

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.

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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

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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.

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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.

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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.

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- 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,

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- 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.