary for the treatment of an emergency medical condition. Such care and services do not include those related to organ-transplant procedures.

The alien must have a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- 1) Placing the patient's health in serious jeopardy;
- 2) Serious impairment of bodily functions; or
- 3) Serious dysfunction of any bodily organ or part.

The alien must meet all other requirements of MassHealth with the exception of furnishing or applying for a social security number.

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

2.1.3.7.2 Medical Coverage Date

The begin date of medical coverage for MassHealth Limited shall be ten (10) calendar days prior to the date a MBR is received at any MEC or outreach site, provided all required verifications with the exception of documentation of immigration status have been submitted within sixty (60) calendar days of the date of the information request.

If required verifications are received after the sixty (60) calendar day period, the begin date of medical coverage shall be ten (10) calendar days prior to the date on which the verifications were received, provided such verifications are received within one (1) year of receipt of the MBR.

2.1.4 Calculation of Financial Eligibility

2.1.4.1 Groupings

In the determination of eligibility for MassHealth, the gross income of all family group members is counted and compared to an income standard based on the family group size. Family groups include families, couples, or individuals.

2.1.4.1.1 Family

Family includes a natural, step or adoptive parents(s) who reside with their child (ren) under age 19, and any of their children, or whose child (ren) are absent from home to attend school; or siblings under age 19, and any of their children, who reside together when no parent(s) are present. A family includes both parents when they are mutually responsible for one or more children who reside with them.

Family may also include a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family.

2.1.4.1.2 Couple

Persons who are married to each other and live together and have no children under the age of 19 residing with them or children under the age of 19 who are absent for the purpose of attending school.

2.1.4.1.3 Individual

A person not included in the definition of family or couple.

2.1.4.2 Countability of Income

Eligibility is based on the family group's gross countable earned and unearned income and countable rental income, as defined in this section.

2.1.4.2.1 Gross Earned Income

This is the total amount of compensation received from work or services performed before any income deduction.

Earned income for the self-employed is the total amount of business income listed or allowable, less any allowable deductions, listed on a U.S. Tax Return.

For persons who are seasonally employed, annual gross income is divided by 12 to obtain a monthly gross income with the following exception. If the person experiences a disabling illness or accident during or after the seasonal employment period which prevents the person's continued or future employment, only current available income shall be considered in the eligibility determination.

2.1.4.2.2 Gross Unearned Income

This is income that does not directly result from the individual's own labor. The total amount of unearned income before any deductions is countable. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, and interest and dividend income.

2.1.4.2.3 Rental Income

Rental income is the total amount of gross income, received from a tenant or boarder, less any allowable deductions listed on an applicant's or member's U.S. Tax Return.

2.1.4.3 Non-Countable Income

The following types of income are non-countable in the determination of eligibility:

- Income received by a TAFDC, EAEDC, or SSI recipient;
- Sheltered workshop earnings;
 - The portion of Federal veterans benefits identified as aid and attendance benefits, unreimbursed medical expenses, housebound benefits, or enhanced benefits;
 - Income-in-kind;
 - Temporary income from U.S. Census Bureau related to Census 2000 activities, or federal unemployment benefits related to the termination of that temporary income.
 - Roomer and boarder income; and
 - Any other income excluded as provided by federal laws other than the Social Security Act (see 42 C.F.R. Part 416, Appendix to Subpart K).

2.1.4.4 Verification of Income

Verification of gross monthly income is mandatory. In lieu of any of the specific sources and verifications listed below, any other evidence of the applicant's or member's earned or unearned income is acceptable.

2.1.4.4.1 Earned income

The following are required to verify earned income:

- Two recent pay stubs;
- A signed statement from the employer; or
- Most recent U.S. Tax Return.

2.1.4.4.2 Unearned Income

The following are required to verify unearned income:

- Copy of a recent check or stub showing gross income from the source; or
- Statement from the income source, where matching is not available.

2.1.4.4.3 Rental Income

The following are required to verify rental income

- Most recent U.S. Tax return

2.1.4.5 Transfer of Income

All family group members are required to avail themselves of all potential income. If MassHealth determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received. If

MassHealth is unable to determine the amount of available income, the family group will remain ineligible until such information is made available.

2.1.4.6 Calculation of Financial Eligibility

The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. The monthly income standards are determined according to annual FPL standards published by the Federal Register using the following formula:

- Divide the annual federal poverty income standard as it appears in the Federal Register by 12;
- Multiply the un-rounded monthly income standard by the applicable FPL standard (e.g. 133%); and
- Round up to the next whole dollar to arrive at the monthly income standards.

MassHealth will adjust these standards in April of each calendar year.

2.1.4.7 COLA Protections

Members whose income increases each January as the result of a cost of living adjustment shall remain eligible until the subsequent FPL adjustment.

2.1.4.8 The One-Time Deductible (Spendedown)

Disabled adults described in **Section 2.1.3.3.2** may establish eligibility by meeting a deductible. Once the deductible has been met, the person may be assessed a monthly (health insurance) premium in accordance with the premium schedule in **Section 2.1.4.10.**

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2.1.4.8.1 Definition of the Deductible

The deductible is the total dollar amount of incurred medical expenses that an applicant, whose gross family group income exceeds the applicable income standard, must be responsible for before CommonHealth eligibility is established. Any bills or portions of bills that are used to meet the deductible shall not be paid by any MassHealth coverage type and remain the responsibility of the applicant.

2.1.4.8.2 The Deductible Period

The deductible period is a six (6) month period beginning ten (10) days prior to the date a Medical Benefit Request is received in any MEC or outreach site.

2.1.4.8.3 Calculating the Deductible

The amount of the deductible is determined by comparing the gross income of the family group to the MassHealth Deductible Income Standard and Multiplying the excess by (6).

The current MassHealth Deductible Standards are:

Family Group Size Income Standards

1. \$542
 2. \$670
 3. \$795
 4. \$911
 5. \$1036
 6. \$1161
 7. \$1286
 8. \$1403
 9. \$1528
 10. \$1653
- \$133 for each additional person

2.1.4.8.4 Notification of the Deductible

The disabled applicant who has excess monthly income shall be informed that he or she is currently ineligible for MassHealth but may establish eligibility by meeting the deductible. The applicant shall be informed in writing of the following:

- 1) The deductible amount; and
- 2) The start and end dates of the deductible period.

A person who meets a deductible shall be eligible for CommonHealth effective with the begin date of the deductible period.

2.1.4.8.5 Persons Deemed to Have Met a Deductible

The following disabled adults shall be considered to have met a deductible:

- Disabled adults who were receiving MassHealth on July 1, 1997 as the result of meeting a deductible; and
- Disabled adults who were denied with a deductible prior to July 1, 1997 but, who submit medical bills after July 1, 1997 to meet the deductible.

2.1.4.8.6 Submission of Bills to Meet the Deductible

To establish eligibility, the applicant or member must submit verification of medical bills whose total equals or exceeds the deductible and that meet the following criteria:

- 1) The bill must not be subject to further payment by health insurance or other liable third-party coverage including the state-legislated Uncompensated Care Pool;
- 2) The bill must be for an allowable medical or remedial expense as provided below; and
- 3) The bill must be unpaid and a current liability, or if paid, paid during the current deductible period.

2.1.4.8.7 Expenses Used to Meet the Deductible

Bills to meet the deductible shall be applied in the following order:

- 1) Medicare and other health insurance premiums credited prospectively for the cost of six months' coverage;
- 2) Expenses incurred by any member of the family group for necessary medical and remedial services that are recognized under state law but not covered by MassHealth;
- 3) Expenses incurred by any member of the family group for necessary medical and remedial services that are covered by the MassHealth Program.

2.1.4.8.8 Expenses that Cannot Be Used to Meet the Deductible

Medical expenses that may not be applied to meet the deductible include, but are not limited to, the following:

- 1) Cosmetic surgery;
- 2) Rest-home care;
- 3) Weight-training equipment;
- 4) Massage therapy;
- 5) Special diets; and
- 6) Room and board charges for individuals in residential programs.

2.1.4.9 Verification of Medical Expenses

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

Verifications must include all of the following information:

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

2.1.4.10 Premiums

Certain Standard, CommonHealth, and Family Assistance members may be assessed a monthly (health insurance) premium.

Premiums for women with breast or cervical cancer who are eligible for the MassHealth Standard as described at Section 2.1.3.1.7, whose family's gross monthly income is 150% to 250% of the federal poverty level are based on gross countable income and family group size as it compares to the federal poverty level. Monthly premiums are assessed in accordance with the following premium schedule.

% of Federal Poverty Level (FPL)	Premium Cost
Above 150 to 160	\$15

Deleted: Except for women described at Section 2.1.3.1.7, and Independent Foster Care Adolescents described at Section 2.1.3.1.2 premiums for Standard eligible members are based on gross countable income and family group size as it compares to the federal poverty level, and whether or not the member has other health insurance. Standard disabled adult members who are not parents and whose family's gross monthly income is above 114 percent of the federal poverty level will be charged a premium of \$12 per family group. Standard eligible members who are parents or children and whose family's gross monthly income is above 133 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$15 per family group. ¶

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Above 160 to 170	\$20
Above 170 to 180	\$25
Above 180 to 190	\$30
Above 190 to 200	\$35
Above 200 to 210	\$40
Above 210 to 220	\$48
Above 220 to 230	\$56
Above 230 to 240	\$64
Above 240 to 250	\$72

CommonHealth premiums are based on gross countable income and family group size as it compares to the federal poverty level, and whether or not the member has other health insurance. Where more than one family group member receives CommonHealth, only one (1) premium per family group shall be assessed. CommonHealth eligible members assessed a monthly premium in accordance with the premium schedule below:

Deleted: Standard eligible infants, children under age six (6), pregnant women, and individuals who meet the requirements set forth in **Section 2.1.3.1.1.2** will not be charged a premium.¶

Full payment is required of members who have no health insurance and of members for whom MassHealth is paying a portion of their health-insurance premium. The full premium formula is provided below.

FULL PREMIUM FORMULA		
Base Premium	Additional Premium Cost	Range of Premium Cost
Above 150% FPL— start at \$15	Add \$5 for each additional 10% FPL until 200% FPL	\$15 — \$35
Above 200% FPL— start at \$40	Add \$8 for each additional 10% FPL until 400% FPL	\$40 — \$192
Above 400% FPL— start at \$202	Add \$10 for each additional 10% FPL until 600% FPL	\$202 — \$392
Above 600% FPL— start at \$404	Add \$12 for each additional 10% FPL until 800% FPL	\$404 — \$632
Above 800% FPL— start at \$646	Add \$14 for each additional 10% FPL until 1000%	\$646 — \$912
Above 1000% FPL— start at \$928	Add \$16 for each additional 10% FPL	\$928 + greater

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CommonHealth and Family Assistance children, 150% to 300% FPL use the below schedule (above 300% FPL, use the above schedule)

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% of Federal Poverty Level (FPL)	Premium Cost
Above 150% to 200%	\$12 per child (\$36 per family group maximum)
Above 200% to 250%	\$20 per child (\$60 per family group maximum)

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	maximum)
Above 250% to 300%	\$28 per child (\$84 per family group maximum)

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MassHealth premiums for children will be waived if there is a parent or caretaker-relative in the family group who is enrolled in and paying premiums for the Commonwealth Care Health Insurance Program administered by the Commonwealth Health Insurance Connector authority.]

Monthly Supplemental Premium Formula. A lower supplemental payment is required of members who have health insurance to which MassHealth does not contribute. The supplemental premium formula is provided below.

SUPPLEMENTAL PREMIUM FORMULA	
% of Federal Poverty Level (FPL)	Premium Cost
Above 150% to 200%	60% of full premium
Above 200% to 400%	65% of full premium
Above 400% to 600%	70% of full premium
Above 600% to 800%	75% of full premium
Above 800% to 1000%	80% of full premium
Above 1000%	85% of full premium

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Family Assistance premiums for adults are based on the family group's gross countable income and family group size as it compares to the federal poverty level. Family Assistance eligible adults (with the exception of persons with HIV disease, whose premiums are calculated as if the member is receiving CommonHealth benefits) are charged as follows:

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% of Federal Poverty Level (FPL)	Covered Adults	Couple
Above 150% to 200%	\$27	\$54
Above 200% to 250%	\$53	\$106
Above 250% to 300%	\$80	\$160

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Deleted: whose family's gross monthly income is between 100 and 150 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$15 per family group, and \$27 per childless adult, up to a maximum of \$54 per family group. Family Assistance eligible members

Deleted: whose family's gross monthly income is between 150 and 200 percent of the federal poverty level will be charged a premium of \$12 per child, up to a maximum of \$36 per family group.

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In the event a household contains at least two members who are receiving different MassHealth benefit types and who would otherwise be assessed two different premiums the household shall be assessed only the highest of all applicable MassHealth premiums.

2.1.4.10.1 Premium Payments:

Persons described in **Sections 2.1.3.1.1, 2.1.3.1.2.1, 2.1.3.1.4, 2.1.3.1.6, 2.1.3.3.1, 2.1.3.3.3, 2.1.3.3.4, 2.1.3.4.1.1, and 2.1.3.4.1.3** who are assessed a premium, shall be responsible for monthly premium payments to MassHealth beginning with the calendar month following the date of their eligibility determination.

Persons described in **Section 2.1.3.3.2**, who are assessed a premium, shall be responsible for monthly premium payments, beginning with the calendar month following the end date of the deductible period or the month after the deductible has been met, whichever is later.

Members who are determined eligible for a new category for which no premium payment is required shall cease to be responsible for the premium payment to MassHealth as of the calendar month in which the coverage changes.

Members who are assessed a revised premium payment as the result of a reported change shall be responsible for the new monthly premium payment beginning with the calendar month following the reported change.

2.1.4.10.2

Delinquent Premium Payments

If MassHealth has billed a member for a premium payment, and the member does not pay all of the amount billed within 60 days of the date on the bill, then the member's eligibility for benefits will be terminated, except as provided in section 2.1.4.11. The member will receive a notice of termination prior to the date of termination.

Provided no waiting list has been established pursuant to Section 2.0 of this Chapter, after the member has paid in full all payments due, and has established a payment plan with MassHealth, MassHealth will reactivate coverage. If a waiting list has been established, adults (age 19 and over) who have been terminated due to nonpayment of premiums will be placed on the waiting list upon payment of all payments due. They will not be allowed to reenroll until MassHealth is able to reopen enrollment for those placed on the waiting list. When is able to open enrollment for those on the waiting list, their eligibility will be processed in the order they were placed on the waiting list.

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2.1.4.10.2.1 Repayment Process

The member's eligibility will not be terminated if the member, prior to the date of termination:

Pays all amounts which have been billed 60 days or more prior to the date such payment is made; or establishes a payment plan acceptable to MassHealth. After such a payment plan has been established, MassHealth will bill the member for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill,

the member's eligibility will be terminated. If the member does not pay monthly premiums due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the member's eligibility will be terminated.

2.1.4.11 Waiver of Premiums

If MassHealth determines that the requirement to pay a premium results in an extreme financial hardship for a MassHealth member, MassHealth may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.

2.1.4.12 Voluntary Withdrawal

In case of a member's voluntary withdrawal, coverage shall continue, and the member shall be responsible for payment of premiums through the end of the calendar month of withdrawal.

2.1.4.13 Change in Premium Calculation

The premium amount is re-calculated when MassHealth is informed of changes in income, family group size, or health insurance status, and whenever an adjustment is made in the Standard, CommonHealth, or Family Assistance premium amounts and/or schedules.

2.2.1 Data Matching and Verification

2.2.1.1 Process for Data Matching

MassHealth initiates matches with other agencies, health insurance carriers, and employers to obtain information necessary to confirm or determine initial and continued eligibility. These agencies and matches include but are not limited to the following: The Department of Employment and Training (DET), Bureau of Vital Statistics, Veteran's Services, Department of Revenue (DOR), Bureau of Special Investigations (BSI), Internal Revenue Service (IRS), Social Security Administration (SSA), Alien Verification Information System, Department of Youth Services (DYS), Department of Social Services (DSS), Department of Correction (DOC) and the Department of Transitional Assistance (DTA).

2.2.1.2 Verification Requirements

Verification only of the following (through either the customer or automated matching) is a prerequisite for eligibility determination:

- Income (for all except MassHealth Prenatal, and for presumptive eligibility determinations for MassHealth Standard and MassHealth Family Assistance, and for those without income);
- Disability (for CommonHealth, Standard or Limited);

- TPL (from accident or injury);
- SSN;
- Citizenship and immigration status in accordance with Section 2.1.2.2;
- HIV disease in accordance with Section 2.1.3.4.5.1;
- Absent parent information;
- Unemployment (for Basic and Essential); and
- Access to, and availability of, health insurance.

2.2.2 Medical Security Plan Eligibility

The Massachusetts Division of Unemployment Assistance (DUA) is responsible for administering the Medical Security Plan (MSP). The MSP offers health insurance to individuals receiving DUA unemployment benefits by paying all or part of the premiums of existing health insurance, such as employer-sponsored insurance continued through COBRA, or all or part of the premiums of indemnity coverage.

Unemployment insurance recipients whose income does not exceed 400% FPL are eligible for the Medical Security Plan. There is no waiting period for eligibility to this program. A few exceptions to this waiting period are those individuals for whom COBRA insurance is available, individuals whose last employer was the military or federal government, those who worked in Massachusetts but are non-resident now, and those who are resident but whose employment was out of state. The data available from DUA identifies these situations.

2.2.3 Notice

All applicants and members shall receive a written notice of the determination of eligibility for MassHealth. The notice will contain the applicable eligibility decision for each member of the household who has requested MassHealth.

Where the notice is an approval, it will provide the coverage type for which the member is eligible, the medical coverage date and, where applicable, the amount of the premium or subsidy payment. Denials will provide the reason, the regulatory cite, and if applicable, the deductible amount and deductible period. Members will also receive a notice of loss of coverage or any changes in a coverage type, premium payment, or subsidy.

Applicants will be notified if they have been placed on a waiting list for the MassHealth Family Assistance program due to a state law limiting the number of adults who can enroll in that programs and will receive a notice of eligibility when MassHealth determines they can be reenrolled.

All notices with the exception of those regarding eligibility for Prenatal and presumptive eligibility of children for Standard and Family Assistance provide information regarding an applicant's or member's right to a fair hearing. Family

Assistance members who receive a premium assistance payment will have the opportunity to appeal the MassHealth decision, including the calculation of the premium assistance payment. Information regarding the appeal process is found in MassHealth regulations at 130 CMR 610.000.

2.2.4 Referred Eligibles

Several groups receiving benefits from DTA receive MassHealth as a result of their eligibility for cash assistance. These groups include members in the following categories:

Elderly/SSI
Disabled/SSI
EAEDC (state-funded until enrolled under Basic)

SSI members all receive Standard. EAEDC members, though normally eligible for enrollment in Basic, are potentially eligible for several coverage types and MassHealth rules must be applied by the system to determine the most comprehensive coverage to which they are entitled.

TAFDC recipients who meet the requirements of section 1931 of Title XIX (42 U.S.C. section 1396U-1) are automatically eligible for Standard.

Assignment of the appropriate coverage type for these cases is accomplished through automated data exchange.

2.2.4.1.1 Transition Groups

Transition groups are those, whose eligibility must be re-determined under a different system or a different set of eligibility rules.

When a TAFDC or SSI member loses cash assistance, MassHealth benefits are extended for a prescribed period of time (*e.g.* Transition Medical Assistance); simultaneously closed (*e.g.*, death); or the member is sent a re-determination if the household is still potentially eligible for MassHealth (*e.g.* failed to comply with a work requirement). These cases have eligibility tested using MassHealth rules.

MassHealth transition groups consist of cases, or households, that move into or out of Traditional Medicaid based on changes such as 65th birthday or admission to (or discharge from) a long term care (LTC) facility. These cases must have eligibility redetermined under the applicable eligibility rules.

2.3 POST-AUDIT REVIEW

Under the demonstration, MassHealth will use an alternative quality control review that is designed to meet its changing needs as well as assist in maintaining program integrity by ensuring that services are rendered only to those meeting the eligibility standards.

This review process will assist MassHealth planners in developing, maintaining and validating policy which will be of value in securing the level of confidence in the MassHealth programs that is required by the general public, Legislators and the Executive Office. This process will also provide CMS with information on the findings and identify areas of improvement.

Based on MassHealth's approved alternative QC process, it is understood that MassHealth will be assigned an MEQC payment error rate equal to the FFY'96 state error rate. This error rate will be assigned for the duration of the 1115 waiver demonstration project.

2.3.1 Description of the Alternative Quality Control (QC) Process

Over the demonstration period MassHealth proposes to complete a series of evaluation or information studies related to MassHealth's eligibility policies, procedures, and processes.

Target populations from both the demonstration and non-demonstration coverage groups will be selected for focused reviews and studies, as required by Special Term and Condition No. 21, general topics shall include the traditional (over-65) Medicaid population and a process to verify eligibility for the Insurance Partnership. The proposals will be submitted to CMS each year for prior approval in accordance with timetables set by CMS.

Reports on findings for any new studies completed during the life of the waiver will be submitted no later than six months after the completion of the review. A sample time line for new studies and reviews is listed below:

Submit idea to CMS	Sample Period	Review & Analysis	Submit Report to CMS
1 month prior	3 month period	6 month period	Following month

2.3.2. Validation of the Division's Classification of Expansion and Non-expansion Eligibles

MEQC will conduct a validation review to determine if the MA21 eligibility system is placing members in the correct category of assistance. MassHealth then uses this categorization to assess if the member is in the base, 1902 (R)(2), or expansion population, MEQC will perform this review for the correct categorization by the system of the expansion and non-expansion cases by drawing 25 cases at random each quarter from the MA21 universe; and reviewing the "case record" (including the paper case record and the computer system) to determine that the correct information is on the system and the information correctly classifies the case.

2.3.3 IP Subsidy Validation Study

MEQC will conduct an annual validation of the premium assistance payment amounts made for the subsidy of employer-sponsored health insurance.

2.3.4 Traditional Medicaid /Health Care Reform Study

Every six months, MEQC will alternate between studies on various aspects of eligibility for (1) the MassHealth “traditional” Medicaid population – including those over 65 and members needing long-term-care services and (2) the MassHealth Health Care Reform population - including members under 65 and non-institutionalized.

2.3.5 Corrective Action

Statistical data generated during the review process will be utilized to analyze trends, identify error prone cases and assess staffing, training, policy or legislative needs. MassHealth will formulate the corrective action process.

Corrective action plans and findings will be transmitted to CMS.