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

MassHealth
Eligibility Letter 213
January 1, 2014

TO: MassHealth Staff

FROM: Kristin L. Thorn, Medicaid Director

RE: **Revisions to MassHealth Regulations-Affordable Care Act**

MassHealth is revising the regulations at 130 CMR 501.000 through 522.000 and 130 CMR 650.000 to conform to the Affordable Care Act (ACA), as described in federal regulations at 42 CFR 431, 435, and 457.

The revised regulations implement the categorical and financial requirements for MassHealth programs mandated by the ACA and changes in Massachusetts state law. In addition, the amended regulations describe operational changes in the application and redetermination processes.

The regulations at 130 CMR 507.000, 521.000, and 650.000 (for the Insurance Partnership) are being repealed. The regulations in 130 CMR 507.000 and 521.000 either have been moved to other chapters or have been deleted. The Insurance Partnership will end when ACA becomes effective, and nearly all current Insurance Partnership members will be eligible for continued assistance with the costs of health insurance either through MassHealth or the Health Connector.

Listed below is the status of each chapter. Since every chapter was either revised or repealed in its entirety, the individual new and obsolete pages are not being listed separately.

These regulations are effective January 1, 2014.

Chapter	Status
501	Revised in Its Entirety
502	Revised in Its Entirety
503	Revised in Its Entirety
504	Revised in Its Entirety
505	Revised in Its Entirety
506	Revised in Its Entirety

Chapter	Status
507	Repealed
508	Revised in Its Entirety
515	Revised in Its Entirety
516	Revised in Its Entirety
517	Revised in Its Entirety
518	Revised in Its Entirety
519	Revised in Its Entirety
520	Revised in Its Entirety
521	Repealed
522	Revised in Its Entirety
650	Repealed

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Section

501.001: Definition of Terms

The terms listed in 130 CMR 501.001 have the following meanings for the purposes of MassHealth, as described in 130 CMR 501.000 through 508.000: *Health Care Reform: MassHealth: Managed Care Requirements*.

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

American Indian or Alaska Native – a person who

(1) is a member of a federally recognized tribe, band, or group as defined in Title 25 of U.S.C.;

(2) is an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act at 43 U.S.C. 1601 et seq.; or

(3) has been determined eligible to receive health care services from Indian Health Care Providers as an Indian pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act.

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

Appeal Representative – a person who

(1) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Office of Medicaid Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy;

(3) is a licensed attorney who notifies the MassHealth Board of Hearings that he or she represents the appellant in an appeal. This shall also include a non-lawyer supervised by a licensed attorney; or

(4) is an authorized representative meeting the requirements of 130 CMR 501.001: Appeal Representative (1), (2), or (3).

Applicant – an individual who submits an application for MassHealth.

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

Authorized Representative –

(1) a person or organization designated as the authorized representative of an applicant or member in a completed, signed Authorized Representative Designation Form or similar designation document submitted to the MassHealth agency in which the authorized representative agrees to comply with rules regarding confidentiality in the course of representing the applicant or member, provided that such person or organization must satisfy one of the following criteria:

(a) an authorized representative may be a person or organization appointed by the applicant or member to act responsibly on his or her behalf in connection with the eligibility process and other ongoing communications with the MassHealth agency. Such person or organization shall have the authority to complete and sign an application on the applicant's behalf select a health plan, complete and sign a renewal form, receive copies of the applicant or member's notices and other communications from the MassHealth agency which may include protected health-care information, personal data, and financial information and unless otherwise specified, act on behalf of the applicant or member in all other matters with the MassHealth agency or the Connector;

(b) an authorized representative may be a person acting responsibly on behalf of the applicant or member who is sufficiently aware of such applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with the MassHealth agency. Such person shall have the authority to complete and sign an application on the applicant's behalf, select a health plan, complete and sign a renewal form, receive copies of the applicant or member's notices and other communications from the MassHealth agency which may include protected health-care information, personal data, and financial information; or

(c) an authorized representative may be a person acting responsibly on behalf of the applicant or member who has, under applicable law, authority to act on behalf of such applicant or member in making decisions related to health care or payment for health care including, but not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy. The extent of such person's authority to act on behalf of the applicant or member is determined by the applicable law or underlying legal document.

(2) As a condition of any organization serving as an authorized representative under 130 CMR 501.001: Authorized Representative (1)(a), a provider or staff member or volunteer of such organization must not have a conflict of interest and must affirm that he or she will adhere to 42 CFR part 431, subpart F.

Basic-Benefit Level (BBL) – benefits provided under a health-insurance plan that are comprehensive and comparable to benefits provided by insurers in the small-group health-insurance market provided that such plan meets minimum creditable coverage requirements as defined in 956 CMR 5.03: *Minimum Creditable Coverage*; provided further that individual and small group plans issued or renewed in Massachusetts must meet the requirements of qualified medical insurance as defined in 211 CMR 64.00: *Definitions of Qualified Medical Insurance for M.G.L. c. 118E, § 9C.*

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.

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

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

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

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

Child – a person younger than 19 years old.

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

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

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

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

Couple Policy – a health-insurance policy that covers a married couple. If an employer does not offer a couple policy, a married couple may be covered under a family policy.

Coverage Date – the date medical coverage begins.

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

Custodial Parent –

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

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

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

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

Disabled – having a permanent and total disability.

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

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

Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

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

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

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

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

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

Family Group – a family, couple, or individual.

Family Policy – a health-insurance policy that covers one or more adults, with one or more children. If an employer does not offer a couple policy, or a one-adult with one-child policy, a couple without children, or a family with one adult and one child may be covered by a family policy.

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

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

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

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

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

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

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

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

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

Individual Policy – a health-insurance policy that covers the policyholder only.

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

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

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

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

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

Managed Care – a system of primary care and other medical services that are provided and coordinated by a MassHealth managed-care provider in accordance with the provisions of 130 CMR 450.117: *Managed Care Participation* and 508.000: *Health Care Reform: MassHealth: Managed Care Requirements.*

Managed-Care Organization (MCO) – any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization (SCO), an integrated care organization, or an entity that is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

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

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

MassHealth Managed-Care Provider – a primary care clinician or managed care organization that has contracted with the MassHealth agency to provide and coordinate primary care and certain other medical services to certain MassHealth members.

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

Member – a person determined by the MassHealth agency to be eligible for MassHealth.

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

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

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

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

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

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

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

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

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

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

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

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

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

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

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

Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

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

Premium Assistance Payment – an amount contributed by the MassHealth agency toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members. Employer-sponsored-health-insurance plans include both "Employer-Sponsored Insurance (ESI) 50% Plans" and "Other Group Insurance Plans" as described in 130 CMR 506.012.

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

(1) The group can be an individual, a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts, or a family.

(2) Two parents are members of the same premium billing family group if they are mutually responsible for one or more children who live with them.

(3) A family making up a PBFG may consist of

(a) a child or children younger than 19 years old, any of their children, and their parents. A child who is absent from the home to attend school is considered as living in the home;

(b) siblings younger than 19 years old and any of their children who live together even if no adult parent or caretaker relative is living in the home; or

(c) a child or children younger than 19 years old, any of their children, and their caretaker relative when no parent is living in the home.

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

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

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

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

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

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

Quality Contro1 – a system of continuing review to measure the accuracy of eligibility decisions.

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

Redetermination – a review of a member's circumstances to establish whether he or she remains eligible for benefits.

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

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

Small Business – see definition for Small Employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

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

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

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

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

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

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

Young Adult – an individual aged 19 and 20.

501.002: Introduction to MassHealth

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

(B) 130 CMR 501.000 through 130 CMR 508.000: *Health Care Reform: MassHealth: Managed Care Requirements* provide the MassHealth requirements for children, young adults, parents and caretaker relatives, adults, pregnant women, disabled persons, persons who are HIV positive, individuals with breast or cervical cancer, and certain other individuals or couples who are under age 65 and not institutionalized. These requirements are prescribed in accordance with all applicable laws, including Title XIX, Title XXI, and MassHealth's 1115 Medicaid Research and Demonstration Waiver.

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

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

501.003: MassHealth Coverage Types

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

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

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

501.004: Administration of MassHealth

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

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA).

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

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

(i) MassHealth Standard: children younger than 19 years old, young adults 19 and 20 years of age who are citizens, qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present, and parents and caretakers who are citizens or qualified noncitizens;

(ii) Mass Health CarePlus: adults aged 21 through 64 who are citizens or qualified noncitizens; and

(iii) MassHealth Family Assistance: children younger than 19 years old, young adults 19 and 20 years of age who are nonqualified persons living under color of law (PRUCOLS), parents and caretakers who are qualified noncitizens barred, nonqualified individuals lawfully present, nonqualified PRUCOLS, and adults 21 through 64 years of age who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLS.

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

(3) Health Connector. The Health Connector is Massachusetts's health insurance marketplace where individuals, families, and small businesses can shop among qualified health insurance carriers and choose a health insurance plan. The Health Connector administers Qualified Health Plans (QHP), premium tax credits (PTC), and the ConnectorCare program. The single, streamlined application is used to determine eligibility for both Health Connector and MassHealth programs as described in 130 CMR 502.000: *Health Care Reform: MassHealth: The Request for Benefits*. The Health Connector and MassHealth also coordinate eligibility notices and eligibility appeals.

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

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

(1) Individuals and families (including caretaker relatives) who were receiving Medical Assistance on June 30, 1997, and whose family group gross income on June 30, 1997, exceeded MassHealth eligibility standards will be provided MassHealth Standard coverage for one year after the date of MassHealth implementation, except in the following circumstances:

(a) the individual or family no longer lives in Massachusetts;
(b) the individual enters an institution;
(c) the individual turns 65;
(d) the individual or all members of the family are deceased; or
(e) the individual or family is no longer categorically eligible.

(2) Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

(B) Families Who Have Met a Deductible.

(1) Families (including caretaker relatives) with children under 18 who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who were denied with a deductible before July 1, 1997, and subsequently meet a deductible on or after July 1, 1997, and whose family group gross income exceeds MassHealth standards will be eligible for MassHealth Standard for one year from the end of the deductible period, except in the following circumstances:

(a) the individual or family no longer lives in Massachusetts;
(b) the individual enters an institution;
(c) the individual turns 65;
(d) the individual or all members of the family are deceased; or
(e) the individual or family is no longer categorically eligible.

(2) A determination of eligibility for MassHealth will be made toward the end of the one-year period.

(C) Disabled Individuals Who Have Met a Deductible. Disabled individuals who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who meet a deductible on or after July 1, 1997, will have their continuing eligibility for MassHealth determined in accordance with 130 CMR 506.009: *The One-Time Deductible*.

501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998

(A) Eligibility.

(1) Children who were receiving benefits under the Children's Medical Security Plan on August 3, 1998, as well as any siblings in their family, will be treated as a protected status group under MassHealth if they

(a) have submitted a complete application (formerly known as Medical Benefit Request) as defined in 130 CMR 502.001: *Application for Benefits* by March 31, 1999;
(b) meet the eligibility requirements of MassHealth; and
(c) have an income less than or equal to 200 percent of the FPL.

(2) Families of children described in 130 CMR 501.006(A)(1) who are determined eligible for MassHealth Family Assistance will have the option of choosing purchase of medical benefits or premium assistance under MassHealth Family Assistance if the MassHealth agency determines the child has access to health insurance from an employer other than the Commonwealth of Massachusetts.

(B) Loss of Protected Status. The protected status of a child described in 130 CMR 501.006(A) will end in the following circumstances:

(1) the income exceeds 200 percent of the FPL;
(2) the family fails to cooperate with the MassHealth eligibility review; or
(3) the child no longer meets MassHealth requirements.

501.007: Receiving Public Assistance from Another State

Persons who are receiving public assistance from another state are not eligible for MassHealth.

(130 CMR 501.008 Reserved)

501.009: Rights of Applicants and Members

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

(A) Right to Nondiscrimination and Equal Treatment. The MassHealth agency does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the MassHealth agency's Affirmative Action Office.

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

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

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

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

(F) Right to Be Assisted by Others.

(1) The applicant or member has the right to be accompanied by an appeal representative as defined in 130 CMR 501.001 during the appeal process.

(2) An application for MassHealth may be filed by an authorized representative, including on behalf of a deceased person.

(3) An appeal of a MassHealth decision, including one brought on behalf of a deceased person, may be filed by an appeal representative, as defined in 130 CMR 501.001.

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

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

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

(I) Right to Interpreter Services. The MassHealth agency 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, the MassHealth agency will provide either telephonic or other interpreter services whenever

(1) the applicant or member who is seeking assistance from the MassHealth agency has limited English proficiency or sensory impairment and requests interpreter services; or
(2) the MassHealth agency determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The MassHealth agency provides a Certificate of Creditable Coverage to members whose coverage under Standard, CommonHealth, CarePlus, or Family Assistance has ended. The MassHealth agency issues a Certificate to members within one week of the MassHealth termination or within one week of the request for a Certificate, as long as the request is made within 24 months of the 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 other insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents are included on the Certificate.

501.010: Responsibilities of Applicants and Members

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

(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

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

501.011: Referrals to Investigative Units

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

501.012: Recovery of Overpayment of Medical Benefits

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

501.013: Estate Recovery

(A) Introduction.

(1) The MassHealth agency will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services provided while the member was 55 years of age or older.

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

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

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

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

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

(C) Waiver of Estate Recovery Due to Financial Hardship. For claims presented on or after November 15, 2003, recovery will be waived if

(1) a sale of real property would be required to satisfy a claim against the member's probate estate; and

(2) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(a) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the MassHealth agency and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate;

(b) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);

(c) the individual is not being forced to sell the property by other devisees or heirs at law; and

(d) at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

(3) The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), the property is sold or transferred, or the person does not use the property as their primary residence, the MassHealth agency will be notified and its claim will be payable in full.

(D) Outstanding Claims.

(1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the then-existing MassHealth regulations were met.

(2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

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

(1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

(a) a special-purpose tax assessment;
(b) based on a fixed-rate-per-acre method; or
(c) based on an assessment ratio or providing only a range.

(2) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official of a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.

(3) The MassHealth agency may also obtain an assessment from a knowledgeable source.

(F) Waiver of Estate Recovery Due to Hardship for American Indians and Alaska Natives.

(1) For claims presented on or after July 1, 2009, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:

(a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;

(b) ownership interest in trust and non-trust property, including real property and improvements

(i) located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or

(ii) for any federally recognized tribe not described in 130 CMR 501.013(F)(1)(b)(i), located within the most recent boundaries of a prior federal reservation;

(c) income left as a remainder in an estate derived from property protected in 130 CMR 501.013(F)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or

(e) ownership interests in or usage rights to items not covered by 130 CMR 501.013(F)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

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

501.014: Voter Registration

(A) Voter registration forms are available through the MassHealth agency to applicants and members who are

(1) U.S. citizens; and

(2) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members are

(1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;

(2) offered assistance in completing the voter registration form unless such assistance is refused; and

(3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.

(C) MassHealth agency staff must not

(1) seek to influence an applicant's or member's political preference or party registration;

(2) display any political preference or party allegiance to the applicant or member;

(3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or

(4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(D) Completed voter registration forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

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

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

(1) A member who
  (a) applied for Supplemental Security Income (SSI);
  (b) was denied SSI benefits by the Social Security Administration; and
  (c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.

(2) A member who
  (a) applied for TAFDC or MassHealth;
  (b) was denied TAFDC by the Department of Transitional Assistance, or was denied MassHealth by the MassHealth agency; and
  (c) had his or her initial denial overturned by a subsequent decision by DTA, the MassHealth agency, the fair hearing process, or the judicial review process.

(B) Limitations.

(1) Reimbursement is limited to bills incurred on or after the coverage start date for the applicable coverage type as described in 130 CMR 505.001: *Introduction* through 505.009: *MassHealth Small Business Employee Premium Assistance* , and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.

(2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, the MassHealth agency may require submission of medical evidence for consideration under the prior-authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

(1) Applicants or members seeking reimbursement must provide MassHealth with
  (a) a bill for medical services that includes
    (i) the provider's name;
    (ii) a description of the services provided; and
    (iii) the date the service was provided; and
  (b) proof of payment of the bill presented, such as a canceled check or receipt.

(2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.

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502.001: Application for Benefits

(A) Filing an Application. To apply for MassHealth, an individual or his or her authorized representative must file an application online at www.MAHealthConnector.org, complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

(1) Date of Application.

(a) The date of application for an online, telephonic, or in-person application is the date the application is submitted to the MassHealth agency.

(b) The date of application for a paper application that is either mailed or faxed is the date the application is received by the MassHealth agency.

(2) Online or Telephone Application Requirements.

(a) Individuals, or their authorized representative, if applicable, completing an application for MassHealth online at www.MAHealthConnector.org or by telephone must be identity proofed pursuant to 130 CMR 502.001(A)(3). Eligibility based on an online or telephonic application cannot be determined until the identity is proven or a paper application is submitted.

(b) If an applicant submits a paper application or applies in person at a MassHealth Enrollment Center, identity proofing is not required.

(3) Identity Proofing Process. An individual or his or her authorized representative, if applicable, completing an online or telephonic application will be asked a series of questions to prove his or her identity.

(a) If the individual is successfully identity proofed, the application may be submitted and an eligibility determination will be performed.

(b) If the individual is not successfully identity proofed, the individual will be asked to provide one or two forms of acceptable documentation proving his or her identity. Documentation proving identity must be received by the MassHealth agency within 15 days from the date of the request.

(c) If identity proof is received within 15 days of the date of the request referenced in 130 CMR 502.001(A)(3)(b) and an otherwise-completed application was submitted at the time of the initial unsuccessful identity proofing, the eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible and the application is considered submitted on the date of the initial unsuccessful identity proofing; and

(ii) the need to request any corroborative information during the provisional eligibility period necessary to determine eligibility, as provided in 130 CMR 502.001(B) through (D).

(d) If identity proof is not received within the 15-day period referenced in 130 CMR 502.001(A)(3)(b), the MassHealth agency will notify the applicant or his or her authorized representative that it is unable to determine eligibility for medical benefits. If acceptable proof of identity is received after the 15-day period, and a completed application has otherwise been submitted, the eligibility process commences and the application is considered submitted on the date the identity proof is received by the MassHealth agency. Notwithstanding the foregoing, if acceptable proof of identity or a paper application is received more than one year after the initial unsuccessful proofing, a new application must be submitted.

(e) To prove his or her identity, an individual can submit the acceptable proofs of identity as described in 130 CMR 504.005(A)(1): *Acceptable Proof of Both Citizenship and Identity* or 130 CMR 504.005(A)(3): *Acceptable Proof of Identity*.

(4) Paper Applications or In-Person Applications at the MEC Containing Missing or Inconsistent Information.

(a) If a paper application is received at a MassHealth Enrollment Center or a MassHealth outreach site and the applicant did not answer all required questions on the application or if the application is unsigned, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(b) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 15 days of the date of the request for the information.

(c) If responses to all unanswered questions necessary to determine eligibility are received within 15 days of the date of the request referenced in 130 CMR 502.001(A)(4)(b), the eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the application is considered submitted on the date the initial incomplete application was received by the MassHealth agency; or

(ii) the need to request any corroborative information during the provisional eligibility period necessary to determine eligibility, as provided in 130 CMR 502.001(B) through (D).

(d) If responses to all unanswered questions necessary for determining eligibility are not received within the 15-day period referenced in 130 CMR 502.001(A)(4)(b), the MassHealth agency notifies the applicant that it is unable to determine eligibility for medical benefits. The date that the incomplete application was received will not be used in any subsequent eligibility determinations. If the required response is received after the 15-day period, the eligibility process commences and the application is considered submitted on the date the response is received. Notwithstanding the foregoing, if the required response is submitted more than one year after the initial incomplete application, a new application must be completed.

(e) Inconsistent answers are treated as unanswered.

(B) Corroborative Information. The MassHealth agency requests all corroborative information necessary to verify eligibility during the provisional eligibility period. The applicant must supply such information within 90 days of the receipt of the Request for Information Notice, as described at 130 CMR 502.003(C).

(C) Corroborative Information Received. If all necessary information is received within the 90-day provisional eligibility period referenced in 130 CMR 502.003(E), the MassHealth agency will determine the most comprehensive medical benefits for which the applicant is eligible.

(D) Corroborative Information Not Received. If the necessary information is not received within the 90-day provisional eligibility period referenced in 130 CMR 502.003(E), with the exception of the individuals described at 130 CMR 502.001(D)(1) through (3), the MassHealth agency notifies the applicant of the termination of benefits.

(1) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of breast or cervical cancer, the individual will not be considered as an individual with breast or cervical cancer and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

(2) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of HIV-positive status, the individual will not be considered as an individual with HIV-positive status and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

(3) If the only necessary information not received within the provisional eligibility period referenced in 130 CMR 502.003(E) is verification of disability status, the individual will not be considered as a disabled individual and will be determined for the most comprehensive coverage for which the individual qualifies without this factor.

502.002: Reactivating the Application

If all required information is received by the MassHealth agency after the period described in 130 CMR 502.001(D), or after a denial of eligibility, the MassHealth agency reactivates the application and considers it submitted as of the date the information is received, and the medical coverage date is established in accordance with 130 CMR 502.006. A new application must be completed if all required information is not received within one year of receipt of the previous application.

502.003: Verification of Eligibility Factors

The MassHealth agency requires verification of eligibility factors including income, residency, citizenship, immigration status, and identity as described in 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements*, 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*, and 506.000: *Health Care Reform: MassHealth: Financial Requirements*.

(A) Information Matches. The MassHealth agency initiates information matches with other agencies and information sources as described at 130 CMR 502.004 in the following order, when an application is received in order to verify eligibility

(1) the Federal Data Hub, which matches with the Social Security Administration, the Department of Homeland Security, and the Internal Revenue Service; and

(2) other federal and state agencies and other informational services.

(B) Electronic Data Sources. If electronic data sources are unable to verify or are not reasonably compatible with the attested information, additional documentation will be required from the individual.

(C) Request for Information Notice. If additional documentation is required including corroborative information as described at 130 CMR 502.001(B), a Request for Information Notice will be sent to the applicant listing all requested verifications and the deadline for submission of the requested verifications.

(D) Time Standards. The following time standards apply to the verification of eligibility factors.

(1) The applicant or member has 90 days from the receipt of the Request for Information Notice to provide all requested verifications.

(2) If the applicant or member fails to provide verification of information within 90 days of receipt of the MassHealth agency's request, MassHealth coverage is denied or terminated except for individuals described at 130 CMR 502.001(D)(1) through (3).

(a) If the required verifications are received within one year from the date of the application or renewal form was received, coverage is reinstated to a date 10 days before the receipt of the verifications.

(b) If the required verifications are not received within one year of receipt of the previous application or renewal form, a new application must be completed.

(E) Provisional Eligibility. The MassHealth agency will provide benefits while the applicant provides the MassHealth agency outstanding corroborative information in accordance with 130 CMR 502.003(D)(1). Except as further set forth below, the MassHealth agency will accept self-attestation for all eligibility factors other than citizenship and immigration status, and make a provisional eligibility determination as if the applicant had supplied the information. MassHealth applicants can receive only one provisional eligibility approval during a 12-month period. MassHealth members are required to enroll in managed care during the provisional eligibility period, if enrollment is otherwise required as described in 130 CMR 508.004: *Members Excluded from Participation in Various Managed Care Options*. MassHealth members who have been assessed a premium are subject to payment of premiums during the provisional eligibility period. Premium assistance is not awarded during the provisional eligibility period. It is only provided when all corroborative information has been received and the health-insurance investigation is complete, as described in 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*. Provisional eligibility is subject to the following limitations.

(1) Coverage Date.

(a) Coverage for children younger than 21 years old and pregnant women who have been determined provisionally eligible begins 10 days before the date the application is received.

(b) Coverage for all other individuals who have been determined provisionally eligible begins on the date the notice of the provisional eligibility determination is sent.

(c) If all required verification are received before the end of the provisional eligibility period, retroactive coverage is provided for the verified coverage type in accordance with 130 CMR 505:000: *Health Care Reform: MassHealth: Coverage Types*.

(2) Limitations. Provisional eligibility is subject to the following limitations.

(a) The MassHealth agency will not accept self-attestation of disability. Disability must be verified as described in 130 CMR 505.002(E)(1): *Disabled Adults*. Eligibility for applicants who apply for benefits on the basis of disability will be determined as if they were not disabled until disability is verified as described in 130 CMR 505.002(E)(1): *Disabled Adults*.

(b) A member's coverage type will not be redetermined during the provisional eligibility period, except that members granted provisional eligibility who attest to pregnancy will be enrolled in MassHealth Standard.

(F) Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status. The MassHealth agency provides applicants and members a reasonable opportunity period to provide satisfactory documentary evidence of citizenship and identity or immigration status if MassHealth's electronic data matches are unable to verify the applicant's citizenship or immigration status.

(1) Time Standards. The reasonable period begins on, and extends 90 days from, the date on which an applicant or member receives a reasonable opportunity notice.

(2) Coverage Start Date.

(a) Coverage for children younger than 21 years old and pregnant women who receive a responsible-opportunity period begins 10 days before the date the application is received.

(b) Coverage for all other individuals who receive a reasonable-opportunity period begins on the date the Request for Information Notice is sent.

(c) If satisfactory documentary evidence of citizenship and identify or immigration status is received before the end of the reasonable-opportunity period, retroactive coverage is provided for the verified coverage type in accordance with 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

(G) Reasonable Opportunity Extension. Applicants or members who have made a good faith effort to resolve inconsistencies or obtain verification of citizenship and identity or immigration status may receive a 90-day extension. Requests for a reasonable opportunity extension must be made before the expiration of the verification time period.

(H) Hospital-Determined Presumptive Eligibility.

(1) Presumptive Eligibility Determinations. A qualified hospital may make presumptive eligibility determinations for its patients in accordance with 130 CMR 450.110: *Hospital Determined Presumptive Eligibility*. Presumptive eligibility will be determined based on attested information. The MassHealth agency will use estimated gross household income rather than MassHealth MAGI to assess whether the financial requirements described below have been met. The qualified hospital may determine presumptive eligibility for the following:

(a) MassHealth Standard if the individual appears to meet categorical and financial requirements in 130 CMR 505.002: *MassHealth Standard* and the individual is

(i) a child younger than one year old;

(ii) a child one through 18 years old;

(iii) a young adult 19 and 20 years old;

(iv) a pregnant woman;

(v) a parent or caretaker relative;

(vi) an individual with breast or cervical cancer;

(vii) an individual who is HIV positive; or

(viii) an independent foster care adolescent up to age 26;

(b) MassHealth CarePlus if the individual appears to meet categorical and financial requirements in 130 CMR 505.008: *MassHealth CarePlus* and the individual is an adult 21 to 64 years old; or

(c) MassHealth Family Assistance if the individual appears to meet categorical and financial requirements in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level* and (E): *Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* and is

(i) a child of a young adult who is a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; or

(ii) an individual who is HIV positive.

(2) Coverage Start Date. Benefits provided through the hospital presumptive eligibility process will begin 10 days before the date that the hospital determined presumptive eligibility and will continue until

(a) the end of the month following the month the hospital determined presumptive eligibility, if the individual has not submitted a complete application as described in 130 CMR 502.001 by that date; or

(b) an eligibility determination is made based upon the individual's submission of a complete application as described in 130 CMR 502.001, if the complete application was submitted before the end of the month following the month of the hospital-presumptive eligibility determination.

(3) Premium Assessment. Individuals who are determined eligible through hospital-determined presumptive eligibility will not be assessed a premium. Premium assistance is not awarded during the presumptive eligibility period.

(4) Continued Eligibility. The individual must submit a complete application as described in 130 CMR 502.001 to determine continued eligibility for MassHealth.

502.004: Matching Information

The MassHealth agency may initiate information matches with other agencies and information sources when an application is received, at annual renewal, and periodically, in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following: the Federal Data Services Hub, the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Social Security Administration, Systematic Alien Verification for Entitlements, Department of Transitional Assistance**,** and health insurance carriers.

502.005: Time Standards for an Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, the MassHealth agency makes an eligibility determination

(1) within 60 days from the date of receipt of the complete application if the applicant is potentially eligible for MassHealth Family Assistance; or

(2) within 45 days from the date of receipt of the complete application for all other nondisabled applicants.

(B) For applicants who apply on the basis of a disability, the MassHealth agency makes an eligibility determination within 90 days from the date of receipt of the complete application.

(C) Households with one or more applicants aged 65 or older who are not eligible for benefits under the regulations in 130 CMR 501.000: *Health Care Reform: MassHealth: General Policies* through 508.000: *Health Care Reform: MassHealth: Managed Care Requirements* will be determined by the time standards described at 130 CMR 516.004: *Time Standards for Eligibility Determination* for the entire household.

(D) The time standards described in 130 CMR 502.005(A) through (C) may be extended by the amount of time used by the applicant to respond to requests for additional information needed to make the disability determination.

502.006: Coverage Dates

(A) Start Date of Coverage. The date of coverage for MassHealth is determined by the coverage type for which the applicant may be eligible. 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types* describes the rules for establishing this date, except as specified in 130 CMR 502.003(E)(1), (F)(2), and (H)(2).

(B) End Date of Coverage. Except as specified in 130 CMR 502.003(H)(2), MassHealth benefits terminate no sooner than 10 days from the date of termination notice unless the MassHealth member timely files an appeal and requests continued MassHealth benefits pending such appeal. MassHealth will extend coverage to the end of the month only for those individuals whose MassHealth eligibility is terminated and who become eligible for the Premium Tax Credit (PTC). If the effective date of the termination is on or before the 15th of the month, MassHealth coverage will end on the last day of that month. If the effective date of the termination is after the 15th of the month, MassHealth coverage will end on the last day of the following month.

502.007: Continuing Eligibility

(A) Annual Renewals. The MassHealth agency reviews eligibility once every 12 months. Eligibility may also be reviewed as a result of a member's change in circumstances, or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification, such as immigration status, breast or cervical cancer status, or HIV-positive status. The MassHealth agency updates eligibility based on information received as a result of such review. The MassHealth agency reviews eligibility

(1) by information matching with other agencies, health insurance carriers, and information sources;

(2) through a written update of the member's circumstances on a prescribed form;

(3) through an update of the member's circumstances in person, by telephone, or on the MAHealthConnector.org account; or

(4) based on information in the member's case file.

(B) Eligibility Determinations. The MassHealth agency determines, as a result of this review, if

(1) the member continues to be eligible for the current coverage type;

(2) the member's current circumstances require a change in coverage type, premium payment, or premium assistance payment; or

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

(C) Eligibility Reviews. MassHealth reviews eligibility in the following ways.

(1) Automatic Renewal. Households whose continued eligibility can be determined based on electronic data matches with federal and state agencies will have their eligibility automatically renewed.

(a) The MassHealth agency will notify the member if eligibility has been reviewed using the automatic renewal process. The notice will include information about the data that was received through electronic data matches and used to determine continued eligibility.

(b) If the member's coverage type changes to a more comprehensive benefit, the start date for the new coverage is the date of the written notice, except that premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month that the insurance deduction begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(2) Prepopulated Review Form. If the individual's continued eligibility cannot be determined based on reliable information contained in their account or electronic data match with federal and state agencies, a prepopulated eligibility review form must be completed.

(a) The MassHealth agency will notify the member of the need to complete the prepopulated review form.

(b) The member will be given 45 days from the date of the request to return the paper prepopulated review form, log onto his or her MAHealthConnector.org account to complete the review online, or call the MassHealth agency to complete the review telephonically.

(i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available. If verification through electronic data match is unsuccessful, the MassHealth agency will request required verifications as described in 130 CMR 502.003 and the individual continues to receive benefits pending verification.

(ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.

(iii) If the individual submits the prepopulated review within 90 days of the termination date and is determined eligible for a MassHealth benefit, eligibility for that benefit is the date of the termination.

(iv) If the prepopulated review is returned, but the required verifications are not submitted with the form, a second 90-day period starts on the date that the prepopulated form is returned.

(v) If the prepopulated review is not submitted within 90 days of the previous termination date, a new application is required.

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

(i) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.

(ii) However, premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month the insurance begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(3) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 502.004 to update or verify eligibility.

(a) If the electronic data match indicates a change in circumstances that would result in potential reduction or termination of benefits, the MassHealth agency will notify the member of the information that was received through the data match and require the member to respond within 30 days of the date of the notice.

(i) If the member responds within 30 days and confirms the data is correct, eligibility will be determined using the confirmed data from the electronic data match.

(ii) If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional verification from the member will be required.

(iii) If the member does not respond within 30 days, eligibility will be determined using the data from the electronic data match.

(b) If the electronic data match indicates a change in circumstances that would result in an increase or no change in benefits, the MassHealth agency will notify the member of the information that was received through the data match and automatically update the case using the information received from the electronic data match and redetermine eligibility. The effective date of the change is the date of the redetermination of eligibility.

502.008: Notice

(A) MassHealth provides all applicants and members a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member who has requested MassHealth, and either provides information so the applicant or member can determine the reason for any adverse decision or directs the applicant or member to such information.

(B) Members also receive a notice, in accordance with 130 CMR 610.015: *Time Limits*, of any loss of coverage, or any changes in coverage type, premium, or premium assistance payments.

(C) The notices described in 130 CMR 502.008(A) and (B) provide information about the applicant's and member's right to a fair hearing, with the exception of notices about hospital-determined presumptive eligibility, as described in 130 CMR 502.003(G), and notices about federal or state law requiring an automatic change adversely affecting some or all members, as described in 42 CFR 431.220(b). Information about the appeal process is found at 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

502.009: Voluntary Withdrawal

The applicant or authorized representative may voluntarily withdraw his or her application for MassHealth.

502.010: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive premium assistance under MassHealth Small Business Employee Premium Assistance as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

(B) A temporary card may be issued to a member if there is an immediate need.

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503.001: Universal Eligibility Requirements

MassHealth applicants and members must meet all of the requirements of 130 CMR 503.000 as a condition of eligibility.

503.002: Residence Requirements

As a condition of eligibility, an applicant or member must be a resident of the Commonwealth of Massachusetts.

(A) Unless otherwise specified
(1) individuals 21 years of age and older are residents of the Commonwealth if they are living in the Commonwealth and either
(a) intend to reside in the Commonwealth, with or without a fixed address; or
(b) have entered the Commonwealth with a job commitment or are seeking employment, whether or not they are currently employed; or
(2) individuals 21 years of age and older who are not capable of stating intent as defined in 42 CFR 435.403(c) are residents of the Commonwealth if they are living in the Commonwealth.
(3) For any other non-institutionalized individuals 21 years of age and older not subject to 130 CMR 503.002(A)(1) or (2), their residence is determined in accordance with 42 CFR 233.40, the rules governing residence under the AFDC program.

(B) Unless otherwise specified
(1) individuals younger than 21 years old are residents of the Commonwealth if they are capable of indicating intent and are either married or emancipated from their parents and meet the requirements of 130 CMR 503.002(A)(1); or
(2) individuals younger than 21 years old not described in 130 CMR 503.002(B)(1) are residents of the Commonwealth if they are
(a) living in the Commonwealth, with or without a fixed address; or
(b) living with their parent or caretaker who is a resident of the Commonwealth in accordance with the requirements of 130 CMR 503.002(A)(1).

(C) Individuals of any age who are receiving a state supplementary payment (SSP) are residents of the Commonwealth if the Commonwealth is the state paying the SSP.

(D) Individuals of any age who are receiving federal payments for foster care and adoption assistance under title IV-E of the Social Security Act are residents of the Commonwealth if the Commonwealth is the state where the individuals live.

(E) (1) The individual's residency is considered verified if the individual has attested to Massachusetts residency and the residency has been confirmed by electronic data matching with federal or state agencies or information services.

(2) If residency cannot be verified through electronic data matching or there is conflicting information, the MassHealth agency may require documentation to validate residency.

(F) Acceptable proof of Massachusetts residency includes the following, as well as any other verification allowed as determined by the MassHealth agency:

(1) copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year);
(2) current utility bill or work order dated within the past 60 days;
(3) statement from a homeless shelter or homeless service provider;
(4) school records (if school is private, additional documentation may be requested);
(5) nursery school or daycare records (if school is private, additional documentation may be requested);
(6) Section 8 agreement;
(7) homeowner’s insurance agreement;
(8) proof of enrollment of custodial dependent in public school;
(9) copy of lease and record of most recent rent payment; or
(10) affidavit supporting residency signed under pains and penalties of perjury.

(G) Examples of applicants or members who do not meet the residency requirement for MassHealth are

(1) 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; and
(2) individuals whose whereabouts are unknown.

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

(1) they are inpatients in a medical facility; or
(2) they are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.

503.003: Social Security Number (SSN)

(A) Requirements.

(1) Condition of Eligibility. As a condition of eligibility for MassHealth, all persons applying in the household must furnish an SSN or proof of application for an SSN, except as provided in 130 CMR 503.003(A)(1). The applicant is notified of the obligation to apply for an SSN for any person applying in the household. The MassHealth agency does not require an SSN or proof of application for an SSN for any applicant who

(a) attests to a religious exemption as described in federal law;
(b) is only eligible for a non-work SSN;
(c) is not eligible to receive an SSN.

(2) Electronic Data Match. The MassHealth agency verifies each SSN by an electronic data match with the Social Security Administration (SSA).

(3) Reasonable Opportunity to Verify a Social Security Number. If the applicant has provided an SSN the MassHealth agency matches with the SSA to verify the SSN. If the SSA is unable to verify the SSN, the individual is required to verify his or her SSN.

(a) The MassHealth agency provides applicants and members a reasonable opportunity period to provide an SSN if SSA is unable to verify the SSN or the individual has not provided the SSN.

(b) The reasonable opportunity period begins on, and will extend 90 days from, the date on which an applicant or member receives a Request for Information Notice.

(c) While the verification of SSN is pending, the individual will receive benefits if there are no other verifications outstanding.

(B) Right to Know Uses of Social Security Numbers. All household members are given a written notice of the following:

(1) the reason the SSNs are requested;
(2) the computer matching of SSNs with SSNs in other personal data files within
(a) the MassHealth agency;
(b) the Federal Data Hub, which matches with the SSA;
(c) the Department of Homeland Security (DHS);
(d) the Internal Revenue Service; and
(e) other federal and state agencies and other informational services; and
(3) the possible denial or termination of benefits, if any applicant or member fails to provide his or her SSN or proof of application for an SSN, unless an exception described in 130 CMR 503.003(A)(1) applies to the applicant or member.

503.004: Assignment of Rights to Medical Support and Third-Party Payments

(A) Every legally able applicant or member must assign to the MassHealth agency his or her rights to medical support and third-party payments for medical benefits provided under MassHealth as well as the rights of applicants or members for whom he or she can legally assign medical support and third-party payments.

(B) The applicant or member must fully cooperate with the MassHealth agency in
(1) establishing paternity;
(2) obtaining any medical support and payments; and
(3) identifying and providing information to assist the MassHealth agency in pursuing third parties, including a noncustodial parent, who may be legally obligated to pay for care and services for the applicant or member, or person on whose behalf benefits are requested, unless the applicant or member has grounds to waive cooperation as described in 130 CMR 503.005 or 505.002 (D): *Eligibility Requirements for Pregnant Women*.

(C) (1) The MassHealth agency will deny eligibility for any applicant who does not attest to a willingness to cooperate and terminate eligibility for any member who refuses to cooperate, unless the applicant or member demonstrates good cause, as described in 130 CMR 503.005, or is a pregnant woman who meets the requirements of 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.
(2) The MassHealth agency will not deny or terminate eligibility of any applicant or member who cannot legally assign his or her own rights, including, but not limited to, a minor child, and who would otherwise be eligible but for the refusal, by a person legally able to assign the child's rights, to assign the child's rights or to cooperate as required in 130 CMR 503.004.

503.005: Waiver of Cooperation for Good Cause

(A) Good cause is established if
(1) the MassHealth agency finds that cooperation is against the best interest of the child with respect to the obligation to establish paternity of a child born out of wedlock, obtain medical-care support and payments, or identify or provide information to assist the MassHealth agency in pursuing a liable third party for a child for whom the applicant or member can legally assign rights; or
(2) the MassHealth agency finds that cooperation is not in the best interest of the applicant or member or the person for whom the benefit is being requested or furnished because it is anticipated that cooperation will result in reprisal against, and cause serious physical or emotional harm to the applicant or member or another person with respect to the obligation to cooperate in all cases not covered by 130 CMR 503.005(A)(1).

(B) Good cause for noncooperation includes, but is not limited to, the following circumstances:
(1) the child was conceived as a result of incest or forcible rape;
(2) legal proceedings for adoption are pending before a court;
(3) a public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three months; or
(4) cooperation would result in serious physical or emotional harm to the child, the relative with whom the child resides, or to the applicant or member.

503.006: Assignment for Third-Party Recoveries

As a condition of eligibility, an applicant or member must inform any MassHealth Enrollment Center when any such individual is involved in an accident, or suffers from an illness or injury, or other loss that has resulted or may result in a lawsuit or insurance claim. The applicant or member must

(A) file an insurance claim for compensation, if available; and

(B) agree to comply with all requirements of M.G.L. c. 118E, § 22 including, but not limited to
(1) assigning to the MassHealth agency or its agent the right to recover an amount equal to the MassHealth benefits provided from the proceeds of any claim or other proceeding against a third party;
(2) providing information about the claim or any other proceeding and cooperating fully with the MassHealth agency or its agent, unless the MassHealth agency determines that cooperation would not be in the best interests of, or would result in serious physical or emotional harm to, the applicant or member, in accordance with 130 CMR 503.005;
(3) notifying a MassHealth Enrollment Center in writing within 10 days of filing any claim, civil action, or other proceeding; and
(4) repaying the MassHealth agency from the money received from a third party for all MassHealth benefits provided on or after the date of the accident or other incident. If the member is involved in an accident or other incident after becoming MassHealth eligible, repayment will be limited to MassHealth benefits provided as a result of the accident or incident.

503.007: Potential Sources of Health Care

The MassHealth agency is the payor of last resort and pays for health care and related services only when no other source of payment is available, except as otherwise required by federal law.

(A) Health Insurance. Every applicant and member must obtain and maintain available group health insurance in accordance with 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*. Failure to do so may result in loss or denial of eligibility unless the applicant or member is
(1) receiving MassHealth Standard or MassHealth CommonHealth; and
(2) younger than 21 years of age or pregnant.

(B) Use of Benefits. The MassHealth agency does not pay for any health care and related services that are available

(1) through the member's health insurance, if any; or

(2) at no cost to the member including, but not limited to, any such services that are available through any agency of the local, state, or federal government, or any entity legally obligated to provide those services.

(C) Employer-Sponsored Health Insurance. The MassHealth agency may enroll MassHealth members in available employer-sponsored health insurance if that insurance meets the criteria for payment of premium assistance under 130 CMR 506.012(B): *Criteria*.

503.008: Utilization of Potential Benefits

(A) An applicant or member must take all necessary steps to obtain benefits to which he or she is legally entitled or for which he or she may be eligible, unless he or she can show that doing so would put the applicant, member, or any of the applicant's or member's family members in harm by supplying information to the policyholder in cases where there is demonstrated necessity for restricting such access. Benefits under this provision include, but are not limited to

(1) Social Security benefits;

(2) Railroad Retirement benefits;

(3) federal Veterans' Administration benefits, including payment provided by the Veterans' Administration to purchase Aid and Attendance;

(4) civil service annuities;

(5) unemployment compensation;

(6) workers' compensation;

(7) state retirement benefits; and

(8) any benefits to which the applicant or member is legally entitled and any share in any estate to which the applicant or member is entitled. Members are not required to maintain a health plan if its cost causes financial hardship to the member.

(B) The applicant or member who is otherwise eligible for MassHealth will receive MassHealth benefits while claims for other benefits are pending provided that MassHealth eligibility is redetermined when such benefits are received.

(C) Applicants and members are not required to apply for TAFDC, EAEDC, SSI, or Massachusetts state veterans' service benefits as a condition of receiving MassHealth only.

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504.001: Introduction

Persons applying for or receiving MassHealth must verify their citizenship and identity or immigration status. Citizens and nationals who receive Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) based upon disability, or Medicare (including those who are entitled to Medicare), and children in receipt of either Title IV-B services or Title IV-E adoption assistance or foster care payments do not need to submit verification. In addition, a child born to a woman who is eligible for MassHealth on the date of the child's birth is exempt from providing citizenship and identity verification as described in 130 CMR 504.004(E).

504.002: U.S. Citizens

A citizen of the United States is

(A) an individual who was born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands (CNMI), except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under § 301 et seq. of the Immigration and Nationality Act (INA);

(B) an individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under § 301 *et seq*. of the Immigration and Nationality Act;

(C) a naturalized citizen; or

(D) a national (both citizen national and noncitizen national) as defined in 130 CMR 504.002(D)(1) or (2).

(1) Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under § 301 et seq. of the Immigration and Nationality Act.

(2) Noncitizen National. A noncitizen national is an individual who was born in one of the outlying possessions of the United States, including American Samoa and Swain's Island, to a parent who is a noncitizen national.

504.003: Immigrants

(A) Lawfully Present Immigrants. Qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present are considered lawfully present immigrants. The applicable coverage for qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present is listed at 130 CMR 504.006.

(1) Qualified Noncitizens. There are two groups of qualified noncitizens:

(a) those who are qualified regardless of when they entered the U.S. or how long they had a qualified status. Such individuals are

(i) persons granted asylum under section 208 of the INA;

(ii) refugees admitted under section 207 of the INA;

(iii) persons whose deportation has been withheld under section 243(h) or 241(b)(3) of the INA, as provided by section 5562 of the federal Balanced Budget Act of 1997;

(iv) veterans, their spouses, and their children

a. veterans of the United States Armed Forces with an honorable discharge not related to their noncitizen 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 noncitizen status on active duty in the U.S. Armed Forces, other than active duty for training; or

e. the spouse, unremarried surviving spouse, or unmarried dependent children of the noncitizen described in 130 CMR 504.003(A)(1)(a)(iv) a. through d.;

(v) conditional entrants under section 203(a)(7) of the INA in effect before April 1, 1980;

(vi) persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980;

(vii) 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);

(viii) Amerasians as described in section 402(a)(2)(A)(i)(V) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);

(ix) victims of severe forms of trafficking; and spouse, child, sibling, or parent of the victim, in accordance with the Victims of Trafficking and Violence Protection Act of 2000 (Pub. L. 106-386);

(x) Iraqi Special Immigrants granted special immigrant status under section 101(a)(27) of the Immigration and Nationality Act, pursuant to section 1244 of Public Law 110-181 or section 525 of Public Law 110-161; or

(xi) Afghan Special Immigrants granted special immigrant status under section 101(a)(27) of the Immigration and Nationality Act, pursuant to section 525 of Public Law 110-161.

(b) noncitizens who are qualified based on having a qualified status identified at 130 CMR 504.003 (A)(1)(b)(i) and who have satisfied one of the conditions listed at 130 CMR 504.003(A)(1)(b)(ii). Such individuals

(i) have one or more of the following statuses:

a. admitted for legal permanent residence (LPR) under the Immigration and Nationality Act (INA); or

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

c. are the battered spouse, battered child, or child of battered parent or parent of battered child who meets the criteria of section 431(c) of PRWORA; and also

(ii) satisfy at least one of the three following conditions:

a. they have had a status in 130 CMR 504.003 (A)(1)(B)(i) for five or more years (a battered noncitizen attains this status when the petition is accepted as establishing a prima facie case);

b. they entered the U.S. prior to August 22, 1996, regardless of status at the time of entry, and have been continuously present in the U.S. until attaining a status listed in 130 CMR 504.003(A)(1)(b)(i); for this purpose an individual is deemed continuously present who has been absent from the U.S. for no more than 30 consecutive days or 90 nonconsecutive days prior to attaining a status listed in 130 CMR 504.003(A)(1)(b)(i); or

c. they also have or had a status listed in 130 CMR 504.003(A)(1)(a).

(2) Qualified Noncitizens Barred. Individuals who have a status listed at 130 CMR 504.003(A)(1)(b)(i) (legal permanent resident, parolee for at least one year, or battered noncitizen) and do not meet one of the conditions in 130 (CMR 504.003(A)(1)(b)(ii). Qualified noncitizens barred, like qualified noncitizens, are lawfully present nonqualified individuals.

(3) Nonqualified Individuals Lawfully Present. Nonqualified individuals lawfully present are not defined as qualified under PRWORA, 8 U.S.C. 1641, but are lawfully present. Nonqualified individuals lawfully present are as follows:

(a) are in a valid nonimmigrant status as otherwise defined in 8 U.S.C. 1101(a)(15) or otherwise under immigration laws (as defined in 8 U.S.C. 1101(a)(17));

(b) are paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(c) belong to one of the following classes:
(i) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;
(ii) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. 1254a, and individuals with pending applications for TPS who have been granted employment authorization;
(iii) granted employment authorization under 8 CFR 274a.12(c);
(iv) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649,;
(v) under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
(vi) granted Deferred Action status, except for applicants or individuals granted status under DHS Deferred Action for Childhood Arrivals Process (DACA);
(vii) granted an administrative stay of removal under 8 CFR part 241; or
(viii) beneficiaries of approved visa petitions who have pending applications for adjustment of status;
(d) have a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who:
(i) have been granted employment authorization; or
(ii) are younger than 14 years old and have had an application pending for at least 180 days;
(e) have been granted withholding of removal under the Convention Against Torture; or
(f) is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J).

(B) Protected Noncitizens. Noncitizens who are not qualified noncitizens as described in 130 CMR 504.003(A)(1) but who are qualified noncitizens barred as described in 130 CMR 504.003(A)(2); nonqualified individuals lawfully present as described in 130 CMR 504.003(A)(3); nonqualified persons residing under color of law (PRUCOLs) as described in 130 CMR 504.003(C); or other noncitizens as described at 130 CMR 504.003(D) and who were receiving medical assistance or CommonHealth on June 30, 1997, are considered protected noncitizens 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.

(C) Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs). Certain noncitizens who are not described at 130 CMR 504.003(A) or (B) may be permanently living in the United States under color of law. The applicable coverage types for nonqualified PRUCOLS are listed at 130 CMR 504.006. If not otherwise described in 504.003(A) or (B) the following are considered nonqualified PRUCOLs:

(1) noncitizens living in the United States in accordance with an indefinite stay of deportation;

(2) noncitizens living in the United States in accordance with an indefinite voluntary departure;

(3) noncitizens and their families who are covered by an approved immediate relative petition, who are entitled to voluntary departure, and whose departure the U.S. Department of Homeland Security (DHS) does not contemplate enforcing;

(4) noncitizens granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing;

(5) noncitizens living under orders of supervision who do not have employment authorization under 8 CFR 274a.12(c);

(6) noncitizens who have entered and continuously lived in the United States since before January 1, 1972;

(7) noncitizens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing;

(8) noncitizens with pending applications for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention against Torture who have not been granted employment authorization, or are under the age of 14 and have not had an application pending for at least 180 days;

(9) noncitizens granted Deferred Action for Childhood Arrivals status or who have a pending application for this status;

(10) noncitizens who have filed an application, petition, or request to obtain a lawfully present status that has been accepted as properly filed, but who have not yet obtained employment authorization and whose departure DHS does not contemplate enforcing; or

(11) any noncitizen living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include persons granted Extended Voluntary Departure due to conditions in the noncitizen's home country based on a determination by the U.S. Secretary of State.)

(D) Other Noncitizens. Noncitizens whose status is not described in 130 CMR 504.003(A) through (C), are considered other noncitizens. The applicable coverage types for other noncitizens are listed at 130 CMR 504.006.

504.004: Verification of U.S. Citizenship and Identity and Immigration Status

(A) U.S. Citizenship and Immigration Status. MassHealth requires verification of U.S. citizenship or immigration status for all MassHealth applicants, except other noncitizens.

(1) The MassHealth agency will initiate electronic data matches as described in 130 CMR 502.004: *Matching Information* to attempt to verify U.S. citizenship or immigration status. If electronic data sources are unable to verify U.S. citizenship or immigration status, additional documentation will be required from the individual.

(2) Acceptable proof of U.S. citizenship is described at 130 CMR 504.005(A)(1) and (2). Individuals who fail to submit proof of U.S. citizenship within 90 days of the MassHealth agency's request will subsequently only be

(a) eligible for Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or

(b) eligible for MassHealth Standard for those who are pregnant if they meet the categorical requirements and financial standards described at 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.

(3) Acceptable proof of immigration status is described at 130 CMR 504.005(B). Individuals who fail to submit proof of immigration status within 90 days of the MassHealth agency's request will subsequently be

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

(b) eligible for Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or

(c) eligible for MassHealth Standard for those who are pregnant if they meet the categorical requirements and financial standards described at 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.

(B) Identity. MassHealth requires verification of identity for U.S. citizens.

(1) The MassHealth agency will initiate electronic data matches as described in 130 CMR 502.003: *Verification of Eligibility Factors* to attempt to verify identity. If electronic data sources are unable to verify identity, additional documentation will be required from the individual.

(2) Acceptable proof of identity is described at 130 CMR 504.005(A)(3).

(3) U.S. citizens as described at 130 CMR 504.002 who fail to verify identity within 90 days of the MassHealth agency's request will subsequently only be

(a) eligible for Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or

(b) eligible for MassHealth Standard for those who are pregnant if they meet the categorical requirements and financial standards as described at 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.

(C) Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status. The MassHealth agency provides applicants and members a reasonable opportunity period to provide satisfactory documentary evidence of citizenship and identity or immigration status in accordance with 130 CMR 502.003(F): *Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status*.

(D) Reasonable Opportunity Extension. Applicants or members who have made a good-faith effort to resolve inconsistencies or obtain verification of citizenship and identity or immigration status may receive a 90-day extension in accordance with 130 CMR 502.003(G): *Reasonable Opportunity Extension*.

(E) Child Born to a MassHealth-Eligible Woman. Regardless of the mother's immigration status, a child born to a woman who is eligible for MassHealth on the date of the child's birth will be deemed eligible for MassHealth from birth until the child's first birthday and is exempt from providing citizenship and identity verification for eligibility.

504.005: Documents for Verifying U.S. Citizenship and Identity and Immigration Status

(A) Acceptable Proof of U.S. Citizenship and Identity. Pursuant to 130 CMR 504.004(B), U.S. citizens must provide proof of both citizenship and identity.

(1) Acceptable Proof of Both Citizenship and Identity. The following documents are satisfactory proof of both citizenship and identity:

(a) U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation;

(b) Certificate of Naturalization;

(c) Certificate of U.S. Citizenship; or

(d) a document issued by a federally recognized Indian tribe, as published in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and identifies the federally recognized Indian tribe that issued the document, identifies the individual by name, and confirms the individual's membership, enrollment, or affiliation with the tribe. These documents include, but are not limited to, a tribal enrollment card, a Certificate of Degree of Indian Blood, a tribal census document, and documents on tribal letterhead, issued under the signature of the appropriate tribal official that meet the requirements of 130 CMR 504.005(A)(1)(d).

(2) Acceptable Proof of Citizenship. If one of the documents listed in 130 CMR 504.005(A)(1) is not provided, the following documents are acceptable as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in 130 CMR 504.005(A)(3):

(a) U.S. public birth certificate showing birth in one of the 50 states (including the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the U.S. Virgin Islands (if born on or after January 17, 1917), American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, CNMI local time). The birth record may be issued by the state, commonwealth, territory, or local jurisdiction. However, if the document shows the individual was born in Puerto Rico, the U.S. Virgin Islands, or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen;
(b) cross-match with the Massachusetts Registry of Vital Statistics that documents a record of birth;
(c) Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.;
(d) Report of Birth Abroad of a U.S. Citizen;
(e) certification of birth;
(f) U.S. Citizen I.D. card;
(g) Northern Mariana Identification Card, issued to a collectively naturalized citizen who was born in the CNMI before November 4, 1986;
(h) final adoption decree showing the child's name and U.S. place of birth, or, if the adoption is not final, a statement from state-approved adoption agency that shows the child's name and U.S. place of birth;
(i) evidence of U.S. civil service employment prior to June 1, 1976;
(j) U.S. military record showing a U.S. place of birth;
(k) data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the U.S. Department of Homeland Security to verify that an individual is a citizen;
(l) documentation that the child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. 1431);
(m) medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from as nursing facility, skilled-care facility, or other institution that indicate place of birth;
(n) life, health, or other insurance records that indicate a U.S. place of birth;
(o) official religious records recorded in the U.S. showing that the birth occurred in the U.S.;
(p) school records, including preschool, Head Start, and day care, showing the child's name and U.S. place of birth;
(q) federal or state census records showing U.S. citizenship or a U.S. place of birth; and
(r) if an individual does not have one of the documents listed at 130 CMR 504.005(A)(2)(a) through (q), he or she may submit an affidavit signed by another individual, under penalty of perjury, who can reasonably attest to the individual's citizenship, and that contains the individual's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(3) Acceptable Proof of Identity. The following are considered acceptable proof of identity.
(a) The following are acceptable proof of identity, provided such documentation has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:
(i) identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority;
(ii) driver's license issued by a state or territory;
(iii) school identification card;
(iv) U.S. military card or draft record;
(v) identification card issued by the federal, state, or local government;
(vi) military dependent's identification card; or
(vii) U.S. Coast Guard Merchant Mariner card;
(b) for children younger than 19 years old, a clinic, doctor, hospital, or school record, including preschool or day care records;
(c) two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to
(i) employer identification cards;
(ii) high school and college diplomas (including high school equivalency diplomas);
(iii) marriage certificates;
(iv) divorce decrees;
(v) property deeds or titles;
(vi) a pay stub from a current employer with the applicant's name and address preprinted, dated within 60 days of the application;
(vii) census verification containing the applicant's name and address, dated not more than 12 months before the date of the application;
(viii) a pension or retirement statement from a prior employer or pension fund stating the applicant's name and address, dated within 12 months of the application;
(ix) tuition or student loan bill containing the applicant's name and address, dated not more than 12 months before the date of the application;
(x) utility bill, cell phone bill, credit card bill, doctor's bill, or hospital bill containing applicant's name and address, dated not more than 60 days before the date of the application;
(xi) valid homeowner's, renter's, or automobile insurance policy with preprinted address, dated not more than 12 months before the date of the application, or a bill for such insurance with preprinted address, dated not more than 60 days before the date of the application;
(xii) lease dated not more than 12 months before the date of the application, or home mortgage identifying applicant and address; or
(xiii) employment verification by means of W-2 forms or other documents bearing the applicant's name and address submitted by the employer to a government agency as a consequence of employment.

(d) a finding of identity from a federal or state agency including, but not limited to, a public assistance, law enforcement, internal revenue, or tax bureau or corrections agency, if the agency has verified and certified the identity of the individual;
(e) a finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Social Security Act; or
(f) if the applicant does not have any document specified in 130 CMR 504.005(A)(3)(a) through (c) and identity is not verified under 130 CMR 504.005(A)(3)(d) or (e), the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in 130 CMR 504.005(A)(3)(a). This affidavit does not have to be notarized.

(4) Verification of Citizenship or Identity by a Federal Agency or Another State. The MassHealth agency may rely, without further documentation of citizenship or identity, on a verification of citizenship or identity made by a federal agency or another state, if such verification was done on or after July 1, 2006.

(5) Assistance with Obtaining Documentation. The MassHealth agency will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(B) Acceptable Proof of Immigration Status. Acceptable proof of immigration status includes any verification allowed under federal law as determined by the MassHealth agency.

(C) Documentary Evidence. A photocopy, facsimile, scan, or other copy of a document will be accepted to the same extent as an original document, unless information on the submitted document is inconsistent with other information available to the MassHealth agency, or the MassHealth agency otherwise has reason to question the validity of the document or the information on the document.

504.006: Applicable Coverage Types

(A) Citizens, qualified noncitizens, and protected noncitizens may receive MassHealth under any coverage type if they meet the eligibility requirements described in 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

(B) Qualified noncitizens barred and nonqualified individuals lawfully present may receive the following coverage.

(1) MassHealth Standard, if they are younger than 19 years old, young adults 19 and 20 years of age, or pregnant women and meet the categorical requirements and financial standards described at 130 CMR 505.002: *MassHealth Standard*; independent foster care children 18 through 20 years of age, and children younger than 19 years old and young adults age 19 and 20 years of age who are receiving EAEDC.

(2) MassHealth CommonHealth, if they are younger than 19 years old and meet the categorical requirements and financial standards as described at 130 CMR 505.004: *MassHealth CommonHealth*;

(3) MassHealth Family Assistance, if they are children younger than 19 years old, disabled adults 21 through 64 years of age and meet the categorical requirements and financial standards as described at 130 CMR 505.005: *MassHealth Family Assistance* or adults 21 through 64 years of age who are receiving EAEDC;

(4) MassHealth Limited, if they are adults 21 through 64 years of age and meet the categorical requirements and financial standards as described in 130 CMR 505.006: *MassHealth Limited*; and

(5) Children's Medical Security Plan, if they are children younger than 19 years old and meet the categorical requirements and financial standards as described at 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

(C) Nonqualified PRUCOLs may receive the following:

(1) MassHealth Standard if they are pregnant and meet the categorical requirements and financial standards as described at 130 CMR 505.002: *MassHealth Standard*;

(2) MassHealth CommonHealth, if they are younger than 19 years old or a young adult 19 or 20 years of age and meet the categorical requirements and financial standards as described at 130 CMR 505.004: *MassHealth CommonHealth*;

(3) MassHealth Family Assistance if they are children younger than 19 years old, young adults 19 and 20 years of age, adults 21 through 64 years of age and meet the categorical requirements and financial standards as described at 130 CMR 505.005: *MassHealth Family Assistance*; or are receiving EAEDC;

(4) MassHealth Limited, if they are children younger than 19 years old, young adults 19 or 20 years of age, adults 21 through 64 years of age and meet the categorical requirements and financial standards as described at 130 CMR 505.006: *MassHealth Limited*; and
(5) Children's Medical Security Plan, if they are children younger than 19 years old and meet the categorical requirements and financial standards as described at 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

(D) Other noncitizens may receive the following coverage:
(1) MassHealth Standard, if they are pregnant and meet the categorical requirements and financial standards as described at 130 CMR 505.002: *MassHealth Standard*;
(2) MassHealth Limited, if they meet the categorical requirements and financial standards as described at 130 CMR 505.006: *MassHealth Limited*; and
(3) Children's Medical Security Plan, if they are children younger than 19 years old and meet the categorical requirements and financial standards as described at 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

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Section

505.001: Introduction

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

(A) The MassHealth coverage types are the following:

(1) Standard – for pregnant women, children, parents and caretaker relatives, young adults, disabled individuals, certain persons who are HIV positive, individuals with breast or cervical cancer, independent foster care adolescents, Department of Mental Health members, and medically frail as such term is defined in 130 CMR 505.008(F);

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

(3) CarePlus – for adults 21 through 64 years of age who are not eligible for MassHealth Standard;

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

(5) Small Business Employee Premium Assistance – for adults or young adults who

(a) work for small employers;

(b) are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or CarePlus;

(c) do not have anyone in their premium billing family group who is otherwise receiving a premium assistance benefit; and

(d) have been determined ineligible for a Qualified Health Plan with a Premium Tax Credit due to access to affordable employer-sponsored insurance coverage;

(6) Limited – for certain lawfully present immigrants as described in 130 CMR 504.003(A), nonqualified PRUCOLs, and other noncitizens as described in 130 CMR 504.003: *Immigrants*; and

(7) Senior Buy-In and Buy-In – for certain Medicare beneficiaries.

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

505.002: MassHealth Standard

(A) Overview.

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

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

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

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

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

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

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

(1) Children Younger than One Year Old.

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

(i) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 200 percent of the federal poverty level (FPL): and

(ii) the child is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A).

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

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

(2) Children One through 18 Years of Age.

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

(i) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 150 percent of the federal poverty level; and

(ii) the child is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A).

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

(3) Young Adults.

(a) A young adult is eligible if

(i) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 150 percent of the federal poverty level (FPL); and

(ii) the young adult is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as described in 130 CMR 504.003(A).

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

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

(C) Eligibility Requirements for Parents and Caretaker Relatives.

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

(a) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133 percent of the federal poverty level (FPL);

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

(c) (i) the parent lives with his or her children, and assumes primary responsibility for the child's care, in the case of a parent who is separated or divorced, has custody of his or her children, or has children who are absent from home to attend school; or

(ii) the caretaker relative lives with children to whom he or she is related by blood, adoption, or marriage (including stepsiblings), or is a spouse or former spouse of one of those relatives, and assumes primary responsibility for the child's care if neither parent lives in the home.

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

(D) Eligibility Requirements for Pregnant Women.

(1) A pregnant woman is eligible if

(a) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 200 percent of the federal poverty level (FPL); and

(b) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens*, lawfully present immigrant, nonqualified PRUCOL, or an other noncitizen as described in 130 CMR 504.003: *Immigrants*.

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

(3) Eligibility, once established, continues for the duration of the pregnancy. Eligibility for postpartum care continues for 60 days following the termination of the pregnancy plus an additional period extending to the end of the month in which the 60-day period ends.

(E) Disabled Individuals.

(1) Disabled Adults. A disabled adult 21 through 64 years of age is eligible for MassHealth Standard coverage if he or she meets the following requirements:

(a) the individual is permanently and totally disabled as defined in 130 CMR 501.001 *Definition of Terms*;

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

(c) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
(d) the individual complies with 130 CMR 505.002(M).

(2) Determination of Disability. Disability is established by
(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
(b) a determination of disability by the SSA; or
(c) a determination of disability by the MassHealth Disability Determination Unit (DDU).

(3) Extended MassHealth Eligibility. Disabled persons whose SSI disability assistance has been terminated and who are determined to be potentially eligible for MassHealth continue to receive MassHealth Standard until the MassHealth agency makes a determination of ineligibility,

(F) Individuals with Breast or Cervical Cancer.

(1) Eligibility Requirements. An individual with breast or cervical cancer is eligible for MassHealth Standard coverage if he or she meets all of the following requirements:
(a) the individual is younger than 65 years old;
(b) the individual has been certified by a physician to be in need of treatment for breast or cervical cancer, including precancerous conditions;
(c) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 250 percent of the federal poverty level (FPL);
(d) the individual is a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and
(e) the individual does not otherwise meet the requirements for MassHealth Standard described at 130 CMR 505.002(B) through (E).

(2) Availability of Health Insurance.
(a) Individuals with breast or cervical cancer whose MassHealth MAGI household modified adjusted gross income is greater than 133 percent of the federal poverty level (FPL), but does not exceed 250 percent of the FPL, may receive benefits described at 130 CMR 505.002(F)(1) if they meet the following requirements:
(i) are uninsured; or
(ii) have insurance that does not provide creditable coverage. An individual is not considered to have creditable coverage when the individual is in a period of exclusion for treatment of breast and cervical cancer, has exhausted the lifetime limit on all benefits under the plan, including treatment for breast and cervical cancer, or has limited scope coverage or coverage only for specified illness; or
(iii) are American Indians or Alaska Natives who are provided care through a medical care program of the Indian Health Service or of a tribal organization.

(b) Individuals with breast or cervical cancer whose MassHealth MAGI household modified adjusted gross income is at or below 133 percent of the FPL

(i) will undergo a health-insurance investigation in regards to the health insurance the individual is enrolled in as described in 130 CMR 505.002(N)(1); or

(ii) will not undergo an access to employer-sponsored health-insurance investigation as described in 130 CMR 505.002(M)(1)(b).

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

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

(G) Eligibility Requirements for Individuals Who Are HIV Positive.

(1) Eligibility Requirements. An individual who is HIV positive is eligible for MassHealth Standard coverage if

(a) the individual is younger than 65 years old;

(b) the individual has verified his or her HIV positive status by providing a letter from doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the individual's name and his or her HIV-positive status;

(c) the modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133 percent of the federal poverty level (FPL);

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

(e) the individual does not meet the requirements for MassHealth Standard described at 130 CMR 505.002(B) through (E).

(2) Availability of Health Insurance. For individuals to receive benefits under 130 CMR 505.002(G) an individual

(a) will undergo a health-insurance investigation in regards to the health insurance the individual is enrolled in as described in 130 CMR 505.002(N)(1); or

(b) will not undergo an access to employer-sponsored health insurance investigation as described in 130 CMR 505.002(M)(1)(b).

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

(1) An individual who was in foster care under the responsibility of a state or tribe and enrolled in Medicaid coverage on his or her 18th birthday, or later date of aging out, receives MassHealth Standard coverage until

(a) his or her 26th birthday if the individual is a citizen, as described at 130 CMR 504.002: *U.S. Citizens*, or qualified noncitizen, as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; or

(b) his or her 21st birthday if the individual is a qualified noncitizen barred, as described at 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, or a nonqualified individual lawfully present, as described at 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*.

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

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

(1) is younger than 65 years old;

(2) has modified adjusted gross income of the MassHealth MAGI household of less than or equal to 133 percent of the federal poverty level;

(3) is a citizen as described at CMR 504.002: *U.S. Citizens* or qualified noncitizen as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and

(4) is not otherwise eligible for MassHealth Standard.

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

(1) is younger than 65 years old;

(2) is medically frail as defined at 130 CMR 505.008(F);

(3) has modified adjusted gross income of the MassHealth MAGI household of less than or equal to 133 percent of the federal poverty level;

(4) is a citizen as described at 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen as described at 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and

(5) has been determined to meet the eligibility criteria for MassHealth CarePlus and has elected to receive MassHealth Standard benefits.

(K) Eligibility Requirements for Certain EAEDC Recipients.

(1) Eligibility Requirements. Individuals are eligible for Standard for certain EAEDC recipients if

(a) the individual is

(i) a child and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A);

(ii) the individual is a young adult and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A);

(iii) the individual is a parent or caretaker relative and is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as defined in 130 CMR 504.003(A)(1): *Qualified Noncitizens*; and

(b) the individual receives EAEDC cash assistance.

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

(L) Extended Eligibility.

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

(a) terminated from EAEDC or TAFDC and are determined to be potentially eligible for MassHealth; or

(b) terminated from TAFDC because of receipt of or an increase in spousal or child support payments.

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

(a) the household continues to include a child;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(M).

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

(a) the MassHealth household continues to include a child younger than age 19 living with the parent or caretaker;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(M).

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

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

(a) the MassHealth household continues to include a child younger than 19 years old living with the parent or caretaker;

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

(c) the parent or caretaker relative complies with 130 CMR 505.002(M).

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

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

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

(1) With the exception of individuals described at 130 CMR 505.002(F)(2)(a), MassHealth may perform an investigation to determine if individuals receiving MassHealth Standard

(a) have health insurance that MassHealth may help pay for; or

(b) have access to employer-sponsored health insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay, as described at 130 CMR 506.012: *Premium Assistance Payments*.

(2) During the investigation, the individual receives MassHealth Standard fee-for-service benefits for a time-limited period while MassHealth investigates the insurance.

(a) Investigations for Individuals Who Have Health Insurance.

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

(ii) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth Standard.

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

(i) If MassHealth determines the individual has access to employer-sponsored health insurance and the employer is contributing at least 50 per cent of the premium cost and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments,* the individual is notified in writing that he or she must enroll in this employer-sponsored coverage. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health-insurance plan, MassHealth provides MassHealth Standard Premium Assistance Payments as described in 130 CMR 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health-insurance plan at the request of MassHealth will result in the loss or denial of eligibility for all individuals unless the individual is under age 21 or is pregnant.

(ii) If MassHealth determines the individual does not have access to employer-sponsored health insurance, the member is notified in writing of his or her continued eligibility for MassHealth Standard.

(O) Medicare Premium Payment.

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

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

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

(c) where applicable, for the deductibles and coinsurance under Medicare Parts A and B.

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

(P) Medical Coverage Date.

(1) The medical coverage date for Mass Health Standard begins on the 10th day before the date of application, if MassHealth receives all required verifications, including a completed disability supplement, within 90 days of the applicant's receipt of MassHealth's Request for Information Notice.

(2) If these required verifications listed on the Request for Information Notice are received after the 90-day period referenced in 130 CMR 505.002(P)(1), the begin date of medical coverage is 10 days before the date on which the verifications were received, if such verifications are received within one year of receipt of the application.

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

(130 CMR 505.003 Reserved)

505.004: MassHealth CommonHealth

(A) Overview.

(1) 130 CMR 505.004 contains the categorical requirements and financial standards for CommonHealth coverage available to both disabled children and disabled adults, and to disabled working adults.

(2) Persons eligible for CommonHealth coverage are eligible for medical benefits as described in 130 CMR 450.105(E): *MassHealth CommonHealth*.

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

(1) be 21 through 64 years of age (For those aged 65 and older, see 130 CMR 519.012: *MassHealth CommonHealth*);

(2) be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the application or MassHealth's eligibility review;

(3) be permanently and totally disabled (except for engagement in substantial gainful activity) as defined in 130 CMR 501.001: *Definition of Terms*;

(4) be a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*;

(5) be ineligible for MassHealth Standard; and

(6) comply with 130 CMR 505.004(J).

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

(1) be 21 through 64 years of age;

(2) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;

(3) be ineligible for MassHealth Standard;

(4) be a citizen as described in 130 CMR 504.002: *U.S. Citizens* or a qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*;

(5) (a) meet a one-time-only deductible in accordance with 130 CMR 506.009: *The One-Time Deductible*; or

(b) have modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 200 percent of the federal poverty level (FPL) and provide verification that they are HIV positive; and

(6) comply with 130 CMR 505.004(J).

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

(1) be permanently and totally disabled (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001: *Definition of Terms*;

(2) be ineligible for MassHealth Standard;

(3) (a) be a citizen as described at 130 CMR 504.002: U.S. Citizens or qualified noncitizen as described in 130 CMR 504.003(A)(1): Qualified Noncitizens and be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the application or MassHealth eligibility review; or

(b) be a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing Under Color of Law (Nonqualified PRUCOLs)* with a modified adjusted gross income of the MassHealth Disabled Adult household income that is less than or equal to 150 percent of the FPL; and

(4) comply with 130 CMR 505.004(J).

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

(1) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;

(2) be ineligible for MassHealth Standard;

(3) (a) be a citizen as described at 130 CMR 504.002: *U.S. Citizens* or qualified noncitizen as described in 130 CMR 504.003(A)(1): *Qualified Noncitizens*, and either

(i) meet a one-time-only deductible in accordance with 130 CMR 506.009: *The One-Time Deductible*; or

(ii) have modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 200 percent of the FPL and provide verification that they are HIV positive; or

(b) be a nonqualified PRUCOL as described in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)* with a modified adjusted gross income of the MassHealth Disabled Adult household income that is less than or equal to 150 percent of the FPL; and

(4) comply with 130 CMR 505.004(J).

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

(1) be ineligible for MassHealth Standard;

(2) be a citizen as described at 130 CMR 504.002: *U.S. Citizens* or lawfully present immigrant or a nonqualified PRUCOL, as described in 130 CMR 504.003: *Immigrants*, and either

(a) if not working, be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*; or

(b) if working, be permanently and totally disabled (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001: *Definition of Terms*.

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

(1) be permanently and totally disabled, as defined in 130 CMR 501.001: *Definition of Terms*;

(2) be ineligible for MassHealth Standard; and

(3) be a citizen as described at 130 CMR 504.002: U.S. Citizens, lawfully present immigrant, or a nonqualified PRUCOL, as described in 130 CMR 504.003: Immigrants.

(H) Determination of Disability. Disability is established by:

(1) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);

(2) a determination of disability by the SSA; or

(3) a determination of disability by the MassHealth Disability Determination Unit (DDU).

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

(J) Use of Potential Health Insurance Benefits. Individuals who meet the requirements of 130 CMR 505.004 must use potential health-insurance benefits, including Medicare, in accordance with 130 CMR 503.007: *Potential Sources of Health Care*, and must enroll in health insurance if purchased by the MassHealth agency in accordance with 130 CMR 505.002(O), 505.005, and 506.012: *Premium Assistance Payments*. Members must access those other health-insurance benefits and must show their private health-insurance card and their MassHealth card to providers at the time services are provided.

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

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

(a) have health insurance that MassHealth may help pay for; or

(b) have access to employer-sponsored health insurance that MassHealth wants the individual to enroll and will help pay for, as described in 130 CMR 506.012: *Premium Assistance Payments*.

(2) During the investigation period, the individual receives MassHealth CommonHealth fee-for-service benefits for a time-limited period while MassHealth investigates the insurance.

(a) Investigations for Individuals Who Have Health Insurance.

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

(ii) If MassHealth determines that the health insurance that the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth CommonHealth.

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

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

(ii) If MassHealth determines the individual does not have access to employer-sponsored health insurance, the member is notified in writing of his or her continued eligibility for MassHealth CommonHealth.

(L) Medicare Premium Payment.

(1) MassHealth also pays the cost of the monthly Medicare Part B premium on behalf of members who meet the requirements of 130 CMR 505.004 and who have modified adjusted gross income of the MassHealth Disabled Adult household that is less than 135 percent of the FPL.

(2) The coverage described in 130 CMR 505.004(L)(1) begins on the first day of the month following the date of the MassHealth eligibility determination and may be retroactive up to three months prior to the date the application was received by MassHealth.

(M) Medical Coverage Date.

(1) The medical coverage date for CommonHealth begins on the 10th calendar day before the date of application, if MassHealth receives all required verifications, including a completed disability supplement, within 90 days of the date the applicant's receipt of MassHealth's Request for Information Notice.

(2) If required verifications listed on the Request for Information are received after the 90-day period referenced in 130 CMR 505.004(M)(1), the begin date of medical coverage is 10 calendar days before the date on which the verifications were received, provided such verifications are received within one year of receipt of the application.

(3) Persons described in 130 CMR 505.004(C) who have been notified by the MassHealth agency that they must meet a one-time deductible have their medical coverage date established in accordance with 130 CMR 506.009(E): *Notification of the Deductible*.

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

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

505.005: MassHealth Family Assistance

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

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

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

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

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

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

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

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

(B) Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 Percent and Less than or Equal to 300 Percent of the Federal Poverty Level. Children younger than 19 years old are eligible for Family Assistance coverage described in 130 CMR 505.005(B) if they meet the following criteria.

(1) Eligibility Requirements. A child is eligible if

(a) the child is younger than 19 years old;

(b) the child's modified adjusted gross income of the MassHealth MAGI household is greater than 150 and less than or equal to 300 percent of the federal poverty level (FPL);

(c) the child is ineligible for MassHealth Standard or CommonHealth;

(d) the child is a citizen as defined in 130 CMR 504.002: *U.S. Citizens* or a lawfully present immigrant as defined in 130 CMR 504.003(A), or a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*;

(e) the child complies with 130 CMR 505.005(B)(2) and meets one of the following criteria:

(i) the child is uninsured; or

(ii) the child has health insurance that meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*.

(2) Health Insurance and Access to Employer-Sponsored Insurance Investigation. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance have health insurance that MassHealth can help pay for or if an individual has access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay, as described at 130 CMR 506.012: *Premium Assistance Payments*.

(a) Investigations for Individuals Who Are Enrolled in Health Insurance. When MassHealth determines an individual should have an investigation because they are currently enrolled in health insurance, the individual will be ineligible for a MassHealth benefit until the investigation is complete.

(i) If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Covered Services* and 506.012: *Premium Assistance Payments*.

(ii) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her ineligibility for MassHealth.

(b) Investigations for Individuals Who Have Potential Access to Employer-Sponsored Health Insurance (ESI). When MassHealth determines an individual should be investigated for potential access to ESI, the individual will receive MassHealth Family Assistance for up to a 60-day period while MassHealth investigates the potential access to ESI.

(i) If MassHealth determines the individual has access to employer-sponsored health insurance, the employer is contributing at least 50 per cent of the premium cost, and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that he or she must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health-insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(G)(1): *Covered Services* and 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health-insurance plan at the request of MassHealth will result in the loss or denial of eligibility.

(ii) If MassHealth determines the individual does not have access to employer-sponsored health insurance, the member is notified in writing of his or her continued eligibility for MassHealth Family Assistance as described in 130 CMR 450.105(H)(3): Covered Services for Members Who Are Not Receiving Premium Assistance and 508.000: Managed Care Requirements.

(C) Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level. Children and young adults who are nonqualified PRUCOLs, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*, are eligible for Family Assistance coverage described in 130 CMR 505.005(C) if they meet the following criteria.

(1) Eligibility Requirements. The individual is eligible if

(a) the individual is younger than 19 years old and the individual's modified adjusted gross income of the MassHealth MAGI household is at or below 300 percent of the federal poverty level (FPL);

(b) the individual is a young adult and individual's modified adjusted gross income of the MassHealth MAGI household is at or below 150 percent of the FPL;

(c) the individual is ineligible for MassHealth Standard or CommonHealth;

(d) the individual is a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; and

(e) the individual complies with 130 CMR 505.005(C)(2).

(2) Health Insurance and Access to Employer-Sponsored Insurance Investigation. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance have health insurance that MassHealth can help pay for or if an individual has access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay, as described at 130 CMR 506.012: *Premium Assistance Payments*.

(a) Investigations for Individuals Who Are Enrolled in Health Insurance. When MassHealth determines an individual should have an investigation because they are currently enrolled in health insurance, the individual will receive MassHealth Family Assistance benefits for up to a 60-day time-limited period while MassHealth investigates the insurance.

(i) If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Covered Services* and (2): *Organ Transplants* and 506.012: *Premium Assistance Payments*.

(ii) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth Family Assistance, as described in 130 CMR 450.105(G)(3): *Managed Care Member Participation*.

(b) Investigations for Individuals Who Have Potential Access to Employer-Sponsored Health Insurance (ESI). When MassHealth determines an individual should have a potential access to ESI investigation, the individual will receive MassHealth Family Assistance for up to a 60-day time-limited period while MassHealth investigates the potential access to ESI.

(i) If MassHealth determines the individual has access to employer-sponsored health insurance, the employer is contributing at least 50 per cent of the premium cost, and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that he or she must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health-insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(H)(1): *Premium Assistance* and (2): *Payment of Copayments, Coinsurance, and Deductibles for Certain Children Who Receive Premium Assistance* and 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health-insurance plan at the request of MassHealth will result in the loss or denial of eligibility.

(ii) If MassHealth determines the individual does not have access to employer-sponsored health insurance, the member is notified in writing of his or her continued eligibility for MassHealth Family Assistance as described in 130 CMR 450.105(G)(3): *Managed Care Participation* and 508.000: *Managed Care Requirements*.

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

(1) The individual is eligible if

(a) the individual is a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*:

(b) the individual is ineligible for MassHealth Standard or CommonHealth;

(c) the individual is uninsured;

(d) the individual does not have access to affordable Minimum Essential Coverage as defined in section 1401 of the Patient Protection and Affordable Care Act; and

(e) the individual is either

(i) younger than 21 years old with modified adjusted gross income of the MassHealth MAGI household greater than 150 and less than or equal to 300 percent of the federal poverty level (FPL); or

(ii) is 21 through 64 years of age with modified adjusted gross income of the MassHealth MAGI household at or below 300 percent of the FPL.

(2) Members eligible for benefits described in 130 CMR 505.005(D) receive MassHealth Family Assistance benefits described in 130 CMR 450.105(G)(3): *Managed Care Participation* and 508.000: *Managed Care Requirements*.

(E) Eligibility Requirement for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level. Individuals who are HIV positive are eligible for Family Assistance coverage described in 130 CMR 505.005(E) if they meet the following criteria.

(1) The individual is eligible if

(a) the individual is younger than 65 years old;

(b) the individual is ineligible for MassHealth Standard or CommonHealth;

(c) the individual's modified adjusted gross income of the MassHealth MAGI household is greater than 133 and less than or equal to 200 percent of the FPL;

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

(e) the individual has verified his or her HIV-positive status by providing a letter from a doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the individual's name and his or her HIV-positive status.

(2) Health Insurance Investigation. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance are enrolled in health insurance that MassHealth may help pay for, as described at 130 CMR 506.012: *Premium Assistance Payments*. When MassHealth determines an individual should have an investigation because he or she is currently enrolled in health insurance, the individual will receive MassHealth Family Assistance benefits for up to a 60-day time-limited period while MassHealth investigates the insurance.

(a) If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Covered Services* and (2): *Organ Transplants* and 506.012: *Premium Assistance Payments*.

(b) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth Family Assistance, as described in 130 CMR 450.105(G)(3): *Managed Care Participation*.

(3) Unless otherwise indicated in 130 CMR 505.005(E)(2), individuals determined eligible for MassHealth Family Assistance as described in 130 CMR 505.005(E) will receive benefits as described in 130 CMR 450.105(G)(3): *Managed Care Participation* and 508.000: *Managed Care Requirements*.

(F) Eligibility Requirement for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level. Individuals who are disabled adults are eligible for Family Assistance coverage described in 130 CMR 505.005(F) if they meet the following criteria.

(1) Eligibility Requirements. The individual is eligible if

(a) the individual is totally and permanently disabled as defined in 130 CMR 501.001: *Definition of Terms*;

(b) the individual is younger than 65 years old;

(c) the individual is ineligible for MassHealth Standard or CommonHealth;

(d) the individual's modified adjusted gross income of the MassHealth Disabled Adult household is at or below 100 percent of the FPL; and

(e) the individual is a qualified noncitizen barred as described in 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individual lawfully present, as defined in 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*, or a nonqualified PRUCOL, as defined in 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*.

(2) Determination of Disability. Disability is established by

(a) certification of legal blindness by the Massachusetts Commission of the Blind (MCB);

(b) a determination of disability by the Social Security Administration (SSA); or

(c) a determination of disability by the MassHealth Disability Determination Unit (DDU).

(3) Health Insurance and Access to Employer-Sponsored Insurance Investigation. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance are enrolled in health insurance that MassHealth can help pay for or if an individual has access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay, as described at 130 CMR 506.012: *Premium Assistance Payments*.

(a) Investigations for Individuals Who Are Enrolled in Health Insurance. When MassHealth determines an individual should have an investigation because he or she is currently enrolled in health insurance, the individual will receive MassHealth Family Assistance benefits for up to a 60-day time-limited period while MassHealth investigates the insurance.

(i) If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth Family Assistance Premium Assistance Payments as described at 130 CMR 450.105(G)(1): *Covered Services* and (2): *Organ Transplants* and 506.012: *Premium Assistance Payments*.

(ii) If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth Family Assistance, as described in 130 CMR 450.105(G)(3): *Managed Care Participation*.

(b) Investigations for Individuals Who Have Potential Access to Employer-Sponsored Health Insurance (ESI). When MassHealth determines an individual should be investigated for a potential access to ESI, the individual will receive MassHealth Family Assistance for up to a 60-day time-limited period while MassHealth investigates the potential access to ESI.

(i) If MassHealth determines the individual has access to employer-sponsored health insurance and the employer is contributing at least 50 per cent of the premium cost and the insurance meets all other criteria described at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that he or she must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: *Premium Assistance Payments*. MassHealth allows the individual up to 60 days to enroll in this coverage. Once enrolled in this health-insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments as described in 130 CMR 450.105(G)(1): *Covered Services* and (2): *Organ Transplants* and 506.012: *Premium Assistance Payments*. Failure to enroll in the employer-sponsored health-insurance plan at the request of MassHealth will result in the loss or denial of eligibility.

(ii) If MassHealth determines the individual does not have access to employer-sponsored health insurance, the member is notified in writing of his or her continued eligibility for MassHealth Family Assistance as described in 130 CMR 450.105(G)(3): *Managed Care Participation* and 508.000: *Managed Care Requirements*.

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

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

(a) the individual is

(i) a child or a young adult and is a nonqualified PRUCOL as described at 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*; or

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

(b) the individual receives EAEDC cash assistance.

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

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

(I) MassHealth Family Assistance Coverage Begin Date.

(1) With the exception of those described at 130 CMR 505.005(B)(2)(a)(i), the medical coverage date for MassHealth Family Assistance begins on the 10th day before the date of the application, if MassHealth receives all required verifications within 90 days of the applicant's receipt of MassHealth's Request for Information Notice.

(2) If the required verifications listed on the Request for Information Notice are received after the 90-day period referenced in 130 CMR 505.005(I)(1), the begin date of MassHealth Family Assistance coverage is 10 days before the date on which the verifications were received, if such verifications are received within one year of receipt of the application.

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

(4) For those individuals eligible for MassHealth Family Assistance as described at 130 CMR 505.005(B)(2)(a)(i), the begin date of the Premium Assistance is in accordance with 130 CMR 506.012(F)(1)(d).

505.006: MassHealth Limited

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

(B) Eligibility Requirements.

(1) MassHealth Limited is available to the following:

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

(i) children younger than one year old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 200 percent of the federal poverty level (FPL);

(ii) children one through 18 years of age with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150 percent of the FPL;

(iii) young adults 19 and 20 years of age with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150 percent of the FPL;

(iv) adults 21 through 64 years of age who are parents, caretakers, or adults with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133 percent of the FPL; and

(v) disabled adults 21 through 64 years of age with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133 percent of the FPL;

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

(i) children younger than one year old with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 200 percent of the federal poverty level (FPL);

(ii) children one through 18 years of age with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150 percent of the FPL;

(iii) young adults 19 and 20 years of age with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 150 percent of the FPL;

(iv) adults 21 through 64 years of age who are parents, caretakers, or adults with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133 percent of the FPL; and

(v) disabled adults 21 through 64 years of age with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133 percent of the FPL;

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

(i) adults, including parents and caretaker relatives, 21 through 64 years of age with modified adjusted gross income of the MassHealth MAGI household that is less than or equal to 133 percent of the FPL;

(ii) disabled adults 21 through 64 years of age with modified adjusted gross income of the MassHealth Disabled Adult household that is less than or equal to 133 percent of the FPL;

(iii) parents and caretakers who 21 through 64 years of age who are receiving EAEDC; and

(iv) adults 21 through 64 years of age who are receiving EAEDC.

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

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

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

(D) Medical Coverage Date.

(1) The medical coverage date for MassHealth Limited begins on the 10th day before the date of application, if MassHealth receives all required verifications, within 90 days of the applicant's receipt of MassHealth's Request for Information Notice.

(2) If these required verifications listed on the Request for Information are received after the 90-day period referenced in 130 CMR 505.006(D)(1), the begin date of MassHealth Limited coverage is 10 days before the date on which the verifications were received, if such verifications are received within one year of receipt of the application.

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

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

505.007: MassHealth Senior Buy-In and Buy-In

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

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

505.008: MassHealth CarePlus

(A) Overview.

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

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

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

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

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

(d) The individual is ineligible for MassHealth Standard.

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

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

(B) Eligibility Requirements for certain EAEDC Recipients.

(1) Eligibility Requirements. Individuals are eligible for CarePlus for certain EAEDC recipients if

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

(b) the individual receives EAEDC cash assistance; and

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

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

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

(D) Access to Employer-Sponsored Insurance and Premium Assistance Investigations. MassHealth may perform an investigation to determine if individuals receiving MassHealth CarePlus have health insurance that MassHealth can help pay for or to determine if an individual has access to employer-sponsored insurance that MassHealth wants the individual to enroll and will help pay for, as described in 130 CMR 506.012: *Premium Assistance Payments*.

(1) When MassHealth determines an individual should have an investigation, the member will receive MassHealth CarePlus fee-for-service benefits for a time-limited period while MassHealth investigates the insurance.

(a) Investigations for Individuals Who Have Health Insurance. If MassHealth determines that the health insurance the individual is enrolled in meets the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing that MassHealth will provide MassHealth CarePlus Premium Assistance Payments as described at 130 CMR 506.012: *Premium Assistance Payments*. If MassHealth determines that the health insurance the individual is enrolled in does not meet the criteria at 130 CMR 506.012: *Premium Assistance Payments*, the individual is notified in writing of his or her continued eligibility for MassHealth CarePlus.

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

(2) If MassHealth determines the individual has does not have access to employer-sponsored insurance, the member will be notified in writing of his or her continued eligibility for MassHealth CarePlus.

(E) MassHealth CarePlus Coverage Begin Date.

(1) The MassHealth CarePlus coverage start date begins on the 10th day before the date the application is received if all required verifications have been received within 90 days of the date the Request for Information is received.

(2) If these required verifications listed on the Request for Information are received after the 90-day period referenced in 130 CMR 505.008(E)(1), the begin date of MassHealth CarePlus coverage is 10 days before the date on which the verifications were received, if such verifications are received within one year of receipt of the application.

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

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

(1) an individual with a disabling mental disorder (including children with serious emotional disturbances and adults with serious mental illness);

(2) an individual with a chronic substance use disorder;

(3) an individual with a serious and complex medical condition;

(4) an individual with a physical, intellectual or developmental disability that significantly impairs his or her ability to perform one or more activities of daily living; or

(5) an individual with a disability determination based on Social Security criteria.

505.009: MassHealth Small Business Employee Premium Assistance

(A) Overview. 130 CMR 505.009 contains the categorical requirements and financial standards for MassHealth Small Business Employee Premium Assistance. This coverage type provides coverage to individuals 19 to 64 years of age through premium assistance payments.

(B) Eligibility Requirements. An individual is eligible for MassHealth Small Business Employee Premium Assistance if they meet the following criteria.

(1) The individual is eligible if

(a) the individual's modified adjusted gross income of the MassHealth MAGI household is greater than 133 and less than or equal to 300 percent of the federal poverty level (FPL);

(b) the individual is 19 through 64 years of age;

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

(d) the individual is ineligible for MassHealth Standard, CommonHealth, CarePlus, Family Assistance, or for a Qualified Health Plan with Premium Tax Credits;
(e) the individual works for a small employer that employs 50 or fewer full-time employees;
(f) the individual has access to an employer-sponsored health-insurance (ESI) plan that meets the rules described in 130 CMR 506.013(B): *Premium Assistance Eligibility Criteria*; and
(g) the individual is either
(i) uninsured; or
(ii) if insured, the individual was a member of the former MassHealth Insurance Partnership program on November 15, 2013.

(2) Access to Employer-Sponsored Insurance Investigation. MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Small Business Employee Premium Assistance have access to employer-sponsored insurance that MassHealth wants the individual to enroll in and will help pay for, as described in 130 CMR 506.013: *MassHealth Small Business Employee (SBE) Premium Assistance Program*.
(a) Investigations for Individuals Who Have Potential Access to Employer-Sponsored Health Insurance (ESI). When MassHealth determines an individual should have an investigation for potential access to ESI, the individual will be ineligible for a MassHealth benefit until the investigation is complete.
(b) Determination of Accessibility. MassHealth will determine the individual has access to employer-sponsored insurance from an employer if
(i) the employer offers an individual health-insurance plan for which the employee contribution costs less than 9.5 percent of the policyholder's MassHealth MAGI household income but more than the minimum monthly member contribution amount as described in 130 CMR 506.013(C): *Required Member Contribution*;
(ii) the employer is contributing at least 50 percent of the premium cost; and
(iii) the insurance meets all other criteria described in 130 CMR 506.013: *MassHealth Small Business Employee (SBE) Premium Assistance Program*.
(c) If the health-insurance plan meets all of the criteria in 130 CMR 505.011(B)(2)(b), the individual is notified in writing that they must enroll in employer-sponsored coverage that meets the criteria described in 130 CMR 506.013(B): *Premium Assistance Eligibility Criteria*.
(d) If MassHealth determines the individual has access to employer-sponsored insurance from an employer
(i) MassHealth will allow the individual up to 60 days to enroll in this coverage;
(ii) once enrolled in the health insurance plan, MassHealth will provide MassHealth Small Business Employee Premium Assistance Payments as described at 130 CMR 506.013: *MassHealth Small Business Employee (SBE) Premium Assistance Program* and 130 CMR 450.105: *Coverage Types*; and
(iii) failure to enroll in the employer sponsored health insurance plan at the request of MassHealth will result in denial of eligibility for MassHealth.

(C) Enrollment Limits. The MassHealth agency may limit the number of people who can be enrolled in MassHealth Small Business Premium Assistance. When the MassHealth agency imposes such a limit, no new adult applicants (19 years of age or older) subject to these limitations will be added to this coverage type, and current adult members in this coverage type who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the MassHealth agency is able to reopen enrollment for adults in this coverage type.

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Section

506.001: Introduction

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

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

506.002: Household Composition

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

(1) MassHealth Modified Adjusted Gross Income (MAGI) Household Composition. MassHealth uses the MassHealth MAGI household composition rules to determine member eligibility for the following benefits:

(a) MassHealth Standard, as described in 130 CMR 505.002(B), (C), (D), (F), and (G);
(b) MassHealth CommonHealth, as described in 130 CMR 505.004(F) and (G);
(c) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;
(d) MassHealth Family Assistance, as described in 130 CMR 505.005(B) through (E);
(e) MassHealth Limited, as described at 130 CMR 505.006: *MassHealth Limited*;
(f) MassHealth Small Business Employee Premium Assistance, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*; and
(g) Children's Medical Security Plan (CMSP), as described in 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

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

(a) MassHealth Standard, as described in 130 CMR 505.002(E): *Disabled Adults*;
(b) MassHealth CommonHealth, as described in 130 CMR 505.004(B) through (E); and
(c) MassHealth Family Assistance, as described in 130 CMR 505.005(F): *Eligibility Requirement for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level*.

(B) MassHealth MAGI Household Composition.

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

(a) the taxpayer; including his or her spouse, if the taxpayers are married and filing jointly regardless of whether they are living together;

(b) the taxpayer's spouse, if living with him or her regardless of filing status;

(c) all persons the taxpayer expects to claim as tax dependents; and

(d) if any woman described in 130 CMR 506.002(B)(1)(a) through (c) is pregnant, the number of expected children.

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

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

(i) the individual;

(ii) the individual's spouse, if living with him or her;

(iii) the taxpayer claiming the individual as a tax dependent;

(iv) any of the taxpayer's tax dependents; and

(v) if any woman described in 130 CMR 506.002(B)(2)(a)(i) through (iii) is pregnant, the number of expected children.

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

(i) individuals other than the spouse or natural, adopted, or stepchild who expect to be claimed as a tax dependent by the taxpayer;

(ii) individuals younger than 19 years old who expect to be claimed by one parent as a tax dependent and are living with both natural, adopted or stepparents, but whose natural, adopted, or stepparents do not expect to file a joint tax return;

(iii) individuals younger than 19 years old who expect to be claimed as a tax dependent by a noncustodial parent. For the purpose of determining custody, MassHealth uses a court order or binding separation, divorce, or custody agreement establishing physical custody controls or, if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

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

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

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

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

506.003: Countable Household Income

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

(A) Earned Income.

(1) Earned income is the total amount of taxable compensation received for work or services performed less pretax deductions. Earned income may include wages, salaries, tips, commissions, and bonuses.

(2) Earned taxable income for the self-employed is the total amount of taxable annual income from self-employment after deducting annual business expenses listed or allowable on a U.S. Individual Tax Return. Self-employment income may be a profit or a loss.

(3) Earned income from S-Corporations or Partnerships is the total amount of taxable annual profit (or loss) after deducting business expenses listed or allowable on a U.S. Individual Tax Return.

(4) Seasonal income or other reasonably predictable future income is taxable income derived from an income source that may fluctuate during the year. Annual gross taxable income is divided by 12 to obtain a monthly taxable gross income with the following exception: if the applicant or member has a disabling illness or accident during or after the seasonal employment or other reasonably predictable future income period that prevents the person's continued or future employment, only current taxable income will be considered in the eligibility determination.

(B) Unearned Income.

(1) Unearned income is the total amount of taxable income that does not directly result from the individual's own labor after allowable deductions on the U.S Individual Tax Return.

(2) Unearned income may include, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, certain trusts, interest and dividend income, state or local tax refund for a tax you deducted in the previous year, and gross gambling income.

(C) Rental Income. Rental income is the total amount of taxable income less any deductions listed or allowable on an applicant’s or member’s U.S. Individual Tax Return.

(D) Deductions. The following are allowable deductions from countable income when determining MAGI:

(1) educator expenses;
(2) reservist/performance artist/fee-based government official expenses;
(3) health savings account;
(4) moving expenses;
(5) self-employment tax;
(6) self-employment retirement account;
(7) penalty on early withdrawal of savings;
(8) alimony paid to a former spouse;
(9) individual retirement account (IRA);
(10) student loan interest; and
(11) higher education tuition and fees.

506.004: Noncountable Household Income

The following types of income are noncountable in the determination of eligibility for individuals described at 130 CMR 506.002:

(A) TAFDC, EAEDC, or SSI income;

(B) sheltered workshop earnings;

(C) federal veteran benefits that are not taxable in accordance with IRS rules;

(D) income-in-kind;

(E) roomer and boarder income derived from persons residing in the applicant's or member's principal place of residence;

(F) most workers' compensation income;

(G) pretax contributions to salary reduction plans for payment of dependent care, transportation, and certain health expenses within allowable limits;

(H) child support received;

(I) taxable amounts received as a lump sum, except in the month received;

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

(K) income from children and tax dependents who are not expected to be required to file a tax return under section 6012(a)(I) of the Internal Revenue code for the taxable year in which eligibility for MassHealth is being determined, whether or not the children or the tax dependents files a tax return; and

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

506.005: Verification of Income

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

(A) Electronic Data Matches.

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

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

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

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

(c) the attested income and the income from the data sources must be within a ten percent range of each other.

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

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

(1) Paper verification of monthly earned income includes, but is not limited to

(a) recent paystubs;

(b) a signed statement from the employer; or

(c) the most recent U.S. Individual Tax Return.

(2) Verification of monthly unearned income is mandatory and includes, but is not limited to

(a) a copy of a recent check or paystub showing gross income from the source;

(b) a statement from the income source, where matching is not available; or

(c) the most recent U.S. Individual Tax Return.

(3) Verification of gross monthly income may also include any other reliable evidence of the applicant's or member's earned or unearned income.
(4) For reasonably predictable fluctuating income, as described at 130 CMR 506.003(A)(4), verification may also include documentation of a contract for employment or clear history of predictable fluctuations in income.

506.006: Transfer of Income

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

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

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

506.007: Calculation of Financial Eligibility

To calculate financial eligibility for an individual, the MassHealth agency will construct a household as described in 130 CMR 506.002 for each individual who is applying for or renewing coverage. Different households may exist within a single family, dependent on the family members' familial and tax relationships to each other. The rules at 130 CMR 506.003 and 506.004 describing countable income and noncountable income apply to both MassHealth MAGI households and MassHealth Disabled Adult households. Countable income includes earned income described in 130 CMR 506.003(A) and unearned income described in 130 CMR 506.003(B) less deductions described in 130 CMR 506.003(C). Income of all the household members forms the basis for establishing an individual's eligibility. A household's countable income is the sum of the MAGI-based income of every individual included in the individual's household with the exception of children and tax dependents who are not expected to be required to file a return as described in 42 CFR 435.603 and 130 CMR 506.004(K).

(A) Financial eligibility for coverage types that are determined using the MassHealth MAGI household rules and the MassHealth Disabled Adult household rules is determined by comparing the sum of all countable income less deductions for the individual's household as described at 130 CMR 506.002 with the applicable income standard for the specific coverage type. In determining monthly income, the MassHealth agency multiplies average weekly income by 4.333. Five percentage points of the current federal poverty level (FPL) is subtracted from the applicable household total countable income to determine eligibility of the individual under the coverage type with the highest income standard.

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

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

(1) Divide the annual federal poverty-level income standard as it appears in the *Federal Register* by 12.

(2) Multiply the unrounded monthly income standard by the applicable federal-poverty-level standard.

(3) Round up to the next whole dollar to arrive at the monthly income standards.

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

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

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

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

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

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

506.009: The One-Time Deductible

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

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

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

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

THE MASSHEALTH COMMONHEALTH
MONTHLY DEDUCTIBLE INCOME STANDARDS

MassHealth Disabled Adult Household 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

(E) Notification of the Deductible.

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

(a) the deductible amount; and

(b) the start and end dates of the deductible period.

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

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

(1) those who were receiving MassHealth on July 1, 1997 as the result of meeting a deductible; and

(2) those who were denied eligibility with a deductible before July 1, 1997, but who submit medical bills on or after July 1, 1997 to meet the deductible.

(G) Submission of Bills to Meet the Deductible.

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

(a) The bill must not be subject to further payment by health insurance or other liable third-party coverage, including the Health Safety Net.

(b) The bill must be for an allowable medical or remedial expense as provided in 130 CMR 506.009(G)(2). A remedial expense is a nonmedical support service made necessary by the medical condition of any individual in the family group.

(c) The bill must be unpaid and a current liability, or, if paid, was paid during the six-month deductible period.

(d) The bill may not be for one of the following services:

(i) cosmetic surgery;
(ii) rest-home care;
(iii) weight-training equipment;
(iv) massage therapy;
(v) special diets; and
(vi) room and board charges for individuals in residential programs.

(2) Meeting the Deductible.

(a) Bills to meet the deductible are applied in the following order:

(i) Medicare and other health-insurance premiums credited prospectively for the cost of six months' coverage;

(ii) expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are recognized under state law but are not covered by MassHealth, including guardianship fees and related expenses as defined at 130 CMR 515.001: *Definition of Terms*, and described in and allowed under 130 CMR 520.026(E)(3): *Guardianship Fees and Related Expenses*; and

(iii) expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are covered by MassHealth.

(b) Premiums for Qualified Health Plans can be applied to meet the deductible as they are incurred.

(c) Any bills or portions of bills that are used to meet the deductible are not paid by the MassHealth agency and remain the responsibility of the applicant.

506.010: Verification of Medical and Remedial-Care Expenses

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

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

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

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

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

(A) Premium Billing Family Groups.

(1) Premium formula calculations for MassHealth and CMSP premiums are based on premium billing family groups (PBFG). A PBFG is comprised of

(a) an individual;

(b) a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts and are living together; or

(c) a family who live together and consist of

(i) a child or children under the age of 19, any of their children, and their parents;

(ii) siblings under the age of 19 and any of their children who live together, even if no adult parent or caretaker is living in the home; or

(iii) a child or children under the age of 19, any of their children, and their caretaker relative when no parent is living in the home.

(2) A child who is absent from the home to attend school is considered as living in the home.

(3) A parent may be natural, adoptive, or a stepparent. Two parents are members of the same PBFG as long as they are mutually responsible for one or more children who live with them.

(4) In a family with more than one child, any child with a MAGI household income that does not exceed 300% FPL will have its premium liability determined based on the MAGI household income of the child in the family PBFG with the lowest percentage of the FPL. If a child in the PBFG has an income percentage of the FPL at or below 150 percent of the FPL, premiums for all children in the PBFG are waived.

(5) MassHealth and CMSP premiums for children with a MassHealth MAGI household income greater than 300 percent of the FPL and all premiums for young adults and adults are calculated using the individual's FPL and the corresponding premium amount as described in 130 CMR 506.011.

(6) For individuals within a PBFG that is approved for more than one premium billing coverage type, except where application of 130 CMR 506.011(A)(4) will result in a lower premium for children in the PBFG, the following apply.

(a) When the PBFG contains members in more than one coverage type or program, including CMSP, and who are responsible for a premium or required member contribution, the PBFG is responsible for only the higher premium or required member contribution.

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

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

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

Standard Breast and Cervical Cancer Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly Premium Cost**
Above 150% to 160%	$15
Above 160% to 170%	$20
Above 170% to 180%	$25
Above 180% to 190%	$30
Above 190% to 200%	$35
Above 200% to 210%	$40
Above 210% to 220%	$48
Above 220% to 230%	$56
Above 230% to 240%	$64
Above 240% to 250%	$72

(2) The premium formulas for MassHealth CommonHealth members whose eligibility is described in 130 CMR 505.004(B): *Disabled Working Adults* through (G): *Disabled Children Younger than 19 Years Old* are as follows.

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

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

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

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

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

CommonHealth Supplemental Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly 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

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

(3) The premium formula for MassHealth Family Assistance children whose eligibility is described at 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 Percent and Less than or Equal to 300 Percent of the Federal Poverty Level* and (E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* is as follows.

Family Assistance for Children Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly Premium Cost**
Above 150% to 200%	$12 per child ($36 PBFG maximum)
Above 200% to 250%	$20 per child ($60 PBFG maximum)
Above 250% to 300%	$28 per child ($84 PBFG maximum)

(4) The premium formulas for MassHealth Family Assistance HIV-positive adults whose eligibility is described at 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* are as follows.

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

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

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

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

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

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

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

(C) Premium Payment Billing.

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

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

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

(a) with the calendar month following the reported change if the premium is increased; or

(b) with the calendar month of the reported change if the premium is decreased or no longer assessed.

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

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

(D) Delinquent Premium Payments.

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

(a) pays all delinquent amounts that have been billed;

(b) establishes a payment plan and agrees to pay the current premium being assessed and the payment-plan-arrangement amount;

(c) is eligible for a nonpremium coverage type;

(d) is eligible for a MassHealth coverage type that requires a premium payment and the delinquent balance is from a CMSP benefit; or

(e) requests a waiver of past-due premiums as described in 130 CMR 506.011(G).

(2) Default on a Payment Plan.

(a) If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's payment plan is terminated and the past due balance is due in full.

(b) If the member is in a premium-paying coverage type and does not pay the past due amount within 60 days of the date on the bill, the member's eligibility is terminated.

(c) If a member has defaulted on a payment plan twice within a 24-month period, the member must pay in full any past due balances before they can be determined eligible for a coverage type that requires a premium payment.

(d) A member may be granted additional payment plans if the member has been approved for a hardship waiver as described at 130 CMR 506.011(F).

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

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

(1) Except as provided in 130 CMR 506.011(E)(2), after the member has paid in full all payments due, has established a payment plan with MassHealth, or has been granted a waiver of past-due balance as described in 130 CMR 506.011(G), the MassHealth agency will reactivate coverage.

(2) For children younger than 19 years old, coverage may be reactivated after 90 days from the date termination upon request, regardless of any outstanding payments due.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

506.012: Premium Assistance Payments

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

(1) MassHealth Standard, as described in 130 CMR 505.002: *MassHealth Standard*;
(2) MassHealth Standard for Kaileigh Mulligan, as described in 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
(3) MassHealth CommonHealth, as described in 130 CMR 505.004: *MassHealth CommonHealth*;
(4) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;
(5) MassHealth Family Assistance for HIV-positive adults and HIV-positive young adults, as described in 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level*;

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

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

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

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

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

(1) The health-insurance coverage meets the Basic Benefit Level (BBL) as defined in 130 CMR 501.001: *Definition of Terms*.

(2) The health-insurance policy holder is either in the PBFG or resides with the individual who is eligible for the premium assistance benefit.

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

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

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

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

(3) Non-group unsubsidized Health Connector individual plans for children only.

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

(a) Health Savings Accounts;

(b) Medicare supplemental coverage, including Medigap and Medex coverage;

(c) Medicare Advantage coverage;

(d) Medicare Part D coverage; and

(e) Qualified Health Plans (QHP) with Premium Tax Credits.

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

(a) MassHealth members who have Medicare coverage as MassHealth provides premium assistance-benefits in the form of Medicare A and/or B Buy-In benefits as described in 130 CMR 505.002(O): *Medicare Premium Payment*. Medicare beneficiaries who are eligible for the benefits described in 130 CMR 505.002(O): *Medicare Premium Payment* are also deemed eligible for the Low Income Subsidy (LIS) benefit which provides Medicare Part D coverage;

(b) all nondisabled nonqualified PRUCOL adults, as described in 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults 19 and 20 Years of Age Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300 Percent of the Federal Poverty Level*; and

(c) disabled nonqualified PRUCOL adults with MassHealth Disabled Adult household income above 100% of the FPL, as described in 130 CMR 505.005(F): *Eligibility Requirements for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level*.

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

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

(2) The following members are responsible for a required member contribution.

(a) MassHealth CommonHealth premium-assistance eligible members who have MassHealth MAGI household income or MassHealth Disabled Adult household income greater than 150 percent of the FPL have the following required member contribution amounts.

(i) The required member contribution formula for children younger than 19 years old with household MAGI between 150 and 300 percent of the FPL is provided as follows.

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

(ii) The required member contribution for adults with household MAGI above 150 percent of the FPL and children with household MAGI above 300 percent of the FPL is provided as follows.

CommonHealth Required Member Formula Adults above 150% FPL and Children above 300% FPL		
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

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

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

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

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

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

(3) The following members do not have a required member contribution:

(a) MassHealth Standard premium assistance eligible members described at 130 CMR 505.002: *MassHealth Standard*;

(b) MassHealth CommonHealth premium assistance eligible members, as described in 130 CMR 505.004: *MassHealth CommonHealth*, who have household MAGI at or below 150 percent of the FPL;

(c) MassHealth CarePlus premium assistance eligible members, as described in 130 CMR 505.008: *MassHealth CarePlus*;

(d) MassHealth Family Assistance premium assistance eligible members, as described in 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 Percent and Less than or Equal to 300 Percent of the Federal Poverty Level*, who household MAGI is at or below 150 percent of the FPL; and

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

(E) MassHealth Premium Assistance Payment Amount Calculation.

(1) Formulas. MassHealth uses two formulas to calculate the premium assistance payments. The formulas are based on the category of assistance a member is enrolled in.

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

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

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

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

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

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

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

(i) If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

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

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

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

(ii) The employer's monthly share of the health-insurance premium = T.

(iii) The MassHealth estimated member share of the monthly health-insurance premium = U.

(iv) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (employer's share of the cost)
V = (employee's share of the cost)
- U = (the MassHealth estimated member share of the cost)
W = (estimated premium assistance payment amount)

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

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

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

(3) MassHealth Premium Assistance Payment Amount Calculation — Other Group Insurance Plans.

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

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

(ii) Cost-Effective Amount. The Other Group Insurance Plans cost-effective amount is the MassHealth agency's cost of covering MassHealth-eligible premium billing family group (PBFG) who are beneficiaries of the Other Group Insurance Plan.

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

(i) If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

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

(c) Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance falls into Other Group Insurance Plans.

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

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

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

(iv) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (monthly contribution from an employer)
V = (employee's share of the cost)
- U = (the MassHealth estimated member share of the cost)
W = (estimated premium assistance payment amount)

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

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

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

(E) MassHealth Premium Payment Administration.

(1) Premium Assistance Payments.

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

(b) Premium assistance payments are made directly each month to the policyholder.

(c) Proof of health-insurance premium payments may be required.

(d) Premium assistance payments begin in the month of the MassHealth eligibility determination or in the month that health-insurance deductions begin, whichever is later.

(e) Each monthly premium assistance payment is for health-insurance coverage in the following month.

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

(2) Change in Premium Assistance Calculation.

(a) The premium assistance amount is recalculated when the MassHealth agency is informed of changes in the federal poverty level, health-insurance premium, employer contribution, and whenever an adjustment is made in the premium assistance payment formula.

(b) Members whose premium assistance amount changes as the result of a reported change or any adjustment in the premium assistance payment formula receive the new premium assistance payment beginning with the calendar month following the reported change.

(3) Termination of Premium Assistance Payments.

(a) If a member's health insurance terminates for any reason, the MassHealth premium assistance payments end.

(b) If there is a change in the services covered under the policy that affects the Basic Benefit Level (BBL) requirements, the premium assistance payments end.

(c) Members who become eligible for a different coverage type in which they are not eligible to receive a premium assistance benefit receive their final premium assistance payment in the calendar month in which the coverage type changes.

(d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth premium assistance payments end.

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

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

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

(1) The ESI meets the Basic Benefit Level (BBL), as described at 130 CMR 501.001: *Definition of Terms*.
(2) The ESI policy holder is in the premium billing family group (PBFG).
(3) At least one person covered by the ESI policy is eligible for MassHealth SBE Premium Assistance benefits, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.
(4) The ESI is from an employer that offers an individual health-insurance plan to the employee for which the employee contribution costs more than the Health Connector affordability schedule as defined at 956 CMR 6.05:*Determining Affordability* but less than 9.5% of the MassHealth MAGI income.
(5) The ESI does not cover any individuals who are eligible for or receiving a MassHealth premium assistance payment as described in 130 CMR 506.012.
(6) Effective January 1, 2015, the ESI is a small group health insurance plan purchased by the individual's employer through the Health Connector.

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

(D) MassHealth SBE Premium Assistance Payment Amount Calculations.
(1) Calculation of Estimated Premium. MassHealth compares the estimated premium assistance payment amount and the maximum premium assistance amount to calculate the actual premium assistance amount.
(a) The estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium, as described in 130 CMR 506.013(C), from the total cost of the health-insurance premium.
(b) The SBE maximum premium assistance amount is $150 per adult covered by the employer-sponsored plan in the PBFG and cannot exceed two adults.
(2) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and the SBE maximum premium assistance amount and uses the following formula to determine the actual premium assistance payment amount.
(a) If the estimated premium assistance payment amount is less than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.
(b) If the estimated premium assistance payment amount is equal to or greater than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the SBE maximum premium assistance amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

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

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

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

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

(d) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (employer's share of the cost)
V = (employee's share of the cost)
- U = (the MassHealth SBE required member contribution)
W = (estimated premium assistance payment amount)

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

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

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

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

(E) MassHealth SBE Premium Payment Administration.

(1) SBE Premium Assistance Payments.

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

(b) SBE premium assistance payments are made directly each month to the policyholder.

(c) Proof of health-insurance premium payments may be required.

(d) SBE premium assistance payments begin in the month of the MassHealth eligibility determination or in the month that health-insurance deductions begin, whichever is later.

(e) Each monthly SBE premium assistance payment is for health-insurance coverage in the following month.

(f) MassHealth reviews the SBE maximum contribution amount and the cost of the member's health insurance at least once every 12 months.

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

(3) Termination of Premium Assistance Payments.
(a) If a member's health insurance terminates for any reason, the MassHealth SBE premium assistance payments end.
(b) If there is a change in the services covered under the policy such that the policy no longer meets the BBL requirements, the SBE premium assistance payments end.
(c) Members who become eligible for a different coverage type in which they are not eligible to receive an SBE premium assistance benefit receive their final SBE premium assistance payment in the calendar month in which the coverage type changes.
(d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth SBE premium assistance payments end.

506.014: Copayments Required by MassHealth

The MassHealth agency requires its members to make the copayments described in 130 CMR 506.016, up to the maximum described in 130 CMR 506.018, except as excluded in 130 CMR 506.015. 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, providing that this amount shall be no greater than the MassHealth payment minus one cent.

506.015: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.
(1) The following individuals do not have to pay the copayments described in 130 CMR 506.016:
(a) members younger than 21 years old;
(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);
(c) MassHealth Limited members;
(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, MassHealth CarePlus, or MassHealth Family Assistance;
(h) members who are independent foster care adolescents who were in the care and custody of the Department of Children and Families on their 18th birthday and who are eligible for MassHealth Standard until they reach the age of 26 for citizens and qualified noncitizens and the age of 21 for lawfully present immigrants; and
(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law.

(2) Members who have accumulated copayment charges totaling the maximum of $250 per calendar year do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who have accumulated copayment charges totaling the maximum of $36 per calendar year on nonpharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.
(4) Members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter do not have to pay further MassHealth copayments during the quarter in which the member reached the five percent cap.
(5) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.
(6) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 506.016:
(1) family planning services and supplies such as oral contraceptives, contraceptive devices, such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) nonpharmacy behavioral-health services;
(3) emergency services; and
(4) provider-preventable services as defined in 42 CFR 447.26(b).

506.016: Services Subject to Copayments

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

(A) Pharmacy Services. The copayment for pharmacy services is
(1) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by the MassHealth agency in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
(2) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by the MassHealth agency.

(B) Nonpharmacy Services. The copayment for nonpharmacy services is $3 for an acute inpatient hospital stay.

506.017: Members Unable to Pay Copayment

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

506.018: Maximum Cost Sharing

Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B): *Services Subject to Copayments*, up to the following maximums:

(A) $250 for pharmacy services per calendar year;

(B) $36 for nonpharmacy services per calendar year; and

(C) five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household per calendar quarter, including both copayments and any applicable premium payments.

506.019: Family Assistance Premium Plus Cap

(A) Copays, Coinsurance, and Deductibles. The MassHealth agency pays copays, coinsurance, and deductibles for children eligible for Family Assistance Premium Assistance as described in 130 CMR 505.005 (B)(2)(b)(i) provided

(1) the MassHealth agency has made a determination that the member was uninsured at the time of the eligibility determination, had access to employer-sponsored health insurance, and the MassHealth agency required the member's enrollment in the health insurance plan; and

(2) the policyholder's annualized share of the employer-sponsored health insurance premium, combined with copays, coinsurance, and deductibles incurred and paid by members, exceeds five percent of the MAGI of the child with the lowest federal poverty level in the PBFG in a 12-month period beginning with the date of eligibility for premium assistance. In such cases, the MassHealth agency pays for any copays, coinsurance, or deductibles incurred by the members during the balance of the 12-month period provided they have submitted proof of payment of bills equal to or exceeding five percent of the MAGI of the child with the lowest federal poverty level in the PBFG. Proof of payment may be submitted during or after the 12-month period, but no later than six months after the 12-month period ends. The five percent cap will be recalculated when there is any circumstance that changes the MAGI of the child with the lowest federal poverty level in the PBFG.

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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth members who are younger than 65 years old, except those MassHealth members who are receiving services from the Department of Children and Families (DCF) or the Department of Youth Services (DYS) or who are receiving Title IV-E adoption assistance described in 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*, those MassHealth members who may voluntarily choose to enroll in the Primary Care Clinician (PCC) Plan or a MassHealth-contracted managed care organization (MCO) as described in 130 CMR 508.001(A)(3), and those excluded from participation as described in 130 CMR 508.004, must enroll in the PCC Plan or a MassHealth-contracted MCO available for their coverage types. MassHealth CarePlus members must enroll in a MassHealth-contracted MCO if two or more MassHealth-contracted MCOs that serve CarePlus members are available in the member's service area. If there are fewer than two MassHealth-contracted MCOs that serve CarePlus members available in the member's service area, MassHealth CarePlus members may enroll in the available MassHealth-contracted MCO or in the PCC Plan.

(2) MassHealth Standard and CommonHealth members who are under the age of 21 and who are excluded from participation in the PCC Plan or a MassHealth-contracted MCO under 130 CMR 508.004(A)(1) or (2) or (B)(1) or (2) must enroll with the MassHealth behavioral-health contractor.

(3) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*, or who are enrolled in a home- and community-based services waiver may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(4) MassHealth members who are receiving services from DCF or DYS may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO must enroll with the MassHealth behavioral-health contractor.

(5) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* may choose to enroll in the PCC Plan or a MassHealth-contracted MCO. Such members who do not choose to enroll in the PCC Plan or a MassHealth-contracted MCO are enrolled with the MassHealth behavioral-health contractor. Such members may choose to receive all services on a fee-for-service basis.

(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 or other specialty 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): *Referral for Services*, 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): *Referral for Services*, 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 and family planning services, are subject to the referral requirements of the MCO. MassHealth members enrolled in an MCO may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. 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 the MassHealth 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.

(4) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

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, in accordance with 130 CMR 508.001 and 508.002.

(A) Selection of a Managed Care Provider.

(1) Procedure. The MassHealth agency 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 the MassHealth agency. The member may select any provider from the MassHealth agency's list of MassHealth managed care providers for the member's coverage type in the member's service area, if the provider is able to accept new members.

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

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

(C) Criteria for Assigning Members.

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

(a) available for the member's coverage type;

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

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

(d) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);

(e) able to communicate with the member directly or through an interpreter, unless there is no medical care available in the member's service area that meets this requirement; and

(f) located in an area to which the member has available transportation.

(2) (a) For MassHealth Standard members only, if the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) is available in the member's service area, the member may

(i) choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or

(ii) select an available MassHealth managed care provider outside of the member's service area.

(b) Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(i) must obtain any behavioral-health services through the MassHealth behavioral-health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.

(3) If, after a determination by the MassHealth agency under 130 CMR 508.002(C)(2)(a), the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(ii).

(D) Notification. The MassHealth agency will notify a member in writing of the name and address of the member's MassHealth managed care provider, and the member's enrollment effective date with the provider.

(E) Transfer. Members may transfer to or from an available MassHealth managed care provider at any time; provided, however, that transfers for MassHealth CarePlus members will take effect on the first day of the month following the member's request for transfer if the reason for such transfer is a reason other than the following reasons defined as "for cause" in 42 CFR 438.56(d)(2):

(1) the member moves out of the MassHealth managed care provider's service area;

(2) the MassHealth managed care provider does not, because of moral or religious objections, cover the service the enrollee seeks;

(3) the enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or

(4) other reasons, including but not limited to, poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the member's health-care needs.

(F) Out-of-Area Managed Care Provider. A member who seeks to enroll with a MassHealth managed care provider outside of the member's service area must submit a request in writing to the MassHealth agency on forms provided by the MassHealth agency. The MassHealth agency will grant a request for an available out-of-area MassHealth managed care provider where the MassHealth agency determines that

(1) there is no MassHealth managed care provider available in the member's service area that is able to communicate with the member directly or through an interpreter; or

(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 the MassHealth agency, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment of Members.

(1) The MassHealth agency may disenroll a member from an MCO, upon request, if the MCO demonstrates to the MassHealth agency's satisfaction that the MCO has made reasonable efforts to provide medically necessary services to the member through available primary care providers or other relevant network providers and, despite such efforts, the continued enrollment of the member with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members.

(2) The MassHealth agency may disenroll a member from a PCC's panel, upon request, if the provider demonstrates to the MassHealth agency's satisfaction that

(a) there is a pattern of noncompliant or disruptive behavior by the member that is not the result of the member's special needs;

(b) the continued enrollment of the member with the provider seriously impairs the provider's ability to furnish services to either this particular member or other members; or

(c) the PCC is unable to meet the medical needs of the member.

(3) If the MassHealth agency approves a request for disenrollment under 130 CMR 508.002(G)(1) and (2), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(11).

(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, or with the MassHealth managed care provider that has the same issuer as the Qualified Health Plan with which the member was most recently enrolled, if such MassHealth-managed care provider is available for the member's coverage type.

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(B)(3).

(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 the MassHealth behavioral-health contractor. The MassHealth 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 the MassHealth behavioral-health contractor.

508.004: Members Excluded from Participation in Various Managed Care Options

(A) The following MassHealth members are excluded from participation in a MassHealth-contracted managed care organization (MCO):

(1) a member who has Medicare;

(2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;

(3) a member who is 65 years of age or older, except such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008;

(4) a member in a nursing facility, chronic disease or rehabilitation hospital, ICF/MR, or a state psychiatric hospital for other than a short-term rehabilitative stay;

(5) a member who is eligible solely for

(a) MassHealth Limited; or

(b) Children's Medical Security Plan (CMSP);

(6) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*;

(7) a member who is receiving hospice care through MassHealth on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and

(8) a member who has presumptive or time-limited eligibility.

(B) The following MassHealth members are excluded from participation in the MassHealth Primary Care Clinician (PCC) Plan:

(1) a member who has Medicare;

(2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;

(3) a member who is 65 years of age or older, except such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008;

(4) a member in a nursing facility, chronic disease or rehabilitation hospital, ICF/MR, or a state psychiatric hospital for other than a short-term rehabilitative stay;

(5) a member who is eligible solely for

(a) MassHealth Limited;

(b) Children's Medical Security Plan (CMSP); or

(c) MassHealth CarePlus, unless there are fewer than two CarePlus MCOs available where the member resides;

(6) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*;

(7) a member who is receiving hospice care through MassHealth on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and

(8) a member who has presumptive or time-limited eligibility.

(C) The following MassHealth members 65 years of age and older are excluded from participating in a senior care organization (SCO):

(1) a member who has access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001; *Definition of Terms*;
(2) a member who does not live in the designated service area of a SCO;
(3) a member in a chronic disease or rehabilitation hospital or ICF/MR;
(4) a member who is not eligible for MassHealth Standard;
(5) a member who has presumptive or time-limited eligibility;
(6) a member who is diagnosed as having end-stage renal disease;
(7) a member who is enrolled in a home- and community-based services waiver, except the Home- and Community-Based Services Waiver-Frail Elder as described at 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*; and
(8) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program.*

(D) The following MassHealth members 21 through 64 years of age who are enrolled in Medicare Parts A and B and are eligible for Medicare Part D are excluded from participation in an integrated care organization (ICO):

(1) a member who has no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
(2) a member in an ICF/MR;
(3) a member who is not eligible for MassHealth Standard or CommonHealth;
(4) a member who has presumptive or time-limited eligibility;
(5) a member who is enrolled in a home- and community-based services waiver; and
(6) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program.*

508.005: MassHealth Managed Care Providers

(A) Primary Care Clinicians Participating in the PCC Plan. The list of primary care clinicians that the MassHealth agency will make available to members may include any one of the following who is approved as a PCC by the MassHealth agency and who practices within the member's service area:

(1) a physician in one of the following fields of medicine:
  (a) internal medicine;
  (b) family or general practice;
  (c) pediatrics;
  (d) obstetrics;
  (e) gynecology;
  (f) obstetrics/gynecology; or
  (g) physiatry;

(2) a physician specialist who is board-certified or eligible for board certification in internal medicine or pediatrics and who agrees to provide primary care in accordance with MassHealth agency requirements;

(3) an independent nurse practitioner;

(4) a licensed community health center with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1);

(5) an acute hospital outpatient department with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1); or

(6) a group practice with one or more practicing physicians or independent nurse practitioners who meet the requirements of 130 CMR 508.005(A)(1).

(B) Managed Care Organizations. The list of MCOs that the MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area.

(C) Senior Care Organizations. The list of senior care organizations (SCOs) that the MassHealth agency will make available to members will include those SCOs that contract with the MassHealth agency and provide services within the member's service area.

(D) Integrated Care Organizations. The list of integrated care organizations (ICOs) that the MassHealth agency will make available to members will include those ICOs that contract with the MassHealth agency and provide services within the member's service area.

508.006: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to appeal

(A) the MassHealth agency's determination that the MassHealth member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);

(B) a determination by the MassHealth behavioral-health contractor, by one of the MassHealth managed care organization (MCO) contractors, or by a senior care organization (SCO) , as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;

(C) the MassHealth agency's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or

(D) the MassHealth agency's disenrollment of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

508.007: Eligibility and Enrollment in an Integrated Care Organization

(A) Eligibility.

(1) In order to be eligible to enroll in an integrated care organization (ICO), a MassHealth member must meet all of the following criteria, and may not be enrolled or concurrently participate in any of the programs or plans listed in 130 CMR 508.007(F):

(a) be 21 through 64 years of age at the time of enrollment;

(b) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;

(c) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and

(d) live in a designated service area of an ICO.

(2) If a member is enrolled in an ICO and turns age 65 and is eligible for MassHealth Standard, he or she may elect to remain in the ICO after age 65.

(B) Selection of an Integrated Care Organization.

(1) The MassHealth agency will notify members

(a) of the availability of an ICO in their service area and how to enroll in an ICO;

(b) that, in any service area with a choice of at least two ICOs, MassHealth will assign eligible members who do not choose an ICO but have not opted out the Duals Demonstration; and

(c) how to opt out of the Duals Demonstration.

(2) An eligible member may enroll in any ICO in the member's service area by making a written or verbal request to MassHealth or its designee. A service area is the specific geographical area of Massachusetts in which an ICO agrees to provide ICO services. Service listings can be obtained from the MassHealth agency or its designee.

(3) MassHealth provides written notice at least 60 days in advance of its assignment of any eligible members to an ICO. The notice includes the ICO to which the member is being assigned, information about how to enroll in a different ICO, and information about how to opt out of the Duals Demonstration Program.

(C) Obtaining Services. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral-health, and long-term services and supports.

(D) Disenrollment from an Integrated Care Organization. A member may disenroll from an ICO at any time by notifying the MassHealth agency or its designee verbally or in writing. A member who disenrolls from an ICO, but does not select another ICO or opt out of the Duals Demonstration, will be automatically assigned another ICO provided that MassHealth provides a written notice at least 60 days in advance of any auto assignment. The notice includes the ICO to which the member is assigned, information about how to enroll in a different ICO, and information about how to opt out of the Duals Demonstration. Disenrollment requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(E) Disenrollment from the Duals Demonstration. A member may opt out of the Duals Demonstration at any time by notifying the MassHealth agency or its designee verbally or in writing. Requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(F) Other Programs. A member may not be enrolled in an ICO and concurrently participate or be enrolled in any of the following programs or plans:

(1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
(2) Medicare demonstration program or Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as an ICO;
(3) any Medicare Demonstrations wherein concurrent participation in the Duals Demonstration is prohibited;
(4) Employer Group Waiver Plans or other employer-sponsored plans; or
(5) plans receiving a retiree drug subsidy.

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be 65 years of age or older;
(2) live in a designated service area of a senior care organization;
(3) not be diagnosed as having end-stage renal disease;
(4) not be subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*;
(5) not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and
(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection of a Senior Care Organization. The MassHealth agency will notify members of the availability of a senior care organization (SCO) in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any SCO in the member's service area. A service area is the specific geographical area of Massachusetts in which a SCO agrees to serve its contract with the MassHealth agency and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee.

(C) Obtaining Services. When a member chooses to enroll in a senior care organization (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each SCO is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral-health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a SCO at any time by submitting a notice of disenrollment to the MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a SCO where the SCO demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization (SCO) under 130 CMR 508.008, a member may not concurrently participate in

(1) any program described in 130 CMR 519.007: *Individuals Who Would Be Institutionalized*, except the Home- and Community-Based Services Waiver-Frail Elder described in 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*;

(2) any Medicare demonstration program or Medicare Advantage plan, except for Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO; or

(3) an ICO described in 130 CMR 508.007.

508.009: Timely Notice of Appealable Actions

(A) Whenever an MCO, SCO, ICO, or the behavioral-health contractor reaches a decision that constitutes an appealable action, as described in 130 CMR 610.032(B), it must send a notice to the member within the following time frames that describes its decision and its internal appeal procedures:

(1) for a standard service authorization decision to deny or provide limited authorization for a requested service, no later than 14 days following receipt of the request for service, unless the time frame is extended up to 14 additional days because the member or a provider requested the extension or the MCO, SCO, and ICO, or behavioral-health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(2) for an expedited service decision to deny or provide limited authorization for a requested service, where a provider requests, or an MCO, SCO, ICO, or behavioral-health contractor determines, that following the standard time frame in 130 CMR 508.009(A) could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, no later than three business days after receipt of the request for service, unless the time frame is extended up to 14 additional calendar days because the member requested the extension or the MCO, SCO, ICO, or behavioral-health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(3) for termination, suspension, or reduction of a previous authorization for a service, at least 10 days before the action, except as provided in 42 CFR 431.213; and

(4) for denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials, which include, but are not limited to, the following:

(a) failure to follow the MCO, SCO, ICO, or behavioral-health contractor's prior authorization procedures;

(b) failure to follow referral rules; and

(c) failure to file a timely claim.

(B) Whenever an MCO, SCO, ICO, or the behavioral-health contractor fails to reach a decision on a standard or expedited service authorization within the time frames described in 130 CMR 508.009(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

508.010: Time Limits for Resolving Internal Appeals

(A) MCOs, SCOs, ICOs, and the behavioral-health contractor must resolve standard internal appeals within 45 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.010(C).

(B) Where the provider requests an expedited appeal or the MCO, SCO, ICO, or behavioral-health contractor determines (for a request from the member) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO, SCO, ICO, or the behavioral-health contractor must resolve the internal appeal on an expedited basis within 72 hours after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.010(C), in which event the MCO, SCO, ICO, or behavioral-health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, SCO, ICO, or behavioral-health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, SCO, ICO, or behavioral-health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.010(A) and must make reasonable efforts to give the member prompt, oral notice of the denial and follow up within two calendar days with a written notice. The MCO, SCO, ICO, or behavioral-health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, SCOs, ICOs, and the behavioral-health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, SCO, ICO, or the behavioral-health contractor extends the time frame, it must give the member written notice of the reason for the extension

(1) the member requested the extension;

(2) the MCO, SCO or the behavioral-health contractor showed (to the MassHealth agency's satisfaction) that there is a need for additional information and how the extension is in the member's interest; or

(3) the ICO showed (to the satisfaction of the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS)) that there is a need for additional information and how the extension is in the member's interest.

508.011: Timely Notice of Internal Appeal Decisions

(A) MCOs, SCOs, ICOs, and the behavioral-health contractor must provide notice of an internal appeal decision concerning an appealable action, as described in 130 CMR 610.032(B), within the timeframes described in 130 CMR 508.010.

(B) Notice from an MCO, a SCO, an ICO, or the behavioral-health contractor concerning an internal appeal must be in writing and, for an expedited internal appeal, reasonable efforts must be made to provide oral notice.

(130 CMR 508.012 through 508.015 Reserved)

508.016: Copayments Required by MassHealth

MassHealth requires MassHealth members who are not enrolled in MCOs to make the copayments described in 130 CMR 506.014 through 506.018 and 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 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;

(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and

(4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

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515.001: Definition of Terms

The terms listed in 130 CMR 515.001 have the following meanings for purposes of MassHealth, as described in 130 CMR 515.000 through 522.000: *MassHealth: Other Division Programs*.

Activities of Daily Living (ADLs) – self-care activities including, but not limited to, bathing, grooming, dressing, eating, and toileting.

Affidavit – a written or printed statement of fact sworn to or affirmed before a person having legal authority to administer such an oath.

American Indian or Alaska Native – a person who

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

Annuity – a legal instrument that makes payments for a designated period of time or for life, regardless if the payments are principal, interest, or both.

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

Appeal Representative – a person who

(1) is sufficiently aware of the appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Office of Medicaid Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;
(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy;
(3) is a licensed attorney who notifies the MassHealth Board of Hearings that he or she represents the appellant in an appeal. This shall also include a non-lawyer supervised by a licensed attorney; or
(4) is an authorized representative meeting the requirements of 130 CMR 501.001: Appeal Representative (1), (2), or (3).

Applicant – a person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Application – see Senior Application.

Asset Limit – the maximum dollar value of assets that can be owned by, or available to, the applicant, member, or the spouse, which if exceeded, results in ineligibility.

Assets – property including, but not limited to, real estate, personal property, and funds. This term has the same meaning as "resources" as defined in 42 U.S.C. 1396p(e)(5).

Authorized Representative –

(1) a person or organization designated as the authorized representative of an applicant or member in a completed, signed Authorized Representative Designation Form or similar designation document submitted to the MassHealth agency in which the authorized representative agrees to comply with rules regarding confidentiality in the course of representing the applicant or member, provided that such person or organization must satisfy one of the following criteria:

(a) an authorized representative may be a person or organization appointed by the applicant or member to act responsibly on his or her behalf in connection with the eligibility process and other ongoing communications with the MassHealth agency. Such person or organization shall have the authority to complete and sign an application on the applicant's behalf, select a health plan, complete and sign a renewal form, receive copies of the applicant or member's notices and other communications from the MassHealth agency which may include protected health-care information, personal data and financial information and unless otherwise specified, act on behalf of the applicant or member in all other matters with the MassHealth agency or the Health Connector;

(b) an authorized representative may be a person acting responsibly on behalf of the applicant or member who is sufficiently aware of such applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with the MassHealth agency. Such person shall have the authority to complete and sign an application on the applicant's behalf, select a health plan, complete and sign a renewal form, receive copies of the applicant or member's notices and other communications from the MassHealth agency which may include protected health-care information, personal data and financial information; or

(c) an authorized representative may be a person acting responsibly on behalf of the applicant or member who has, under applicable law, authority to act on behalf of such applicant or member in making decisions related to health care or payment for health care including, but not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy. The extent of such person's authority to act on behalf of the applicant or member is determined by the applicable law or underlying legal document, and:

(2) As a condition of any organization serving as an authorized representative under 130 CMR 515.001: Authorized Representative (1)(a), a provider or staff member or volunteer of such organization must not have a conflict of interest and must affirm that he or she will adhere to 42 CFR part 431, subpart F.

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 the MassHealth agency'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 collection of written documents and electronic information required to determine eligibility and to provide benefits to applicants and members.

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

Citizen – see 130 CMR 518.002: *U.S. Citizens*.

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

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.

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

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 laws of the Commonwealth of Massachusetts.

Coverage Date – the date medical coverage begins.

Coverage Type – a scope of medical services, other benefits, or both that is available to members who meet specific eligibility criteria. MassHealth coverage types include the following: MassHealth Standard (Standard), MassHealth Limited (Limited), MassHealth Family Assistance (Family Assistance), 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: *Coverage Types.*

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.

Deductible – the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards must be responsible for before the applicant is eligible for MassHealth, as described at 130 CMR 520.028: *Eligibility for a Deductible*.

Deductible Period – a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible through incurred and/or paid medical expenses equaling or exceeding the deductible of the applicant or the spouse.

Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Disabled – having a permanent and total disability.

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

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

Fair-Market Value – an estimate of the value of a resource if sold at the prevailing price. For transferred resources, the fair-market value is based on the prevailing price at the time of transfer.

Family Group – a family, couple, or individual.

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

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

Global Developmental Skills – a child's average developmental skill level, taking into account the physical, psychological, motor, intellectual, emotional, communicative, and social aspects of the child's functional capabilities.

Grantor – an individual or spouse who creates a trust.

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

Guardian – an individual or entity appointed as guardian by the probate and family court under the provisions of M.G.L. c. 201.

Guardianship Fees and Related Expenses – fees for guardianship services and incurred expenses that are essential to enable an incompetent applicant or member to gain access to or consent to medical treatment.

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

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

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

Income Deductions – specified deductions, as described in 130 CMR 520.011: *Standard Income Deductions* through 520.014: *Long-Term-Care Earned-Income Deductions* that may be made from the gross income of an applicant or member.

Incompetent Applicant or Member – an applicant or member who has been adjudicated as incompetent and in need of a guardian by the probate and family court under the provisions of M.G.L. c. 201.

Institution (Medical) – a public or private facility providing acute, chronic, or long-term care, unless otherwise defined within 130 CMR 515.000 through 522.000: *Other Division Programs*. This includes acute inpatient hospitals, licensed nursing facilities, state schools, intermediate-care facilities for the mentally retarded, public or private institutions for mental diseases, freestanding hospices, and chronic-disease and rehabilitation hospitals.

Institutionalization – placement of an individual in one or more medical institutions, where placement lasts or is expected to last for a continuous period of at least 30 days.

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

Irrevocable Trust – a trust that cannot be in any way revoked by the grantor.

Jointly Held Resources – resources that are owned by an individual in common with another person or persons in a joint tenancy, tenancy-in-common, or similar arrangement.

Lawfully Present Immigrants – see 130 CMR 518.003(A): *Lawfully Present Immigrants*.

Life Estate – a life estate is established when all of the remainder legal interest in a property is transferred to another, while the legal interest for life rights to use, occupy, or obtain income or profits from the property is retained.

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

Look-Back Period – a period of consecutive months that the MassHealth agency may review for transfers of resources to determine if a period of ineligibility for payment of nursing-facility services should be imposed.

Lump-Sum Payment – a one-time only payment that represents either a windfall payment, or the accumulation of recurring countable income, such as retroactive unemployment compensation or federal veterans' retirement benefits.

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

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

Member – a person determined by the MassHealth agency to be eligible for MassHealth.

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

Nonqualified Individuals Lawfully Present – see 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*.

Nonqualified Person Residing under Color of Law (nonqualified PRUCOL) – see 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*.

Nursing-Facility Resident – an individual who is a resident of a nursing facility, is a resident in any institution, including an intermediate-care facility for the mentally retarded (ICF/MR), for whom payment is based on a level of care equivalent to that received in a nursing facility, is in an acute hospital awaiting placement in a nursing facility, or lives in the community and would be institutionalized without community-based services provided in accordance with 130 CMR 519.007(B): *Home- and Community Based Services Waiver*.

Other Noncitizens – see 130 CMR 518.003(D): *Other Noncitizens*.

Patient-Paid Amount – the amount that a member in a long-term-care facility must contribute to the cost of care under the laws of the Commonwealth of Massachusetts.

Period of Ineligibility – the period of time during which the MassHealth agency denies or withholds payment for nursing-facility services because the individual has transferred resources for less than fair-market value.

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

(1) For Adults and 18-Year-Olds.

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

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of 130 CMR 515.001: Permanent and Total Disability, an individual 18 years of age or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Younger Than 18 Years Old. The condition of an individual younger than 18 years old who has any medically determinable physical or mental impairment, or combination of impairments, that causes marked and severe functional limitations, as defined in Title XVI of the Social Security Act, and can be expected to cause death or can be expected to last for a continuous period of not less than 12 months. Disability for children eligible for MassHealth CommonHealth under 130 CMR 519.012(B): *Certain Institutionalized Immigrant Children* is determined in accordance with the definition for permanent and total disability for children younger than 18 years old in 130 CMR 501.001: *Definition of Terms*.

Personal Needs Allowance (PNA) – the designated portion of monthly income that a person in long-term care is allowed to retain for personal expenses. In some instances, the MassHealth agency pays all or a portion of the PNA to the member. The PNA must not be used for payment of any item included in the daily rate at the long-term-care facility.

Personal Needs Allowance (PNA) Account – an account administered by a long-term-care facility on behalf of a member. Regulations regarding the administration of PNA accounts are contained in 130 CMR 456.601: *Personal Needs Allowance Account* through 456.615: *Annual Accounting to the Division of PNA Balance*.

Pooled Trust – a trust that meets all the following criteria as determined by the MassHealth agency.

(1) The trust was created by a nonprofit organization.
(2) A separate account is maintained for each beneficiary of the trust, but the assets of the trust are pooled for investment and management purposes.
(3) The account in a pooled trust was created for the sole benefit of the individual by the individual, the individual's parents or grandparents, or by a legal guardian or court acting on behalf of the individual.
(4) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the MassHealth agency for services to the individual. The trust may retain reasonable and appropriate amounts as determined by the MassHealth agency.
(5) The individual was disabled at the time his or her account in the pool was created.

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

Promissory Note – a written promise to pay another.

Protected Noncitizens – see 130 CMR 518.003(B): *Protected Noncitizens.*

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

Qualified Noncitizens – see 130 CMR 518.003(A)(1): *Qualified Noncitizens.*

Qualified Noncitizens Barred – see 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred.*

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

Reapplication – the MassHealth agency's reopening of the application process when the application has been denied pursuant to 130 CMR 516.001(D): *Receipt of Corroborative Information*.

Redetermination – a review of a member's circumstances to establish whether or not he or she remains eligible for benefits.

Resources – all income and assets owned by the individual or the spouse. For the purposes of determining eligibility, resources include income and assets to which the individual or the spouse is or would be entitled whether or not they are actually received. This term has the same meaning as "assets" as defined in 42 U.S.C. 1396p(e)(1).

Reverse Mortgage – a loan on the equity value of a house paid in installments by a lender to the homeowner who is 60 years of age or older.

Revocable Trust – a trust whose terms allow the grantor to take action to regain any of the property or funds in the trust.

Senior Application or Application – the request for health benefits for an individual who is 65 years of age and older, or not living in the community that is received by the MassHealth agency and includes all required information and a signature by the applicant or his or her authorized representative.

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

Skilled-Nursing Services – the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that must be provided by a registered nurse, a licensed practical nurse, or a licensed vocational nurse.

Special-Needs Trust – a special-needs trust is one that meets all the following criteria as determined by the MassHealth agency.

(1) The trust was created for a disabled individual younger than 65 years old.
(2) The trust was created for the sole benefit of the individual by the individual's parent, grandparent, legal guardian, or a court.
(3) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the MassHealth agency for services to the individual.
(4) When the member has lived in more than one state, the trust must provide that the funds remaining upon the death of the member are distributed to each state in which the member received Medicaid based on each state's proportionate share of the total amount of Medicaid benefits paid by all states on the member's behalf.

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

Stream of Income – income received on a regular basis.

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

Supplemental Security Income (SSI) Program – a program that provides financial assistance to needy persons who are 65 years of age or older, blind, or disabled. This program is established under Title XVI of the Social Security Act and is administered by the Social Security Administration. Such persons automatically receive MassHealth.

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

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

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

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

Trust – a legal device satisfying the requirements of state law that places the legal control of property or funds with a trustee. It also includes, but is not limited to, any legal instrument, device, or arrangement that is similar to a trust, including transfers of property by a grantor to an individual or a legal entity with fiduciary obligations so that the property is held, managed, or administered for the benefit of the grantor or others. Such arrangements include, but are not limited to, escrow accounts, pension funds, and similar devices as managed by an individual or entity with fiduciary obligations.

Trustee – any individual or legal entity that holds or manages a trust.

Uncompensated Value – the difference between the fair-market value of the resource or interest in the resource at the time of transfer less any outstanding debts and the actual amount the individual received for the resource. The MassHealth agency uses the uncompensated value in the calculation of the period of ineligibility.

515.002: Introduction to MassHealth

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

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

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

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

515.003: MassHealth Coverage Types

(A) The MassHealth agency provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for 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) The MassHealth agency offers the following types of coverage: MassHealth Standard, MassHealth Family Assistance, 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 and the spouse's income and assets, as described in 130 CMR 519.000: *MassHealth: Coverage Types* and 520.000: *MassHealth: Financial Eligibility*, and immigration status, as described in 130 CMR 518.000: *MassHealth: Citizenship and Immigration*.

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

(1) Applicants who cannot be enrolled under MassHealth Family Assistance pursuant to 130 CMR 515.003(C), will be placed on a waiting list when their eligibility has been determined. When the MassHealth agency 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 Family Assistance 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. The MassHealth agency formulates requirements and determines eligibility for all MassHealth coverage types.

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA).

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

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

(i) MassHealth Standard: children younger than 19 years old, young adults 19 and 20 years old who are citizens, qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present, parents and caretakers who are citizens or qualified noncitizens, and elders 65 years of age or older who are citizens or qualified noncitizens;

(ii) Mass Health CarePlus: adults 21 through 64 years of age who are citizens or qualified noncitizens; and

(iii) MassHealth Family Assistance: children younger than 19 years old, young adults 19 and 20 years of age who are nonqualified persons living under color of law (PRUCOLs), parents and caretakers who are qualified noncitizens barred, nonqualified individuals lawfully present, nonqualified PRUCOLs, adults 21 through 64 years of age who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs, and elders age 65 or older who are qualified noncitizens barred, nonqualified individual lawfully present, or nonqualified PRUCOLs.

(2) Social Security Administration (SSA). The Social Security Administration administers the Supplemental Security Income (SSI) program and determines the eligibility of persons aged 65 or older. Persons receiving SSI who are 65 or older are automatically eligible for MassHealth Standard coverage.

(3) Health Connector. The Health Connector is Massachusetts' health insurance marketplace where individuals, families, and small businesses can shop among qualified health insurance carriers and choose a health insurance plan. The Health Connector administers Qualified Health Plans (QHP), premium tax credits (PTC), and the ConnectorCare program. The single, streamlined application is used to determine eligibility for both Health Connector and MassHealth programs as described in 130 CMR 516.000: MassHealth: The Eligibility Process. The Health Connector and MassHealth also coordinate eligibility notices and eligibility appeals.

515.005: Receiving Public Assistance from Another State.

Persons who are receiving public assistance from another state are not eligible for MassHealth.

(130 CMR 515.006 Reserved)

515.007: Rights of Applicants and Members

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

(A) Right to Nondiscrimination and Equal Treatment. The MassHealth agency does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the MassHealth agency's Affirmative Action Office.

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

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 516.000: *MassHealth: The Eligibility Process*.

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

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

(F) Right to Be Assisted by Others

(1) The applicant or member has the right to be accompanied by an appeal representative during the appeal process.

(2) An application for MassHealth may be filed by an authorized representative, including on behalf of a deceased person.

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

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

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

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

(I) Right to Interpreter Services. The MassHealth agency 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, the MassHealth agency will provide either telephonic or other interpreter services whenever

(1) the applicant or member who is seeking assistance from the MassHealth agency has limited English proficiency or sensory impairment and requests interpreter services; or
(2) the MassHealth agency determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The MassHealth agency provides a Certificate of Creditable Coverage to members whose coverage under Standard, CommonHealth, or Family Assistance has ended. The MassHealth agency 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 the 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 other 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 the MassHealth agency in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining other health insurance.

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

515.009: Referrals to Investigative Units

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

515.010: Recovery of Overpayment of Medical Benefits

The MassHealth agency has the right to recover payment of medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 515.010 will limit the MassHealth agency's right to recover overpayments.

515.011: Estate Recovery

(A) Introduction.

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

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

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

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

(3) Notwithstanding 130 CMR 515.011(A)(1) and in accordance with 42 U.S.C. 1396p(b)(B), MassHealth will not recover Medicare cost-sharing benefits described at 42 U.S.C. 1396(a)(10)(E) with dates of payment on or after January 1, 2010, for persons who received such benefits under 130 CMR 505.002: *MassHealth Standard*, 505.007: *MassHealth Senior Buy-In and Buy-In*, 519.010: *MassHealth Senior Buy-In*, and 519.011: *MassHealth Buy-In*, when they were 55 years of age or older.

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

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

(B) Exception. No recovery for nursing facility or other long-term-care services may be made from the estate of any person who

(1) was institutionalized;

(2) notified the MassHealth agency that he or she had no intent of returning home; and

(3) on the date of admission to the long-term-care institution, had long-term-care insurance that met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

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

(D) Waiver of Estate Recovery Due to Financial Hardship.

(1) For claims presented on or after November 15, 2003, recovery will be waived if

(a) a sale of real property would be required to satisfy a claim against the member's probate estate; and

(b) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:

(i) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the MassHealth agency and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member’s estate;

(ii) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);

(iii) the individual is not being forced to sell the property by other devisees or heirs at law; and

(iv) at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group was less than or equal to 133 percent of the applicable federal-poverty-level income standard for the appropriate family size.

(2) The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for waiver no longer exist, including meeting the same income standards under 130 CMR 515.011(D)(1)(b)(iv), the property is sold or transferred, or the individual does not use the property as his or her primary residence, the MassHealth agency will be notified and its claim will be payable in full.

(E) Outstanding Claims.

(1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the then-existing MassHealth regulations were met.

(2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

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

(1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

(a) a special-purpose assessment;

(b) based on a fixed-rate-per-acre method; or

(c) based on an assessment ratio or providing only a range.

(2) The executor or administrator of the probate estate or, in the case of real property that passed outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official from a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.
(3) The MassHealth agency may also obtain an assessment from a knowledgeable source.

(G) Waiver of Estate Recovery Due to Hardship for American Indians and Alaska Natives.
(1) For claims presented on or after July 1, 2009, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:
(a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
(b) ownership interest in trust and nontrust property, including real property and improvements
(i) located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
(ii) for any federally recognized tribe not described in 130 CMR 515.011(G)(1)(b)(i), located within the most recent boundaries of a prior federal reservation;
(c) income left as a remainder in an estate derived from property protected in 130 CMR 515.011(G)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;
(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or
(e) ownership interests in or usage rights to items not covered by 130 CMR 515.011(G)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

(2) Protection of non-trust property described in 130 CMR 515.011(G)(1) is limited to circumstances when it passes from an Indian, as defined in section 4 of the Indian Health Care Improvement Act, to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses or stepchildren, that their culture would nevertheless protect as family members, to a tribe or tribal organization, or to one or more Indians.

515.012: Real Estate Liens

(A) Liens. A real estate lien enables the MassHealth agency to recover the cost of medical benefits paid or to be paid on behalf of a member. Before the death of a member, the MassHealth agency will place a lien against any property in which the member has a legal interest, subject to the following conditions:

(1) per court order or judgment; or

(2) without a court order or judgment, if all of the following requirements are met:

(a) the member is an inpatient receiving long-term or chronic care in a nursing facility or other medical institution;

(b) none of the following relatives lives in the property:

(i) a spouse;

(ii) a child younger than 21 years old, or a blind or permanently and totally disabled child; or

(iii) a sibling who has a legal interest in the property and has been living in the house for at least one year before the member's admission to the medical institution;

(c) the MassHealth agency determines that the member cannot reasonably be expected to be discharged from the medical institution and return home; and

(d) the member has received notice of the MassHealth determination that the above conditions have been met and that a lien will be placed. The notice includes the member's right to a fair hearing.

(B) Recovery. If property against which the MassHealth agency has placed a lien under 130 CMR 515.012(A) is sold during the member's lifetime, the MassHealth agency may recover all payment for services provided on or after April 1, 1995. This provision does not limit the MassHealth agency’s ability to recover from the member's estate in accordance with 130 CMR 515.011.

(C) Exception. No recovery for nursing-facility or other long-term-care services may be made under 130 CMR 515.012(B) if the member

(1) was institutionalized;

(2) notified the MassHealth agency that he or she had no intention of returning home; and

(3) on the date of admission to a long-term-care institution had long-term-care insurance whose coverage met the requirements of 130 CMR 515.014 and the Division of Insurance regulations at 211 CMR 65.09(1)(e)(2).

(D) Repayment Deferred.

(1) In the case of a lien on a member's home, repayment under 130 CMR 515.012 is not required while any of the following relatives are still lawfully living in the property:

(a) a sibling who has been living in the property for at least one year before the member's admission to the nursing facility or other medical institution; or

(b) a son or daughter who

(i) has been living in the property for at least two years immediately before the member was admitted to a nursing facility or other medical institution;

(ii) establishes to the satisfaction of the MassHealth agency that he or she provided care that permitted the parent to live at home during the two-year period before institutionalization; and

(iii) has lived lawfully in the property on a continual basis while the parent has been in the institution.

(2) Repayment from the estate of a member that would otherwise be recoverable under any regulation is still required even if the relatives described in 130 CMR 515.012(D) are still living in the property.

(E) Dissolution. The MassHealth agency will discharge a lien placed against property under 130 CMR 515.012(A) if the member is released from the medical institution and returns home.

(F) Verification. The applicant or member must cooperate in providing verification as to whether the conditions under 130 CMR 515.012(A) exist, and in providing any information necessary for the MassHealth agency to place a lien.

(G) Recording Fee. The MassHealth agency is not required to pay a recording fee for filing a notice of lien or encumbrance, or for a release or discharge of a lien or encumbrance under 130 CMR 515.012.

515.013: Voter Registration

(A) Voter registration forms are available through the MassHealth agency to applicants and members who are

(1) U.S. citizens; and

(2) 18 years of age or older, or who will be 18 years old on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members are

(1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;

(2) offered assistance in completing the voter registration application form unless such assistance is refused; and

(3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.

(C) MassHealth agency staff must not

(1) seek to influence an applicant's or member's political preference or party registration;

(2) display any political preference or party allegiance to the applicant or member;

(3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or

(4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(D) Completed voter registration application forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

515.014: Long-Term-Care Insurance Minimum Coverage Requirements for MassHealth Exemptions

For purposes of the financial eligibility exemption under 130 CMR 520.007(G)(8)(d), concerning treatment of the former home as an asset, and the exemption under 130 CMR 515.011(B) and 515.012(C), concerning repayment of assistance provided for nursing facility and other long-term-care services (hereafter collectively referred to as “MassHealth exemptions”), a long-term-care insurance policy must provide certain minimum coverage requirements as determined by the Division of Insurance.

(A) Under Division of Insurance regulations at 211 CMR 65.09(1)(e)(2), to qualify for the MassHealth exemptions, an individual must be a covered person under an individual, group, or employment-based group policy issued on or after March 15, 1999, that meets the individual policy minimum standards of 211 CMR 65.05: *Minimum Standards for Individual Policies* and all of the following requirements.

(1) Scope of Benefits. The policy must cover nursing and custodial care in a nursing facility licensed by the Department of Public Health.

(2) Daily Dollar Benefits. The policy must have available benefits of at least $125 per coverage day in a nursing facility, except where the actual expense incurred is less, regardless of whether accrued benefits are measured in terms of days or dollar amount.

(3) Nursing Facility Coverage Days: Lifetime Benefit Period. The policy must have benefits available sufficient to cover at least 730 days in a nursing facility.

(4) Elimination Period. No policy may have an elimination period (days on which services are provided to an insured before the policy begins to pay benefits) longer than 365 days in a nursing facility. The application of more than one elimination period is not allowed unless the insured has received no benefits for a period of at least 180 consecutive days. In lieu of an elimination period, the policy may have a deductible of no more than $54,750.

(B) All policies issued prior to March 15, 1999, need only comply with the minimum standards of 211 CMR 65.05: Minimum Standards for Individual Policies, and the limitations and exclusion provision of 211 CMR 65.06: Mandatory Benefit Offers for Individual Policies, which were effective from April 1, 1989, through September 2, 1999.

515.015: Reimbursement of Certain Out-of-Pocket Medical Expenses

(A) Eligibility Requirements. The following Standard coverage members are entitled to reimbursement for certain medical expenses for which they paid, subject to the provisions of 130 CMR 515.015:

(1) an individual who
   (a) applied for Supplemental Security Income (SSI);
   (b) was denied SSI benefits by the Social Security Administration; and
   (c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality; or

(2) an individual who
   (a) applied for MassHealth;
   (b) was denied MassHealth; and
   (c) had his or her initial denial overturned by a subsequent decision, MassHealth, the fair hearing process, or the judicial review process.

(B) Limitations.

(1) Reimbursement is limited to bills incurred on or after the coverage start date for the applicable coverage type as described in 130 CMR 519.000: *MassHealth: Coverage Types* , and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.

(2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, MassHealth may require submission of medical evidence for consideration under the prior-authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

(1) Applicants or members seeking reimbursement must provide MassHealth with

(a) a bill for medical services that includes

(i) the provider's name;

(ii) a description of the services provided; and

(iii) the date the service was provided; and

(b) proof of payment of the bill presented, such as a canceled check or receipt.

(2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.

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516.001: Overview

(A) Filing an Application.

(1) Application. To apply for MassHealth

(a) for an individual living in the community, an individual or his or her authorized representative must file a Senior Application online at www.MAHealthConnector.org, complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

(b) for an individual in need of long-term-care services in a nursing facility, a person or his or her authorized representative must file a complete paper Senior Application and Supplements or apply in person at a MassHealth Enrollment Center (MEC).

(2) Online or Telephone Application Requirements.

(a) Individuals, or their authorized representative, if applicable, completing an application for MassHealth online or by telephone must be identity proofed pursuant to 130 CMR 516.002(A)(3). Eligibility based on an online or telephonic application cannot be determined until the identity is proven or a paper application is submitted.

(b) If an applicant submits a paper application or applies in person at a MassHealth Enrollment Center, identity proofing is not required.

(3) Identity Proofing Process. An individual or his or her authorized representative, if applicable, completing an online or telephonic application will be asked a series of questions to prove his or her identity.

(a) If the individual is successfully identity proofed, the application may be submitted and an eligibility determination will be performed.

(b) If the individual is not successfully identity proofed, the individual will be asked to provide one or two forms of acceptable documentation proving his or her identity. Documentation proving identity must be submitted to the MassHealth agency within 15 days from the date of the request.

(c) If identity proof is received within 15 days of the date of the notice referenced in 130 CMR 516.001(A)(3)(b), the eligibility process commences. The MassHealth agency will determine the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the application is considered submitted on the date of the initial unsuccessful identity proofing.

(d) If identity proof is not received within the 15-day period referenced in 130 CMR 516.001(A)(3)(b), the MassHealth agency will notify the applicant or his or her authorized representative that it is unable to determine eligibility for medical benefits. If acceptable proof of identity is received after the 15-day period, the eligibility process commences and the application is considered submitted on the date the identity proof is received by the MassHealth agency, provided that if acceptable proof of identity or a paper application is received more than one year after the initial unsuccessful identity proofing, a new application must be submitted.

(e) To prove his or her identity, an individual can submit the acceptable proofs of identify as described in 130 CMR 518.005(A)(3): *Acceptable Proof of Identity*.

(4) Paper Applications or In-Person Applications at the MassHealth Enrollment Center (MEC) — Missing or Inconsistent Information.

(a) If a paper application is received at a MassHealth Enrollment Center or MassHealth outreach site and the applicant did not answer all required questions on the senior application, the MassHealth agency is unable to determine the applicant's eligibility for MassHealth.

(b) The MassHealth agency requests responses to all of the unanswered questions necessary to determine eligibility. The MassHealth agency must receive such information within 15 days of the date of the request for the information.

(c) If responses to all unanswered questions necessary to determine eligibility are received within 15 days of the date of the notice, referenced in 130 CMR 516.001(A)(4)(b), the MassHealth agency eligibility process commences. The MassHealth agency will determine

(i) the coverage type providing the most comprehensive medical benefits for which the applicant is eligible, and the application is considered submitted on the date the initial incomplete application was received by the MassHealth agency; or

(ii) the need to request any corroborative information necessary to determine eligibility, as provided in 130 CMR 516.001(C) and (D).

(d) If responses to all unanswered questions necessary for determining eligibility are not received within the 15-day period referenced in 130 CMR 516.001(A)(4)(b), the MassHealth agency notifies the applicant that it is unable to determine eligibility. The date that the incomplete application was received will not be used in any subsequent eligibility determinations. If the required response is received after the 15-day period, the eligibility process commences and the application is considered submitted on the date the response is received, provided that if the required response is submitted more than one year after the initial incomplete application, a new application must be completed.

(e) Inconsistent answers are treated as unanswered.

(B) Corroborative Information. The MassHealth agency requests all corroborative information necessary to determine eligibility.

(1) The MassHealth agency sends the applicant written notification requesting the corroborative information generally within five days of receipt of the application.

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

(C) Receipt of Corroborative Information. If the requested information, with the exception of verification of citizenship, identity, and immigration status, is received within 30 days of the date of the request, the application is considered complete. The MassHealth agency will determine the coverage type providing the most comprehensive medical benefits for which the applicant is eligible. If such information is not received within 30 days of the date of the request, MassHealth benefits may be denied.

(1) If the requested information is received within 30 days of the date 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 application to pursue eligibility for MassHealth. The earliest date of eligibility for MassHealth is based on the date of the new application.

516.002: Date of Application

(A) The date of application for an online, telephonic, or in-person application is the date the application is submitted to the MassHealth agency.

(B) The date of application for a paper application that is either mailed or faxed is the date the application is received by the MassHealth agency.

(C) An application is considered complete as provided in 130 CMR 516.001(C).

(D) 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

The MassHealth agency initiates information matches with other agencies and information sources when an application is received in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following agencies: Federal Data Services Hub, the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Social Security Administration, Systematic Alien Verification for Entitlements, Department of Transitional Assistance, health-insurance carriers, 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 completed application. All requested information must be received within 30 days of the date of request.

(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 completed application, including a disability supplement, if required.

(C) If the MassHealth agency determines that unusual circumstances exist, the timeframes for determining eligibility are extended. Unusual circumstances include delay caused by the applicant, by an examining physician, or by other events beyond the control of the MassHealth agency.

516.005: Coverage Date

The begin date of MassHealth Standard, Family Assistance, 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.

516.006: Continuing Eligibility

(A) Annual Renewals. The MassHealth agency reviews eligibility once every 12 months. Eligibility may also be reviewed as a result of a member's changes in circumstances or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification of immigration status. The MassHealth agency updates eligibility based on information received as the result of such review. The MassHealth agency reviews eligibility

(1) by information matching with other agencies, health insurance carriers, and information sources;
(2) through a written update of the member's circumstances on a prescribed form;
(3) through an update of the member's circumstances, in person, by telephone, or on the MAHealthConnector.org account; or
(4) based on information in the member's case file.

(B) Eligibility Determinations. The MassHealth agency determines, as a result of this review, if

(1) the member continues to be eligible for the current coverage type;
(2) the member's current circumstances require a change in coverage type; or
(3) the member is no longer eligible for MassHealth.

(C) Eligibility Reviews. MassHealth reviews eligibility in the following ways.

(1) Automatic Renewal. Households whose continued eligibility can be determined based on electronic data matches with federal and state agencies will have their eligibility automatically renewed.

(a) The MassHealth agency will notify the member if eligibility has been reviewed using the automatic renewal process. The notice will include information about the data that was received through electronic data matches and used to determine continued eligibility.

(b) If the member's coverage type changes to a more comprehensive benefit, the start date for the new coverage is the date of the written notice,

(2) Prepopulated Review Form. If the individual is residing in the community and his or her continued eligibility cannot be determined based on reliable information contained in his or her account or electronic data match with federal and state agencies, a prepopulated eligibility review form must be completed.

(a) The MassHealth agency will notify the member of the need to complete the prepopulated review form.

(b) The member will be given 45 days from the date of the request to return the paper prepopulated review form, log onto his or her MAHealthConnector.org account to complete the review online, or call the MassHealth agency to complete the review telephonically.

(i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available. If verification through electronic data match is unsuccessful, the MassHealth agency will request required verifications as described in 130 CMR 502.003: *Verification of Eligibility Factors* and the individual continues to receive benefits pending verification.

(ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.

(iii) If the individual submits the prepopulated review within 90 days of the termination date and is determined eligible for a MassHealth benefit, eligibility for that benefit is the date of the previous termination.

(iv) If the prepopulated review is returned, but the required verifications are not submitted with the form, a second 90-day period starts on the date that the prepopulated form is returned.

(v) If the prepopulated review is not submitted within 90 days of the previous termination date, a new application is required.

(c) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.

(3) Review Form for Individuals In need of Long-Term-Care Services in a Nursing Facility. If the individual is in need of long-term-care services in a nursing facility and his or her continued eligibility cannot be determined based on reliable information contained in his or her account or electronic data match with federal and state agencies, a written update of the member's circumstances on a prescribed form must be completed.

(a) The MassHealth agency will notify the member of the need to complete the prescribed review form.

(b) The member will be given 45 days to return the review form to the MassHealth agency.

(i) If the review is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available.

(ii) If the review is not completed within 45 days, eligibility will be terminated within 14 days from the date of determination.

(iii) If the requested review form 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.

(c) If the member's coverage type changes, the start date for the new coverage type is effective as of the date of the written notice.

(4) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 516.003 to update or verify eligibility,

(a) If the electronic data match indicates a change in circumstances that would result in potential reduction or termination of benefits, the MassHealth agency will notify the member of the information that was received through the data match and require the member to respond within 30 days of the date of the notice.

(i) If the member responds within 30 days and confirms the data is correct, eligibility will be determined using the confirmed data from the electronic data match.

(ii) If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional verification will be required.

(iii) If the member does not respond within 30 days, eligibility will be determined using the data from the electronic data match.

(b) If the electronic data match indicates a change in circumstances that would result in an increase or no change in benefits, the MassHealth agency will notify the member of the information that was received through the data match and automatically update the case using the information received from the electronic data match and redetermine eligibility. The effective date of the change is the date of the redetermination of eligibility.

516.007: Notice

(A) All applicants and members, as well as certain others described below in 130 CMR 516.007, receive written notice of the determination of their eligibility for MassHealth. The notice contains an eligibility decision for each member who has requested MassHealth, and provides information enabling the applicant or member to determine the reason for any adverse decision.

(B) Members also receive notice of any changes in coverage type or patient-paid amount, or loss of coverage.

(C) In addition to sending notices to applicants and members, such written notices are provided to the institution or authorized representative, as well as to the community spouse, as defined at 130 CMR 520.016(B)(1)(c): *Right to Appeal*. This may include, in the case of death, the executor, administrator, or legal representative of the deceased individual's estate.

(D) All notices provide information about the right of the applicant or member to a fair hearing, with the exception of asset assessments described at 130 CMR 520.016: *Long-Term Care: Treatment of Assets* and notices about federal or state law requiring an automatic change adversely affecting some or all members as described in 42 CFR 431.220(b). Information about the appeal process is found at 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

516.008: Voluntary Withdrawal

The applicant or authorized representative may voluntarily withdraw his or her application for MassHealth. An authorized representative may also withdraw a request for MassHealth on behalf of a deceased applicant.

516.009: Issuance of a MassHealth Card

(A) The MassHealth agency issues a MassHealth card to new members, with the exception of those who receive MassHealth Buy-In coverage.

(B) A temporary card may be issued to a member if there is an immediate need.

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UNIVERSAL ELIGIBILITY REQUIREMENTS

517.001: Universal Eligibility Requirements

All MassHealth applicants and members must meet the requirements of this chapter (130 CMR 517.000) as a condition of eligibility.

517.002: Residence Requirements

As a condition of eligibility, an applicant or member must be a resident of the Commonwealth of Massachusetts.

(A) Unless otherwise specified
(1) individuals 21 years of age and older are residents of the Commonwealth if they are living in the Commonwealth and either
(a) intend to reside in the Commonwealth, with or without a fixed address; or
(b) have entered the Commonwealth with a job commitment or are seeking employment, whether or not they are currently employed; or
(2) individuals 21 years of age and older who are not capable of stating intent as defined in 42 CFR 435.403(c) are residents of the Commonwealth if they are living in the Commonwealth; or
(3) for any other non-institutionalized individuals 21 years of age and older not subject to 130 CMR 517.002(A)(1) or (2), their residence is determined in accordance with 42 CFR 233.40, the rules governing residence under the AFDC program.

(B) Unless otherwise specified
(1) individuals younger than 21 years old are residents of the Commonwealth if they are capable of indicating intent, and are either married or emancipated from their parents, and meet the requirements of 130 CMR 517.003(A)(1); or
(2) individuals younger than 21 years old not described in 130 CMR 517.002(B)(1) are residents of the Commonwealth if they are
(a) living in the Commonwealth, with or without a fixed address; or
(b) living with their parent or caretaker who is a resident of the Commonwealth in accordance with the requirements of 130 CMR 517.002(A)(1).

(C) Individuals of any age who are receiving a state supplementary payment (SSP) are residents of the Commonwealth if the Commonwealth is the state paying the SSP.

(D) Individuals of any age who are receiving federal payments for foster care and adoption assistance under Title IV-E of the Social Security Act are residents of the Commonwealth if the Commonwealth is the state where the individuals live.

(E) (1) The individual's residency is considered verified if the individual has attested to Massachusetts residency and the residency has been confirmed by electronic data matching with federal or state agencies or information services.

(2) If residency cannot be verified through electronic data matching or there is conflicting information, the MassHealth agency may require documentation to validate residency.

(F) Acceptable proof of Massachusetts residency includes the following, as well as any other verification allowed as determined by the MassHealth agency:

(1) copy of deed and record of most recent mortgage payment (if mortgage is paid in full, provide a copy of property tax bill from the most recent year);
(2) current utility bill or work order dated within the past 60 days;
(3) statement from a homeless shelter or homeless service provider;
(4) school records (if school is private, additional documentation may be requested);
(5) nursery school or daycare records (if school is private, additional documentation may be requested);
(6) Section 8 agreement;
(7) homeowner’s insurance agreement;
(8) proof of enrollment of custodial dependent in public school;
(9) copy of lease and record of most recent rent payment; or
(10) affidavit supporting residency, signed under pains and penalties of perjury.

(G) Examples of applicants or members who do not meet the residency requirement for MassHealth are

(1) 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; and
(2) individuals whose whereabouts are unknown.

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

(1) they are inpatients in a medical facility; or
(2) they are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.

517.003: Residence of Institutionalized Individuals

(A) Placement by a Public Agency. An individual who has been placed in an institution or a foster care home in another state by a public agency of the Commonwealth shall be considered a resident of the Commonwealth. An individual placed in an institution or a foster care home in the Commonwealth by a public agency of another state shall be considered a resident of that state and not of the Commonwealth. If an individual who has been placed in an institution leaves the institution and is competent at the time of leaving, the individual is a resident of the Commonwealth if he or she is physically located in the Commonwealth.

(B) Other Institutionalized Individuals. Unless otherwise specified, residency for an institutionalized individual who has not been placed in the institution by a public agency is determined as follows:

(1) If the individual is younger than 21 years old, is not married, and is not emancipated, or is 21 years of age or older and became incapable of indicating intent before 21 years old, the individual is a resident of the Commonwealth if:

(a) the residence of the parent, parents, or legal guardian at the time of placement is the Commonwealth, regardless of the physical location of the individual;

(b) the current residence of the parent, parents, or legal guardian who filed the application is the Commonwealth, and the individual is institutionalized in the Commonwealth;

(c) in the case of an individual 21 years of age or older who became incapable of indicating intent before 21 years old, the current residence of a parent who filed the application is the Commonwealth, regardless of the physical location of the individual, if the parents reside in separate states; or

(d) the current residence of the person or party filing the application is the Commonwealth, the individual is institutionalized in the Commonwealth, and the individual has been abandoned by his or her parents and does not have a legal guardian.

(2) If the individual is 21 years of age or older and became incapable of indicating intent at or after 21 years old, the individual's state of residence is the Commonwealth if he or she is institutionalized in the Commonwealth. For any other institutionalized individual 21 years of age or older, the individual is a resident of the Commonwealth if the individual is residing in and intends to reside in the Commonwealth.

(130 CMR 517.004 Reserved)

517.005: Persons Institutionalized for Mental Disease

(A) Individuals younger than 18 years old and those 65 years of age or older who are patients in a public or private institution for mental disease may be eligible for MassHealth.

(B) Individuals who reach the age of 18 while they are patients in an institution for mental disease may be eligible for MassHealth until they reach age 22, provided they are disabled in accordance with Title XVI requirements.

(C) Individuals between 18 and 65 years of age who are patients in public or private institutions for mental disease are not eligible for MassHealth, except as provided in 130 CMR 517.005(B). Such individuals may establish eligibility for MassHealth when entering an acute hospital from a public or private institution for mental disease if otherwise categorically and financially eligible.

517.006: Social Security Number (SSN)

(A) Requirements.

(1) Condition of Eligibility. As a condition of eligibility for MassHealth, all persons applying in the household must furnish an SSN or proof of application for an SSN, except as provided in 130 CMR 517.006(A)(1). The applicant is notified of the obligation to apply for an SSN for any person applying in the household. The MassHealth agency does not require a SSN or proof of application for an SSN for any applicant who

(a) attests to a religious exemption as described in federal law;
(b) is only eligible for a non-work SSN; or
(c) is not eligible to receive an SSN.

(2) Electronic Data Match. The MassHealth agency verifies each SSN by an electronic data match with the Social Security Administration (SSA).

(3) Reasonable Opportunity to Verify a Social Security Number. If the applicant has provided an SSN, the MassHealth agency matches with the SSA to verify the SSN. If the SSA is unable to verify the SSN, the individual is required to verify his or her SSN.

(a) The MassHealth agency provides applicants and members a reasonable opportunity period to provide an SSN if SSA is unable to verify the SSN or the individual has not provided the SSN.

(b) The reasonable opportunity period begins on, and will extend 90 days from, the date on which an applicant or member receives a reasonable opportunity notice.

(c) While the verification of SSN is pending, the individual will receive benefits if there are no other pending verifications outstanding.

(B) Right to Know Uses of Social Security Numbers. All household members are given a written notice of the following:

(1) the reason the SSNs are requested;

(2) the computer matching of SSNs with SSNs in other personal data files within

(a) the MassHealth agency;

(b) the Federal Data Hub, which matches with the SSA;

(c) the Department of Homeland Security (DHS);

(d) the Internal Revenue Service; and

(e) other federal and state agencies and other informational services, and

(3) the possible denial or termination of benefits, if any applicant or member fails to provide his or her SSN or proof of application for an SSN, unless an exception described in 130 CMR 517.006(A)(1) applies to the applicant or member.

517.007: Utilization of Potential Benefits

(A) An applicant or member must take all necessary steps to obtain benefits to which he or she is legally entitled or for which he or she may be eligible, unless he or she can show that doing so would put the applicant, member, or any of the applicant's or member's family members in harm by supplying information to the policyholder in cases where there is demonstrated necessity for restricting such access. Benefits under this provision include, but are not limited to

(1) Social Security benefits;

(2) Railroad Retirement benefits;

(3) federal Veterans' Administration benefits, including payment provided by the Veterans' Administration to purchase Aid and Attendance;

(4) civil service annuities;

(5) unemployment compensation;

(6) workers' compensation;

(7) state retirement benefits; and

(8) any benefits to which the applicant or member is legally entitled and any share in any estate to which the applicant or member is entitled. Members are not required to maintain a health plan if its cost causes financial hardship to the member.

(B) The applicant or member who is otherwise eligible for MassHealth will receive MassHealth benefits while claims for other benefits are pending provided that MassHealth eligibility is redetermined when such benefits are received.

(C) Applicants and members are not required to apply for TAFDC, EAEDC, SSI, or Massachusetts state veterans' service benefits as a condition of receiving MassHealth only.

517.008: Potential Sources of Health Care

The MassHealth agency is payer of last resort and pays for health care and related services only when no other source of payment is available, except as otherwise required by federal law.

(A) Health Insurance. Every applicant and member must obtain and maintain health insurance available at no cost to the member including, but not limited to, Medicare and insurance purchased by the MassHealth agency in accordance with 130 CMR 506.012: *Premium Assistance Payments*. Failure to do so may result in loss of eligibility.

(B) Use of Benefits. The MassHealth agency does not pay for any health-care and related services that are available

(1) through the member's health insurance, if any; or

(2) at no cost to the member including, but not limited to, any such services that are available through any agency of the local, state, or federal government, or any entity legally obligated to provide those services.

517.009: Assignment of Rights to Medical Support and Third-Party Payments

(A) Every legally able applicant or member must assign to the MassHealth agency his or her rights to medical support and third-party payments for medical benefits provided under MassHealth as well as the rights of applicants or members for whom he or she can legally assign medical support and third-party payments.

(B) The applicant or member must fully cooperate with the MassHealth agency in

(1) establishing paternity;

(2) obtaining any medical support and payments; and

(3) identifying and providing information to assist the MassHealth agency in pursuing third parties, including a noncustodial parent, who may be legally obligated to pay for care and services for the applicant or member, or person on whose behalf benefits are requested, unless the applicant or member has grounds to waive cooperation as described in 130 CMR 517.010 or 505.002(D): *Eligibility Requirements for Pregnant Women*.

(C) (1) The MassHealth agency will deny eligibility for any applicant who does not attest to a willingness to cooperate and terminate eligibility for any member who refuses to cooperate, unless the applicant or member demonstrates good cause, as described in 130 CMR 517.010, or is a pregnant woman who meets the requirements of 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.

(2) The MassHealth agency will not deny or terminate eligibility of any applicant or member who cannot legally assign his or her own rights, including, but not limited to, a minor child, and who would otherwise be eligible but for the refusal, by a person legally able to assign the child's rights, to assign the child's rights or to cooperate as required in 130 CMR 517.009.

517.010: Waiver of Cooperation for Good Cause

(A) Good cause is established if

(1) with respect to the obligation to establish paternity of a child born out of wedlock, obtain medical-care support and payments, or identify or provide information to assist the MassHealth agency in pursuing a liable third party for a child for whom the applicant or member can legally assign rights, the MassHealth agency finds that cooperation is against the best interest of the child; or

(2) with respect to the obligation to cooperate in all cases not covered by 130 CMR 517.010(A)(1), the MassHealth agency finds that cooperation is not in the best interest of the applicant or member or the person for whom the benefit is being requested or furnished because it is anticipated that cooperation will result in reprisal against, and cause serious physical or emotional harm to, the applicant or member or another person.

(B) Good cause for noncooperation includes, but is not limited to, the following circumstances:

(1) the child was conceived as a result of incest or forcible rape;

(2) legal proceedings for adoption are pending before a court;

(3) a public agency or licensed facility is assisting in resolving the issue of adoption and discussions have not lasted longer than three months; or

(4) cooperation would result in serious physical or emotional harm to the child, the relative with whom the child resides, or to the applicant or member.

517.011: Assignment of Rights to Spousal Support

An institutionalized spouse whose community spouse refuses to cooperate or whose whereabouts is unknown will not be ineligible due to

(A) assets determined to be available for the cost of care in accordance with 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; or

(B) his or her inability to provide information concerning the assets of the community spouse when one of the following conditions is met:

(1) the institutionalized spouse assigns to the MassHealth agency any rights to support from the community spouse;

(2) the institutionalized spouse lacks the ability to assign rights to spousal support due to physical or mental impairment as verified by the written statement of a competent medical authority; or

(3) the MassHealth agency determines that the denial of eligibility, due to the lack of information concerning the assets of the community spouse, would otherwise result in undue hardship.

517.012: Assignment for Third-Party Recoveries

As a condition of eligibility, an applicant or member must inform the MassHealth agency when the individual or spouse is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. The applicant or member must

(A) file a claim for compensation; and

(B) agree to comply with all requirements of M.G.L. c. 118E, §. 22 including, but not limited to

(1) assigning to the MassHealth agency the right to recover an amount equal to the MassHealth benefits provided from the proceeds of any claim or other proceeding against a third party;

(2) providing information about the claim or any other proceeding, and fully cooperating with the MassHealth agency or its contractor, unless the MassHealth agency determines that cooperation would not be in the best interests of, or would result in serious physical or emotional harm to, the applicant or member, in accordance with 130 CMR 517.010;

(3) notifying the MassHealth agency in writing within ten days of filing any claim, civil action, or other proceeding; and

(4) repaying the MassHealth agency from the money received from a third party for all MassHealth benefits provided on or after the date of the accident or other incident. However, if the member was involved in an accident or other incident after becoming eligible for MassHealth, only MassHealth benefits provided as a result of the accident or other incident will be repaid.

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518.001: Introduction

Persons applying for or receiving MassHealth must verify their citizenship and identity or immigration status. Citizens and nationals who receive Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) based upon disability, or Medicare (including those who are entitled to Medicare), and children in receipt of either Title IV-B services or Title IV-E adoption assistance or foster care payments do not need to submit verification. In addition, a child born to a woman who is eligible for MassHealth on the date of the child's birth is exempt from providing citizenship and identity verification as described in 130 CMR 518.004(E).

518.002: U.S. Citizens

A citizen of the United States is

(A) an individual who was born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Commonwealth of the Northern Mariana Islands (CNMI), except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under § 301 et seq. of the Immigration and Nationality Act (INA);

(B) an individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under § 301 et seq. of the Immigration and Nationality Act;

(C) a naturalized citizen; or

(D) a national (both citizen national and noncitizen national) as defined in 130 CMR 518 .002 (D)(1)or (2).

(1) Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under § 301 et seq. of the Immigration and Nationality Act.

(2) Noncitizen National. A noncitizen national is an individual who was born in one of the outlying possessions of the United States, including American Samoa and Swain's Island, to a parent who is a noncitizen national.

518.003: Immigrants

(A) Lawfully Present Immigrants. Qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present are considered lawfully present immigrants. The applicable coverage types for qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present are listed at 130 CMR 518.006.

(1) Qualified Noncitizens. There are two types of qualified noncitizens:

(a) those who are qualified regardless of when they entered the U.S. or how long they have had a qualified status. Such individuals are

(i) persons granted asylum under section 208 of the INA;

(ii) refugees admitted under section 207 of the INA;

(iii) persons whose deportation has been withheld under section 243(h) or 241(b)(3) of the INA, as provided by section 5562 of the federal Balanced Budget Act of 1997;

(iv) veterans, their spouses, and their children

a. veterans of the United States Armed Forces with an honorable discharge not related to their noncitizen 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 noncitizen status on active duty in the U.S. Armed Forces, other than active duty for training; or

e. the spouse, unremarried surviving spouse, or unmarried dependent children of the noncitizen described in 130 CMR 518.003(A)(1)(a)(iv)(a) through (d).

(v) conditional entrants under section 203(a)(7) of the INA in effect before April 1, 1980;

(vi) persons who entered as Cuban/Haitian entrants under section 501(e) of the Refugee Education Assistance Act of 1980;

(vii) 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);

(viii) Amerasians as described in section 402(a)(2)(A)(i)(V) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA);

(ix) victims of severe forms of trafficking, and spouse, child, sibling, or parent of the victim in accordance with the Victims of Trafficking and Violence Protection Act of 2000 (Pub. L. 106-386);

(x) Iraqi Special Immigrants granted special immigrant status under section 101(a)(27) of the Immigration and Nationality Act, pursuant to Section 1244 of Public Law 110-181 or section 525 of Public Law 110-161; or

(xi) Afghan Special Immigrants granted special immigrant status under section 101(a)(27) of the Immigration and Nationality Act, pursuant to section 525 of Public Law 110-161.

(b) noncitizens who are qualified based on having a qualified status identified at 130 CMR 518.003(A)(1)(b)(i) and who have satisfied one of the conditions listed at 130 CMR 518.003(A)(1)(b)(ii). Such individuals are

(i) persons who have one or more of the following statuses:

a. admitted for legal permanent residence (LPR) under the Immigration and Nationality Act (INA); or

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

c. are the battered spouse, battered child, or child of battered parent, or parent of battered child who meets the criteria of section 431(c) of PRWORA; and also

(ii) satisfy at least one of the three following conditions:

a. have had a status in 130 CMR 518.003(A)(1)(b)(i) for five or more years (a battered noncitizen attains this status when the petition is accepted as establishing a prima facie case);

b. entered the U.S. prior to August 22, 1996, regardless of status at the time of entry, and have been continuously present in the U.S., until attaining a status listed in 130 CMR 4518.003(A)(1)(b)(i); for this purpose an individual is deemed continuously present who has been absent from the U.S. for no more than 30 consecutive days or 90 nonconsecutive days prior to attaining a status listed in 130 CMR 518.003(A)(1)(b)(i); or

c. also have or had a status listed in 130 CMR 518.003(A)(1)(a).

(2) Qualified Noncitizens Barred. Individuals who have a status listed in 130 CMR 518.003(A)(1)(b)(i) (legal permanent resident, parolee for at least one year, or battered noncitizen) and do not meet one of the conditions in 130 CMR 518.003(A)(1)(b)(ii). Qualified noncitizens barred, like qualified noncitizens, are lawfully present nonqualified individuals.

(3) Nonqualified Individuals Lawfully Present. Nonqualified individuals lawfully present are not defined as qualified under PRWORA, 8 U.S.C. § 1641, but are lawfully present. Nonqualified individuals lawfully present are as follows:

(a) in a valid nonimmigrant status as otherwise defined in 8 U.S.C. § 1101(a)(15) or otherwise under immigration laws (as defined in 8 U.S.C. § 1101(a)(17));

(b) paroled into the United States in accordance with 8 U.S.C. § 1182(d)(5) for less than one year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

(c) belong to one of the following classes:

(i) granted temporary resident status in accordance with 8 U.S.C. § 1160 or 1255a, respectively;

(ii) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

(iii) granted employment authorization under 8 CFR 274a.12(c);

(iv) Family Unity beneficiaries in accordance with section 301 of Public Law 101–649;

(v) under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(vi) granted Deferred Action status, except for applicants or individuals granted status under DHS Deferred Action for Childhood Arrivals Process (DACA);

(vii) granted an administrative stay of removal under 8 CFR part 241;

(viii) beneficiary of approved visa petition who has a pending application for adjustment of status;

(d) have a pending application for asylum under 8 U.S.C. § 1158, or for withholding of removal under 8 U.S.C. § 1231, or under the Convention Against Torture who

(i) have been granted employment authorization; or

(ii) are younger than 14 years old and have had an application pending for at least 180 days;

(e) have been granted withholding of removal under the Convention Against Torture; or

(f) is a child who has a pending application for Special Immigrant Juvenile status, as described in 8 U.S.C. § 1101(a)(27)(J).

(B) Protected Noncitizens. Noncitizens who are not qualified noncitizens as described in 130 CMR 518.003(A)(1) but who are qualified noncitizens barred as described at 130 CMR 518.003(A)(2), nonqualified individuals lawfully present as described in 130 CMR 518.003(A)(3), nonqualified persons residing under color of law (PRUCOLs) as described in 130 CMR 518.003(C), or other noncitizens as described in 130 CMR 518.003(D), are considered protected noncitizens and may continue to 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.

(C) Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOL). Certain noncitizens who are not described at 130 CMR 518.003(A) or (B) may be permanently living in the United States under color of law. The applicable coverage types for nonqualified PRUCOLS are listed at 130 CMR 518.006. If not otherwise described in 518.003(A) or (B), the following are considered nonqualified PRUCOLs:

(1) noncitizens living in the United States in accordance with an indefinite stay of deportation;
(2) noncitizens living in the United States in accordance with an indefinite voluntary departure;
(3) noncitizens 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;
(4) noncitizens granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing;
(5) noncitizens living under orders of supervision who do not have employment authorization under 8 CFR 274a 12(c);
(6) noncitizens who have entered and continuously lived in the United States since before January 1, 1972;
(7) noncitizens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing;
(8) noncitizens with pending applications for asylum under 8 U.S.C. § 1158 or for withholding of removal under 8 U.S.C. § 1231 or under the Convention Against Torture who have not been granted employment authorization, or are younger than 14 years old and have not had an application pending for at least 180 days;

(9) noncitizens granted Deferred Action for Childhood Arrivals status or have a pending application for this status;
(10) noncitizens who have filed an application, petition, or request to obtain a lawfully present status that has been accepted as properly filed but who have not yet obtained employment authorization and whose departure the DHS does not contemplate enforcing; or
(11) any other noncitizens living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include persons granted Extended Voluntary Departure due to conditions in the noncitizen's home country based on a determination by the Secretary of State.)

(D) Other Noncitizens. Noncitizens whose status is not described in 130 CMR 518.003(A) through (C) are considered other noncitizens.

518.004: Verification of U.S. Citizenship and Identity and Immigration Status

(A) U.S. Citizenship and Immigration Status. MassHealth requires verification of U.S. citizenship or immigration status for all MassHealth applicants, except other noncitizens.
(1) The MassHealth agency will initiate electronic data matches as described in 130 CMR 516.003: *Matching Information* to attempt to verify U.S. citizenship or immigration status. If electronic data sources are unable to verify U.S. citizenship or immigration status, additional documentation will be required from the individual.
(2) Acceptable proof of U.S. citizenship is described at 130 CMR 518.005(A)(1) and (2). Individuals who fail to submit proof of U.S. citizenship within 90 days of the MassHealth agency's request will subsequently only be
(a) eligible for Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or
(b) eligible for MassHealth Standard for those who are pregnant if they meet the categorical requirements and financial standards described at 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.
(3) Acceptable proof of immigration status is described at 130 CMR 518.005(B). Individuals who fail to submit proof of immigration status within 90 days of the MassHealth agency's request will subsequently be eligible
(a) only for MassHealth Limited if they meet the categorical requirements and financial standards of MassHealth Standard;
(b) for Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or
(c) for MassHealth Standard if they are pregnant and meet the categorical requirements and financial standards described at 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women.*

(B) Identity. MassHealth requires verification of identity for U.S. citizens.

(1) The MassHealth agency will initiate electronic data matches as described in 130 CMR 516.003: *Matching Information* to attempt to verify identity. If electronic data sources are unable to verify identity, additional documentation will be required from the individual.

(2) Acceptable proof of identity is described at 130 CMR 518.005(A)(3).

(3) U.S. citizens as described at 130 CMR 518.002 who fail to verify identity within 90 days of the MassHealth agency's request will subsequently only be eligible for

(a) Children's Medical Security Plan (CMSP) if they meet the categorical requirements for CMSP described at 130 CMR 522.000: *MassHealth: Other Division Programs*; or

(b) MassHealth Standard if they are pregnant and meet the categorical requirements and financial standards as described in 130 CMR 505.002(D): *Eligibility Requirements for Pregnant Women*.

(C) Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status. The MassHealth agency provides applicants and members a reasonable opportunity period to provide satisfactory documentary evidence of citizenship and identity or immigration status in accordance with 130 CMR 502.003(F): *Reasonable Opportunity to Verify Citizenship and Identity or Immigration Status*.

(D) Reasonable Opportunity Extension. Applicants or members who have made a good faith effort to resolve inconsistencies or obtain verification of citizenship and identity or immigration status may receive a 90-day extension in accordance with 130 CMR 502.003(G): *Reasonable Opportunity Extension*.

(E) Child Born to a MassHealth-Eligible Woman. Regardless of the mother's immigration status, a child born to a woman who is eligible for MassHealth on the date of the child's birth will be deemed eligible for MassHealth from birth until the child's first birthday and is exempt from providing citizenship and identity verification for eligibility.

518.005: Documents for Verifying U.S. Citizenship and Identity and Immigration Status

(A) Acceptable Proof of U.S. Citizenship and Identity. Pursuant to 130 CMR 518.004(B), U.S. citizens must provide proof of both citizenship and identity.

(1) Acceptable Proof of Both Citizenship and Identity. The following documents are satisfactory proof of both citizenship and identity:

(a) U.S. passport, including a U.S. Passport Card issued by the Department of State, without regard to any expiration date as long as such passport or Card was issued without limitation;

(b) Certificate of Naturalization;

(c) Certificate of U.S. Citizenship;

(d) a document issued by a federally recognized Indian tribe, as published in the Federal Register by the Bureau of Indian Affairs within the U.S. Department of the Interior, and identifies the federally recognized Indian tribe that issued the document, identifies the individual by name, and confirms the individual's membership, enrollment, or affiliation with the tribe. These documents include, but are not limited to, a tribal enrollment card, a Certificate of Degree of Indian Blood, a tribal census document, and documents on tribal letterhead, issued under the signature of the appropriate tribal official that meet the requirements of 130 CMR 518.005(A)(1)(d).

(2) Acceptable Proof of Citizenship. If one of the documents listed in 130 CMR 518.005(A)(1) is not provided, the following documents are acceptable as satisfactory evidence to establish citizenship if also accompanied by an identity document listed in 130 CMR 518.005(A)(3):

(a) U.S. public birth certificate showing birth in one of the 50 states (including the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, the U.S. Virgin Islands (if born on or after January 17, 1917), American Samoa, Swain's Island, or the Commonwealth of the Northern Mariana Islands (CNMI) (if born after November 4, 1986, CNMI local time). The birth record may be issued by the state, commonwealth, territory, or local jurisdiction. However, if the document shows the individual was born in Puerto Rico, the U.S. Virgin Islands, or the CNMI before these areas became part of the U.S., the individual may be a collectively naturalized citizen;

(b) cross-match with the Massachusetts Registry of Vital Statistics that documents a record of birth;

(c) Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.;

(d) Report of Birth Abroad of a U.S. Citizen;

(e) certification of birth;

(f) U.S. Citizen I.D. card;

(g) Northern Mariana Identification Card, issued to a collectively naturalized citizen who was born in the CNMI before November 4, 1986;

(h) final adoption decree showing the child's name and U.S. place of birth, or, if the adoption is not final, a statement from state-approved adoption agency that shows the child's name and U.S. place of birth;

(i) evidence of U.S. civil service employment prior to June 1, 1976;

(j) U.S. military record showing a U.S. place of birth;

(k) data match with the Systematic Alien Verification for Entitlements (SAVE) Program or any other process established by the U.S. Department of Homeland Security to verify that an individual is a citizen;

(l) documentation that the child meets the requirements of section 101 of the Child Citizenship Act of 2000 (8 U.S.C. § 1431);
(m) medical records, including, but not limited to, hospital, clinic, or doctor records or admission papers from a nursing facility, skilled-care facility, or other institution that indicate place of birth;
(n) life, health, or other insurance records that indicate a U.S. place of birth;
(o) official religious records recorded in the U.S. showing that the birth occurred in the U.S.;
(p) school records, including preschool, Head Start, and day care, showing the child's name and U.S. place of birth;
(q) federal or state census records showing U.S. citizenship or a U.S. place of birth; and
(r) if an individual does not have one of the documents listed at 130 CMR 518.005(A)(2)(a) through (q), he or she may submit an affidavit signed by another individual, under penalty of perjury, who can reasonably attest to the individual's citizenship, and that contains the individual's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

(3) Acceptable Proof of Identity. The following are considered acceptable proof of identity.
(a) The following are acceptable proof of identity, provided such documentation has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address.
(i) identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority;
(ii) driver's license issued by a state or territory;
(iii) school identification card;
(iv) U.S. military card or draft record;
(v) identification card issued by the federal, state, or local government;
(vi) military dependent's identification card; or
(vii) U.S. Coast Guard Merchant Mariner card;
(b) for children younger than 19 years old, a clinic, doctor, hospital, or school record, including preschool or day care records;
(c) two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to
(i) employer identification cards;
(ii) high school and college diplomas (including high school equivalency diplomas);
(iii) marriage certificates;
(iv) divorce decrees;
(v) property deeds or titles;

(vi) a pay stub from a current employer with the applicant's name and address preprinted, dated within 60 days of the application;
(vii) census verification containing the applicant's name and address, dated not more than 12 months before the date of the application;
(viii) a pension or retirement statement from a prior employer or pension fund stating the applicant's name and address, dated within 12 months of the application;
(ix) tuition or student loan bill containing the applicant's name and address, dated not more than 12 months before the date of the application;
(x) utility bill, cell phone bill, credit card bill, doctor's bill, or hospital bill containing applicant's name and address, dated not more than 60 days before the date of the application;
(xi) valid homeowner's, renter's, or automobile insurance policy with preprinted address, dated not more than 12 months before the date of the application, or a bill for such insurance with preprinted address, dated not more than 60 days before the date of the application;
(xii) lease dated not more than 12 months before the date of the application, or home mortgage identifying applicant and address; or
(xiii) employment verification by means of W-2 forms or other documents bearing the applicant's name and address submitted by the employer to a government agency as a consequence of employment.

(d) a finding of identity from a federal or state agency including, but not limited to, a public assistance, law enforcement, internal revenue, or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual;
(e) a finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Social Security Act; or
(f) if the applicant does not have any document specified in 130 CMR 518.005(A)(3)(a) through (c) and identity is not verified under 130 CMR 518.005(A)(3)(d) or (e), the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in 130 CMR 518.005(A)(3)(a). This affidavit does not have to be notarized.

(4) Verification of Citizenship or Identity by a Federal Agency or Another State. The MassHealth agency may rely, without further documentation of citizenship or identity, on a verification of citizenship or identity made by a federal agency or another state, if such verification was done on or after July 1, 2006.

(5) Assistance with Obtaining Documentation. The MassHealth agency will provide assistance to individuals who need assistance in securing satisfactory documentary evidence of citizenship in a timely manner.

(B) Acceptable Proof of Immigration Status. Acceptable proof of immigration status includes any verification allowed under federal law as determined by the MassHealth agency.

(C) Documentary Evidence. A photocopy, facsimile, scan, or other copy of a document will be accepted to the same extent as an original document, unless information on the submitted document is inconsistent with other information available to the MassHealth agency or the MassHealth agency otherwise has reason to question the validity of the document or the information on the document.

518.006: Applicable Coverage Types

(A) Citizens, qualified noncitizens, and protected noncitizens may receive MassHealth under any coverage type for which they are eligible as described in 130 CMR 519.000: *MassHealth: Coverage Types*.

(B) Qualified noncitizens barred and nonqualified individuals lawfully present may receive the following coverage:

(1) MassHealth Family Assistance if they are adults 65 years of age and older and meet the categorical requirements and financial standards as described at 130 CMR 519.013: *MassHealth Family Assistance* or are receiving EAEDC; or

(2) MassHealth Limited if they are adults 65 years of age and older and meet the categorical requirements and financial standards as described at 130 CMR 519.009: *MassHealth Limited*.

(C) Nonqualified PRUCOLs may receive the following:

(1) MassHealth Family Assistance if they are adults 65 years of age and older and meet the categorical requirements and financial standards as described at 130 CMR 519.013: *MassHealth Family Assistance* or are receiving EAEDC; or

(2) MassHealth Limited if they are adults 65 years of age and older and meet the categorical requirements and financial standards as described at 130 CMR 519.009: *MassHealth Limited*.

(D) Other noncitizens 65 years of age and older may receive only MassHealth Limited if they meet the eligibility requirements at 130 CMR 519.009: *MassHealth Limited*.

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MASSHEALTH
COVERAGE TYPES

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: *MassHealth: Financial Eligibility*.

(B) MassHealth Coverage Types. The MassHealth coverage types available to individuals 65 years of age 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 Family Assistance.

(C) Determining Eligibility. The MassHealth agency 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, the MassHealth agency 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 65 years of age 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: *Definition of Terms*. The medical benefits are described in 130 CMR 450.105(A): *MassHealth Standard*.

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

(4) The MassHealth agency pays the following costs for members eligible for MassHealth Standard who meet the requirements of 130 CMR 519.010(A)(1) and (2):

(a) Medicare Part B premiums for members with countable income that is less than or equal to 120 percent of the federal poverty level;

(b) Medicare Part A premiums for adult members of MassHealth Standard who are entitled to Medicare Part A with a countable income that is less than or equal to 100 percent of the federal poverty level; and

(c) the deductibles and coinsurance under Medicare Parts A and B for members with a countable income that is less than or equal to 100 percent of the federal poverty level.

(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 the MassHealth agency in accordance with 130 CMR 516.005: *Coverage Date*.

(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 the MassHealth agency.

(D) Automatic and Extended Eligibility for EAEDC Recipients 65 Years of Age and Older.

(1) Automatic Eligibility. Individuals 65 year of age and older who meet the requirements of the Emergency Aid to the Elderly, Disabled and Children (EAEDC) program administered by the Department of Transitional Assistance and who are United States citizens as described in 130 CMR 518.002: *U.S. Citizens* or qualified noncitizens, as described in 130 CMR 518.003(A)(1): *Qualified Noncitizens*, are automatically eligible for MassHealth Standard benefits.

(2) Extended Eligibility. Individuals described in 130 CMR 519.002(D)(1) whose EAEDC cash assistance ends will continue to receive MassHealth Standard benefits until the MassHealth agency determines that the member is ineligible.

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 Retirement, Survivors, and Disability Insurance 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 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: *Countable-Income Amount*, of the individual or couple is compared to the SSI payment standards to determine Pickle eligibility. Each calendar year, the SSI Payment Standards shall be made available on MassHealth's website.

(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: *Asset Reduction*, meeting a deductible as described in 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or both.

519.004: Disabled Adult Children

(A) Eligibility Requirements. Individuals who lose eligibility for Supplemental Security Income (SSI) benefits may retain eligibility for MassHealth Standard provided that they

(1) are 18 years old or older;
(2) became blind or disabled before attaining the age of 22;
(3) receive or received SSI based on their blindness or disability;
(4) received an increase in child's insurance benefits under section 202(d) of the Social Security Act, or became entitled to those benefits on the basis of blindness or disability, on or after July 1, 1987;
(5) lose or lost SSI as a result of this entitlement or increase in child's insurance benefits under section 202(d) of the Social Security Act; and
(6) would still be eligible for SSI in the absence of such RSDI benefits or increase in benefits.

(B) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.004(A) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or both.

519.005: Community Residents 65 Years of Age and Older

(A) Eligibility Requirements. Except as provided in 130 CMR 519.005(C), noninstitutionalized individuals 65 years of age and older may establish eligibility for MassHealth Standard coverage provided they meet the following requirements:

(1) the countable-income amount, as defined in 130 CMR 520.009: *Countable-Income Amount*, of the individual or couple 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. Except as provided in 130 CMR 519.005(C), individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.005(A) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or both.

(C) Parents and Caretaker Relatives of Children Younger Than 19 Years Old.

(1) Eligibility Requirements. Adults who are 65 years of age and older and are the parents or caretaker relatives of a child younger than 19 years old receive MassHealth Standard if they meet the requirements of 130 CMR 505.002(C): *Eligibility Requirements for Parents and Caretaker Relatives* or (L): *Extended Eligibility*.

(2) Other Provisions. The following provisions apply to adults described in 130 CMR 519.005(C)(1) and 130 CMR 505.002(A)(6), (M): *Use of Potential Health Insurance Benefits*, (O): *Medicare Premium Payment*, and (P): *Medical Coverage Date*.

(3) Countable Income. Eligibility for adults described in 130 CMR 519.005(C)(1) is based on the individual's modified adjusted gross income of the MassHealth MAGI household and the income rules described at 130 CMR 506.002: *Household Composition*, 506.003: *Household Income*, and 506.004: *Noncountable Household Income*.

(4) Exemption from Asset Limits. The asset limits in 130 CMR 520.003: *Asset Limit* do not apply to applicants or members described in 130 CMR 519.005(C)(1).

519.006: Long-Term-Care Residents

(A) Eligibility Requirements. Institutionalized individuals may establish eligibility for MassHealth Standard coverage subject to the following requirements. They must

(1) be younger than 21 years old or 65 years of age or older or, for individuals 21 through 64 years of age meet Title XVI disability standards or be pregnant;

(2) be determined medically eligible for nursing-facility services by the MassHealth agency or its agent as a condition for payment, in accordance with 130 CMR 456.000: *Nursing Facility*;

(3) contribute to the cost of care as defined at 130 CMR 520.026: *Long-Term-Care General Income Deductions*;

(4) have countable assets of $2,000 or less for an individual and, for married couples where one member of the couple is institutionalized, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and

(5) not have transferred resources for the sole purpose of obtaining MassHealth as described at 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(B) Verification of Disability or Pregnancy.

(1) Disability is verified by:

(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);

(b) a determination of disability by the Social Security Administration (SSA); or

(c) a determination of disability by the MassHealth Disability Determination Unit (DDU). Until this determination is made, the applicant's submission of a completed disability supplement will satisfy the verification requirement.

(2) Pregnancy is verified by a written statement from a competent medical authority certifying the pregnancy.

519.007: Individuals Who Would Be Institutionalized

130 CMR 519.007 describes the eligibility requirements for MassHealth Standard coverage for individuals who would be institutionalized if they were not receiving home- and community-based services.

(A) The Kaileigh Mulligan Program. The Kaileigh Mulligan Program enables severely disabled children younger than 18 years old to remain at home. The income and assets of their parents are not considered in the determination of eligibility.

(1) Eligibility Requirements. Children younger than 18 years old may establish eligibility for the Kaileigh Mulligan Program by meeting the following requirements. They must

(a) (i) meet Title XVI disability standards in accordance with the definition of permanent and total disability for children younger than 18 years old in 130 CMR 515.001: *Definition of Terms* or have been receiving SSI on August 22, 1996; and (ii) continue to meet Title XVI disability standards that were in effect before August 22, 1996;

(b) have $2,000 or less in countable assets;

(c) (i) have a countable-income amount of $72.80 or less; or (ii) if greater than $72.80, meet a deductible in accordance with 130 CMR 520.028: *Eligibility for a Deductible* through 520.035*: Conclusion of the Deductible Process*; and

(d) require a level of care equivalent to that provided in a hospital or nursing facility in accordance with 130 CMR 519.007(A)(3) and (4).

(2) Additional Requirements. The MassHealth agency must have determined

(a) that care provided outside an institution is appropriate; and

(b) that the estimated cost paid by the MassHealth agency would not be more than the estimated cost paid if the child were institutionalized.

(3) Level of Care That Must Be Required in a Hospital. To require the level of care provided in a hospital, the child must have a medical need for the following:

(a) direct administration of at least two discrete skilled-nursing services (as defined in 130 CMR 515.001: *Definition of Terms*) on a daily basis, each of which requires complex nursing procedures, such as administration of intravenous hyperalimentation, changing tracheotomy tubes, assessment or monitoring related to an uncontrolled seizure disorder, assessment or monitoring related to an unstable cardiopulmonary status, or other unstable medical condition;

(b) direct management of the child's medical care by a physician or provided directly by someone who is under the supervision of a physician on at least a weekly basis;

(c) ongoing use of invasive medical technologies or techniques to sustain life (such as ventilation, hyperalimentation, gastrostomy tube feeding), or dialysis, or both; and

(d) at least one of the following:

(i) assistance in one or more activities of daily living (ADLs), as defined in 130 CMR 515.001: *Definition of Terms*, beyond what is required at an age-appropriate activity level; or

(ii) one or more skilled therapeutic services (occupational therapy, physical therapy, or speech and language therapy), provided directly by or under the supervision of a licensed therapist at least five times a week.

(4) Level of Care That Must Be Required in a Skilled-Nursing Facility. To require the level of care provided in a skilled-nursing facility, the child must be nonambulatory and meet the following requirements.

(a) A child 12 months of age or older must have global developmental skills (as defined in 130 CMR 515.001: *Definition of Terms*) not exceeding those of a 12-month-old child as indicated by a developmental assessment performed by the child's physician or by another certified professional. In addition, the child's developmental skills level must not be expected to improve.

(b) A child less than 12 months of age must have global developmental skills significantly below an age-appropriate level and such skills must not be expected to progress at an age-appropriate rate as indicated by a developmental assessment performed by the child's physician or by another certified professional.

(c) Regardless of age, the child must also require all of the following:
(i) direct administration of at least two discrete skilled-nursing services on a daily basis, each of which requires complex nursing procedures as described at 130 CMR 519.007(A)(3);
(ii) direct management of the child's medical care by a physician or provided directly by someone who is under the supervision of a physician on a monthly basis;
(iii) assistance in one or more ADLs beyond what is required at an age-appropriate activity level; and
(iv) any combination of skilled therapeutic services (physical therapy, occupational therapy, speech and language therapy) provided directly by or under the supervision of a licensed therapist at least five times a week.

(5) Premium Assistance for Standard Kaileigh Mulligan. Individuals eligible for MassHealth Standard in 130 CMR 519.007(A) may be eligible for Premium Assistance if they meet the requirements described in 130 CMR 505.002(N): *Access to Employer-Sponsored Insurance and Premium Assistance Investigations for Individuals Who Are Eligible for MassHealth Standard* and 506.012: *Premium Assistance Payments*.

(B) Home- and Community-Based Services Waiver-Frail Elder.

(1) Clinical and Age Requirements. The Home- and Community-Based Services Waiver allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing-facility services to receive certain waiver services at home if he or she
(a) is 60 years of age or older and, if younger than 65 years old, is permanently and totally disabled in accordance with Title XVI standards; and
(b) would be institutionalized in a nursing facility, unless he or she receives one or more of the services administered by the Executive Office of Elder Affairs under the Home- and Community-Based Services Waiver-Frail Elder authorized under section 1915(c) of the Social Security Act.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must
(a) meet the requirements of 130 CMR 519.007(B)(1)(a) and (b);
(b) have a countable-income amount less than or equal to 300 percent of the federal benefit rate (FBR) for an individual; and
(c) have countable assets of $2,000 or less and have not transferred resources for the sole purpose of obtaining MassHealth as described at 130 CMR 520.018: *Transfer of Resources Regardless of the Transfer Date* and 520.019: *Transfer of Resources Occurring on or After August 11, 1993*.

(3) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(B)(2) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described at 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or by both.

(C) Program of All-Inclusive Care for the Elderly (PACE).

(1) Overview. The PACE program is a comprehensive health program that is designed to keep frail, older individuals who are certified eligible for nursing-facility services living in the community.

(a) A complete range of health-care services is provided by one designated community-based program with all medical and social services coordinated by a team of health professionals.

(b) The MassHealth agency administers the program in Massachusetts as the Elder Service Plan (ESP).

(c) Persons enrolled in PACE have services delivered through managed care

(i) in day-health centers;

(ii) at home; and

(iii) in specialty or inpatient settings, if needed.

(2) Eligibility Requirements. In determining PACE eligibility, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must meet all of the following criteria:

(a) be 55 years of age or older;

(b) meet Title XVI disability standards if 55 through 64 years of age;

(c) be certified by the MassHealth agency or its agent to be in need of nursing-facility services;

(d) live in a designated service area;

(e) have medical services provided in a specified community-based PACE program;

(f) have countable assets whose total value does not exceed $2,000 or, if assets exceed these standards, reduce assets in accordance with 130 CMR 520.004: *Asset Reduction*; and

(g) have a countable-income amount less than or equal to 300 percent of the federal benefit rate (FBR) for an individual.

(3) Income Standards Not Met. Individuals whose income exceeds the standards set forth in 130 CMR 519.007(C)(2) may establish eligibility for MassHealth Standard by meeting a deductible as described at 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*.

(D) Home- and Community-Based Services Waivers for Persons with an Intellectual Disability.

(1) Adult Residential Waiver.

(a) Clinical and Age Requirements. The Adult Residential Home- and Community-Based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for the mentally retarded to receive residential habilitation and other specified waiver services in a provider-operated 24-hour supervised residential setting if he or she meets all of the following criteria:

(i) has an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;

(ii) needs one or more of the services administered by the Department of Developmental Services under the Adult Residential Home- and Community-Based Services Waiver authorized under section 1915(c) of the Social Security Act;

(iii) needs residential habilitation as provided under the Adult Residential Waiver; and

(iv) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must meet all of the following criteria:

(i) meet the requirements of 130 CMR 519.007(D)(1)(a);

(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;

(iii) have countable assets of $2,000 or less; and

(iv) have not transferred resources for the sole purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(1)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or by both.

(d) Enrollment Limits. Enrollment in the Adult Residential Home- and Community-Based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(2) Community Living Waiver.

(a) Clinical and Age Requirements. The Community Living Home- and Community-Based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for the mentally retarded to receive certain waiver services, other than residential habilitation, at home or in the community provided he or she

(i) has an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;

(ii) needs one or more of the services administered by the Department of Developmental Services under the Community Living Home- and Community-Based Services Waiver authorized under section 1915(c) of the Social Security Act;

(iii) needs one or more of the services provided only under the Community Living Waiver; and

(iv) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must meet all of the following criteria:

(i) meet the requirements of 130 CMR 519.007(D)(2)(a);

(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;

(iii) have countable assets of $2,000 or less; and

(iv) have not transferred resources for the sole purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(2)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or by both.

(d) Enrollment Limits. Enrollment in the Community Living Home- and Community-Based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(3) Adult Supports Waiver.

(a) Clinical and Age Requirements. The Adult Supports Home- and Community-Based Services Waiver for Persons with an Intellectual Disability allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for the mentally retarded to receive certain waiver services, other than residential habilitation, at home or in the community provided he or she

(i) has an intellectual disability/developmental disability in accordance with Department of Developmental Services standards;

(ii) needs one or more of the services administered by the Department of Developmental Services under the Adult Supports Home- and Community-Based Services Waiver authorized under section 1915(c) of the Social Security Act;

(iii) needs one or more of the services provided only under the Adult Supports Waiver; and

(iv) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must meet all of the following criteria:

(i) meet the requirements of 130 CMR 519.007(D)(3)(a);

(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;

(iii) have countable assets of $2,000 or less; and

(iv) have not transferred resources for the sole purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Financial Eligibility Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(D)(3)(b) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described in 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or by both.

(d) Enrollment Limits. Enrollment in the Adult Supports Home- and Community-Based Services Waiver for Persons with an Intellectual Disability is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in the waiver may be limited in a manner determined by the MassHealth agency.

(E) Home- and Community-Based Services Waiver for Young Children with Autism.

(1) Clinical Requirements. The Home- and Community-Based Services Waiver allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of inpatient care at an intermediate-care facility for the mentally retarded to receive certain waiver services at home or in the community provided he or she

(a) has a confirmed diagnosis of an autism spectrum disorder (which includes autistic disorder, pervasive developmental disorder-not otherwise specified (PDD-NOS), Rhett's syndrome, childhood disintegrative disorder, and Asperger's syndrome);

(b) would be institutionalized in an intermediate-care facility for the mentally retarded unless he or she receives one or more of the services administered by the Department of Developmental Services under the Home- and Community-Based Services Waiver authorized under section 1915(c) of the Social Security Act; and

(c) is able to be safely served in the community.

(2) Eligibility Requirements and Limitations.

(a) The applicant or member must be younger than nine years old.

(b) The child must be eligible for MassHealth Standard in accordance with 130 CMR 505.002(B)(1): *Children Younger Than One Year Old* and (2): *Children One through 18 Years of Age*.

(c) Assets are not considered in the eligibility determination.

(d) The number of children who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency or its agent.

(F) Home- and Community-Based Services Waiver for Persons with Traumatic Brain Injury.

(1) Clinical and Age Requirements. The Home- and Community-Based Services Waiver for Persons with Traumatic Brain Injury allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic or rehabilitation hospital services to receive specified waiver services in the home or community if he or she

(a) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards;

(b) has traumatic brain injury, as defined in Massachusetts Rehabilitation Commission (MRC) regulations at 107 CMR 12.02: *Meaning of Terms in 107 CMR 12.00*;

(c) needs one or more of the services administered by MRC under the Home- and Community-Based Services Waiver authorized under section 1915(c) of the Social Security Act; and

(d) is able to be safely served in the community.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must

(a) meet the requirements of 130 CMR 519.007(F)(1);

(b) have a countable income amount that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;

(c) have countable assets of $2,000 or less; and

(d) have not transferred resources for the purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(3) Enrollment Limits. Enrollment in this waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency or its agent.

(G) Home- and Community-Based Services Waivers for Persons with Acquired Brain Injury.

(1) Residential Habilitation Waiver for Persons with Acquired Brain Injury.

(a) Clinical and Age Requirements. The Residential Habilitation Waiver for Persons with Acquired Brain Injury, as authorized under section 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services to receive residential habilitation and other specified waiver services in a provider-operated 24-hour supervised residential setting if he or she meets all of the following criteria:

(i) is 22 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards;

(ii) acquired, after reaching the age of 22, a brain injury including, without limitation, brain injuries caused by external force, but not including Alzheimer's disease and similar neuro-degenerative diseases, the primary manifestation of which is dementia;

(iii) is an inpatient in a nursing facility or chronic disease or rehabilitation hospital with a continuous length of stay of 90 or more days at the time of application for the waiver;

(iv) is not expected to incur annual MassHealth expenditures, including MassHealth expenditures under the Residential Habilitation Waiver, in excess of the individual cost limit specified in the Residential Habilitation Waiver;

(v) needs residential habilitation under the Residential Habilitation Waiver; and

(vi) is able to be safely served in the community within the terms of the Residential Habilitation Waiver.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must

(i) meet the requirements of 130 CMR 519.007 (G)(1)(a);

(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;

(iii) have countable assets of $2,000 or less; and

(iv) not have transferred resources for the purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the Residential Habilitation Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency. Applications will be subject to an open application period and a random-selection process, as may be announced from time to time by the MassHealth agency. Applications that are not submitted during an open enrollment application period will be denied.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the Residential Habilitation Waiver are eligible for the waiver services described in 130 CMR 630.405(A): *Acquired Brain Injury with Residential Rehabilitation (ABI-RH) Waiver*.

(2) Non-Residential Habilitation Waiver for Persons with Acquired Brain Injury.

(a) Clinical and Age Requirements. The Non-Residential Habilitation Waiver for Persons with Acquired Brain Injury, as authorized under section 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services or chronic disease or rehabilitation hospital services to receive specified waiver services, other than residential rehabilitation, in the home or community if he or she meets all of the following criteria:

(i) is 22 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards;

(ii) acquired, after reaching age of 22, a brain injury including, without limitation, brain injuries caused by external force, but not including Alzheimer's disease and similar neuro-degenerative diseases, the primary manifestation of which is dementia;

(iii) is an inpatient in a nursing facility or chronic disease or rehabilitation hospital with a continuous length of stay of 90 or more days at the time of application for the waiver;

(iv) is not expected to incur annual MassHealth expenditures, including MassHealth expenditures under the Non-Residential Habilitation Waiver, in excess of the individual cost limit specified in the Non-Residential Habilitation Waiver;
(v) needs one or more of the services under the Non-Residential Habilitation Waiver; and
(vi) is able to be safely served in the community within the terms of the Non-Residential Habilitation Waiver.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must
(i) meet the requirements of 130 CMR 519.007 (G)(2)(a);
(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;
(iii) have countable assets of $2,000 or less; and
(iv) not have transferred resources for the purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the Non-Residential Habilitation Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the Non-Residential Habilitation Waiver are eligible for the waiver service described in 130 CMR 630.405(B): *Acquired Brain Injury Non-Residential Habilitation (ABI-N) Waiver*.

(H) Money Follows the Person Home- and Community-Based Services Waivers.

(1) Money Follows the Person (MFP) Residential Supports Waiver.

(a) Clinical and Age Requirements. The MFP Residential Supports Waiver, as authorized under section 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services, chronic disease or rehabilitation hospital services, or, for participants 18 through 21 years of age or 65 years of age and older, psychiatric hospital services to receive residential support services and other specified waiver services in a 24-hour supervised residential setting if he or she meets all of the following criteria:
(i) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards;
(ii) is an inpatient in a nursing facility, chronic disease or rehabilitation hospital, or, for participants 18 through 21 years of age or 65 years of age and older, psychiatric hospital with a continuous length of stay of 90 or more days, excluding rehabilitation days;

(iii) must have received MassHealth benefits for inpatient services, and be MassHealth eligible at least the day before discharge;
(iv) must be assessed to need residential habilitation, assisted living services, or shared living 24-hour supports services within the terms of the MFP Residential Supports Waiver;
(v) is able to be safely served in the community within the terms of the MFP Residential Supports Waiver; and
(vi) is transitioning to the community setting from a facility, moving to a qualified residence, such as a home owned or leased by the applicant or a family member, an apartment with an individual lease, or a community-based residential setting in which no more than four unrelated individuals reside.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must

(i) meet the requirements of 130 CMR 519.007 (H)(1)(a);
(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;
(iii) have countable assets of $2,000 or less; and
(iv) not have transferred resources for the purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the MFP Residential Supports Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the MFP Residential Supports Waiver are eligible for the waiver services described in 130 CMR 630.405(C): *Money Follows the Person Residential Supports (MFP-RS) Waiver*.

(2) Money Follows the Person (MFP) Community Living Waiver.

(a) Clinical and Age Requirements. The MFP Community Living Waiver, as authorized under section 1915(c) of the Social Security Act, allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing facility services, chronic disease or rehabilitation hospital services, or, for participants 18 through 21 years of age or 65 years of age and older, psychiatric hospital services to receive specified waiver services, other than residential support services in the home or community, if he or she meets all of the following criteria:

(i) is 18 years of age or older and, if younger than 65 years old, is totally and permanently disabled in accordance with Title XVI standards;
(ii) is an inpatient in a nursing facility, chronic disease or rehabilitation hospital, or, for participants 18 through 21 years of age or 65 years of age and older, psychiatric hospital with a continuous length of stay of 90 or more days, excluding rehabilitation days;
(iii) must have received MassHealth benefits for inpatient services, and be MassHealth eligible at least the day before discharge;
(iv) needs one or more of the services under the MFP Community Living Waiver;
(v) is able to be safely served in the community within the terms of the MFP Community Living Waiver; and
(vi) is transitioning to the community setting from a facility, moving to a qualified residence, such as a home owned or leased by the applicant or a family member, an apartment with an individual lease, or a community-based residential setting in which no more than four unrelated individuals reside.

(b) Eligibility Requirements. In determining eligibility for MassHealth Standard and for these waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must

(i) meet the requirements of 130 CMR 519.007 (H)(2)(a);
(ii) have countable income that is less than or equal to 300 percent of the federal benefit rate (FBR) for an individual;
(iii) have countable assets of $2,000 or less; and
(iv) not have transferred resources for the purpose of obtaining MassHealth, as described in 130 CMR 520.018: *Transfer of Resources Regardless of Date of Transfer* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.

(c) Enrollment Limits. Enrollment in the MFP Community Living Waiver is subject to a limit on the total number of waiver participants. The number of participants who can be enrolled in this waiver may be limited in a manner determined by the MassHealth agency.

(d) Waiver Services. Eligible members who are enrolled as waiver participants in the MFP Community Living Waiver are eligible for the waiver services described in 130 CMR 630.405(D): *Money Follows the Person Community Living (MFP-CL) Waiver*.

(130 CMR 519.008 Reserved)

519.009: MassHealth Limited

(A) Eligibility Requirements.

(1) MassHealth Limited is available to community residents 65 years of age and older meeting the financial and categorical requirements of MassHealth Standard coverage as described at 130 CMR 519.005(A) and (B) and who are

(a) other noncitizens described in 130 CMR 518.003(D): *Undocumented Noncitizens*;

(b) qualified noncitizens barred as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*;

(c) nonqualified individuals lawfully present as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*; or

(d) nonqualified PRUCOLs as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*.

(2) Community residents 65 years of age and older who are qualified noncitizens barred, as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individuals lawfully present, as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*, and nonqualified PRUCOLs, as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*, may also be eligible for MassHealth Family Assistance if they meet the categorical and financial requirements of 130 CMR 519.013.

(3) Persons eligible for MassHealth Limited coverage are eligible for medical benefits described at 130 CMR 450.105(F): *MassHealth Limited*.

(B) Use of Potential Benefits. All individuals who meet the requirements of 130 CMR 519.009 must use potential health-insurance benefits in accordance with 130 CMR 517.008: *Potential Sources of Health Care* and must enroll in health insurance, including Medicare, if available at no greater cost to the applicant or member than he or she would pay without access to health insurance. Members must access those other health-insurance benefits and must show both their private health-insurance card and their MassHealth card to providers at the time services are provided.

(C) Coverage Date. The begin date of medical coverage is established in accordance with 130 CMR 516.005: *Coverage Date*.

519.010: MassHealth Senior Buy-In

(A) Eligibility Requirements. MassHealth Senior Buy-In coverage is available to Medicare beneficiaries who

(1) are entitled to hospital benefits under Medicare Part A;

(2) have a countable income amount (including the income of the spouse with whom he or she lives) that is less than or equal to 100 percent of the federal poverty level;

(3) have countable assets less than or equal to the amount of allowable assets for Buy-in programs as identified by the Centers for Medicare and Medicaid Services in the *Federal Register*. Each calendar year, the allowable asset limits shall be made available on MassHealth's website; and

(4) meet the universal requirements of MassHealth Standard coverage.

(B) Benefits. The MassHealth agency pays for Medicare Part A and Part B premiums and for deductibles and coinsurance under Medicare Parts A and B.

(C) Begin Date. The begin date for MassHealth Senior Buy-In coverage is the first day of the calendar month following the date of the MassHealth eligibility determination.

519.011: MassHealth Buy-In

(A) MassHealth Buy-In for Specified Low Income Medicare Beneficiaries.

(1) Eligibility Requirements. MassHealth Buy-In coverage for Specified Low Income Medicare Beneficiaries is available to Medicare beneficiaries who meet the eligibility requirements of MassHealth Senior Buy-In coverage at 130 CMR 519.010 with the following exception: the countable income amount of the individual and his or her spouse must be greater than 100 percent of the federal poverty level and less than 120 percent of the federal poverty level.

(2) Benefits. The MassHealth agency pays the cost of the monthly Medicare Part B premium for members who establish eligibility for MassHealth Buy-In coverage in accordance with 130 CMR 519.011(A).

(3) Begin Date. MassHealth Buy-In coverage, in accordance with 130 CMR 519.011(A), begins with the month of application and may be retroactive up to three calendar months before the month of application.

(B) MassHealth Buy-In for Qualifying Individuals.

(1) Eligibility Requirements. MassHealth Buy-In coverage for Qualifying Individuals is also available to Medicare beneficiaries who

(a) are entitled to hospital benefits under Medicare Part A;

(b) are not eligible for MassHealth Standard or CarePlus under the Medicaid State Plan;

(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 less than or equal to the amount of allowable assets for Buy-in programs as identified by the Centers for Medicare and Medicaid Services in the *Federal Register*. Each calendar year, the allowable asset limits shall be made available on MassHealth's website.

(2) Benefits. The MassHealth agency 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 equal to or greater than 120 percent of the federal poverty level and 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) The MassHealth agency does not extend eligibility to individuals who meet the requirements of 130 CMR 519.011(B), if the MassHealth agency 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.

(b) The MassHealth agency gives preference to members who were eligible for MassHealth Buy-In, as described in 130 CMR 519.011, or MassHealth Senior Buy-In, as described in 130 CMR 519.010, in December of the previous calendar year when determining an individual's eligibility for MassHealth Buy-In, as described in 130 CMR 519.011(B), in the subsequent calendar year.

519.012: MassHealth CommonHealth

(A) Working Disabled Adults.

(1) Eligibility Requirements. MassHealth CommonHealth for working disabled adults is available to community residents 65 years of age and older in the same manner as they are available to those younger than 65 years old. This means they must meet the requirements of 130 CMR 505.004(B)(2), (3), and (5).

(2) Other Provisions. The following provisions apply to CommonHealth applicants and members 65 years of age and older: 130 CMR 505.004(A)(2), (H) through (J), (M)(1) and (2), and (N).

(B) Certain Disabled Institutionalized Children Who Are Noncitizens.

(1) Eligibility Requirements. MassHealth CommonHealth is available to institutionalized disabled children who meet the requirements of 130 CMR 505.004(G): *Disabled Children Younger Than 18 Years Old* and 519.006(A)(2), and who

(a) have attained the immigration status described in 130 CMR 518.003(A)(2): *Qualified Aliens Barred*, and five years have not passed from the date they attained such status;

(b) are noncitizens under the Immigration and Nationality Act (INA); or

(c) are noncitizens paroled into the United States under section 212(d)(5) of the INA for less than one year.

(2) Other Provisions. The following provisions apply to CommonHealth applicants and members who are described above in 130 CMR 519.012(B)(1), 130 CMR 505.004(A)(2), (H), and (J), and (M)(1) and (2).

(C) Financial Eligibility. Financial eligibility for all MassHealth CommonHealth applicants and members is based on the regulations in 130 CMR 506.000: *Health Care Reform: MassHealth: Financial Requirements*. 130 CMR 520.000: *MassHealth: Financial Eligibility* does not apply.

519.013: MassHealth Family Assistance

(A) Eligibility Requirements. MassHealth Family Assistance is available to community residents 65 years of age and older who meet the following requirements:

(1) be a qualified noncitizen barred, as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individuals lawfully present, as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*, or a nonqualified PRUCOL, as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*,

(a) with the countable-income amount, as defined in 130 CMR 520.009: *Countable-Income Amount*, of the individual or married couple living together is less than or equal to 100 percent of the federal poverty level (FPL);

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

(c) without health insurance, or access to health insurance; or

(2) be a nonqualified PRUCOL, as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*,

(a) with modified adjusted gross income of the MassHealth MAGI household as described in 130 CMR 506.000: *Health Care Reform: MassHealth: Financial Requirements* between 100 and 300 percent of the federal poverty level (FPL); and

(b) without health insurance, or access to health insurance.

(B) Financial Standards Not Met. Individuals described in 130 CMR 519.013(A)(1) whose income, assets, or both exceed the standards set forth in 130 CMR 519.013(A) may establish eligibility for MassHealth Family Assistance by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, meeting a deductible as described at 130 CMR 520.028 : *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*, or both.

(C) Automatic Eligibility for EAEDC Recipients 65 Years of Age and Older.

(1) Individuals 65 years of age and older who meet the requirements of the Emergency Aid to the Elderly, Disabled and Children (EAEDC) program administered by the Department of Transitional Assistance and who are qualified noncitizens barred, as described in 130 CMR 518.003(A)(2): *Qualified Noncitizens Barred*, nonqualified individuals lawfully present, as described in 130 CMR 518.003(A)(3): *Nonqualified Individuals Lawfully Present*, or nonqualified PRUCOLs, as described in 130 CMR 518.003(C): *Nonqualified Persons Residing under Color of Law (nonqualified PRUCOLs)*, are automatically eligible for benefits under 130 CMR 519.013.

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

(D) Benefits. Individuals eligible for MassHealth Family Assistance are eligible for medical benefits on a fee-for-service basis as defined in 130 CMR 515.001: *Definition of Terms*. These medical benefits are described in MassHealth regulations at 130 CMR 450.105(G): *MassHealth Family Assistance*.

(E) Coverage Date. The begin date of medical coverage is established in accordance with 130 CMR 516.005: *Coverage Date*. MassHealth Family Assistance members are eligible for medical coverage under MassHealth Limited if otherwise eligible for MassHealth Limited as described in 130 CMR 519.009.

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520.001: Introduction to General Financial Requirements

(A) 130 CMR 520.000 describes the rules governing financial eligibility for MassHealth. 130 CMR 520.000 is based on financial responsibility, countable income, and countable assets.

(B) The methods for the calculation of the countable-income amount, the deductible, and the income standards used in the determination of eligibility are also explained in 130 CMR 520.000.

520.002: Financial Responsibility

(A) Community Residents.

(1) Spouses Living Together. In the determination of eligibility for MassHealth, the total countable-income amount and countable assets of the individual and the spouse who are living together are compared to an income standard and asset limit, unless one spouse is covered by MassHealth under a home- and community-based services waiver, as described in 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*.

(2) Spouses Living Apart. When spouses live apart for reasons other than admission to a medical institution, their assets and income are considered mutually available only through the end of the calendar month of separation.

(B) Residents of Medical Institutions.

(1) Spouses Living Together. When spouses live in the same long-term-care facility, the income and assets are not mutually available.

(2) One Spouse Institutionalized.

(a) If only one spouse is a resident of a medical institution who is expected to remain in the facility for 30 days or more, the community spouse's income is not counted in the determination of eligibility for the institutionalized spouse. The institutionalized spouse may provide for the maintenance needs of the community spouse in accordance with 130 CMR 520.026(B).

(b) The countable assets of both spouses must be evaluated and a spousal share established in accordance with 130 CMR 520.016(B).

(3) Institutionalized Child. When a child under age 18 lives in a medical institution, the income and assets of the parents are considered available only through the end of the calendar month of separation.

520.003: Asset Limit

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

(1) for an individual — in calendar year 2011, $6,680 and, in calendar year 2012, $6,940; and

(2) for a couple living together in the community where there is financial responsibility according to 130 CMR 520.002(A)(1) — in calendar year 2011, $10,290 and, in calendar year 2012, $10,410.

(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, Family Assistance, 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. The MassHealth agency 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: *Date of Application*; and

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

(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), the MassHealth agency 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. The MassHealth agency 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, the MassHealth agency 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. The MassHealth agency 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 the MassHealth agency 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.

(D) Verifications. Individual or joint ownership of any countable asset must be verified by a written document providing reasonable evidence of ownership. The MassHealth agency determines whether a verification is acceptable in accordance with 130 CMR 520.007(B)(3) and 130 CMR 520.005(D). Acceptable verification includes, but is not limited to, the following:

(1) a title;

(2) a purchase contract;

(3) documents establishing ownership of joint bank accounts that demonstrate the following:

(a) the origin of the funds in a joint bank account, who opened the account, or whose money was used to open the account;

(b) federal and state tax records as to which joint account holders pay the tax on interest credited to the account as income;

(c) records of who makes deposits and withdrawals and, if appropriate, how withdrawn funds are spent;

(d) any evidence of written or oral agreements made between the parties at the time of the creation of the account;

(e) evidence of age, relationship, physical or mental condition, or place of residence of the co-holders when the applicant or member states that he or she does not own the account but is listed as a co-holder solely as a convenience to the other co-holder to conduct bank transactions on his or her behalf; and

(f) why the applicant or member is listed on the account;

(4) certification of ownership;

(5) financial-institution records indicating the establishment of an account that accurately reflect the ownership interest of funds from the joint account;

(6) other documentation that indicates ownership, asset value, and restrictions on access;

(7) a notarized affidavit, sworn to under penalty of perjury, signed by all owners of the asset, and attesting to the distribution of ownership; or

(8) the self-declaration of the individual who is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B): *MassHealth Buy-In for Qualifying Individuals*. The MassHealth agency may, at its discretion, request additional verification.

520.006: Inaccessible Assets

(A) Definition. An inaccessible asset is an asset to which the applicant or member has no legal access. The MassHealth agency does not count an inaccessible asset when determining eligibility for MassHealth for the period that it is inaccessible or is deemed to be inaccessible under 130 CMR 520.006.

(B) Examples of Inaccessible Assets. Inaccessible assets include, but are not limited to
(1) property, the ownership of which is the subject of legal proceedings (for example, probate and divorce suits); and
(2) the cash-surrender value of life-insurance policies when the policy has been assigned to the issuing company for adjustment.

(C) Date of Accessibility. The MassHealth agency considers accessible to the applicant or member all assets to which the applicant or member is legally entitled
(1) from the date of application or acquisition, whichever is later, if the applicant or member does not meet the conditions of 130 CMR 520.006(C)(2)(a) or (b); or
(2) from the period beginning six months after the date of application or acquisition, whichever is later, if
(a) the applicant or member cannot competently represent his or her interests, has no guardian or conservator capable of representing his or her interests, and the authorized representative (which may include a provider) of such applicant or member is making a good-faith effort to secure the appointment of a competent guardian or conservator; or
(b) the sole trustee of a Medicaid Qualifying Trust, under 130 CMR 520.022(B), is one whose whereabouts are unknown or who is incapable of competently fulfilling his or her fiduciary duties, and the applicant or member, directly or through an authorized representative (which may include a provider), is making a good-faith effort to contact the missing trustee or to secure the appointment of a competent trustee.

520.007: Countable Assets

Countable assets are all assets that must be included in the determination of eligibility. Countable assets include assets to which the applicant or member or his or her spouse would be entitled whether or not these assets are actually received when failure to receive such assets results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf. In determining whether or not failure to receive such assets is reasonably considered to result from such action or inaction, the MassHealth agency considers the specific circumstances involved. The applicant or member and the spouse must verify the total value of countable assets. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B): *MassHealth Buy-In for Qualifying Individuals*, verification is required only upon request by the MassHealth agency. 130 CMR 520.007 also contains the verification requirements for certain assets. The assets that the MassHealth agency considers include, but are not limited to, the following.

(A) Cash.

(1) Definition. Cash is defined as currency, checks, and bank drafts in the possession of or available to the applicant, member, or spouse.

(2) Verification. The applicant's or member's declaration on the application or redetermination form stating the amount of cash available to him or her is sufficient verification.

(B) Bank Accounts.

(1) Definition. Bank accounts are defined as deposits in a bank, savings and loan institution, credit union, or other financial institution. Bank accounts may be in the form of savings, checking, or trust accounts, term certificates, or other types of accounts.

(2) Determination of Ownership and Accessibility. The MassHealth agency considers funds in a bank account available only to the extent that the applicant or member has both ownership of and access to such funds. The MassHealth agency determines the ownership of and access to the funds in accordance with 130 CMR 520.005 and 520.006.

(3) Verification of Account Balances. The MassHealth agency requires verification of the current balance of each account at application, during eligibility review, and at times of reported change.

(a) Noninstitutionalized individuals excluding the individuals described at 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder* must verify the amount on deposit by bank books or bank statements that show the bank balance within 45 days of the date of application or the date that the eligibility review is received in a MassHealth Enrollment Center or outreach site.

(b) Nursing-facility residents as described at 130 CMR 515.001: *Definition of Terms* must verify the amount on deposit by bank books or bank statements that show the current balance and account activity during the look-back period.

(c) If during an eligibility review the member states either orally or in writing that an account other than a checking account contains a balance of $25 or less, the MassHealth agency does not require verification provided that, in combination with other countable assets, it would not affect continued eligibility.
(d) If lack of either access to or ownership of funds in an account is verified, the MassHealth agency will not consider the funds a countable asset.

(C) Individual Retirement Accounts, Keogh Plans, and Pension Funds.
(1) Individual Retirement Accounts. An Individual Retirement Account (IRA) is a tax-deductible savings account that sets aside money for retirement. Funds in an IRA are counted as an asset in their entirety less the amount of penalty for early withdrawal.
(2) Keogh Plans. A Keogh Plan is a retirement plan established by a self-employed individual. A Keogh Plan may be established for the self-employed individual alone or for the self-employed individual and his or her employees. If the Keogh Plan was established for the self-employed individual alone, the funds in the Plan are counted as an asset in their entirety less the amount of penalty for early withdrawal. If the Keogh Plan was established for employees other than the spouse of the applicant or member, the MassHealth agency does not count the funds as an asset.
(3) Pension Funds. A pension fund is a retirement plan established by an employer to provide benefit payments to employees upon retirement or disability. Pension funds that are being set aside by an individual's current employer are not countable as an asset. Pension funds from an individual's former employer are countable in their entirety less any penalties for withdrawal provided such funds are accessible. (See 130 CMR 520.006.)

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

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

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

(F) Vehicles as Countable Assets.

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

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

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

(2) Exemption.

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

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

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

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

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

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

(i) the wholesale value (for cars and trucks) and finance value (for recreational vehicles) tables in the most recent vehicle valuation book that is used by the MassHealth agency;

(ii) the low value in an older car valuation book (for cars and trucks). If the car or truck is too old to be listed in an older car valuation book, the MassHealth agency will assign a value of $250;

(iii) the written appraisal of a licensed automobile dealer who deals with classic, custom-made, or antique vehicles, if the vehicle is considered a classic, custom-made, or antique; or

(iv) for recreational vehicles, the projected loan value as quoted by a bank or other lending institution; documents showing the value of the vehicle for insurance purposes; or a written estimate of the cash value of the vehicle from a licensed recreational vehicle dealer.

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

(G) Real Estate.

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

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

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

(a) The applicant or member must verify the fair-market value by a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

(i) a special purpose assessment;

(ii) based on a fixed-rate-per-acre method; or

(iii) based on an assessment ration or providing only a range.

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

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

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

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

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

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

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

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

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

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

(i) a spouse;

(ii) a child who is younger than 21 years old or who is blind or permanently and totally disabled;

(iii) a sibling who has a legal interest in the home and who was living there for a period of at least one year immediately before the applicant's or member's admission to the medical institution;

(iv) a son or daughter who was living in the applicant's or member's home for a period of at least two years immediately before the date of the applicant's or member's admission to the medical institution, and who establishes to the satisfaction of the MassHealth agency that he or she provided care to the applicant or member that permitted him or her to live in the home rather than in a medical institution; or

(v) a dependent relative. A dependent relative is any of the following who has any kind of medical, financial, or other dependency: a child, stepchild, or grandchild; a parent, stepparent, or grandparent; an aunt, uncle, niece, or nephew; a brother, sister, stepbrother, or stepsister; a half brother or half sister; a cousin; or an in-law.

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

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

(9) Verification of Dependency and Residence of Relative Living in the Former Home.

(a) Relationship. The institutionalized individual must verify his or her relationship to the relative living in the former home by birth certificates, marriage licenses, or any other documents necessary to establish the relationship.

(b) Dependency. The institutionalized individual must verify the relative's dependency on the institutionalized individual by a signed statement from the relative attesting to the existence and duration of the dependency. The MassHealth agency may require additional evidence if the relative's claim of dependency is questionable or self-contradictory.

(c) Residence. The institutionalized individual must verify the relative's residence in his or her former home only if there is conflicting or contradictory evidence regarding the relative's residence.

(10) Option to Liquidate to Pay for Medical Care. Instead of selling the countable former home, the individual may liquidate its equity value to pay for his or her medical care. If the individual chooses this option, the home will be noncountable until the equity value is liquidated, but not longer than nine calendar months after the date of the MassHealth agency's notice.

(11) Undue Hardship: Jointly Owned Assets.

(a) The MassHealth agency will continue to exclude otherwise countable property, including a former home, when it is jointly owned and the sale of the property by an individual would cause the other owners to lose housing.

(b) Loss of housing would result when the property serves as the principal place of residence for one (or more) of the other owners, and sale of the property would result in loss of that residence, and no other housing would be readily available for the displaced other owner. If undue hardship as defined in 130 CMR 520.007(G)(11) ceases to exist, the property becomes a countable asset.

(12) Lien. The MassHealth agency will place a lien before the death of a member against any real estate in which the member has a legal interest. This lien will be placed only if all of the conditions of 130 CMR 515.012: *Real Estate Liens* are met.

(13) Waiver of the Period of Ineligibility Due to Excess Equity Value in the Principal Place of Residence Causing Undue Hardship.

(a) The MassHealth agency may waive the denial of payment of long-term-care services for excess equity value in the principal place of residence if ineligibility would cause the individual undue hardship when the following conditions exist:

(i) the denial of long-term-care services would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation; and

(ii) the institution has notified the nursing-facility resident of its intent to initiate discharge the resident because the resident has not paid for his or her institutionalization; and

(iii) there is no less costly noninstitutional alternative available to meet the nursing-facility resident's needs.

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

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

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

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

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

(H) Retroactive SSI and RSDI Benefit Payments.

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

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

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

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

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

(a) when the beneficiary is other than the applicant, member, or spouse;

(b) when the beneficiary is the applicant, member, or spouse and when the total present value of projected payments from the annuity is less than the value of the transferred asset (purchase price). In this case, the MassHealth agency determines the amount of the disqualifying transfer based on the actuarial value of the annuity compared to the beneficiary's life expectancy using the life-expectancy tables as determined by the MassHealth agency, giving due weight to the life-expectancy tables of institutions in the business of providing annuities;

(c) when the terms of the annuity postpone payment beyond 60 days, the MassHealth agency will treat the annuity as a disqualifying transfer of assets until the payment start date; or

(d) when the terms of the annuity provide for unequal payments, the MassHealth agency may treat the annuity as a disqualifying transfer of assets. Commercial annuity payments that vary solely as a result of a variable rate of interest are not considered unequal payments under 130 CMR 520.007(J)(1)(d).

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

(a) The purchase of an annuity will be considered a disqualifying transfer of assets unless

(i) the Commonwealth of Massachusetts is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual;

(ii) the Commonwealth of Massachusetts is named as such a remainder beneficiary in the second position after the community spouse, or minor or disabled children; or

(iii) the Commonwealth of Massachusetts is named as such a remainder beneficiary in the first position if the community spouse or the representative of any minor or disabled children in 130 CMR 520.007(J)(2)(a)(ii) disposes of any such remainder for less than fair-market value.

(b) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(1) and (J)(2)(a) and is irrevocable and nonassignable, or unless the annuity satisfies 130 CMR 520.007(J)(2)(c).

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

(i) described in section 408(b) or (q) of the Internal Revenue Code of 1986;

(ii) purchased with the proceeds from an account or trust described in section 408(a), (c), or (p) of the Internal Revenue Code of 1986;

(iii) purchased with the proceeds from a simplified employee pension described in section 408(k) of the Internal Revenue Code of 1986; or

(iv) purchased with the proceeds from a Roth IRA described in section 408A of the Internal Revenue Code of 1986.

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

(a) the repayment terms of the promissory note, loan, or mortgage are actuarially sound, based on actuarial tables as determined by the MassHealth agency;

(b) the promissory note, loan, or mortgage provides for equal payment amounts during the life of the loan, with no deferral and no balloon payments; and

(c) the promissory note, loan, or mortgage prohibits cancellation of the balance upon the death of the lender.

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

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

520.008: Noncountable Assets

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

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

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

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

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

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

(F) Funeral or Burial Arrangements.

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

(a) any burial space, including any burial space for any immediate family member;

(b) one of the following:

(i) a separately identifiable amount not to exceed $1,500 expressly reserved for funeral and burial expenses; or

(ii) life-insurance policies designated exclusively for funeral and burial expenses with a total face value not to exceed $1,500;

(c) the cash-surrender value of burial insurance; and

(d) prepaid irrevocable burial contracts or irrevocable trust accounts designated for funeral and burial expense.

(2) Appreciated value or interest earned or accrued and left to accumulate on any contracts, accounts, or life insurance is also noncountable. If the applicant, member, or spouse uses any of these assets, including the interest accrued, for other than funeral or burial arrangements of the applicant, member, or spouse, the MassHealth agency considers the asset available and countable under the provisions of 130 CMR 520.007, 520.018, and 520.019.
(3) The applicant, member, or spouse has the right to establish a burial arrangement or change the designation of his or her funds to a burial arrangement described in 130 CMR 520.008(F). If such arrangement is made within 60 days after the date that the applicant or member was notified of his or her right to do so, then the MassHealth agency considers the arrangement to have been in existence on the first day of the third month before the application.

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

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

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

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

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

520.009: Countable-Income Amount

(A) Overview.
(1) An individual’s and the spouse's gross earned and unearned income less certain business expenses and standard income deductions is referred to as the countable-income amount. In determining gross monthly income, the MassHealth agency multiplies the average weekly income by 4.333 unless the income is monthly.
(2) For community residents, the countable-income amount is compared to the applicable income standard to determine the individual's financial eligibility.

(3) For institutionalized individuals, specific deductions described in 130 CMR 520.026 are applied against the individual's countable-income amount to determine the patient-paid amount.

(4) The types of income that are considered in the determination of eligibility are described in 130 CMR 520.009, 520.018, 520.019, and 520.021 through 520.024. These include income to which the applicant, member, or spouse would be entitled whether or not actually received when failure to receive such income results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf. In determining whether or not failure to receive such income is reasonably considered to result from such action or inaction, the MassHealth agency will consider the specific circumstances involved.

(B) MassHealth Income Standards. Generally, financial eligibility is based on a percentage of the federal poverty level. The monthly federal poverty level standards are determined according to annual standards published in the *Federal Register*. The MassHealth agency adjusts these standards annually using the following formula.

(1) Divide the annual federal poverty level income standard as it appears in the *Federal Register* by 12.

(2) Multiply the unrounded monthly income standard by the applicable federal poverty level percentage.

(3) Round up to the next whole dollar to arrive at the monthly income standards.

(C) Types of Earned Income. Earned income is the total amount of compensation received for work or services performed. Earned income includes wages, self-employment income, and payment from roomers and boarders.

(1) Self-employment Income. Gross income for the self-employed is the total amount of income listed on the most recent tax return before adjustments to income are made. A real-estate dealer, if engaged in the business of selling real estate to customers for profit, is considered to have self-employment earned income. Income from property that is owned by an individual who is not a real-estate dealer or is owned by the individual's spouse is considered unearned income.

(2) Income from Roomers and Boarders. Payment for room and meals received from anyone other than the spouse of the applicant or member is countable earned income. Gross income from roomers and boarders is the amount received for the room and board, less business expenses as described at 130 CMR 520.010(B).

(3) Verification of Earned Income. The applicant or member must verify gross earned income. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B): *MassHealth Buy-In for Qualifying Individuals*, verification is required only upon the request of the MassHealth agency. Verifications include

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

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

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

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

(1) Exceptions. The following lump-sum payments are noncountable:

(a) a retroactive RSDI and/or SSI benefit payment, subject to the provisions of 130 CMR 520.007(H)(1);

(b) proceeds reserved for the replacement or repair of an asset that is lost, damaged, or stolen and any interest earned on such proceeds are exempt from consideration as assets for nine calendar months after the month of receipt and may be exempt for an additional nine calendar months where good cause exists;

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

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

(2) Verifications. The applicant or member must verify a lump-sum payment. However, if he or she is applying solely for MassHealth Buy-In, as described at 130 CMR 519.011(B): *MassHealth Buy-In for Qualifying Individuals*, verification is required only at MassHealth agency request. Verifications include
(a) a benefit or settlement award letter;
(b) a retirement-fund document indicating the amount of the lump-sum payment;
(c) a written statement from the agency, company, or institution making the payment;
(d) a copy of the payment document; or
(e) other reliable evidence.

520.010: Business Expenses

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

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

(C) Rental Income.
(1) Allowable business expenses from rental income include carrying charges, cost of fuel and utilities provided to tenants, and any maintenance and repair costs.
(2) If the individual occupies an apartment in the same building from which he or she receives rental income, carrying charges are prorated per unit. The cost of fuel and utilities are prorated if they are paid through a single heating unit or meter.
(3) The MassHealth agency may deduct actual maintenance and repair costs, other than cosmetic changes, from the amount of rental income if the individual verifies such expenses.

520.011: Standard Income Deductions

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

520.012: Community Earned-Income Deductions

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

(A) $20, if there is no unearned income or, if there is unearned income that is less than $20, the balance of the $20 is disregarded from earned income;

(B) the next $65 a month of earned income; and

(C) one-half of the remaining earned income.

520.013: Community Unearned-Income Deductions

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

(A) a deduction of $20 per individual or married couple; or

(B) in determining eligibility for MassHealth Standard, a deduction that is equivalent to the difference between the applicable MassHealth deductible-income standard at 130 CMR 520.030 and 133 percent of the federal poverty level. This deduction includes, and is not in addition to, the $20 disregard.

(1) This deduction from gross unearned income is allowed only for persons who
   (a) are 65 years of age and older;
   (b) are receiving personal-care attendant services paid for by the MassHealth agency, or have been determined by the MassHealth agency, through initial screening or by prior authorization, to be in need of personal-care attendant services; and
   (c) prior to applying the deduction at 130 CMR 520.013(B), have countable income that is over 100 percent of the federal poverty level.

(2) The MassHealth agency will redetermine eligibility without this deduction if
(a) after 90 days from the date of the MassHealth agency eligibility approval notice, the person is not receiving personal-care attendant services paid for by the MassHealth agency or has not submitted, upon request from the MassHealth agency, proof of efforts to obtain personal-care attendant services paid for by the MassHealth agency; or
(b) the MassHealth agency denies the prior-authorization request for personal-care attendant services.

(3) If countable income, prior to applying the deduction at 130 CMR 520.013(B), is greater than 133 percent of the federal poverty level, eligibility is determined under 130 CMR 519.005(B): *Financial Standards Not Met*.

520.014: Long-Term-Care Earned-Income Deductions

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

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

520.015: Noncountable Income

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

(A) the income of any individual who is a recipient of EAEDC or SSI;

(B) the portion of the income that is disregarded
(1) for disabled adult children according to 130 CMR 519.004: *Disabled Adult Children*; and
(2) under the Pickle Amendment according to 130 CMR 519.003: *Pickle Amendment Cases*;

(C) income-in-kind;

(D) money received from a loan secured by the equity in the home of an individual who is aged 60 or older (reverse mortgage);

(E) veterans' aid and attendance benefits, unreimbursed medical expenses, housebound benefits, enhanced benefits ($90 Veterans' Administration pension to long-term-care-facility residents, including veterans and their childless surviving spouses who live in a state veterans' home), or veterans' benefits that are based on need and are provided by municipalities to resident veterans;

(F) the amount of the increase due to a social security cost-of-living adjustment (COLA), if the amount of such increase can be verified, until the subsequent federal-poverty-level adjustment for applicants and members who are community residents;

(G) retroactive RSDI and SSI benefit payments;

(H) income received by individuals who have verified their membership as an American Indian or Alaska Native and who are members of an Indian tribe, a tribal organization, or an urban Indian organization in accordance with federal law that meets one of the following:

(1) distributions from Alaska Native Corporations and Settlement Trusts;

(2) distributions from any property held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(3) distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from

(a) rights of ownership or possession in any lands described in 130 CMR 520.008(K)(2); or

(b) federally protected rights about off-reservation hunting, fishing, gathering, or usage of natural resources;

(4) distributions resulting from real property ownership interests related to natural resources and improvements

(a) located on or near a reservation or within the most recent boundaries of a prior federal reservation; or

(b) resulting from the exercise of federally protected rights relating to such real property ownership interests;

(5) payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or traditional lifestyle according to applicable tribal law or custom;

(6) student financial assistance provided under the Bureau of Indian Affairs education programs; or

(I) any other income considered noncountable under Title XIX.

520.016: Long-Term Care: Treatment of Assets

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

(A) Institutionalized Individuals. The total value of assets owned by an institutionalized single individual or by a member of an institutionalized couple must not exceed $2,000.

(B) Treatment of a Married Couple's Assets When One Spouse Is Institutionalized.

(1) Assessment.

(a) Requirement. The MassHealth agency completes an assessment of the total value of a couple's combined countable assets and computes the community spouse's asset allowance as of the date of the beginning of the most recent continuous period of institutionalization of one spouse.

(b) Right to Request an Assessment. When one spouse has entered a medical institution and is expected to remain institutionalized for at least 30 days, either spouse may request the MassHealth agency to make this assessment, even if the institutionalized spouse is not applying for MassHealth Standard at that time. The period of institutionalization must be continuous and expected to last for at least 30 days.

(c) Right to Appeal. The MassHealth agency must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or authorized representative) applies for MassHealth Standard.

(2) Determination of Eligibility for the Institutionalized Spouse. At the time that the institutionalized spouse applies for MassHealth Standard, the MassHealth agency must determine the couple's current total countable assets, regardless of the form of ownership between the couple, and the amount of assets allowed for the community spouse as follows. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for MassHealth Standard.

(a) Deduct the community spouse's asset allowance, based on countable assets as of the date of the beginning of the most recent continuous period of institutionalization of the institutionalized spouse, from the remaining assets. The community spouse's asset allowance is the greatest of the following amounts:

(i) the combined total countable assets of the institutionalized spouse and the community spouse, not to exceed $109,560;

(ii) a court-ordered amount; or

(iii) an amount determined after a fair hearing in accordance with 130 CMR 520.017.

(b) Compare the amount of the remaining assets to the MassHealth asset standard for one person, which is $2,000. When the amount of the remaining assets is equal to or below $2,000, the institutionalized spouse has met the asset test of eligibility.

(3) Post-Eligibility Transfer of Assets.

(a) To meet the needs of the community spouse and to allow the continuing eligibility of the institutionalized spouse, the MassHealth agency allows the institutionalized spouse, after he or she has been determined eligible for MassHealth Standard, to transfer assets to or for the sole benefit of the community spouse in accordance with 130 CMR 520.016(B)(1) and (2).

(b) The institutionalized spouse must transfer any of his or her assets that are part of the community spouse's asset allowance no later than 90 days immediately after the date of the notice of approval for MassHealth Standard. During this 90-day period, the MassHealth agency

(i) will continue to exclude these assets in the determination of continuing eligibility; and

(ii) will not apply the transfer rules in 130 CMR 520.018 and 520.019 to the assets transferred to the community spouse.

(c) The MassHealth agency may extend the 90-day period if any of the following conditions exist:

(i) the court is involved in assigning the couple's property through support actions;

(ii) an appeal of the asset allowance has been filed with the Office of Medicaid Board of Hearings; or

(iii) the condition of the institutionalized spouse requires the appointment of a conservator or guardian to act on his or her behalf.

(d) The amount of the transferred assets added to the assets owned by the community spouse cannot exceed the community spouse's asset allowance as defined in 130 CMR 520.016(B)(2).

(e) After the initial 90-day period or the extension is over, the MassHealth agency counts all assets that remain in the institutionalized spouse's name in determining his or her eligibility.

(4) Retroactive Eligibility. In determining the eligibility of the institutionalized spouse for the three-month retroactive period before application in a continuous period of institutionalization, the MassHealth agency deducts the amount defined in 130 CMR 520.016(B)(2) from the couple's total countable assets.

(5) Eligibility of the Community Spouse. The amount defined in 130 CMR 520.016(B)(2) must be counted in determining the community spouse's eligibility for MassHealth.

520.017: Right to Appeal the Asset Allowance or Minimum-Monthly-Maintenance-Needs Allowance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

520.018: Transfer of Resources Regardless of Date of Transfer

(A) The provisions of 42 U.S.C. 1396p apply to all transfers of resources. In the event that any portion of 130 CMR 520.018 and 520.019 conflicts with federal law, the federal law supersedes.

(B) The MassHealth agency denies payment for nursing-facility services to an otherwise eligible nursing-facility resident as defined in 130 CMR 515.001: *Definition of Terms* who transfers or whose spouse transfers countable resources for less than fair-market value during or after the period of time referred to as the look-back period.

(C) The denial of payment for nursing-facility services does not affect the individual's eligibility for other MassHealth benefits.

(D) Circumstances giving rise to disqualifying transfers of resources are also described at 130 CMR 520.007(J).

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

(A) Payment of Nursing-Facility Services. The MassHealth agency applies the provisions of 130 CMR 520.018 and 520.019 to nursing-facility residents as defined at 130 CMR 515.001: *Definition of Terms* requesting MassHealth agency payment for nursing-facility services provided in a nursing facility or in any institution for a level of care equivalent to that received in a nursing facility or for home- and community-based services provided in accordance with 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*.

(B) Look-Back Period. Transfers of resources are subject to a look-back period, beginning on the first date the individual is both a nursing-facility resident and has applied for or is receiving MassHealth Standard.

(1) For transfers occurring before February 8, 2006, this period generally extends back in time for 36 months.

(2) For transfers of resources occurring on or after February 8, 2006, the period generally extends back in time for 60 months. The 60-month look-back period will begin to be phased in on February 8, 2009. Beginning on March 8, 2009, applicants will be asked to provide verifications of their assets for the 37 months prior to the application. As each month passes, the look-back period will increase by one month until the full 60 months is reached on February 8, 2011.

(3) For transfers of resources from or into trusts, the look-back period is described in 130 CMR 520.023(A).

(C) Disqualifying Transfer of Resources. The MassHealth agency considers any transfer during the appropriate look-back period by the nursing-facility resident or spouse of a resource, or interest in a resource, owned by or available to the nursing-facility resident or the spouse (including the home or former home of the nursing-facility resident or the spouse) for less than fair-market value a disqualifying transfer unless listed as permissible in 130 CMR 520.019(D), identified in 130 CMR 520.019(F), or exempted in 130 CMR 520.019(J). The MassHealth agency may consider as a disqualifying transfer any action taken to avoid receiving a resource to which the nursing-facility resident or spouse is or would be entitled if such action had not been taken. Action taken to avoid receiving a resource may include, but is not limited to, waiving the right to receive a resource, not accepting a resource, agreeing to the diversion of a resource, or failure to take legal action to obtain a resource. In determining whether or not failure to take legal action to receive a resource is reasonably considered a transfer by the individual, the MassHealth agency considers the specific circumstances involved. A disqualifying transfer may include any action taken that would result in making a formerly available asset no longer available.

(D) Permissible Transfers. The MassHealth agency considers the following transfers permissible. Transfers of resources made for the sole benefit of a particular person must be in accordance with federal law.

(1) The resources were transferred to the spouse of the nursing-facility resident or to another for the sole benefit of the spouse. A nursing-facility resident who has been determined eligible for MassHealth agency payment of nursing-facility services and who has received an asset assessment from the MassHealth agency must make any necessary transfers within 90 days after the date of the notice of approval for MassHealth in accordance with 130 CMR 520.016(B)(3).

(2) The resources were transferred from the spouse of the nursing-facility resident to another for the sole benefit of the spouse.

(3) The resources were transferred to the nursing-facility resident's permanently and totally disabled or blind child or to a trust, a pooled trust, or a special-needs trust created for the sole benefit of such child.

(4) The resources were transferred to a trust, a special-needs trust, or a pooled trust created for the sole benefit of a permanently and totally disabled person who was younger than 65 years old at the time the trust was created or funded.

(5) The resources were transferred to a pooled trust created for the sole benefit of the permanently and totally disabled nursing-facility resident.

(6) The nursing-facility resident transferred the home he or she used as the principal residence at the time of transfer and the title to the home to one of the following persons:

(a) the spouse;

(b) the nursing-facility resident's child who is younger than 21 years old, or who is blind or permanently and totally disabled;

(c) the nursing-facility resident's sibling who has a legal interest in the nursing-facility resident's home and was living in the nursing-facility resident's home for at least one year immediately before the date of the nursing-facility resident's admission to the nursing facility; or

(d) the nursing-facility resident's child (other than the child described in 130 CMR 520.019(D)(6)(b)) who was living in the nursing-facility resident's home for at least two years immediately before the date of the nursing-facility resident's admission to the institution, and who, as determined by the MassHealth agency, provided care to the nursing-facility resident that permitted him or her to live at home rather than in a nursing facility.

(7) The resources were transferred to a separately identifiable burial account, burial arrangement, or a similar device for the nursing-facility resident or the spouse in accordance with 130 CMR 520.008(F).

(E) Repayment of Financial and Medical Assistance. A nursing-facility resident who has received or will be receiving payment from a third party as a result of an accident, injury, or other loss must first repay the MassHealth agency for medical assistance under M.G.L. c. 118E, § 22 and 42 U.S.C. 1396a(a)(25)(A) and (B) and the Department of Transitional Assistance for financial assistance under M.G.L. c. 18, § 5G, before the MassHealth agency will consider whether a transfer of such third-party payments may be permissible under 130 CMR 520.019(D), (F), or (J).

(F) Determination of Intent. In addition to the permissible transfers described in 130 CMR 520.019(D), the MassHealth agency will not impose a period of ineligibility for transferring resources at less than fair-market value if the nursing-facility resident or the spouse demonstrates to the MassHealth agency's satisfaction that

(1) the resources were transferred exclusively for a purpose other than to qualify for MassHealth; or

(2) the nursing-facility resident or spouse intended to dispose of the resource at either fair-market value or for other valuable consideration. Valuable consideration is a tangible benefit equal to at least the fair-market value of the transferred resource.

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) the date that the countable trust resources are transferred to someone other than the nursing-facility resident or spouse; or

(b) the latest of the following:

(i) the date that payment to the nursing-facility resident or the spouse was foreclosed under the terms of the trust;

(ii) the date that the trust was established; or

(iii) the date that any resource was placed in the trust.

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

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

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

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

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

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

(K) Exempting Transfers from the Period of Ineligibility.

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

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

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

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

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

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

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

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

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

(ii) If the nursing-facility resident provides proof later than the 60th day after the date of the notice of a period of ineligibility that the transfer has been fully or partially cured, the nursing-facility resident must reapply. The MassHealth agency recalculates the period of ineligibility based on the amount of the transfer remaining after the cure, beginning with the date of transfer or, for cures of transfers occurring on or after February 8, 2006, the later of the date of transfer or the date on which the individual would have otherwise been eligible.

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

(1) The MassHealth agency may waive a period of ineligibility due to a disqualifying transfer of resources if ineligibility would cause the nursing-facility resident undue hardship. The MassHealth agency may waive the entire period of ineligibility or only a portion when all of the following circumstances exist.

(a) The denial of MassHealth would deprive the nursing-facility resident of medical care such that his or her health or life would be endangered, or the nursing-facility resident would be deprived of food, shelter, clothing, or other necessities such that he or she would be at risk of serious deprivation.

(b) Documentary evidence has been provided that demonstrates to the satisfaction of the MassHealth agency that all appropriate attempts to retrieve the transferred resource have been exhausted and that the resource or other adequate compensation cannot be obtained to provide payment, in whole or part, to the nursing-facility resident or the nursing facility.

(c) The institution has notified the nursing-facility resident of its intent to initiate a discharge of the resident because the resident has not paid for his or her institutionalization.

(d) There is no less costly noninstitutional alternative available to meet the nursing-facility resident's needs.

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

(3) Where the MassHealth agency has issued a notice of the period of ineligibility due to a disqualifying transfer of resources, the nursing-facility resident may request a hardship waiver. For transfers occurring on or after February 8, 2006, nursing facilities may apply for a hardship waiver on behalf of a resident, with the consent of the nursing-facility resident or the resident's authorized representative.

(4) If the nursing-facility resident feels the imposition of a period of ineligibility would result in undue hardship, the nursing-facility resident must submit a written request for consideration of undue hardship and any supporting documentation to the MassHealth Enrollment Center listed on the notice of the period of ineligibility within 15 days after the date on the notice. Within 30 days after the date of the nursing-facility resident's request, the MassHealth agency will inform the nursing-facility resident in writing of the undue-hardship decision and of the right to a fair hearing. The MassHealth agency will extend this 30-day period if the MassHealth agency requests additional documentation or if extenuating circumstances as determined by the MassHealth agency require additional time.

(5) The nursing-facility resident may appeal the MassHealth agency's undue-hardship decision and the imposition of a period of ineligibility by submitting a request for a fair hearing to the Office of Medicaid Board of Hearings within 30 days after the nursing-facility resident's receipt of the MassHealth agency's written undue-hardship notice, in accordance with 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(6) The nursing-facility resident's request for consideration of undue hardship does not limit his or her right to request a fair hearing for reasons other than undue hardship.

(M) Fraudulent Transfer or Sale. If a nursing-facility resident whose estate would be subject to a claim under 130 CMR 515.011: *Estate Recovery* transfers or sells any property including a home or an interest in the property for less than fair-market value, the MassHealth agency may consider the transfer or sale that does not meet the conditions of 130 CMR 520.019(D)(6) to be fraudulent under the Uniform Fraudulent Conveyance Act (M.G.L. c. 109(A)) and take appropriate legal action to set aside the transfer or sale.

(N) No Double Penalty. In the event that application of the transfer rules and the trust rules in 130 CMR 520.000 results in a nursing-facility resident being subject to a transfer penalty twice for actions involving the same resource, the trust rules will supersede the transfer rules in the determination of eligibility.

(130 CMR 520.020 Reserved)

520.021: Treatment of Trusts

130 CMR 520.021 through 520.024 explains how to treat the principal of and payments from a revocable or irrevocable trust established by the individual or by the spouse. 130 CMR 520.024(A) also includes trusts established by other than the individual or spouse and trusts whether or not established by will. In the event that a portion of 130 CMR 520.021 through 520.024 conflicts with federal law, the federal law supersedes.

520.022: Trusts or Similar Legal Devices Created before August 11, 1993

(A) Revocable Trust. The assets and income of an individual or spouse in a revocable trust are countable. The fair-market value of the home or former home of the nursing-facility resident or spouse in a revocable trust is a countable asset. Where the home or former home is an asset of the trust, the home or former home is not subject to the exemptions of 130 CMR 520.007(G)(2) or 520.007(G)(8).

(B) Medicaid Qualifying Trust.

(1) A Medicaid qualifying trust is a revocable or irrevocable trust or similar legal device, created or funded by the individual or spouse, other than by a will, under which

(a) the individual is a beneficiary of all or part of the discretionary or required payments or distributions from the trust; and

(b) a trustee or trustees are permitted to exercise any discretion to make payments or distributions to the individual.

(2) The maximum amount of payments or fair-market value of property that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the individual is countable in the determination of eligibility.

(3) The fair-market value of the home or former home of the nursing-facility resident in a Medicaid qualifying trust is a countable asset and is not subject to the exemptions described at 130 CMR 520.007(G)(2) or 520.007(G)(8).

(C) Certain Trusts Created before April 7, 1986. A trust created before April 7, 1986, solely for the benefit of a resident in an intermediate-care facility for the mentally retarded (ICF/MR) is not considered a Medicaid qualifying trust.

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

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

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

(1) Look-Back Period.

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

(b) The look-back period is 60 months

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

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

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

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

(B) Revocable Trusts.

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

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

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

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

(C) Irrevocable Trusts.

(1) Portion Payable.

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

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

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

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

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

(D) Exemptions to the Trust Rules.

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

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

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

520.024: General Trust Rules

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

(A) Irrevocable Trust.

(1) The assets and income held in an irrevocable trust established by the individual or spouse that the trustee is required to distribute to or for the benefit of the individual are countable.

(2) Payments from the income or principal of an irrevocable trust established by the individual or spouse to or for the benefit of the individual are countable.

(3) The assets and income held in an irrevocable trust established by other than the individual or spouse that the trustee is required to distribute to the individual are countable.

(4) Payments from the income or the principal of an irrevocable trust established by other than the individual or spouse to the individual are countable.

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

(C) Home in Trust: Cure.

(1) If the MassHealth agency has denied or terminated MassHealth because the home or former home in trust is considered an excess asset, the MassHealth agency will rescind that action if the home or former home has been removed from the trust and returned to the nursing-facility resident in accordance with the full cure rules at 130 CMR 520.019(K).

(2) When the home or former home is removed from a trust, as determined by the MassHealth agency, the MassHealth agency will redetermine eligibility using the rules at 130 CMR 520.007(G)(8) and the full cure rules at 130 CMR 520.019(K).

(3) When the home or former home has been removed from the trust, the MassHealth agency may place a lien in accordance with 130 CMR 515.012: *Real Estate Liens*.

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

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

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

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

520.025: Long-Term-Care Income Standard

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

520.026: Long-Term-Care General Income Deductions

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

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

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

(1) The MassHealth agency determines the MMMNA by adding the following amounts:
(a) $1,822 (the federal standard maintenance allowance); and
(b) an excess shelter allowance determined by calculating the difference between the standard shelter expense of $547 and the shelter expenses for the community spouse's principal residence, including
(i) the actual expenses for rent, mortgage (including interest and principal), property taxes and insurance, and any required maintenance charge for a condominium or cooperative; and
(ii) the applicable standard deduction under the Supplemental Nutrition Assistance Program for utility expenses. If heat is included in the rent or condominium fee, this amount is $375. If heat is not included in the rent or condominium fee, this amount is $611.

(2) The maximum-monthly-maintenance-needs allowance is $2,739.00 per month, unless it has been increased as the result of a fair-hearing decision based on exceptional circumstances in accordance with 130 CMR 520.017(D).

(3) If the institutionalized individual is subject to a court order for the support of the community spouse, the court-ordered amount of support must be used as the spousal-maintenance-needs deduction when it exceeds the spousal-maintenance-needs deduction calculated according to 130 CMR 520.026(B) or resulting from a fair hearing.

(C) Deductions for Family-Maintenance Needs.

(1) The MassHealth agency allows a deduction from the income of a long-term-care resident to provide for the maintenance needs of the following family members if they live with the community spouse:
(a) a minor child — a child younger than 21 years old of either member of the couple;
(b) a dependent child — a child 21 years of age and older who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code;
(c) a dependent parent — a parent of either spouse who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code; and
(d) a dependent sibling — a brother or sister of either spouse (including a half-brother or half-sister) who lives with the community spouse and who is claimed as a dependent by either spouse for income-tax purposes under the Internal Revenue Code.

(2) The deduction for family-maintenance needs is one-third of the amount by which the federal standard maintenance allowance exceeds the monthly gross income of the family member. The federal standard maintenance allowance is $1,822.

(D) Deductions for Maintenance of a Former Home.

(1) The MassHealth agency allows a deduction for maintenance of a home when a competent medical authority certifies in writing that a single individual, with no eligible dependents in the home, is likely to return home within six months after the month of admission. This income deduction terminates at the end of the sixth month after the month of admission regardless of the prognosis to return home at that time.

(2) The amount deducted is the 100 percent federal-poverty-level income standard for one person.

(E) Deductions for Health-Care Coverage and Other Incurred Expenses.

(1) Health-Insurance Premiums or Membership Costs. The MassHealth agency allows a deduction for current health-insurance premiums or membership costs when payments are made directly to an insurer or a managed-care organization.

(2) Incurred Expenses.

(a) After the applicant is approved for MassHealth, the MassHealth agency will allow deductions for the applicant's necessary medical and remedial-care expenses. These expenses must not be payable by a third party. These expenses must be for medical or remedial-care services recognized under state law but not covered by MassHealth.

(b) These expenses must be within reasonable limits as established by the MassHealth agency. The MassHealth agency considers expenses to be within reasonable limits provided they are

(i) not covered by the MassHealth per diem rate paid to the long-term-care facility; and

(ii) certified by a treating physician or other medical provider as being medically necessary.

(3) Guardianship Fees and Related Expenses. The MassHealth agency allows deductions from a member's income for guardianship fees and related expenses when a guardian is essential to enable an incompetent applicant or member to gain access to or consent to medical treatment, as provided below.

(a) Expenses Related to the Appointment of a Guardian.

(i) The MassHealth agency allows a deduction for fees and expenses related to the appointment of a guardian if the guardian's appointment is made for the purpose of

a. assisting an incompetent applicant to gain access to medical treatment through MassHealth; or

b. consenting to medical treatment on behalf of a MassHealth member.

(ii) The MassHealth agency allows a deduction for reasonable costs, including attorney fees, as approved by the probate court, not to exceed $500 for the appointment, except as provided in 130 CMR 520.026(E)(3)(a)(iii).
(iii) The MassHealth agency may allow a deduction, as approved by the probate court, of up to $750 for the appointment when the medical issues before the court are more complex. An example of such complexities includes providing evidence of the need for anti-psychotic medications.
(iv) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(b) Guardianship Services Related to the Application Process.
(i) The MassHealth agency allows a deduction for fees for guardianship services related to the MassHealth application process when the guardian has been appointed by the probate court to assist an incompetent person with the MassHealth application when the securing of MassHealth benefits is essential for the member to gain access to medical treatment.
(ii) The MassHealth agency allows a deduction for reasonable costs related to the MassHealth application process, as approved by the probate court, not to exceed $500. In cases where an administrative hearing is held, the total deduction may not exceed $750 for the costs related to the application process and hearing.
(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(c) Guardianship Services Related to the Redetermination Process.
(i) The MassHealth agency allows a deduction for fees for guardianship services related to the MassHealth redetermination process when the guardian has been appointed by the probate court to assist an incompetent person with securing continued access to medical treatment.
(ii) The MassHealth agency allows a deduction for reasonable costs related to the MassHealth redetermination process, as approved by the probate court, not to exceed $250. In cases where an administrative hearing is held, the total deduction may not exceed $375 for the costs related to the redetermination process and hearing.
(iii) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

(d) Monthly Guardianship Services.
(i) The MassHealth agency allows a deduction for monthly fees for a guardian to the extent the guardian's services are essential to consent to medical treatment on behalf of the member.
(ii) The MassHealth agency allows a deduction, as approved by the probate court, for up to 24 hours per year at a maximum of $50 per hour for guardianship services.

(iii) The MassHealth agency allows the deduction only if the guardianship services provided include the attendance and participation of the guardian in quarterly care meetings held by the nursing facility where the member lives.

(iv) The MassHealth agency allows this deduction only if each year the guardian submits to the MassHealth agency a copy of the affidavit that describes the guardianship services provided to the member.

(v) The deduction is made from the member's monthly patient-paid amount over a 12-month period.

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

(i) The MassHealth agency allows a deduction up to, but not exceeding, the member's monthly patient-paid amount for filing and court fees incurred by the guardian in connection with monthly guardianship services that are essential to consent to medical treatment for the member.

(ii) If monthly guardianship services are provided, these expenses are included in the affidavit of services required under 130 CMR 520.026(E)(3)(d)(iv).

(iii) The deduction is made from the member's monthly patient-paid amount in the month following receipt of the affidavit of services.

(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 Office of Medicaid 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

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

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

(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: *The One-Time Deductible* or 520.032 to meet a deductible;

(v) expenses, fees, or costs for expenses that are not essential to obtain medical treatment for the ward including financial management, except when the management is necessary to accurately complete a MassHealth application or redetermination form;

(vi) expenses, fees, or costs for transportation or travel time.

(vii) attorney fees, except when payment of the fees is required for the appointment of the guardian; and

(viii) fees for guardianship services provided by a parent, spouse, sibling, or child, even if appointed by the probate court. However, the MassHealth agency allows a deduction for guardianship expenses in accordance with 130 CMR 520.026(E)(3)(a) and (e).

520.027: Long-Term-Care Deductible

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

520.028: Eligibility for a Deductible

The following individuals may establish eligibility by meeting a deductible:

(A) former SSI recipients who are not eligible under the Pickle Amendment;

(B) community-based individuals whose countable-income amount exceeds the 100 percent federal poverty level income standards;

(C) long-term-care-facility residents whose income, after general deductions described in 130 CMR 520.026, exceeds the public rate in a long-term-care facility;

(D) disabled adult children whose incomes exceed the standards set forth in 130 CMR 519.004(A): *Eligibility Requirements*; and

(E) persons who are eligible for an increased disregard as described at 130 CMR 520.013(B).

520.029: The Deductible Period

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

520.030: Calculating the Deductible

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

MASSHEALTH DEDUCTIBLE-INCOME STANDARDS

Number of Persons	Monthly-Income Standard for Community Residents	Monthly-Income Standard for Long-Term-Care-Facility Residents
1	$522	
2	650	$72.80

520.031: Notification of Potential Eligibility

(A) The MassHealth agency informs the applicant who has excess monthly income that he or she is currently ineligible for MassHealth Standard, Family Assistance, or Limited but may establish eligibility for a six-month period by meeting the deductible. The MassHealth agency 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 agency payment.

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

520.032: Submission of Bills to Meet the Deductible

(A) Criteria. To establish eligibility by meeting a deductible, the individual 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 Health Safety Net.
(2) The bill must be for an allowable medical or remedial-care expense in accordance with 130 CMR 520.032(B). A remedial-care expense is a nonmedical support service made necessary by the medical condition of the individual or the spouse.
(3) The bill must be unpaid and a current liability or, if paid, paid during the current six-month deductible period.
(4) Any bill or portion of a bill used to meet a deductible may not be applied to any other deductible period. However, any portion of a bill not used to meet the current deductible may be used in a future deductible period. The MassHealth agency will not pay any bills or portions of bills that are used to meet the deductible. These bills remain the responsibility of the applicant.

(B) Expenses Used to Meet the Deductible. The MassHealth agency applies bills to meet the deductible in the following order:

(1) Medicare and other health-insurance premiums credited prospectively for the cost of six months' coverage, deductibles, enrollment fees, or coinsurance charges incurred by the individual and the spouse including copayments imposed under 130 CMR 520.036;

(2) expenses incurred by the individual and the spouse for necessary medical and remedial-care services that are recognized under state law but are not covered by MassHealth, including guardianship fees and related expenses as described in and allowed under 130 CMR 520.026(E)(3); and

(3) expenses incurred by the individual, a family member, or financially responsible relative for necessary medical and remedial-care services that are covered by MassHealth.

(C) Expenses That Cannot Be Used to Meet the Deductible. 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.

520.033: Verification of Medical Expenses

(A) 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. Any unpaid bill incurred before the deductible period must be verified by a bill dated within the six-month deductible period.

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

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

520.034: Interim Changes

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

520.035: Conclusion of the Deductible Process

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

520.036: Copayments Required by the MassHealth Agency

The MassHealth agency requires its members to make the copayments described in 130 CMR 520.038, up to the 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, provided that this amount shall be no greater than the MassHealth payment minus one cent.

520.037: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.

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

(a) members younger than 21 years old;

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

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, or MassHealth Family Assistance;
(h) members who are former foster care individuals and who are eligible for MassHealth Standard until they reach the age of 21 or the age of 26, as specified in 130 CMR 505.002(H):*Eligibility Requirements for Former Foster-Care Individuals*; and
(i) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization or an urban Indian organization, or through referral, in accordance with federal law.

(2) Members who have accumulated copayment charges totaling the maximum of $250 per calendar year do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who have accumulated copayment charges totaling the maximum of $36 per calendar year on nonpharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.
(4) Members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's countable income as described at 130 CMR 520.000 in a given calendar quarter do not have to pay further MassHealth copayments during the quarter in which the member reached the five percent cap.
(5) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.
(6) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 520.038:
(1) family-planning services and supplies such as oral contraceptives, contraceptive devices such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) nonpharmacy behavioral-health services;
(3) emergency services;
(4) provider-preventable services as defined in 42 CFR 447.26(b).

520.038: Services Subject to Copayments

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

(A) Pharmacy Services. The copayment for pharmacy services is
(1) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by MassHealth in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and
(2) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by MassHealth.

(B) Nonpharmacy Services. The copayment for nonpharmacy services is $3 for an acute inpatient hospital stay.

520.039: Members Unable to Pay Copayment

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

520.040: Maximum Cost Sharing

Members are responsible for the MassHealth copayments described in 130 CMR 520.038, up to the following maximums:

(A) $250 for pharmacy services per calendar year;

(B) $36 for nonpharmacy services per calendar year; and

(C) five percent of household income per calendar quarter, including both copayments and any applicable premium payments.

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522.001: Massachusetts Insurance Connection for Individuals with AIDS or HIV-Related Diseases

(A) Introduction. The Massachusetts Insurance Connection (MIC) is a health insurance buy-in program administered by the MassHealth agency for individuals with Acquired Immune Deficiency Syndrome (AIDS) or diseases related to the human immunodeficiency virus (HIV). Individuals who have existing health insurance policies through group or private plans may be eligible to participate in the program, provided their insurance coverage is both comprehensive and cost effective.

(B) Eligibility Requirements. The MassHealth agency pays the monthly health insurance premiums of an applicant (and his or her spouse and dependent children if they are already covered under the existing policy) provided that the applicant

(1) has a health insurance policy (group or private) before becoming eligible for this program (individuals who elect to continue employer-based group health insurance are subject to the provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272) that

(a) has comprehensive coverage, as determined by the MassHealth agency on an individual basis; and

(b) requires premium payments that do not exceed the average monthly cost incurred by the MassHealth agency for the care of an individual with AIDS or HIV-related diseases;

(2) has a diagnosis of AIDS or HIV-related diseases;

(3) applies for and meets the Social Security Administration's definition of disability for AIDS or HIV-related diseases;

(4) is a resident of Massachusetts;

(5) in conjunction with his or her spouse and dependent children, has a gross annual income that does not exceed 300 percent of the annualized federal poverty level income standard for a household of that size; and

(6) is not eligible for a MassHealth coverage type that provides or pays for comprehensive benefits.

(C) Verifications. Applicants must submit the following verifications to the MIC program coordinator within 45 days of the receipt of the application by the MassHealth agency:

(1) a written statement of a diagnosis of AIDS or HIV-related diseases by the examining licensed physician;

(2) documentation of receipt of social security disability benefits or SSI; and

(3) documentation of gross annual income.

(D) Presumptive Eligibility for the MIC Program.

(1) An applicant is presumptively eligible for premium payments through the MIC program on the basis of preliminary information if

(a) he or she has a diagnosis of AIDS or HIV-related diseases; and

(b) he or she appears to meet the applicable eligibility requirements listed in 130 CMR 522.001(B).

(2) If the SSA determines that the applicant is not eligible for either disability benefits or SSI, the applicant automatically becomes ineligible for program participation and the MassHealth agency will discontinue premium payments.

(3) Premium payments made by the MassHealth agency on behalf of an applicant who is presumptively eligible are subject to recovery if the applicant is subsequently determined to be ineligible.

(E) Redetermination of Eligibility. The MassHealth agency completes a redetermination of eligibility for each program participant on an annual basis, or as needed.

(F) Termination of Benefits.

(1) When any one of the conditions in 130 CMR 522.001(B) no longer apply, the termination of premium payments is effective on the date the next premium payment is due. However, the following exceptions apply:

(a) in the event of the death of a qualified individual who has coverage under a family plan, payment for the continuation of the existing plan will not exceed a period of three months following his or her death; and

(b) if a qualified individual relocates to another state, he or she will be afforded one additional premium payment after relocation to cover the transition period.

(2) The MassHealth agency sends written notice to program participants of the termination of premium payments, the reason for the termination, and the individual's right to appeal such termination in accordance with the provisions of 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

522.002: Refugee Resettlement Program

(A) Regulatory Authority. The Refugee Resettlement Program (RRP) is regulated pursuant to Chapter 2 of Title IV of the Immigration and Nationality Act (INA), 8 U.S.C. 1521 et seq.

(B) Overview.

(1) The RRP was established by the Refugee Act of 1980. The Act authorizes funds for the administration and implementation of social and educational services and employment training and placement, as well as cash assistance and medical assistance to refugees without regard to race, religion, nationality, sex, or political opinion. It is the intent of the Act to promote the resettlement and economic self-sufficiency of refugees within the shortest time frame possible.

(2) The Massachusetts Office for Refugees and Immigrants (MORI) is the state agency responsible for the delivery of services to refugees under the Refugee Resettlement Program. The MassHealth agency has been contracted to provide medical benefits to refugees whom MORI has determined meet the requirements of 130 CMR 522.002.

(C) Eligibility Requirements. Individuals must submit an application for MassHealth and meet the following requirements:

(1) have valid documentation of refugee status from INS;
(2) be a resident of Massachusetts;
(3) have modified adjusted gross income of the MassHealth MAGI household that is less than 200 percent of the federal poverty level (FPL) standards or meet a deductible in accordance with 130 CMR 520.028: *Eligibility for a Deductible* through 520.035: *Conclusion of the Deductible Process*; and
(4) be ineligible for MassHealth Standard, CommonHealth, CarePlus, and Family Assistance.

(D) Period of Eligibility.

(1) Eight-Month Eligibility Period. A refugee who meets the requirements of the RRP is eligible to receive MassHealth Standard or CarePlus for an eight-month period beginning with the date of entry into the United States.
(2) End of Eight-Month Eligibility Period. A refugee who has been in the country for eight months is no longer eligible for MassHealth under the refugee resettlement program. Such refugee will be notified in advance of termination.
(3) Extended MassHealth Eligibility. A refugee who becomes ineligible for MassHealth solely by reason of increased earnings from employment or increased hours of employment will have coverage extended for four months provided the total period of eligibility does not exceed eight months.

(E) Continuation of Benefits. Individuals who were receiving MassHealth Standard benefits through the RRP as of December 31, 2013, will continue to receive these benefits through the RRP until the end of the eight-month period from the date on which they began receiving benefits, unless MassHealth determines such individuals eligible for MassHealth Standard, CommonHealth, CarePlus, or Family Assistance prior to the end of the eight-month period.

522.003: Adoption Assistance and Foster Care Maintenance

Any child placed in subsidized adoption or foster care under Title IV-E of the Social Security Act is automatically eligible for medical assistance provided by the state where the child resides.

(A) Children receiving state-subsidized adoption payments from a state that is a member of the Interstate Compact on Adoption and Medical Assistance (ICAMA) will be eligible for medical assistance provided by the state where the child resides if that state is a member of ICAMA.

(B) Children receiving state-subsidized adoption payments from a state that is not a member of ICAMA, or any child receiving state-subsidized foster-care payments will only be eligible for medical assistance provided by his or her state of origin.

522.004: Children's Medical Security Plan (CMSP)

(A) Regulatory Authority. The Children's Medical Security Plan (CMSP) is administered pursuant to M.G.L. c. 118E, §10F.

(B) Overview. CMSP provides coverage to uninsured children younger than 19 years old who do not qualify for any other MassHealth coverage type, other than MassHealth Limited, and who do not have physician and hospital health-care coverage. To apply for these benefits, an applicant must submit an application as described in 130 CMR 502.001: *Application for Benefits* and 502.002: *Reactivating the Application*.

(C) Eligibility Requirements. Children are eligible for CMSP if they are
(1) a resident of Massachusetts, as defined in 130 CMR 503.002: *Residence Requirements*;
(2) younger than 19 years old;
(3) not otherwise eligible for any other MassHealth coverage type, other than MassHealth Limited. Children who are otherwise eligible and who are not receiving MassHealth coverage as a result of not complying with administrative requirements of MassHealth are not eligible for CMSP. Children who lose eligibility for MassHealth Family Assistance as a result of nonpayment of premiums or as a result of not enrolling in employer-sponsored health insurance through Premium Assistance are not eligible for CMSP; and
(4) uninsured. An applicant or member is uninsured if he or she
(a) does not have insurance that provides physician and hospital health-care coverage;
(b) has insurance that is in an exclusion period; or
(c) had insurance that has expired or has been terminated.

(D) Premiums. The premium schedule and payment policies for CMSP are described in 130 CMR 506.011: *MassHealth and the Children's Medical Security Plan (CMSP) Premiums*.

(E) Copayments. Members are required to pay copayments for certain covered services. There are no required copayments for preventive and diagnostic services. No member will be exempt from copayment requirements.

(1) The copayments for prescription drugs are
  (a) $3 for each generic drug prescription; and
  (b) $4 for each brand-name drug prescription.

(2) The copayments for dental services are
  (a) $2 for members with modified adjusted gross income of the MassHealth MAGI household equal to or below 199.9% of the federal poverty level (FPL);
  (b) $4 for members with modified adjusted gross income of the MassHealth MAGI household between 200.0% to 400.0% FPL; and
  (c) $6 for members with modified adjusted gross income of the MassHealth MAGI household equal to or greater than 400.1% FPL.

(3) The copayments for medical (nonpreventive visits) and mental health services are
  (a) $2 for members with modified adjusted gross income of the MassHealth MAGI household equal to or below 199.9% FPL;
  (b) $5 for members with modified adjusted gross income of the MassHealth MAGI household between 200.0% to 400.0% FPL; and
  (c) $8 for members with modified adjusted gross income of the MassHealth MAGI household equal to or greater than 400.1% FPL.

(F) Medical Coverage Date. Except as provided at 130 CMR 522.004(H), coverage begins on the date of the final eligibility determination. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005: *Time Standards for an Eligibility Determination* and 502.007: *Eligibility Review*.

(G) Benefits Provided. Benefits provided are described at M.G.L. c. 118E, §10F. Included benefits are

(1) preventive pediatric care;
(2) sick visits;
(3) office visits, first-aid treatment, and follow-up care;
(4) provision of smoking prevention educational information and materials to the parent, guardian, or the person with whom the enrollee resides, as distributed by the Department of Public Health;
(5) prescription drugs up to $200 per state fiscal year;
(6) urgent care visits, not including emergency care in a hospital outpatient or emergency department;
(7) outpatient surgery and anesthesia that is medically necessary for the treatment of inguinal hernia and ear tubes;
(8) annual and medically necessary eye exams;

(9) medically necessary mental-health outpatient services, including substance-abuse treatment services, not to exceed 20 visits per fiscal year;
(10) durable medical equipment, up to $200 per state fiscal year, with an additional $300 per state fiscal year for equipment and supplies related to asthma, diabetes, and seizure disorders only;
(11) dental health services, up to $750 per state fiscal year, including preventive dental care, provided that no funds will be expended for cosmetic or surgical dentistry;
(12) auditory screening;
(13) laboratory diagnostic services; and
(14) radiologic diagnostic services.

(H) Enrollment Cap. The MassHealth agency may limit the number of children who can be enrolled in CMSP. When the MassHealth agency imposes such a limit, applicants will be placed on a waiting list when their eligibility has been determined. When the MassHealth agency is able to open enrollment for CMSP, the MassHealth agency will process the applications in the order they were placed on the waiting list.

(130 CMR 522.005 Reserved)