

MassHealth Advocacy Guide

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MassHealth Advocacy Guide

About MLRI

The Massachusetts Law Reform Institute is a statewide legal advocacy and support center. Our mission is to represent low-income people, disabled people and elders in their struggle for basic human needs, to defend against policies and actions that harm and marginalize people living in poverty, and to advocate for systemic reforms that achieve social and economic justice. Our activities include advice, litigation, policy analysis, research, technical assistance and public information.

Acknowledgments

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This Guide was written by Victoria Pulos of Massachusetts Law Reform Institute.

Note on scope of Guide: A detailed description of the financial eligibility rules for nursing facility care is beyond the scope of this Guide. For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

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Part 1

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1 What is MassHealth?

“MassHealth” is the name of the health coverage programs administered by a state agency called the Executive Office of Health and Human Services Office of Medicaid to benefit certain groups of low- and moderate-income people.

MassHealth includes the federal-state Medicaid program under Title XIX of the Social Security Act and the State Children’s Health Insurance program under Title XXI of the Social Security Act, as well as programs created and funded entirely by Massachusetts with no federal assistance.

MassHealth provides comprehensive health coverage to financially needy people who fit into an eligibility group such as families with children, the disabled, and the elderly. Most people eligible for MassHealth get a plastic MassHealth card that enables them to get health care services from participating providers at little or no cost. The federal government pays half the costs of Medicaid expenditures in Massachusetts, and state government pays for most of the remaining costs.

MassHealth provides health coverage to over one million people representing over 15 percent of Massachusetts residents. While the number of seniors on MassHealth has remained stable over the years, enrollment of people under 65 has steadily grown. Most of this growth is attributable to the 1997 implementation of a comprehensive Medicaid demonstration project under Section 1115 of the Social Security Act referred to in this Guide as Medicaid reform.

In 2006 Massachusetts enacted a wide-ranging health reform law, Chapter 58 of the Acts of 2006, designed to increase health insurance coverage for almost all state residents. Key components of the plan include expanding MassHealth coverage to uninsured children from 200 percent to 300 percent of poverty, and creating a new program called Commonwealth Care to assist uninsured adults under 300 percent of poverty to purchase insurance from participating plans. Starting in July 2007, an individual mandate requires all adults to be insured or face a state tax penalty. While questions remain about the affordability and sustainability of the health reform plan, the need for informed health advocates is greater than ever.

2 Medicaid reform in Massachusetts

Under Section 1115 of the Social Security Act, a state can apply for a comprehensive research and demonstration project in order to get certain federal rules waived that otherwise would apply to its Medicaid program, and to get federal Medicaid matching funds to expand coverage and services. The Massachusetts Medicaid program has been operating under a Section 1115 waiver since July 1, 1997.

The overall goals of the initial demonstration project in Massachusetts were to expand access to insurance to more people under age 65 while also controlling costs by streamlining the eligibility process, saving on the Uncompensated Care Pool (now called the Health Safety Net) and expanding the use of managed care. The waiver expands eligibility to higher income levels for existing eligible groups of children, parents, and people with disabilities, extends coverage to a new group of long-term unemployed adults and people who are HIV positive, and subsidizes premiums for certain workers and small employers.

The most recent renewal of the demonstration also provides funds for a new subsidized insurance program called Commonwealth Care that began on October 1, 2006 for adults not otherwise eligible for MassHealth. While funded under Title XIX, Commonwealth Care operates much differently than the MassHealth programs.

The demonstration generally does not affect people age 65 and older, people requiring long-term nursing home care, and certain other groups for whom eligibility is still governed by traditional Medicaid rules. One key difference is that traditional Medicaid considers asset ownership as well as income in determining financial eligibility, but Medicaid reform only considers income.

In addition to different rules about assets, Medicaid reform and traditional Medicaid have different rules about counting income, when benefits begin, the use of managed care, premium charges, and options available to people who exceed financial eligibility limits.

Under the terms of the most recent renewal of the demonstration, the MassHealth agency may apply to amend the waiver in order to impose enrollment caps in MassHealth Basic, Essential, and Family Assistance. The state also has statutory authority to cap enrollment in Commonwealth Care. Currently, there are no enrollment caps.

3 The 2006 health reform law and the individual mandate

The 2006 health reform law required all individuals age 18 or older to have “creditable” health insurance coverage if it is available at an “affordable” cost or incur state tax penalties. In 2008 and later years, the penalty is assessed based on one-half the lowest cost available coverage. A new entity called the Health Insurance Connector Authority was created to define minimum creditable coverage and affordability and hear appeals on hardship grounds from those assessed the penalty, and to create more affordabled insurance options through subsidized and unsubsidized plans. The new subsidized health insurance program is called Commonwealth Care, and is described in Part 10 of this Guide.

For purposes of the individual mandate, all comprehensive MassHealth programs and Commonwealth Care itself count as “creditable” coverage, but the Health Safety Net does not. The affordability schedule corresponds to the minimum premium schedule in Commonwealth Care for individuals with income under that program’s 300 percent of poverty upper limit. Individuals whose income does not exceed 150 percent of poverty can obtain Commonwealth Care with no minimum premium contribution and, accordingly, are not subject to individual mandate penalties if they remain uninsured. Higher-income individuals who were uninsured complete a series of tax worksheets to determine if insurance was affordable, and may appeal the assessment of a penalty on hardship grounds.

G.L. c. 111, § 2 (individual mandate); 956 C.M.R. § 5.00 (definition of creditable coverage); 956 C.M.R. § 6.00 (affordability and hardship standards; the annual affordability schedule is published separately); Dept. of Revenue, TIR-07-18 and 09-01 (tax penalties for Tax Year 2008 and proposed penalties for Tax Year 2009).

4 The main types of MassHealth coverage

There are several different kinds of MassHealth coverage. See Table 1 and Figure 1, below. Coverage types differ in their eligibility criteria, the scope of covered benefits, the premiums or other costs charged to beneficiaries, when

coverage begins, and whether beneficiaries must enroll in managed care in order to be eligible for coverage. People in traditional Medicaid receive coverage under MassHealth Standard or MassHealth Limited. People eligible under Medicaid reform may qualify under any one of five MassHealth coverage types or in Commonwealth Care.

In determining whether a person is eligible for MassHealth, the eligibility system tries to provide the MassHealth coverage type with the most comprehensive benefits for which the individual is eligible. Only individuals not eligible for MassHealth are considered for Commonwealth Care. The coverage types in the order in which eligibility is determined are:

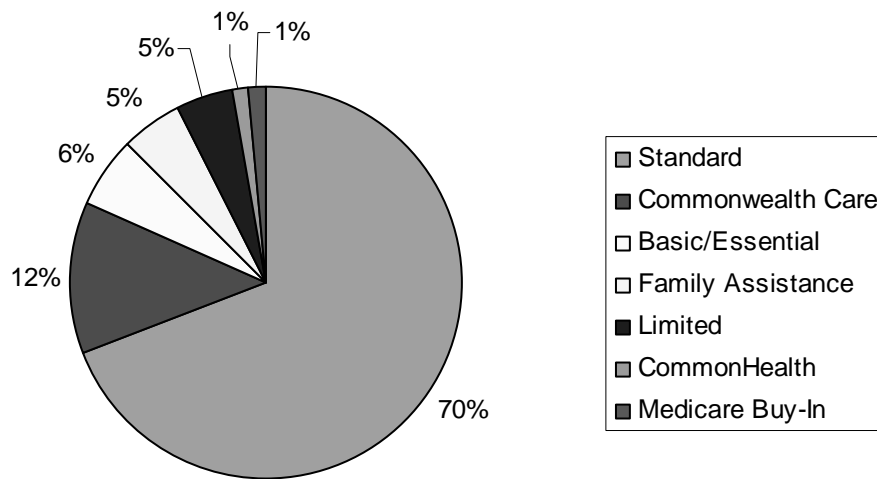
- First: MassHealth Standard
- Second: MassHealth CommonHealth
- Third: MassHealth Family Assistance
- Fourth: MassHealth Basic
- Fifth: MassHealth Essential
- Sixth: Commonwealth Care

The features of the five main MassHealth coverage types and of Commonwealth Care are summarized below. MassHealth also administers four other health coverage programs: MassHealth Limited (also known as emergency Medicaid); Medicare Savings Programs (help paying Medicare premiums and Medicare cost sharing); the Healthy Start Program (prenatal care for pregnant women); and the Children’s Medical Security Plan (primary and preventive care for children). In addition, the MassHealth agency makes eligibility determinations for the Health Safety Net (formerly called the Uncompensated Care Pool or Free Care) that is administered by the Division of Health Care Finance and Policy. These other programs are described in Part 15 (MassHealth Limited), Part 11 (Medicare Savings Programs), and Part 19 of this Guide.

Table 1: Numbers Enrolled on October 31, 2008

Coverage type	Number enrolled
Standard	908,094
Commonwealth Care	162,721
Basic/Essential	76,622
Family Assistance	63,804
Limited	61,873
CommonHealth	18,929
Medicare Buy-In	18,334
Total	1,310,377

Figure 1: Enrollment in Commonwealth Care & MassHealth



5

How MassHealth is administered

Federal law requires a “single state agency” to be responsible for Medicaid. In Massachusetts, that agency is the Executive Office of Health and Human Services (EOHHS).¹ Within EOHHS, the Office of Medicaid is responsible for much of the

¹ G.L. c. 118E, § 1; 42 C.F.R. § 431.10.

day-to-day administration of MassHealth. The Department of Elder Affairs and the Office of Long Term Care (both under EOHHS) oversee MassHealth services for the elderly and disabled. This Guide will generally refer to the state agency administering MassHealth as the MassHealth agency or the agency. The MassHealth agency has a central office in Boston and four regional MassHealth Enrollment Centers (MECs) in Revere, Taunton, Tewksbury, and Springfield.²

The demonstration authorized a new entity called the Health Insurance Connector Authority (the Connector) to administer the Commonwealth Care program. However, the Connector has arranged for the MassHealth agency to make initial eligibility determinations for Commonwealth Care. The organization and operation of the Connector is discussed in more detail in Part 10.

The MassHealth agency relies on its computer system to make most eligibility determinations. Applications are entered into the system at the central processing unit of the MassHealth agency in Boston. Incomplete applications and renewals are handled by one of the four regional MECs.

Clinical decisions about approving payment for specific services are made by the prior approval unit at the MassHealth agency central office in Boston, not at the MECs. For members in managed care, such decisions are made by the managed care organizations and the behavioral health and substance abuse vendor under contract with the MassHealth agency.

In addition, the MassHealth agency has contracts with many private and public entities to perform specific functions for it. For example, it has contracts with the University of Massachusetts Medical Center to do disability evaluations and drug utilization review. The agency contracts with a national for-profit company called Maximus for a variety of functions including: provider services, managed care enrollment assistance, and operation of the Customer Service Center.

The federal agency that oversees both the Medicaid and the State Children's Health Insurance components of MassHealth and Commonwealth Care is the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration. It has a regional office in Boston and central offices in Baltimore, and is part of the U.S. Department of Health and Human Services.

² Part 20 of this Guide lists the address and telephone number for the offices described here.

6 **How to obtain MassHealth or Commonwealth Care**

There are four main ways to apply for MassHealth or Commonwealth Care: by mail; in person at a MassHealth Enrollment Center; over the Internet at a hospital, health center, or other site authorized to submit applications via the “Virtual Gateway”; or by applying for and obtaining certain cash assistance programs including SSI, TAFDC, and EAEDC. See Part 4 for more about how to apply for MassHealth.

There are two main MassHealth application forms: the Medical Benefit Request (MBR) used primarily by people under age 65, and the Senior Medical Benefit Request form (S-MBR) used by most people age 65 and older, people of any age seeking payment for long-term nursing home care, and certain people seeking MassHealth for services to live at home instead of in a nursing home. There is also a separate form to apply for the Medicare Savings Program (also called the Medicare Buy-In).

The MBR and S-MBR constitute an application for almost all programs for which the MassHealth agency makes an eligibility determination. This includes all types of MassHealth coverage described below, as well as MassHealth Limited, the Medicare Savings Programs, the Children’s Medical Security Plan (CMSP), the Healthy Start Program (HSP), the Health Safety Net (formerly called the Uncompensated Care program/Free Care), and starting October 1, 2006, the new Commonwealth Care program.

However, applications must go through an intermediary in order to be considered for certain MassHealth programs: Women’s Health Network sites for the Breast and Cervical Cancer Treatment program; and an employer participating in the Insurance Partnership program for certain premium assistance programs.

7 **The role of advocates**

The Section 1115 demonstration greatly expanded eligibility and simplified the eligibility process by eliminating an asset test, but it also complicated the work of

advocates by creating many different coverage types with different eligibility criteria and different benefits. Advocates have an important role to play in helping low-income people navigate the MassHealth system in order to obtain access to necessary health care services. With the introduction of Commonwealth Care and the tax penalties for adults who do not enroll in affordable insurance, the role of advocates is more important than ever.

Advocates commonly represent people with two kinds of problems with MassHealth and Commonwealth Care:

- n they are denied initial or continuing eligibility for the programs; or
- n they are eligible but are denied coverage for a particular service.

Advocates will need consent from their clients to obtain information from the MassHealth agency or the Connector. If a client is not present to give oral consent, a written release form must be on file with the agency. MassHealth has developed a form called the “Permission to Share Information” (PSI) that complies with federal health insurance privacy law known as HIPAA and is available on the MassHealth website. The PSI authorizes both the MassHealth agency and the Connector to release information. An Eligibility Representative form also authorizes the release of information and allows the representative to apply on behalf of someone else.

Legal services programs have trained advocates who may be able to represent clients with health access problems. While many problems can be resolved informally, some can only be solved by an administrative appeal to the appropriate agency. Lawsuits are another way to resolve problems that cannot be fixed any other way. A list of legal services programs is included in Part 20 of this Guide.

8

Sources of information for advocates

The first place to look to resolve a MassHealth problem is in the state regulations. The regulations for MassHealth, CMSP, and HSP are written by the MassHealth agency and are found in Chapter 130 of the Code of Massachusetts Regulations (130 C.M.R.). Eligibility regulations for the Medicaid reform population are in Sections 501–508; regulations for the 65 and older and nursing home population

and for CMSP and HSP are in Sections 515–521. The regulations are posted on the MassHealth website along with a wealth of additional information about MassHealth at www.mass.gov/MassHealth. Look for citations to relevant regulations throughout this Guide.

The regulations of Commonwealth Care are written by the Connector and are found in Chapter 956 of the Code of Massachusetts Regulations (956 C.M.R. 3.00). The Commonwealth Care regulations, administrative bulletins, descriptions of benefits, copayments and premium schedules along with other information are posted on the Connector website at www.mahealthconnector.org.

In some cases, it will be necessary to look beyond the state regulations to state statutes, agency policy materials, provider manuals, and contracts with managed care plans, as well as federal laws, regulations, and sub-regulatory materials such as Dear State Medicaid Director letters and the CMS State Medicaid Manual. Most federal resources and many state resources are available on the Internet.³

9 Summary of the main types of MassHealth coverage

Summary 1: MassHealth Standard

- 1. Overview** MassHealth Standard is the traditional type of full Medicaid coverage. It has the broadest scope of benefits. The vast majority of people enrolled in MassHealth have MassHealth Standard. It covers most of those who fall within the groups of low-income people typically eligible for Medicaid: pregnant women, families with children, and people who are disabled or elderly.

³ Part 20 of this Guide lists legal citations and websites for many of the resources described here.

2. Eligible groups

Medicaid Reform: Parents or caretaker relatives living with children under age 19, children under age 19, pregnant women, disabled individuals, women with breast or cervical cancer who have been screened through the Women’s Health Network, youth under age 21 who have aged out of foster care.

Traditional Medicaid: People age 65 and over, certain disabled individuals, individuals of any age living in nursing homes or other medical institutions, foster children, certain adoptive children, and certain refugees. Also recipients of cash assistance from SSI or TAFDC.

3. Eligibility of Noncitizens

Only noncitizens eligible for Medicaid under federal rules (qualified aliens) and certain people who were already on Medicaid in 1997 (protected aliens) are eligible for MassHealth Standard. Noncitizens who satisfy all the eligibility criteria for MassHealth Standard except for immigration status receive instead MassHealth Limited, and some may receive state-funded Family Assistance, CommonHealth, Essential, or Commonwealth Care.

4. Financial Eligibility

Medicaid Reform: For parents or caretaker relatives with children: gross family income cannot exceed 133 percent of the federal poverty level. For children age 1–18: gross family income cannot exceed 150 percent of poverty. For pregnant women and infants, gross family income cannot exceed 200 percent of poverty. For disabled individuals under age 65: gross family income cannot exceed 133 percent of poverty. For women with breast or cervical cancer, gross family income cannot exceed 250 percent of poverty. For youth aging out of foster care, there are no income limits. There are no eligibility criteria related to asset ownership.

Traditional Medicaid: For people age 65 and over: adjusted family income cannot exceed 100 percent of poverty and countable assets cannot exceed \$2,000 for an individual or \$3,000 for a couple. Seniors with income in excess of 100 percent of poverty can become eligible after meeting a recurring six-month deductible.

For people of any age living in a nursing home or medical

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institution there is no upper income limit but there is a required contribution to the costs of care based on income, and asset limits apply.

In addition, people who satisfy the eligibility criteria of other agencies for certain cash assistance programs such as SSI or TAFDC automatically qualify for MassHealth Standard.

5. Coverage begin date

Medicaid Reform: Coverage begins 10 days prior to the date the MassHealth agency receives the application form.

Traditional Medicaid: Coverage begins up to three months prior to the month of application if the individuals satisfied the eligibility criteria in the prior months.

6. Covered services

MassHealth Standard provides the most comprehensive coverage of any MassHealth coverage type. MassHealth Standard is the only coverage type that provides long-term care to adults living in nursing homes or other medical institutions. See Table 18 for a list of covered services.

7. Premiums & copayments

Most people in MassHealth Standard have no premium charge, but women eligible through the Breast and Cervical Cancer Treatment program (BCCTP) with gross family income over 150 percent of poverty are charged premiums on a sliding scale. See Table 18. Adults, regardless of income, are also charged a copayment for drugs.

8. Managed Care

Medicaid Reform: Unless an exemption applies, managed care is required.

Traditional Medicaid: Managed care is not required for the elderly or residents of nursing homes. Voluntary managed care is available for some elderly individuals through Senior Care Options (SCO) plans and PACE plans.

Summary 2: CommonHealth

- 1. Overview** CommonHealth began as a state-funded program for disabled children and working people with disabilities with income in excess of traditional Medicaid limits, but is now part of MassHealth under Medicaid reform. Many disabled people use CommonHealth to supplement the limitations of private health insurance plans. The Section 1115 waiver expanded CommonHealth to include nonworking adults under age 65 who have met a one-time deductible/spenddown.
- 2. Eligible groups** Children under 19 with disabilities, working adults with disabilities (including those 65 and over), and nonworking disabled adults (under age 65 only) who are not eligible for MassHealth Standard may be eligible for CommonHealth.
- 3. Eligibility of noncitizens** As in MassHealth Standard, “qualified” and “protected” aliens are eligible for CommonHealth. In addition, disabled children under age 19 who are not “qualified” but are in the United States legally during a five-year bar period (special status) or “under color of law” (PRUCOL) may be eligible for CommonHealth.
- 4. Financial Eligibility** There is no upper income limit. However, nonworking disabled adults must meet a one-time deductible: such adults will be eligible only after incurring medical expenses that equal or exceed the amount of the deductible.
- 5. Coverage begin date** Coverage begins ten days prior to the date the MassHealth agency received the application.
- 6. Covered services** CommonHealth covers the same types of services as MassHealth Standard but some of the rules relating to the amount, duration and scope of services are more limited in CommonHealth. See Table 18 for a list of covered services.
- 7. Premiums & copayments** Premiums are charged for all individuals with family income over 150 percent of poverty based on a sliding scale. See Table 18. Adults are also charged a copayment for drugs.
- 8. Managed Care** Managed care is not currently required, but starting in July 2009 may be required where CommonHealth is the primary coverage (no other insurance).

Summary 3: Family Assistance

- 1. Overview** MassHealth Family Assistance combines several programs:
- n a non-Medicaid health coverage program for children created pursuant to the federal-state State Children’s Health Insurance Program (Title XXI);
 - n a program to encourage employer-sponsored health insurance under the Section 1115 waiver; and
 - n coverage for people who are HIV positive.

There are two types of Family Assistance: direct coverage and premium assistance toward the cost of private insurance. The Section 1115 waiver also created a program called the Insurance Partnership that pays a subsidy to small employers to encourage them to offer health insurance to low- and moderate-income employees who in turn are eligible for premium assistance toward the cost of coverage.

2. Eligible groups **Direct Coverage:** Children under age 19 who are uninsured and currently without access to cost-effective, employer-sponsored insurance; and people under age 65 who are HIV positive may be eligible. Starting July 1, 2006 children with income between 201 and 300 percent of poverty are eligible but only if they have been uninsured for the past six months prior to application.

Premium Assistance: Children under age 19 with access to cost-effective, employer-sponsored insurance, individuals under age 65 who are HIV positive with access to cost-effective insurance, and employees (and their spouses) of “qualified” employers participating in the Insurance Partnership program. Starting July 1, 2006 children with income between 201 and 300 percent of poverty with access to cost-effective insurance are eligible but only if they have been uninsured for the past six months prior to application. See Table 2 in Part 5. Starting October 1, 2006 employees of employers in the Insurance Partnership program will be eligible only if they did not have insurance in the past six months.

All family members may benefit from family coverage if at least one member of the family is eligible for Family Assistance Premium Assistance. It is not necessary that all members of the family be eligible.

3. Eligibility of noncitizens

Qualified immigrants and children who are special status or PRUCOL are eligible. Immigrant children who would be eligible for MassHealth Standard but for special status/PRUCOL are instead provided Family Assistance.

4. Financial Eligibility

For employees of qualified employers, starting October 1, 2006, gross family income cannot exceed 300 percent of the federal poverty level. For uninsured children, starting July 1, 2006 income cannot exceed 300 percent of poverty. For HIV-positive individuals, insured children, and special status/PRUCOL children income cannot exceed 200 percent of poverty. There is no asset test.

5. Coverage begin date

Direct Coverage begins 10 days prior to the MassHealth agency's receipt of the application. Children will receive direct coverage while premium assistance is being investigated. Under **Premium Assistance**, payroll withholding and premium reimbursement payments should begin in the month in which eligibility is determined and coverage through the employer begins the following month.

6. Covered services

Direct Coverage is less extensive than MassHealth Standard; it excludes nonemergency transportation, personal care attendants, private duty nursing, and certain other services. See Table 18 for a list of covered services. With **Premium Assistance**, employer-sponsored insurance benefits will vary based on the employer's plan. However, to be eligible for the subsidy, the employer's policy must provide "minimum creditable coverage."

7. Premiums & copayments

Direct Coverage for children with family income over 150 percent of poverty requires a premium charge per child with a family maximum for the cost of three children. See Table 18.

Employer-sponsored insurance for a child subsidized by **Premium Assistance** will cost at least as much as direct coverage but may cost up to 5 percent of gross family

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income. Childless employees of a qualified employer in the Insurance Partnership with income over 150 percent of poverty pay a monthly premium that varies by income; the maximum premium assistance amount is also capped. See Table 8 for Premium Assistance Upper Payment Limits. For adults, additional copayments and other cost-sharing will depend on the employer's plan.

For HIV-positive adults with income over 150 percent of poverty, there is a monthly premium based on income, and a higher premium assistance cap. See Tables 8 and 19. Adults with **Direct Coverage** in the HIV program are also charged a copayment for drugs.

8. Managed are

Unless an exemption applies, managed care is required in Direct Coverage. In Premium Assistance, the terms of coverage are determined by the employer's insurance plan, not by MassHealth.

Summary 4: MassHealth Basic

1. Overview

MassHealth **Basic** was created by the Section 1115 waiver for childless unemployed adults not traditionally eligible for Medicaid. In 2003, it was limited to unemployed adults who are also clients of the Department of Mental Health (DMH), and to recipients of a cash assistance program called EAEDC. The **Basic Buy-In** offers premium assistance toward the purchase of private health insurance instead of direct coverage through MassHealth Basic.

2. Eligible groups

Adults under age 65 who are either chronically (long term) unemployed and clients of the Department of Mental Health or receive cash assistance from EAEDC are eligible. To be a client of DMH, a person with a serious mental illness must apply for DMH services and be determined eligible by DMH, and then apply to the MassHealth agency for Basic. To receive EAEDC, a person must apply to the Department of Transitional Assistance (DTA), and, if eligible, he or she will automatically receive Basic. There are five groups eligible for EAEDC including adults having a disability expected to last at least 60 days.

3. Eligibility of Noncitizens	Noncitizens must be qualified to be eligible for Basic as long-term unemployed DMH clients. Noncitizens who are subject to the five-year bar or PRUCOL may be eligible for EAEDC, but most will receive MassHealth Essential instead of MassHealth Basic.
4. Financial Eligibility	For EAEDC recipients, eligibility is determined by DTA, income levels depend on living arrangements and there is an asset test. For the long-term unemployed DMH clients: gross family income cannot exceed 100 percent of the federal poverty level, and there is no asset test.
5. Coverage begin date	For the long-term unemployed under age 65, coverage begins only after the MassHealth agency has enrolled the individual with a primary care provider/managed care plan. For EAEDC recipients, a limited EAEDC benefit is available from the point of eligibility for EAEDC until enrollment into MassHealth Basic.
6. Covered services	MassHealth Basic is less extensive than MassHealth Family Assistance, CommonHealth or MassHealth Standard. It excludes nonemergency transportation and eight other services that primarily benefit people with disabilities or chronic illness. See Table 18 for a list of covered services. The Basic Buy-In does not specify any minimum scope of coverage for private plans.
7. Premiums & copayments	There are no premiums for MassHealth Basic , but there are copayments for drugs. Under the Basic Buy-In , MassHealth will contribute toward the costs of a health insurance premium and the recipient pays any balance as well as any other cost-sharing required by the private plan.
8. Managed Care	Unless exempt, people under age 65 enrolled in MassHealth Basic are required to use managed care.

Summary 5: MassHealth Essential

- 1. Overview** In 2003, MassHealth Essential coverage replaced coverage under Basic for long-term unemployed adults who are not clients of DMH. In 2004 state-funded MassHealth Essential also became available to certain elderly and disabled special status and PRUCOL noncitizens. Currently there are no enrollment caps in Essential.
- 2. Eligible groups** Essential is available to unemployed adults under age 65 who have been unemployed for the past 12 months or earned less than \$3,300 (FY 2009) in the past 12 months. It is also available to special status/PRUCOL adults under age 65 who are disabled, and to special status/PRUCOL adults who are age 65 or older.
- 3. Eligibility of Noncitizens** Qualified noncitizens are eligible for MassHealth Essential based on long-term unemployment alone. Immigrants who are subject to the five-year bar or PRUCOL are eligible for Essential only if they are also disabled or are age 65 or older.
- 4. Financial Eligibility** Gross family income cannot exceed 100 percent of poverty. There is no asset test except for elderly five-year bar/PRUCOL immigrants who must have countable assets less than \$2,000 for an individual or \$3,000 for a couple.
- 5. Coverage begin date** For adults under age 65, coverage begins only when the MassHealth agency has enrolled an individual in a managed care plan. Elderly five-year bar/PRUCOL noncitizens may be covered for up to three months prior to the month of application.
- 6. Covered services** MassHealth Essential covers fewer services than MassHealth Basic or the other coverage types. See Table 18 for a list of covered services.
- 7. Premiums & copayments** There is no premium charge for Essential, but there are copayments for drugs.
- 8. Managed Care** Unless exempt, managed care is required for individuals under age 65. Elderly five-year bar/PRUCOL immigrants are in fee-for-service rather than managed care.

Summary 6: Commonwealth Care

- | | |
|--------------------------------------|--|
| 1. Overview | This is a new program created by the 2006 health reform law to provide affordable coverage to uninsured adults who are not otherwise eligible for MassHealth and have gross family income under 300 percent of poverty. It is administered by the Health Insurance Connector Authority, but uses a common application form with MassHealth and the MassHealth agency makes the eligibility determination. |
| 2. Eligible groups | Individuals who are uninsured and not eligible for MassHealth, the Children’s Medical Security Plan (CMSP), Medicare, the Medical Security Plan, the Fishing Partnership, TRICARE or Qualifying Student Health Insurance (QSHIP) and are not offered insurance in which an employer pays at least 33 percent of the cost of an individual premium or 20 percent of the cost of a family premium may be eligible for Commonwealth Care. Individuals paying the full cost of insurance as self-employed or COBRA or in a waiting period for employer coverage may be eligible for Commonwealth Care. |
| 3. Eligibility of Noncitizens | To be eligible, non-U.S. citizens must be “qualified,” subject to the five-year bar or PRUCOL. |
| 4. Financial Eligibility | Gross family income cannot exceed 300 percent of the poverty level. There is no asset test. |
| 5. Coverage begin date | Coverage begins on the first of the month after an eligible individual has chosen a health plan, and paid the first month’s premium if due. If choice of plan or receipt of the premium occurs after a cut-off date in the current month, enrollment will be delayed until the first of the second following month. |
| 6. Covered services | Only those under the poverty level are covered for dental care. Otherwise, covered services are similar to MassHealth Family Assistance or Basic. See Table 18. |

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- 7. Premiums & copayments** Premiums are charged to anyone over 150 percent of poverty, and also to those from 101 to 150 percent of poverty who choose any Managed Care Organization (MCO) other than the lowest cost MCO. Premiums vary by income, region, and MCO choice. See Table 18. There are three plan types that charge different levels of copayments based on income. Copayments are the same as MassHealth for those under the poverty level, similar to copayments in small group commercial plans for those over 200 percent of poverty, and somewhat lower for those from 101 to 200 percent of poverty. See Table 9.
- 8. Managed Care** All services are provided only through participating MCOs.

Part 2

Massachusetts Residence

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10 Does an applicant have to live in Massachusetts in order to get MassHealth?

Yes. All MassHealth coverage types and Commonwealth Care require that the applicant be a Massachusetts resident. Residence means someone lives in the Commonwealth with the intention to remain indefinitely. In other words, Massachusetts is home. People who come to Massachusetts to get medical care, but intend to return to their home states remain residents of their home states. If someone is a Massachusetts resident, a temporary absence from the state does not change residence.

G.L. c. 118E, § 8(h); 130 C.M.R. §§ 503.002, 517.002; 130 C.M.R. § 517.003 (residence of institutionalized individuals); 956 C.M.R. § 3.04 (Commonwealth Care).

11 Can an immigrant still be a “resident” of Massachusetts?

Yes. Residence is different from immigration status. Even if a person enters with a tourist visa, if he or she forms the intention to remain in Massachusetts, he or she can establish residence here. However, a noncitizen with a valid visitor’s visa (e.g., tourist, student, business) should be referred to an immigration specialist for advice before declaring that he or she is a Massachusetts resident.

130 C.M.R. § 505.008(A)(3).

12 How long must the applicant have resided in Massachusetts?

In MassHealth, residence does not require that an applicant live in Massachusetts for any specific length of time. The Commonwealth Care statute says that someone must have lived in Massachusetts for at least six months. However, a durational residency requirement is unconstitutional and the six-month standard has never been enforced in Commonwealth Care.

Compare G.L. c. 118H, § 3 with 956 C.M.R. § 3.04.

13 How is residence verified?

Applicants must supply a Massachusetts address. If mail is returned by the Post Office as undeliverable, the MassHealth agency will generally terminate eligibility as “whereabouts unknown” unless the individual is homeless. Eligibility should be restored if a Massachusetts resident who has lost coverage for this reason supplies the agency with a current address or identifies himself as homeless. The Office of Medicaid also checks whether someone is receiving benefits in any other state; if so, the individual will be notified to supply proof of residence in Massachusetts in order to remain eligible.

130 C.M.R. § 503.002 (whereabouts unknown); 42 C.F.R. § 431.231(d).

14 What is the residence of someone who is homeless?

An applicant does not need a fixed address to be a resident of Massachusetts. However, an applicant must supply the MassHealth agency with a mailing

Part 2 n Massachusetts Residence

address. If an applicant is homeless, his or her mailing address can be a Post Office address, or the address of a homeless shelter, for example, or he or she may want to designate an eligibility representative who will receive copies of MassHealth notices on his or her behalf.

The MassHealth agency will not terminate coverage as “whereabouts unknown” if it has been notified that an individual is homeless. There is a checkbox for this purpose on the application form; be sure to use it for homeless clients.

MassHealth has no definition of homeless. However, other federal health programs recognize that a person who is temporarily staying with different friends or relatives, just like a person who is living in a shelter or outside, is considered homeless.

Part 3

Relationship Between MassHealth Eligibility and Receipt of Cash Assistance

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15 Do you have to receive cash assistance to be eligible for MassHealth?

No. Most people receiving MassHealth do not receive cash assistance. However, people eligible for certain cash assistance programs are automatically eligible for MassHealth. In these cases, an agency other than the MassHealth agency determines eligibility for the cash assistance program based on rules that apply to that program. Some cash assistance programs, like EAEDC, cover types of individuals not otherwise eligible for MassHealth were they to apply directly to the MassHealth agency. If an individual is eligible for the cash assistance program, he or she will also be enrolled in MassHealth without the need for a separate application to the MassHealth agency. When cash assistance ends, MassHealth will not automatically end; the MassHealth agency must determine if the former cash recipient is still eligible for MassHealth. See Part 4 for the rules regarding continued eligibility for MassHealth after cash assistance ends.

16 Which cash assistance recipients are eligible for MassHealth?

People who are automatically eligible for MassHealth based on receipt of cash assistance include:

- n Blind or disabled children and adults, and adults age 65 and over who receive Supplemental Security Income (SSI) are eligible for MassHealth Standard. The Social Security Administration (SSA) determines eligibility. For more information on the eligibility criteria for SSI, see *An Advocate's Guide to Surviving the SSI System* (MLRI/MCLE, Inc. 2005). 130 C.M.R. §§ 501.004, 519.002; 42 C.F.R. Part 416 (SSI).
- n Families with children eligible for Transitional Assistance for Families with Dependent Children (TAFDC), or Emergency Aid to Elders, Disabled and Children (EAEDC) are eligible for MassHealth Standard. The Department of Transitional Assistance (DTA) determines eligibility. For more information on the eligibility criteria for TAFDC and EAEDC, see *TAFDC Advocacy*

Part 3 n Relationship Between MassHealth Eligibility and Receipt of Cash Assistance

Guide (MLRI/MCLE, Inc. 2008), and *EAEDC Advocacy Guide* (MLRI/MCLE, Inc. 2008). 130 C.M.R. § 501.004(B)(2).

- n Certain former recipients of SSI are treated as if they still have SSI in order to remain eligible for MassHealth Standard under special rules. See the Q & A below for a fuller explanation.
- n Children eligible for foster care payments or adoption assistance subsidies are eligible for MassHealth Standard. The Department of Children and Families (DCF) transmits eligibility information to MassHealth. 130 C.M.R. § 522.003.
- n Childless adults eligible for EAEDC are eligible for MassHealth Basic. See the Q & A below for more about eligibility for EAEDC.
- n Refugees eligible for refugee resettlement assistance are eligible for MassHealth Standard for eight months from the date of entry into the United States. The Massachusetts Office of Refugees and Immigrants determines eligibility for refugee resettlement assistance. See the Q & A below for a fuller explanation.

17 Who is eligible for EAEDC?

Emergency Assistance for the Elderly, Disabled and Children (EAEDC) is a cash assistance program administered by the Department of Transitional Assistance (DTA). Childless adults with EAEDC automatically obtain MassHealth Basic; children receiving EAEDC receive MassHealth Standard. Some special status and PRUCOL immigrants collecting EAEDC receive MassHealth Essential. In order to be eligible for EAEDC, an individual must be a Massachusetts resident and a citizen or lawfully present noncitizen who is financially eligible and fits into one of the following five categories:

- n elders age 65 or older;
- n disabled persons suffering from a physical or mental impairment or a combination of impairments that substantially reduce the ability to work and are expected to last at least 60 days;

Part 3 n Relationship Between MassHealth Eligibility and Receipt of Cash Assistance

- n persons providing constant care for a disabled person who would otherwise need institutional care;
- n persons participating in a Massachusetts Rehabilitation Commission program; or
- n certain children and their unrelated caretakers who do not qualify for cash assistance from TAFDC.

To be financially eligible for EAEDC an individual must have countable income (after allowable deductions) that does not exceed the EAEDC income standards, and countable assets that do not exceed the asset standard. The income standard for EAEDC varies by family composition and living arrangement but is extremely low. The maximum asset allowance is \$250. However, certain assets are not counted such as a home, and a car with an equity value of \$1,500 or less.

For more information on EAEDC, see the DTA regulations at 106 C.M.R. § 320 et seq., the DTA website at www.mass.gov/dta, and Baker, Patricia, *EAEDC Advocacy Guide* (MLRI/MCLE, Inc. 2008).

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When are former recipients of SSI eligible for MassHealth?

In certain circumstances, federal Medicaid law requires that someone who no longer gets SSI should still be treated as if he or she gets SSI in order to qualify for Medicaid. Often this requires determining whether the individual would still be eligible for SSI if certain Retirement, Survivors, or Disability Insurance (RSDI) from Social Security were excluded from his or her income. Generally, the MassHealth agency must identify whether a former SSI recipient has this “deemed SSI” status based on data exchanged with Social Security. Whenever a member received SSI in the past, currently receives RSDI benefits and is not otherwise income-eligible for MassHealth, an advocate should explore whether a “deemed SSI” status may apply. These cases usually come up when an elderly or disabled person loses MassHealth and is unable to meet a spenddown in MassHealth Standard or CommonHealth.

Part 3 n Relationship Between MassHealth Eligibility and Receipt of Cash Assistance

The following types of people are eligible for MassHealth based on the “deemed SSI” status:

- n **“Pickle Amendment” cases:** Some people who no longer receive SSI but do receive RSDI benefits from Social Security with income that exceeds the MassHealth Standard income limits may remain eligible for MassHealth Standard thanks to a federal Medicaid law called the Pickle Amendment. These individuals are treated as if they still received SSI for MassHealth purposes if the individual—
 - n received both SSI and RSDI in some month after April 1977,
 - n is currently receiving RSDI,
 - n is no longer eligible for SSI, and
 - n would be eligible for SSI if his or her income were reduced by all the RSDI cost of living adjustments (COLA) received since he or she was last eligible for both RSDI and SSI.⁴

130 C.M.R. §§ 505.002(F)(2), 519.003.

Example: An 80-year-old woman receives Social Security retirement benefits and MassHealth. The annual increase in her Social Security puts her over the poverty level income standard for MassHealth; she appears to be ineligible until she meets a substantial spenddown. She last received both Social Security and SSI in 1991. Disregarding the portion of her Social Security income that represents each year’s COLA since 1991, her adjusted income is below the current SSI amount for an elderly person living alone. She should be eligible for MassHealth Standard without a spenddown under the Pickle amendment.

- n **Disabled adult children:** Adults who became blind or disabled before age 22, were receiving SSI, and would still be eligible for SSI but for the receipt or increase in the amount of disabled adult child’s Social Security benefits on the account of a deceased, retired, or disabled parent are eligible for MassHealth Standard. 130 C.M.R. §§ 505.002(F)(2), 519.004.

Example: A 48-year-old woman with cerebral palsy has received SSI since she was a child. Her father dies and she becomes eligible for RSDI benefits

⁴ A formula for reducing income under the Pickle Amendment is published annually in the *Clearinghouse Review*, www.povertylaw.org.

Part 3 n Relationship Between MassHealth Eligibility and Receipt of Cash Assistance

based on her deceased father's earnings record in an amount higher than her SSI benefits. Her Social Security benefits now appear to exceed the eligibility level for MassHealth Standard (133 percent of the poverty level). However, because this woman would be eligible for SSI but for the receipt of disabled adult child benefits, she remains eligible for MassHealth Standard. If the MEC worker fails to pick up on this and simply enters the new income amount into the system, this woman will incorrectly lose MassHealth Standard and face a one-time deductible for CommonHealth.

- n **Disabled widows:** Disabled widows and widowers, under age 65, who were receiving SSI and would still be eligible for SSI except for receipt of widow's benefits based on the earnings record of a deceased spouse and who are not entitled to Medicare Part A are eligible for MassHealth Standard.

Note: The MassHealth agency regulations refer to this group only by cross-reference to Section 1634 of the Social Security Act. 130 C.M.R. § 505.002(F)(2). You must look to federal law for a description of the eligibility criteria. 42 U.S.C. § 1383c(d). *See also* 42 U.S.C. § 402(e) and (f) (widow's benefits).

Example: A married woman with a disability was ineligible for SSI based on her husband's earnings. Her husband died when she was 49 leaving her destitute. She obtained SSI and MassHealth. When she turned 50 she applied to Social Security for widow's benefits based on her deceased husband's earnings record. Her widow's benefits exceeded 133 percent of poverty and she lost both SSI and MassHealth. She consulted an advocate about how to meet a large spenddown for CommonHealth. The advocate was able to get her MassHealth Standard reinstated because of the disabled widow's rule: she was under age 65 and disabled, she had received SSI, she would still be eligible for SSI but for the receipt of widow's benefits, and she was not eligible for Medicare.

- n **Disabled workers/Section 1619(b):** Social Security rules include several work incentive programs for SSI recipients. Under 1619(b), working disabled individuals who are no longer financially eligible for SSI are able to retain MassHealth Standard. In order to qualify, adults who lost SSI based on earnings must still be medically disabled, need Medicaid coverage to work, and earn gross income at levels insufficient to replace Medicaid with private insurance. Unlike the Pickle, disabled adult child, and disabled widow rules described above, for Section 1619(b), the SSA determines whether a worker meets the criteria, and conveys the information to the MassHealth agency in the same way SSA conveys information about who is an SSI recipient.

Note: The MassHealth agency regulations do not mention this group; SSA identifies them and MassHealth treats them as if they were SSI recipients. If someone is not correctly identified, the solution will require advocacy with SSA. 42 C.F.R. § 416.267. *See An Advocate's Guide for Surviving the SSI System* (MLRI/MCLE, Inc. 2005).

19 When are recipients of refugee resettlement assistance eligible for MassHealth?

The Massachusetts Office for Refugees and Immigrants (ORI) has contracted with the MassHealth agency to provide MassHealth Standard for eight months from the date of entry to the United States to refugees eligible for medical assistance under the federal Refugee Resettlement Program. To be eligible individuals must meet the following criteria:

- n have refugee status as determined by ORI;
- n be a resident of Massachusetts;
- n be between the ages of 18 and 64;
- n have countable assets of no more than \$2,000 for an individual or \$3,000 for a couple; and
- n have income less than 100 percent of poverty or meet a deductible.

See 130 C.M.R. § 522.002.

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20 How do people apply for MassHealth & Commonwealth Care?

Mail-in application forms. One way to apply for MassHealth and Commonwealth Care is to submit a paper application form. There are two main forms: the Medical Benefit Request (MBR) for most people under age 65, and the Senior-Medical Benefit Request (S-MBR) for the elderly, people of any age seeking long-term nursing home care or services to live at home instead of in a nursing home.

Application forms can be submitted by mail or filed in person at the office of a MassHealth Enrollment Center (MEC). Forms are widely available at many locations throughout the state. An application form can be ordered by telephone from the MECs at 1-888-665-9993 or the Customer Service Center at 800-841-2900. Forms can also be downloaded from the MassHealth website at www.mass.gov/MassHealth.

In addition, application forms are available at outreach assistance sites in hospitals and community health centers and from community health workers, homeless shelters, SHINE counselors, and many other human service agencies. Applications are also available at offices of the Department of Transitional Assistance.

The Virtual Gateway. Most hospitals and community health centers and some community organizations have been trained and approved by the MassHealth agency to submit applications online using the Virtual Gateway. At these sites, applications are transmitted electronically and the applicant's signature is mailed and required verifications are faxed to the MassHealth agency. If necessary information is missing, a request for information will be sent to the applicant as it is in the mail-in application system. Applicants can also apply for other EOHHS programs such as food stamps and subsidized child care through the Virtual Gateway, and each EOHHS agency will follow up as needed to complete its application process.

Applications for certain programs through an intermediary. Women who are applying for MassHealth through the breast and cervical cancer treatment program (BCCTP) must be screened at a Women's Health Network site and applications must go through the Women's Health Network site. To locate a site, visit www.massmammography.com or call 877-414-4447.

For individuals seeking premium assistance as employees of qualified employers in the Insurance Partnership, the employee's MBR must be submitted with an affidavit and a cover letter from the employer.

Children in the foster care system will go through the Department of Children and Families to obtain MassHealth. Refugees in the resettlement program will go through the Office of Refugees and Immigrants.

Cash assistance programs. People eligible for certain cash welfare benefits are automatically eligible for MassHealth. These cash benefit programs include SSI, TAFDC, and EAEDC. People who apply to the Department of Transitional Assistance (DTA) for TAFDC or EAEDC or who apply to the Social Security Administration (SSA) for SSI, and whose applications are approved will automatically receive MassHealth. However, if an application for cash assistance is denied, unsuccessful SSI and EAEDC applicants must file a separate application to be considered for MassHealth eligibility on some basis other than receipt of cash assistance. Applicants denied TAFDC will receive an independent determination of MassHealth eligibility without being required to submit a separate application.

21 Who must be included in the application?

A separate application form must be filed for each "family group." The income of all members of a family group will be considered in determining eligibility of any member of the family group. Each member of the family group must designate on the application whether or not he or she is applying for health benefits in his or her own right. All family members age 18 or older and all parents applying for their children must sign the application for the family group. Family groups consist of individuals, married couples, or families with children under age 19:

- n **Individual**—An individual age 19 or older who does not live with a spouse or with the individual's child/ren under age 19; also an individual under age 19 who does not live with a parent, spouse, child under 19, or sibling under 19. An individual applies as a family group of one.
- n A young child living with an unrelated adult will need the adult to complete the application as the child's eligibility representative, but the adult will not be a member of the family group.

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- n **Married couple**—A person who is married and lives with his or her spouse but does not live with the children under age 19 of either spouse must apply as part of a family group consisting of himself or herself and his or her spouse.
 - n Starting October 31, 2008, MassHealth will recognize same sex married couples as married, *see* G.L. c. 118E, § 61 (MassHealth Equality Act).
- n **Married couples, where one spouse is under 65 and one is 65 or older**—In this situation, a couple should fill out the S-MBR. There is a special section in the S-MBR for the spouse under age 65.
- n **Families that include a child under age 19**—Both parents of a child under 19 who live together must be included in the family group whether they are married or not, and all natural, adopted and stepchildren under age 19 must be included in the family as well as all siblings under 19 of a child under 19.

There are two kinds of households in which members can choose whether or not to be treated as one family group or two. Depending on the circumstances, it may be preferable to apply as a separate household to keep family income under the applicable income ceiling, or it may be preferable to apply together to extend eligibility to grandparents or caretaker relatives who would not qualify as a separate family group:

- n **Minor parents**—A child under 19 who is pregnant or a parent and living with his or her parents may either apply as a separate family group or be included in the same family group as his or her parents.
- n **Caretaker relatives**—A relative who is living with a child under age 19 and caring for the child in the absence of a parent may apply as a family group with the child or the child may apply as a separate family group.

130 C.M.R. § 501.001 (definition of individual, couple, family, and family group).

22 What kind of proof must be sent in to complete the Medicaid reform application?

Income. To be complete and get a decision on eligibility, an application must include proof of the amount of all sources of income. Two recent pay stubs are

sufficient proof of earned income. The most recent tax return with schedules or a letter from the employer can also be used. Proof must also be submitted for unearned income such as veteran's benefits or child support income. People with income from self-employment or rental income will need to submit tax returns showing allowable deductions from self-employment and rental income. A sworn statement from the applicant is acceptable if no other more reliable proof of income is available.

Citizenship status. As of July 1, 2006, U.S. citizens must submit proof of their U.S. citizenship and identity.

Immigration status. In order to qualify for any type of MassHealth other than MassHealth Limited, noncitizens must submit proof of their immigration status.

Health insurance. People with health insurance must send in a copy of the insurance card or other proof of coverage.

HIV-positive status. People applying for coverage based on HIV-positive status must submit verification of HIV-positive status.

Blindness. A person applying for coverage based on blindness must submit a certification of blindness. (If no certification has been made, blindness may also be proved through the disability determination process.)

23 What is acceptable proof of U.S. citizenship and identity?

A new federal rule requires that U.S. citizens applying for MassHealth or Commonwealth Care after July 1, 2006 or renewing eligibility after July 1, 2006 submit proof of U.S. citizenship and identity. U.S. citizens who are recipients of SSI, Social Security Disability Insurance (SSDI), Medicare, adoption assistance or foster care assistance are exempt from this requirement. The MassHealth agency will be able to verify citizenship and/or identity for some people through electronic data matches with other agencies such as the Social Security Administration, the Department of Transitional Assistance, and the Registry of Motor Vehicles. If a data match is not available, the applicant will be asked to submit proof. Once citizenship has been verified, the record will remain in the

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MassHealth system and will not have to be verified again. The following are examples of acceptable proof (more examples are listed in the regulations):

Proof of both citizenship and identity: a U.S. passport (current or expired); a certificate of naturalization, or a certificate of U.S. citizenship.

Proof of citizenship only (a separate document will be needed to prove identity): a birth certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico, or one of the U.S. territories; a certification of birth abroad to U.S. citizen parents, a final adoption decree showing a U.S. place of birth, a U.S. military record showing a U.S. place of birth, a hospital record of birth, or other medical records made more than five years ago that show a U.S. place of birth.

n **Obtaining a birth certificate.** For people born in Massachusetts, the MBR includes a supplement that the agency can use to obtain verification of birth directly from the Registry of Vital Records. For people born elsewhere in the United States the following website has information on where to obtain a birth certificate: www.cdc.gov/nchs/howto/w2w/w2welcom.htm.

n **Proof by affidavit.** If no better proof is available, citizenship may be proved by affidavits. This requires at least two sworn statements from U.S. citizens who state that they have personal knowledge that the applicant is a U.S. citizen and how they know this. The witnesses must also supply acceptable proof that they are themselves U.S. citizens. The witness may have personal knowledge based on knowledge that the applicant was born in the United States, or, for a naturalized citizen, being present at the naturalization ceremony or having seen the naturalization certificate. At least one of the persons making the statement must be a nonrelative. Relative is not defined; a statement from a remote relative will probably be acceptable as a nonrelative. The applicant, or one of the witnesses, must also explain why documentary evidence is not available.

Proof of identity only (a separate document will be needed to prove citizenship): a driver's license or other government issued identification with a photo or physical description; or a school identity card. For children under 16 with no such ID, the MBR incorporates a sworn statement from his or her parent or guardian of the child's date and place of birth. Also acceptable proof is submission of at least three other documents such as a marriage license, divorce decree, high school diploma, employment ID card, or property deed.

Consult the regulations for a complete list of acceptable documents. The MassHealth agency may grant additional time to gather necessary documents by

request. The agency should also provide additional assistance to those unable to gather the necessary documents due to a disability.

130 C.M.R. §§ 504.002, 518.002.

24 What is acceptable proof of an eligible immigration status?

An eligible immigration status for MassHealth and Commonwealth Care purposes is not the same thing as a legal status under the immigration laws. An eligible immigration status may be affected by: date of entry into the United States, current immigration status, past immigration status, date of obtaining an immigration status, pending applications for status, and circumstances not related to immigration such as service in the U.S. military or domestic violence. Some of this information can be self-declared on the “Questions for Immigrants” section of the application form (Supplement D of the MBR). Past, current, and pending immigration status must be proved by submitting immigration documents. Common documents include: Permanent Resident cards (“green cards”), Employment Authorization cards, I-94 cards, visas in a foreign passport, and other notices, receipts, or correspondence from the U.S. Citizenship and Immigration Service, the Department of Justice or the Bureau of Immigration Appeals. See Part 13 and Tables 12–16 in Appendix B for more information on documents that prove an eligible immigration status.

Make sure the codes and dates on photocopied immigration documents are legible! Write the code and date in the margin of the photocopy and initial it.

25 What is presumptive eligibility for pregnant women, children, and people who are HIV positive?

Presumptive eligibility is available to pregnant women, children, and people who are HIV positive to enable them to get MassHealth coverage before a final decision has been made on their application. The MassHealth agency will issue MassHealth cards for pregnant women or children who appear to be eligible based on the information on the application form prior to receiving any required verification of income or U.S. citizenship or eligible immigration status. People who are HIV positive who have applied and submitted proof of income and U.S. citizenship or eligible immigration status will be presumptively eligible while awaiting proof of HIV-positive status. If the required information is not submitted within 60 days, eligibility will end. In the case of pregnant women, presumptive eligibility only covers ambulatory prenatal care under the MassHealth Prenatal coverage type. Children and people who are HIV positive have full fee-for-service coverage during the temporary period.

130 C.M.R. §§ 502.003 (children), 505.003 (pregnant women), 505.005(G) (HIV positive).

26 What additional information may be required prior to a favorable decision?

If basic information (“critical data”) is missing from a paper MBR, the entire application may be returned along with a request to submit the missing information. If the completed application is returned on time, the original filing date will be protected. This is not a problem with applications on the Virtual Gateway where the basic information is a required field that must be completed in order to continue with the application.

If an otherwise complete application is missing some information, such as verification of income or U.S. citizenship, the applicant will be mailed a request for the missing information as discussed further in the next question.

In some cases, information that is not solicited on the application form is needed to make an eligibility determination. This is most often true when eligibility is affected by access to other subsidized insurance. MassHealth will provide time-limited direct coverage to children in Family Assistance while investigating the availability of employer-sponsored insurance (ESI). Families will be sent a form for the employer to complete, and if ESI is available, the family may be offered Premium Assistance to purchase the ESI instead of direct coverage for the child. In Commonwealth Care, individuals who may have access to other subsidized insurance will be denied subject to an exception process. Individuals will be sent an exception form, and if an exception is claimed and verified, it may supercede the denial. See Part 10 for more on the Commonwealth Care exception process.

27 When will applicants hear whether they are eligible?

MassHealth must make eligibility decisions within 45 days of receipt of an application, unless a determination of disability is needed in which case the decision may take up to 90 days. However, decisions are usually made in much less time if the application is complete and no disability determination is needed. Virtual Gateway applications can often be processed even more quickly.

If information is missing, an applicant under Medicaid reform will be sent a notice to submit additional information within 60 days from the request for information. Children, pregnant women, and people who are HIV positive will be given temporary coverage under presumptive eligibility while awaiting missing information as explained above. Applicants can request assistance and additional time to submit information if needed. If missing information is not returned by the deadline, the family's application will be denied. Applicants will be sent a computer-generated notice informing them whether or not they are eligible for benefits. Applicants who are denied MassHealth have the right to appeal. See Part 18, Notice and Appeal Rights.

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If individuals are not eligible for MassHealth (or only eligible for MassHealth Limited), the notice of decision will also notify the applicant whether he or she is eligible for the Healthy Start Program (prenatal care for pregnant women), the Children’s Medical Security Plan (primary and preventive care for children), the Health Safety Net (relief from debt at hospitals and health centers), and, starting October 1, 2006, Commonwealth Care program. Be warned: MassHealth notices of decision can be difficult to understand. Call the MEC to explain a notice if needed.

130 C.M.R. §§ 502.005, 516.004.

28 When will benefits begin under Medicaid reform?

When benefits begin will depend on the coverage type. Under MassHealth Standard, CommonHealth, and Family Assistance, benefits begin 10 days prior to the date the application is received by the agency. Under MassHealth Basic and Essential (except Essential for those age 65 or older), benefits do not begin until the member is enrolled in a managed care plan; this is also true for Commonwealth Care. See Part 10 for more on when Commonwealth Care begins. If someone is an EAEDC recipient, eligibility for a reduced EAEDC benefit package begins on the effective date of eligibility for cash assistance and continues until enrollment in managed care under MassHealth Basic. For TAFDC recipients, eligibility begins 10 days prior to the application with the DTA. Traditionally, Medicaid provided retroactive benefits for up to three months prior to the month of application, but the Section 1115 demonstration program waived this requirement for the Medicaid reform population; it still applies to those age 65 and over in traditional Medicaid.

130 C.M.R. §§ 505.000 (look for the “medical coverage date” heading under the rule on each coverage type), 516.005.

29 When will an applicant get a MassHealth card?

The applicant will be sent a plastic MassHealth card shortly after receiving a notice of eligibility for MassHealth. However, if the only assistance someone is receiving is premium assistance toward the purchase of employer-sponsored insurance or a Medicare Savings Program he or she will not get a MassHealth card. Starting in late 2008, MassHealth developed a new card. Under the new system, each eligible family member is given his or her own card, and each card has a unique identifying number that will remain assigned to the individual. Social Security numbers will no longer be displayed. Individuals enrolled with a MassHealth Managed Care Organization (MCO) or in Commonwealth Care will receive a plastic card from their MCO.

30 What is a temporary MassHealth card?

The MassHealth agency or DTA offices can also issue a temporary MassHealth paper eligibility card until a plastic card is issued if there is an “immediate need.” The DTA can issue temporary cards only for EAEDC and TAFDC applicants. The temporary card is valid for the dates specified on the card. Some providers may not be familiar with the paper card, and the automated online Recipient Eligibility Verification System (REVS) that providers use to verify eligibility will not confirm eligibility, but providers can confirm eligibility with MEC or DTA workers. There is a special protocol for pharmacy claims described in the example below.

Example: An insulin-dependent diabetic applies for EAEDC and obtains a temporary MassHealth card to obtain insulin. At the pharmacy, the pharmacist must complete a temporary ID card form (Request for Exception Processing Consideration) and fax it to ACS (the vendor that manages the pharmacy payment system). Within one hour of faxing, the relevant information will be entered into the computerized payment system and the pharmacy claim can then be submitted and approved for payment.

130 C.M.R. §§ 502.010(B), 516.009(B); 130 C.M.R. § 450.107(D), Pharmacy Billing Guide, 11.00.

31 How do people age 65 and over in traditional Medicaid apply for MassHealth?

The traditional Medicaid application is the Senior Medical Benefit Request form (S-MBR). This form is for most people age 65 or older including a person under age 65 married to someone age 65 or older. However, seniors who are working and disabled or the parents or caretakers of children under age 19 should use the Medicaid reform application, the MBR. The S-MBR form is also for people of any age who are applying for coverage of nursing home care, and for certain individuals living in the community who are seeking home- and community-based services as an alternative to nursing home care.

The S-MBR, like the MBR, can be ordered by telephone, downloaded from the MassHealth website, or obtained from many providers and community organizations, SHINE counselors, or elder service agencies and returned by mail. It can also be filed in person at a MEC. People who are not seeking long-term nursing home care can also file an application online with the assistance of hospitals, health centers, or other sites authorized to use the Virtual Gateway.

32 Who can apply on behalf of someone else?

In order to apply for an adult who is unable to apply for himself, someone must be an “eligibility representative.” A person can become an eligibility representative if the applicant is able to complete and sign a form designating that person as his or her eligibility representative. If the applicant is physically or mentally unable to designate a representative, a knowledgeable person acting responsibly on behalf of the applicant (typically a spouse or adult child) can assume the duties of eligibility representative. A person with court-appointed authority such as a guardian or conservator or executor filing a posthumous application can also become an eligibility representative. The eligibility representative may complete

and sign an application on behalf of the applicant, but must also submit the properly completed eligibility representative designation form and any required documentation; a form is included with the application packet.

130 C.M.R. §§ 501.001, 515.001 (definition of “eligibility representative”).

33 What kind of proof must be sent in along with the traditional application form?

Income. To be complete, an application must include proof of the amount of all sources of income of the individual and his or her spouse. However, the agency can verify the amount of Social Security income through a data exchange with SSA.

Assets. Proof of the value of countable assets must also be submitted in order to complete the application. See Part 12 for more information on countable assets.

Citizenship status. As of July 1, 2006, U.S. citizens must submit proof of their U.S. citizenship and identity. However, recipients of SSI, Social Security Disability Insurance (SSDI), and Medicare are exempt from this requirement. Once U.S. citizenship is verified, it remains in the system and need not be verified again.

Immigration status. In order to qualify for any type of MassHealth other than MassHealth Limited, noncitizens must submit proof of their immigration status.

Health insurance. People with private health insurance must send in a copy of the insurance card or other proof of coverage.

34 When will a traditional applicant hear if he or she is eligible?

MassHealth must make eligibility decisions within 45 days of receipt of an application if the application is complete. If more verification is needed, the MassHealth agency will send out a request for information allowing applicants for traditional Medicaid 30 more days for supplying information. Applicants can request assistance from the agency if needed and request more time to submit required verification. However, if verification is not submitted by the deadline, the application will be denied.

Applicants will be sent a computer-generated notice informing them whether or not they are eligible for benefits. Applicants who are denied MassHealth have the right to appeal. See Part 18, Notice and Appeal Rights. Applicants denied MassHealth will also receive a determination about whether they are eligible for the Health Safety Net, and applicants not eligible for Medicare may also be eligible for Commonwealth Care.

130 C.M.R. § 516.000.

35 When will traditional benefits begin?

Benefits begin on the first day of the month of application if all eligibility requirements are met on that date. If an applicant must spenddown resources to become eligible, eligibility begins on the earliest date after application that all requirements are met. In addition, retroactive eligibility is available for up to three months prior to the month of application, for any or all of the three prior months in which eligibility criteria have been met. Retroactive eligibility is important if someone has incurred medical bills before he or she applied.

130 C.M.R. § 516.005.

36 How long will someone remain eligible for MassHealth?

There is no time limit for MassHealth under Medicaid reform or traditional Medicaid. However, the agency will request information at least annually to determine if an individual continues to be eligible. Benefits may be terminated if a recipient either fails to return information at renewal, or is found to no longer meet eligibility criteria. Decisions may also occur between annual renewals if the recipient reports a change as he or she is required to do within 10 days, or if the MassHealth agency learns of a change through a data match with another agency or by other means.

Otherwise, a member can continue getting benefits for as long as he or she continues to meet eligibility requirements. In some circumstances, a member can receive time-limited, extended, or transitional benefits after he or she no longer meets eligibility criteria. Changes in age, income, employment, insured status, and ability to work may all affect whether a member continues to meet eligibility criteria. MassHealth should consider all pathways to eligibility before terminating benefits.

Example. When a high school student turns 19 and no longer qualifies as a child, MassHealth should consider whether the individual qualifies for MassHealth Essential as an unemployed adult or for Commonwealth Care as an uninsured adult before terminating his or her benefits.

130 C.M.R. §§ 502.007, 516.006; 42 C.F.R. § 435.930(b).

37 What happens to MassHealth when cash welfare recipients lose cash benefits?

MassHealth will not automatically end when someone loses eligibility for cash assistance. The MassHealth agency will review eligibility for MassHealth under other available categories of assistance, and only if there is no basis for eligibility under any coverage type will MassHealth benefits terminate. Members will

receive advance notice of any termination notice and the opportunity to appeal. In some circumstances, a person losing cash benefits may be eligible for a period of extended or transitional MassHealth benefits for a certain period of time regardless of income, see the Q & A below.

42 C.F.R. 435.930(b); 130 C.M.R. § 505.002(F) (SSI-Disability).

38 What are extended or transitional benefits?

For several coverage types, people who have been found eligible for MassHealth whose circumstances change can continue receiving benefits for a limited period of time even if they no longer meet eligibility criteria. There are no financial eligibility rules during this period of extended eligibility but someone must continue to be a Massachusetts resident, and, if eligibility is based on the presence of a child under 19 in the home, the members must continue to have a child living with them. Where extended eligibility is based on employment, the member must continue to be employed. Extended benefits are available in the following circumstances:

- n Infants who would otherwise lose eligibility for Standard when they turn age one, and 18-year-olds who would otherwise lose eligibility when they turn 19, if they are hospitalized, retain eligibility for MassHealth Standard throughout the course of the inpatient hospital stay.
- n Families who lose EAEDC or TAFDC for any reason, receive at least four additional months of MassHealth Standard coverage.
- n Youth who were in the care and custody of the Department of Children and Families on turning 18 remain eligible for MassHealth Standard up to age 21 regardless of income.
- n Transitional Medical Assistance (TMA) is available to certain families with children under age 19 who have earned income—
 - n Families who lose TAFDC due to an increase in earned income are eligible for at least 12 months of additional MassHealth Standard coverage.

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- n Families with income at or under 133 percent of poverty on MassHealth Standard (including families who may have already received a period of extended eligibility after losing TAFDC) who have earned income that brings total income over 133 percent of poverty retain eligibility for MassHealth Standard for 12 months from the date income exceeded 133 percent.
- n Families with fluctuating income should be sure to report decreases in income during the TMA period in order to return to a type of coverage that is not time-limited. If the family later experiences an increase in income, TMA will again be available for up to 12 months.

TMA advocacy: MassHealth regulations require an increase in earnings to trigger TMA for families with children when gross income exceeds 133 percent of poverty. However, two federal courts of appeal have held that, under federal law, if such a family has earnings, any change that makes them over-income for medical assistance triggers TMA; there need not be an increase in earnings. *See, e.g., Kai v. Ross*, 336 F.3d 650 (8th Cir. 2003); *Rabin v. Wilson-Coker*, 362 F.3d 190 (2d Cir. 2004).

- n Disabled working adults in CommonHealth who lose employment remain eligible for CommonHealth without a spenddown for three months so long as they pay any premium due.
- n Long-term unemployed individuals who are DMH clients or individuals and couples on EAEDC receiving MassHealth Basic who become employed can retain MassHealth Basic coverage for six months if employer-sponsored insurance is not available.
- n Individuals or couples getting the MassHealth Basic Buy-In can retain Buy-In eligibility for six months after income goes over 100 percent of poverty because of earnings.

130 C.M.R. §§ 505.002(B), (C)(1), (C)(2), (K) (Standard); 505.004(J) (CommonHealth); 505.006(B)(4), (C)(4) (Basic).

39 What happens when extended or transitional benefits end?

MassHealth benefits will not automatically end at the end of an extended eligibility period. The MassHealth agency will send out an Eligibility Review form before benefits end, and the MassHealth agency will determine whether someone remains eligible for MassHealth on any other basis. If someone is no longer eligible, he or she will be sent an advance notice of termination before benefits end. A member who disagrees with the termination notice can continue receiving benefits pending appeal if the appeal is filed within 10 days of the notice. If no longer eligible for MassHealth, the agency will also make a Commonwealth Care determination. The income ceiling for Commonwealth Care is 300 percent of the poverty level, but it is only available to those not offered subsidized insurance through an employer. See Part 10.

40 How often will the MassHealth agency review eligibility?

MassHealth is required to review eligibility at least once every 12 months with regard to circumstances that may change. Eligibility may be reviewed more frequently if MassHealth receives information that circumstances have changed or that the information on which eligibility was based may have been incorrect. Members are supposed to report changes that may affect eligibility within 10 days. Eligibility will also be reviewed before the end of an extended or transitional medical assistance period.

Eligibility reviews are handled by the regional MassHealth Enrollment Centers (MECs). Under Medicaid reform, the MECs mail out an Eligibility Review Verification Form (ERV) to be returned by a deadline. The deadline has been changed from 60 to 30 days and back and is expected to be 45 days in 2009. If the form is not returned, the case will be closed. If the form is returned but required verification is missing, the agency will request additional information and allow 60 days for it to be submitted. Recipients can request assistance if needed and additional time to submit information. If information is not returned by the

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deadline, the case will be terminated. If the case is closed, and the member appeals within 10 days of the closing notice, benefits can continue pending appeal. See Part 18, Notice and Appeal Rights.

Under traditional Medicaid, seniors are initially allowed only 30 days to respond to a request for information. If a case is closed for lack of information, and the information is submitted within 30 days of the closing, a second eligibility decision will be made and eligibility may date back to the date of closing.

130 C.M.R. §§ 502.007, 516.006.

Part 5

Eligibility Criteria for Children

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41 Which children are eligible for the most comprehensive coverage: MassHealth Standard?

A child who receives SSI, TAFDC, EAEDC, or a child for whom an adoption subsidy or foster care assistance is paid is automatically eligible for MassHealth Standard. A youth in the custody of the Department of Children and Families on turning age 18 is eligible for MassHealth Standard, without regard to income, until age 21.

See 130 C.M.R. §§ 501.004 (TAFDC, EAEDC, and SSI), 522.003 (subsidized adoption/foster care), 505.002(K), 506.004(G) (youth aging out of DCF care).

A child is also eligible for MassHealth Standard if he or she meets the following criteria:

- n residence in Massachusetts,
- n U.S. citizenship, or
- n qualified or protected immigration status (see Part 13 for a definition of these terms).

Infants (under age 1)

- n An infant born to a mother on MassHealth Standard or Limited is automatically eligible for MassHealth for one year from birth so long as the infant lives with the mother.
- n An infant born to a mother who was not on MassHealth, is eligible if gross family income does not exceed **200 percent of poverty**.
- n There is no asset test.

See 130 C.M.R. § 505.002(C).

Children, age 1–18 (under age 19)

- n Gross family income does not exceed **150 percent of poverty**.

Part 5 n Eligibility Criteria for Children

n There is no asset test.

See 130 C.M.R. § 505.002.

Special status and PRUCOL immigrant children: Children who would meet all the eligibility criteria for MassHealth Standard but who are subject to the five-year bar or permanently residing in the United States under color of law (PRUCOL) are not eligible for MassHealth Standard. Instead of MassHealth Standard, these children will receive MassHealth Family Assistance, or, if a child is disabled, CommonHealth.

Children with disabilities, age zero–17 (Kaileigh Mulligan)

The Kaileigh Mulligan program enables severely disabled children under the age of 18 to qualify for MassHealth Standard while living at home rather than in a medical institution by not counting the income and assets of their parents. Applicants for this program should use the S-MBR.

In order to be eligible for the Kaileigh Mulligan program, children must meet the following criteria:

- n either meet SSI disability standards or have been receiving SSI in 1996 and meet 1996 disability standards (see the Question below for more on the change in childhood disability criteria);
- n have \$2,000 or less in countable assets (not counting assets of the parents);
- n have a countable income of \$72.80 or less (not counting income of the parents), or meet a deductible/spenddown;
- n require a level of care equivalent to that provided in a hospital or nursing facility; and
- n have appropriate care outside an institution at an estimated cost no greater than the cost of institutional care.

See 130 C.M.R. § 519.007.

42 Which children with disabilities who do not qualify for MassHealth Standard are eligible for CommonHealth?

Disabled children ineligible for MassHealth Standard based on family income, disability, or immigration status, may be eligible for MassHealth under the more liberal criteria of CommonHealth. This is a particularly important source of benefits for disabled children who may be covered under a parent's employer-based health plan, but who need additional services that the private plan does not cover.

The following children who are not eligible for Standard are eligible for **CommonHealth**:

- n residents of Massachusetts;
- n U.S. citizens; or
- n noncitizens who are qualified, protected, special status, or PRUCOL (see Part 13 for an explanation of these terms); and
- n children under age 19 who have a permanent and total disability (explained more fully below).
- n There is no income ceiling or asset test for children in CommonHealth.

Family Assistance pending disability determination: Children who meet the eligibility criteria for Family Assistance should be enrolled in MassHealth Family Assistance while the child's disability is being determined, and upgraded to CommonHealth if disability is established.

130 C.M.R. § 505.004.

43 What is the disability standard for children in Commonwealth?

Children under 18 must have a medically determinable impairment of comparable severity to an impairment that would disable an adult or of such severity that the child is unable to engage in age-appropriate activities, as defined in Title XVI (SSI) as in effect on July 1, 1996.⁵ The disability must be expected to last 12 months or more or to result in death.

Individuals who are 18 are evaluated under the SSI disability standard for adults. Disability is established by

- n a determination of disability by the Social Security Administration (SSA);,
- n a certification of blindness by the Massachusetts Commission for the Blind;,
or
- n a determination of disability by the MassHealth agency's contractor, the Disability Evaluation Services (DES)/Disability Determination Unit at the University of Massachusetts Medical School.

See 130 C.M.R. §§ 505.004(F), 501.001 (Definition of Permanent and Total Disability).

⁵ Every year since 1996, the Massachusetts legislature has adopted a budget proviso requiring the MassHealth agency to continue using the July 1996 SSI childhood disability standard. The 1996 standard is sometimes called the *Zebley* standard in reference to a U.S. Supreme Court case called *Zebley v. Sullivan*. The *Zebley* standard requires an individualized assessment of a child's functioning in different domains to determine disability. It is a more liberal standard of disability than the current SSI childhood disability standard. See 58 Fed. Reg. 47532 (1993) (*Zebley* standard).

44 Which children are eligible for MassHealth Standard/CommonHealth Premium Assistance?

Children who are eligible for MassHealth Standard or CommonHealth as explained above may also be eligible for reimbursement for the costs of private insurance. MassHealth Standard/CommonHealth Premium Assistance (MSCPA) reimburses members for the employee share of the premium for employer-sponsored insurance or other available insurance if it is cost-effective to do so. (It is the same program that used to be called the Health Insurance Premium Payment (HIPP) program.)

If a MassHealth Standard or CommonHealth recipient is insured or has access to insurance, the MassHealth agency will investigate the availability, coverage, and costs of insurance to determine if it is cost effective for the recipient to have both MassHealth Standard/CommonHealth and private insurance coverage. If it is cost effective, the agency may require recipients to enroll in the private plan as a condition of continuing to receive MassHealth Standard/CommonHealth. However, if the private plan will cost the recipient more than MassHealth for such charges as monthly premiums, coinsurance, deductibles, or copayments, the MassHealth agency must reimburse the eligible recipient for the added costs.

Eligible individuals will continue to have MassHealth Standard or CommonHealth to supplement the private insurance. Refusal to enroll after being notified to do so may result in termination for individuals other than pregnant women and children under 19. In some circumstances, the agency may directly enroll the family in the employers' plan.

If family coverage is cost-effective, premium assistance will also benefit family members otherwise ineligible for MassHealth who are included in the private family coverage plan. See Table 8 in Appendix B for the SFY 2009 premium assistance payment upper limits based on the cost effective amounts.

Example: Two children live with their mother who works and earns \$2,000 per month. The mother's employer offers a family health insurance plan, but it would cost her \$500 per month and she cannot afford it. The children are eligible for MassHealth Standard. Because the employer-sponsored plan will cost MassHealth less than the cost-effective amount for two children, the children are eligible for MassHealth Standard Premium Assistance. MassHealth will reimburse the family

\$500 for the added premium cost of the employer's family plan. Now the mother has insurance, and the children still have MassHealth Standard to cover items like dental care that may not be included in the private plan.

130 C.M.R. § 507.003.

45 Which children are eligible for MassHealth Family Assistance?

There are two kinds of Family Assistance: Premium Assistance and Direct Coverage (the MassHealth agency calls the latter Purchased Coverage). Unlike MassHealth Standard and CommonHealth, in Family Assistance a person may get Premium Assistance or Direct Coverage but generally not both. With Premium Assistance, the MassHealth agency reimburses the family for most of the premium cost for employer-sponsored insurance for the child and other family members covered by the employer's family coverage policy. If employer-sponsored coverage is not available or is not cost-effective, a child can get MassHealth direct coverage but the family must pay a monthly premium to the state for coverage. The July 2006 expansion to higher income children added eligibility criteria designed to discourage families from dropping private insurance in order to obtain MassHealth. See Table 2, How Employer-Sponsored Insurance Affects Children's Eligibility for Family Assistance.

Family Assistance Premium Assistance

Children not eligible for MassHealth Standard or CommonHealth who meet the following criteria are eligible for Family Assistance Premium Assistance to help reimburse the family for the costs of employer-sponsored insurance that covers the eligible children:⁶

n under age 19;

n residents of Massachusetts,

⁶ See Part 17 for more information on the costs to the family of Family Assistance Premium Assistance.

Part 5 n Eligibility Criteria for Children

- n U.S. citizens, or
- n noncitizens who are qualified, special status, or PRUCOL (see Part 13 for a definition of these terms);
- n gross family income does not exceed 300 percent of poverty for U.S. citizen or qualified noncitizen children, or 200 percent of poverty for noncitizen children who are special status or PRUCOL;
- n for children at or under 200 percent of poverty, insured or uninsured with access to employer-sponsored health insurance;
- n for children between 200 and 300 percent of poverty, not insured through employer sponsored insurance in the six months prior to application unless an exception applies (*see* 130 C.M.R. § 505.005(H));
- n Children from 201 to 300 percent of poverty who are ineligible for up to six months because of this requirement will still be eligible for primary and preventive care from the Children’s Medical Security Plan (CMSP) during their waiting period.
- n have access to employer-sponsored health insurance that meets the following criteria:
 - n is available through a member of the family group;
 - n the employer pays at least 50 percent of total premium costs;
 - n the benefits equal a “basic benefit level” defined at 130 C.M.R. § 501.001,⁷ and
 - n the MassHealth agency determines that Premium Assistance is “cost effective” relative to the costs of Direct Coverage. See Table 8 in Appendix B for the current premium assistance upper payment limits based on the “cost effective” amounts.

Example: Assume the total premium cost for family coverage under an employer’s plan is \$800 per month, and the employer and employee each pay \$400. Premium assistance of \$400 will not be cost effective to MassHealth if there is only one eligible child in the family, but it will be cost effective if there are two or more eligible children in the family.

⁷ The basic benefit standard must satisfy the definition of “minimum creditable coverage” established by the Health Insurance Connector Authority at 956 C.M.R. § 5.00

n There is no asset test.

130 C.M.R. §§ 505.005(B), 505.005(H).

Family Assistance Direct Coverage

Children not eligible for Family Assistance Premium Assistance because they do not have access to cost effective employer-sponsored health insurance are eligible for Family Assistance Direct Coverage if they meet the following criteria:

- n under age 19;
 - n Massachusetts residents,
 - n U.S. citizens, or
 - n noncitizens who are qualified, special status, or PRUCOL (see Part 13 for an explanation of these terms);
- n gross family income does not exceed 300 percent of poverty for U.S. citizen or qualified noncitizen children, or 200 percent of poverty for noncitizen children who are special status or PRUCOL; and
- n for children with family income over 200 percent but not over 300 percent of poverty, uninsured in the six months prior to application, unless one of the following exceptions applies:
 - n special or serious health care needs of child,
 - n prior coverage involuntarily terminated,
 - n loss of prior coverage due to death of parent,
 - n loss of prior coverage due to domestic violence,
 - n loss of prior coverage due to parent's self-employment, or
 - n exhaustion/reduction of lifetime benefits.
- n Children who are ineligible for up to six months because of this requirement will still be eligible for CMSP.
- n Children who are HIV positive with family income not in excess of 200 percent of poverty are eligible to have Family Assistance direct coverage as a supplement or "wraparound" to employer-sponsored health insurance.

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n There is no asset test.

130 C.M.R. § 505.005(E).

Table 2: How Employer-Sponsored Insurance Affects Children’s Eligibility for Family Assistance

Insured Status	Eligible for Family Assistance Direct Coverage?	Eligible for Family Assistance Premium Assistance?
Insured at time of application and insurance meets criteria for Premium Assistance (PA)	No*	Yes if under 201% FPL; No if over 200% FPL
Insured at time of application and insurance does not meet criteria for PA	No	No
Uninsured with no access to insurance meeting criteria for PA and no insurance in past six months	Yes if under 300% FPL	No
Uninsured with no access to insurance meeting criteria for PA but insured in past six months	Yes if under 201% FPL; No if over 200% FPL unless exception applies	No
Uninsured with access to insurance that meets criteria for PA and no insurance in past six months	No*	Yes
Uninsured with access to insurance that meets criteria for PA but insured in past six months	No*	Yes if under 201% FPL; No if over 200% FPL unless exception applies

* Children who are HIV positive with income that does not exceed 200 percent of poverty may be eligible to receive both premium assistance and direct coverage.

46 Which children ineligible for other coverage due to immigration status are eligible for MassHealth Limited?

Children who would qualify for MassHealth Standard based on their age and gross family income but are unable to document an eligible immigration status are eligible for emergency Medicaid through MassHealth Limited. These children are also eligible for health programs other than MassHealth that do not have eligibility rules related to citizenship or immigration status such as the Children’s Medical Security Plan (CMSP). The notice of decision will typically describe their benefits as CMSP Plus Limited. They will also be eligible for the Health Safety Net. See Part 19 for more on these programs.

130 C.M.R. §§ 505.008, 504.002(F).

47 Can a child living on his or her own get MassHealth?

Yes. There is no requirement that a child be living with a parent or caretaker relative in order to qualify for MassHealth; this is based on the definition of “Family Group” at 130 C.M.R. § 501.001. A child old enough to be living on his or her own should be able to file an application on his or her own. However, a child who is too young to be living independently, should have a responsible adult fill out the MBR as the child’s eligibility representative.

See G.L. c. 112, § 12F regarding the capacity of a minor to consent to medical treatment.

48 Can a high school student age 19 or older get MassHealth?

A high school student age 19 or older who is not working may qualify for MassHealth Essential as a long-term unemployed adult. If the high school student is working, but is not offered subsidized insurance at work, he or she may qualify for Commonwealth Care. The parents will not be included in the family group of a child age 19 or older, and the parents' income will not be counted against the child for either MassHealth or Commonwealth Care.

130 C.M.R. § 505.007 (MassHealth Essential).

49 Can a college student get MassHealth?

It depends. College students are required to obtain qualifying student health insurance (QSHIP) from their college or university as a condition of enrolling in a Massachusetts institution of higher education or to have comparable coverage. MassHealth Basic, MassHealth Essential and Commonwealth Care all exclude college students eligible for QSHIP offered by the college or university they attend. However, college students may obtain MassHealth Standard or Family Assistance if they otherwise meet the eligibility requirements for coverage.

114.6 C.M.R. § 3.03(2) (QSHIP); 130 C.M.R. §§ 505.006 (MassHealth Basic), 505.007 (MassHealth Essential); 956 C.M.R. § 3.09 (Commonwealth Care).

50 What programs are available for children who do not qualify for MassHealth?

All uninsured children in Massachusetts have access to some kind of affordable primary and preventive care. Children in families with income over 300 percent of poverty, or children who are not eligible for MassHealth because of their immigration status have access to coverage through the Children's Medical Security Plan and the Health Safety Net. See Part 19, Health Programs Other than MassHealth.

Part 6

Eligibility Criteria for Pregnant Women

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54.	Which pregnant women are eligible for MassHealth Limited?	69
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51 Which pregnant women are eligible for MassHealth Standard?

Pregnant women who are Massachusetts residents and U.S. citizens or qualified noncitizens with gross family income that does not exceed 200 percent of poverty are eligible for **MassHealth Standard**. The fetus of a pregnant woman is counted in determining family size for purposes of income eligibility. Coverage continues throughout the pregnancy and for 60 days after the child's birth. If a mother is on MassHealth Standard or MassHealth Limited at the time the child is born, the infant will be automatically enrolled in MassHealth Standard. The hospital will send a notification of birth form to the MassHealth agency in order to automatically enroll the newborn.

Example: A single woman is pregnant with twins. Her income is compared to a family size of three to determine if she is financially eligible for MassHealth Standard.

130 C.M.R. § 505.002(E).

52 Do assets count for pregnant women?

No. There is no asset test for pregnant women in MassHealth Standard, MassHealth Limited, or Healthy Start. Pregnant women are also exempt from premiums and copayments.

53 What is MassHealth Prenatal?

MassHealth Prenatal is a temporary form of MassHealth that begins right away but only covers ambulatory prenatal care. A pregnant woman who submits a MassHealth application and whose self-declared family income does not exceed

200 percent of poverty is eligible for MassHealth Prenatal for up to 60 days while the agency is awaiting submission of required verification needed to make a formal eligibility determination: income, U.S. citizenship, or an eligible immigration status.

130 C.M.R. § 505.003.

54 Which pregnant women are eligible for MassHealth Limited?

Pregnant women with gross family income up to 200 percent of poverty who would be eligible for MassHealth Standard but are noncitizens who do not document an eligible immigration status are eligible for emergency Medicaid under MassHealth Limited. Limited will cover labor and delivery costs but not prenatal care.

See 130 C.M.R. § 505.008.

55 What programs cover prenatal care for pregnant women not eligible for MassHealth?

The **Healthy Start** program covers prenatal care and 60-day postpartum care for pregnant women with gross family income at or under 200 percent of poverty; the fetus counts in determining family size. There is no citizenship or immigration status requirement but women must be Massachusetts residents. Healthy Start uses the same application form as MassHealth. Women eligible for Healthy Start will also qualify for MassHealth Limited to cover the hospital charges for labor and delivery and for the Health Safety Net. See Part 19, Health Programs Other than MassHealth. Healthy Start receives federal funding from the T. XIX State Children's Health Insurance Program.

130 C.M.R. § 522.005.

Part 7

Eligibility Criteria for Parents and Caretaker Relatives

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56 Who is a parent or “caretaker relative”?

A parent may be a natural, step or adoptive parent living with a child under age 19. A caretaker relative is defined as 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 in the home.

A parent living with a child under 19 must be included in the same family group as the child. However, a caretaker relative who does not want MassHealth for himself or herself can choose not to be included in the child’s household and to apply only on behalf of the child. A caretaker relative may not want to apply if he or she has income that would make the child ineligible or if the relative does not want to disclose his or her immigration status. However, a caretaker relative may be able to qualify for MassHealth as the member of an eligible group if he or she chooses to apply with the child.

Unrelated caretakers: A caretaker who is *not* a relative and has very low income may be able to qualify for EAEDC cash assistance from DTA which brings with it automatic MassHealth eligibility for the family.

130 C.M.R. § 501.001.

57 Are parents and caretaker relatives eligible for MassHealth Standard?

Parents or caretaker relatives living with children under age 19 qualify for MassHealth Standard if:

- n they are Massachusetts residents;
- n they are U.S. citizens or qualified or protected noncitizens;
- n gross family income does not exceed 133 percent of poverty; or

Part 7 n Eligibility Criteria for Parents and Caretaker Relatives

- n they receive TAFDC (DTA determines eligibility for TAFDC, and families automatically receive MassHealth Standard); or
- n they would have qualified for AFDC based on the eligibility rules in effect in July 1996.
 - n The 1996 welfare reform law restricted eligibility for cash welfare for families with children and linked Medicaid eligibility to pre-welfare reform standards rather than the new more restrictive standards. In MassHealth, the 133 percent of poverty income standard is much higher than 1996 AFDC standards, but reference to the 1996 standards is sometimes useful when a family has income from a source that is included under the MassHealth gross income test but would not have been included in AFDC.

130 C.M.R. § 505.002(D).

58 When are parents eligible for other types of MassHealth?

MassHealth Standard is the only type of direct MassHealth coverage available to low-income individuals just because they are parents living with a child under age 19. However, adults may be eligible for other types of MassHealth regardless of whether or not they are parents if they are: disabled, HIV-positive, long-term unemployed or working for certain small employers in the Insurance Partnership. Also, parents who are not eligible for MassHealth based on income or immigration status may be eligible for Commonwealth Care. See Parts 8 and 9 for types of MassHealth available to people with disabilities and other adults, and Part 10 for Commonwealth Care.

59 When are parents eligible for Premium Assistance?

Premium Assistance reimburses a family for most of the employee's share of the premium cost of employer-sponsored family health insurance coverage. Parents may be eligible for premium assistance in their own right, or they may be the incidental beneficiaries of premium assistance for which their children are eligible.

In MassHealth, the income eligibility for children (300 percent of poverty) is much higher than the income eligibility for parents (133 percent of poverty). With direct MassHealth coverage, this often means eligible children have coverage and their parents have Commonwealth Care or only Health Safety Net. However, with Premium Assistance, the children and their parents can all be covered under the same family coverage plan offered through an employer.

Premium Assistance is available in most of the MassHealth coverage types. In MassHealth Standard and CommonHealth Premium Assistance (MSCPA), it supplements MassHealth direct coverage for those family members who are eligible for direct coverage, and is not limited to employer-subsidized insurance. See Part 5 for more about MSCPA. In Family Assistance Premium Assistance, it replaces direct coverage, see below.

60 Are parents and caretaker relatives eligible for Family Assistance Premium Assistance?

In Family Assistance, either a family is reimbursed for most of the premium cost for employer-sponsored insurance or the child receives direct MassHealth coverage but, unlike MSCPA, an eligible person generally cannot receive both direct coverage *and* premium assistance.

A parent, just like a childless adult, may qualify for Family Assistance Premium Assistance in his or her own right if he or she is not eligible for MassHealth Standard or CommonHealth and is working for a qualified employer participating

in the Insurance Partnership. See Part 9 for the eligibility criteria for the Insurance Partnership. However, unlike a childless adult who will be charged a premium at the adult rate, a parent working for a qualified employer will be charged a premium only for his or her eligible children.

If the parent is not eligible for Family Assistance in his or her own right through the Insurance Partnership, the parent may still be able to benefit from premium assistance for family coverage through the eligibility of his or her child for Family Assistance. See Part 5, for a description of children eligible for Family Assistance Premium Assistance.

130 C.M.R. § 506.012.

61 What benefits are available to parents ineligible for MassHealth Standard due to immigration status?

As discussed above, if a child is eligible for Premium Assistance, the family coverage will benefit parents who may not themselves be eligible for MassHealth benefits. Also, immigrant parents who are special status or PRUCOL are not eligible for MassHealth Standard but may be able to qualify for Commonwealth Care. See Part 10.

Noncitizen parents or caretaker relatives who would qualify for MassHealth Standard but who cannot document an eligible immigration status are eligible for emergency Medicaid through MassHealth Limited and the Health Safety Net. *See* 130 C.M.R. § 505.008.

62 For what programs other than MassHealth are parents eligible?

Parents with income under 300 percent of poverty who are not offered subsidized insurance by their employers may be eligible for subsidized insurance through the Commonwealth Care program. Parents eligible for unemployment compensation may be eligible for health coverage under the Medical Security Plan administered by the Division of Unemployment Assistance. Parents may also be eligible for the Health Safety Net. For more information on these programs, see Part 19, Health Programs Other than MassHealth, and Part 10, Commonwealth Care.

Part 8

Eligibility Criteria for Disabled Adults Ages 18–64

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63 Which adults with disabilities can get the most comprehensive coverage—MassHealth Standard?

People under age 65 who are Massachusetts residents, U.S. citizens, or qualified or protected noncitizens, and who meet the following criteria are eligible for MassHealth Standard:

- n individuals or couples who receive Supplemental Security Income (SSI) or received SSI in the past and are still “deemed” SSI recipients (see Part 3, Relationship Between MassHealth Eligibility and Receipt of Cash Assistance);
- n individuals or couples who are “permanently and totally disabled” and have gross family income no more than 133 percent of poverty without regard to their assets;
- n certain older individuals who meet the level of care criteria for nursing home or other institutional care but are able to live at home and qualify under the requirements of the Home and Community Based waiver (age 60 or older), or the PACE program (age 55 or older) described in Part 11; or
- n individuals who meet the level of care criteria for nursing home or other institutional care and who satisfy the financial eligibility criteria applicable to long-term nursing home care (see Parts 12 and 15 for more on the eligibility criteria for nursing home care).

See 130 C.M.R. §§ 505.002(F), 519.007 (HCBS and PACE), 519.006 (nursing home care).

64 What is the disability test for adults?

The disability test for MassHealth Standard is the same test used in the SSI program: a medically determinable physical or mental impairment that prevents the individual from engaging in substantial gainful activity and can be expected to

last for at least 12 months or result in death. *See* 130 C.M.R. § 501.001 (definition of “permanent and total disability”). For more information on the SSI disability standard, *see* 20 C.F.R. Part 416, and *Legal Rights of Individuals with Disabilities* (MCLE, Inc. 2002).

65 Who makes the determination as to an adult’s disability?

Disability is established by

- n a determination of disability by the Social Security Administration (SSA);
- n a certification of blindness by the Massachusetts Commission for the Blind; or
- n a determination of disability by the MassHealth agency’s contractor, the Disability Evaluation Service (DES)/Disability Determination Unit at the University of Massachusetts Medical School.

Disability determination for DTA: The DES determines disability for DTA for purposes of TAFDC and EAEDC eligibility as well as for MassHealth. It conducts a consolidated evaluation under all three standards regardless of whether the application came from the DTA or the MassHealth agency. Someone applying to DTA for EAEDC will be automatically upgraded from MassHealth Basic to MassHealth Standard if the DES finds that the individual meets the SSI-level disability criteria. *See* 130 C.M.R. § 505.002(F)(3). The reverse is not true—a MassHealth applicant who only meets the EAEDC standard will be denied MassHealth Standard benefits for not meeting the SSI-level standard but may be eligible for Commonwealth Care. The individual will have to separately apply to DTA for EAEDC and MassHealth Basic.

66 Which adults with disabilities who are not eligible for MassHealth Standard can get CommonHealth?

Adults who are not eligible for MassHealth Standard but meet the following criteria are eligible for CommonHealth:

- n resident of Massachusetts;
- n U.S. citizen; or
- n qualified or protected noncitizen;
- n “permanently and totally disabled,” as defined at 130 C.M.R. § 501.001;
- n age 19 to 64, not working 40 hours or more per month, and having met a one-time deductible amount; or
- n any age if working 40 hours or more per month.

There is no income eligibility ceiling and no asset test, but monthly premiums are due for individuals with gross family income over 150 percent of poverty. See Part 17 for more information on premiums.

130 C.M.R. §§ 505.004 (under age 65), 519.012 (working disabled age 65 and older).

67 What is the one-time deductible?

Disabled adults who are not working and have gross income over 133 percent of poverty or, if they are HIV positive, over 200 percent of poverty, are not eligible for CommonHealth until they have incurred medical expenses that equal or exceed the amount of a deductible. Once they have incurred medical and related expenses that equal or exceed the amount of the deductible, they will not have to meet a deductible again until they turn age 65. For information on how to

calculate the amount of the one-time deductible, and what expenses can be used to meet the deductible, see Part 12, Financial Eligibility.

Disabled individuals with a one-time deductible and income under 300 percent of poverty will generally be eligible for Commonwealth Care. If they are later able to meet the CommonHealth deductible, they will then be upgraded to that program . (The similarity in the names of the two programs is an unfortunate source of confusion.) See Q & A 71 below and Part 10 for more on Commonwealth Care.

68 **What are CommonHealth eligibility criteria for working disabled adults?**

Working disabled adults eligible for CommonHealth without a deductible must meet the following criteria regarding disability and work:

- n “permanent and total disability” as defined in 130 C.M.R. § 501.001, except for engaging in substantial gainful activity; and
- n employment for at least 40 hours per month or if employed less than 40 hours, employment for at least 240 hours in the six months prior to the month of application or renewal.
 - n Employment is not defined, and there is no minimum earnings requirement. Advocates report that the MECs apply a flexible standard in recognizing employment, sometimes using a \$1 per hour rule of thumb to identify employment.

See 130 C.M.R. §§ 505.004, 519.012.

69 What are the CommonHealth eligibility criteria for 18-year-olds?

In SSI, there is a different disability standard for children under 18 and for adults age 18 and over. In MassHealth, persons who are age 18 must meet the SSI adult disability standards as working or not working adults, but they do not have to meet a one-time deductible if they are not working. See Part 5 for the disability criteria for persons under age 18.

130 C.M.R. § 505.004(E).

70 What are the disability standards for adults ages 18–64 in CommonHealth?

Disability is determined by the same agencies that determine disability for MassHealth Standard and the definition of disability is also the same SSI standard used in MassHealth Standard except for working disabled adults.

Under the SSI disability standard, someone who is working and earning enough for the work to be considered “substantial gainful activity” is not considered disabled. This bar does not apply to the working disabled in CommonHealth. However, applicants must still have a medical condition that satisfies all other aspects of the SSI disability standard.

See 130 C.M.R. § 505.004(B).

71 Which adults ages 18–64 with disabilities get MassHealth Basic/Essential or Commonwealth Care?

Adults with disabilities may be enrolled in MassHealth Basic or Essential or Commonwealth Care in the following situations:

- n **Pending disability determination.** Adults with disabilities who do not yet have a disability determination and who are also long-term unemployed will be enrolled in MassHealth Essential until the Disability Evaluation Service/Disability Determination Unit (DES) makes a disability determination. If they are clients of DMH and long-term unemployed, they may be enrolled in MassHealth Basic. If their gross family income exceeds 133 percent of poverty, they may be enrolled in Commonwealth Care pending the disability determination. If the DES eventually determines that they are disabled, their MassHealth will be upgraded to MassHealth Standard or to Commonwealth Care if they are working or can meet the spenddown. If DES determines that they are not disabled, and their income is under 133 percent of poverty and they are not in MassHealth Essential or Basic, they may then be determined eligible for Commonwealth Care.
- n **Disability less than SSI.** Adults with disabilities who do not have a disability that is expected to last 12 months or more or does not otherwise meet the SSI disability standard may be able to qualify for EAEDC under the EAEDC disability standard. Recipients of EAEDC are eligible for MassHealth Basic (some “special status” immigrants are eligible for Essential instead).
 - n To be disabled under EAEDC rules someone must have one or more impairments that substantially reduce his or her ability to support himself or herself, and that are expected to last at least 60 days. 106 C.M.R. § 320.200.
 - n To be eligible for EAEDC, an applicant must also apply to the DTA, and meet EAEDC income and asset rules. *See EAEDC Advocacy Guide* (MLRI/MCLE, Inc. 2008).
- n **Aliens with special status.** Adult noncitizens who satisfy the disability criteria and who are subject to the five-year bar or PRUCOL are also eligible for MassHealth Essential. See Part 13.

- n **Disputed disability or unable to meet spenddown.** Adults with disabilities who are determined by DES *not* to meet the disability criteria, or who are ineligible for CommonHealth until meeting a spenddown, may be eligible for Commonwealth Care. See Part 10.

72 What MassHealth coverage is available for women with breast or cervical cancer?

Women at higher income levels may be eligible for MassHealth Standard through the Breast and Cervical Cancer Treatment program (BCCT) if they meet the following criteria:

- n age 19 to 64;
- n uninsured (or underinsured for cancer treatment);
- n not otherwise eligible for MassHealth Standard;
 - n Women eligible for MassHealth Basic/Essential or Commonwealth Care can qualify for BCCT in order to be upgraded to MassHealth Standard.
- n gross family income not over 250 percent of poverty; and
- n screened through a clinic that is part of the Department of Public Health Women’s Health Network (WHN) and found to need treatment for breast or cervical cancer.
 - n Applications for MassHealth based on the need for breast or cervical cancer treatment must be processed by a Women’s Health Network site.
 - n A woman who has already been diagnosed with breast or cervical cancer may still satisfy the screening requirement if her clinician completes a form supplied by the WHN site.
 - n To locate a WHN site, call the Women’s Health Network at 1-877-414-4447.

There is a sliding scale premium charge for women with income over 150 percent of poverty. See Table 18 in Appendix B. Eligibility for BCCTP continues only

while the woman is receiving cancer treatment. When treatment ends, the MassHealth agency will review whether the woman is eligible on some other basis for MassHealth or Commonwealth Care.

130 C.M.R. § 505.002(H).

73 What other programs are available for people with disabilities?

The following programs for seniors described in Part 11 are also available to some people under 65 with disabilities. The MassHealth programs listed below use traditional Medicaid financial eligibility rules including an asset test, except as noted, not the rules under Medicaid reform.

MassHealth Programs:

- n Home and Community Based Services Waiver (age 60 or over);
- n PACE Program (age 55 or over); and
- n Medicare Savings Programs (no minimum age).

Also see Part 10 for Commonwealth Care and Part 19, Health Programs Other than MassHealth, for a description of the following programs:

- n Commonwealth Care (age 19 or older and not eligible for Medicare);
- n Prescription Advantage (no minimum age);
- n Massachusetts Home Care (age 60 or over or diagnosis of Alzheimer’s disease);
- n Health Safety Net (no minimum age); and
- n veterans’ health benefits (no minimum age).

Individuals with HIV/AIDS may be eligible for assistance from one of these programs:

Part 8 n Eligibility Criteria for Disabled Adults Ages 18–64

- n The Massachusetts Insurance Connection will make premium payments to continue existing insurance coverage for disabled individuals with HIV/AIDS and gross family income under 300 percent of poverty. For more information, see 130 C.M.R. § 522.000 or call the MIC Program Coordinator at 617-210-5320.

- n The Department of Public Health provides HIV drug assistance or health insurance premium assistance for HIV-positive state residents. For more information visit www.crine.org or call 800-228-2714.

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Eligibility Criteria for Other Adults Under Age 65

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74 Which other adults under age 65 can get MassHealth?

MassHealth is available to adults under age 65 who need not be pregnant, parents, or disabled if they fall under one of these eligible groups:

- n HIV positive,
- n employees of or self-employed “qualified employers,”
- n long-term unemployed,
- n recipients of EAEDC, or
- n recipients of refugee resettlement assistance.

Adult not eligible for MassHealth with gross family income not in excess of 300 percent of poverty may also be eligible for Commonwealth Care. See Part 10.

75 What are the eligibility requirements for individuals who are HIV positive?

Individuals who are HIV positive but are not disabled are eligible for Family Assistance if they meet the following criteria:

- n residents of Massachusetts,
- n U.S. citizens or qualified noncitizens,
- n not eligible for Standard or CommonHealth,
- n under age 65,
- n HIV positive, and
- n with gross family income that does not exceed 200 percent of poverty.

- n There is no asset test.
- n There is a monthly premium charge for individuals with income over 150 percent of poverty. See Table 18.

Family Assistance Premium Assistance. Individuals with cost-effective insurance or access to such insurance are eligible to receive premium assistance to reimburse them for most of the premium costs of private insurance. See Table 8 for the cost effective amounts in SFY 2009.

Family Assistance direct coverage. HIV-positive individuals are eligible for direct coverage if they are uninsured or as a wraparound to cover services not available through the private plan for which they are reimbursed under Premium Assistance. Being able to receive both Family Assistance Premium Assistance and Family Assistance direct coverage is only available to HIV-positive children and adults. 130 C.M.R. § 505.005D(5)(b).

Other programs for people with HIV disease.

- n The Office of Medicaid also administers an insurance reimbursement program for individuals disabled by HIV disease who are not otherwise eligible for MassHealth called the Massachusetts Insurance Connection. For more information see 130 C.M.R. 522.000 or call 617-210-5320.
- n The Department of Public Health HIV/Aids Bureau administers an HIV Drug Assistance Program (HDAP) that can pay for HIV drugs or pay for insurance for coverage that includes HIV drugs (the Comprehensive Health Insurance Initiative). For more information visit www.crine.org or call 800-228-2714.

130 C.M.R. §§ 505.005(D) (Premium Assistance), 505.005(F) (direct coverage).

76 Can other adults get MassHealth premium assistance to pay for employer-sponsored insurance?

Adults who work for certain small employers or who are self-employed may qualify for Family Assistance Premium Assistance to pay part of the employee's

Part 9 n Eligibility Criteria for Other Adults Under Age 65

share of the cost of employer-sponsored insurance. See Table 18 for the minimum cost to the employee with Premium Assistance, and Table 8 for the maximum subsidy available to the employee. To be eligible for premium assistance, the application must go through an employer who is participating in the Insurance Partnership program, and an employee must meet the following criteria:

- n resident of Massachusetts;
- n U.S. citizen or qualified noncitizen;
- n not eligible for Standard or CommonHealth;
- n adult age 19 to 64;
- n with gross family income less than or equal to 300 percent of poverty;
 - n Income eligibility increased from 200 to 300 percent of poverty effective October 1, 2006.
- n not insured with his or her current employer in the past six month; and
 - n This is a new requirement effective October 1, 2006; it does not apply to employees who were already enrolled in Family Assistance Premium Assistance prior to the effective date or to self-employed individuals who purchased their own insurance.
- n employed by a qualified employer or self-employed as a qualified employer participating in the Insurance Partnership.
 - n The employee completes the usual application for MassHealth (the MBR), but it must be accompanied by a cover sheet from the employer identifying the employer as a participant in the Insurance Partnership, and an affidavit regarding coverage in the past six months.

130 C.M.R. § 505.005(C).

77 What is a “qualified employer”?

A qualified employer is a small employer who has no more than 50 full-time employees, or a self-employed person, who:

- n offers or intends to offer health insurance that meets the “basic benefit level” defined at 130 C.M.R. § 501.001;
- n contributes at least 50 percent of the total cost of the health insurance premiums; and
- n has applied and been approved as a qualified employer under the Insurance Partnership program.

See 130 C.M.R. § 650.010 (Insurance Partnership).

78 What is the Insurance Partnership program?

The Insurance Partnership (IP) is a program funded under the Section 1115 demonstration waiver that pays “qualified employers” a portion of the cost of providing insurance to eligible employees. Eligible employees of qualified employers receive assistance from MassHealth to pay the employee’s share of the premium cost. Employees of an employer who offers subsidized insurance are not eligible for Commonwealth Care but may be eligible for Premium Assistance if their employer participates in the IP.

The Insurance Partnership will pay the employer monthly for each eligible employee: \$400 per year for individual coverage, \$800 per year for couple/dual coverage, or \$1,000 per year for family coverage.

The 2006 health reform law made several changes to the program. It raised the employee’s income eligibility from 200 percent to 300 percent of poverty, but also imposed a new requirement that the employee not have been insured through his or her current employer for the six months prior to application. Another change eliminated the employer subsidy for self-employed individuals but they remain eligible for premium assistance.

130 C.M.R. § 650.000.

79 What is the difference between Family Assistance Premium Assistance and Commonwealth Care for self-employed adults?

Since its inception in 2000, most of the participants in the IP have been self-employed. Now Commonwealth Care offers self-employed individuals an alternate source of assistance. Self-employed individuals with gross family income that does not exceed 300 percent of poverty may be eligible for either Premium Assistance or Commonwealth Care. Premium Assistance requires the individual to choose from among any insurance plan available in the commercial market that meets certain minimum standards, and it reimburses a portion of the cost. Commonwealth Care provides benefits through participating managed care plans that offer a prescribed set of benefits at a premium cost that varies with income.

In Premium Assistance, the cost to the self-employed individual will always be at least 50 percent of the full premium cost plus the minimum premium charge shown in Table 18, but it may well be more. The maximum amount of premium assistance cannot exceed the amount shown in Table 8. The minimum premium charge for Commonwealth Care is shown in Table 18, but it may be more if the individual chooses a managed care organization other than the lowest cost one participating in the region.

Currently, there is uncertainty about the circumstances in which a self employed person who is in the Insurance Partnership as a qualified employer can voluntarily terminate participation in the IP and enroll in Commonwealth Care instead.

See 130 C.M.R. §§ 505.005(C) (Premium Assistance), 650.000 (Insurance Partnership); 956 C.M.R. § 3.09 (Commonwealth Care).

80 Which unemployed adults are eligible for MassHealth Basic?

Individuals or couples who meet the following criteria are eligible for MassHealth Basic:

- n residents of Massachusetts;
- n U.S. citizens or qualified noncitizens;
- n long-term unemployed clients of the Department of Mental Health (DMH) who have gross family income under 100 percent of poverty;
 - n long-term unemployment is defined the same way it is in MassHealth Essential; see below.
 - n to be a DMH client, an individual must apply to DMH and be determined a person with a severe and persistent mental illness. Individuals on the waiting list for DMH services as well as those receiving services are considered clients of DMH. Unlike cash assistance recipients, DMH clients must file a separate application with the MassHealth agency to qualify for MassHealth; coverage is not automatic but the DMH determination is electronically transmitted to the MassHealth agency and need not be proved by the applicant; or
- n recipients of cash welfare under Emergency Aid to Elders, Disabled and Children (EAEDC). The Department of Transitional Assistance determines eligibility for EAEDC and recipients automatically receive MassHealth Basic (certain special status/PRUCOL immigrants receive MassHealth Essential instead).

130 C.M.R. § 505.006.

81 Which unemployed adults are eligible for MassHealth Essential?

On April 1, 2003, state law eliminated MassHealth Basic coverage for long-term unemployed adults unless they were also clients of the Department of Mental Health (DMH). However, on October 1, 2003, the state created a new program called MassHealth Essential for long-term unemployed adults who were not DMH clients. The new program had an enrollment cap and operated with a waiting list reaching into the thousands until July 1, 2006 when the cap was raised to enroll everyone off the waiting list as part of the health reform law. Currently, there is no enrollment cap.

Eligible individuals or couples must be:

- n residents of Massachusetts;
- n U.S. citizens or qualified noncitizens; or
- n special status or PRUCOL noncitizens who are disabled;⁸
- n under age 65;
- n currently unemployed; and
 - n unemployed for at least the past 12 months, or
 - n with earnings in the past 12 months that are less than the minimum required to qualify for unemployment compensation (\$3,300 per year in SFY 2009),
 - n individuals cannot be denied if they are employed only intermittently or on a nonregular basis;⁹
- n not eligible for unemployment compensation;
- n not eligible for health insurance offered by a college or university that the applicant attends;

⁸ See Part 11 regarding the MassHealth Essential eligibility of elderly special status and PRUCOL immigrants.

⁹ This provision is included in annual budget language. St. 2008, c. 182, § 2, item 4000-1405.

- n without affordable health insurance;
- n with gross family income at or under 100 percent of poverty; and
- n with a spouse, if any, employed no more than 100 hours per month.
- n There is no asset test.

130 C.M.R. § 505.007.

Premium assistance: Individuals or couples who would be eligible for MassHealth Basic or Essential except that they have access to health insurance for which they must pay a premium may be eligible for Premium Assistance. The MassHealth agency will contribute the actual cost of the premium up to a maximum amount per month instead of providing direct coverage.

82 How do MassHealth Basic and MassHealth Essential differ?

MassHealth Essential covers fewer services than MassHealth Basic; see Table 18. Currently, none of the MassHealth managed care organizations participate in Essential, but this may be changing in SFY 2010. In Basic, up to six months extended eligibility is available for individuals who return to work and do not have insurance at work, but there is no extended eligibility in MassHealth Essential. Also, Essential is available to elderly and disabled special status and PRUCOL immigrants.

83 Which childless adult refugees are eligible for MassHealth Standard?

Refugees eligible for assistance from the refugee resettlement program are eligible for eight months of coverage under MassHealth Standard if they are under

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65 with gross family income under 100 percent of poverty and assets under \$2,000 for an individual or \$3,000 for a couple. This provision for eight months of coverage primarily benefits childless, nondisabled adults who would not otherwise be eligible for MassHealth. After eight months, the MassHealth agency will determine whether the refugees qualify for MassHealth under any other basis or for Commonwealth Care.

130 C.M.R. § 522.02.

84 What is EAEDC?

Emergency Aid to Elders, Disabled and Children is a cash assistance program administered by the Department of Transitional Assistance (DTA). Recipients automatically receive MassHealth. Disabled individuals who do not meet the SSI disability or immigration status criteria or are waiting for an SSI disability determination are often able to receive EAEDC. Emergency Aid to Elders, Disabled and Children recipients are also eligible for a limited EAEDC benefit while awaiting selection of a managed care plan and enrollment into MassHealth Basic. For more information on the eligibility criteria for EAEDC, see Part 3 and *EAEDC Advocacy Guide* (MLRI/MCLE, Inc. 2008).

130 C.M.R. § 501.004(B)(2).

85 What other programs are available for adults who are not eligible for MassHealth?

Adults with income under 300 percent of poverty who are not offered subsidized insurance by their employers may be eligible for subsidized insurance through the new Commonwealth Care health insurance program beginning October 1, 2006. See Part 10 for a discussion of Commonwealth Care.

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Adults eligible for unemployment compensation may be eligible for health coverage under the Medical Security Plan administered by the Division of Unemployment Assistance. Childless adults may also be eligible for the Health Safety Net. Many veterans are eligible for health care from the Veterans Administration. For more information on these programs see Part 19, Health Programs Other than MassHealth.

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Part 10

Eligibility Criteria for Uninsured Adults in Commonwealth Care

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86 Which uninsured adults are eligible for Commonwealth Care?

The 2006 Health Reform law required all adults age 18 or older to obtain health insurance if it is affordable. Because commercial insurance is not affordable to many low and moderate income people, the law created a new subsidized insurance program for uninsured adults up to 300 percent of the poverty level. The eligibility criteria include several provisions to discourage “crowd out”—individuals dropping other coverage in order to obtain Commonwealth Care. To be eligible, individuals must be:

- n Massachusetts residents;
- n U.S. citizens or noncitizens who are lawfully residing in the United States as qualified, special status or PRUCOL immigrants (see Part 13 for a definition of these terms);
- n with gross family income not in excess of 300 percent of the poverty level;
- n not eligible for MassHealth (except for MassHealth Limited), Medicare, the State Children’s Health Insurance Program, or the Children’s Medical Security Plan;¹⁰
- n uninsured;
 - n insured individuals who pay the full cost of insurance themselves such as those paying for COBRA or nongroup coverage are treated as uninsured;
 - n uninsured individuals must *not* be eligible for certain other programs such as—
 - college students eligible for Qualifying Student Health Insurance (QSHIP) from the college or university they attend;
 - commercial fishermen and their spouses eligible for the Fishing Partnership;

¹⁰ There is no age limit in the statute or regulations, but any uninsured person under age 19 will be eligible for either MassHealth or the Children’s Medical Security Plan, and therefore not eligible for Commonwealth Care.

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- individuals collecting unemployment compensation and their spouses who are eligible for the Medical Security Plan, and
- active service members or retirees and their spouses who are eligible for TRICARE.

For more about the eligibility criteria for these other programs, see Part 19.

- n not receiving an incentive to decline employer-sponsored insurance; and
- n not eligible for employer-sponsored insurance provided in the last six months by a current employer of the applicant or a family member in which the employer subsidizes at least 33 percent of the premium cost of individual coverage or 20 percent of the cost of family coverage;
 - n the law provides that this provision may be waived if the employer pays its share of the premium cost to Commonwealth Care, but the waiver provision has not been implemented to date.
 - n An individual is eligible during the waiting period for employer-sponsored insurance to begin.

G.L. c. 118H, § 3; 956 C.M.R. §§ 3.04, 3.05, 3.09.

87 How is Commonwealth Care administered?

The 2006 Health Reform law created a new entity called the Health Insurance Connector Authority to administer Commonwealth Care and to implement other aspects of the new law. It is governed by a 10 member appointed board of directors and a paid staff. There is an executive director of the Connector and under him a director of the Commonwealth Care program. Unlike the MassHealth agency, the Connector is an independent authority and is not under EOHHS. However, the health reform law requires the Connector to coordinate with the MassHealth agency in administering Commonwealth Care.

Commonwealth Care is part of the 1115 Medicaid demonstration waiver, however the federal agency, CMS, has given its approval for Commonwealth Care to operate differently than MassHealth in many respects.

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The Connector has arranged for the MassHealth agency to make initial eligibility determinations for Commonwealth Care using the common application form, the MBR. Commonwealth Care essentially incorporates by reference the MassHealth rules defining family group, income, residence, qualified or PRUCOL immigrants and requires compliance with MassHealth procedural rules for verifying eligibility.

Like MassHealth, the Connector has contracted with private vendors to deliver a variety of services. Currently a company called Perot Systems staffs the Commonwealth Care customer service line and administers premium billing. Another company called HMS investigates access to insurance as part of the eligibility determination.

One of the challenges of Commonwealth Care is determining which agency, MassHealth or the Connector, is responsible for a given decision and is able to correct an error.

G.L. c. 176Q (the Connector); G.L. c. 118H, § 2; 956 C.M.R. §§ 3.04, 3.05 (use of MassHealth eligibility procedures and definitions in Commonwealth Care).

88 What benefit are available in Commonwealth Care?

Commonwealth Care provides comprehensive benefits comparable to private insurance through participating managed care organizations. Commonwealth Care has several plan types: Plan Type 1 is for individuals under the poverty level; Plan Type 2A is for those with income between 101 and 150 percent of poverty, Plan Type 2B is for those with income between 151 and 200 percent of poverty, and Plan Type 3 is for those with income over 200 percent of poverty. Only Plan Type 1 offers dental benefits. However, enrollees in Plan Types 2 and 3 are eligible for dental care through the Health Safety Net where it is available. Each plan type has a different schedule of copayments, but except for dental, the required benefits in all plan types are the same. The scope of Commonwealth Care benefits is similar to MassHealth Basic or Family Assistance. See Table 18.

The benefits in Commonwealth Care are not specified in regulations and provider manuals as they are in MassHealth but rather through a contract between each MCO and the Connector. The Connector must approve the Explanation of

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Benefits (EOB) prepared by each MCO as the official description of benefits for members. New members are sent a member handbook with this information. It can also be found on the MCOs' websites. Advocates should look to the EOB for the most detailed account of covered benefits. Links to the MCOs websites, and a benefit and copayment schedule are on the Connector's website at www.mahealthconnector.org.

G.L. c. 118H, § 6 (required benefits for those under the poverty level); 956 C.M.R. §§ 2.00 (standards for MCO participation), 3.04 (definition of Plan Types).

89 How are services delivered in Commonwealth Care?

Commonwealth Care delivers services exclusively through managed care organizations (MCOs). Unlike MassHealth, Commonwealth Care has no fee-for-service system or Primary Care Clinician Plan. For its first three years, only the four MassHealth MCOs were eligible to participate in Commonwealth Care. However, for FY 2010, bidding will be open to any MCO.

Each MCO has a network of participating hospitals and other providers, and enrollees are restricted to its network of providers. Because the required benefits of each Commonwealth Care plan are the same, the primary basis for selecting one MCO over another is whether it is available in the member's service area, the MCO's network of providers, and its premium cost. Most of the MCOs also offer extra benefits that may differ.

Individuals can switch MCOs within the first 60 days of enrollment with an MCO, but after that, they are locked into an MCO until the next open enrollment period unless they have good cause to switch earlier. The Connector has a Health Plan Change Request form for this purpose; if a request is denied, it can be appealed. 956 C.M.R. § 3.13(5) (good cause to transfer). This is different from MassHealth managed care where members can change MCOs at any time.

Commonwealth Care enrollees are entitled to the consumer protections of the state managed care law. This requires the MCOs to pay for out of network services in certain limited circumstances. Disputes over whether a service is medically necessary can be appealed to the Department of Public Health Office of

Patient Protections (OPP) under the state managed care law. The OPP contracts with three external review agencies to review managed care appeals. In most cases ongoing treatment can be continued pending appeal. For more information on the external review process including the statute and regulations and frequently asked questions, see www.mass.gov/dph/opp.

G.L. c. 118H, § 4; G.L. c. 176O; 105 C.M.R. § 128.00 (MCO consumer protections).

90 How much does Commonwealth Care cost?

There are two kinds of member costs in Commonwealth Care: monthly premium contributions and copayments. Copayments are charges to the member that are collected by the provider at the point of delivering certain services. Monthly premium costs vary by income/plan type, by choice of MCO, and by region. The copayments vary only by income/plan type. The following costs are in effect through June 30, 2009:

- n Gross family income does not exceed 100 percent of poverty (Plan Type 1)—
 - n no premium charge regardless of MCO choice;
 - n copayments no higher than MassHealth, i.e., \$2 for generic drugs, \$3 for brand name drugs, \$200 annual cap for drug copayments.
- n Gross family income between 101 and 150 percent of poverty (Plan Type 2A)—
 - n at least one MCO available for no premium charge; premium charges may apply for other MCO choices;
 - n copayments somewhat less than average commercial plans, e.g., \$10 for an office visit (see Table 9).

Copayment waivers. Individuals with income under 150 percent of poverty in an MCO with no premium charge can apply for a waiver of copayments on hardship grounds. 956 C.M.R. § 3.11(5)(c). Such individuals who are recorded as homeless in the MassHealth computer system automatically have their copayments waived on hardship grounds.

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- n Gross family income between 151 and 200 percent of poverty (Plan Type 2B)—
 - n at least one MCO for \$39 per month (SFY2009); higher premium for other MCO choices;
 - n copayments same as 2A but no waiver available.
- n Gross family income between 201 and 250 percent of poverty (Plan Type 3)—
 - n at least one MCO for \$77 per month (SFY2009); higher premium for other MCO choice;
 - n copayments similar to average commercial insurance, e.g., \$15 for an office visit (see Table 9).
- n Gross family income between 251 and 300 percent of poverty (Plan Type 3)—
 - n at least one MCO for \$116 per month (SFY2009); higher premium for other MCO choice;
 - n copayments similar to average commercial insurance, e.g., \$15 for an office visit (see Table 9).

The minimum premium contribution and copayment and benefits schedules are determined annually by the Board of the Connector and published by posting on www.mahealthconnector.org. 956 C.M.R. §§ 3.11(8) (premium schedule), 3.12 (premium contribution). See Table 9 in Appendix B for the copayment schedules through June 30, 2009. Premiums and copayments are adjusted on July 1 of each year.

91 When does coverage begin in Commonwealth Care?

Unlike most types of MassHealth, the start of coverage is not determined by the application date. Instead coverage does not begin in Commonwealth Care until the first of the month after someone chooses an MCO plan, and, if a premium is due, pays the first month's premium in advance. Individuals in Plan Type 1 who

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never have a premium charge regardless of MCO choice, will be automatically assigned to an MCO if they do not select one on their own. Currently, the Connector only has the capacity to enroll individuals prospectively on the 1st of the month. When coverage ends, it ends on the last day of the month.

In order to avoid a delay in coverage, enrollees should select an MCO as soon as possible. If no premium is due and the MCO choice is made in time to allow three business days before the end of the current month, an individual should be enrolled on the first of the following month. If an enrollee will owe a premium, the first premium contribution must be received by the Connector by the 25th day of the current month to ensure enrollment by the first of the following month. Individuals who are currently insured must also meet a cut-off in the current month to be enrolled by the first of the following month as explained below. If any cut-off date is missed, enrollment will be delayed for an entire month.

- n To assure receipt of the premium, it may be paid in person at the Boston Office of the Customer Service Center, or mailed by overnight mail to a designated address. See Part 20.

Some gaps in coverage may occur when individuals are moving from one form of subsidized coverage to Commonwealth Care and may easily occur in other circumstances as well:

- n For individuals who are losing MassHealth, MSP or other subsidized coverage, the other subsidized coverage must have ended by the 25th of the current month in order for Commonwealth Care to begin on the first of the following month.
- n For individuals who are insured through COBRA or nongroup coverage, the Connector Customer Service Center must obtain verification that insurance is not subsidized and “take down” the record of other insurance by the 25th of the current month in order for Commonwealth Care to begin on the first of the following month.

Individuals determined eligible for Commonwealth Care will also be eligible for time-limited Health Safety Net (HSN) coverage from 10 days before the application date until 90 days after the application date; if an individual has enrolled in this time, HSN will continue until the first of the month that Commonwealth Care coverage begins.

See Commonwealth Care Administrative Bulletin 01-07 (May 31, 2007), and Frequently Asked Questions about Commonwealth Care posted at www.mahealthconnector.org.

92 Why are some eligible individuals denied Commonwealth Care?

Implementation of the Commonwealth Care rules designed to assure that people do not have access to other insurance has been problematic. Many individuals have experienced delays in enrollment and gaps in coverage due to complicated and confusing rules. Advocates are still trying to understand and find solutions to these problems.

In many cases, people who report earnings will be assumed to have access to employer-sponsored insurance and will be provisionally denied or terminated from Commonwealth Care subject to approval or reinstatement after meeting an exception. In these cases, the initial MassHealth notice of decision will be followed by a separate notice from the Connector including an exception form to be completed and returned to a PO Box. A private vendor contacts the employer to verify the exception, and if an exception applies, a new determination will be made.

n It is important that anyone with earnings who is not offered insurance by an employer, answer No to the questions on the VG, MBR, ERV (renewal form), or Job Update form asking if the employer offers insurance or has offered insurance in the past six months. Also anyone reporting a new job should be sure to inform the MEC if the employer does not offer insurance.

Similarly, individuals who may be eligible for QSHIP, MSP, the Fishing Partnership, or TRICARE are asked certain screening questions on the MBR and will be initially denied if the answers suggest they are eligible for the other program. The denial is subject to later approval on proof of ineligibility for the other program but there is no provision for retroactive enrollment. It is not always clear from the notice whether proof of ineligibility should be submitted to the MassHealth agency or to the Connector or to the same PO Box used for exceptions. However, if the denial is based on incorrect information, it should almost always be communicated to the MEC and in most cases should lead to a new eligibility determination. In some cases, it may be necessary to inquire, or to submit the information in more than one way and/or appeal to cover all options.

Applicants and recipients harmed by these policies should be referred to a legal advocate.

See MassHealth Eligibility Operations Memo 08-03 (Feb. 15, 2008); and Commonwealth Care Exception Form Investigation Overview (October 2008), posted on www.mahealthconnector.org.

93 How do you resolve disputes in Commonwealth Care?

There are three different agencies that may resolve disputes in Commonwealth Care depending on the nature of the dispute.

Eligibility. Most eligibility issues, except those related to access to insurance should be resolved with the MassHealth agency. This includes issues related to income and employment, family group composition, eligible immigration status, as well as procedural issues related to the receipt of forms and verification. Generally, if information initially submitted to MassHealth has changed (or was submitted or processed incorrectly), MassHealth should be notified of the updated or corrected information. If matters cannot be resolved informally with the MEC, Commonwealth Care eligibility decisions (except those related to access to insurance) can be appealed to the Board of Hearings.

Eligibility issues related to access to insurance. Most eligibility issues related to access to insurance should be resolved with the Connector or through the PO Box to its vendor. This includes issues related to whether a current employer offers or has in the past six months offered subsidized insurance. Appeals related to access to insurance can be appealed directly to the Connector.

Enrollment effective date. After the MassHealth agency determines eligibility, the Connector handles enrollment, so most enrollment issues should be raised with the Connector. This includes situations where the applicant has met all cut-off dates in the current month and is still not enrolled on the first of the following month. Sometimes the reason enrollment does not occur is because the MassHealth MMIS system is blocking enrollment into managed care based on incorrect information that the applicant has other insurance. However, even in these cases the Connector Customer Service Office is probably the best source for a remedy. Appeals related to enrollment should go to the Connector.

Managed care assignment. In Commonwealth Care, unlike MassHealth, MCO choices are “locked in” 60 days after they are made unless the enrollee has good cause to change plans. There is a Connector form to request good cause to change plans, and if the request is denied, the appeal goes to the Connector.

Premiums. Premiums are based on two factors Plan Type and MCO choice. Plan Type is a function of income and income is determined by MassHealth. Therefore premium disputes related to assignment to the wrong Plan Type based on income should be raised with MassHealth. Premium disputes related to MCO choice, or premium billing disputes, premium nonpayment, payment plans, etc., should be raised with the Connector. The Connector also has a procedure to waive premium charges based on hardship as discussed further below.

Medical necessity/covered benefits. Most disputes about whether a particular medical service is covered should be raised in the first instance with the MCO. Each MCO has a grievance/appeal process for resolving such disputes that is described in the member handbook. If a dispute about the medical necessity of a covered service cannot be resolved with the MCO, an enrollee is entitled to an external appeal with the DPH Office of Patient Protections. This is the same appeal mechanism available under commercial insurance plans. In some cases it may also be helpful to bring such a dispute to the attention of the Connector legal office.

G.L. c. 118H, § 4 (notice and appeal rights); 956 C.M.R. §§ 3.14 (right to a hearing), 3.17(1) (hearings by MassHealth Board of Hearings), 3.17(2) (hearings by the Connector), 3.16 (appeals of MCO actions to Office of Patient Protections).

94 **What happens if a person cannot afford the premiums in Commonwealth Care?**

After an eligibility determination, a person who will be charged a premium cannot enroll until paying the premium or obtaining a hardship waiver in advance of the first month of enrollment. Enrollment will take place only after a waiver is granted (or premium paid). After initial enrollment, members will receive an invoice early in the month that is due by the 25th of the month for coverage in the current month.

Part 10 n Eligibility Criteria for Uninsured Adults in Commonwealth Care

A person who is charged a premium will be disenrolled if a premium is more than 60 days past due. To avoid loss of benefits for nonpayment of premiums, an enrollee has the following options.

- n If the individual has experienced a drop in income, or increase in family size (or other change in circumstance that may affect eligibility), he or she should notify MassHealth so that a new determination can be made that may reduce or eliminate the premium due.
- n Past due premiums will remain a debt unless a hardship waiver is granted but will not be grounds to terminate someone whose income is now below 150 percent of poverty.
- n If the premiums are due, payment of at least two months of past due premium contributions will prevent termination.
- n If the premiums are due, negotiating a payment plan to catch up on the premium arrearage with the Connector Customer Service office will prevent termination.
- n If the premium is due but the individual is experiencing an extreme financial hardship, he or she can request a waiver of premium payments for the duration of the hardship situation for up to 12 months at a time. The Connector has a request form for this purpose. The hardship request will postpone a termination until the request is granted or denied provided the request is made at least five days before the scheduled termination. The following circumstances are considered hardships if the enrollee:
 - n is homeless, more than 30 days behind in housing payments or has received eviction or foreclosure notices;
 - n has a current shut-off notice or service refusal for an essential utility;
 - n incurred unreimbursed medical expenses that exceed 7.5 percent of gross family income in certain circumstances; or
 - n has incurred significant increase in essential expenses in the last six months due to domestic violence, death of a partner, need for a caregiver, or natural disaster.
- n If there is a dispute about the amount of premiums due and the individual cannot resolve the billing dispute with the Connector Customer Service Center, the dispute can be appealed. However, it is not clear whether an

Part 10 n Eligibility Criteria for Uninsured Adults in Commonwealth Care

appeal of a disputed premium debt would stop a scheduled termination. The assistance of a legal advocate may be needed.

- n If the individual is in Plan Type 2A (income not in excess of 150 percent of poverty), rather than being terminated for nonpayment of premiums, he or she will be transferred to an MCO that has no premium charge.

956 C.M.R. § 3.11.

95 What are appeal rights in Commonwealth Care?

An individual determined ineligible for Commonwealth Care will receive a notice of decision and notice of appeal rights from the MassHealth agency along with a form to appeal to the MassHealth Board of Hearings. The notice will also include a notice of decision regarding eligibility for MassHealth benefits and these too are appealable to the Board of Hearings. Under the rules and practices of the Board of Hearings, a current recipient of Commonwealth Care should be able to continue receiving benefits pending appeal to the Board of Hearings. However, if the Board of Hearings determines that the issue on appeal is related to access to insurance, it will dismiss the Board of Hearings appeal and transfer the appeal to the Connector. The Connector does not currently provide aid pending appeal.

An individual determined ineligible for Commonwealth Care based on access to insurance will receive a notice of decision from the MassHealth agency along with a form to appeal to the Connector. An individual sent an Exceptions form by the Connector will also be sent a form to appeal to the Connector in the event that no exception applies. If an appeal is filed with the Connector that it determines should have been filed with the Board of Hearings, the Connector will dismiss the appeal and transfer it to the Board of Hearings.

Any other decision made directly by the Connector such as denying a request for good cause to switch plans, or denying a request for a premium or copayment hardship waiver will be accompanied by a notice of the right to appeal to the Connector and its appeal form. A decision to terminate benefits based on nonpayment of premiums will also be issued by the Connector along with its own appeal form.

Part 10 n Eligibility Criteria for Uninsured Adults in Commonwealth Care

An individual may want to appeal both the MassHealth and the Commonwealth Care eligibility denial. It is probably safest to file both appeals along with notice to each agency of the other appeal; in most cases it will make more sense for the MassHealth appeal to be heard first since its success will usually make the Commonwealth Care appeal moot.

One of the Connector's staff lawyers is the director of its Appeals Unit but appeals are heard by private attorneys under contract to hear Connector appeals. Appeals take place in the Boston offices of the Connector, or by telephone. Fair hearing decisions by the Connector are subject to judicial review under G.L. c. 30A.

Advocacy note: There are two serious due process problems with the Connector appeal process: it does not provide current recipients with an opportunity for a hearing before their benefits are terminated, and it has no mechanism for providing corrective action back to the date of the erroneous decision in the event that the appeal is successful. To date relief has been negotiated on a case by case basis with Connector legal staff, but eventually these issues will need to be resolved through legislation or court action.

Disputes with the MCOs about the medical necessity of covered services are raised first through the MCOs internal appeal process and then through an external appeal to the Office of Patient Protections. The filing fee for OPP appeals is waived for Commonwealth Care. In most cases ongoing treatment can be continued pending appeal. The OPP contracts with three different external review organizations to conduct a paper review of the issue on appeal, but such reviews are not due process hearings. For more information, see the OPP website at www.mass.gov/dph/opp.

G.L. c. 118H, § 4; 956 C.M.R. §§ 3.14–3.17; 801 C.M.R. 1.00 (hearing procedures); 105 C.M.R. 128.00 (DPH OPP); 130 C.M.R. 610 (MassHealth Board of Hearings); Commonwealth Care Administrative Bulletin 01-07, ¶ 8 (May 31, 2007) (“No appeal that is timely filed will be dismissed only because it was incorrectly filed at either BOH or the Connector.”).

Part 11

Eligibility Criteria for Adults Age 65 and Over

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96 Which people age 65 or over are eligible for MassHealth Standard?

Noninstitutionalized individuals age 65 or older can qualify for MassHealth Standard if:

- n they have countable income no more than 100 percent of poverty and countable assets no more than \$2,000 for an individual or \$3,000 for a couple (see Part 12, Financial Eligibility, on what income counts, what deductions from income are allowed, and what assets count);
- n their income or assets exceed 100 percent of poverty or \$2,000/\$3,000, but they have met a deductible or reduced their assets;
- n they qualify for Home and Community-Based Waiver or PACE services;
- n they receive SSI or TAFDC;
- n they no longer receive SSI but are deemed to receive it; or
- n they are the parents or caretaker relatives (e.g., grandparents) living with a child under 19 with gross family income at or under 133 percent of poverty.

See 130 C.M.R. §§ 519.002–.005.

97 What Medicaid protections apply to seniors who no longer receive SSI?

There are several programs designed to protect Medicaid eligibility for former SSI recipients when they lose SSI due to eligibility for Retirement, Survivors, and Disability Insurance (RSDI). See Part 3 for more information about when former SSI recipients who appear to be over-income for MassHealth Standard are “deemed” to be still receiving SSI in order to remain eligible for Medicaid.

98 Which people age 65 or over can get CommonHealth?

Working disabled individuals age 65 and over are eligible for CommonHealth under the same criteria as those under 65: hours of work must be at least 40 hours per month, or 240 hours in the past six months; there is no upper income limit or asset test, but monthly premiums are charged on a sliding scale starting at 150 percent of poverty. Disabled seniors who are not working are not eligible for CommonHealth. See Part 8.

See 130 C.M.R. § 519.012.

99 When are people age 65 and over eligible for MassHealth Essential?

The only people age 65 and older eligible for MassHealth Essential are noncitizens who are not eligible for MassHealth Standard because of their immigration status but who are legally present in the United States and considered special status or PRUCOL. Such immigrants may receive MassHealth Essential based on receipt of EAEDC cash assistance or based on an application to the MassHealth agency. See Part 13 for an explanation of the immigration issues.

Like other elders, special status immigrants receive services on a fee-for-service basis, but unlike other elders, the benefit package is restricted to that of MassHealth Essential plus MassHealth Limited. See Table 18. MassHealth Essential does not include nursing home care or home health care services, but some home care services may be available through the Department of Elder Affairs. In some circumstances it may be possible to establish an emergency need for home care services under MassHealth Limited on a case by case basis. See the Q & A below.

130 C.M.R. §§ 519.002(D) (EAEDC), 519.013 (Essential).

100 Which people age 65 or over can get MassHealth Limited?

Seniors who would be eligible for MassHealth Standard but for immigration status are eligible for emergency Medicaid through MassHealth Limited. Those with “special status” will have Essential plus Limited. In some unusual cases it may be possible to obtain home health services under Limited. There is no prescribed form for this, but some advocates have had success writing to the Medicaid Director and the Legal Office with extensive medical documentation showing that without a visiting nurse or other home care services the individual will imminently face a life-threatening situation.

See 130 C.M.R. § 519.009.

101 How can people age 65 or over get MassHealth Standard if their incomes or assets exceed the limits?

If an applicant’s income exceeds the limits for MassHealth Standard, he or she can qualify for coverage for up to six months at a time after incurring medical expenses that equal or exceed a deductible amount in each six-month period. If his or her assets exceed the limits for MassHealth, he or she can qualify for coverage by spending down his or her assets. See Part 12, Financial Eligibility, for more information on how to calculate and meet the deductible and how to spend down assets.

102 What is the Home and Community-Based Services Waiver?

The Home and Community-Based Services (HCBS) waiver, sometimes called the spousal income waiver or the Section 2176 waiver, both expands the eligibility criteria for MassHealth Standard and provides additional services not otherwise available in MassHealth Standard to people who would otherwise require nursing home care. Aging Service Access Points (ASAPs) help determine eligibility for the HCBS waiver. To qualify for the HCBS waiver, an individual:

- n must be 60 years of age or older;
- n if under 65, must be disabled in accordance with SSI standards;
- n must be someone who would be institutionalized in a nursing facility without one or more waiver services provided by the Executive Office of Elder Affairs;
- n must not have transferred resources for less than fair market value as described at 130 C.M.R. §§ 520.018 and 520.019;
- n must have countable income (not counting the income of a spouse) no more than three times the federal benefit amount for SSI for an individual, i.e., not over \$2,022 per month in 2009;
- n must have countable assets (not counting the assets of a spouse) of \$2,000 or less;
- n if income or assets are over these limits, must have reduced assets or met a deductible.

See 130 C.M.R. § 519.007(B).

103 What is the PACE program?

The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive health program designed to keep frail, older individuals living in the community.

Part 11 n Eligibility Criteria for Adults Age 65 and Over

It both expands eligibility and provides additional services and coordination of care for those participating in the program through a Medicare/Medicaid managed care program. An individual is eligible for the PACE program if he or she—

- n is 55 years of age or older;
- n if under 65, is disabled in accordance with SSI standards;
- n meets the clinical level of care for MassHealth nursing home payment;
- n has countable income (not counting the income of a spouse) no more than three times the federal benefit amount for SSI for an individual, i.e., not over \$2,022 per month in 2009;
- n has countable assets (not counting the assets of a spouse) no greater than \$2,000;
- n lives in a designated service area; and
- n receives services from a community-based PACE program (currently, there are only six PACE providers operating in 10 sites).

See 130 C.M.R. § 519.007(C).

104 When are seniors covered by the more generous eligibility rules under Medicaid reform?

Seniors with the following characteristics are eligible for MassHealth based on the same criteria as those under 65 under Medicaid reform. This means no asset test and income limits higher than the poverty level standard:

- n seniors who are disabled and working more than 40 hours per month or 240 hours in the past six months are eligible for CommonHealth; and
- n seniors who are the parents or caretaker relatives of children under the age of 19 are eligible for MassHealth Standard if gross family income does not exceed 133 percent of poverty.

n Seniors who do not have Medicare with income that does not exceed 300 percent of poverty may also be eligible for Commonwealth Care.

The regulations require that someone not be eligible for Medicare, but in practice this appears to mean someone not be enrolled in Medicare and not be eligible for premium-free Medicare Part A.

130 C.M.R. §§ 519.005(C), 519.012 (MassHealth); 956 C.M.R. § 3.09 (Commonwealth Care).

105 What are the eligibility rules if a senior is a nursing home resident?

In order for people age 65 or older (and younger people with disabilities) to qualify for MassHealth payment for long-term nursing home care, in addition to satisfying clinical criteria and universal MassHealth eligibility requirements, the nursing home resident must satisfy financial eligibility rules that are different from the rules that apply to someone who is not in an institution. *See* 130 C.M.R. § 519.006.

An eligible nursing home resident may have income higher than the federal poverty level but will be required to contribute most of it to the costs of his or her care except for a monthly personal needs allowance. For a nursing home resident, the countable asset limit is \$2,000 but special deductions may apply. For a married couple, the rules allow for the spouse who will remain at home to retain a certain amount of the couple's income and assets to meet his or her own needs. Also, individuals who have transferred resources for less than fair market value during a specified look-back period, may be ineligible for a period of time. These rules are briefly described in Part 12 but a detailed account is beyond the scope of this Guide. For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

106 What Medicare costs does MassHealth cover?

If a person has both Medicare and MassHealth Standard coverage, MassHealth Standard will pay the Medicare premiums, and the recipient will not be liable for Medicare deductibles and coinsurance. MassHealth will continue to cover all MassHealth Standard services, except prescription drugs, so long as providers bill Medicare first.¹¹ Medicare recipients are not limited to the elderly but include people under age 65 with disabilities who have been eligible for Social Security insurance-based disability benefits for at least 24 months.

In addition, some people who have Medicare but who are not financially eligible for MassHealth Standard are eligible for Medicare Savings Programs in which the Office of Medicaid pays some or all of the Medicare premiums, deductibles, and coinsurance. Paying these Medicare costs is the only benefit the Medicare Savings Programs offer; people eligible for these programs do not receive a MassHealth card, and do not have MassHealth coverage to supplement services that Medicare does not cover.

107 What are the Medicare Savings Programs?

MassHealth Buy-In for Qualified Medicare Beneficiaries (QMB) pays for Medicare premiums under Medicare Part A (if any) and Part B, and the recipient will not be liable for Medicare deductibles and coinsurance. The Buy-In/QMB is available to Medicare beneficiaries (of any age) who:

- n are Massachusetts residents;
- n are U.S. citizens or qualified noncitizens;
- n are entitled to Medicare Part A;

¹¹ See Part 15 for a description of how Medicare prescription drug which began on January 1, 2006 affects MassHealth recipients.

Part 11 n Eligibility Criteria for Adults Age 65 and Over

- n have adjusted countable income no more than 100 percent of poverty (in some cases, applicable deductions may allow a disabled person to have higher *gross* income than 133 percent of poverty for MassHealth Standard);
- n have countable assets no more than \$4,000 for an individual or \$6,000 for a couple (this is higher than the asset limit for seniors in MassHealth Standard which is \$2,000 individual/\$3,000 couple); and
- n meet the nonfinancial eligibility criteria for MassHealth Standard.

See 130 C.M.R. § 519.010.

MassHealth Buy-In for Specified Low-Income Beneficiaries (SLMB) and Qualifying Individuals (Q-1) pays the costs of Medicare Part B premiums. In 2009, the standard Part B premium is \$96.40 per month. It does not pay for Medicare deductibles and coinsurance or Part A premiums. This program is available to Medicare beneficiaries (of any age) who:

- n are entitled to Medicare Part A,
- n have adjusted countable income no more than 135 percent of poverty,
- n have countable assets no more than \$4,000 for an individual or \$6,000 for a couple, and
- n meet the nonfinancial eligibility criteria for MassHealth Standard.

130 C.M.R. § 519.011.

108 What other programs are available to seniors who do not qualify for MassHealth?

Seniors not eligible for MassHealth due to excess income or assets or due to immigration status may get help paying for prescription drugs and home care as well as relief from debt for treatment in hospitals and community health centers under the following programs:

- n Prescription Advantage,

Part 11 n Eligibility Criteria for Adults Age 65 and Over

- n Massachusetts Home Care, and
- n Health Safety Net (formerly Uncompensated Care Pool /Free Care) (see Part 19, Health Programs Other than MassHealth, for a description of these programs).

Seniors not eligible for Medicare may also qualify for Commonwealth Care. See Part 10.

Part 12

Financial Eligibility

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109 What are the criteria for financial eligibility?

MassHealth eligibility is generally based on the gross income of all family group members not exceeding a specified percentage of the federal poverty level for a family of that size. The poverty level is published in the Federal Register, usually in January, and takes effect in MassHealth on March 1 or April 1. Table 5 in Appendix B shows the percentage of poverty that applies to different coverage types and the dollar values for different family sizes in 2008–2009 (March 1, 2008 to February 28, 2009). An updated table for 2009–2010 will be posted on www.masslegalservices.org.

People covered under the Section 1115 waiver (Medicaid reform) have income counted differently than people in traditional Medicaid. Also, assets are not considered in Medicaid reform, but to be eligible for traditional Medicaid, countable assets cannot exceed certain limits. Another route to MassHealth is through the receipt of cash assistance where eligibility is determined under rules applicable to the cash assistance program; see Part 3 for more information on cash assistance financial eligibility rules.

110 Whose income counts under Medicaid reform?

The MassHealth Section 1115 waiver included a waiver of federal Medicaid law regarding whose income counts and what counts as income.¹² The incomes of people who are included in the family group are counted in determining eligibility of any member of the family group who is applying for MassHealth. A family group can consist of:

- n an individual who is not included as a couple or a family;

¹² The Medicaid reform rules apply to those under 65 who do not need institutional care and are not eligible based on “deemed SSI” status; the Medicaid reform rules also apply to seniors who are eligible as parents or disabled workers.

- n a couple who are married, live together, and have no children under 19 living with them;
 - n As of October 31, 2008, the MassHealth agency will treat two people of the same sex who are married as a couple.
 - n Marriage can be an advantage or disadvantage for MassHealth eligibility and access to services depending on the circumstances, e.g., a spouse is not eligible to receive compensation as a personal care attendant or adult foster caregiver for his or her own spouse.
- n a family consisting of one or more children under 19, and the parents living with them;
- n a family consisting of one or more children under 19 and their children; if the parents of a minor parent or pregnant minor also live in the home, they (the grandparents) can choose whether or not to be included in the family group of the minor parent and child;
- n a family consisting of one or more children under 19 and, if no parent is in the home, a caretaker relative; the caretaker relative can choose whether or not to be included in the family group; or
- n a family consisting of siblings under the age of 19 and their children even if no adult parent or caretaker is in the home.

Example: A household consists of a 20-year-old girl living with her 40-year-old parents, brothers aged 10 and 12, and grandparents aged 67 and 70. It contains three MassHealth family groups: the 20-year-old is an individual; the parents and younger brothers are a family; and the grandparents are a couple. If all three family groups choose to apply for MassHealth, they must submit three application forms: one MBR for the 20-year-old, one MBR for her parents and brothers, and an S-MBR for her grandparents.

130 C.M.R. §§ 501.001, 506.002; 2008 Mass. c. 251 (MassHealth equality for married couples regardless of sex).

111 What counts as income under Medicaid reform?

Under the Section 1115 waiver (Medicaid reform), there is no asset test and the income standard is higher than traditional Medicaid but most of the Medicaid rules allowing for income deductions and disregards have been waived. As with traditional Medicaid, income from certain sources is not counted at all.

Countable income includes all nonexempt gross earned and unearned income of members of the family group. The following deductions from gross income are the only ones allowed:

- n business expenses allowable on a U.S. tax return can be deducted from income from self-employment, and
- n rental expenses allowable on a U.S. tax return can be deducted from rental income.

130 C.M.R. § 506.003.

The MassHealth agency will also count income that someone no longer receives if the income was transferred to someone else for the primary purpose of establishing eligibility for MassHealth.

130 C.M.R. § 506.006.

112 What does not count as income under Medicaid reform?

Income from certain sources is exempt and does not count as part of gross family income. Income from the following sources does not count:

- n income received by a TAFDC, EAEDC, or SSI recipient;
- n sheltered workshop earnings;

- n certain federal veteran's benefits;
- n income in kind, e.g., the value of free lodging;
- n roomer and boarder income from someone sharing the applicant's home; and
- n any other income excluded by federal laws other than the Social Security Act. A partial list of such federal laws that exclude income can be found in the SSI regulations at 20 C.F.R. Part 416, Appendix K (located after Section 416.1182).

130 C.M.R. § 506.004.

Other excluded income: Sometimes when treatment of income is not clear in a particular case, the MassHealth agency makes a legal/policy decision to exclude income without amending its regulations to clarify how the income is treated. Instead a sub-regulatory policy is communicated internally to the MECs but usually not provided to the public. From the resolution of past cases, we know the MassHealth agency has determined the following sources of income do not count: **adoption assistance subsidies to the adoptive parents, adult foster care stipends to the caregiver, Americorps stipends, and certain flexible benefit contributions** that may be recorded on a pay stub as part of gross income but can only be used for health insurance.

113 How is monthly income determined?

MassHealth bases its income determinations on current monthly income. To arrive at monthly income, it multiplies weekly income by 4.333, two-week income by 2.166, and divides annual income by 12. Watch out for twice monthly income (24 paychecks per year) being mistakenly calculated as two-week income (26 paychecks per year).

For seasonal workers where earnings depend on the time of year, monthly income can be based on average annual income. The MBR has a space to identify someone as a seasonal worker and list annual income. A seasonal worker must also submit verification of annual income (rather than just two pay stubs) in order to have annual income divided by 12.

130 C.M.R. §§ 506.007, 506.003.

114 Do assets matter under Medicaid reform?

There is no asset test used to determine eligibility under Medicaid reform. Income derived from assets will be counted, such as interest on a savings account. Most lump sums, such as lottery winnings, will be income in the month of receipt. However, all individuals, regardless of age, who require long-term care in a nursing home or other medical institution, must meet the eligibility criteria for long-term care, which do include an asset test.

115 How is the CommonHealth one-time deductible calculated for disabled adults?

There is no upper income limit in CommonHealth, but disabled adults, age 19 to 64, with income in excess of the MassHealth Standard limit of 133 percent of poverty *and who are not working* must meet a one-time deductible or “spenddown” in order to become eligible for CommonHealth. Disabled adults who are HIV positive and who are not working do not have to meet a deductible unless gross family income exceeds 200 percent of the poverty level. Disabled children under age 19 and disabled working adults do not have to meet a deductible in order to qualify for CommonHealth.

For disabled adults with a spenddown, eligibility depends on incurring medical expenses that equal or exceed a deductible amount. The deductible amount is the difference between gross family income for a six month budget period and the deductible income standard for six months. The deductible income standard is not the same as the 133 percent of poverty standard for MassHealth Standard; it is much lower. See Table 3 below. Only after a disabled adult with a deductible incurs medical expenses that equal the amount of the deductible and provides proof to the MassHealth agency, will he or she be eligible for CommonHealth. He or she will never again have to meet a deductible to qualify for CommonHealth, but at age 65 will face a different set of eligibility rules as explained in Part 11. CommonHealth will not pay the expenses used to meet the deductible.

Example: A disabled 57-year-old woman has a monthly Social Security disability check of \$1,155, \$1 over the 133 percent of poverty income limit for MassHealth Standard in 2008. The CommonHealth deductible income standard used to calculate the deductible for a household of one is \$542, see Table 3 below. Her spenddown amount is $(\$1,155 - \$542) \times 6 = \$3,678$. Once she submits proof that she has incurred medical bills of \$3,678 she will be eligible for CommonHealth. She will not have to meet a deductible again to remain eligible for CommonHealth.

130 C.M.R. § 506.009.

Table 3: CommonHealth Income Standard Used to Calculate the Deductible

Family Group Size	Income Standards
1	\$542
2	670
3	795
4	911

See 130 C.M.R. § 506.009 for family sizes greater than four.

116 How does someone meet the deductible?

To become eligible by meeting a deductible, the individual must submit proof of medical bills that equal or exceed the amount of the deductible. The family must incur medical bills but does not have to pay them in order for the bills to be used to meet the deductible. Bills used to meet the deductible will not be paid by MassHealth.

The following criteria apply to bills that can be used to meet the deductible:

- n The bill may have been incurred at any time, but must be unpaid and a current liability in the six-month budget period, or paid within the six-month budget period.

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- n The bill may be for any member of the family group (not just the disabled adult).
- n Medicare and other health insurance premiums can be credited in advance for the six-month budget period.
- n Necessary medical and remedial care services covered under MassHealth rules count.
- n Necessary medical and remedial care services not covered under MassHealth rules but recognized under state law count.
- n Remedial expenses are defined as nonmedical support services made necessary by the medical condition of any individual in the family group.

Example: Expenses such as respite care, or installation of a wheelchair ramp should count as remedial expenses. If unsure whether a particular expense will count, ask the MassHealth Enrollment Center to check with the MassHealth central office policy hotline or consult a legal advocate.

- n The bill must not be subject to further payment by health insurance or other liable third-party coverage including the Health Safety Net.
 - n **The Health Safety Net.** A medical bill that is reimbursed by the Health Safety Net cannot be used to meet the spenddown. Because MassHealth now determines eligibility for the Health Safety Net, someone denied CommonHealth subject to a spenddown whose family income does not exceed 400 percent of poverty will be approved for full or partial Health Safety Net. In order to use a hospital bill to meet the CommonHealth spenddown, the applicant will have to arrange with the hospital not to submit the bill to the Safety Net.
- n Bills for the following services are specifically excluded:
 - n cosmetic surgery,
 - n rest-home care,
 - n weight-training equipment,
 - n massage therapy,
 - n special diets, and
 - n room and board in residential facilities.

- n Medical or remedial care expenses must be verified by a bill or statement from a health care provider, or, for nonprescription drugs, a receipt. A recent bill will be needed to show that an unpaid past expense is still a current liability.

Example: An applicant with a seizure disorder aggravated by heat who purchases an air conditioner on medical advice will need a letter from her doctor explaining why her medical condition makes the the air conditioner necessary in order to use the cost of the air conditioner as a remedial expense toward meeting her spenddown.

130 C.M.R. § 506.009(G).

117 What are the financial eligibility rules for traditional Medicaid?

The traditional Medicaid rules apply to those aged 65 and over who are not covered by the MassHealth Section 1115 waiver (Medicaid reform). The traditional Medicaid rules also apply to people under age 65 with “deemed SSI” status, disabled children eligible under Kaileigh Mulligan and to people applying for the Medicare Savings Programs. Special rules apply when someone is institutionalized or one spouse is institutionalized and the other is at home.

118 Whose income counts in traditional Medicaid?

Income of the following persons is counted in determining eligibility of a family member:

- n **Spouses living together:** the total countable income and assets of the individual and spouse who are living together are counted; however, if one

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spouse is eligible for either the home and community based waiver or the PACE program, the income of the other spouse will not count (see Part 11);

- n Effective October 31, 2008, MassHealth recognizes two people of the same sex who are married as spouses.
- n **Spouses living apart (for reasons other than admission to a medical institution):** the income and assets of the individual are counted; the assets and income of the absent spouse are not counted in the month following the month of separation;
- n **Unmarried individual:** the income and assets of the individual are counted.

130 C.M.R. § 520.002; 2008 Mass. Acts c. 251.

119 What deductions are allowed for community residents in traditional Medicaid?

Deductions from countable monthly income include:

- n Allowable business expenses for income from self-employment, room and board, or rental income. 130 C.M.R. § 520.010.
- n Standard income deduction of \$20.
- n Earned income deduction of \$65 and one-half of the remaining earned income. 130 C.M.R. § 520.012.
- n For disabled elders who need personal care attendant (PCA) services, a new unearned income deduction is available. The amount of the deduction represents the difference between 133 percent of the poverty level and the Senior Deductible Income Standard (the PCA deduction cannot be combined with the \$20 per month standard deduction). In order to obtain the deduction, the Disability Evaluation Service must make a presumptive determination that the individual is clinically eligible for PCA services. Once found presumptively eligible, the individual has 90 days to begin receiving PCA services paid for by MassHealth, or submit proof that efforts to receive PCA services are underway in order to remain eligible.

Example: A 67-year-old woman receives Social Security in the amount of \$1,000 per month. She has a personal care attendant to assist her in bathing, dressing, using a toilet, and getting in and out of bed. Because of the PCA income deduction, her adjusted monthly income is well below the MassHealth Standard income ceiling per month. Without the PCA deduction, she would have a deductible of thousands of dollars to meet in each six-month period in order to qualify for MassHealth.

130 C.M.R. § 520.013(B).

120 What income is not counted in traditional Medicaid?

Exempt income includes:

- n income of a recipient of EAEDC or SSI;
- n income disregarded for disabled adult children, or under the Pickle amendment (see Part 4 on deemed SSI);
- n income in kind;
- n reverse mortgage payments;
- n certain veteran's payments;
- n Social Security COLAs until the next annual poverty level adjustment;
- n retroactive SSI and RSDI; and
- n other income not countable under Title XIX.
 - n Title XIX of the Social Security Act is the federal Medicaid law; it uses the income methodology of cash assistance programs, for seniors, the SSI rules. 42 C.F.R. § 435.601. See 20 C.F.R. Part 416 (SSI); *An Advocate's Guide to Surviving the SSI System* (MLRI/MCLE, Inc. 2005) and Appendix K (located after 42 C.F.R. § 416.1182).

130 C.M.R. § 520.015.

121 What is the income limit for community residents 65 and over?

In order to be eligible for MassHealth, seniors who are not living in a nursing home must have adjusted family income that does not exceed 100 percent of the federal poverty level. See Table 5 in Appendix B. The poverty level is updated on March 1 or April 1 of each year. Cost of living adjustments (COLA) in Social Security take effect in January of each year, but the resulting increase in income does not count for MassHealth purposes until the following spring when the poverty level standard is also increased.

130 C.M.R. § 519.005.

122 What is the asset limit for traditional Medicaid?

For MassHealth Standard or Limited, the total value of countable assets cannot exceed:

- n \$2,000 for an individual or
- n \$3,000 for a couple.

For the Medicare Savings Programs, the total value of countable assets cannot exceed:

- n \$4,000 for an individual or
- n \$6,000 for a couple.

130 C.M.R. § 520.003.

123 What assets do not count for community residents age 65 and over?

The value of certain assets does not count against the asset limits. Some common assets that do not count include:

- n the home (130 C.M.R. § 520.008(A));
- n one car per household regardless of value (130 C.M.R. § 520.007(F));
- n the portion of jointly owned assets that is owned by someone else (130 C.M.R. § 520.005);
- n an asset that is inaccessible, e.g., property that cannot be sold based on a court order (130 C.M.R. § 520.006);
- n life insurance without a cash-surrender value (130 C.M.R. § 520.007(E));
- n life insurance if the total cash-surrender value of all policies does not exceed \$1,500 (130 C.M.R. § 520.007(E));
- n property essential to self-support, e.g., tools used to earn a living (130 C.M.R. § 520.008(D));
- n retroactive SSI and RSDI payment for six months from the date of receipt (130 C.M.R. § 520.007(H));
- n a loan or grant (130 C.M.R. § 520.008(E));
- n certain funeral and burial arrangements (130 C.M.R. § 520.008(F));
- n certain veteran's payments (130 C.M.R. § 520.008(G));
- n certain trusts established in accordance with special rules about Medicaid trusts (130 C.M.R. §§ 520.021–520.024);
- n proceeds for the replacement or repair of an asset do not count for nine months after receipt of the proceeds (130 C.M.R. § 520.009(E)(1)); and
- n certain annuities (130 C.M.R. § 520.007(J)).

124 How can seniors with excess income become eligible?

Seniors who are not eligible for MassHealth Standard or Limited because adjusted family income exceeds 100 percent of poverty can qualify for MassHealth after meeting a deductible or spenddown. The deductible is the difference between adjusted family income for six months and the deductible income standard for six months. The deductible income standard is not the same as the 100 percent of poverty standard; it is much lower. In fact, the deductible income standard has not been increased since 1988. See Table 4 below. Once a senior submits proof that he or she has incurred medical expenses that equal the amount of the deductible, she can establish MassHealth eligibility for the six-month budget period.

However, MassHealth will not pay for any of the expenses that were used to meet the deductible. The senior is only eligible through the end of the six-month budget period. At the end of the period, the MassHealth agency notifies the senior of a new six-month budget period and a new deductible amount that must be met.

Example: A 66-year-old woman lives alone and has a monthly Social Security retirement check of \$888. Her adjusted income exceeds 100 percent of poverty by \$1 in 2008. She is eligible for MassHealth in a six-month budget period only after she meets a deductible of \$2,076 in each period.

Gross Monthly Income	\$888
Less Standard Disregard	– <u>\$20</u>
Adjusted Income	\$868
Less Deductible Income Standard	– <u>\$522</u>
Excess Monthly Income	\$346
Times 6 Months	x <u>6</u>
6-Month Deductible	\$2076

130 C.M.R. §§ 520.028–.030.

Table 4: MassHealth Income Standard Used to Calculate the Deductible for Seniors

Family Group Size	Income Standard
1	\$522
2	\$650

130 C.M.R. § 520.030.

125 How is the senior deductible different from the CommonHealth deductible?

The MassHealth Senior and CommonHealth spenddown programs differ in several ways:

- n The CommonHealth deductible must be met only once and the individual will remain eligible until age 65; the senior deductible must be met every six months to be eligible for the balance of the six-month budget period.
- n The CommonHealth deductible uses gross family income, the senior deductible uses adjusted family income to compare to their respective income standards.
- n The CommonHealth monthly income standard used to calculate the deductible is \$20 higher than the senior monthly income standard (however, seniors are allowed a \$20 income disregard in calculating adjusted monthly income).
- n In both programs, the six-month deductible period can start on the first day of the month of application, but seniors also have the option of starting the deductible period up to three months before the first day of the month of application.

126 What expenses can be used to meet the deductible?

The rules on what expenses count against the deductible are the same as those in the CommonHealth program, see Question 116, above. 130 C.M.R. § 520.032.

127 How does the asset spenddown work?

A senior otherwise eligible for MassHealth Standard or Limited whose *assets* exceed the allowable limits may be eligible for MassHealth as of the earlier of:

- n the date assets have been spent to below allowable limits; or
- n the date medical bills have been incurred that equal the amount of excess assets, provided assets have been spent to below allowable limits within 30 days after receipt of notice of excess assets.¹³

Assets cannot be spent in a way that would violate the transfer of assets rule. See Question 130, below.

Example: A 66-year-old man applies for MassHealth on March 1 at which time he has \$5,000 in his savings account. His assets exceed the \$2,000 asset limit. He uses part of his savings to buy furniture and spends \$3,000 by March 17 leaving him with \$2,000. He submits his furniture receipts to the MassHealth agency and becomes eligible for Medicaid starting March 17, the first date that his assets did not exceed \$2,000.

130 C.M.R. § 520.004.

¹³ MassHealth recognizes the asset spenddown thanks to a lawsuit called *Haley v. Commissioner*.

128 What are the financial eligibility rules for nursing home residents?

Different financial eligibility rules apply when a person of any age requires long-term care in a nursing home or other medical institution. Individuals who were eligible for MassHealth Standard under Medicaid reform rules without regard to assets, upon becoming nursing home residents, will need to satisfy traditional Medicaid rules applicable to nursing home residents in order to remain eligible for MassHealth Standard. *See* 130 C.M.R. § 519.006.

Income standard. The MassHealth income standard for nursing home residents is currently \$72.80 per month (SFY 2009). This amount is also called the Personal Needs Allowance. The monthly income that remains to a nursing home resident after allowable deductions and the \$72.80 personal needs allowance must be paid to the nursing home as the patient's contribution to the costs of his or her care or Patient Paid Amount. 130 C.M.R. §§ 520.009 (A)(3), 520.025, 520.026.

- n The income of the spouse remaining at home is not counted in determining the income of the institutionalized spouse. 130 C.M.R. § 520.002(B).
- n Deductions from the resident's income are allowed for maintenance of an at-home spouse and certain other dependents, health insurance premiums and other medical and remedial expenses not covered by MassHealth or other insurance, certain fees and expenses related to guardianship, and if the individual is expected to return home within six months, a deduction for maintenance of the home. 130 C.M.R. § 520.026.
- n If an individual has monthly income greater than the Massachusetts nursing facility payment rate but less than the private pay rate, the resident is subject to a six-month spenddown. 130 C.M.R. § 520.027.

Asset standard. Nursing home residents must have countable assets of \$2,000 or less, *see* 130 C.M.R. § 520.002, but special deductions and allowances apply. *See* 130 C.M.R. § 520.016.

- n **Treatment of the home.** The former home of a nursing home resident does not count toward the \$2,000 asset limit if a spouse or certain other relatives are living in the home, the resident intends to return home, the resident has long-term care insurance meeting certain criteria, or the home is jointly owned and a sale would cause the other owner to lose housing. If none of these

exceptions apply, a resident will be allowed time to sell an otherwise countable former home. For applications after January 1, 2006, an equity interest in the home that exceeds \$750,000 makes the owner ineligible for payment of nursing home care unless a spouse or child lives in the home, or a hardship waiver applies. See 130 C.M.R. §520.007(G)(3), (8)–(13).

- n **Trusts and annuities.** Special rules apply to trusts and annuities. 130 C.M.R. §§ 520.021–520.024 (trusts), 520.007(J) (annuities).
- n **Transfer of assets.** There are restrictions on certain transfers of assets for less than fair market value that may result in a period of ineligibility for MassHealth payment of nursing home care. Some transfers are permissible. Some disqualifying transfers may be cured, and a waiver of the period of ineligibility is available in cases of undue hardship. 130 C.M.R. §§ 520.018, 520.019.

Return home. If an individual is expected to return home within six months of admission, he or she is allowed a deduction from income in order to maintain the home. 130 C.M.R. § 520.026(D). Further, the home is not counted as a resource if an individual intends to return home. 130 C.M.R. § 520.007(G)(8).

For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

129 What are the rules if one spouse is in a nursing home and one is at home?

For married couples where one spouse is a nursing home resident but one remains at home, the community spouse is entitled to enough of the couples' joint income and assets to meet his or her needs. 130 C.M.R. §§ 520.026(B), 520.016(B).

Income. The income of the community (at home) spouse is not attributed to the nursing home resident. If the community spouse's gross income is less than the "monthly maintenance needs allowance" (MMNA) as calculated by the agency, it will allow a deduction from the institutionalized spouse's income to be allocated to the community spouse. In determining the MMNA, the agency combines a

standard minimum MMNA with an excess shelter allowance that takes account of actual costs in excess of a standard shelter to arrive at an MMNA up to a maximum level. However, the MMNA maximum may be increased as the result of a fair hearing decision showing exceptional circumstances or based on a court order for support. In SFY 2009, the minimum MMNA is \$1,750 per month and the maximum MMNA is \$2,610 per month. 130 C.M.R. § 520.026.

Assets. Generally, the assets of both spouses are considered together regardless of how title is held, but the at-home spouse may retain or have transferred to him or her assets up to the maximum spousal asset allowance. In 2009 the maximum spousal asset allowance will be \$109,560. A higher asset allowance may be ordered by a court or fair hearing. The asset allowance may also be increased if a deduction from the institutionalized spouse's income is not sufficient and additional income-generating assets are required to bring the community spouse's income up to the MMNA. The countable assets remaining to the nursing home resident must not exceed the \$2,000 asset standard in order for him or her to be eligible. 130 C.M.R. § 520.016.

130 What are the transfer of asset rules?

A nursing home resident (or applicant for services under the HCBS waiver) who transfers resources for less than fair market value, in some circumstances, will be ineligible for MassHealth for a period of time. However, certain transfers for less than fair market value, such as transfers for the sole benefit of a spouse, are permitted. The penalty period may be eliminated in cases of undue hardship.

The law regarding transfers of assets changed in 2006 based on a change in federal law effective for transfers after February 8, 2006. The MassHealth agency will review transfers that took place during a "look back" period going back 36 months from the first date the resident was both in a nursing facility and applied for MassHealth. After February 8, 2006, the look back period will increase month by month until it reaches the new look back period of 60 months on February 8, 2011. If there is a disqualifying transfer after February 8, 2006, the penalty period begins on the date the applicant would otherwise be eligible or the date of the transfer, whichever is later. For transfers prior to February 8, 2006, the disqualification begins on the date of the transfer.

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Special care should be taken in advising clients on asset transfers. Poor planning may result in a client who is ineligible for MassHealth but has no other means to pay for his or her care. For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed.2007).

130 C.M.R. §§ 520.007(J), 520.018, 520.019; 42 U.S.C. § 1396p.

Part 13

Eligibility Rules About Citizenship and Immigration Status

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131 How does citizenship affect eligibility for MassHealth?

United States citizens are eligible for all MassHealth coverage types. (See Part 4 for more information on verification of U.S. citizenship.) Undocumented noncitizens are only eligible for emergency Medicaid under MassHealth Limited. Some noncitizens known to the U.S. Citizenship and Immigration Service (C.I.S.)¹⁴ are eligible for more comprehensive coverage than emergency Medicaid depending on many factors, including: their current and former immigration status, the date they entered the United States, the date of obtaining status, as well as factors unrelated to immigration such as domestic violence, service in the military, age, and disability.

The federal welfare reform law enacted on August 22, 1996 imposed new restrictions on the Medicaid eligibility of noncitizens in the United States legally or residing under color of law (PRUCOL) who previously were eligible for Medicaid. Most legal permanent residents (green card holders) who entered the United States after August 22, 1996 are barred from federal Medicaid eligibility for five years after obtaining their status.¹⁵ Massachusetts provides MassHealth using state-only funds to some of the lawfully present noncitizens who are not eligible under the restrictive 1996 federal Medicaid rules. Noncitizens who are “protected aliens” as well as children, the disabled and the elderly who are “special status or PRUCOL aliens,” as defined below, are still eligible for health coverage under state law.

Federal Medicaid restrictions: 8 U.S.C. §§ 1612(b), 1613, 1641.

State law: G.L. c. 118E, § 16D (MassHealth); G.L. c. 118H, § 1 (definition of “resident” in Commonwealth Care).

See Tables 10–16 in Appendix B for charts summarizing immigrant eligibility rules and lists of documents and codes on documents that verify different types of immigration status.

¹⁴ The CIS is one of several agencies under the U.S. Department of Homeland Security that has taken over the functions of the former Immigration and Naturalization Service (INS).

¹⁵ Federal law uses the term “qualified aliens” to describe both noncitizens currently eligible for Medicaid and those barred for five years. MassHealth uses the term “qualified alien” to mean only currently eligible immigrants and has created the term “special status alien” to include those who are barred for 5 years. This Guide will follow the MassHealth terminology.

132 Which noncitizens are “qualified aliens” eligible for *all* MassHealth coverage types (including long-term institutional care)?

1. **Qualified aliens who have satisfied or are exempt from the five-year bar.** People with the following immigration status at the time they apply for benefits are eligible for all MassHealth coverage types if they entered the country before August 22, 1996 (regardless of status at the time of entry) and remained continuously present until obtaining status; or if they entered the country after August 22, 1996 and have had their status for five or more years:
 - n legal permanent residents,
 - n conditional entrants, or
 - n persons granted parole for at least one year.

130 C.M.R. §§ 504.002(B), 518.002(B).
2. **Qualified aliens to whom the five-year bar never applies.** Noncitizens are eligible for all MassHealth coverage types *regardless of their date of entry, or how long they had their status*, if they currently have one of the statuses listed below or previously had one of these statuses before attaining current legal permanent resident status:
 - n refugees and persons granted political asylum;
 - n persons whose deportation has been withheld;
 - n veterans and the spouses or widows and dependent children of veterans;
 - n certain people (and their dependent children) subjected to battery or extreme cruelty by a spouse, parent, or sponsor who no longer live with the batterer;
 - n certain Cubans and Haitians who are Cuban/Haitian entrants;
 - n Native Americans born outside the United States;
 - n certain Amerasians from Vietnam;

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- n victims of severe forms of trafficking (and their dependent children); and
- n special immigrants from Iraq for their first six months, and special immigrants from Afghanistan for their first eight months in the United States. After six or eight months Iraqi/Afghani special immigrants will no longer be “qualified” but will be aliens with “special status” under MassHealth rules.

130 C.M.R. §§ 504.002(B), 518.002(B).

U.S. entry prior to August 22, 1996 and continuous presence: Some recent permanent residents are not subject to the five year bar if they were living in the United States prior to becoming legal permanent residents (LPRs). To qualify, the applicant must have been continuously present in the United States from the time of his or her last entry into the United States before August 22, 1996 until the date of obtaining LPR status. Continuous presence requires no absence longer than 30 consecutive days or 90 days in total prior to attaining LPR status. To benefit from this provision of federal law, immigrants must declare the U.S. entry date on the MassHealth application, and make sure the agency has used the U.S. entry date, not the later date on the green card showing the date LPR status was obtained.

133 Which noncitizens are “protected aliens” eligible for *all* MassHealth coverage types (including long-term institutional care)?

People who were receiving Medical Assistance or CommonHealth on June 30, 1997 (in the community or in a nursing home) or who were residing in a nursing facility on June 30, 1997 and who are otherwise eligible can receive MassHealth Standard or any other coverage type for which they are eligible. The MassHealth rules refer to people in this category as “protected aliens.”

130 C.M.R. §§ 504.002(C), 518.002(C).

134 Which noncitizens are “special status or PRUCOL aliens” eligible for only some MassHealth coverage types or Commonwealth Care?

Individuals under age 19, disabled or elderly who are known to CIS but not “qualified aliens,” either because they are legal permanent residents subject to the five year bar or because they are not qualified but are residing in the United States under color of law (PRUCOL), are not eligible for MassHealth Standard, but may be eligible for other coverage types. Children may be eligible for CommonHealth or Family Assistance; adults who are disabled or elderly may be eligible for MassHealth Essential. 130 C.M.R. §§ 504.002(F) (children and disabled adults), 519.013 (elderly). Other uninsured adults may be eligible for Commonwealth Care. 956 C.M.R. § 3.04 (definition of “resident”).

Special status and PRUCOL aliens include:

- n Individuals with the following status who are not “qualified aliens” because they entered the country on or after August 22, 1996 and have had their status for less than five years:
 - n legal permanent residents,
 - n conditional entrants,
 - n persons granted parole for at least one year.

130 C.M.R. §§ 504.002(D)(2), 518.002(D).

- n Individuals who are not “qualified aliens” but who are permanently residing in the United States under color of law (PRUCOLs). These are people who are residing in the United States with the knowledge of immigration officials who are not contemplating deporting them. Prior to 1996, people who were PRUCOL were eligible for Medicaid and other federal benefits. It is not a status conferred by immigration officials, PRUCOL is a status created by

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public benefit law. The MassHealth regulations give 12 examples of PRUCOL status.¹⁶ Some examples of PRUCOL include:

- n a person who is the subject of a pending immediate relative petition, or who is covered by an approved petition and has a pending application for adjustment of status;
- n a person granted Temporary Protected Status;
- n a person with a pending application for asylum; and
- n any person who immigration officials know is resident in the United States and whose departure DHS does not contemplate enforcing.

130 C.M.R. §§ 504.002(D), (F); 518.002(D), (F). *See also Cruz v. DPW*, 395 Mass. 107 (1985) (PRUCOL). 956 C.M.R. § 3.04 (definition of “resident” in Commonwealth Care).

135 How does one prove an eligible immigration status?

Unfortunately, there are few publications from MassHealth to help applicants and outreach workers identify which immigration documents prove an eligible status. However, MassHealth has published subregulatory guidance with examples of documents that verify that someone is a Cuban-Haitian entrant or a person permanently residing in the United States under color of law (PRUCOL). The MassHealth guidance is posted on www.masslegalserives.org.

Part 20 lists several sources of useful information about immigration documents. Consult Tables 12–16 in Appendix B for help identifying some of the more common documents used to prove an eligible immigration status including a key to codes on the documents.

¹⁶ Under the regulations, PRUCOLs are included as aliens with special status, however in practice the MECS often reserve the term special status to describe those subject to the five-year bar; to avoid confusion this Guide uses the phrase “special status and PRUCOL.”

136 What MassHealth coverage is available to noncitizens who are not documented?

Noncitizens who are not qualified immigrants, protected immigrants, or special status/PRUCOL immigrants are referred to as “nonqualified aliens.” Nonqualified aliens include undocumented persons. They are eligible for MassHealth Limited (emergency Medicaid) if they would qualify for MassHealth Standard except that they do not have an eligible immigration status. Nonqualified immigrants do not have to submit proof of immigration status or have Social Security numbers. However, Limited only covers emergency services, including labor and delivery.

130 C.M.R. §§ 505.008, 519.009.

137 What other health programs are available to nonqualified immigrants?

Public health and safety net programs generally do not have eligibility rules related to citizenship or immigration status. However, most of these programs are limited to Massachusetts residents; this will exclude visitors who intend to return to a home outside of Massachusetts. The following health programs, described in Part 19, Health Programs Other than MassHealth, do not ask about immigration status:

- n The Children’s Medical Security Plan—primary and preventive insurance coverage for children.
- n The Health Safety Net—free or reduced cost care at acute care hospitals and community health centers.
- n Healthy Start—prenatal care for pregnant women.
- n Prescription Advantage—prescription drug coverage for seniors and people with disabilities.

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- n Massachusetts Home Care Assistance—home care for seniors and people with Alzheimer’s.
- n Programs of the Department of Public Health (DPH)—DPH funds a wide variety of public health programs such as cancer screening programs, HIV drug assistance programs, and substance abuse treatment programs.

Commonwealth Care. The new Commonwealth Care health insurance program is available to uninsured Massachusetts residents who are U.S. citizens, or noncitizens who are qualified, special status aliens or PRUCOL. However, it is not available to undocumented immigrants. For more information, see Part 10.

Long-term care. There are few options for nonqualified and special status/PRUCOL immigrants who need long-term care. See MLRI, *Practice Memo: Services available to noncitizens denied MassHealth long-term care services*, in the “Health” section of www.masslegalservices.org.

138 Will an immigrant who receives MassHealth be a public charge or face other immigration problems?

Immigrants sometimes fear that there will be negative consequences if they receive a public benefit like MassHealth. They fear that they will be unable to adjust to legal permanent resident (LPR) status because they will be considered likely to become a “public charge.” If they are already LPRs, they fear that they will be unable to sponsor relatives or become a citizen if they use public benefits. Most of these fears are unwarranted. According to the CIS, receipt of medical benefits like MassHealth will not be considered evidence that the immigrant is likely to become a public charge, and has no bearing on the ability to sponsor a relative or become a citizen. The CIS has issued detailed guidance and a handy fact sheet containing all this information. MassHealth also includes information for immigrants including referral resources in the booklet containing the MBR.

There are two circumstances in which receipt of MassHealth may have negative immigration consequences and both relate to the use of MassHealth for nursing home care. If someone has gotten MassHealth to pay for nursing home care, the CIS may consider that fact in determining whether someone is likely to become a

public charge. Someone who is likely to become a public charge may not be able to reenter the United States after an absence or adjust status to lawful permanent resident status. The only other circumstance in which receipt of MassHealth may jeopardize immigration status is when all of these factors are true: the person was in a nursing home for reasons that existed before entering the United States, entered the nursing home within five years of entry to the United States, and the person or sponsor had a legal debt to repay Medicaid, and refused to repay after the government filed a lawsuit and won. In these very rare circumstances, an immigrant can be deported.

See the 2000 USCIS publication: *A Quick Guide to “Public Charge” and Receipt of Public Benefits* (Mass. Edition) at www.uscis.gov/graphics/publicaffairs/factsheets/Charge.pdf.

Sponsor deeming: Family members sponsoring immigrants after December 19, 1997, are required to sign a legally enforceable affidavit of support. The federal agency governing Medicaid (CMS) has not issued any regulations on how the sponsor’s obligation to support should affect the determination of Medicaid eligibility. Currently, MassHealth does not consider the sponsor’s income to be available to the immigrant when it is not (a practice called sponsor deeming), and sponsor deeming is specifically prohibited in G.L. c. 118E, § 16D.

139 What services are available for people who have limited English proficiency?

All recipients of federal funds, including all Medicaid providers as well as the MassHealth agency, the Connector and their contractors, must be able to serve people with limited English proficiency (LEP). This may include providing translation services at no cost to the LEP person, providing written notices in the primary language of the LEP person, and ensuring the availability of qualified interpreters. Also, under state law, all acute care hospital emergency rooms and psychiatric hospitals are required to provide competent interpreter services.¹⁷

¹⁷ See Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (courts have interpreted discrimination against non-English speakers as national origin discrimination); *Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency*, revised, 67 Fed. Reg. 47311 (Aug. 8, 2003), www.hhs.gov/ocr/lep. G.L. c. 111 § 25J(b)

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The MassHealth agency will provide interpreter services by telephone or in person when the applicant requests it or the MassHealth agency determines that it is necessary. 130 C.M.R. § 501.009(I). The state also has a contract with QWEST to provide interpreters by telephone.

The Managed Care Organizations must also be able to provide care to LEP members and this may include translating materials into languages other than English, having network providers who speak languages other than English, and having available interpreters to communicate with LEP members.

The MassHealth agency currently provides the MBR (application form) in English and Spanish. It provides the MassHealth member booklet in 10 languages. Each application also includes a primary language declaration form with the toll-free number for the Customer Service Center. Eligibility notices are only in English or Spanish, but are accompanied by a flyer translated into 10 languages informing people that they have received an important notice and should get it translated.

The Board of Hearings will provide an interpreter at no cost to LEP appellants, and the hearing officer has a duty to inform appellants of this right. All statements of all persons participating in the hearing must be translated to enable non-English speaking appellants to understand and fully participate in the entire hearing. 130 C.M.R. § 610.065(A)(9).

(acute hospital emergency room); G.L. c. 23, § 23 (psychiatric hospitals); and 105 C.M.R. 130.1100 (DPH regulations).

Part 14

Other Eligibility Rules

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140 Does someone have to have a Social Security number to get MassHealth?

Federal Medicaid rules require that someone have a Social Security number or apply for a Social Security number in order to get Medicaid with the exception of Emergency Medicaid (MassHealth Limited). However, a person does not need to have a Social Security number if he or she is applying on behalf of someone else, such as a child, but is not applying for full MassHealth for himself or herself.

Certain otherwise eligible immigrants may not be able to obtain Social Security numbers. They should not be denied MassHealth for this reason, but may have to explain their problem in reply to computer-generated notices that ask for proof that they have obtained or applied for a Social Security number or may have to supply proof that they applied for a number and were unable to obtain one.

130 C.M.R. §§ 503.003, 517.006; 42 C.F.R. § 435.910

141 What does it mean when the application says applicants have to assign rights to medical support and third-party payments?

MassHealth is generally the payer of last resort, and the MassHealth agency will attempt to identify third parties who may be liable to pay part or all of a member's medical costs. The MassHealth agency requires that applicants assign to it rights to medical support and other third-party payments as a condition of eligibility for MassHealth. Third-party payments include health insurance payments or other payments for medical benefits that a third party is legally liable to make on a member's behalf. If there is a spouse or former spouse or parent living outside the home, that person may have a duty to provide support, including medical support, to a spouse or child. The assignment includes a duty to cooperate with the agency if necessary to establish paternity, obtain an order of medical support, enforce an existing order or identify other liable third parties. The child support enforcement

agency (the Department of Revenue) is supposed to pursue medical support for a child when health insurance is available from an absent parent for a reasonable cost.

130 C.M.R. §§ 503.004, 517.009; 42 C.F.R. § 433.145.

142 What can be done when pursuing medical support may lead to domestic violence?

If cooperating with medical support would result in serious physical or emotional harm to the parent, the child, or someone else in the household, the member has good cause not to cooperate. Good cause can be claimed on Supplement B of the MassHealth MBR form or, if the situation arises after application, by notifying the Benefit Coordination unit at the MassHealth agency (617-886-8048, Michelle). Without good cause, a member may lose MassHealth coverage for failure to cooperate unless the member is a minor child or pregnant woman.

130 C.M.R. § 503.005; 42 C.F.R. § 433.147(c)(2).

143 What does it mean when the application says applicants have to assign rights to third-party recoveries?

Third-party recoveries are payments as a result of an accident, illness, injury, or other loss. Members must inform the MassHealth agency when anyone covered by MassHealth is involved in an accident or has an injury that may result in a lawsuit or insurance claim, and assign to the MassHealth agency the right to recover medical benefits from the proceeds of any claim. Under state law the assignment of the right to recover from third parties is automatic when the applicant applies for MassHealth, and the MassHealth agency has a lien against the third-party recovery.

130 C.M.R. §§ 503.006; 517.011. *See also* G.L. c. 118E, § 22. For limitations on recovery imposed by federal law, see *Arkansas Dept. of Health and Human Svs. v. Ahlborn*, 547 U.S. 268 (2006) (Medicaid lien against personal injury settlement must be limited to portion of settlement allocated to past medical expenses).

144 When does someone with MassHealth have to maintain other available health insurance?

Applicants for and recipients of MassHealth Standard or CommonHealth may be required to cooperate in maintaining health insurance available at no greater cost to them than the premiums otherwise charged for MassHealth, or in enabling the agency to purchase cost-effective health insurance under MassHealth Standard/CommonHealth Premium Assistance (MSCPA). Under MSCPA, the member will remain eligible for Standard/CommonHealth to supplement coverage not available under the other health insurance.

130 C.M.R. § 507.003 (MSCPA).

Children eligible for Family Assistance may also be required to obtain private employer-sponsored insurance as a condition of eligibility. MassHealth will provide Family Assistance Premium Assistance to enable the family to afford the employer-sponsored insurance. In Family Assistance Premium Assistance, unlike MSCPA, a child will not be able to keep MassHealth direct coverage to supplement the employer-sponsored plan.

130 C.M.R. § 503.007 (Family Assistance).

People age 65 and over and institutionalized individuals of any age are required to take all necessary steps to obtain any benefits to which the member is legally entitled unless doing so would cause them harm. However, members are not required to apply for TAFDC, EAEDC, SSI, or state veteran's benefits. In addition, seniors are required to maintain health insurance available to them at no cost including Medicare and private insurance where the premium cost is paid by the MassHealth agency.

130 C.M.R. § 517.008.

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145 What services does MassHealth cover?

Federal Medicaid requires coverage of certain “mandatory” services and permits coverage of other “optional” services; it also permits reasonable limits on the amount, duration, and scope of both mandatory and optional services. MassHealth covers all mandatory and most optional services in MassHealth Standard and CommonHealth but imposes a variety of limitations and controls on the scope of services. The 1115 demonstration and SCHIP authorize the agency to offer fewer benefits for the other types of MassHealth coverage. Further, even if a service is included as a covered benefit, the MassHealth agency may still deny payment if the service is not medically necessary for the particular patient.

Each type of MassHealth covers certain specific medical services. Table 17 lists 40 services covered in MassHealth Standard and CommonHealth and the fewer number of services available in three other types of MassHealth: Family Assistance, Basic and Essential and in Commonwealth Care. The MassHealth Managed Care Organizations (MMCOs), the SCO plans and the Behavioral Health Partnership provide certain additional services as well. See Part 10 and Table 9 in Appendix B for a further description of services covered in Commonwealth Care.

146 What sources describe the services covered in MassHealth?

To know whether a particular service is covered one must first know what type of MassHealth the individual has: MassHealth Standard, CommonHealth, Family Assistance, Basic, Essential or Limited. Once this is known, the best place to start is with the state regulations. Table 17 cites to the regulation for each service. Medicaid services are often described by the type of provider that bills for the service, e.g., physician or community health center. When consulting the regulations be sure to look for the description of eligible providers as well as eligible services. For example, the regulations at 130 C.M.R. § 432 on therapy services only describe services by independent therapists. Therapy services by home health agencies, and outpatient hospital departments are described in the regulations for home health services and outpatient hospital services at 130 C.M.R. §§ 403 and 410.

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In addition to the regulations, the MassHealth agency publishes 50 provider manuals that describe services in more detail, such as by listing specific procedure codes that are covered or excluded. The MassHealth agency also publishes provider bulletins and transmittal letters notifying providers of changes to the manuals and new policies. The regulations, provider manuals and provider bulletins, transmittals and other information about covered services are posted on the MassHealth website.

The Partnership and the MassHealth Managed Care Organizations offer additional services that are not described in the regulations, but are generally described in their member handbooks and websites as well as in their contracts with the MassHealth agency. Some MCOs may offer such extras as child bicycle helmets and child car seats for example. See Part 20 for their websites.

Finally, state and federal law should be consulted to identify the required scope of covered services. Generally only a few services are specified in state law. *See, e.g.,* G.L. c. 118E, §§ 10A–10C (prenatal care, childbirth, and postpartum care; newborn hearing screening tests; and items necessary for treatment of diabetes). A useful starting point in researching federal law is the National Health Law Program Guide to the Medicaid Program listed in Part 20.

For Commonwealth Care, the most detailed description of covered benefits will be in the Explanation of Benefits produced by each Managed Care Organization. It will be included in a Member Handbook and is generally posted on the MCOs website. Like the MassHealth MCOs, some Commonwealth Care MCOs may offer extra benefits not required in the MCOs contract with the Connector such as chiropractic services. The Connector website also includes a schedule of copayments and required benefits for each Commonwealth Care plan type.

147 What services are covered by MassHealth Standard?

MassHealth Standard is the most comprehensive type of coverage. It is more comprehensive than most private health insurance because it covers long-term nursing home and other institutional care and a range of long-term services and supports designed to avoid institutional care such as personal care attendants, private duty nursing, and adult day health. The services it covers are listed in

Table 17. Generally, MassHealth Standard is the only type of MassHealth that covers long-term nursing home care, but it is covered under traditional Medicaid rules not the 1115 demonstration (Medicaid reform).

130 C.M.R. § 450.105(A).

148 What is covered by CommonHealth?

CommonHealth covers the same kinds of services as MassHealth Standard. See Table 17. However, there are differences between CommonHealth and Standard in the amount, duration, and scope of services and when prior authorization is required. For example, CommonHealth generally only covers short-term nursing home stays. It covers long-term institutionalized care only for children who are ineligible for MassHealth Standard during the five-year period after becoming legal permanent residents. 130 C.M.R. § 519.012(B).

130 C.M.R. § 450.105(E).

149 What is covered by Family Assistance Premium Assistance?

Under Family Assistance Premium Assistance, the individual receives assistance paying the employee share of the premium cost of employer-sponsored coverage. The benefits consist of whatever benefits are covered under the employer-sponsored plans. However, the employer-sponsored plan must meet the basic benefit level in order for the employee to be eligible for Premium Assistance. The basic benefit level must equal “minimum creditable coverage” as defined by the Connector. Family Assistance direct coverage is not available to supplement the limitations of the employer-sponsored plan except for individuals who are HIV positive. Cost-sharing for children in premium assistance will be reimbursed for well-child visits, and after total costs exceed 5 percent of gross family income.

130 C.M.R. § 505.005; 956 C.M.R. § 500.00 (minimum creditable coverage).

150 What is covered by Family Assistance Direct Coverage?

Family Assistance direct coverage covers fewer services than MassHealth Standard or CommonHealth as shown in Table 17 but still provides comprehensive coverage comparable to most commercial insurance. It does not cover nonemergency transportation, or certain other specialized services for adults or people with disabilities.

130 C.M.R. § 450.105(H)(3).

151 What is covered by MassHealth Basic?

MassHealth Basic covers fewer services than MassHealth Standard, CommonHealth or Family Assistance as shown in Table 17. Further, even where the same kinds of services are listed for MassHealth Standard and Basic there are differences between them in the amount, duration, and scope of services and when prior authorization is required. For example, a home health agency must have prior authorization to provide skilled nursing to MassHealth Basic members and the service is limited to a short-term period following discharge from a hospital (130 C.M.R. § 403.419(C)); these limitations on home health services do not apply to the other coverage types.

130 C.M.R. § 450.105(B).

152 What coverage is available to recipients of EAEDC prior to enrollment into MassHealth Basic?

Coverage under MassHealth Basic, unlike the other MassHealth coverage types (except Essential), does not begin until enrollment with a managed care plan. Individuals and couples who are eligible for cash assistance under EAEDC are eligible for certain covered services before they enroll in managed care and begin MassHealth Basic coverage. The DTA office will issue a temporary paper Medicaid card on request to enable a member to use the EAEDC benefits before receiving a MassHealth card. See Part 4 on the use of temporary MassHealth cards. The following services are covered for EAEDC recipients from the effective date of EAEDC eligibility:

- n physician services;
- n community health center services;
- n prescription drugs;
- n insulin and diabetic supplies;
- n intravenous therapies, e.g., chemotherapy;
- n substance abuse treatment in public detoxification and outpatient centers; and
- n diagnostics and testing necessary for the determination or redetermination of eligibility for EAEDC upon referral from a physician or community health center.

130 C.M.R. § 450.106.

153 What is covered by MassHealth Essential?

MassHealth Essential covers fewer services than MassHealth Standard, CommonHealth, Family Assistance or Basic as shown in Table 17. Unlike Basic,

no home health services are covered in MassHealth Essential, and it does not cover eyeglasses or orthotics. The limitations of MassHealth Essential are a significant problem for the elderly and disabled special status and PRUCOL immigrants who have this type of coverage.

130 C.M.R. § 450.105(I).

154 What is covered by MassHealth Limited?

MassHealth Limited covers emergency services only. This coverage type is available to people who meet the eligibility criteria for MassHealth Standard, but are noncitizens who do not have an immigration status eligible for Standard. It is sometimes coupled with another type of coverage with no immigration status criteria or more liberal immigration status criteria than Standard such as Essential plus Limited, CMSP plus Limited, or Healthy Start plus Limited.

Emergency services are defined as the treatment of a medical condition with acute symptoms of sufficient severity to seriously jeopardize the individual's health without immediate medical attention. This includes labor and delivery, and treatment for certain chronic conditions in limited circumstances, such as dialysis for people with kidney failure. Organ transplants are specifically excluded by federal law. A 1997 provider bulletin provides a more detailed description of covered emergency services. The following services should be covered by MassHealth Limited:

- n emergent and urgent inpatient acute hospital admissions;
- n services provided by an outpatient hospital emergency department;
- n elective inpatient stays and outpatient ambulatory visits, and ancillary services, including services provided by community health centers or dialysis clinics, but only for certain medical conditions requiring immediate attention (this includes chronic dialysis);
- n emergency dental treatment;
- n transportation by ambulance for emergency services;
- n oxygen equipment and supplies;

- n antibiotics and other medically necessary drugs needed to treat an emergency medical condition, e.g., insulin for an insulin-dependent diabetic;
- n For drugs other than antibiotics, the pharmacist must follow instructions on the Pharmacy On-Line Payment System (POPS) screen, to code the emergency need.
- n when physicians bill separately from a hospital or clinic, physician services are generally only covered if the site of care is a hospital emergency room;
- n other services from other providers such as home health agencies or chronic/rehabilitation hospitals are generally not covered unless there has been a determination by the MassHealth office of clinical affairs, on a case by case basis, of an emergency medical need.
- n **Example:** An indigent individual in a wheelchair with renal failure was living in a homeless shelter within a short distance from a chronic care hospital that offered outpatient dialysis and provided all his other medical care. MassHealth Limited pays for dialysis provided by a clinic or acute care hospital but does not ordinarily cover any chronic hospital services. The chronic care hospital wrote to the Medicaid director requesting an exception in order to bill Limited for this service for this individual, and it was granted. There is no established process to request such an exception.

130 C.M.R. § 450.105(G). *See also* All Provider Bulletin 101, June 1997, *Reimbursable Services for MassHealth Limited Members*; G.L. c. 118E, § 16D(5).

155 What is covered by MassHealth Prenatal?

MassHealth Prenatal provides immediate temporary coverage for pregnant women who appear to be eligible based on information in the application form that has not yet been verified. This immediate coverage only extends to ambulatory prenatal care. Once verification is supplied, pregnant women who qualify for MassHealth Standard will be eligible for all covered services.

130 C.M.R. § 450.105(F).

156 What additional services are available to seniors?

Senior Care Options (SCO) is a voluntary managed care program that provides comprehensive coverage through senior care organizations and their network of providers. It blends funding from Medicaid, Medicare, and Elder Services to provide more flexible benefits to people age 65 and older who are eligible for MassHealth Standard without a spenddown and live within designated service areas. The **Home and Community Based Services** program and **PACE** programs also offer services to individuals who are enrolled in those programs that are not otherwise available in MassHealth Standard. See Part 11 for more about those two programs.

See 130 C.M.R. § 508.008.

157 What additional services and benefits are available for children under EPSDT?

Children and young adults under age 21 are entitled to a broad range of health services under a Medicaid program called Early and Periodic Screening, Diagnosis and Treatment (EPSDT).¹⁸ All children enrolled in MassHealth Standard and CommonHealth are entitled to EPSDT services.

Under EPSDT, the MassHealth agency is obligated to:

- n assure that all children have regular check-ups, up-to-date immunizations, and other preventive health care services;
- n assure that the health problems of children are promptly diagnosed and treated; and

¹⁸ For MassHealth eligibility purposes a child becomes an adult at age 19, but for purposes of services, a child becomes an adult at age 21.

n inform families about Medicaid services for children and provide families help in obtaining services.

Under EPSDT, states must provide all necessary optional services to children whether or not the state offers such services to adults, and states cannot limit the amount, duration, and scope of medically necessary services to children regardless of the limitations that apply to adults. Under EPSDT, state Medicaid programs must provide services needed to “correct or ameliorate” physical or mental illnesses and conditions in a child. See Question 172, *How can EPSDT help a child get additional services?*, below.

130 C.M.R. § 450.140 et seq.; 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).

158 What additional services are available to children with serious mental disorders or with autism?

Children with serious mental disorders were successful in an EPSDT lawsuit seeking additional behavioral health services, particularly additional in-home services. The lawsuit was called Rosie D. The Children’s Behavioral Health Initiative is the name of the program that is implementing the relief ordered by the court in the Rosie D. lawsuit. Improved education, outreach and screening services were implemented in December 2007. Improved assessments became available in 2008; in 2009 five new behavioral health services will be available: in-home behavior management and monitoring, in-home therapy, therapeutic mentoring, mobile crisis intervention, and crisis stabilization. The lawyers for the children have created a website with more information for parents, advocates, and providers about available and soon to be available services. See www.rosied.org.

For children who do not have serious mental disorders but do have autism another new program was implemented in November 2007. The Home and Community Based Services Waiver for Young Children with Autism provides specialized services such as applied behavioral analysis for certain children under age nine diagnosed with autism spectrum disorder. Total enrollment is capped at 80 children and there is currently a waiting list. The program is jointly operated by

the Office of Medicaid and the Department of Developmental Services (formerly known as the Department of Mental Retardation). 130 C.M.R. § 519.007(E).

159 What dental services are available in MassHealth?

From 2003 to 2006, dental services for adults were generally limited to emergency services. However, on July 1, 2006 MassHealth restored dental services to adults. Adults do not have access to the same scope of services as children and youth under age 21, however, they do now have access to a relatively full range of dental services including preventative and restorative services and dentures. MassHealth has also begun to post a list of participating dental providers and take other steps to address the longstanding shortage of dentists willing to participate in MassHealth. A third-party administrator, DORAL Dental, administers the MassHealth dental program.

Children and youth under age 21 are eligible for a fuller range of dental services than adults including medically necessary orthodontia. The agency evaluates the medical need for orthodontia by using a measure called the Par Index. A score of 24 or more on the Par Index is considered evidence of the need for braces, a lower score requires additional evidence of medical necessity. Information about the Par Index is in the Dental Provider Manual.

130 C.M.R. § 420 et seq. (dental services).

160 When is a service medically necessary?

MassHealth will pay for a service only if it is medically necessary. A service is medically necessary if:

- n it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause

suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

- n there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services less costly to the agency include services that will be paid by third-party insurers or are available at no cost to the member.

130 C.M.R. § 450.204(A). *See also* MassHealth Guidelines for Medical Necessity Determinations posted in the “Provider Library” section of www.mass.gov/MassHealth.

Example: A Medicaid MCO refused to pay for a transplant procedure that was part of a clinical trial on the grounds that its contract excluded experimental procedures. The MCO refused to reverse its decision in the internal grievance procedure. The fair hearing officer found that the MassHealth recipient and his doctors had supplied sufficient authoritative evidence that the procedure was reasonably calculated to prevent or alleviate a condition that endangered life. Therefore, the procedure satisfied the definition of medical necessity and could not be denied as experimental. *See* 130 C.M.R. § 450.204(E).

161 When does a service require prior authorization?

For most services, a participating MassHealth provider can deliver the service and send his or her bill to MassHealth. If the service is covered and the patient was eligible on the date of service, MassHealth will ordinarily pay the provider at the Medicaid rate. However, for certain services, the provider must get advance approval from the MassHealth agency before the service is delivered; these services are subject to prior authorization. The regulations on specific categories of service describe when a particular service requires prior authorization. The provider manuals also contain instructions for providers on when prior authorization is required and how to submit a request for prior approval. If prior authorization is denied, both the provider and the member should get notice, and have the right to appeal.

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A process similar to prior authorization applies prior to a hospital admission for elective surgery. The process is called preadmission screening. It requires the provider to give notice to the MassHealth agency and get approval before a hospital admission for elective surgery. Denials of admission can be appealed on an expedited basis. After admission, the agency may determine that a hospital level of care is no longer required. Patients will be given notice and an opportunity to appeal such level of care decisions as well.

130 C.M.R. §§ 450.207, 610.015(E).

162 What are the time limits for the MassHealth agency to give prior authorization?

The MassHealth agency must act on requests for prior authorization within the following time limits from the date of the request:

- n **pharmacy services:** 24 hours (in an emergency the pharmacist can provide at least a 72-hour supply of the prescribed drug without prior authorization);
- n **transportation to medical services:** seven calendar days or earlier if necessary to avoid risk to health;
- n **private duty nursing:** 14 calendar days;
- n **durable medical equipment (DME):** 15 calendar days or earlier in a medical emergency; and
- n **all other services:** 21 calendar days.

130 C.M.R. §§ 450.303, 409.408 (DME).

163 What can be done if prior authorization is denied?

The beneficiary and the provider should each receive a notice when a request for prior authorization is denied. The denial can be appealed through the fair hearing process. Unfortunately, MassHealth prior authorization denial notices are often difficult to understand. The agency or the provider should be able to decode the notice. The recipient or his or her advocate have the right to obtain a copy of the prior authorization file, and can attempt to speak to the consultant who made the clinical decision. To succeed the member will usually need additional information from the provider substantiating the need for the service within the meaning of the applicable rules. See Part 18, Notice and Appeal Rights.

164 When are out-of-state services covered?

In MassHealth Standard out-of-state services are covered if

- n there is a medical emergency,
- n return to Massachusetts for needed care would endanger health, or
- n it is the general practice of a particular locality to receive services out of state.

Out-of-state services must also be covered when there are no in-state providers who can deliver the service.

In Basic, CommonHealth, and Family Assistance, out-of-state services are only covered if there is a medical emergency.

130 C.M.R. § 450.109.

165 How does MassHealth help with transportation?

All MassHealth coverage types include emergency ambulance service. Only MassHealth Standard and CommonHealth also cover nonemergency transportation. Unfortunately return trips from the provider to home, and facility to facility transfers by ambulance are usually considered a nonemergency. Such medically necessary nonemergency ambulance trips were briefly covered in Family Assistance, Basic and Essential but proposed rules are expected to eliminate this coverage in 2009. Check the rules for the current status of this coverage.

In MassHealth Standard and CommonHealth, only transportation to obtain medical services reimbursable under MassHealth will be covered for nonemergency transportation. Members who have nonemergency transportation available at no cost through family or friends are not eligible for transportation services. Maximus, the private contractor that administers the Customer Service Center, also administers the program for nonemergency transportation.

Members are eligible for reimbursement for the costs of public transportation or private automobile, whichever is less expensive, or, in the case of urgent medical need, of taxis. The member is responsible for submitting a bill to MassHealth for reimbursement of transportation expenses including documentation from the medical provider that the travel was for the purpose of obtaining reimbursable services, and receipts for the costs of transportation. Members can obtain more information about how to get reimbursed for transportation costs from the Customer Service Center. 130 C.M.R. §§ 407.415; 407.431(A), (B).

For people who do not have access to transportation or who cannot use public transportation due to a medical condition, the MassHealth agency will arrange transportation. A medical provider must authorize non-emergency transportation by completing a Prescription for Transportation form (PT-1). The MassHealth agency has contracts with Regional Transportation Authorities to provide transportation. The Customer Service Center notifies the member that he or she is eligible for assistance with transportation and provides a toll-free number for the Regional Transit Authority in the area to arrange accessible transportation in advance of the medical appointment. The authorization is good for all trips for all approved services to the approved provider for six months for acute care or one year for chronic care.

130 C.M.R. §§ 407.421 (authorization for transportation), 407.401 et seq. generally.

166 What is the MassHealth drug list?

The MassHealth agency is trying to control pharmacy costs by making it harder to get certain expensive drugs that it considers no more effective than less costly drugs. It has developed a drug list identifying which drugs can be obtained with only a doctor's prescription, and which drugs also require prior authorization from the MassHealth agency. The drug list is posted on the pharmacy page of the MassHealth agency website at www.mass.gov/MassHealth.

Generally, prior authorization is needed for any brand name drug if a generic equivalent is available. Also, for certain classes of drugs, prior authorization is needed for any but the least expensive therapeutic equivalent drug. In order to obtain prior authorization, a prescriber must document why the more costly drug is medically necessary; often, this requires evidence of an unsuccessful attempt to use the less costly drug. Prior authorization forms for different classes of drugs are posted on the pharmacy page of the MassHealth website.

Starting in October 2007, drugs available through outpatient pharmacies eligible for payment from the Health Safety Net must follow the rules applicable to the MassHealth drug list including its procedures for requesting prior authorization, and will charge the same copayments as MassHealth.

Under federal Medicaid law, MassHealth must cover any FDA-approved drug produced by a manufacturer who participates in the federal drug rebate program for any "medically accepted indication." This term includes the FDA-approved uses as well as certain off-label uses recognized in national drug compendia. *See* 42 U.S.C. §§ 1396r-8(d), 1396r-8(k)(6).

Additional useful information about the MassHealth pharmacy benefit:

- n In an emergency, a pharmacist can dispense at least a three-day supply of a prescribed drug even if prior authorization is required and was not obtained. 130 C.M.R. § 406.422(C).

- n MassHealth members who are denied prior authorization for a drug that MassHealth had approved in the past, can appeal and continue receiving the prescribed drug pending appeal; the Drug Utilization Review (DUR) office at the University of Massachusetts Medical School represents the agency in pharmacy appeals.
- n Even if the MassHealth rules limit coverage of an FDA-approved drug, most can be obtained with prior authorization if the limitations on payment would result in inadequate treatment for a diagnosed medical condition. 130 C.M.R. § 406.422(A).
- n Certain over the counter drugs are covered by MassHealth if a doctor has prescribed them; a list of over the counter drugs available with a prescription and that do not require prior authorization are posted on the MassHealth website. 130 C.M.R. § 406.412(B).

167 How has drug coverage changed for people with both MassHealth and Medicare?

Almost all elderly MassHealth recipients and many younger people with disabilities have Medicare coverage in addition to MassHealth; these people are called dual eligibles. On January 1, 2006 Medicare began offering a drug benefit through participating drug plans (Medicare Part D). Dual eligibles no longer have MassHealth drug coverage for drugs that are covered under Medicare Part D. (A few drugs like benzodiazepines and over the counter drugs are not covered by Medicare Part D and remain available to dual eligibles through MassHealth.) Instead, most dual eligibles have drug coverage through private Medicare drug plans or through their Medicare Advantage plans. Some dual eligibles with private health insurance may choose to forego Medicare drug coverage in favor of the drug coverage offered by their private health insurance.

Dual eligibles (and people eligible for the Medicare Savings Programs) are automatically eligible for “extra help” in the form of a low-income subsidy to make the Medicare drug plans affordable. In addition, MassHealth recipients newly eligible for Medicare will be randomly enrolled into a drug plan by CMS if they do not first choose a plan on their own. However, dual eligibles are able to

change drug plans at any time; this is important because plans differ in various ways including what drugs they cover.

To further protect dual eligibles, under state law, MassHealth will pay the difference between any higher copayment charged dual eligibles under Medicare Part D and the MassHealth copayment limits of \$2 or \$3, and will provide a one-time 72-hour emergency supply of a drug if the Medicare drug plan will not pay.

For more information on Medicare Part D, see www.medicare.gov.

130 C.M.R. § 406.414(C); Chapter 175, St. 2005 as amended by Section 86, Chapter 139, St. 2006; 20 C.F.R. Part 423 (Medicare Prescription Drug Benefit).

168 What benefits are available to help people quit smoking?

On July 1, 2006 MassHealth began offering a new smoking cessation benefit in all MassHealth coverage types (except MassHealth Limited). The new benefit includes individual and group tobacco cessation counseling and pharmacotherapy and is described in the regulations and manuals for physicians, community health centers, outpatient hospitals and pharmacies.

See All Provider Bulletin 155 (June 2006).

169 What happens if someone needs to go into a nursing home?

MassHealth Standard, CommonHealth, and Commonwealth Care all cover short-term nursing home care. However, only MassHealth Standard covers long-term nursing home care, and, in addition to clinical criteria for nursing home care, special financial eligibility rules apply. In order to be eligible for MassHealth

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Standard to pay or continue paying for nursing home care, an “institutionalized individual” must meet the following eligibility criteria:

- n be a Massachusetts resident;
- n be a U.S. citizen, or a qualified or protected noncitizen;
- n be under age 18 or over 64, or between 18 and 64 and disabled;
 - n Certain disabled special status immigrant children under age 19 may be eligible for long-term nursing home care in CommonHealth, see 130 C.M.R. § 519.012(B).
- n be determined medically eligible for nursing facility services in accordance with 130 C.M.R. § 456.00;
 - n For children under 22 the clinical criteria are in 130 C.M.R. § 519.007(A)(4);
 - n for adults age 22 or older the clinical criteria are in 130 C.M.R. § 456.409 (except for persons age 65 or older enrolled in a SCO).
- n have countable assets less than \$2,000 for an individual or assets under a married couple standard in accordance with 130 C.M.R. § 520.016(B);
- n instead of an upper income limit, contribute a portion of income to the costs of care as defined in 130 C.M.R. § 520.026; and
- n not have transferred resources for less than fair market value during a specified “look-back” period as described in 130 C.M.R. § 520.0018 and § 520.019.

130 C.M.R. § 519.006.

For more information on this topic, see *Estate Planning for the Aging or Incapacitated Client in Massachusetts* (MCLE, Inc. rev. ed. 1998 & Supp. 2002, 2005, 2007).

170 What can be done if a needed service is denied or not covered?

What can be done about a service denial depends on the reason for the denial. If MassHealth acts on a prior authorization request for a service, or makes a level of care determination, the recipient should get notice and the agency's action can be appealed by the recipient as explained above. If MassHealth denies payment after the provider has delivered a service, under current agency policy, only the provider can appeal the payment denial. However, if the reason for the payment denial was because the recipient was not eligible on the date of service, the recipient can appeal the underlying eligibility denial or termination, but may have to address questions about the timeliness of his or her appeal.

If a provider refuses to provide a service because the provider anticipates that MassHealth will deny payment because the service is not covered, there are several ways that the recipient can resolve the situation as discussed further below:

- n If a member is not now on MassHealth Standard or CommonHealth, he or she may be able to upgrade his or her MassHealth coverage to Standard or CommonHealth and obtain additional services.
- n If a member is under 21 years of age, he or she may be able to get additional services covered and avoid service limitations under EPSDT.
- n A person with a disability may be able to avoid limitations on covered services if necessary as a reasonable accommodation to a disability.
- n Depending on the covered service, a request for prior authorization may be a way to get additional services.
- n A member may be able to challenge the legality of state limitations on the amount, duration, and scope of services under federal Medicaid law.

171 How can upgrading MassHealth coverage help get additional services?

Some types of MassHealth coverage cover more services than others. See Table 17. If a service would be covered under a richer type of MassHealth than the type in which the member is currently enrolled, one solution is to try to upgrade coverage. A recipient may not be in the most comprehensive benefit for which he or she is eligible if he or she has not reported a change in circumstances, did not complete the disability determination process, or simply did not supply all relevant information.

Example: A long-term unemployed person obtained MassHealth Essential but never reported or verified that he was also HIV positive. He was unable to get eyeglasses because it is not a covered benefit in MassHealth Essential. When his social worker assisted him in sending MassHealth verification of his HIV-positive status, he was able to obtain Family Assistance which does cover eyeglasses.

172 How can EPSDT help a child get additional services?

Early and Periodic Screening, Diagnosis and Treatment can both help a child get services that are authorized under the Medicaid law, but that MassHealth has not chosen to cover, and it can help avoid service limitations, like a limitation on only a certain number of catheters per year. In both cases, the services must be necessary to “correct or ameliorate” a medical condition.

The regulations state that a medical provider can use the prior authorization process to request prior authorization for a medically necessary service for a child under age 21 that is not otherwise covered by MassHealth. 130 C.M.R. § 450.144. However, it appears that this procedure is little known and little used. The assistance of an advocate will likely be required to use EPSDT to access services not otherwise covered by MassHealth.

Example: A recent lawsuit challenged the failure of MassHealth to provide comprehensive in-home mental health services for mentally ill children. After a trial in which experts testified about the mental health needs of the children and the limitations of available MassHealth services, the federal district court agreed that additional services were required by EPSDT. The state is now implementing the relief ordered as the Children’s Behavioral Health Initiative. *Rosie D. v. Romney* (W.D. Mass. 2006) (opinion posted in the “Health” section of www.masslegalservices.org).

173 How can someone get services as a reasonable accommodation of a disability?

State and federal antidiscrimination laws require government programs to make reasonable modifications to rules, policies, or practices to enable a person with a disability who meets the essential eligibility requirements of a program to benefit from the program unless to do so would be a fundamental alteration of the program. 28 C.F.R. Part 35.

Example: The MassHealth agency denied coverage for the client’s daughter to be her personal care attendant (PCA) based on a rule then in place excluding family members as PCAs. (The rule has been liberalized since then.) The client could not benefit from the services of other PCAs, despite repeated trials, because her mental illness made her unmanageable around anyone but her daughter. The daughter had given up her job to care for her mother. The Superior Court agreed that the limitation on PCAs had to be modified in order to avoid denying an otherwise qualified person access to a program benefit on the basis of her disability. The court ordered the MassHealth agency to approve and pay for the client’s daughter as a PCA. *Garcia v. Warring*, Hampden Superior Court No. 01-907 B, Order of July 29, 2002 (opinion posted in the “Health” section of www.masslegalservices.org).

174 How can someone get additional services through the prior authorization process?

Prior authorization requirements differ in the extent to which otherwise uncovered services can be approved. For example, the rule on pharmacy services contains various limitations but authorizes prior authorization “if the limitations on payment would result in inadequate treatment for a diagnosed medical condition.” 130 C.M.R. § 406.412. If a provider can supply information showing that the need for an otherwise not covered pharmacy benefit meets this standard, and is medically necessary, it should be covered. However, not all the covered service rules provide opportunities for additional coverage through the prior authorization process. Advocates must consult the rule for the particular service required.

175 How can federal Medicaid law expand state limitations on services?

Federal Medicaid law requires that states cover certain “mandatory” services and gives states the option of covering other “optional” services. 42 U.S.C. § 1396d. Within each kind of service, federal regulations require that services be “sufficient in amount, duration, and scope to reasonably achieve their purpose.” 42 C.F.R. § 440.230(b). Federal regulations also prohibit a state from imposing arbitrary limitations on services based solely on diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c). However, a state may impose reasonable limitations based on medical necessity or utilization review. MassHealth is required by federal Medicaid law to comply with these federal standards. The National Health Law Program’s *Guide to the Medicaid Program* is a good source for researching federal Medicaid requirements.

Part 16

Service Delivery

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176 What is fee-for-service?

Sometimes MassHealth beneficiaries are entitled to see any provider who is participating in the MassHealth program, and providers are paid a fee for each covered service they provide. This system is called fee-for-service. Providers must apply to the MassHealth agency to become participating providers and agree to comply with MassHealth billing rules and other requirements. MassHealth providers must accept the MassHealth payment rate as payment in full. In Massachusetts, the Division of Health Care Finance and Policy sets the rates for the fee-for-service system.

G.L. c. 118E, § 36 (eligible providers); G.L. c. 118G, § 7 (determination of rates of payment).

177 What is managed care?

Sometimes, MassHealth beneficiaries are not free to see any provider participating in MassHealth. Instead they are required to enroll in some kind of managed care plan. In managed care, a primary care physician or other provider acts as a gatekeeper and the MassHealth member can generally only see other providers and specialists if the primary care physician makes a referral.

MassHealth uses several different kinds of managed care arrangements. It contracts with Managed Care Organizations (MCOs) that are paid a flat amount per month to deliver certain MassHealth covered services to each person who chooses to enroll in the MCO. The beneficiary receives care only from the network of providers who participate in the MCO; this may include some providers who do not participate in MassHealth fee-for-service. However, some kinds of MassHealth services, like dental services, are not covered by the MCO contract. The member continues to use the fee-for-service system for these services.

MassHealth also uses another kind of managed care arrangement called the Primary Care Clinician Plan (PCC). MassHealth contracts with certain clinicians to act as gatekeepers. They are paid an enhanced rate under the fee-for-service

system. The member needs a referral from the PCC to see a specialist, but with a referral, can see any participating Medicaid provider. Providers are still paid on a fee-for-service basis. People who choose the PCC Plan receive mental health and substance abuse services through another kind of managed care called a behavioral health carve-out.

Currently, the Massachusetts Behavioral Health Partnership (the Partnership) provides behavioral health services to people enrolled in the PCC plan. MassHealth has a contract with the Partnership to organize a network of providers of mental health and substance abuse services. The agency pays the Partnership a monthly fee for each enrolled member, and the Partnership is responsible for recruiting providers, authorizing services, and paying providers for authorized mental health and substance abuse services for people enrolled in the PCC Plan.

For the past 10 years, only four Managed Care Organizations (and the Partnership) have participated in MassHealth. Starting in July 2009, the Office of Medicaid will be entering into new Managed Care contracts and a different set of MCOs may be participating in MassHealth after that date.

178 Which MassHealth members are required to use Managed Care?

Currently, people covered by MassHealth Standard, Family Assistance, Basic, or Essential must participate in managed care unless excluded for one of the reasons listed below. People who are excluded or are in CommonHealth are currently not required to be in managed care: some of them may voluntarily choose managed care, the remainder receive services through the fee-for-service system. However, the Office of Medicaid is proposing to require individuals in CommonHealth who do not have other health insurance to participate in managed care beginning July 2009. Currently, the following members are excluded from mandatory participation in managed care:

- n those with other health insurance,
- n age 65 or over,
- n institutionalized,

- n solely eligible for Basic/Essential Buy-In,
- n terminally ill or receiving hospice care,
- n receiving EAEDC health benefits, or
- n presumptively eligible during a 60-day period.

130 C.M.R. §§ 508.001, 508.004.

179 What kind of managed care choices do MassHealth members have?

MassHealth members who must participate in managed care have a choice between participating in the PCC Plan, or enrolling with one of the MCOs under contract with the MassHealth agency. If no suitable managed care provider is available, as determined by the agency, a member in MassHealth Standard can be excused from enrolling in managed care. To be suitable, a provider must be physically accessible to the member and meet certain other requirements. An important protection in MassHealth is that members can choose to change doctors within plans or change plans at any time. This enables individuals to switch plans when dissatisfied with the current plan or when they were automatically assigned to a plan that does not meet their needs. (This is different from Commonwealth Care, where members are generally locked-into plan choices for the year.)

The elderly and certain people with disabilities who are not required to enroll in managed care may voluntarily choose to participate in the SCO or PACE managed care programs.

See 130 C.M.R. § 508.002.

180 Which MCOs currently participate in MassHealth?

The MassHealth agency enters into contracts with participating MCOs to enroll MassHealth beneficiaries. Providers participating in the MCO network deliver all services covered by the MCO's contract with the agency. Beneficiaries may prefer an MCO because some providers who do not participate in MassHealth as fee-for-service providers do participate as part of an MCO network. The Office of Medicaid will enter into new contracts for July 2009 that may result in a different set of participating MCOs, but currently only four MCOs participate in MassHealth:

- n Health Net (operated by the Boston Medical Center);
- n Neighborhood Health Plan;
- n Network Health (operated by the Cambridge Health Alliance); and
- n Fallon Community Health Plan.

181 What services are not delivered by the MassHealth MCOs?

People enrolled in an MCO receive most services from the MCO network of providers, but still receive some MassHealth services under the fee-for-service system. For example, the current MCO contracts do not include dental services. MCO members use their MassHealth cards to obtain dental services from any dentist who participates in MassHealth. Also, federal Medicaid law guarantees families the right to obtain family planning services from any participating Medicaid provider of such services not just those in the MCO network. Beneficiaries are mailed information about what services are covered by the MCO and what services are available on a fee-for-service basis when they enroll.

182 What providers are in the PCC Plan?

The primary care clinician in the PCC Plan delivers primary care, decides if care is needed by other providers and makes referrals to specialists and other providers as necessary. Eligible clinicians include physicians, nurse practitioners, community health centers, acute hospital outpatient departments, and group practices. There are over 1,700 PCC sites available to MassHealth members. Currently, less than one-half of those required to use managed care are in the PCC Plan.

130 C.M.R. § 508.005.

183 Is a referral from the PCC needed for every type of service?

No. Although generally, the PCC must make a referral in order for a member to see another provider, no referral from the PCC is needed for certain types of services, including:

- n abortion;
- n anesthesia;
- n home and community based waiver services (age 60 or older);
- n behavioral health (mental health and substance abuse);
 - n Behavioral health services are delivered through a vendor, currently the Partnership, not through the fee-for-service system (see Question 188, *How are mental health services delivered in MassHealth managed care?*, below).
- n dental;
- n drugs and diabetic supplies;
- n emergency care;

- n family planning services and supplies;
- n HIV testing and counseling at community health centers;
- n hospice services;
- n nursing facility services;
- n sexually transmitted disease diagnosis and treatment from DPH contractors;
- n intermediate care facilities for the mentally retarded (ICF-MR);
- n surgical pathology;
- n transportation; and
- n vision services for eyeglasses.

See 130 C.M.R. § 450.118.

184 Which MassHealth coverage types use primarily fee-for-service?

Currently disabled persons enrolled in CommonHealth, and persons over age 65 in MassHealth Standard receive services primarily through the fee-for-service system. People age 65 and over have voluntary managed care options through the Senior Care Options (SCO) program and the PACE program, and CommonHealth members who do not have other insurance can choose to voluntarily enroll in managed care. For fiscal year 2009, the Office of Medicaid is proposing to require managed care for CommonHealth members who do not have other insurance.

130 C.M.R. §§ 508.002 (when managed care is required), 508.004 (members excluded from managed care), 508.008 (SCO), 519.007(C) (PACE).

185 How does someone decide on a PCC versus an MCO?

A vendor for the MassHealth agency sends out an Enrollment Guide describing the PCC Plan and the available MCOs including a selection form to be returned by the member within 14 days. Individuals may also call health benefits advisors at the Customer Service Center toll-free line, 1-800-841-2900, for assistance in choosing a plan.

Currently, people enrolled in MassHealth Essential, in MassHealth Standard through the Breast and Cervical Cancer Treatment program or in MassHealth Family Assistance as HIV positive only have the option of the PCC plan and the Partnership. Their choices are limited to a participating primary care clinician within the PCC plan. However, starting July 2009, the MassHealth agency is proposing to offer them a choice of MCOs in addition to the PCC plan.

Where there is a choice offered among MCOs and the PCC plan, usually people decide between a PCC and the Partnership or one of the four MCOs based on the availability of primary care providers and specialists who have cared for them in the past. Health benefits advisors at the Customer Service Center should be able to answer questions about which providers are participating in which plan.

If members do not choose a PCC or MCO by telephoning Customer Service with their choice or returning the enrollment form, they will be assigned to a plan by MassHealth. Currently, the agency will only assign the PCC plan to a disabled person who has not made his or her own choice. However, starting in July 2009, the agency is proposing to make assignments to MCOs as well as PCC plans for disabled persons. Currently, about 80 percent of members choose their own managed care plan, and 20 percent are automatically assigned.

186 If a member is assigned to a plan and wishes to change, can he or she do so?

If a member is assigned to a plan he or she does not want, he or she can change plans at any time. A member required to participate in managed care can change plans and providers within plans at any time for any reason.

See 130 C.M.R. § 508.002(D).

187 How long will it take to enroll in managed care in MassHealth Basic and Essential?

In MassHealth Basic and MassHealth Essential, unlike the other MassHealth coverage types, eligibility for services does not begin until the member is enrolled in managed care on the effective date established by the agency. The member can establish a managed care enrollment effective date in the following ways:

- n After a member receives a notice of eligibility for MassHealth Basic or Essential, call the Customer Service Center and supply all the information needed to enroll into managed care. The agency will enroll the member effective no later than 10 business days after the receipt of the needed information.
- n The MassHealth agency will send members a managed care selection provider form to be returned by a deadline. The agency will enroll the member effective no later than 10 business days after receipt of the completed form.
- n If members do not select a managed care provider by the deadline, the MassHealth agency will select one for the member and enroll him no later than 35 days after he was found eligible for MassHealth.

See 130 C.M.R. § 508.002(I).

188 How are mental health services delivered in MassHealth Managed Care?

People enrolled in the PCC Plan receive mental health and substance abuse services from the Behavioral Health Partnership (the Partnership), a subsidiary of a national company called ValueOptions. For members enrolled in a PCC plan, the Partnership is responsible for delivering all covered mental health and substance abuse services, including inpatient hospitalization, through its network of providers. However, PCC members can receive emergency mental health services from any provider and the emergency service provider will be paid by the Partnership. The Partnership is not an MCO, but, like an MCO, it decides when a service proposed by a provider in its network will be authorized.

People who are enrolled in an MCO plan do not receive services from the Partnership but from the MCO. However, some MCOs may have their own behavioral health carve-outs, e.g., Neighborhood Health Plan contracts out its behavioral health services to a company called Beacon Health Systems.

People who are not in managed care receive behavioral health and substance abuse services from any participating Medicaid provider under the fee-for-service system.

See 130 C.M.R. § 450.124, and the Partnership's and MCOs' websites listed in Part 20.

189 How does managed care work for the homeless?

The MassHealth application form asks if a member is homeless. If someone indicates that he or she is homeless and does not select a managed care provider, the agency's practice is to assign the PCC plan and not an MCO. A homeless person can obtain services from an approved provider at a site like a homeless shelter or soup kitchen without a referral from the PCC.

See 130 C.M.R. § 450.118.

190 What can be done if a MassHealth MCO, SCO or the Partnership refuses a needed service?

Federal Medicaid law requires that state contracts with managed care plans include an internal grievance procedure. 42 C.F.R. § 434.32. The information included in the enrollment packet sent to new members should describe how to file a grievance under the MCO's or SCO's internal grievance procedure. People enrolled in the PCC Plan are referred to the Partnership's toll-free number for all information. In addition to the internal grievance procedure, members can also file appeals under the Medicaid fair hearing process. The MassHealth regulations provide a right to a fair hearing to resolve the following disputes related to managed care:

- n the agency's decision that the member must enroll in managed care;
- n a decision by the Partnership, MCO, or SCO to deny, reduce, modify, or terminate a covered service *if the member has exhausted all remedies through the internal grievance system*;
- n the agency's denial of a request for an out of state managed care provider; or
- n the agency's involuntary disenrollment or transfer of a member from a managed care provider.

See 130 C.M.R. § 508.006.

Legal assistance: It is advisable to consult a legal advocate if someone has a service denied by a Medicaid MCO, SCO, or the Partnership. Disputes must go through the plan's internal grievance system; and access to the contract between the plan and the agency may be necessary.

191 What can be done to find a provider who accepts MassHealth?

The Customer Service Center maintains a database of providers participating in MassHealth, and is supposed to assist members in finding a provider. If a service is the responsibility of an MCO, SCO, or the Partnership, it should assist members in locating a provider and members have the right to file a grievance about the failure to deliver covered services promptly. Sometimes, the lack of adequate providers may be grounds to avoid the requirement that someone participate in managed care and to return to the fee-for-service system. On the other hand, sometimes an MCO, SCO, or the Partnership may have providers in their networks who do not otherwise participate in MassHealth and changing to a managed care plan may improve access to more providers.

The agency has an affirmative obligation under the Medicaid Act to assure that beneficiaries receive services with “reasonable promptness.” Legal advocates have been able to use this and other provisions of the Medicaid act to challenge inadequate rates and other barriers that prevent members from finding participating providers. A recent case successfully challenged the shortage of participating dentists in MassHealth and has resulted in a series of changes designed to increase access to dental services. *See Health Care for All v. Romney* (D. Mass. 2006) (court decision posted on the “Health” section of www.masslegalservices.org).

192 Can a provider legally choose not to accept a new MassHealth patient?

Federal law does not require providers to participate in Medicaid. However, under state law, health care providers are among those prohibited from discriminating against patients on the basis of the source of payment of their health care. This antidiscrimination rule prohibits health care providers who do participate in MassHealth from discriminating against MassHealth patients, for example by accepting no new MassHealth patients when new patients with private insurance are being accepted. There is an exception to this rule to allow dentists to limit the

number of MassHealth patients they accept; it is intended to encourage more dentists to participate in MassHealth. *See* St. 2006, c. 139, § 90.

G.L. c. 151B, § 4(10); 130 C.M.R. § 450.202; *see Hennessey v. Berger*, 403 Mass. 648 (1988) (interpreting G.L. c. 151B, § 4(10) prior to its amendment in 1989).

193 How are bills paid if someone has health insurance and MassHealth?

People enrolled in MassHealth Standard and CommonHealth may have other insurance in addition to MassHealth. If a MassHealth recipient has other health insurance, MassHealth will be the payer of last resort. This means a participating MassHealth provider must bill the other health insurance first before it can bill MassHealth. Like all MassHealth providers, the provider must accept the MassHealth payment for a covered service as payment in full even if the MassHealth payment is nothing. If the other health insurance pays only part of the bill, MassHealth will pay the lesser of:

- n what the member would owe under the insurance policy including coinsurance, deductibles, and copayments; or
- n the provider's charge or maximum MassHealth payment, whichever is less, minus the payment by the other insurance.

Example: A provider charges \$1,000 for a medical service. The member's insurance pays \$800 representing 80 percent of the usual and customary charge; the member's coinsurance is \$200. The maximum MassHealth payment for this kind of service is \$850. In this situation, MassHealth will pay \$50 because its maximum payment less the insurance payment (\$850-\$800) is less than the member's coinsurance of \$200. Participating providers must accept the MassHealth payment as payment in full therefore the member is not liable for the remaining \$150.

See 130 C.M.R. § 450.317.

Domestic violence: If the private insurance is through an absent parent and using the private coverage would disclose the location or otherwise jeopardize a

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victimof domestic violence, the member can avoid the obligation to use the private coverage by asserting good cause with the MassHealth Benefit Coordination office. See Part 14.

Part 17

Premiums and Cost-Sharing

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194 How much does it cost to get MassHealth?

There are no premium charges for MassHealth Basic, Essential, Prenatal, or Limited. There are monthly premium charges for some people in MassHealth Standard Family Assistance and CommonHealth. See Table 18 in Appendix B for a comparison of premium charges in MassHealth. There are also nominal copayments for prescription drugs and inpatient hospital stays that apply to adults in all direct coverage types except MassHealth Limited.

In addition, some people with income (and assets) in excess of program limits can qualify for MassHealth after meeting a deductible or spenddown. For more information on establishing eligibility after meeting a deductible, see Part 12, Financial Eligibility.

195 How much does MassHealth Standard cost?

There are no premium charges for anyone in MassHealth Standard except for women who enrolled through the Breast and Cervical Cancer Treatment Program with gross family income over 150 percent of poverty. Their premium varies with income. See Table 18 in Appendix B. Adults in MassHealth are charged copayments, see below.

See 130 C.M.R. § 506.011(I).

196 How much does Family Assistance for Children cost?

There is a monthly premium charge for children in Family Assistance with family income over 150 percent of the poverty level. (The only children in Family Assistance with income below 150 percent are five-year bar and PRUCOL

children who would be in MassHealth Standard but for their immigration status.) The premium charge is per child up to a family maximum for three or more children, and varies by income. See Table 18 for current monthly premium amounts for children with Family Assistance direct coverage.

For **Family Assistance Premium Assistance**, MassHealth will pay a “premium assistance payment” representing a portion of the employee’s share of the health insurance premium; the family will be responsible for the balance of the employee’s premium cost. The “estimated” family share of the premium cost is the same amount that the family would have been charged for direct coverage, and will always be the minimum cost to the family. However, in some circumstances a family may have to pay more than the estimated amount if the premium assistance payment would otherwise exceed the “cost effective” amount. See Table 8 in Appendix B for the upper payment limits in SFY 2009. A family may opt for direct coverage for the child if their share of the premium cost exceeds 5 percent of gross family income. Premium Assistance will also reimburse families for cost-sharing for any preventive services for eligible children or after aggregate premium and cost-sharing payments for children exceed 5 percent of gross family income.

See 130 C.M.R. §§ 506.012(D), 506.011(I).

197 How much does MassHealth for HIV-positive adults cost?

For HIV-positive adults with income over 150 percent of poverty, there is a monthly premium charge for MassHealth Family Assistance direct coverage or Premium Assistance that varies by income. See Table 18 for the current premium amounts. In premium assistance, the amount MassHealth pays toward the cost of private insurance will never exceed the upper payment limits shown in Table 8.

130 C.M.R. § 506.011(I).

198 How much does MassHealth Family Assistance for employees in the Insurance Partnership cost?

For employees of qualified employers or self-employed individuals in the Insurance Partnership, MassHealth Family Assistance will pay a “premium assistance payment” representing a portion of the employee’s share of the health insurance premium; the employee will be responsible for the balance of the employee’s premium cost. Family Assistance Premium Assistance will not reimburse adults for their copayments, deductibles or other cost sharing under the employer’s plan. However, the “minimum creditable coverage” standard that insurance must satisfy imposes some limits on cost-sharing.

The premium cost to the employee will be the difference between the employee share of the premium cost and either the upper payment limit shown on Table 8 or the premium charge that varies by income shown on Table 18 whichever is more. Unlike the other cost-effective amounts shown in Table 8, the amount for childless adults in Family Assistance Premium Assistance has never been raised since the program began; it remains \$150 per person per month.

If there are children in the family, the premium will be based on the Family Assistance income-based premium schedule and the cost effective amounts for children. See Tables 19 and 8 in Appendix B. The adults in the family will not have to pay an additional premium for their coverage.

If the qualified employer in the Insurance Partnership is a self-employed person, he or she will have to pay 50 percent of the cost of coverage in order to be a qualifying employer in addition to paying the employee share of the premium cost. Self-employed individuals receive a subsidy of up to \$150 per month for single coverage or up to \$300 per month for coverage as a married couple. Since July 1, 2007, self-employed individuals have not been eligible to receive the employer subsidy in addition to premium assistance.

See 130 C.M.R. §§ 506.012(E), 506.011(I).

199 How does Family Assistance work if an applicant is self-employed?

Since it began in 2000, most of the adults receiving Family Assistance Premium Assistance in the Insurance Partnership have been self-employed. Health reform changed this in two ways: first, it disqualified self-employed individuals from receiving the employer subsidy in addition to the premium assistance payment, and second, it created the Commonwealth Care program. In the Insurance Partnership, a self-employed person pays 50 percent of the cost of coverage as a qualified employer, and is reimbursed for a portion of the remaining 50 percent of the cost of coverage. In most cases, it will be significantly less expensive for the self-employed individual not to apply for the Insurance Partnership but for Commonwealth Care instead.

Example: Assume a self-employed mother has two children and income at 175 percent of poverty; private health insurance costs her \$800 per month for family coverage with no subsidy. Her costs for health insurance go down to \$424 per month with assistance from MassHealth Family Assistance and the Insurance Partnership. See the calculations below. However, if instead of applying for the Insurance Partnership, she applies for Commonwealth Care for herself and Family Assistance for her children, her premium cost for Commonwealth Care for herself may be as little as \$39 per month and the \$24 premium for her two children in Family Assistance will be waived.

Total monthly premium cost	\$800
Employer share of cost (50% minimum)	– <u>400</u>
Employee share of cost	400
Estimated employee share (\$12 * 2 children)	– <u>24</u>
Estimated MassHealth premium assistance	\$376
Compare to cost-effective amount for 2 children	\$227 *2=\$554
MassHealth payment (Lesser of estimated or cost effective)	\$376
Total cost to self-employed mother (\$400 +24)	\$424

200 How much does CommonHealth cost?

Individuals with family income greater than 150 percent of poverty who are enrolled in CommonHealth are charged a monthly premium. The amount of the premium is based on income and whether or not the individual has other health insurance. A full premium is charged for someone with no other insurance or with insurance that MassHealth helps pay. A reduced “supplemental” premium is charged for someone who has other insurance that MassHealth does not help pay.

See Table 18 for the current premium amounts by income. Effective July 1, 2006 premium charges for children under 300 percent of poverty in CommonHealth were adjusted to be the same as premium charges for children in Family Assistance.

130 C.M.R. § 506.011.

201 What happens if family members are in programs with different premium charges?

A family with members in two different MassHealth programs that charge premiums such as CommonHealth and Family Assistance will be charged the premium for only one program, whichever one is higher. A family with more than one member in CommonHealth is generally charged only one premium. However, in both Family Assistance and CommonHealth, a family with income between 150 percent and 300 percent of poverty will be charged per child for up to three children.

For families with income between 150 percent and 300 percent of poverty, premiums for a child in Family Assistance, CommonHealth or CMSP will be waived if the child’s parent is enrolled in a premium-paying Commonwealth Care Plan.

130 C.M.R. § 506.011.

202 What happens if someone misses a premium payment?

MassHealth members who are charged a monthly premium are mailed a monthly invoice. MassHealth has a contract with a private vendor, Maximus, the same company that administers the Customer Service Center, to administer premium billing. If a member is billed for a premium payment and does not pay within 60 days of the date of the bill, the MassHealth agency will send an advance notice of termination. Benefits will not end if the member:

- n reports a decrease in gross family income to 150 percent of poverty or less;
 - n Someone with income too low to be charged a premium will not be terminated for nonpayment of past due premiums but the past due amounts remain a debt for which he or she will continue to be billed.
- n pays all premium payments that have been due for 60 days or more; or
- n establishes a satisfactory payment plan with the premium billing office.
 - n If the member does not make a payment on the payment plan within 30 days of the date on the bill, he or she will receive another notice of termination, and if no payments are made, benefits will end.

Currently, a premium hardship waiver in MassHealth is only available to excuse premium payments going forward, not to waive overdue payments. This is different from Commonwealth Care where a hardship can waive overdue payments. However, a hardship waiver of ongoing premiums may make it possible for the member to afford to enter into a payment plan for the overdue payments.

In cases of extreme financial hardship, the MassHealth agency can waive payment of future premiums or reduce the amount of premiums. A hardship request form is available from the MassHealth agency and posted at www.masslegalservices.org. Denial of a hardship waiver is appealable. It is important to request a waiver *before* benefits are terminated since only future payments will be waived.

If benefits are terminated, a member can reestablish eligibility only by

- n paying in full all payments due;

- n entering into a payment plan with premium billing office; or
- n reapplying and if eligible, waiting 24 months after which outstanding premiums will be waived;

Customer Service or MEC. Contact the Customer Service office to work out a payment plan, request a hardship waiver or dispute whether payments were made. Contact the MEC if a drop in income or increase in family size brings gross family income to 150 percent of poverty or less and no monthly premium is due for ongoing coverage, or to dispute whether premiums were correctly charged based on the family's past income.

130 C.M.R. § 506.011.

203 What are the grounds for a MassHealth hardship premium waiver?

People with income over 150 percent of poverty who are charged premiums in MassHealth but cannot afford them can obtain a waiver or reduction of premiums based on extreme financial hardship. The waiver request form can be obtained from the Customer Service/Premium billing office. (A similar process is available in Commonwealth Care, but the grounds are a little different and a different request form is used.) A family experiencing one of the following hardships may qualify for a MassHealth premium waiver:

- n homeless, more than 30 days in arrears in rent or mortgage, or has a current eviction or foreclosure notice;
- n has been shut off, refused service, or has a current shut off notice for an essential utility;
- n has debts for medical/dental expenses that are more than 7.5 percent of gross family income; or
- n has experienced a significant, unexpected increase in essential expenses within the last six months.

130 C.M.R. § 506.011(F).

204 Can providers who accept MassHealth still send members bills?

Generally, participating providers must accept the amounts paid by MassHealth as payment in full for covered services for an eligible member. There is no balance billing. If MassHealth pays nothing because the provider made a billing error, the provider cannot demand payment from the member. The only exceptions are the limited situation in which MassHealth providers are authorized to collect a nominal copayment, or when people in long-term care are required to contribute a patient-paid amount to the costs of care. Also, MassHealth members who are receiving only premium assistance to pay for employer-sponsored insurance will be liable for the copayments and other cost-sharing allowed under the employer's plan.

If a member sees a provider who is not a participating MassHealth provider, or if a member is in managed care and sees a provider for whom a referral is needed without a referral, or if a health service is not covered at all by MassHealth or if someone was not eligible on the date of service, the provider may be sending a bill. Whether or not a MassHealth member is liable will depend on the circumstances. Someone in this situation should consult a legal advocate.

In addition, under the Health Safety Net rules, an acute hospital cannot pursue collection activity for a debt owed by a current MassHealth recipient.

130 C.M.R. § 450.203; G.L. c. 118E, § 36; 42 C.F.R. § 447.15 (Medicaid/MassHealth); 114.3 C.M.R. § 13.08(3) (Health Safety Net).

205 How much are the copayments in MassHealth?

The copayments shown below are the maximum currently allowed in MassHealth. Subject to the exemptions described below, the following copayments are due at the pharmacy or the hospital when services are received:

Part 17 n Premiums and Cost-Sharing

- n \$2 for each pharmacy prescription or refill for most generic drugs; \$1 for certain generic drugs for chronic conditions, i.e., antihyperglycemics, antihypertensives, or antihyperlipidemics, and \$3 for brand-name drugs; and
- n \$3 for a hospital in-patient stay.

If someone has private insurance and MassHealth, the pharmacy should bill the private insurance first, and bill MassHealth for any private insurance copay greater than the \$1–\$3 copay allowed in MassHealth.

- n MassHealth does not currently allow mail order pharmacies to participate as providers, therefore it will not pay for mail order copayment charges higher than \$1–\$3 for recipients with private insurance who use a mail order option. If the private insurer requires use of mail order for maintenance drugs and charges more than a \$1–\$3 copayment, the pharmacy should assist the member to arrange for MassHealth to be the primary payer for drug coverage.

See 130 C.M.R. §§ 450.130, 520.038.

Annual caps: There is an annual cap of \$200 for pharmacy copayments and \$36 for in-patient hospital copayments. Once a cap has been reached, no further copayments are due for the year. *See* 130 C.M.R. § 520.040.

206 What happens if someone cannot afford the copayment?

A provider cannot deny a service to someone who is unable to pay at the time the service is needed, however, a member will still owe the provider the amount of the copayment. If a pharmacy insists on payment as a condition of dispensing the drug and the member is unable to pay, the Customer Service Center should be able to intervene with the pharmacy.

See 130 C.M.R. §§ 450.130, 520.039.

207 Who is exempt from copayments?

The following MassHealth members (with direct coverage) are not required to make copayments for any service:

- n children under age 19;
- n pregnant women;
- n inpatients in nursing facilities, chronic disease hospitals, or ICF-MRs;
- n hospice patients;
- n MassHealth Limited members and EAEDC-Medical recipients; and
- n people who have met the annual copayment cap.

Premium Assistance: Family Assistance Premium Assistance and Basic/Essential Premium Assistance members may be charged copayments under the terms of their employer-sponsored insurance. For children in Family Assistance Premium Assistance, the MassHealth agency will reimburse copayments incurred for well-child care, and after a family has spent more than 5 percent of its income on premiums and copayments for eligible children, the MassHealth agency will reimburse any additional costs for the year. However, the family must keep track of its costs and verify that costs have exceeded 5 percent of income; because of this very few families benefit from the 5 percent cap.

See 130 C.M.R. §§ 450.130, 520.037 (copay exemptions), 505.005(B)(6) (Family Assistance 5 percent cap).

208 Which services do not require a copayment?

There is no copayment for the following services:

- n family planning services and supplies,

- n Medicare-covered services for individuals with Medicare and MassHealth Standard or the Senior Buy-In/QMB, and
- n emergency services.

See 130 C.M.R. §§ 450.130, 520.037.

209 Will MassHealth members ever have to pay back MassHealth benefits?

In most cases members do not have to pay back MassHealth benefits, but there are some special circumstances in which the member or his or her estate may have to repay MassHealth:

- n Members are required to assign to MassHealth their rights to third-party recovery in order to repay medical expenses from an insurance settlement or other recovery for a loss. See Part 14 for more information.
- n Members who were provided money for premium assistance may be required to repay money to which they were not entitled.
- n If a member chooses to receive benefits pending an appeal from the termination of assistance and loses the appeal, the member is liable to repay the benefits paid pending appeal, however, in practice the MassHealth agency has not sought recovery from the member. 130 C.M.R. § 610.036(D).
- n After the member's death, if he or she left an estate, the member's estate may be liable to repay MassHealth benefits received for services to someone age 55 or older. Estate recovery can be deferred until the death of a surviving spouse, minor child, or disabled adult child. There are also provisions to waive recovery on hardship grounds. 130 C.M.R. § 501.013.
- n Someone who received Medicaid fraudulently may be court-ordered to repay the benefits received.
- n An institutionalized individual of any age receiving nursing home level of care is also subject to estate recovery. *See* 130 C.M.R. §§ 515.011–515.012.

See 130 C.M.R. §§ 501.011–.013.

- n Medicare-covered services for individuals with Medicare and MassHealth Standard or the Senior Buy-In/QMB, and
- n emergency services.

See 130 C.M.R. §§ 450.130, 520.037.

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- n An institutionalized individual of any age receiving nursing home level of care is also subject to estate recovery. *See* 130 C.M.R. §§ 515.011–515.012.

See 130 C.M.R. §§ 501.011–.013.

Part 18

Notice and Appeal Rights

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210 When should MassHealth members get a notice from the MassHealth agency?

The MassHealth agency must give notice of any action to deny, reduce, suspend, terminate, or restrict assistance. The notice must describe the action, the reason for the action, the regulation supporting the action and an explanation of the right to request a fair hearing. Except for actions on initial applications, the MassHealth agency generally must give notice at least 10 days before the intended action. The notice must contain an eligibility determination for each member of the family group who has applied for MassHealth. Notice is also required for any changes in coverage type, or premium assistance payments. When a request for prior authorization is denied or a level of care decision is made both the provider and the member should get notice of the decision and notice of appeal rights.

Because the MassHealth agency also makes determinations for Commonwealth Care and the Health Safety Net, notices are often confusing. Typically there is a separate heading dividing the portion of the notice pertaining to MassHealth programs, Commonwealth Care and the Safety Net.

The notice is important in informing an applicant or recipient what decision was made, the reason for the decision and how to appeal. The purpose of an appeal is to let an impartial person, the hearing officer, decide whether the decision made in an individual's case was correct.

130 C.M.R. §§ 502.008, 610.004.

211 What role does MassHealth play in Commonwealth Care appeals?

Individuals apply for Commonwealth Care with the same application form used for all MassHealth programs and for the Health Safety Net. The MassHealth agency makes the initial eligibility determination for all of these programs. Only if an applicant is determined ineligible for MassHealth will there be a decision about Commonwealth Care. The decisions made by the MassHealth agency about

Commonwealth Care can be appealed to the MassHealth Board of Hearings, and, of course, every Commonwealth Care decision also includes a decision denying MassHealth that can be appealed to the Board of Hearings.

However, the Commonwealth Care eligibility criteria related to access to insurance trigger a confusing two-step eligibility determination process. The MassHealth agency may provisionally deny Commonwealth Care based on access to insurance. However, the individual may then receive a notice from the Connector giving him or her an opportunity to claim an exception from the denial, or to appeal to the Connector in the event no exception is claimed. If an exception is claimed, a later notice will either award or deny benefits with notice of the right to appeal the denial to the Connector.

Given the predictable confusion about where to file an appeal, both the MassHealth Board of Hearings and the Connector provide that an appeal filed with either agency will be regarded as a timely appeal, and will be transferred to the appropriate agency.

Appeals from decisions of the Connector unrelated to eligibility follow its appeal process not that of the MassHealth Board of Hearings, See Part 10.

130 C.M.R. §§ 610.004, 610.012, 610.032; 956 C.M.R. §§ 3.14, 3.17; Connector Administrative Bulletin 01-07.

212 What types of actions are appealable?

The following kinds of MassHealth agency actions are grounds for appeal:

- n denial of an application or request for assistance;
- n failure to make a timely decision on an application or request for assistance;
- n any action to suspend, reduce, terminate, or restrict assistance;
- n decisions regarding the scope and amount of assistance (including level of care determinations);
- n imposition of any unauthorized condition of eligibility;

Part 18 n Notice and Appeal Rights

- n a decision that the member is required to use managed care;
- n the denial of an out-of-area managed care provider;
- n involuntary disenrollment from a managed care provider;
- n any action by the Partnership, one of the Managed Care Organizations (MCOs), or Senior Care Options plans (SCO) to suspend, reduce, terminate, or restrict assistance provided the member has first exhausted the internal plan grievance process;
- n any discharge or transfer initiated by a nursing facility; or
- n the MassHealth agency's determination on behalf of the Connector as set forth in 956 C.M.R. § 3.17 (Commonwealth Care).

See 130 C.M.R. § 610.032 for a complete list of appealable actions.

213 When are decisions of a provider appealable?

The Board of Hearings rules say that no action by a provider is an appealable action with two exceptions: nursing home transfer and discharge actions, and adverse decisions by the Partnership or a MassHealth MCO or SCO. 130 C.M.R. § 610.004.

Ordinarily if a member has a dispute with a provider, the member's recourse is to consult a different provider not to file an appeal. However, in some cases where the member has no choice of provider and the provider's decision is based on its interpretation of a MassHealth rule rather than a medical judgment, an appeal may be appropriate. Consult a legal advocate in a situation like this. *See, e.g., Mansfield v. Commissioner*, 40 Mass. App. Ct. 1, 660 N.E.2d 684 (1996).

Where MassHealth makes a determination that a patient no longer requires a hospital level of care, both the provider and the patient have a right to notice and an opportunity to appeal. 130 C.M.R. §§ 415.417 (acute care hospitals), 435.416 (chronic care hospitals).

214 How does someone appeal?

To appeal, a MassHealth member, or someone authorized to act on his or her behalf, must ask for a hearing in writing and mail or fax the request to the MassHealth agency Board of Hearings (BOH) by the appeal deadline. The notice of decision generally has printed on the back of it a request for a fair hearing form that can be used to request an appeal. It is useful to include a copy of the notice being appealed along with the request for a hearing. The appeal should identify what action the MassHealth agency took, but need not describe why that action was incorrect.

Generally, the written request for a hearing must be *received* by the BOH within 30 days of receipt of the notice of action. The rules assume receipt of the notice three days after the date it was mailed unless a post mark or other evidence proves it took longer than that for someone to receive the notice. A member can also appeal from the MassHealth agency's failure to act. The MassHealth agency rules say that appeals from inaction or actions taken without notice must be filed within 120 days of the application or request not acted upon or the action taken. The Director of the Board of Hearings can waive this 120-day limitation.

The Board of Hearings receives a high volume of appeals and is strict about deadlines. When in doubt about whether or not to appeal, it is wiser to file the appeal and withdraw it later if need be than to miss a deadline.

130 C.M.R. §§ 610.015, 610.034.

215 Can benefits continue while waiting for the appeal to be heard?

Yes. This is a very important protection for current recipients, and advocates should be sure not to miss the deadline for aid pending appeal. When appealing the termination or reduction of assistance, benefits can be continued pending appeal or reinstated if the member appeals and requests continued benefits before the date of the intended action or within 10 days of the mailing of the notice of intended action, whichever is later. A member can get continued services pending

appeal after expiration of the prior authorization for a service that was authorized for a limited period of time only if the provider has submitted a new prior authorization request on time.

130 C.M.R. § 610.036.

216 How much advance notice will be given for a fair hearing?

The Board of Hearings sends at least 10 days' notice of the time and place of the hearing.

217 Where do fair hearings take place?

Fair hearings can take place at the office of the Board of Hearings in Boston, at Regional MEC offices or other locations accessible to the MassHealth member. If a member consents, a hearing can be conducted entirely by telephone.

218 Who will be present at the hearing?

One hearing officer representing the Board of Hearings will preside. One or more representatives of the MassHealth agency will represent MassHealth regarding the action it took that is under appeal. For denials of prior approval, the medical consultant who made the decision will ordinarily be present. Consultants will appear in person if the hearing is in Boston, but generally only participate by telephone outside of Boston. For managed care appeals a representative from the Partnership, MCO or SCO will be present. Occasionally, an attorney from the

MassHealth agency's general counsel's office may attend. If the member requested an interpreter, the BOH should arrange for an interpreter to be present. Members have the right to appear with a representative. Members also have the right to request that the Board of Hearings subpoena necessary witnesses. 130 C.M.R. § 610.052.

219 How does the appellant prepare for a hearing?

MassHealth members should try to find a legal aid advocate or other experienced advocate to assist with an appeal. The notice of decision is an important document in understanding why MassHealth took the action it did, and what the issues on appeal will be. In prior authorization cases the notice may refer to technical terms and codes that the agency should be asked to explain. Members and their advocates have the right to examine the case file before the hearing as well as all documents and records to be used by the MassHealth agency at the hearing. In eligibility cases, this may involve having someone from MassHealth review and print out copies of the computer file, in addition to a review of any paper file. The Customer Service Center also maintains a log of its contacts with members that can be obtained in preparation for a hearing. 130 C.M.R. § 610.050.

Obtain copies of all documents referred to in the notice of decision that may not be part of the case file such as the regulation on which the decision was based. Members and their advocates have the right to request that the Board of Hearings subpoena necessary witnesses and that they bring documents and other evidence in their possession with them to the hearing. 130 C.M.R. § 610.052. An appellant can arrange in advance for a witness who is not available to attend the hearing in person, such as the doctor, to testify by telephone. Ordinarily, the advocate should try to interview the consultant or agency employee who made the decision under appeal in order to fully understand the reason for the decision. Beyond the right to examine the case file, there is no formal process to enable an advocate to obtain additional information from the agency in advance of the hearing (discovery), but an advocate can pursue informal discovery, and in an appropriate case can try writing to the Board of Hearings to allow additional methods of discovery.

220 Is there a chance that the appeal can be resolved without a hearing?

Sometimes appeals can be resolved prior to the hearing based on informal discussion with staff at MassHealth or the submission of additional information that causes the agency to change its position. However, be sure that the terms of the agreement to resolve the case are clear before dismissing the appeal. Because a pending appeal may block the agency's computer systems from making certain changes, it may be necessary to dismiss the appeal before the agency can issue a new determination. The BOH should not unilaterally dismiss an appeal when the agency notifies it of an "adjustment" without the agreement of the appellant that the adjustment resolves the issues in dispute. 130 C.M.R. § 610.051.

221 What happens at the hearing?

At the hearing, the hearing officer will typically ask the agency representative to explain why the agency made its decision. Agency representatives often read a prepared statement. Documents will be marked and entered as exhibits. The appellant will then have an opportunity to explain why the agency's decision was incorrect. The member has the right to present evidence of all relevant facts and circumstances, and cross-examine adverse witnesses. The hearing officer will also ask questions of the witnesses. All evidence and testimony will be tape-recorded. 130 C.M.R. § 610.061. The appellant is not limited to the evidence that was already in the case file; he or she can submit new information. This kind of hearing is called "de novo." 130 C.M.R. § 610.071(A)(2). If an issue comes up at the hearing that takes the appellant by surprise, he or she can ask for a postponement or ask that the record be held open for a certain period of time in order to submit additional information.

222 How long will it take to get a decision?

The hearing officer must make a decision within 45 days of the hearing request if the issue under appeal was the denial of an application or failure to act on an application. For all other issues the hearing officer must make a final decision within 90 days of the request unless good cause exists to extend the time. Appeals from denial of prior authorization for an elective hospital admission may be expedited, and a decision may be issued within 14 days. The decision will be in writing, summarize the facts and arguments of the parties, and make findings of fact and conclusions of law.

130 C.M.R. §§ 510.015(D) (time frame), 610.083 (contents).

223 Do MassHealth members have to file a grievance with the Partnership, MCO, or SCO before requesting a fair hearing?

If appealing an action of the Partnership, MCO, or SCO, MassHealth rules require that the member first exhaust the internal grievance procedures which all Medicaid managed care organizations are required to have. Generally, the internal grievance will give the member and his or her provider an opportunity to talk by telephone and to submit medical records to the physician who initially approved the service reduction or denial and to the medical director or some other physician who was not involved in the original decision. The enrollment packet sent out by the MCO or SCO at the time of enrollment should describe the internal grievance process; someone must call the Partnership's toll-free number or consult its website to find out how to appeal its decision. Members should be able to have ongoing services continued during the grievance process. Members should also be able to have the grievance heard on an expedited basis in accordance with health care needs. If the grievance is not resolved to the member's satisfaction, he or she can request a fair hearing before the Board of Hearings. MassHealth members should seek the assistance of a legal advocate if denied services by the Partnership or an MCO or SCO. See Part 16, Service Delivery, for more information on managed care denials.

130 C.M.R. §§ 508.006, 610.032.

224 If a MassHealth member wins an appeal, can he or she get back the money spent on care?

Yes. If a MassHealth member wins an appeal, any MassHealth provider who delivered covered services to him or her can now bill MassHealth and receive payment. If services were incurred more than 90 days ago, the provider may need to submit evidence of the reversed decision along with its claim.

If the member incurred out of pocket expenses for prescription drugs or other covered services, he or she can be directly reimbursed by the MassHealth agency. Appellants should be sure to keep receipts pending appeal. A MassHealth member should be reimbursed for the amounts he or she actually had to pay even if the amount exceeds the MassHealth payment rate, and even if the provider does not participate in MassHealth.

The regulations also recognize the right to direct reimbursement of covered medical expenses whenever someone was denied MassHealth and the denial is later reversed with or without a fair hearing. This also applies to applicants for cash welfare who are initially denied SSI, TAFDC, or EAEDC and later succeed in having the denial of benefits reversed.

The Customer Service Center typically advises members who win back benefits to ask the provider to reimburse them for any out of pocket expenses and to rebill MassHealth. Sometimes this works. However, some providers are reluctant to do this and some providers may not be participating in MassHealth. It may be necessary for an advocate to contact the legal office to obtain direct reimbursement for a client in such cases. If a hearing officer reversed the denial, the appellant may also obtain further assistance from the Board of Hearings if MassHealth does not implement the hearing decision within 30 days.

130 C.M.R. §§ 507.002 (reimbursement for out of pocket medical expenses), 610.086 (implementation of fair hearing decisions).

225 What happens if a MassHealth member loses an appeal?

Members and their advocates have 30 days from receipt of the fair hearing decision to file a request for judicial review in the Superior Court. 130 C.M.R. § 610.092. Or, members can request a rehearing with the Director of the Office of Medicaid within 14 days of the date of the hearing decision (not the date of receipt). The filing of a request for rehearing suspends the hearing officer's decision until the rehearing request is acted on by the Medicaid Director. 130 C.M.R. § 610.091. If the request for rehearing is not granted, or if it is granted and the appeal is again denied, the member has 30 days from the decision denying the rehearing request, or the new decision after rehearing, to file for judicial review (file an appeal in state court). If the member was receiving benefits pending appeal, just filing a request for judicial review will not prevent benefits from ending.

130 C.M.R. §§ 610.091, 610.092; G.L. c. 30A, § 14; Superior Court Modified Standing Order 1-96: Processing and Hearing of Complaints for Judicial Review of Administrative Agency Proceedings. See MLRI, *ABCs of Filing a Complaint for Judicial Review of a MassHealth Fair Hearing Decision*, posted on www.masslegalservices.org.

Part 19

Health Programs Other than MassHealth

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226 Where can information on health programs be found?

For more information on health programs other than MassHealth, see Part 20 for a list of references and websites. The Division of Health Care Finance and Policy produces a catalogue of health programs that is still a useful reference tool but has not been updated since 2004: *Access to Health Care in Massachusetts: A Catalog of Health Care Programs for Uninsured and Underinsured Individuals*. It is available at www.mass.gov/dhcfp.

227 What is the Health Safety Net?

The Health Safety Net (HSN), formerly called the Uncompensated Care Pool or Free Care, relieves an eligible individual from medical debt to acute care hospitals for “critical access services” received there and to community health centers for their services. It is not a coverage program like MassHealth and does not provide a defined set of benefits. It provides funds to acute hospitals and health centers that treat the uninsured and underinsured. The Health Safety Net reimburses acute hospitals for their charges, but will not cover the costs of providers who bill separately from the hospital. Depending on the hospital, physicians, specialists, lab and x-ray technicians and other providers may not be employees of the hospital reimbursed from HSN, and therefore are not prevented from billing the HSN patient for their services.

Eligibility. The Health Safety Net is available to Massachusetts residents, regardless of age or immigration status who are determined to be “low income patients.” People who do not live in Massachusetts are not eligible for any services. (However, hospitals and health centers may be able to obtain HSN reimbursement for emergency bad debt incurred by out of state residents). Individuals with gross family income that does not exceed 200 percent of poverty may be eligible for “full” benefits from HSN. Individuals with gross family income over 200 percent but not over 400 percent of poverty may be eligible for “partial” benefits. With partial HSN the patient must pay a deductible before the HSN is available. There is also a medical hardship program for Massachusetts

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residents who are not otherwise eligible for HSN coverage of incurred expenses at hospitals and CHCs.

Starting in October 2007, individuals who are eligible for MassHealth Standard, CommonHealth, and Family Assistance direct coverage are no longer eligible for six months retroactive HSN. Individuals who are only eligible for MassHealth Limited, CMSP, HSP, or Family Assistance premium assistance, along with other low income patients, remain eligible for six months retroactive HSN.

With these restrictions on retroactive HSN, it is important that hospital patient file an application within 10 days of incurring hospital charges to avoid medical debt.

Individuals who are eligible for coverage in MassHealth Basic, Essential or Commonwealth Care only after they enroll in a managed care plan, are eligible for time-limited HSN from 10 days prior to application to 90 after application, and those who enroll in Commonwealth Care remain eligible for HSN until the effective date of coverage. Also, those in Commonwealth Care who do not otherwise have dental coverage, remain eligible for HSN for dental care.

At some point, individuals who have access to affordable insurance will be ineligible for HSN. The effective date of this restriction has been delayed several times and is currently scheduled for April 2009.

Also starting in October 2007, individuals who were terminated from MassHealth or Commonwealth Care for nonpayment of premiums are no longer eligible for HSN.

Application and determination of eligibility. Applications for HSN are included in the MBR and S-MBR, the common application form used for MassHealth programs and Commonwealth Care. The MassHealth agency determines eligibility for HSN in addition to the other programs. All acute hospitals and health centers use the online (Virtual Gateway) common intake form to apply for HSN. (A separate confidential application form is available for teens seeking confidential services and for domestic violence victims.) The Health Safety Net defines income and family group the same way MassHealth does, and requires applicants to comply with MassHealth verification requirements. The one exception to the MassHealth verification rules is that U.S. citizens do not have to verify citizenship and identity, and immigrants are not required to verify immigration status in order to obtain HSN.

Services. Acute outpatient hospital services are eligible for reimbursement from HSN only for the following services:

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- n all medically necessary services if there is no community health center (CHC) within five miles,
- n emergency or urgent care,
- n specialty care (including mammograms),
- n maternity care, or
- n complex care not available at a CHC.

In order for drugs to be covered by HSN, the hospital or health center must have an outpatient pharmacy and the prescription must be written by a clinician associated with the hospital or health center. Drug coverage in HSN is also now subject to the same prior authorization and other rules applicable to the MassHealth drug list, and the minimum MassHealth copays of \$1–\$2 for a generic and \$3 for a brand name drug apply.

Medical hardship. With new restrictions on eligibility for HSN, the criteria for HSN coverage for debts under the Medical Hardship program were liberalized. There is no longer an asset test. Hardship is based on the patient incurring medical expenses in the past 12 months that exceed a certain percentage of his or her annual income; this amount represents the patient's expected contribution to the costs of care. The percentage of income varies by income starting at 10 percent of income for those at 0 to 200 percent of poverty and going up to 40 percent of income for those over 600 percent of poverty. Medical expenses are not limited to services eligible for payment by HSN but include any potentially tax deductible medical expense. Expenses not eligible for reimbursement by HSN will be counted first toward the patient's contribution. Patients can apply only twice in a 12-month period and applications are filed on behalf of the patient by the hospital or health center. If DHCFP grants an application, HSN will only pay for HSN eligible services that have already been incurred and that were not counted as part of the patient's contribution. If a patient is currently a low income patient, payment of the patient's contribution to HSN providers will be deferred.

114.6 C.M.R. § 13.00 et seq. See also information on the HSN posted at the website of the Division of Health Care Finance and Policy, www.mass.gov/dhcfp.

For more information, call the HSN Helpline at 617-988-3222 or 877-910-2100.

228 What is the Children's Medical Security Plan?

The Children's Medical Security Plan (CMSP) provides primary and preventive care for all children who are uninsured and are not eligible for MassHealth (except for MassHealth Limited). There are no citizenship or immigration rules, but children must be Massachusetts residents. The CMSP is administered by the MassHealth agency and uses the MBR application form.

Premiums. No premiums are charged children in families with income under 200 percent of poverty; monthly premiums for children in families with income between 201 and 300 percent of poverty are \$7.80 per child up to a \$23.40 family maximum; with income between 301 and 400 percent of poverty, monthly premiums are \$33.14 per family; with income over 400 percent of poverty, monthly premiums are \$38.99 per child (SFY 2009). CMSP also charges copayments of \$2–8 depending on the service and the family income.

Services. The CMSP contracts with Unicare to administer benefits. The CMSP benefits are restricted; they include dental up to \$750, prescription drugs up to \$200, mental health and substance abuse up to 20 visits, durable medical equipment up to \$200 (or more for certain conditions) along with outpatient office visits and immunizations and certain other benefits. The CMSP does not include inpatient hospital care, however, families eligible for the CMSP with income at or under 200 percent of poverty are eligible for full Health Safety Net benefits at hospitals and community health centers, and families eligible for CMSP with income over 200 percent but under 400 percent of poverty are eligible for partial Health Safety Net benefits. Children ineligible for MassHealth based on their immigration status and with income not over 150 percent of poverty will receive CMSP plus MassHealth Limited for emergency services.

G.L. c. 118E, § 10F; 130 C.M.R. § 522.004. For more information, visit www.cmspkids.com.

229 What is the Healthy Start Program?

The Healthy Start Program (HSP) is administered by the MassHealth agency as part of its State Children's Health Insurance Title XXI program. Healthy Start covers prenatal care and 60-day postpartum care for pregnant women with gross family income at or under 200 percent of poverty for a family size that includes the fetus. There is no citizenship or immigration status requirement, but women must be Massachusetts residents. Healthy Start uses the MassHealth application form. Women will be eligible for Healthy Start plus MassHealth Limited to cover labor and delivery.

G.L. c. 118E, § 10E; 130 C.M.R. § 522.005. For more information, visit www.hspmoms.com.

230 What is the Medical Security Plan?

The Medical Security plan (MSP) subsidizes private insurance or provides direct coverage for individuals eligible to collect unemployment compensation under Massachusetts law. It is administered by Blue Cross/Blue Shield under a contract with the Division of Unemployment Assistance.

Eligibility. The MSP is only available to Massachusetts residents who become unemployed from a Massachusetts employer, receive unemployment insurance benefits and have annual family income under 400 percent of poverty. Annual family income is based on actual income in the past six months and projected income for the next six months. The DUA mails an application packet to all individuals filing a claim for unemployment insurance benefits.

Individuals who were on Commonwealth Care while employed, or who apply for CommonwealthCare after losing employment will be asked questions on the MBR or ERV intended to screen for potential MSP eligibility. Individuals will be denied Commonwealth Care if they are collecting unemployment benefits and otherwise appear to be eligible for MSP. If someone is denied who is not eligible for MSP, in order to re-establish eligibility for Commonwealth Care, he or she will either have to correct misinformation that went into the screening with the

MEC, e.g., that the employer was not a Massachusetts employer but a federal or out of state employer, or submit proof of the MSP denial to the same vendor the Connector uses to process exceptions.

Benefits. The MSP either pays part of the cost of continuing coverage under the health insurance offered by a former employer (COBRA) or other private coverage, or offers direct health coverage if COBRA/private coverage is not available or is so expensive it would be a hardship to pay. An unemployed person with family income under 200 percent of poverty automatically meets the hardship standard. For COBRA/private coverage, DUA currently pays for 80 percent of the actual premium paid up to a maximum of \$1080 per month for a family plan and \$440 per month for an individual plan (FY 2009). The direct care plan is the Blue Cross/Blue Shield Network Blue HMO plan; it has copayments such as \$15 for an office visit, but no deductibles and no premium charge. Premium assistance or direct coverage ends when an individual's unemployment insurance benefits end.

G.L. c. 151A, § 14G; 430 C.M.R. § 7.00 et seq. For more information call 800-908-8801 (MSP Customer Service) or go to www.mass.gov/dua.

231 What is the Prescription Advantage Program?

The Prescription Advantage program helps pay the costs of prescription drugs for seniors and people with disabilities and is administered by the Executive Office of Elder Affairs. When Medicare began offering a drug benefit through private drug plans in January 2006, the scope of the Prescription Advantage program changed. As a condition of Prescription Advantage eligibility, Medicare recipients now must enroll with a Medicare drug plan or have comparable coverage and low-income Medicare recipients must apply for “extra help” to make Medicare drug plans more affordable. Prescription Advantage will subsidize some of the remaining out of pocket costs for seniors and certain people with disabilities enrolled in Medicare drug plans, and will continue to provide its own pharmacy insurance plan for those not eligible for Medicare.

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Eligibility: Prescription Advantage is available to Massachusetts residents (without regard to U.S. citizenship or immigration status) who are not MassHealth or CommonHealth members and who are:

- n 65 years of age or older, eligible for Medicare, and have a gross annual household income that is less than 500 percent of poverty;
- n 65 years of age or older and not eligible for Medicare; or
- n under age 65, work no more than 40 hours per month, meet MassHealth's CommonHealth disability requirements, and have a gross annual income at or below 188 percent of poverty; and
- n if eligible for Medicare, enrolled in a Medicare drug plan or have drug coverage through another insurance plan that is as good as the Medicare drug plan, and if family income does not exceed 150 percent of poverty applied for "extra help" in paying for Medicare drug coverage.

Application and enrollment: Applications can be downloaded from the Elder Affairs website and submitted by mail. Health counselors are available to assist applicants through the SHINE program (800-AGE-INFO).

Benefits: The benefits of Prescription Advantage vary by income level and Medicare coverage; there are five levels of assistance. If enrollees have Medicare, Prescription Advantage provides supplemental coverage to reduce the costs of drug coverage. If enrollees are not eligible for Medicare, Prescription Advantage offers primary prescription drug coverage. Prescription Advantages helps people with Medicare drug coverage by subsidizing monthly premium, deductible and co-payments with the amount of the subsidy depending on the individual's level of assistance and available state funds. See Table 19 for assistance levels in 2009. For more information on benefits available for individuals at different income levels, see www.800ageinfo.com.

651 C.M.R. § 15.00. For more information, call 800-AGE-INFO.

232 What is the Massachusetts Home Care Program?

The Massachusetts Home Care Program, administered by the Executive Office of Elder Affairs, provides home care through 27 local Aging Services Access Points (ASAPs). Eligible individuals generally must be age 60 or over with a certain level of functional impairment, and one or more critical unmet needs. There are no U.S. citizenship or immigration status criteria. Gross annual income must not exceed \$24,837 for an individual, \$35,144 for a couple (2009). A range of home care services are available including homemakers, adult day health, personal care homemakers, home delivered meals, transportation, and adaptive housing services. There are copayments based on income. People with Alzheimer's disease are eligible regardless of age. Certain services such as protective services or emergency shelter may be provided without regard to income or copayments. Services are subject to appropriation and there may be waiting lists for some services.

651 C.M.R. § 3.00 et seq. For more information call 1-800-882-2003 or visit www.mass.gov/elders.

233 What health services are available to veterans and military families?

The Veteran's Administration (VA) provides a medical benefit plan for all enrolled veterans. All honorably discharged veterans who apply will be enrolled to the extent appropriations allow in accordance with a priority schedule.

Generally, veterans will receive preventive and primary health care at a VA health care facility. For more specialized treatment veterans may have a choice of locations. Veterans accepted for enrollment in the VA health care system will be eligible to receive necessary inpatient and outpatient services, including preventative and primary care. These include:

n diagnostic and treatment services;

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- n mental health, substance abuse, and home health;
- n respite and hospice care; and
- n drugs in conjunction with VA treatment.

For application information call a VA health care facility, the Health Benefits Service Center at 1-877-222-8387 or apply online at www.va.gov/elig. Additional veteran's medical benefits, and assistance with VA applications, are available through the city or town veteran's agent under G.L. c. 115.

TRICARE. Apart from the health services of the VA described above, the TRICARE (formerly called CHAMPUS) programs offer health plans to active duty military personnel and military retirees, and their dependants. Individuals eligible for TRICARE are not eligible for Commonwealth Care. For more information about TRICARE, call 877-874-2273 or visit www.healthnetfederalservice.com.

234 What health services are available to college students?

Students enrolled in at least 75 percent of the full-time curriculum of a college or university in Massachusetts are required to participate in a qualifying student health insurance plan (QSHIP) or in a plan with comparable coverage. Schools will automatically enroll students in QSHIP and add the charges to tuition unless the student demonstrates that he or she has comparable coverage. Many students may have coverage as a dependant on their parents' health plan. (Massachusetts insurers who offer dependent coverage must offer such coverage to children until age 26 or two years after ceasing to qualify as a tax dependent of the insured whichever is earlier). The cost and scope of coverage of QSHIP plans vary. Students who are eligible for QSHIP are not eligible for MassHealth Basic, Essential or Commonwealth Care or for primary coverage from the Health Safety Net. However, the Health Safety Net is available to supplement coverage for students who are enrolled in QSHIP or have comparable coverage. Qualifying Student Health Insurance Plans are regulated by the Division of Health Care Finance and Policy.

114.6 C.M.R. § 3.00.

235 What is the Fishing Partnership?

The Fishing Partnership is a subsidized health plan available to individuals and families who derive more than 50 percent of their income from the commercial fishing industry. Comprehensive benefits are available through Harvard Pilgrim Health Care for a sliding scale premium charge. People who are eligible for the Fishing Partnership are not eligible for Commonwealth Care. For more information call 888-282-8816 or visit www.fphp.org.

Part 20

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236 Office of Medicaid

**Executive Office of Health
and Human Services,**

One Ashburton Place, 11th Floor
Boston, MA 02108
Tel. 617-573-1600

Office of Medicaid (Operations)

600 Washington Street, 5th Floor
Boston, MA 02111
Tel. 617-210-5000

MassHealth Board of Hearings

2 Boylston Street
Boston, MA 02116
Tel. 617-210-5800, 800-655-0338
Fax: 617-210-5820

**MassHealth Enrollment Center
in Springfield**

333 Bridge Street
Springfield, MA 01103
Tel. 800-322-5545
Fax: 413-785-4180

**MassHealth Enrollment Center
in Tewksbury**

367 East Street
Tewksbury, MA 01876-1957
Tel. 800-408-1253
Fax: 978-863-9300

Insurance Partnership

Tel. 800-399-8285

Office of Medicaid (Policy & Legal)

One Ashburton Place, 11th Floor
Boston, MA 02108
Tel. 617-573-1600
Fax: 617-573-1895 (Legal Dept.)

Central Processing Unit

PO Box 290794
Charlestown, MA 02129-0214
Tel. 800-843-7114
Fax: 617-241-6005

**MassHealth Enrollment Center
in Revere**

300 Ocean Avenue
Revere, MA 02151
Tel. 800-322-1448
Fax: 781-485-3400

**MassHealth Enrollment Center
in Taunton**

21 Spring Street, Suite 4
Taunton, MA 02780-0711
Tel. 800-242-1340
Fax: 508-828-4611

MassHealth Enrollment Centers (All)

Tel. 888-665-9993
TTY: 888-665-9997

Customer Service Center (Maximus)

(Choice of health plan; transportation
assistance; questions about services)

Tel. 800-841-2900
Fax: 617-350-3489
TTY: 800-497-4648

Part 20 n Sources of Additional Information

Premium Billing Office

(Premium payment problems and hardship waivers are now handled by Maximus)

Tel. 800-841-2900

TTY: 800-497-4648

Disability Evaluation Service

Tel. 800-888-3420

Fax: 617-241-6005

Drug Utilization Review Appeals

Tel. 508-421-6148

Fax: 877-208-7428

Boston Medical Center HealthNet Plan

Member Services Department

Tel. 1-888-566-0010

Mental Health and Substance Abuse Services

Tel. 1-888-217-3501

Neighborhood Health Plan

Member Services Department

Tel. 1-800-462-5449

Mental Health and Substance Abuse Services

Tel. 1-800-414-2820

Network Health

Member Services Department

Tel. 1-888-257-1985

Mental Health and Substance Abuse Services

Tel. 1-888-257-1986

Behavioral Health Partnership

Tel. 800-495-0086

Premium Assistance, Benefit Coordination & Recoveries Unit

MassHealth Standard and CommonHealth Premium Assistance; & Medicare savings programs

Tel. 800-462-1120;

Family Assistance Premium Assistance

Tel. 888-291-4464

Unicare

(administers CMSP and HSP benefits)

Tel. 800-909-2677 (CMSP);

888-488-9161 (HSP)

Prior Approval Unit

Tel. 617-451-7017

Fax: 617-451-7092

Fallon Community Health Plan

Member Services Department

Tel. 1-800-868-5200

Mental Health and Substance Abuse Services

Tel. 1-888-421-8861

Primary Care Clinician Plan (PCC Plan)

Member Services Department

Tel. 1-800-841-2900

Mental Health and Substance Abuse Services

Tel. 1-800-495-0086

237 Other Useful Telephone Numbers

State Agencies:

MassHealth, Commonwealth Care, Health Safety Net self-service line for members & applicants. 888-665-9993 anytime, day or night, *except* from Saturday, 10:00 p.m. to Sunday, 6:00 a.m. (Select English or Spanish; press “1” when you hear the option “If you are calling about a notice you received or to check on the status of your case, press 1”; follow instruction in a series of menus to obtain information about the status of your case or application.)

Department of Mental Health

617-626-8000

Department of Public Health

800-531-2229

- n *Women’s Health Network:* 1-877-414-4447 (breast and cervical cancer screening and application for MassHealth for women diagnosed with such cancers and in need of treatment).
- n *HIV Drug Assistance Program (H-DAP):* 800-228-2714 (help with costs of HIV drugs or for the costs of insurance that will cover HIV drugs).
- n *Substance Abuse Information & Referral:* 617-292-5065; 800-327-5050 (including treatment for uninsured state residents).
- n *Office of Patient Protections:* 1-800-436-7757 (information on managed care consumer protections, and external review of managed care coverage denials).

Department of Transitional Assistance

800-249-2007

Division of Health Care Finance and Policy/Health Safety Net Help Line

617-988-3222; 877-910-2100

Division of Unemployment Assistance/MSP Customer Service Line

800-908-8801

Executive Office of Elder Affairs

617-727-7750
800-AGE-INFO

Health Insurance Connector Authority

100 City Hall Plaza
Boston, MA 02109
Tel. 617-933-3030
Fax: 617-933-3070

Commonwealth Care Customer Service

133 Portland Street (premiums can be paid in person at this address)
Boston, MA
Tel. 877-623-6765
TTY: 1-877-623-7773

Commonwealth Care Exceptions Department

PO Box 9212
Chelsea, MA 02150

Other organizations:

Health Care for All Help Line: 617-350-7279; 800-272-4232 (information, referrals, and application assistance).

Mayor's Health Line: 617-534-5050; 800-847-0710 (information, referrals, and application assistance).

Massachusetts Medline: 866-633-1617 (information and referrals for free or low-cost medications).

238 Legal Citations and References

Laws and Regulations

Federal Law:

Federal Medicaid Law: Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq., 42 C.F.R. Parts 430–456.

Part 20 ⁿ Sources of Additional Information

Medicaid waiver authority: Section 1115 of the Social Security Act, 42 U.S.C. § 1315.

Federal eligibility based on immigration status: 8 U.S.C. §§ 1612(b), 1613, and 1641.

State Children’s Health Insurance Program (SCHIP): Title XXI of the Social Security Act, 42 U.S.C. § 1397aa–jj; 42 C.F.R. Part 457.

Federal Anti-Discrimination Laws: The Americans with Disabilities Act, 42 U.S.C. §§ 12131–34 and 28 C.F.R. Part 35; the Rehabilitation Act of 1973, 29 U.S.C. § 794.

State Law:

MassHealth, G.L. c. 118E; 130 C.M.R. §§ 401–42, 456, 484–85 (covered services), 450 (administrative and billing), 501–08 (health reform), 515–21 (traditional Medicaid), 522 (other programs), 610 (fair hearings), and 650 (insurance partnership).

Medical Security Plan: G.L. c. 151A, § 14G; 430 C.M.R. § 7.00 et seq.

Children’s Medical Security Plan: G.L. c. 118E, § 10F; 130 C.M.R. § 522.004.

Healthy Start: G.L. c. 118E, § 10E; 130 C.M.R. § 522.005.

Health Safety Net/Free Care: G.L. c. 118G, §§ 35–39; 114.6 C.M.R. §§ 13.00 and 14.00.

Prescription Advantage: G.L. c. 19A, § 39; 651 C.M.R. § 15.

Massachusetts Home Care: 651 C.M.R. § 3.00 et seq.

Commonwealth Care Health Insurance Program: G.L. c. 118H; 956 C.M.R. 2.00 and 3.00.

Managed Care Consumer Protections: G.L. c. 170O; 105 C.M.R. 128.000 (Department of Public Health) and 211 C.M.R. 52.00 (Department of Insurance).

An Act Providing Access to Affordable, Quality, Accountable Health Care: St. 2006, c. 58 as amended by c. 324 and c. 450 St. 2006, and c. 205, St. 2007.

Annual Appropriations Acts, c. 182, St. 2008 (the General Appropriation Act for fiscal year 2009)

239 Other Sources

Baker, Patricia, *EAEDC Advocacy Guide*, 2008 edition (Massachusetts Law Reform Institute and Massachusetts Continuing Legal Education, Boston, MA). To order: 1-800-966-6253.

Eichner, Stanley and Griffin, Christine ed., *Legal Rights of Individuals with Disabilities*, 2002 (Disability Law Center and Massachusetts Continuing Legal Education, Boston, MA). To order: 1-800-966-6253.

Bauer, Linda G., Freedman, Don and Starr, Emily eds., *Estate Planning for the Aging or Incapacitated Client in Massachusetts*, 2007 edition (Massachusetts Continuing Legal Education, Boston, MA). To order: 1-800-966-6253.

Harris, Deborah et al., *TAFDC Advocacy Guide*, 2008 edition (Massachusetts Law Reform Institute and Massachusetts Continuing Legal Education, Boston, MA). To order: 1-800-966-6253.

Landry, Linda et al., *An Advocate's Guide to Surviving the SSI System*, 2005 edition (Disability Law Center, Massachusetts Law Reform Institute, and Massachusetts Continuing Legal Education, Boston, MA). \$15
To order: 1-800-966-6253.

Massachusetts Division of Health Care Finance and Policy, *Access to Health Care in Massachusetts: A Catalog of Health Care Programs for Uninsured and Underinsured Individuals* (2004, Boston, MA).
To order: 617-988-3100.

National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs* (4th ed. 2002). To order: 213-639-3900, ext. 3.

Perkins, Jane et al., *An Advocate's Guide to the Medicaid Program*, 2001, (National Health Law Program, Los Angeles, CA) To order: 310-204-6010.

240 Websites

National

Centers on Medicare and Medicaid Services: www.cms.hhs.gov

This website by the federal agency that administers Medicaid contains extensive information on Medicare, Medicaid, and SCHIP, including CMS's State Medicaid Manual and Letters from CMS Officials to State Medicaid Officials.

National Health Law Program: www.healthlaw.org

An excellent site for legal advocates with extensive information on Medicaid and links to other useful sites.

Kaiser Commission on Medicaid and the Uninsured: www.kff.org

Reports on Medicaid, Medicare, the uninsured, and other topics, including a comparison of health facts among the states.

Bazelon Center for Mental Health Law: www.bazelon.org

Resources on legal rights of people with mental disabilities.

Center on Budget and Policy Priorities: www.cbpp.org

Reports on Medicaid, children's health, and other policy issues.

Families USA: www.familiesusa.org

Reports on Medicaid, Medicare and the uninsured, and current legislative developments, and links to other health-related sites.

Massachusetts

Office of Medicaid: www.mass.gov/MassHealth

This website contains summaries of MassHealth programs, the application form and member booklet, regulations, provider manuals and bulletins, transmittal letters, and other information about MassHealth administered programs.

n *Provider regulations (covered services):* www.mass.gov/masshealth
From the main page, select "MassHealth Regulations and Other Publications."

n *MassHealth Drug List:* www.mass.gov/masshealth
From the main page, select "MassHealth Drug List."

n *Massachusetts Behavioral Health Partnership:* www.masspartnership.com

Part 20 n Sources of Additional Information

n *Children’s Medical Security Plan:* www.cmspkids.com

n *Healthy Start Program:* www.hspmoms.com

n **Website for the MassHealth Managed Care Organizations:**

n *BMC Health Net:* www.bmchp.org; *Neighborhood Health Plan:* www.nhp.org; *Network Health Plan (Cambridge Health Alliance):* www.network-health.org; *Fallon Community Health Plan:* www.fchp.org

MassHealth Training Forum: www.masshealthmtf.org

Training materials and other information presented at regional training forums sponsored by the MassHealth agency for providers and consumers.

Division of Health Care Finance and Policy: www.mass.gov/dhcfp

This website contains information on the Health Safety Net/Free Care program, rate regulations for MassHealth services, Key Indicators reports on the health reform implementation and reports on managed care, the uninsured, the hospital system, and other topics.

Department of Public Health: www.mass.gov/dph

This website contains information about various public health programs including:

n the Women’s Health Network breast and cervical cancer screening programs, for participating medical sites, see www.massmammography.com,

n substance abuse services, www.helpline-online.com,

n services for people with HIV disease, www.crine.org, and

n the Office of Patient Protections (external review of managed care organization medical necessity determinations), www.mass.gov/dph/opp.

The Division of Unemployment Assistance: www.mass.gov/dua

This website contains information about health insurance coverage for unemployment insurance recipients through the Medical Security Plan.

Executive Office of Elder Affairs: www.mass.gov/elders and www.800ageinfo.com

Information about services to elders including Medicare, the Prescription Advantage Program, Home Care Services, Aging Service Access Points, and free health counseling for elderly and disabled individuals through the SHINE program.

Part 20 ⁿ Sources of Additional Information

Department of Mental Health: www.mass.gov/dmh

This site includes the eligibility criteria for DMH services.

Department of Transitional Assistance: www.mass.gov/dta

This site includes information about programs administered by DTA including EAEDC and TAFDC.

Health Insurance Connector Authority: www.mahealthconnector.org

Extensive information about programs administered by the Connector including descriptions of Commonwealth Care eligibility criteria, premiums, copayment and benefit schedules, regulations and administrative bulletin and a section where members can log-in; information about unsubsidized health plans offered through the Connector's Commonwealth Choice program; information about health reform, the affordability schedule and the individual mandate, and proceedings of the Connector's Board of Directors.

Department of Revenue: www.mass.gov/dor

Information about tax filing including Schedule HC and instructions and individual mandate penalties for the current tax year.

Department of Insurance: www.mass.gov/doi

Information from the agency regulating health insurance including a Health Insurance Consumer Guide, insurance laws and regulations; and lists of licensed insurers.

Massachusetts Blue Cross Blue Shield Foundation:

www.bcbsmafoundation.org

Massachusetts Medicaid Policy Institute: www.massmedicaid.org

The Foundation website includes a series of reports on health reform in Massachusetts as well as health-related grant opportunities. The Foundation-supported MMPI includes reports focusing on the MassHealth program.

Massachusetts Legal Services Programs: www.masslegalservices.org

This site includes information for advocates about health, benefits, housing, family law, and other substantive areas of poverty law. The Health section is maintained by MLRI and includes updates on current developments and other advocacy materials. The related site, www.masslegalhelp.org, includes community education materials for clients as well as information listing legal services programs throughout the state.

Health Care for All: www.hcfama.org

This site describes the advocacy and organizing projects of Health Care for All and describes pending health access legislation as well as the activities of Coalitions working on such issues as children’s health, eliminating health disparities, and implementing health reform. A daily blog is indispensable reading for those working on health policy issues.

Massachusetts Community Partners: www.compartners.org

This site includes materials to assist community outreach workers who help low-income uninsured and elderly people enroll in available health benefits.

Outreach Grantees:

[www.umassmed.edu/uploadedFiles/Commed_Microsites/ocp/MHEOG/FY%2008%20Grant%20Organization%20Directory%20Information%20for%20website%20\(2\).pdf](http://www.umassmed.edu/uploadedFiles/Commed_Microsites/ocp/MHEOG/FY%2008%20Grant%20Organization%20Directory%20Information%20for%20website%20(2).pdf)

Information on how to contact each of 40 organizations across the state funded by EOHHS to assist individuals in obtaining and maintaining health coverage.

241 Legal Services Offices

Legal services programs located throughout the state provide free legal services to low-income and elderly state residents who live in their service areas in certain civil (non-criminal) legal matters. Different offices have different areas of expertise and priorities. For more information, visit www.masslegalhelp.org.

Boston College Legal Assistance Bureau (Waltham).....	781-893-4793
Cambridge & Somerville Legal Services	617-603-2700
Center for Public Representation (disability issues)	
Northampton.....	413-587-6265
Newton.....	617-965-0776
Children’s Law Center of Massachusetts	781-581-1977
Community Legal Services & Counseling Center (Cambridge)	617-661-1010
Disability Law Center	
Boston	617-723-8455; 800-872-9992
Northampton	413-584-6337; 800-222-5619
Greater Boston Legal Services.....	617-371-1234; 800-323-3205
Harvard Legal Aid Bureau.....	617-495-4408

Part 20 n Sources of Additional Information

Legal Advocacy & Resource Center.....	617-603-1700; 800-342-5297
(Statewide intake & referral)	
Legal Assistance Corp. of Central Mass. (Worcester).....	508-752-3718; 800-649-3718
Legal Services Center (Wilmer-Hale -Jamaica Plain).....	617-522-3003
Mass. Justice Project	
Holyoke.....	413-533-2660; 800-639-1209
Worcester.....	508-831-9888
Massachusetts Law Reform Institute.....	617-357-0700; 800-717-4133
Merrimack Valley North Shore Legal Services	
Lynn.....	781-599-7730
Lowell (main office).....	978-458-1465; 800-525-0989
Mental Health Legal Advisors Committee.....	617-3382345; 800-342-9092
MetroWest Legal Services (Framingham).....	508-620-1830; 800-696-1501
Neighborhood Legal Services	
Lawrence.....	978-686-6900; 888-657-2889
Lynn.....	781-599-7730; 800-747-5056
New Center for Legal Advocacy	
New Bedford.....	508-996-8576; 800-244-9023
Plymouth.....	508-746-2777; 800-585-4933
New England School of Law Clinical Law Office (Boston).....	617-422-7380
South Coastal Counties Legal Services	
Brockton.....	508-586-2110; 800-244-8393
Fall River.....	508-676-6265; 800-287-3777
Hyannis.....	508-775-7020; 800-742-4107
New Bedford.....	508-979-7150; 800-929-9721
Plymouth.....	508-747-1444; 800-742-4107
Suffolk University Law School Disability Advocacy Clinic.....	617-573-8000
Volunteers Lawyers Project of the Boston Bar Association.....	617-426-0648
Western Massachusetts Legal Services	
Greenfield.....	413-774-3747; 800-639-1309
Northampton.....	413-584-4034; 800-639-1309
North Adams.....	413-664-4531
Pittsfield.....	413-499-1950; 800-639-1509
Springfield.....	413-781-7814; 800-639-1109

Legal assistance is also available from Health Law Advocates, who provide representation to low and moderate income clients and make referrals to a panel of pro bono lawyers on health-related issues

Health Law Advocates..... 617-338-5241; 800-272-4232 (Help Line)

Appendix A

MassHealth Eligibility Checklist

The MassHealth Eligibility Checklist is designed to provide an overview of the many pathways to coverage under MassHealth. It can be used as an interview tool to assure that none of the paths to coverage have been overlooked. Reviewing the checklist will also provide a summary of factors affecting eligibility and the footnotes show where these factors are defined and discussed in more detail in later sections of the Guide.

Recent eligibility changes in MassHealth include:

- n Creating the new Commonwealth Care program in 2006 for adults without access to subsidized insurance;
- n Expanding eligibility for Family Assistance from 200 percent to 300 percent of the poverty level; and
- n Providing MassHealth Standard to youth up to age 21 who were in custody of the Department of Children and Families on turning 18.

MassHealth Eligibility Checklist¹⁹

1. Does the applicant live in Massachusetts?²⁰

If No:

Stop. If the applicant is not a Massachusetts resident, he or she is not eligible for MassHealth.²¹

2. Is the applicant potentially eligible for cash assistance from TAFDC, EAEDC, SSI, or refugee resettlement assistance?²²

If Yes:

Stop. An applicant for one of these cash assistance programs will automatically be eligible for MassHealth if cash assistance is awarded. Individuals eligible for EAEDC include very low income individuals who are not otherwise in an eligible group for MassHealth purposes including those who are disabled for 60 days or more; are caring for someone who is severely disabled; participate in a Massachusetts Rehabilitation Commission program; or are caring for unrelated children. The elderly are also eligible for EAEDC. See Part 3 for more about EAEDC.

3. Is the applicant a child eligible for an adoption assistance subsidy or foster care payments?²³

If Yes:

Stop. The applicant is eligible for MassHealth if cash assistance is awarded and a youth who was in custody of the Department of Children and Families at 18 is eligible until age 21.

4. Is the applicant under age 19?

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

¹⁹ If the applicant or the applicant's spouse lives in a nursing home, do not use this checklist.

²⁰ See Part 2, for the definition of Massachusetts residence.

²¹ See Part 19, *Health Programs Other Than MassHealth*.

²² See Part 3 for more information on these cash assistance programs.

²³ See Part 5 *Eligibility Criteria for Children*.

5. *Is the applicant pregnant?*

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

6. *Is the applicant the parent or “caretaker relative”²⁴ living with a child under age 19?*

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

7. *Is the applicant between the ages of 19 and 64 and “disabled”²⁵?*

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

8. *Is the applicant between the ages of 19 and 64, and unemployed for 12 months or longer (or unemployed and earned less than \$3,300 in the last year)²⁶?*

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

9. *Is the applicant between the ages of 19 and 64 and HIV positive?*

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

10. *Is the applicant between the ages of 19 and 64, and self-employed or working for an employer with fewer than 50 employees willing to contribute 50 percent toward the cost of insurance?*

If Yes:

²⁴ See Part 7 for a definition of caretaker relative.

²⁵ See Part 8 for a definition of disability.

²⁶ See Part 9 for a definition of long-term unemployed.

Appendix A n MassHealth Eligibility Checklist

The applicant may belong to an eligible population group if his employer is eligible to participate in the Insurance Partnership, and the application goes through the employer.²⁷ **If so, skip to question 16.**

11. Is the applicant 65 or over?

If Yes:

The applicant belongs to an eligible population group. **Skip to question 16.**

12. Is the applicant receiving treatment for breast or cervical cancer?

If Yes:

The applicant belongs to an eligible population group, but the cancer diagnosis and need for treatment must be screened through the Women's Health Network.²⁸ **Skip to question 16.**

13. Was the applicant in foster care at age 18 and is he or she under age 21?

If Yes:

Stop. The applicant may be eligible, regardless of income, as a youth aging out of foster care. See Part 5.

14. Do any of the eligible population groups described in Questions 4–13 apply to the applicant?

If none applies:

Continue, the applicant is not eligible for MassHealth but may be eligible for Commonwealth Care

15. Is the applicant age 19 or older and uninsured or paying the full cost for his or her insurance?

If Yes: The individual may be eligible for Commonwealth Care but if the individual is offered subsidized insurance from an employer, is enrolled in college, is collecting unemployment insurance, has a family group member in the commercial fishing industry or in the active or retired military, he or she

²⁷ See Part 9 for the definition of qualified employer and more about the Insurance Partnership.

²⁸ See Part 8 for more about eligibility criteria for women with breast/cervical cancer.

Appendix A n MassHealth Eligibility Checklist

may be eligible for another health coverage program instead of Commonwealth Care.²⁹ **Continue to question 16.**

If No: The individual is not eligible for MassHealth or Commonwealth Care but may be eligible for the Health Safety Net or another program, see Part 19.

16. Identify the members of the applicant’s family group whose income will be included in calculating the applicant’s family income.³⁰

17. If the applicant is under 65, what is his or her “gross family income”?³¹

18. If the applicant is 65 or over, is he or she a parent or caretaker relative of a child under 19 or disabled and working more than 40 hours per month or not eligible for Medicare?

If Yes:

What is his or her “gross family income”?³²

If No:

What is his or her adjusted “family income” after reducing gross income by allowable “deductions” and what are his or her “countable assets.”³³

NEXT: Compare the applicant’s income and family size (and assets if applicable) to the applicable upper income level for the applicant’s family size and eligibility group using the Financial Eligibility by Poverty Level and Eligible Group at Table 5 and the MassHealth Income Standards at Table 6.

19. Is the applicant’s family income and assets, where applicable, under the limits shown on the Income Standards Table?

If Yes:

Stop: The applicant is eligible.

²⁹ See Part 10 for more about Commonwealth Care.

³⁰ See Part 12 to learn who is included in the family.

³¹ See Part 12 to learn what income counts under Medicaid reform.

³² Ibid.

³³ See Part 12 to learn what income and assets count and what deductions are allowed in traditional Medicaid.

Appendix A n MassHealth Eligibility Checklist

20. Is the applicant's income over the limit shown on the Income Standards Table?

If Yes:

Continue. The applicant still may be eligible for MassHealth or Commonwealth Care.

21. Is the applicant a parent or caretaker relative living with a child with gross family income under 300 percent of poverty, and does the family have access to employer-sponsored family coverage?

If Yes:

The parent/caretaker relative may benefit from Premium Assistance to help with the costs of employer-sponsored family coverage if the insurance meets certain requirements and the child/ren are eligible for MassHealth.³⁴

22. Is the applicant under age 19 and disabled?

If Yes:

Stop. The applicant is eligible. He or she will be subject to a monthly premium charge based on income.³⁵

23. Is the applicant a disabled adult (of any age) who works more than 40 hours a month?

If Yes:

Stop. The applicant is eligible. He or she may be charged a monthly premium based on income.³⁶

24. Is the applicant between the ages of 19 and 64, disabled, and not working, and does he or she have past unpaid, current, or anticipated medical bills?

If Yes:

³⁴ See Parts 5 and 6 for the requirements that must be satisfied for the Premium Assistance programs.

³⁵ See Part 5 for the requirements for coverage under CommonHealth for disabled children.

³⁶ See Part 8 for the requirements for coverage under CommonHealth for working disabled adults.

Appendix A n MassHealth Eligibility Checklist

The applicant may become eligible if he or she is able to meet a one-time deductible amount. Thereafter, the applicant will also be subject to a monthly premium charge based on income.³⁷

25. Was the applicant recently receiving MassHealth?

If Yes:

The applicant may be eligible for extended or transitional benefits.³⁸

26. Is the applicant 65 or over, and does he or she have past unpaid, current, or anticipated medical bills?

If Yes:

The applicant may be eligible for six-month periods after meeting a deductible amount in each period.³⁹

27. If the applicant now has Social Security Insurance-based benefits, did he or she receive SSI at some time in the past?

If Yes:

In some circumstances, some or all of the applicant's Social Security income may not count in figuring family income.⁴⁰

28. Is the applicant under age 19 and needs the equivalent to a nursing facility or hospital level of care but lives at home?

If Yes:

The applicant's parents' income and assets may not count when figuring the applicant's family income under the so-called Kaileigh Mulligan program.⁴¹

³⁷ See Part 8 for the requirements for coverage under CommonHealth for nonworking disabled adults.

³⁸ See Part 4 for the availability of extended or transitional benefits.

³⁹ See Part 12 for a description of the spenddown program for seniors.

⁴⁰ See Part 3 for the rules that apply to certain former SSI recipients.

⁴¹ See Part 5 for a description of the Kaileigh Mulligan program.

29. Is the applicant 55 or over and does he or she need the equivalent to a nursing facility level of care but lives at home?

If Yes:

An applicant age 55 or older may be eligible for the PACE program or an applicant age 60 or older may be eligible for the home and community based services (HCBS) waiver. In both programs, the income and assets of the applicant's spouse do not count when figuring the applicant's family income, and the monthly income limit is three times the federal SSI amount.⁴²

30. Does the applicant have Medicare coverage?

If Yes:

Applicant may be eligible for a Medicare Savings Program to pay some or all of his or her Medicare premiums, deductibles, and co-insurance.⁴³

31. Does the applicant's income exceed the limits on the chart, and none of the conditions in Questions 21–30 apply?

If Yes:

Stop. The applicant is not eligible for MassHealth or Commonwealth Care but may be eligible for other programs. See Part 19 for discussion of the Health Safety Net and other health programs for which the applicant may be eligible.

NEXT: If the individual is eligible, in order to find what type of MassHealth coverage applies, see Table 7 on Eligibility for MassHealth Coverage Types or Commonwealth Care. If the applicant is a noncitizen, the coverage type will depend on the applicant's immigration status as well as other factors. The type of coverage will determine the benefits that are covered, the costs a member must pay, when his or her coverage begins, and whether he or she must use managed care.

⁴² See Part 11 for a description of the Home and Community-Based Services program and the PACE program.

⁴³ See Part 11 for more on Medicare Savings Programs.

Appendix B

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Table 5: Financial Eligibility by Poverty Level and Eligible Group in MassHealth

This table shows upper income limits applicable to different populations expressed as a percentage of the federal poverty level (where applicable) as well as the upper limit for countable assets and whether a deductible is required above certain income limits in MassHealth. Eligibility for Commonwealth Care is not shown.

	Not based on poverty level	100% of poverty level	133% of poverty level	200% of poverty level	300% of poverty level	Countable Assets	One-time deductible if over 133% level	Every 6-month deductible if over 100% level
Pregnant women				✓				
Child under 19					✓			
Disabled child under 19	no upper limit or deductible ✓							
Parents/ Caretakers			✓					
Disabled adult 19–64				✓			✓	
Working disabled adult	no upper limit or deductible ✓							
Unemployed adults under 65		✓						
HIV+ under 65				✓				
Employee of qualified employer under 65					✓			
Age 65 and over		✓				\$2,000 individual/ \$3,000 couple		✓

Table 6: MassHealth Income Standards

Table 6. MassHealth Income Standards, March 1, 2008 - February 28, 2009												
Upper income levels	Seniors (Standard); unemployed adults (Essential); DMH clients (Basic)			Parents/caretakers; disabled adults (Standard)			Children 1-18 (Standard); Uninsured adults (Premium-free Commonwealth Care)			Pregnant women & infants (Standard); HIV+ individuals (Family Assistance); All residents (Full Health Safety Net)		
	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly
Percent of poverty	100%			133%			150%			200%		
Family Size	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly
1	\$867	\$10,404	\$200.09	\$1,154	\$13,848	\$266.33	\$1,301	\$15,612	\$300.25	\$1,734	\$20,808	\$400.18
2	\$1,167	\$14,004	\$269.33	\$1,553	\$18,636	\$358.41	\$1,751	\$21,012	\$404.11	\$2,334	\$28,008	\$538.66
3	\$1,467	\$17,604	\$338.56	\$1,952	\$23,424	\$450.50	\$2,201	\$26,412	\$507.96	\$2,934	\$35,208	\$677.13
4	\$1,767	\$21,204	\$407.80	\$2,351	\$28,212	\$542.58	\$2,651	\$31,812	\$611.82	\$3,534	\$42,408	\$815.60
5	\$2,067	\$24,804	\$477.04	\$2,750	\$33,000	\$634.66	\$3,101	\$37,212	\$715.67	\$4,134	\$49,608	\$954.07
6	\$2,367	\$28,404	\$546.27	\$3,149	\$37,788	\$726.75	\$3,551	\$42,612	\$819.52	\$4,734	\$56,808	\$1,092.55
7	\$2,667	\$32,004	\$615.51	\$3,548	\$42,576	\$818.83	\$4,001	\$48,012	\$923.38	\$5,334	\$64,008	\$1,231.02
8	\$2,967	\$35,604	\$684.74	\$3,947	\$47,364	\$910.92	\$4,451	\$53,412	\$1,027.23	\$5,934	\$71,208	\$1,369.49

Yearly amounts reflect monthly rounding multiplied by 12.
 Add the fetus to the family size of a pregnant woman.
 For people under 65, eligibility is based on gross monthly income.
 For seniors, eligibility is based on adjusted income after deductions including a \$20 per month standard deduction, and there is an asset test.
 The Senior deductible income standard is \$522 per mo. for an individual; \$650 per mo. for a couple.
 The income standard for an institutionalized individual is \$72.80 per month.
 MassHealth determines financial eligibility for MassHealth programs, Commonwealth Care and Free Care (Uncompensated Care/Health Safety Net)
 Prepared by the Massachusetts Law Reform Institute

See additional income levels on reverse side

Additional Income Levels, March 1 2008 - February 28, 2009												
Upper income level	Women with breast/cervical cancer (MH Standard)			Children under 19 & workers in Insurance Partnership (Family Assistance); Uninsured adults (Commonwealth Care)			All residents (Partial Health Safety Net); Children under 19 (Children's Medical Security Plan-subsidized) & Unempl. Comp. recipients (Medical Security Plan)			Disabled non-working adults (Common-Health)	Certain seniors (PACE & Home and Community-Based Services) 2009	
	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly			
Percent of poverty	250%			300%			400%			Deductible Income Standard		
Family Size	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Monthly	
1	\$2,168	\$26,016	\$500.35	\$2,601	\$31,212	\$600.28	\$3,468	\$41,616	\$800.37	\$542	\$2,022	
2	\$2,918	\$35,016	\$673.44	\$3,501	\$42,012	\$807.99	\$4,668	\$56,016	\$1,077.31	\$670		
3	\$3,668	\$44,016	\$846.53	\$4,401	\$52,812	\$1,015.69	\$5,868	\$70,416	\$1,354.26	\$795		
4	\$4,418	\$53,016	\$1,019.62	\$5,301	\$63,612	\$1,223.40	\$7,068	\$84,816	\$1,631.20	\$911		
5	\$5,168	\$62,016	\$1,192.71	\$6,201	\$74,412	\$1,431.11	\$8,268	\$99,216	\$1,908.15	\$1,036		
6	\$5,918	\$71,016	\$1,365.80	\$7,101	\$85,212	\$1,638.82	\$9,468	\$113,616	\$2,185.09	\$1,161		
7	\$6,668	\$80,016	\$1,538.89	\$8,001	\$96,012	\$1,846.53	\$10,668	\$128,016	\$2,462.04	\$1,286		
8	\$7,418	\$89,016	\$1,711.98	\$8,901	\$106,812	\$2,054.23	\$11,868	\$142,416	\$2,738.98	\$1,403		
<p>Children with income over 400% of the poverty level can buy-in to the Children's Medical Security plan at full cost. There is no income upper limit or deductible for disabled children or disabled working adults in CommonHealth.</p> <p>The 2008 federal poverty levels were published in the Jan. 23, 2008 Federal Register</p>												

Prepared by Massachusetts Law Reform Institute

See additional income levels on reverse side

MassHealth Income Standards, March 1, 2009 - February 28, 2010 *CORRECTED*												
Upper income levels	Seniors (Standard); unemployed adults (Essential); DMH clients (Basic)			Parents/caretakers; disabled adults (Standard)			Children 1-18 (Standard); Uninsured adults (Premium-free Commonwealth Care)			Pregnant women & infants (Standard); HIV+ individuals (Family Assistance); All residents (Full Health Safety Net)		
	100%			133%			150%			200%		
Percent of poverty	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly
Family Size												
1	\$903	\$10,836	\$208.40	\$1,201	\$14,412	\$277.18	\$1,355	\$16,260	\$312.72	\$1,806	\$21,672	\$416.80
2	\$1,215	\$14,580	\$280.41	\$1,616	\$19,392	\$372.95	\$1,823	\$21,876	\$420.72	\$2,430	\$29,160	\$560.81
3	\$1,526	\$18,312	\$352.18	\$2,030	\$24,360	\$468.50	\$2,289	\$27,468	\$528.27	\$3,052	\$36,624	\$704.36
4	\$1,838	\$22,056	\$424.19	\$2,445	\$29,340	\$564.27	\$2,757	\$33,084	\$636.28	\$3,676	\$44,112	\$848.37
5	\$2,150	\$25,800	\$496.19	\$2,860	\$34,320	\$660.05	\$3,225	\$38,700	\$744.29	\$4,300	\$51,600	\$992.38
6	\$2,461	\$29,532	\$567.97	\$3,274	\$39,288	\$755.60	\$3,692	\$44,304	\$852.07	\$4,922	\$59,064	\$1,135.93
7	\$2,773	\$33,276	\$639.97	\$3,689	\$44,268	\$851.37	\$4,160	\$49,920	\$960.07	\$5,546	\$66,552	\$1,279.94
8	\$3,085	\$37,020	\$711.98	\$4,104	\$49,248	\$947.15	\$4,628	\$55,536	\$1,068.08	\$6,170	\$74,040	\$1,423.96
Add'l.	\$312	\$3,744	\$72.01	\$415	\$4,980	\$95.78	\$468	\$5,616	\$108.01	\$624	\$7,488	\$144.01

Yearly amounts reflect monthly rounding multiplied by 12.
 Add the fetus to the family size of a pregnant woman.
 For people under 65, eligibility is based on gross monthly income.
 For seniors, eligibility is based on adjusted income after deductions including a \$20 per month standard deduction, and there is an asset test.
 The Senior deductible income standard is \$522 per mo. for an individual; \$650 per mo. for a couple.
 The income standard for an institutionalized individual is \$72.80 per month.
 MassHealth determines financial eligibility for MassHealth programs, Commonwealth Care and the Health Safety Net

Prepared by the Massachusetts Law Reform Institute

Additional Income Levels, March 1 2009 - February 28, 2010 *CORRECTED*											
Upper income level	Women with breast/cervical cancer (MH Standard)			Children under 19 & workers in Insurance Partnership (Family Assistance); Uninsured adults (Commonwealth Care)			All residents (Partial Health Safety Net); Children under 19 (Children's Medical Security Plan-subsidized) & Unempl. Comp. recipients (Medical Security Plan)			Disabled non-working adults (Common-Health)	Certain seniors (PACE & Home and Community-Based Services) 2009
	250%			300%			400%				
Percent of poverty	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Yearly	Weekly	Monthly	Monthly
Family Size											
1	\$2,258	\$27,096	\$521.12	\$2,709	\$32,508	\$625.20	\$3,612	\$43,344	\$833.60	\$542	\$2,022
2	\$3,038	\$36,456	\$701.13	\$3,645	\$43,740	\$841.22	\$4,860	\$58,320	\$1,121.62	\$670	
3	\$3,815	\$45,780	\$880.45	\$4,578	\$54,936	\$1,056.54	\$6,104	\$73,248	\$1,408.72	\$795	
4	\$4,595	\$55,140	\$1,060.47	\$5,514	\$66,168	\$1,272.56	\$7,352	\$88,224	\$1,696.75	\$911	
5	\$5,375	\$64,500	\$1,240.48	\$6,450	\$77,400	\$1,488.58	\$8,600	\$103,200	\$1,984.77	\$1,036	
6	\$6,153	\$73,836	\$1,420.03	\$7,383	\$88,596	\$1,703.90	\$9,844	\$118,128	\$2,271.87	\$1,161	
7	\$6,933	\$83,196	\$1,600.05	\$8,319	\$99,828	\$1,919.92	\$11,092	\$133,104	\$2,559.89	\$1,286	
8	\$7,713	\$92,556	\$1,780.06	\$9,255	\$111,060	\$2,135.93	\$12,340	\$148,080	\$2,847.91	\$1,403	
Addtl.	\$780.00	\$9,360	\$180.01	\$936	\$11,232	\$216.02	\$1,248	\$14,976	\$288.02		
Children with income over 400% of the poverty level can buy-in to the Children's Medical Security plan at full cost. There is no income upper limit or deductible for disabled children or disabled working adults in CommonHealth. Income in the Medical Security Plan is based on income in past 6 months and projected income for future 6 months. The 2009 federal poverty levels were published in the Jan. 23, 2009 Federal Register											

Prepared by Massachusetts Law Reform Institute

Table 7: Eligibility for MassHealth Coverage Types and Commonwealth Care

This table shows the types of coverage in the top row available to the eligibility groups listed in the far left column. The second row shows the kinds of immigration status eligible for the coverage types shown. Where more than one coverage type is available to an eligibility group, differences in eligibility criteria are listed with income shown as a percentage of the poverty level.

Coverage Type	Standard	Common-Health	Family Assistance Premium Assistance	Family Assistance Direct Coverage	Basic / Essential	Limited	Commonwealth Care
Eligibility Group	Citizenship/Immigration Status						
	- Citizens - Protected Status - Qualified Status	- Citizens - Protected Status - Qualified Status - (Special Status—under 19)	- Citizens - Qualified Status - (Special Status—under 19)	- Citizens - Qualified Status - (Special Status—under 19)	- Citizens - Qualified Status - (Special Status—Essential)	- Special Status - Non-qualified	- Citizens - Qualified Status - Special Status
Pregnant & infants	200%					200%	201–300%
Age under 19	150%	No Income Limit-Disabled	300%; Access to employer insurance; (Special status 200%)	300%; No access to employer insurance ; (Special status 200%)		150%	
Parents / Caretakers (not employee in IP)	133%		Incidental to child's eligibility			133%	134–300% (Special status 0–300%)
Disabled adult 19–64	133%	No Income Limit But Deductible			Special status—unemployed & 100%	133%	134–300% (Special status 101–300%)
Working disabled adult		No Income Limit					
Unemployed adults under age 65					100%; (Special status—disabled)		101–300%

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Coverage Type	Standard	Common-Health	Family Assistance Premium Assistance	Family Assistance Direct Coverage	Basic / Essential	Limited	Commonwealth Care
HIV+ under age 65			200%; Access to employer insurance	200%			201–300% (special status 0–300%)
Employee in Insurance Partnership (IP)			300%				
Breast/cervical cancer under age 65	250%						251–300% (special status 0–300%)
65 and over	100%				Special status 100%	100%	101–300% if no Medicare
Uninsured adult not eligible for MassHealth							300%

Table 8: MassHealth Premium Assistance Upper Payment Limits, July 1, 2008 to June 30, 2009

MassHealth Coverage Type	Maximum Premium Payment per Member per Month
MassHealth Standard Non-disabled MassHealth Standard Disabled	\$329 w/wrap \$1,106 w/wrap
CommonHealth	\$905 w/wrap
Essential Buy-In	\$385
Family Assistance Child (non-HIV)	\$263
Insurance Partnership— Family Assistance Adult	\$150
Family Assistance HIV	\$1,312 w/wrap

W/wrap means the member has private insurance and MassHealth as secondary (wraparound) coverage.

**Table 9: Commonwealth Care Plans,
July 2008 to June 2009**

**Table 9
Commonwealth Care Plans (July 2008-June 2009)**

PLAN TYPE 1 for individuals with income ≤ 100 percent of poverty

PLAN TYPE 2 for individuals with income $> 100 \leq 200$ percent of poverty

PLAN TYPE 3 for individuals with income $> 200 \leq 300$ percent of poverty

BENEFITS	COPAYMENTS		
	PLAN TYPE 1	PLAN TYPE 2	PLAN TYPE 3
Outpatient Care			
Office visit to primary care provider	\$0	\$10	\$15
Office visit to specialist	\$0	\$18	\$22
Outpatient Surgery (OP Hospital/Ambulatory Surgery Center)	\$0	\$50	\$125
X-rays/Labs	\$0	0	0
Abortion	\$0	\$50	\$100
Inpatient Medical Care			
Room and Board (includes deliveries/surgery/x-rays/labs)	\$0	\$50	\$250
Prescription Drugs			
30 day supply from a pharmacy	\$1/\$3 (generic/brand)	\$10/\$20/\$40	\$12.50/\$25/\$50
Emergency Care			
ER visit	\$0	\$50	\$100
Mental Health & Substance Abuse			
Inpatient stay	\$0	\$50	\$250
Outpatient or office visit	\$0	\$10	\$15
Methadone maintenance	\$0	\$0	\$0
Rehabilitation Services			
Cardiac Rehab	\$0	0	0

Appendix B n Tables

Benefits	Copayments		
	Plan Type 1	Plan Type 2	Plan Type 3
Home Health Care	\$0	0	0
Extended care (100 day max)			
Skilled nursing facility	\$0	0	0
Rehab/chronic hospital	\$0	\$50	\$250
Therapy (PT/OT/Speech/Hearing/Pulmonary)	\$0	\$10	\$20
Diabetes Care			
Office visit to PCP or podiatrist (may include foot orthotics)	\$0	\$5	\$10
Visit to specialist (may include foot orthotics)	\$0	\$10	\$20
Maternity and family planning			
Outpatient office visit	\$0	0	0
Other Benefits			
Ambulance (emergency & facility transfer only)	\$0	0	0
Dental (restorative/preventative/radiography/ diagnostic/prosthetic/oral surgery)	\$0	Not covered	Not covered
Prosthetics/Oxygen & Respiratory Th. Equip/Other DME	\$0	0	10%
Hospice	\$0	0	0
Vision (exam and glasses every 24 months)	\$0	\$10 for exam	\$20 for exam
Maximum Annual Out-of-Pocket Expenses			
Pharmacy	\$200	\$500	\$800
Other excluding pharmacy		\$750	\$1500

90 day mail order pharmacy available in Plan Types 2 & 3

Inpatient copay waived if admitted from ER or transferred from another inpatient unit

Plan approval needed for more than 20 therapy visits

For a detailed description of coverage including optional benefits, see the Explanation of Coverage sent to members & posted on the MCO websites.

Table 10: “Qualified” Immigrants Eligible for All Available MassHealth Benefits

If Immigration Status is...	and...	or...
<p style="text-align: center;">➔</p> <p>Legal Permanent Resident (LPR)</p> <p style="text-align: center;">or</p> <p>Parole granted for more than 1 year</p>	<p style="text-align: center;">➔</p> <p>5 years have passed since this status was granted</p>	<p style="text-align: center;">➔</p> <p>This status was obtained within the last 5 years, but person had been continuously present in U.S. since before August 22, 1996</p>
<p>OR if non-citizen is currently (or LPR was previously) one of the following, regardless of entry date to U.S.</p>		
<p>A person fleeing persecution like a Refugee, or someone granted Political Asylum or Withholding of Deportation; certain citizens of Cuba or Haiti; a victim of severe forms of Trafficking; certain aliens subjected to Domestic Violence (and their children); certain Veterans or active duty personnel or their spouse/unremarried widow/child; and certain other special groups.</p>		
<p>IMMIGRANTS with "SPECIAL STATUS" (5 years have not passed since receiving Legal Permanent Resident or Parole status) or Person Residing in U.S. Under Color of Law (PRUCOL) are eligible for benefits shown below if any of the following applies...</p>		
<ul style="list-style-type: none"> ➤ Adult with countable income 100% of poverty or less and long term unemployed and disabled is eligible for <u>Essential plus Limited</u> ➤ Senior with countable income 100% of poverty or less and limited assets is eligible for <u>Essential plus Limited</u> ➤ Child under age 19 with countable income 200% of poverty or less is eligible for <u>Family Assistance</u> ➤ Child under 19 and disabled is eligible for <u>CommonHealth</u> 		
<p>Adults who are not eligible for MassHealth but are legal immigrants (qualified, special status, or PRUCOL) with income 300% of poverty or less may be eligible for Commonwealth Care (free or low cost health plans)</p>		
<p>Undocumented residents of Massachusetts may be eligible for emergency Medicaid and other safety net care programs</p>		

Table 11: Immigrant Eligibility for Commonwealth Care

Non-U.S. citizens are eligible for Commonwealth Care benefits if immigration status is...	
	LPR for 5 or more years is eligible as "qualified alien"
<u>Legal Permanent Resident (LPR)</u>	LPR for less than 5 years is eligible as "special status alien"
<i>Either way, legal permanent residents are eligible for Commonwealth Care!</i>	
OR if immigration status is one of the following, regardless of entry date to U.S.	
<p>A person fleeing persecution like a Refugee, or someone granted Political Asylum or Withholding of Deportation; certain citizens of Cuba or Haiti; a victim of severe forms of Trafficking; certain aliens subjected to Domestic Violence (& their children); certain Veterans or active duty personnel or their spouse/unremarried widow/child; and certain other special groups.</p>	
OR if a non-citizen is a Person Residing in the U.S. under Color of Law (PRUCOL)	
<p>An immigrant is PRUCOL if the Dept. of Homeland Security (Immigration) knows he is living in the U.S. and is not trying to deport him. Many different kinds of immigration status satisfy the definition of PRUCOL, FOR EXAMPLE:</p>	
➤	People with a pending application for adjustment of status,
➤	People granted temporary protected status (incl. Burundi, El Salvador, Honduras, Liberia, Nicaragua, Somalia, Sudan),
➤	People with a pending application for political asylum,
➤	People with a K, S, U, V, or R visa classification, or
➤	People granted an indefinite stay of deportation, and
➤	THERE ARE MANY MORE EXAMPLES OF PRUCOL.
<p>Non-citizens who are undocumented or who are only in the U.S. as visitors (for example, people with a B-1 or B-2 tourist visa) are not eligible for Commonwealth Care.</p>	

**Table 12: Key to Employment Authorization Document
(Form I-688B or I-766)**

Code on EAD under “Provision of Law” or “Category”	Immigration Status	Eligibility
274a.12(a)(3) or A3	Refugee	MassHealth Standard & all other types
274a.12(a)(4) or A4	Paroled as a refugee	Group 1- MH Standard if conditions met
274a.12(a)(5) or A5	Granted asylum	MassHealth Standard & all other types
274a.12(a)(6) or A6	Fiancé of US citizen or dependent of fiancé	PRUCOL
274a.12(a)(7) or A7	Parent or child of LPR “special immigrant”	PRUCOL
274a.12(a)(8) or A8	Citizen of Micronesia or Marshall Islands	PRUCOL
274a.12(a)(9) or A9	Spouse or child under K status	PRUCOL
274a.12(a)(10) or A10	Granted withholding of deportation or removal	MassHealth Standard & all other types
274a.12(a)(11) or A11	Granted extended voluntary departure	PRUCOL
274a.12(a)(12) or A12	Granted Temporary Protected Status (TPS)	PRUCOL
274a.12(a)(13) or A13	Granted voluntary departure under Family Unity	PRUCOL
274a.12(a)(14) or A14	Granted Family Unity under LIFE Act	PRUCOL
274a.12(a)(15) or A15	V Status	PRUCOL
274a.12(a)(16) or A16	T status (trafficking victim)	MassHealth Standard & all other types
274a.12(c)(3)(i)–(iii) or C3	Foreign student	MassHealth Limited, CMSP, Healthy Start
274a.12(c)(6) or C6	Foreign student in training program	MassHealth Limited, CMSP, Healthy Start
274a.12(c)(8) or C8	Applicant for asylum, applicant for withholding of deportation/removal	PRUCOL*
274a.12(c)(9) or C9	Applicant for adjustment to LPR status	PRUCOL
274a.12(c)(10) or C10	Applicant for suspension of deportation/cancellation of removal	PRUCOL
274a.12(c)(11) or C11	Paroled for at least one year	Group 1-MH Standard if conditions met

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Code on EAD under “Provision of Law” or “Category”	Immigration Status	Eligibility
274a.12(c)(11) or C11	Paroled for less than one year	PRUCOL
274a.12(c)(12) or C12	Granted Family Unity	PRUCOL
274a.12(c)(14) or C14	Granted deferred action	PRUCOL
274a.12(c)(16) or C16	Applicant for registry	PRUCOL
274a.12(c)(18) or C18	Under order of supervision	PRUCOL
274a.12(c)(19) or C19	Applicant for TPS	PRUCOL
274a.12(c)(20) or C20	Applicant for special agricultural worker legalization	PRUCOL
274a.12(c)(21) or C21	S status	PRUCOL
274a.12(c)(22) or C22	Applicant for legalization under §245A	PRUCOL
274a.12(c)(24) or C24	Applicant for adjustment under the LIFE Act	PRUCOL
274a.12(c)(25) or C25	Family member of trafficking victim	MassHealth Standard & all other types
<p>* Cubans and Haitians who are applicants for asylum or parolees or under orders of supervision are Cuban-Haitian Entrants, Qualified not PRUCOL. If employment authorization documents have codes not listed here, consult 8 C.F.R. § 274a.12, or National Immigration Law Center (NILC) Guide.</p>		

Table 13: Permanently Residing Under Color of Law (PRUCOL)

<p>Non-citizens who are PRUCOL may include but are not limited to:</p>	<p>Proof may include Employment Authorization card with listed code, other listed proof, or other immigration document (whether or not listed)*</p>
<ul style="list-style-type: none"> • Applicant for adjustment of status 	<p>EAD code 274a.12(c)(9) or C9; receipt or notice of filing Form I-485</p>
<ul style="list-style-type: none"> • Continuously lived in US since before Jan. 1, 1972 	<p>Rent receipts, utility bills, personal affidavits</p>
<ul style="list-style-type: none"> • Granted temporary protected status (TPS) because country of origin unsafe 	<p>EAD code 274a12(a)(12) or A12; immigration document</p>
<ul style="list-style-type: none"> • Granted deferred enforced departure (DED) 	<p>EAD code 274a12(a)(11) or A11; immigration document</p>
<ul style="list-style-type: none"> • Applicant for temporary protected status (TPS) 	<p>EAD code 274a12(c)(19) or C19; receipt or notice of filing Form I-821</p>
<ul style="list-style-type: none"> • Applicant for asylum** 	<p>EAD code 274a12(c)(8) or C8; receipt or notice of filing Form I-589</p>
<ul style="list-style-type: none"> • Granted indefinite stay of deportation or indefinite voluntary departure 	<p>Immigration documents</p>
<ul style="list-style-type: none"> • Granted stay of deportation or voluntary departure & DHS does not contemplate enforcing deportation 	<p>Immigration documents</p>
<ul style="list-style-type: none"> • Pending or approved immediate relative petition 	<p>Receipt or notice of filing I-130 petition, or I-797 showing I-130 approved</p>
<ul style="list-style-type: none"> • Applicant for legalization under 245A 	<p>EAD code 274a.12(c)(22) or C22; Immigration document</p>
<ul style="list-style-type: none"> • Granted deferred action status 	<p>EAD code 274a12(c)(14) or C14; Form I-797 Notice of Approval</p>
<ul style="list-style-type: none"> • Under orders of supervision ** 	<p>EAD code 274a12(c)(18) or C18; Notice of release under order of supervision</p>
<ul style="list-style-type: none"> • Certain permanent non-immigrants from South Sea islands 	<p>EAD code 274a12(a)(8) or A8; immigration document</p>
<ul style="list-style-type: none"> • Granted extended voluntary departure 	<p>EAD code 274a12(a)(11) or A11; immigration document</p>
<ul style="list-style-type: none"> • Granted Family Unity 	<p>EAD code 274a12(a)(13) or A13 or 274a12(c)(12) or C12; notice approving I-817 application</p>
<ul style="list-style-type: none"> • Paroled less than one year ** 	<p>EAD code 274a12(a)(4) or A4 or 274a12(c)(11) or C11; I-94 with “parole” or “212(d)(5)” or “PIP”; immigration document</p>
<ul style="list-style-type: none"> • Applicant for suspension of deportation or cancellation of removal 	<p>EAD code 274a12(c)(10) or C10; receipt or notice of filing Form EOIR-40, EOIR-42 or I-881</p>

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<ul style="list-style-type: none"> • Pending request for voluntary departure, deferred action status, extension of voluntary departure, or special immigration status as a minor under § 101(a)(27)(J) 	Receipt or notice of filing application or request; immigration document
<ul style="list-style-type: none"> • Applicant for registry 	EAD code 274a.12(c)(16) or C16; receipt or notice of filing Form I-485
<ul style="list-style-type: none"> • Person granted K, S, U, or V status 	EAD code 274a.12(a)(15) or A15; I-94 coded K-3, K-4, S, U, V-1, V-2, V-3, or visa in foreign passport
<ul style="list-style-type: none"> • Religious worker & dependents 	R-1, R-2 on I-94 card or foreign passport
<ul style="list-style-type: none"> • Any other person living in the US with the knowledge and consent of DHS and whose departure DHS does not contemplate enforcing 	Immigration document, document from immigration lawyer or other reliable source
<p>* Immigration document includes but is not limited to any document from USCIS, immigration judge, Board of Immigration Appeals, court or other authoritative source.</p> <p>** Cuban or Haitians seeking asylum, paroled or under orders of supervision are Cuban Haitian entrants, Qualified not PRUCOL. If other documents or statuses are presented, consult NILC Guide.</p>	

Table 14: Key to Selected Codes on Permanent Resident Cards

<i>Alphanumeric codes are listed under “category” on Permanent Resident card (I-551)</i>			
I-551 Codes that exempt a permanent resident from the five-year bar			
Code	Additional criteria	Exempt status	Eligibility
R8-6, RE-6, RE-7, RE-8, RE-9		Refugee	MH Standard & all other types
AS-6, AS-7, AS-8, GA-6 to GA-8		Asylee	MH Standard & all other types
AM-1, AM-2, AM-3, AM-6, AM-7, AM-8	National of Vietnam	Amerasian	MH Standard & all other types
NC-6 to NC-9; HA-6 to HA-9; HB-6 to HB-9; HD-6 to HD-9; HE-6 to HE-9; CUP, CU0, CU-6 to CU-9, CNP or CH6.	National of Cuba or Haiti	Cuban-Haitian entrant	MH Standard & all other types
S1-3	National of Canada	Native American	MH Standard & all other types
B2-1, B2-6, B2-3, B2-8		Domestic violence victim	MH Standard & all other types
SI-1, 2 & 3; SI-6, 7 & 9	National of Afghanistan or Iraq	Afghani/Iraqi Special Immigrant	MH Standard & all other types for 6 to 8 months
Other commonly seen I-551 codes that do not affect the five-year bar			
Code	Meaning of code	Additional criteria	Eligibility
LA-6	Parole (Lautenberg)	1. Obtained status 5 or more years ago or meets domestic violence or veteran exception or entered U.S. before 8/22/96 & continuously present until obtaining permanent resident or parole status, or conditions above not met but 2. Elderly or disabled, or 3. Under age 19, or 4. Uninsured adult	1. MH Standard & all other types; 2. MH Essential; 3. MH Family Assistance or Commonwealth Care (low cost health insurance)
IR-0 to IR-9, IF-1 & IF-2; CR-0 to CR-7; F-11 to F-48	Family based immigrant		
E1-1 to E1-5; E2-1 to E2-3, E3-1 to E3-5; EW-3 to EW-5.	Employment based immigrant		
<p>NOTES: This is not a comprehensive list of codes. Anyone with an I-551 card is a legal permanent resident. Most codes not listed here have no affect on the five-year bar.</p>			

Table 15: Key to Selected Codes on Arrival/Departure Record (I-94 Card)

<i>Alphanumeric codes or phrases are written on red stamp above "class"</i>			
Codes	Status	Additional criteria	Potential Eligibility
I-551	Permanent resident	1. meets or is exempt from 5-year bar, or conditions above. not met but 2. elderly or disabled, or 3. under age 19 or 4. Uninsured adult	1. MH Standard & all other types, 2. MH Essential, 3. MH Family Assistance or CommonHealth; 4. Commonwealth Care
212(d)(5) or "parole" or "PIP"	Parolee	1. meets or is exempt from 5-year bar, or 2. elderly or disabled, or 3. under age 19 or 4. Uninsured adult	1. MH Standard & all other types, 2. MH Essential, 3. MH Family Assistance or CommonHealth; 4. Commonwealth Care
212(d)(5) or "parole" or "PIP" or "Cuban-Haitian entrant" "OOE" or "outstanding orders of exclusion"	Cuban-Haitian Entrant	National of Cuba or Haiti	MH Standard & all other types
AM 1, 2, 3	Amerasian	National of Vietnam	MH Standard & all other types
207 or REFUG or codes RE1 to RE5	Refugee		MH Standard & all other types
208 or "asylee" or codes AS1 to AS3	Asylee		MH Standard & all other types
243(h) or 241(b)(3)	Person granted withholding of deportation		MH Standard & all other types
T-1 or T-2	Trafficking victim		MH Standard & all other types
106	Person granted indefinite stay of deportation-PRUCOL	1. Elderly or disabled 2. Under age 19; 3. Uninsured adult	1. MH Essential, 2. MH Family Assistance or CommonHealth 3. Commonwealth Care
242(b)	Person granted voluntary departure-PRUCOL	1. Elderly or disabled 2. Under age 19 3. Uninsured adult	1. MH Essential, 2. MH Family Assistance or CommonHealth; 3. Commonwealth Care
K-1	Fiancé of U.S. citizen-PRUCOL	1. Elderly or disabled 2. Under age 19; 3. Uninsured adult	1. MH Essential, 2. MH Family Assistance or CommonHealth; 3. Commonwealth Care
R-1, R-2	Religious worker/dependents	1. Elderly or disabled 2. Under age 19; 3. Uninsured adult	1. MH Essential, 2. MH Family Assistance or CommonHealth; 3. Commonwealth Care

<i>Alphanumeric codes or phrases are written on red stamp above "class"</i>			
Codes	Status	Additional criteria	Potential Eligibility
SI-1,2,3; SI-6, 7, 9	Afghani/Iraqi Special Immigrant	National of Afghanistan/Iraq	MH Standard etc. for 6/8 mo. (then eligible as LPR/ PRUCOL)
NOTE: This is not a comprehensive list of codes. If code on I-94 is not shown here, consult National Immigration Law Center Guide, www.nilc.org.			

Table 16: Other Documentary Evidence of Immigration Status

Document	Status
I-551 Stamp in Foreign Passport	Permanent Resident
Reentry permit (I-327)	Permanent Resident
Orders of U.S. Dept of Justice / Board of Immigration Appeals granting suspension of deportation or cancellation of removal	Permanent Resident
Refugee Travel Document (I-571)	Refugee
Order of US Dept of Justice / Board of Immigration Appeals granting asylum	Asylee
Order of US Dept of Justice / Board of Immigration Appeals granting voluntary departure	PRUCOL
HHS certification letter	Trafficking victim
Authorization for Parole (I-512)	Parole
Notice of Action (I-797)	Status depends on content of notice. The notice of action is also proof of receipt of an application/petition and may show PRUCOL status: e.g., Form I-485 (application for adjustment); Form I-821 (application for TPS); Form I-589 (application for asylum); Form I-130 (relative petition)
NOTE: This is not a complete list of documents. If unable to interpret a document, consult an immigration lawyer.	

Table 17: Services Included in MassHealth by Coverage Type and in Commonwealth Care

This Table compares the services required in each of the five main types of direct MassHealth coverage and in Commonwealth Care. Additional information on the scope of covered services in MassHealth can be found in MassHealth regulations and Provider Manuals posted at www.mass.gov/masshealth. MassHealth and Commonwealth Care managed care plans may provide services in addition to the minimum required in the regulations. For information on managed care plans, the following are the websites of the MassHealth and Commonwealth Care managed care plans and of the Behavioral Health Partnership: bmchp.org (BMC HealthNet Plan); nhp.org (Neighborhood Health Plan); network-health.org (Network Health); fchp.org (Fallon Community Health Plan); masspartnership.com (Behavioral Health partnership/MassHealth PCC Plan).

Services	MassHealth Regulations 130 C.M.R.	MassHealth Coverage Types ¹					Commonwealth Care ²
		Standard	Common Health	Family Assistance (Direct Coverage)	Basic	Essential	
Total number of services		40	40	33	30	22	24–28*
Abortion	§ 484	✓	✓	✓	✓	✓	✓
Acute Inpatient Hospital	§ 415	✓	✓	✓	✓	✓	✓
Adult Day Health	§ 404	✓	✓	No	No	No	No
Adult Foster Care	§ 408	✓	✓	No	No	No	No
Ambulance	§ 407	✓	✓	✓	✓	✓	✓
Ambulatory Surgery Center	§ 423	✓	✓	✓	✓	✓	✓
Audiologist	§ 426	✓	✓	✓	✓	No	*

¹ The required benefits in each type of MassHealth coverage are set out in 130 C.M.R. 450.105.

² The required benefits in Commonwealth Care are set out in the contracts between the Health Insurance Connector and the Managed Care Organizations and are described at www.mahealthconnector.org.

* Hearing/audiology services are covered as an outpatient benefit, but plans are not required to include audiologists in their networks.

		MassHealth Coverage Types ¹					
Services	MassHealth Regulations 130 C.M.R.	Standard	Common Health	Family Assistance (Direct Coverage)	Basic	Essential	Common wealth Care ²
Behavioral health (mental health & substance abuse)	§§ 411, 417, 418, 425, 429, 434	✓	✓	✓	✓	✓	✓
Chapter 766: Assessments & Team Meetings	§ 439	✓	✓	✓	✓	No	No
Chiropractor	§ 441	✓	✓	✓	✓	No	No
Chronic Disease and Rehabilitation Hospital Acute Inpatient	§ 435	✓	✓	✓	No	No	100 day max.
Community Health Center	§ 405	✓	✓	✓	✓	✓	✓
Day Habilitation	§ 419	✓	✓	No	No	No	No
Dental Services	§ 420	✓	✓	✓	✓	✓	Plan Type 1 only
Durable Medical Equipment and Supplies	§ 409	✓	✓	✓	✓	✓	✓
Early Intervention	§ 440	✓	✓	✓	No	No	No
Family Planning	§ 421	✓	✓	✓	✓	✓	✓
Hearing Aid	§ 416	✓	✓	✓	✓	No	No
Home Health	§ 403	✓	✓	✓	✓	No	✓
Hospice	§ 437	✓	✓	✓	No	No	✓
Laboratory	§ 401	✓	✓	✓	✓	✓	✓
Nurse midwife	§ 433.402	✓	✓	✓	✓	No	✓
Nurse practitioner	§ 433.433	✓	✓	✓	✓	✓	*
Nursing Facility	§ 456	✓	✓	No	No	No	100 day max.

* Plans may include nurse practitioners as primary care practitioners but are not required to do so.

Appendix B n Tables

		MassHealth Coverage Types¹					
Services	MassHealth Regulations 130 C.M.R.	Standard	Common Health	Family Assistance (Direct Coverage)	Basic	Essential	Commonwealth Care²
Orthotic	§ 442	✓	✓	✓	✓	No	Diabetes care only
Outpatient Hospital	§ 410	✓	✓	✓	✓	✓	✓
Oxygen and Respiratory Therapy Equipment	§ 427	✓	✓	✓	✓	✓	✓
Personal Care	§ 422	✓	✓	No	No	No	No
Pharmacy	§ 406	✓	✓	✓	✓	✓	✓
Physician	§ 433	✓	✓	✓	✓	✓	✓
Podiatrist	§ 424	✓	✓	✓	✓	✓	Diabetes care only
Private Duty Nursing/ Continuous Skilled Nursing	§§ 403, 414	✓	✓	No	No	No	No
Prosthetic	§ 428	✓	✓	✓	✓	✓	✓
Rehabilitation Center	§ 430	✓	✓	✓	✓	✓	*
Renal Dialysis Clinic	§ 412	✓	✓	✓	✓	✓	*
Speech and Hearing Center	§ 413	✓	✓	✓	✓	✓	*
Therapy: Physical, Occupational, and Speech/Language	§ 432	✓	✓	✓	✓	✓	✓
Transportation (non-emergency)	§ 407	✓	✓	No	No	No	No
Vision Care/eyeglasses	§ 402	✓	✓	✓	✓	No eyeglasses	✓
X-ray/Radiology		✓	✓	✓	✓	✓	✓

Table 18: Monthly Premium Charges in MassHealth and Commonwealth Care, July 1, 2008 to June 30, 2009

Income as Percentage of Federal Poverty Level	MassHealth ¹						Commonwealth Care ²
	Standard Disabled Adults	Standard Children	Common-Health Adults ³	Common-Health Children ⁴	Family Assistance Adults ⁵	Family Assistance Children ⁶	
Under 150%	None	None	None	None	None	None	None
150–200%	\$15–\$35/ women with breast-cervical cancer	N/A	\$15–\$35	\$12/child, \$36 max. for 3 or more children	\$15–\$35/ HIV; \$27/IP single adult or \$54/IP couple	\$12/child, \$36 max. for 3 or more children	\$39/single adult; \$78/couple
200–250%	\$40–\$72/ women with breast-cervical cancer		\$40–\$80	\$20/child, \$60 max. for 3 or more children	\$53/IP single adult; \$106 couple	\$20/child, \$60 max. for 3 or more children	\$77/single adult; \$154/couple
250–300%	N/A		\$88–\$128	\$28/child, \$84 max. for 3 or more children	\$80/IP single adult; \$160 couple	\$28/child, \$84 max. for 3 or more children	\$116/single adult; \$232/couple
Over 300%	N/A	N/A	See regulation	See regulation	N/A	N/A	N/A

Source: 130 C.M.R. § 506.011 (MassHealth) and mahealthconnector.org (Commonwealth Care Frequently Asked Questions)

¹ If a family group includes members in more than one MassHealth coverage type who are charged premiums, only the higher premium is due. 130 C.M.R. § 506.011(A)(5).

² The premiums shown are the charge for the lowest cost plan available; the charge will be higher if an individual with gross family income over 100% of poverty chooses a higher cost plan.

³ For disabled adults above 150% FPL, add \$5 for each additional 10% FPL to 200%, add \$8 for each additional 10% FPL to 400%. See regulation for higher incomes. The premium charge is reduced by 40% if the family is also paying for private insurance.

⁴ Children's premiums will be waived if the parents are enrolled & charged premiums in Commonwealth Care. 130 C.M.R. § 506.011(L)(4).

⁵ In Family Assistance Premium Assistance, the Office of Medicaid provides partial reimbursement for the costs of employer coverage. Premiums shown are the minimum charge. Actual charges may be higher because reimbursement is capped by a "cost effective" amount for each eligible person. See Table 8 for cost-effective amounts in state fiscal year 2009.

⁶ Children's premiums will be waived if the parents are enrolled and charged premiums in Commonwealth Care.

Table 19: Prescription Advantage Rate Schedule Guide for Members Eligible for Medicare

Effective January 1, 2009

Prescription Advantage Rate Schedule Guide for Members Eligible for Medicare

Membership Categories S0 – S1

- No annual fee
- May help pay Medicare drug plan premium
- Immediate drug plan co-payment assistance

Membership Categories S2 – S4

- No annual fee
- May help pay Medicare drug plan premium (\$2, \$3 only)
- Drug plan co-payment assistance begins once total retail costs of covered prescription drugs reaches \$2,700

Membership Category S5

- \$200 annual enrollment fee
- Assistance begins when \$3,120 in out-of-pocket costs are accumulated as a Prescription Advantage member

Category	Income if single		Income if married		Medicare Extra Help	Your payment towards first \$31.70 of basic Medicare drug plan premium	Generic co-payments (up to 30-day supply)		Brand Name co-payments (up to 30-day supply)		Annual out-of-pocket spending limit
	Yearly \$	Monthly \$	Yearly \$	Monthly \$			Before \$2700 in drug costs	After \$2700 in drug costs	Before \$2700 in drug costs	After \$2700 in drug costs	
S0	0 - 14,040	0 - 1,170	0 - 18,900	0 - 1,575	Full	\$0	\$2.40	\$2.40	\$6	\$6	N/A
S1	0 - 15,600	0 - 1,300	0 - 21,000	0 - 1,750	Partial	\$0	\$7	\$7	\$18	\$18	\$1,405
S2	0 - 19,552	0 - 1,629	0 - 26,320	0 - 2,193	None	\$0	Drug plan co-payment	\$7	Drug plan co-payment	\$18	\$1,560
S3	19,553 - 23,400	1,630 - 1,950	26,321 - 31,500	2,194 - 2,625	None	\$20	Drug plan co-payment	\$12	Drug plan co-payment	\$30	\$1,955
S4	23,401 - 31,200	1,951 - 2,600	31,501 - 42,000	2,626 - 3,500	None	100% of drug plan premium	Drug plan co-payment	\$12	Drug plan co-payment	\$30	\$2,340
S5	31,201 - 52,000	2,601 - 4,333	42,001 - 70,000	3,501 - 5,833	None	100% of drug plan premium	Drug plan co-payment	Drug plan co-payment	Drug plan co-payment	Drug plan co-payment	\$3,120

Medicare provides “Extra Help” to lower costs for beneficiaries with limited income and resources. Prescription Advantage requires all applicants who may qualify for Extra Help to apply for this benefit. You may qualify for Extra Help if your income is at or below the S1 income and your resources (other than your home) are no more than the current Medicare limits: \$12,510 single, \$25,010 married.

Medicare Plan Premium Assistance: For Medicare basic plans, Prescription Advantage pays up to \$31.70. For Medicare enhanced plans, Prescription Advantage pays up to \$31.70 toward the portion of the premium that covers the plan’s basic benefits. No premium assistance for creditable coverage.

Co-payment Assistance: Once co-payment assistance begins, you will not pay more than the co-payments listed above for drugs covered by your drug plan. Prescription Advantage will pay any additional co-payment amount. Co-payment assistance begins immediately for Category S0 and S1 members. Prescription Advantage will not pay for prescription drugs not covered by a drug plan EXCEPT for benzodiazepine drugs. Co-payments for benzodiazepine drugs for Category S0 members are \$7 for generic and \$18 for brand name. All other categories are as listed.

Out-of-Pocket Spending Limit: When your total spending for co-payments reaches the annual out-of-pocket spending limit, Prescription Advantage will cover 100% of all co-payments for the remainder of the plan year. **Note:** Benefits for new members begin on the effective date of Prescription Advantage coverage. Any costs incurred prior to the effective date cannot be applied towards the out-of-pocket spending limit.

Note: If you are under age 65 and disabled, your income cannot exceed the S2 income limits listed on the chart above.

Prescription Advantage Rate Schedule Guide for Members Not Eligible for Medicare

- Prescription Advantage may be able to offer primary prescription drug coverage to Massachusetts residents not eligible for Medicare.
- If you are under age 65 and disabled, your income cannot exceed the Category 2 income limits listed on the chart below.
- If you become eligible for Medicare, it is your responsibility to inform Prescription Advantage.

Category	Income if single		Income if married		Annual out-of-pocket spending limit	Individual quarterly deductible	RETAIL co-payments up to 30-day supply			MAIL ORDER co-payments up to 90-day supply		
	Yearly \$	Monthly \$	Yearly \$	Monthly \$			Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
1	0 - 14,040	0 - 1,170	0 - 18,900	0 - 1,575	\$700	\$0	\$7	\$18	\$40	\$14	\$36	\$80
2	14,041 - 19,552	1,170 - 1,629	18,901 - 26,320	1,576 - 2,193	\$1,405	\$0	\$7	\$18	\$40	\$14	\$36	\$80
3	19,553 - 23,400	1,630 - 1,950	26,321 - 31,500	2,194 - 2,625	\$1,955	\$65	\$12	\$30	\$50	\$24	\$60	\$100
4	23,401 - 31,200	1,951 - 2,600	31,501 - 42,000	2,626 - 3,500	\$2,340	\$110	\$12	\$30	\$50	\$24	\$60	\$100
5	31,201 - 52,000	2,601 - 4,333	42,001 - 70,000	3,501 - 5,833	\$3,120	\$220	\$12	\$30	\$50	\$24	\$60	\$100
6	52,001 or over	4,334 or over	70,001 or over	5,834 or over	\$5,200	\$350	\$12	\$30	\$50	\$24	\$60	\$100

Monthly Premium:
You are not required to pay a monthly premium to receive Prescription Advantage benefits.

Deductibles and Co-payments:
Each quarter, you must pay the deductible amount (if any) listed. Once the deductible is paid, you pay only the co-payments for the remainder of that quarter.

Annual Out-of-Pocket Spending Limit:
If your total spending for deductibles and co-payments reaches your spending limit amount, Prescription Advantage will cover your co-payments for the remainder of the Plan year for all drugs covered by Prescription Advantage.

How to Determine Which Drugs are Covered:
Prescription Advantage uses a Plan formulary, which is a list of prescription drugs available to members. The Plan formulary is developed, reviewed and updated by a select panel of pharmacists. For detailed information regarding your medications and whether or not they are covered, please call Prescription Advantage Customer Service or check the Prescription Advantage website at www.800ageinfo.com.

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