August 1, 2025

Mike Levine, Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted by email to: masshealthpublicnotice@mass.gov

Dear Assistant Secretary Levine,

On behalf of Massachusetts Law Reform Institute (MLRI), Health Law Advocates (HLA) and Health Care For All (HCFA), thank you for the opportunity to provide comments on proposed amendments to several MassHealth member regulations: 130 CMR 501.000: MassHealth: General Policies; 130 CMR 502.000: MassHealth: The Eligibility Process; 130 CMR 503.000: MassHealth: Universal Eligibility Requirements; 130 CMR 505.000: MassHealth: Coverage Types; 130 CMR 506.000: Health Care Reform: MassHealth: Financial Requirements; 130 CMR 515.000: MassHealth: General Policies; 130 CMR 516.000: MassHealth: The Eligibility Process; 130 CMR 517.000: MassHealth: Universal Eligibility Requirements; 130 CMR 519.000: MassHealth: Coverage Types, and 130 CMR 522.000: MassHealth: Other Division Programs.

We applaud MassHealth for making some positive changes that will help streamline access to coverage and seek to incorporate language needed to reflect current 1115 waiver authority, state budget requirements and current practice. At the same time, we recommend some changes and seek clarification on several provisions to understand policy intent, improve alignment among MassHealth's regulations, and ensure effective implementation.

Because this letter addresses so many regulations, we include a table of contents here for ease of navigation:

130 CMR 501- Health Care Reform: MassHealth: General Policies

1. Continuous Eligibility Definition: 501.001

The proposed definition of "Continuous Eligibility" (CE) in 501.001, contains several ambiguities, as well as misstatements of policy. First, subsection (2) of the definition says:

> (2) *A CE period lasts from initial determination or renewal until the person is picked up for their next renewal…*

This misstates the start date for continuous eligibility for members released from incarceration. As stated in MassHealth's approved 1115 demonstration,[1] the Reentry Implementation Plan,[2]

[1] CMS, *Special Terms and Conditions: Massachusetts MassHealth Section 1115 Demonstration Extension*, at 13 (Sept. 28, 2022): "...each individual's 12-month continuous eligibility period shall begin at the date of their release… Eligible individuals for whom an eligibility determination is made after their release date but before 12 months after their release date shall be eligible for continuous eligibility through the end of the 12th month following release."

[2] MassHealth, *Reentry Demonstration Initiative Implementation Plan: MA Attachment X*, at 5 (May 2025): "Continuous eligibility will be effective on the date of release…."

and MassHealth's own EOM guidance,[3] continuous eligibility for justice-involved individuals begins on the date of release from jail or prison and continues through the last day of the 12th month following release.

Also, this description of the CE start date for the homeless conflicts with the corresponding coverage regulations at 130 CMR 505.There, the proposed regulations state that the CE period begins *upon completion of initial application, annual renewal period, or notification of long-term homeless status as received by applicable data sources.* We encourage MassHealth to mirror the language here that the CE start date for homeless members may be the date MassHealth receives a data match verifying that the member is unhoused.

Recommendation: Clarify that the CE start date for members released from incarceration is not the date of initial determination or renewal but is in fact the date of the member's release from jail or prison; and that the CE start date for members experiencing homelessness could also be the date MassHealth is notified by data sources of the member's long-term homelessness status.

This subsection is also incorrect about the end of the CE period: even for people with a 12-month CE period, it is unclear what it means to be "picked up for renewal." The 12-month CE has a specific end date that is 12 months after the start date. When the CE period is for 24 months from the start date, it should not end at the 12-month renewal point. MassHealth told us that it planned to send 12-month renewals to members with 24-month continuous eligibility based on homelessness, but that it would not act on changes or failure to return those 12-month renewal forms.

Recommendation: The phrase "until the person is picked up for their next renewal" should be replaced with "until the person's 12- or 24-month Continuous Eligibility period has expired."

Subsection (2) of the Continuous Eligibility definition goes on to say:

> *(2) … If MassHealth determines the person remains eligible for MassHealth, another period of continuous eligibility may be granted.*

However, when a member is qualified for continuous eligibility, as described in this section and MassHealth determines that they remain eligible, they *will* be given another continuous eligibility period. The use of the "may" suggests it is up to MassHealth's discretion to grant another continuous eligibility period, based on undefined factors.

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[3] MassHealth, *Eligibility Operations Memo 24-02: Continuous Eligibility for Certain MassHealth Members* at 2 (Mar. 2024): "The continuous eligibility period will start on the date of release and will end at the end of the 12th month following the release date… If an eligibility determination is made after the date of release but before 12 months following the date of release, the individual is eligible for continuous eligibility from the date of the determination until the last day of the 12th month following the date of release."

Recommendation: change "may be granted" to "shall be granted".

Subsection (2) of the Continuous Eligibility definition then says:

> (2) …*If the person does not respond to their renewal within the given timeframe, or is found to be ineligible for MassHealth, MassHealth will not grant the person another CE period.*

This sentence is unclear. It could simply mean that the member will be terminated for failure to complete the renewal or for being found ineligible after their CE period expires, or it could mean that if the member is terminated for failure to complete the renewal or for no longer being eligible, they will never again requalify for another CE period.

Recommendation: This sentence should be changed to say "Upon completion of the person's continuous eligibility period, MassHealth will terminate coverage if the person does not respond to their renewal within the given timeframe or is found to be ineligible for MassHealth."

Next, the proposed definition of "Continuous Eligibility" in subsection (3) lists the exceptions to continuous eligibility as follows:

> *(a) voluntary withdrawal;*
> *(b) person moved out of state;*
> ***(c) a child attains age 19;***
> *(d) death of eligible member; or*
> *(e) the agency determines that eligibility was erroneously granted at the most recent determination, redetermination or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.*

However, "a child attains age 19" is an exception *only* for members whose only basis for receiving continuous eligibility is being under age 19. As stated in MassHealth's Eligibility Operations Memo 24-02 (fn: See page 1), as well as the Special Terms and Conditions of MassHealth's section 1115 waiver (fn: see page 14), turning 19 is not an exception to continuous eligibility based on homelessness or recent release from incarceration.

Also, it should be clear that "voluntary" withdrawal means that a person has affirmatively stated that they no longer want their MassHealth benefits. In the past we have seen it apply to people who are simply reporting a change of address or household composition but not asking to have their benefits or those of a household member terminated. The federal regulations on continuous eligibility for children describes it more clearly as "the child or child's representative requests a voluntary termination of eligibility." 42 CFR 435.926(d).

Recommendation: We urge MassHealth to clarify this definition so that it's clear the "attains age 19" exception applies only to continuous eligibility on the basis of being under 19.

Recommendation: We also recommend that the reference to "voluntary withdrawal" track the language of the federal regulation and state "the person or person's representative requests voluntary termination of eligibility" instead of just "voluntary withdrawal."

Further, before listing the exceptions, subsection (3) states "MassHealth may end a person's CE period outside of the completed renewal period for the following reasons". At best, this sentence is duplicative of the sentence before it and otherwise is ambiguous and confusing.

Recommendation: This sentence should be removed or replaced with something like "MassHealth may end a person's CE period before the 12- or 24-month continuous eligibility period has expired for the following reasons:"

For more comments on proposed regulations related to continuous eligibility see the section below addressing the cross-references contained in the definition of continuous eligibility in 505.002: (Q) Continuous Eligibility; 505.004: (M) Continuous Eligibility; 505.005: (J): Continuous Eligibility; and 505.008: (F): Continuous Eligibility.

2. Federal Poverty Level definitions 501.001 and 515.001

We are confused by the addition of language saying that MassHealth updating the poverty levels on March 1 is "within its discretion." The federal poverty level is updated every year. There is no fixed date for HHS to update the poverty level but for many years HHS has reliably published the updated amounts in mid to late January. Once published, the updated amounts must be applied by MassHealth: that decision is not discretionary. MassHealth has had no difficulty updating its FPLs by March 1. Perhaps it could do so by February 1. But we don't think MassHealth has discretion to delay updating the poverty levels for any reason other than a delay in their publication by HHS.

Recommendation: Delete the language "within its discretion" from the Federal Poverty Level definition.

3. EAEDC Eligibility Changes 501.004(B), 515.004(B), 505.002(K), 519.002(D)

In both the Volume 1 and 2 regulations, MassHealth amends the MassHealth Standard Coverage rule in **505.002(K)** and **519.002(D)** to provide that all EAEDC recipients will be eligible for Standard. This is a welcome change that simplifies eligibility and makes coverage easier to understand and more equitable. However, we believe there has been an unintended omission of certain elderly non-citizen EAEDC recipients in the proposed rules at **501.004(B)(1)(b)** and **515.004(B)(1)(b)**. We are also concerned that **130 CMR 504.006** and **518.006** describing which coverage types are available to non-citizens with different kinds of eligible immigration status, including those receiving EAEDC, have not been amended to align with the change to Standard.

Instead, these rules still provide that EAEDC recipients may be eligible for Standard, CarePlus or Family Assistance depending on their eligible immigration status.

Currently, sections 501.004 and 515.002 describe the role of DTA in making eligibility determinations for EAEDC and the role of MassHealth in providing coverage to beneficiaries of EAEDC. Between these two regulations, EAEDC beneficiaries at all ages, 0 to 64 and 65 or older, who are US citizens or eligible immigrants (Qualified, Qualified Barred, Non-Qualified Lawfully Present and PRUCOL) are eligible for Standard, CarePlus or Family Assistance. EAEDC eligibility for noncitizens is also addressed in 130 CMR 504.006 and 518.006 which also, between them, provide for coverage for all ages and all eligible immigration categories, but are not being amended. We assume that the proposed regulations are intended to make all the groups who now have full MassHealth coverage eligible for Standard.

However, the proposed 501.004 and 515.004 regulations appear to have inadvertently omitted EAEDC beneficiaries who are 65 and older and who are Qualified Barred, Non-Qualified Lawfully Present and PRUCOL from any coverage. Each of the proposed regulations list only thstzaose 65 or older who are U.S. Citizens or Qualified Non-Citizens as eligible EAEDC recipients. We assume this was not an intended omission, and we are confident MassHealth will want to correct the omission of EAEDC recipients who are 65 or older and Qualified Barred, Non-Qualified Lawfully Present or PRUCOL.

Recommendation: We suggest that if the distinctions in age and eligible immigration status no longer affect MassHealth eligibility, both 501.004 and 515.004 will be easier to understand if they simply state that the MassHealth agency will provide MassHealth Standard to all EAEDC recipients regardless of age who are US citizens or noncitizens who are Qualified, Qualified Barred, Lawfully Present or Persons Residing in the US under Color of Law. If MassHealth does not take that approach, it should be sure to restore the reference to EAEDC eligibility for adults 65 or older who are Qualified Barred, Non-Qualified Lawfully Present and PRUCOL in these two regulations.

Recommendation: We also recommend updating the regulations at 504.006 and 518.006 to align with the change in coverage that makes all EAEDC recipients eligible for MassHealth Standard.

4. Recouping Overpayments 501.012 and 515.010

We are pleased to see that MassHealth is deleting the overly broad regulations on recoupment of overpayments at 130 CMR 501.012 and 515.010 and also amending the 506.000 regulations to delete certain regulations for recouping past due premiums. The 501.012 and 515.010 regulations went far beyond the limited statutory authorization for recoupment of overpayments from beneficiaries in the Medicaid program. The notice summarizing the changes states that "[t]his aligns with recent CMS guidance and does not preclude MassHealth from recovering within

limits set by federal law." We are aware of the recent December 2024 CMS Letter clarifying the limited scope of permissible recoupment under the Medicaid statute and reminding states of the procedural safeguards that must precede any recoupment action.

Recommendation: We are concerned that if MassHealth does pursue recoupment "within the limits set by federal law" that beneficiaries be notified of those limits. MassHealth beneficiaries will be unaware of their rights unless recoupment notices explain and cite to the applicable federal law. We would also like to work with MassHealth in the future to better understand its policies on recoupment and make sure they are implemented fairly considering issues such as the need for communications that accommodate people with disabilities and are accessible to people with Limited English Proficiency (LEP).

5. Estate Recovery 501.013 and 515.011

The proposed amendments to 501.013 and 515.011 on MassHealth Estate Recovery make minor housekeeping changes, but nothing updates the language to reflect changes in state law that were enacted in 2024 and approved by CMS as amendments to the Medicaid state plan in 2024. The changes in state law and the state plan significantly limit the scope of estate recovery for beneficiaries who died on or after Aug 1, 2024. We are aware that MassHealth has updated its website and issued an Eligibility Operations Memo to acknowledge the change in the law, but neither is a substitute for notice and comment rulemaking. The website and EOM are helpful but do not address all the questions that have arisen about the new law and have not provided an opportunity for the public to raise concerns with certain problematic interpretations reflected in the EOM and in the various summaries and examples on the website.

The amended regulation, if finalized as expected before Oct 1, 2025, will incorrectly describe the scope of estate recovery. The recent release date of the amended 501.013 and 515.011, which will carry with it legal authority that a website or Eligibility Operations Memo do not, will be a great source of confusion. It will mislead current MassHealth members as well as families dealing with the estate of a beneficiary who died on or after August 1, 2024,

Recommendation: MassHealth should withdraw the 515.011 regulation, prepare proposed amendments that comply with current law and the state plan, and republish 515.011 as amended for notice and comment.

130 CMR 502- Health Care Reform: MassHealth: Eligibility Process

1. Coverage Start Dates: 502.006

We are pleased to see that provisions for three months retroactive coverage are being implemented and set out in the regulations. However, the wording of the coverage start date

proposed rule is confusing and implies there may be a later start date than the first of the month of the date of a completed and timely application. We suggest this language be clarified to avoid confusion.

130 CMR 502.006(A)(2)(a) as proposed states that "If covered medical services were received during such period, and the individual would have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the application or upon receipt of any requested verifications and may be retroactive to the first day of the third calendar month before the month of application except as specified in 130 CMR 502.006(C)."

The phrase "during such a period" is confusing because no other period is described earlier. The reference to a start date on the receipt of application *or* the receipt of verification is confusing because it does not state which date governs if the two dates differ. Further, there is no need for 502.006(A)(2)(a) to mention receipt of verification at all because the two scenarios where the start date is based on the date verification is submitted have their own subsections –(c) and (d) – and each one contains its own provision for a start date from the date of verification.

Recommendation: Clarify 502.006(A)(2)(a) to read as follows:

> (a) If covered medical services were received during the period from the first day of the month of application to the first day of the third calendar month before the month of application, and the individual would have been eligible at the time services were provided during such period, the start date of coverage may be retroactive to the first day of the third calendar month before the month of application, except as specified in 130 CMR 502.006(C)
>
> (b) If covered medical services were not received during such period, or the individual would not have been eligible at the time services were provided, the start date of coverage is determined upon receipt of the application and coverage begins on the first day of the month that the application was received, except as specified in 130 CMR 502.006(C).

2. Automatic Renewals 502.007(C)(1) and 516.007(C)(1)

We support the regulatory change to reflect the practice of conducting auto-renewals on an individual member rather than household level and only require additional information for individuals for whom information is not readily available. This amendment is in accordance with CMS guidance released in 2023 during the reinstatement of eligibility redeterminations after the public health emergency. However, this change may also result in the unintended consequence of different renewal dates for members of the same household, adding a layer of complexity,

confusion and risk of loss of coverage. CMS provided updated guidance in November 2024 providing Medicaid agencies options for syncing renewal dates while continuing to comply with the requirement to conduct eligibility redeterminations on an individual basis.

Recommendation: We ask MassHealth to clarify how it will streamline the redetermination process both for the individual member and household within the regulations and release subregulatory guidance, such as Eligibility Operations memos, as well as conduct enrollment assister trainings and develop member-facing materials that explain the process. We hope to work with you on this additional guidance.

3. 90 Day Reconsideration: 502.007(C)(2)(b)(3)

We are sorry to see that MassHealth is eliminating the provision that has been in the Volume 1 regulations since 2014 providing that when coverage is terminated for not returning a renewal form and the renewal form is returned within 90 days of the termination, an eligible individual may be reinstated back to the date of termination. In the recent Eligibility Operations Memo 25-12 (July 2025) MassHealth notes that the 1902(e)(14) waiver authority for MassHealth to redetermine eligibility back to the date of termination has expired, but the regulation at 502.007 (C) (2)(b)(3) pre-dated the unwinding and was not dependent on the 1902(e)(14) waiver. We understand that CMS may have clarified that the ACA does not require state Medicaid agencies to do more than allow individuals to reapply within 90 days of termination without submitting a new application. However, unless CMS has determined that MassHealth may not retain its current redetermination regulation, we urge MassHealth to retain this provision. With 6 month renewals on the horizon for the expansion population, this provision for maintaining continuity of coverage back to the date of termination will be needed.

Recommendation: MassHealth should retain this provision unless CMS has directed it not to do so. If MassHealth is unable to retain this provision, we recommend that the regulation at least specify that determinations that are made after a termination are the kind of initial eligibility determinations that may entitle the individual to a retroactive coverage period.

130 CMR 503- Health Care Reform: MassHealth: Universal Eligibility Requirements

1. Pre-release coverage- 503.002(H) and 517.003(H)

We support the proposed amendment to 130 CMR 503.002(H), which clarifies that individuals in correctional facilities are considered residents of Massachusetts for MassHealth eligibility

purposes during the "pre-release period," and may qualify for coverage under the Section 1115 Demonstration, the Consolidated Appropriations Act (CAA) of 2023, or the SUPPORT Act.

Recommendation: Add the same language regarding the 1115 Demonstration to 517.002(H) to ensure that individuals aged 65 and older in correctional settings receive the same pre-release protections as members under age 65. Many justice-involved older adults are eligible for MassHealth during pre-release. Including this reference in both sections promotes consistency and equitable treatment across age groups. We note some of the provisions of the CAA of 2023 and the SUPPORT Act do not apply to older adults.

Recommendation: Define or cross-reference the term "pre-release period." The 1115 Reentry Demonstration and Implementation Plan describe it as the 90-day period prior to an individual's expected release from incarceration. For jails or short-term stays without fixed release dates, MassHealth uses a proxy based on average length of stay. Including this definition or cross-reference will improve clarity and support uniform implementation across eligibility workers, providers, and correctional agencies.

Recommendation: Include a cross-reference to the services available during the pre-release period, as outlined in the 1115 Implementation Plan or Eligibility Operations Memo. Pre-release coverage is intended to include physical and behavioral health services, access to prescribed medications, and care coordination. Clarifying the intended scope of services will help members, providers, and corrections partners understand and fulfill their roles in this process.

Recommendation: MassHealth should issue additional written guidance—such as an Eligibility Operations Memo, Provider Bulletin, or future rulemaking—clarifying how the Reentry Demonstration will be operationalized. Topics should include coverage types eligible for pre-release services, approved provider types (e.g., CHCs, ACOs, BH-JI providers), and procedures for transitioning members between inpatient-only, pre-release, and post-release coverage. Written guidance will be essential to support implementation, especially in cases of short-term or unplanned releases.

130 CMR 505- Health Care Reform: MassHealth: Coverage Types

1. Continuous Eligibility populations 505.002(Q); 505.004(M); 505.005(J); and 505.008(F)

The regulations regarding continuous eligibility for the different coverage types at 505.002(Q)(1)- MassHealth Standard, 505.004(M)(1)- MassHealth CommonHealth; 505.005(J)(1)- MassHealth Family Assistance; and 505.008(F)(1)- MassHealth CarePlus, all contain the same language about continuous eligibility, in fact, they all refer to eligibility for

MassHealth Standard, even though that only makes sense for the Standard regulations at 505.002.

> *(1) Continuous Eligibility, as defined in 501.001: Continuous Eligibility (CE), will be granted to certain groups of members who are eligible for MassHealth Standard.*

This appears to be a simple drafting error, and should be corrected as follows:

Recommendation: Change the word "Standard" in 505.004(M)(1) to "CommonHealth; change the word "Standard" in 505.005(J)(1) to "Family Assistance"; change the word "Standard" in 505.008(F)(1) to "CarePlus".

a. Continuous Eligibility for Homeless Population

The regulations regarding continuous eligibility for homeless members at 505.002(Q)(1)(b), 505.004(M)(1)(b); 505.005(J)(1)(b); and 505.008(F)(1)(b) state:

> *(b) People who are verified long-term homeless, defined as those who are registered with local homeless shelters for a period of greater than 6 months and notified by data sources as determined by the MassHealth agency, will receive 24 months of continuous coverage upon completion of initial application, annual renewal period, or notification of long-term homeless status as received by applicable data sources.*

This subsection's reference to "applicable data sources" is too vague. MassHealth has defined the only sources it will accept for verification of homelessness in its Eligibility Operations Memo[4] as (1) the Statewide Homeless Management Information System, or (2) the Executive Office of Housing and Livable Communities, Emergency Assistance shelter system. For transparency, these regulations should refer to these data sources by name. However, we also strongly urge MassHealth to also accept self-attestation of 6 months of homelessness, as *many* homeless members are not eligible for or cannot access the Emergency Assistance shelter system, or do not stay in homeless shelters- because of safety concerns, accessibility, or otherwise.

Recommendation: (1) Clearly define the "applicable data sources" of homelessness verification by name, and (2) accept self-attestation as verification of 6 months of homelessness.

[4] MassHealth, *Eligibility Operations Memo 24-02: Continuous Eligibility for Certain MassHealth Members* at 2 (Mar. 2024)

b. Continuous Eligibility for Justice-Involved Members

As mentioned above, MassHealth's proposed regulation at 130 CMR 501.001 does not describe the correct start date for CE for justice-involved members. The corresponding regulations at 505.002(Q)(1)(c), 505.004(M)(1)(c); 505.005(J)(1)(c); and 505.008(F)(1)(c) duplicate this error, stating:

> *(c) People who have recently been released from jail or prison will receive 12 months of continuous coverage upon completion of application or renewal.*

This language conflicts with the approved 1115 demonstration,[5] the Reentry Implementation Plan,[6] and MassHealth's own EOM guidance,[7] all of which state that CE for justice-involved individuals begins on the date of release from incarceration— not upon application or renewal.

This is not merely a technical discrepancy. The period immediately following release from incarceration is consistently recognized as one of the most dangerous for justice-involved individuals. Delays in coverage during this time can lead to harmful gaps in care, including heightened risk of overdose, suicide, and other preventable health emergencies. Ensuring that CE begins on the date of release is essential to supporting continuity of care and fulfilling the goals of the Reentry Demonstration.

While the goal of the Reentry Demonstration is for all eligible individuals to be enrolled in full MassHealth coverage on the date of release, we recognize that this will not occur in every case—for example, when individuals are released unexpectedly from the courtroom. The regulation should clarify that CE applies both to individuals who are released with inpatient-only coverage—due to delays or gaps in information exchanged between correctional facilities and MassHealth—and to individuals who are not enrolled in any coverage at the time of release but are later found eligible.

Recommendation: Replace the current language of "People who have recently been released from jail or prison will receive 12 months of continuous coverage upon completion of application or renewal" to "members who have been released from jail or prison will receive 12 months of continuous coverage beginning on the date of their release." This change would accurately reflect the 1115 demonstration authority and ensure coverage begins at the time

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[5] CMS, *Special Terms and Conditions: Massachusetts MassHealth Section 1115 Demonstration Extension*, at 13 (Sept. 28, 2022)

[6] MassHealth, *Reentry Demonstration Initiative Implementation Plan: MA Attachment X*, at 5 (May 2025)

[7] MassHealth, *Eligibility Operations Memo 24-02: Continuous Eligibility for Certain MassHealth Members* at 2 (Mar. 2024)

individuals reenter the community—when they are at greatest risk of overdose, hospitalization, and other preventable health crises.

Recommendation: Add a provision that "Individuals released from a correctional facility with inpatient-only coverage are entitled to full MassHealth benefits retroactive to their date of release." This provision ensures that administrative or communication delays do not prevent access to full benefits, helping members avoid care gaps at a critical time.

Recommendation: Add a provision stating that "[T]he release date may be verified through a signed statement attesting that the individual is no longer incarcerated." Allowing self-attestation as a verification method is especially important for individuals released under unpredictable or informal circumstances, such as from court, where formal paperwork may be delayed or unavailable.

Recommendation: Add a provision stating: "Individuals who are released from incarceration without MassHealth coverage, once determined eligible, are entitled to continuous eligibility through the 12th month following their date of release." This ensures that individuals who were not enrolled in MassHealth at the time of release—whether due to missed pre-release enrollment or administrative delays—can still receive the full 12-month period of CE once they are approved.

Recommendation: Modify the MassHealth application to include an optional field where applicants can indicate whether they have been released from incarceration within the past 12 months. This would help identify individuals who may be eligible for CE under the Reentry Demonstration and streamline enrollment for those applying after release.

2. EAEDC Eligibility. 505.002(K) and 519.002(D)

In both the Volume 1 and 2 regulations, MassHealth amends the MassHealth Standard Coverage rules in **505.002(K)** and **519.002(D)** to provide that all EAEDC recipients will be eligible for Standard. This is a welcome change that simplifies eligibility and makes coverage easier to understand and more equitable. However, please see our concerns with the related language about EAEDC Eligibility in 501.004(B), 515.004(B) above.

3. MassHealth CommonHealth - 505.004

We applaud MassHealth for updating its regulations to incorporate the changes to the CommonHealth program approved by CMS under our Section 1115 Waiver and implemented earlier through Eligibility Operations Memoranda for people under 65. Elimination of the one-time deductible for working disabled adults under age 65 is critical to ensuring access to care for

people living with disabilities. It will allow many more people with disabilities who greatly need MassHealth coverage to benefit from having it without incurring unaffordable medical bills.

a. Disabled Adults and Disabled Young Adults 505.004(B) and (C) (as proposed): Substantial Gainful Activity

The current regulation at 505.004(B)(3) requires that a person have a permanent and total disability but adds the phrase "except for engagement in substantial gainful activity." Substantial Gainful Activity (SGA) is the term used by the Social Security Administration to rule out disability for an applicant based on earnings over the SGA amount at Step One of its disability evaluation process. It has been important for CommonHealth not to apply SGA at Step One in order to enable people with disabilities to work up to their potential without risking the loss of LTSS that make work possible. While CommonHealth no longer has a work requirement for people under 65, it is still an important program that makes work possible for many of its members. The proposed regulations in 505.004(B) and (C) omit the phrase except for SGA in defining the disability standard.

Recommendation: We strongly urge the agency to retain the "except for substantial gainful activity" in the proposed regulations at 505.004(B) and (C) for adults and young adults. The language has been retained in the proposed 505.004(F) for 18-year-olds.

b. Medicare Premium Payment: 505.004(J) (as proposed)

We are heartened to see MassHealth's inclusion of regulations allowing simultaneous enrollment in CommonHealth and Medicare Savings Programs (MSP) for members who qualify for both coverage types in its amendment of the current 505.004 (L) relettered in the proposed rule as 505.004(J). However, MassHealth's changes to the regulation lack clarity. Instead of clearly articulating that *CommonHealth members earning up to 190% FPL qualify for QMB, those earning up to 210% FPL qualify for SLMB, and those earning up to 225% FPL qualify for QI*, the regulations opaquely refer to federal law (i.e. "Members who meet the requirements of 130 CMR 505.004 may, subject to federal authority and meeting any other eligibility requirements of the respective MSP…").

Recommendation: We recommend that you amend the regulations to clearly state the income levels for each type of MSP program, as stated above in italics. Given that the income methodology for calculating members' income for joint MSP-CommonHealth coverage will be changing as of January 1, 2026, we recommend adding a sentence that says: "The income methodology used to calculate eligibility for MSP when coupled with CommonHealth is currently based on MAGI methodology; if the federal authority for use of MAGI methodology expires, the applicable methodology will be updated in an Eligibility Operations Memorandum."

4. MassHealth Standard for Certain Immigrants Needing Long Term Services: 505.002

MassHealth has provided state-funded coverage for elderly and disabled adult immigrants since 1996 through MassHealth Family Assistance or its predecessor programs, MassHealth Essential and MassHealth Basic. Starting in 2021, MassHealth created a pathway for immigrants with more severe disabilities to obtain long term services and supports (LTSS) through MassHealth Standard or CommonHealth. Today the eligibility criteria for the pathway are set out in EOM 25-08 (May 2025) and a series of Provider Bulletins updated in June 2025, but there is nothing about the LTSS pathway in the regulations. Updating the regulations to include this program will help ensure MassHealth members receive the right care in the right setting, in part by addressing the problem of "stuck patients" who remain as hospital inpatients when another care setting would be more appropriate to meet their medical needs. This policy is crucial in reducing bottlenecks in the health care delivery system while providing much needed care to a vulnerable population.

Recommendation: We urge MassHealth to include language in the section 505.002 regulations for MassHealth Standard and MassHealth CommonHealth that set out the basic eligibility criteria for the LTSS Pathway for disabled and elderly adults who are Qualified Barred, NonQualified Lawfully Present or PRUCOL.

130 CMR 506 - MassHealth: Financial Requirements

1. Premium Assistance Reimbursement Adjustment: 506.012(F)(4) and Referral to State Intercept Program: 506.012(F)(5)

We support the deletion of these sections for recovering overpayments of premium assistance. They were based on the overly broad overpayment recoupment regulation that is also proposed for deletion because it is not in keeping with federal law. As discussed in our comments on the recoupment of overpayment regulation, we are concerned that to the extent MassHealth determines it may lawfully pursue recovery, its notices should include information on the scope of its recoupment authority and protections set out in federal law and be in an accessible format.

2. Delinquent Premium Payments, Referral to State Intercept: 506.011(D)(3) and Reactivating Coverage Following Termination: 506.011(E)

We support the deletion of the referral to state intercept for delinquent premium payments for the same reason and with the same concern regarding adequate notice as discussed above in reference to recovery for premium assistance overpayments.

We are pleased to see that MassHealth has eliminated lock-out periods for people terminated for past due premiums. This is in keeping with the December 2024 CMS Letter in which CMS writes, "Lock-outs impermissibly prevent individuals from applying, deny individuals coverage if they are eligible, and violate the requirement that states provide services to eligible individuals with reasonable promptness." However, the proposed regulation which simply states that someone who was terminated for nonpayment can reapply is not clear that the past due premium balance will not affect the eligibility decision.

Recommendation: We recommend that the proposed regulation specifically add that an eligibility determination based on a reapplication will not be affected by any past due premium balance.

3. MassHealth and CMSP Premium Formulas: 506.011(B)

All of the programs subject to premiums in 506.011 delete the Tables that now set out the premium formulas (or premium amounts in the case of children with income of 150-300% FPL) and replace them with a statement that "MassHealth shall annually adjust and publish premium amounts for each coverage type to account for last year's increase in the federal poverty level" starting with calendar year 2026.

Other than stating that premiums will go up every year by the same percentage that the FPL goes up, the NPR provides no information about how the base premiums will be determined. This complete lack of information about what the premium formulas will be and how they will differ from those in the current Tables largely defeats the purpose of notice and comment rulemaking.

Will CMSP premiums for children in families from 300%-400% FPL be higher or lower than those today? Will there be any buy-in option for those over 400% FPL? Will premiums in Family Assistance and CommonHealth for children in families from 150-300% still be set at the same amount as one another and at a lower amount than the premium charges for adults at 150-300% FPL? Will there still be maximums per family for families with more than 3 children? Will PRUCOL adults with income of 150-300% still be charged higher premiums than other adults now that the schedule is no longer linked to the minimum premium schedule in the ConnectorCare program? Will premiums be adjusted upward at every 10% increment of the poverty level as they are now for BCCTP and CommonHealth, or will they be adjusted at 50% increments as they are for children 150-300% FPL? Will there be an adjustment for people who are seeking MassHealth secondary to private coverage that MassHealth does not help them pay for, and what will the adjustment be?

The answers to all these questions are policy decisions that should be set out in the regulations and openly disclosed and discussed in order to give the public a meaningful opportunity to

comment as intended by GL 30A and the existence of the rulemaking process. MassHealth is essentially taking premium setting policies out of the rules. We strongly object to this.

Recommendation: We urge MassHealth to withdraw these sections of 506.011 that delete the Tables and issue a new proposed regulation that reflects the base premium formulas that MassHealth will be using to determine premium amount in 2026 and future years. This is necessary to provide a meaningful opportunity to comment on any changes in those formulas and policies.

Or if MassHealth is retaining the base premium formulas as set out in the Tables, it should retain the Tables and just add the description of how it will calculate annual adjustments based on the percent increase in the last FPL. Annual publication of the premium amounts would be all that is needed in that case. It would not be necessary to go through rulemaking just to apply a COLA based on a formula set out in the regulation.

4. Premium Billing Hardship: 506.011

Proposed regulations at 130 CMR 506.011(G)(1) eliminate the premium waiver for CommonHealth members for whom the monthly premium would cause extreme financial hardship. This provision provides necessary financial relief, which allows access to coverage for families who would otherwise struggle to afford premiums along with their essential expenses. As stated in the current regulation, this premium waiver furthers MassHealth's goal of "providing affordable health insurance to low-income persons" and should be included in the amended regulation for all MassHealth enrollees who are charged a premium.

Recommendation: We urge MassHealth to retain the premium waiver for CommonHealth members for whom the monthly premium would cause extreme financial hardship and extend it to all MassHealth enrollees who are charged a premium.

5. MassHealth Premiums and CMSP Premiums Introduction: 130 CMR 506.011(A)

We appreciate the removal of CMSP premiums for children with family incomes below 300% FPL. This change aligns the regulations with the Eligibility Operations Memo published by MassHealth in December 2024 and the elimination of the statutory requirement that CMSP be supported by premium contributions. It will provide children with needed coverage and families with financial relief. However, the changes to premiums for families with income over 300% are concerning and need further clarification. The proposed change indicates that MassHealth "may provide" an option for families with income above 300% FPL to buy into CMSP with premiums on a sliding scale based on income. This differs from the December 2024 EOM, which offered a formula for premiums for families above 300%. The "may" language suggests that CMSP upper

income limits for subsidized coverage may be lowered from 400% to 300% FPL. On the other hand, it is also possible that if the buy-in is on a sliding income scale it may go beyond the current 400% FPL. The proposed amendment to 506.011 and elimination of the premium formulas provides families and enrollment assisters with less transparency around their premium costs.

Recommendation: We encourage MassHealth to revisit the plan for premiums for children with family incomes above 300% FPL in order to clarify eligibility and the premium formula and urge them not to lower the upper income limit for subsidized coverage.

130 CMR 515- MassHealth: General Policies

1. Federal Poverty Level. 130 CMR 515.001

This section is discussed above together with our comments on 130 CMR 501.001 Federal Poverty Level.

2. Estate Recovery 130 CMR 515.011(A)(3)

This section is discussed above together with our comments on 130 CMR 501.013 Estate Recovery.

3. Recoupment of Overpayments 130 CMR 515.010

This section is discussed above together with our comments on 130 CMR 501.012 Recoupment of Overpayments.

130 CMR 516- MassHealth: The Eligibility Process

1. Automatic Renewal: 516.007

This section is discussed together with our comments on 502.007(C)(1) Automatic Renewals.

2. Renewal Application Form: 516.007(C)(2)(b)2.

This section provides that if a renewal form is not returned within 45 days, older adults will have their coverage terminated. This is in sharp contrast to the comparable rule for adults under 65 at 502.007(b)(2) that provides "If the renewal application is not completed within 45 days, the MassHealth agency will a. use information received from electronic sources, if available, and redetermine eligibility; or b. if information is not available from electronic sources, terminate MassHealth coverage…"

Because MassHealth is required to consult electronic data sources for both older and younger adults, it will have information for some individuals that will enable it to use information from electronic sources to make a determination rather than to terminate coverage. This is particularly important for older adults who may not have been automatically renewed due to the limited data sources available to verify assets but whose income was electronically verified and who could be redetermined into a Medicare Savings Program rather than terminated.

Recommendation. We urge MassHealth to amend 516.007(C)(2)(b)(2) to mirror 502.007(b)(2) with respect to the consequences of not returning a renewal form in 45 days. Termination should only be allowed if there is insufficient information to make a redetermination that may be a downgrade but still provides a meaningful benefit for which the older adult is eligible, like MSP.

130 CMR 517- MassHealth: Universal Eligibility Requirements

1. Residency of Institutionalized Individuals 517.003

Residency of Institutionalized Individuals is discussed above together with our comments on residency of institutionalized individuals in 130 CMR 503.002.

130 CMR 519- MassHealth: Coverage Types

1. Medicare Savings Programs, 519.010 and 519.011

This is a housekeeping change to an earlier amendment of the regulations that eliminated the asset test for the Medicare Savings Program (MSP) effective March 1, 2024. We greatly appreciate MassHealth for having made this crucial policy change to eliminate the asset test.

2. EAEDC Eligibility Changes 519.002(D)

This section is discussed above together with our comments on 505.002(K)

3. CommonHealth Eligibility 519.012

In 2022, the Section 1115 Demonstration Waiver authorized CommonHealth coverage for disabled adults ages 65 and older who had been on CommonHealth for at least 10 years in addition to reaffirming the existing coverage pathway for those who were working. This policy was implemented through Eligibility Operations Memo 23-19. We strongly support inclusion of this policy in MassHealth's regulations. The introduction of the deductible waiver for CommonHealth members over age 65 will help ensure that people with disabilities who have extensive work history will be able to retire and retain CommonHealth without facing unaffordable deductibles.

However, as written, the proposed regulations at section 519.012(A)(1)(b) are ambiguous about how MassHealth calculates the 10-year time period for the over-65 CommonHealth-eligible population. In numerous meetings over many months, MassHealth leadership has affirmed that people can meet the 10-year time timeframe in multiple ways, including by:

1) Working for 10-years while insured by CommonHealth *prior* to turning 65;
2) Working for 10-years while insured by CommonHealth with some or all of those years occurring *after* turning 65.

The regulations frame the 10-year time period as applying to over-65 CommonHealth recipients as follows: "if they are not employed, they must have had CommonHealth for at least ten years before stopping working or turning 65."

Ensuring crystal clear regulations is crucial because there has been significant confusion about when a person must accrue the 10 years. An initial *Eligibility OperationsMemo 23-19: Changes to MassHealth CommonHealth Eligibility for Seniors*, erroneously stated that to be eligible for CommonHealth, someone had to have been on the program for 10 years *before* turning age 65. The agency then issued a second version of the EOM, *Eligibility Operations Memo 23-19: Updated - Changes to MassHealth CommonHealth Eligibility for Seniors*, which correctly stated that, "Members who were enrolled in MassHealth CommonHealth for at least ten years are now eligible to remain on MassHealth CommonHealth after turning 65 whether they work or not." Nevertheless, confusion persisted about when the 10 years had to accrue. Early versions of the Senior Guide describing the new coverage stated the 10-year period of CommonHealth had to occur before turning age 65. This, too, was corrected but not until the current March 2025 edition of the Senior Guide.

Since implementation of the CommonHealth "retirement benefit" three years ago, other issues have arisen where advocates and beneficiaries have reported that members have been denied benefits based on criteria that were not contained in the section 1115 Waiver Documents or in an EOM. Some MEC workers denied benefits to individuals who had been on CommonHealth for 10 years but were most recently on Standard. Other MEC workers denied benefits because the 10-year period had not been continuous or consecutive. We are glad to see that these additional eligibility criteria have not been added to the proposed regulation. However, we are concerned that such unwritten criteria may persist. MassHealth should not be imposing any eligibility criteria that are not in the regulations.

A requirement of continuous or consecutive coverage is not appropriate for people with disabilities. Members may lose CommonHealth briefly or be placed into MassHealth Standard for a period of time - *despite consistent work history* - due to income fluctuations, procedural issues like renewal processing delays, or health flare-ups that reduce someone's ability to work

for months at a time (during which time they may be covered by Standard). The "consecutive" standard unfairly penalizes people with such medical needs.

Recommendation: We urge MassHealth to revise section 519.012(A)(1)(b) to explicitly state that a person can accrue the 10-years of work before turning age 65, after turning age 65, or during a time period that straddles both before and after the member turns 65. Alternatively, MassHealth could delete the ambiguous phrase "before stopping working or turning 65," so the regulation would read: "if they are not employed, they must have had CommonHealth for at least ten years."

Recommendation: We also recommend the regulation specify that the10 years on CommonHealth need not have been continuous or consecutive.

A technical note: both the current and proposed section 519.002 regulations cross-reference to the same subsections in 505.004 (H), (I), (J), (M) and (N), but there are proposed amendments to section 505.004 that change the subsection lettering. If the agency intended to cross-reference to the same subsections as it does currently, it will need to update its cross reference citations to correspond to their new location within an amended section 505.004**.**

130 CMR 522- MassHealth: Other Division Programs

1. Children's Medical Security Plan (CMSP): 522.004

We support the elimination of copays for CMSP enrollees in compliance with the provisions of the FY2025 state budget. We also urge MassHealth to consider further changes to the CMSP regulations to help children access services that may otherwise be uncovered, as allowable under state law.

Recommendation: Specifically, we request MassHealth to consider the following: eliminating the $750 cap on dental services; allowing a prescription drug benefit higher than $200 in cases where it would prevent hospitalization; and authorizing the higher $500 per year durable medical equipment benefit to prevent hospitalizations for children with chronic medical conditions beyond asthma, diabetes and seizure disorders.

2. Massachusetts Insurance Connection (MIC): 522.001

The amended regulation clarifies the policy to permit people who become eligible for a comprehensive MassHealth coverage type to instead remain enrolled in MIC. We request information as to how MassHealth will communicate to MIC members who are found eligible for comprehensive MassHealth coverage. We understand that it is a small program, and want to

ensure that there are staff at MassHealth familiar with the program and able to answer questions about members' coverage options.

3. Refugee Medical Assistance: 522.002

Refugee Medical Assistance (RMA) is a federally funded program for refugees who do not qualify for Medicaid that MassHealth has operated through an agreement with the Office of Refugees and Immigrants.

Under the federal RMA rules, the benefit is available for a limited time after a refugee enters the U.S. At one time it was 8 months as reflected in the current MassHealth RMA rules. In 2022 it was increased to 12 months which was not reflected in Section 522 until these proposed rules. Unfortunately, the federal government has now reduced the RMA period to only 4 months for refugees entering the U.S. after May 2025. See HHS Notice, 90 Fed. Reg. 13370 (March 21, 2025).

This federal curtailment of RMA precedes Medicaid eligibility changes enacted on July 4, 2025 that will end Medicaid reimbursement for refugees and many other categories of Qualified immigrants in October 2026. Inadequate as four months of RMA may be, Massachusetts should take advantage of all federally funded resources available for refugees.

Recommendation: It will be important for MassHealth to work together with the state Office of Refugees and Immigrants to make sure the RMA program is operational by October 2026. Coordination is particularly important because it is our understanding that since Medicaid expansion in 2014, the RMA program in Massachusetts has been largely moribund.

Effective Dates of the Proposed Regulations

The Notice of Proposed Regulations states that amended regulations are not likely to go into effect before October 1, 2025. However, many of the amendments to the regulations have already taken effect pursuant to the Eligibility Operations Memoranda issued as far back as 2022. Policies already in effect include continuous eligibility, CommonHealth eligibility for individuals under 65 without a deductible or work requirement, and the so-called CommonHealth retirement benefit. Other policies, such as the extension of retroactive eligibility to non-pregnant adults under 65 we understand will be taking effect in mid-August.

To avoid any confusion about what policies were in effect when, particularly for individuals who may have pending appeals where the effective dates of these policies will matter, we request that MassHealth acknowledge the earlier effective dates that preceded the regulatory changes. One way to do this is with the Eligibility Letters that accompany final regulations, and which often contain information on effective dates. For example the 2024 Eligibility Letter 248 releasing

regulations eliminating copayments included this statement: “Copayments are eliminated for MassHealth members, effective April 1, 2024. Copayments had been temporarily eliminated since May 1, 2023; this update extends this policy indefinitely.”

Conclusion

Thank you for the opportunity to make these comments and for extending the comment deadline. We look forward to continuing to work with the agency on implementation of these new rules and are available to clarify or provide any additional information that may be useful to MassHealth as it considers our comments and finalizes the rules. For any questions, please contact Kate Symmonds, ksymmonds@mlri.org, 617-357-0700 Ext 349.

Yours truly,

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