

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*

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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;

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- 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).

18 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.

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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.

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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.

