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THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin
Secretary of the Commonwealth

Regulation Filing *To be completed by filing agency*

CHAPTER NUMBER: 956 CMR 3.00

CHAPTER TITLE: Eligibility and Hearings Process for Commonwealth Care

AGENCY: Commonwealth Health Insurance Connector Authority

SUMMARY OF REGULATION: *State the general requirements and purposes of this regulation.*

The purpose of this regulation is to implement the provisions of M.G.L. chs. 118H and 176Q as to the eligibility for participation in Commonwealth Care, enrollment, responsibility of Enrollees, Enrollee premium contributions, disenrollment, and the related fair hearing and hearing processes.

REGULATORY AUTHORITY: M.G.L.c. 176Q

AGENCY CONTACT: Jon Kingsdale, Executive Director PHONE: 617-573-1694

ADDRESS: 1 Ashburton Place, Room 805, Boston, MA 02108

Compliance with M.G.L. c. 30A

EMERGENCY ADOPTION - *If this regulation is adopted as an emergency, state the nature of the emergency.*

PRIOR NOTIFICATION AND/OR APPROVAL - *If prior notification to and/or approval of the Governor, Legislature or others was required, list each notification, and/or approval and date, including notice to the Local Government Advisory Commission.*

PUBLIC REVIEW- *M.G.L. c. 30A. §§ 2 and/or 3 requires notice of the hearing or comment period be filed with the Secretary of the Commonwealth, published in appropriate newspapers, and sent to persons to whom specific notice must be given at least 21 days prior to such hearing or comment period.*

Date of public hearing or comment period: November 15, 2006

FISCAL EFFECT - *Estimate the fiscal effect of the public and private sectors.*

For the first and second year: _____

For the first five years: _____

No fiscal effect: X

SMALL BUSINESS IMPACT - *State the impact of this regulation on small business. Include a description of reporting, record keeping and other compliance requirements as well as the appropriateness of performance versus design standards and whether this regulation duplicates or conflicts with any other regulation. If the purpose of this regulation is to set rates for the state, this section does not apply.*

There will be no impact on small businesses as a result of this regulation.

CODE OF MASSACHUSETTS REGULATIONS INDEX - *List key subjects that are relevant to this regulation:*

Insurance
Healthcare

PROMULGATION - *State the action taken by this regulation and its effect on existing provisions of the Code of Massachusetts Regulations (CMR) to repeal, replace or amend. List by CMR number:*

This a new title and chapter - 956 CMR 3.00

ATTESTATION - *The regulation described herein and attached hereto is a true copy of the regulation adopted by this agency.* ATTEST:

SIGNATURE: Jon M Kingsdale DATE: 12/15/06

Publication - *To be completed by the Regulations Division*

MASSACHUSETTS REGISTER NUMBER: 1068 DATE: 12/29/06

EFFECTIVE DATE: 12/29/06

CODE OF MASSACHUSETTS REGULATIONS

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A TRUE COPY ATTEST
William Francis Galvin
WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH
DATE 12/15/06 CLERK

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956 CMR 3.00: ELIGIBILITY AND HEARING PROCESS FOR COMMONWEALTH CARE

Section

3.01: Authority

956 CMR 3.00 is promulgated in accordance with the authority granted to the Connector by M.G.L. c. 176Q.

3.02: Purpose

The purpose of 956 CMR 3.00 is to implement the provisions of M.G.L. chs. 118H and 176Q and thereby facilitate the availability, choice and adoption of private health benefit plans to eligible individuals and groups.

3.03: Scope

956 CMR 3.00 contains the Connector's regulations governing eligibility for participation in Commonwealth Care, enrollment, responsibility of Enrollees, Enrollee premium contributions, disenrollment and the related fair hearing process under M.G.L. chs. 118H and 176Q. The Connector also promulgates other regulations, and publishes other documents affecting its programs, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, administrative information bulletins and other documents as necessary.

3.04: Definitions

As used in 956 CMR 3.00, the following terms shall mean:

Adverse Determination – a determination, based on a review of information provided by a Contracted Medicaid Managed Care Organization (MMCO) or its designated utilization review organization, to deny, reduce, modify or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care, or effectiveness.

Adverse Eligibility Determination - a determination that an applicant is not eligible to participate in Commonwealth Care or a determination that an Enrollee is no longer eligible to participate in Commonwealth Care.

3.04: continued

Appeal Representative – a person who:

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

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

Applicant – a person who completes and submits a Commonwealth Care application.

Application - a form prescribed by the Connector to be completed by the applicant or a representative, and submitted to the Connector or its designee as a request for a determination that the Applicant is eligible for enrollment in Commonwealth Care.

Board - the Board of the Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q, § 2.

Commonwealth Care Covered Services or Covered Services - services required to be provided by a Contracted MMCO under Commonwealth Care.

Commonwealth Care Health Insurance Program or Commonwealth Care - the programs administered by the Authority pursuant to M.G.L. c. 118 H and other applicable laws to furnish and to pay for health benefit plans for Eligible Individuals.

Commonwealth Care Rules and Regulations – all regulations, bulletins and other written directives duly adopted or issued by the Connector relating to the Commonwealth Care program.

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

Complaint – any Inquiry made by or on behalf of an Enrollee to a Contracted MMCO or a utilization review organization employed by a Contracted MMCO that is not explained or resolved to the Enrollee's satisfaction within three business days of the Inquiry.

Contracted Medicaid Managed Care Organization ("MMCO") - any MMCO that enters into a contract with the Authority for the provision of health benefit plans under Commonwealth Care.

Contractor's Plan – the set of health benefit plans offered under Commonwealth Care and administrated by a Contracted MMCO pursuant to its contract, or, as applicable, by another Contracted MMCO under its similar contract, including Plan Types I-IV and Plan Type V, if any.

Co-payment - a fixed amount paid by an Enrollee for applicable services or for prescription medications at the time they are provided.

Coverage Date - the date medical coverage becomes effective for a particular Enrollee.

Coverage Type - a scope of medical services, other benefits, or both that is available to Enrollees in Commonwealth Care.

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

Eligible Individual - an uninsured individual who is a resident of the Commonwealth shall be eligible to participate in Commonwealth Care in accordance with M.G.L. c. 118H if:

(a) an individual's or family's household income does not exceed 300% of the Federal Poverty Level;

(b) the individual is not eligible for any MassHealth program including the Children's Medical Security Plan (other than emergency care under MassHealth Limited), for Medicare, or for the State Children's Health Insurance Program established by M.G.L. c. 118, § 16C;

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(c) unless waived by the Board pursuant to M.G.L. c. 118H, § 3(b), the individual's or family member's employer has not provided health insurance coverage in the last six months for which the individual is eligible and for which the employer covers at least 20% of the annual premium cost of a family health insurance plan or at least 33% of an individual health insurance plan; and

(d) the individual has not accepted a financial incentive from his employer to decline his employer's subsidized health insurance plan.

Eligibility Process - activities conducted by the Connector or its designee for the purposes of determining, redetermining and maintaining the eligibility of Eligible Individuals for Commonwealth Care participation.

Enrollee - an Eligible Individual enrolled by the Connector or its designee in a Contractor's Plan, either by choice or assignment.

Enrollee Cost Sharing - personal spending by an Enrollee toward applicable Covered Services, in addition to, but not including the Enrollee Premium Contribution.

Enrollee Premium Contribution - an Enrollee's actual required periodic financial contribution for health benefit coverage under Commonwealth Care, determined in accordance with applicable regulations of the Connector, paid to the Connector.

Family - persons who live together, and consists of:

(a) two persons who are married to each other and have no children under the age of 19 living with them;

(b) a child or children under age 19, any of their children, and their parent(s);

(c) siblings under age 19 and any of their children who live together even if no adult parent or caretaker relative is living in the home; or

(d) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is:

1. pregnant; or
2. a parent.

A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children who live with them.

Fair Hearing – an administrative, adjudicatory proceeding pursuant to 130 CMR 610.000 to determine the legal rights, duties, benefits or privileges of Applicants and Enrollees pertaining to initial eligibility determinations, eligibility reviews, and certain other determinations by MassHealth.

Federal Poverty Level (FPL) - the income standard, by such name, issued annually in the *Federal Register*, as adjusted to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Final Adverse Determination – An adverse determination made after an Enrollee has exhausted all remedies available through the Contracted MMCO's internal Grievance process.

Fraud – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the Commonwealth Care program to himself, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or state health care fraud laws. Examples of Enrollee fraud include, but are not limited to: improperly obtaining prescriptions for controlled substances and card sharing.

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Grievance – any oral or written complaint submitted to a Contracted MMCO that has been initiated by an Enrollee, or the Enrollee's authorized representative, concerning any aspect or action of the Contracted MMCO relative to the Enrollee, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and 105 CMR 128.000

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

Hearing - an administrative, adjudicatory proceeding pursuant to 801 CMR 1.00 to determine the legal rights, duties, benefits or privileges of Applicants (in certain, limited circumstances) and Enrollees pertaining to enrollment and plan assignments, disenrollments of Enrollees for failure to pay, disenrollments of Enrollees based upon the discretion of the Connector; Enrollee Premium Contributions and co-payment maximum limits; and denials of waiver requests.

Inquiry – any communication by or on behalf of an Enrollee to a Contracted MMCO that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Contracted MMCO.

Medically Necessary or Medical Necessity – health care services that:

(a) are consistent with generally accepted principles of professional medical practice as determined by whether:

1. the service is the most appropriate available supply or level of service for the Enrollee in question considering potential benefits and harms to the individual;
2. is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
3. for services and interventions not in widespread use, is based on scientific evidence.

(b) are the least intensive and most cost-effective available.

Medicaid Managed Care Organization (MMCO) - Subject to any limitations under Federal law or the MassHealth Waiver and the requirements of St. 2006, c. 58, § 123, an entity with which EOHHS contracts as of July 1, 2006, and continues to contract to provide primary care and certain other medical services to members on a capitated basis to serve MassHealth enrollees, which is either a managed care organization as that term is defined under 42 CFR 438 where that entity entered into such contract pursuant to MassHealth's most recent MCO Request for Response or is a health plan referenced in St. 1997, c. 47, § 28.

Office of Patient Protection (OPP) – the office within the Commonwealth's Department of Public Health responsible for the administration and enforcement of certain provisions of MGL c. 176O.

Plan Type – a Coverage Type established for Enrollees with income within a certain range and including Covered Services and Co-payments prescribed by the Authority.

Plan Type I – a Contracted MMCO's health benefit plan for Eligible Individuals whose individual or family household income does not exceed 100% of FPL and which includes at least the Covered Services prescribed by the Authority.

Plan Type II – a Contracted MMCO's health benefit plan for Eligible Individuals whose individual or family household income is in excess of 100% of FPL but does not exceed 200% of FPL and which includes at least the Covered Services and Co-payments prescribed by the Authority.

Plan Type III – a Contracted MMCO's health benefit plan relying on lower Premiums and higher Co-payments for Eligible Individuals whose individual income or family household income is in excess of 200% of FPL but does not exceed 300% of FPL and which includes at least the Covered Services and Co-payments prescribed by the Authority.

3.04: continued

Plan Type IV – a Contracted MMCO's health benefit plan relying on higher Premiums and lower Co-payments for Eligible Individuals whose individual or family household income is in excess of 200% of FPL but does not exceed 300% of FPL and which includes at least the Covered Services and Co-payments prescribed by the Authority.

Plan Type V – a Contracted MMCO's health benefit plan, if any, for Eligible Individuals whose individual or family household income is in excess of 100% of FPL and which does not exceed 300% of FPL and which includes at least the Covered Services and Co-payments described in a Contracted MMCO's contract with the Authority, representing an alternate health benefit plan offered only by such Contracted MMCO as part of Commonwealth Care, as approved by the Authority.

Premium - a periodic payment made to a Contracted MMCO by the Connector for Covered Services for an Enrollee.

Premium Assistance Payment - a periodic payment made to a Contracted MMCO by the Commonwealth or the Connector on behalf of an Enrollee from funds appropriated by the Commonwealth or other funds made available to the Connector for such purpose.

Resident - a person living in the Commonwealth, as defined by the office of Medicaid by regulation, including a qualified alien, as defined by section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, or a person who is not a citizen of the United States but who is otherwise permanently residing in the United States under color of law; provided, however, that the person has not moved into the Commonwealth for the sole purpose of securing health insurance under M.G.L. c. 118H; and provided, further, that confinement of a person in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify a person as a resident.

Service Areas – the Authority's grouping of the cities and towns within the Commonwealth into distinct areas for Commonwealth Care, as established by contract with the Contracted MMCO.

Standard Enrollee Contribution - the minimum Enrollee Premium Contribution set forth in 956 CMR 3.11(H).

3.05: Eligibility for Commonwealth Care

(1) Eligibility for Commonwealth Care is determined by the Connector through the Eligibility Process, with assistance from the Commonwealth's Office of Medicaid, using substantially the same methods as are used for MassHealth to verify that an Applicant is an Eligible Individual and to determine individual or family household income level.

(2) The financial eligibility for various Commonwealth Care Plan Types is determined by comparing the individual or family group's monthly Gross Income with the applicable income standard for the specific Coverage Type. In determining monthly Gross Income, the Connector multiplies average weekly income by 4.333.

(3) Generally, financial eligibility is based on Eligible Individual's individual or family household income. The following are the different levels of such income for each Plan Type:

(a) Plan Type I - not in excess of 100% of Federal Poverty Level.

(b) Plan Type II - more than 100% but not in excess of 200% of Federal Poverty Level.

(c) Plan Types III and IV - more than 200% but not in excess of 300% of Federal Poverty Level.

(d) Plan Type V - more than 100% of Federal Poverty Level but not in excess of 300% of Federal Poverty Level, unless further limited in the applicable Contractor's Plan, as approved by the Authority.

(4) The monthly Federal Poverty Level income standards are determined according to annual standards published in the Federal Register using the formula set forth in 956 CMR 3.05(4)(a) through (c). The Connector adjusts these standards in April of each calendar year.

3.05: continued

(a) Divide the annual Federal Poverty Level income standard as it appears in the Federal Register by 12.
(b) Multiply the unrounded monthly income standard by the applicable Federal Poverty Level standard.
(c) Round up to the next whole dollar to arrive at the monthly income standards.

3.06: Matching Information

The Connector or its designee initiates information matches with other agencies and information sources when an Application is received, when eligibility is redetermined, or at other times in the Connector's administrative processes in order to verify eligibility or certain information. These agencies and information sources may include, but are not limited to, the following: the Division of Employment Assistance, MassHealth, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance and health insurance carriers.

3.07: Time Standards for an Eligibility Determination

The Connector or its designee makes an eligibility determination within 45 days from the date of receipt of the completed applications if the applicant is potentially eligible for Commonwealth Care.

3.08: Eligibility Review

(1) The Connector or its designee may review eligibility every 12 months. Eligibility may also be reviewed more frequently as a result of an Enrollee's change in circumstances, or a change in Commonwealth Care eligibility rules. The Connector or its designee updates the case file based on information received as the result of such review. The Connector reviews eligibility:
(a) by information matching with other agencies, health insurance carriers, and information sources as set forth in 956 CMR 3.06;
(b) through a written update of the Enrollee's circumstances on a prescribed form; and
(c) based on information in the Enrollee's case file.

(2) The Connector determines, as a result of this review, if:
(a) the Enrollee continues to be eligible for Commonwealth Care;
(b) the Enrollee's current circumstances require a change in the Coverage Type, or Enrollee Premium Contribution; or
(c) the Enrollee is no longer eligible for Commonwealth Care.

(3) The Connector or its designee will notify the Enrollee if there is a change in the Enrollee's Coverage Type or Enrollee Premium Contribution, or a change in Enrollee's eligibility.

(4) In the event of a determination that the Enrollee is no longer eligible, the Enrollee will be sent a notice of termination 14 days before the termination occurs.

3.09: Eligibility Limitations

(1) Enrollees who reside outside of the Contracted MMCO's Service Areas for a continuous 90 day period or greater are not eligible to participate in that Contracted MMCO's Contractor's Plan.

(2) Persons shall not be deemed uninsured for purposes of determining Eligible Individuals if:
(a) such persons are eligible for other government funded and/or state-authorized insurance programs including, but not limited to, one of the following programs:
1. TRICARE, the Department of Defense's managed health care program for active duty military, active duty service families, retirees and their families, and other beneficiaries, established pursuant to 10 U.S.C. § 1073;

3.09: continued

2. Massachusetts Fishermen's Partnership, Inc.'s health insurance program, funded, in part, pursuant to St. 2006, c. 58, § 102 and in accordance with M.G.L. c. 118G, § 18;
3. student health insurance programs available to full-time or part-time students enrolled in a public or independent institution of higher learning located in the Commonwealth pursuant to M.G.L. c. 15A, §18; and
4 the Massachusetts Division of Unemployment Assistance's Medical Security Program, which provides health insurance assistance for residents of the Commonwealth who are receiving unemployment insurance benefits, pursuant to M.G.L. c. 151A; or

(b) such persons are eligible as a dependent for coverage under a family member's health insurance coverage.

(3) Persons shall be deemed uninsured for purposes of determining Eligible Individuals if:
(a) such persons are insured solely under a health benefit plan for which they pay the full premium obtained pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA") at 29 U.S.C. § 1161 or the Small Group Health Insurance Continuous Coverage Act at M.G.L. c. 176J, § 9 or obtained as an individual in the non-group insurance commercial market; or
(b) if and to the extent such persons are in a waiting period prior to becoming eligible under an employer-provided health benefit plan for which the employer covers at least 20% of the annual premium cost of a family health benefit plan or at least 33% of an individual health benefit plan.

3.10: Responsibilities of Applicants and Enrollees

(1) Responsibility to Cooperate. The Applicant or Enrollee must cooperate with the Connector or its designee in providing information necessary to establish and maintain eligibility and to bill and collect Enrollee Premium Contributions, and must comply with all the rules and regulations of the Connector or its designee.

(2) Responsibility to Report Changes. The Applicant or Enrollee must report to the Connector, within ten days or as soon as possible, changes that may affect eligibility or Enrollee Premium Contributions. Such changes include, but are not limited to, residency, address, income, employment, the availability of health insurance, and third-party liability.

(3) Third Party Liability. If an Enrollee is involved in an accident or suffers an injury in some manner and subsequently receives money from a third party as a result of that accident or injury, the Connector or the Enrollee's then-current MMCO may have a right to recover some or all of those funds to repay the Connector or the then-current MMCO for certain medical services provided to the Enrollee by the MMCO. In the event that the Connector and/or the MMCO intend to recover any funds from an Enrollee, the Connector and/or the MMCO will provide notice to the Enrollee of any obligation to pay funds back.

3.11: Commonwealth Care Enrollee Premium Contributions

(1) Enrollee Premium Contribution Payments. Enrollees who are assessed an Enrollee Premium Contribution are responsible for monthly payments beginning the calendar month following the date of the Enrollee's selection of a Contracted MMCO. The Connector will establish and maintain a number of convenient payment methods for Enrollees.

(2) Delinquent Enrollee Premium Contribution Payments.
(a) If the Connector or its designee has billed an Enrollee for a payment, and the Enrollee does not pay all of the amount billed within 60 days of the date on the bill, then the Enrollee's eligibility for participation in the Commonwealth Care is terminated, except as provided below. The Enrollee will be sent a notice of termination 14 days before the date of termination. The Enrollee's eligibility will not be terminated if, before the date of termination, the Enrollee:
1. pays all the amounts due;
2. submits an application for a financial hardship waiver pursuant to 956 CMR 3.11(5); or
3. establishes a payment plan acceptable to the Connector.

3.11: continued

(b) After such a payment plan has been established, the Connector will bill the Enrollee for:
1. payments in accordance with the payment plan; and
2. monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan. If the Enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the Enrollee's eligibility is terminated. If the Enrollee does not pay monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the Enrollee's eligibility is terminated as set forth in the first paragraph of 956 CMR 3.11(2).

(3) Reactivating Coverage Following Termination Due to Delinquent Payment.
(a) If capacity exists in Commonwealth Care, after the Eligible Individual has paid in full all payments due, or has established a payment plan with the Connector, Connector will reenroll the Eligible Individual.
(b) If no capacity exists in Commonwealth Care an Eligible Individual's whose eligibility has been terminated due to nonpayment of Enrollee Contribution Payments will be placed on a waiting list upon payment of all payments due. They will not be allowed to reenroll until the Connector is able to reopen enrollment for those placed on the waiting list. When the Connector is able to open enrollment for those on the waiting list, their eligibility will be processed in the order they were placed on the waiting list.

(4) Waiver of Outstanding Enrollee Premium Contribution Payments. If an Enrollee whose eligibility has been terminated due to nonpayment of Enrollee Premium Contributions reapplies and is determined eligible for Commonwealth Care after 24 or more months have passed since the termination of eligibility, the outstanding Enrollee Premium Contribution payments are waived.

(5) Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship.
(a) Extreme financial hardship means that the Enrollee has shown to the satisfaction of the Connector that the Enrollee:
1. is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice; or
2. has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone); or
3. within the 12 month period immediately preceding the date of the waiver application, has non-cosmetic medical and/or dental out-of-pocket expenses (exclusive of premium payments), totaling more than 7.5% of the individual or family's gross annual income that are not subject to payment by a third-party. (In this case "non-cosmetic medical and/or dental out-of-pocket expenses" must be incurred by the individual or family for services rendered while enrolled in a Commonwealth Care plan and incurred within the 12 months immediately preceding the date of the waiver application.); or
4. that the Enrollee has incurred a significant, unexpected increase in essential expenses within the last six months resulting directly from the consequences of:
a. domestic violence;
b. the death of a spouse, family member, or partner with primary responsibility for child care;
c. the sudden responsibility for providing full care for an aging parent or other family member, including a major, extended illness of a child that requires a working parent to hire a full-time caretaker for the child; and
d. a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee.
(b) If the Connector determines that the requirement to pay an Enrollee Premium Contribution results in extreme financial hardship for the Enrollee, the Connector, in its sole discretion, may waive payment of such Contribution or reduce the amount of such Contribution assessed to a particular individual or family.
(c) If the Connector determines, in the case of an Enrollee whose annual income is at or below 100% of FPL, that the payment of any Co-payment results in extreme financial hardship for such Enrollee, the Connector, in its sole discretion, may waive or reduce any Co-payment incurred by such Enrollee.

3.11: continued

(d) Hardship waivers will be authorized for up to six months. The six-month time period begins in the month after a documented hardship waiver is granted. An Enrollee who is granted a hardship waiver will be assigned to the lowest cost Coverage Type available in that Enrollee's Service Area. At the end of the six-month period, the Enrollee may submit another request. Requests for Enrollee Premium Contribution or Co-payment relief should be addressed to the Connector.

(6) Voluntary Withdrawal If an Enrollee wishes to voluntarily withdraw from receiving Commonwealth Care coverage, it is the Enrollee's responsibility to notify the Connector of his or her intention by phone or, preferably, in writing. Coverage continues through the end of the calendar month of withdrawal. The Enrollee is responsible for the payment of all Enrollee Premium Contributions up to and including the calendar month of withdrawal.

(7) Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes in income, family group size, or health-insurance status, and may be changed whenever an adjustment is made in the Commonwealth Care Premiums paid to one or more Contracted MMCO's or as a result of MMCO's changing their service areas.

(8) Minimum Monthly Commonwealth Care Enrollee Premium Contribution Schedule. The formulas that the Connector uses to determine the minimum monthly Enrollee Premium Contributions for Enrollees who are participating in the Commonwealth Care Program are as follows:

(a) Formula for Commonwealth Care for Plan Type I. No Enrollee Premium Contribution payment is required.

(b) Formula for Commonwealth Care for Plan Types II and III. The minimum monthly Enrollee Premium Contributions for Eligible Individuals are set forth in the following table:

Plan Type	Percent of FPL	Monthly Contribution
II	>100%-150%	$18
II	>150%-200%	$40
III	>200%-250%	$70
III	>250%-300%	$106

(c) Formula for Commonwealth Care for Plan Type IV. The Enrollee Premium Contribution for Plan Type IV is derived from the minimum Enrollee Premium Contribution set forth in 956 CMR 3.11(8)(b) for Plan Type III in the manner set forth in 956 CMR 3.12.

(9) The Monthly Commonwealth Care Premium Assistance Payments. The Premium Assistance Payments will be paid by the Connector monthly from funds appropriated by the Commonwealth for the purpose, or otherwise made available to the Connector, in amounts sufficient, together with the Enrollee Premium Contributions received by the Connector, to pay the Premiums due to the Contracted MMCOs.

(10) Termination of Health Insurance. If an Enrollee's health insurance terminates for any reason, beginning the first day of the following month the Enrollee Premium Contributions and the allocable Premium Assistance Payments end.

3.12: Total Monthly Enrollee Premium Contribution

(1) For Enrollees qualified for Plan Type II, the Enrollee Premium Contribution will be equal to the Standard Enrollee Contribution if the Enrollee chooses the lowest priced plan among the Plan Type II options offered in the Enrollee's Service Area. If an Enrollee chooses a Plan Type II option other that the lowest priced Plan Type II, the Enrollee Premium Contribution will be the Standard Enrollee Contribution plus the full increment of the monthly Premiums between the lowest priced Plan Type II and the Plan Type II option chosen by the Enrollee.

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(2) For Enrollees qualified for Plan Types III and IV, the Enrollee Premium Contribution will be equal to the Standard Enrollee Contribution if the Enrollee chooses Plan Type III and the lowest priced plan among the Plan Type III options offered in the Enrollee's Service Area. If an Enrollee chooses a Plan Type III option other that the lowest priced Plan Type III, the Enrollee Premium Contribution will be the Standard Enrollee Contribution plus the full increment of the monthly Premiums between the lowest priced Plan Type III and the Plan Type III option chosen by the Enrollee. If an Enrollee chooses a Plan Type IV option, the Enrollee Premium Contribution is equal to the sum of the Standard Enrollee Contribution, the full increment of the monthly Premium between the lowest priced Plan Type III and the Plan Type III offered by the same contractor chosen by the Enrollee for Plan Type IV, and 50% of the difference between the cost of the Plan Type III offered by the same contractor providing the Enrollee with a Plan Type IV and the Enrollee's Plan Type IV.

3.13: Choosing a Contracted MMCO

(1) Selection of a Contracted MMCO.

(a) Procedure. The Connector notifies an Applicant who has been determined to be eligible to enroll of the availability of Contracted MMCO's in the Applicant's Service Area, and of the Applicant's obligation to select a Contracted MMCO within the time period to be specified by the Connector. The Applicant may select any Contracted MMCO from the Connector's list of Contracted MMCOs in his Service Area, if the Contracted MMCO is able to accept new Enrollees.

(b) Applicant's Service Area. The Applicant's Service Area is determined by the Connector and is based on those established for MassHealth. Service Area listings may be obtained from the Connector.

(2) Assignment to a Contracted MMCO. If an Applicant who has been determined to be eligible to enroll in Plan Type I does not choose a Contracted MMCO within the time period specified by the Connector in a notice to the Applicant, the Connector assigns the Applicant to a Contracted MMCO.

(3) Criteria for Assigning Applicant in Plan Type I.

(a) The Connector assigns an Applicant determined to be eligible to enroll with a Contracted MMCO only if the Contracted MMCO is:

1. able to provide service in the Applicant's Service Area; and
2. has capacity in Plan Type I.

(b) Assignments will be made as follows:

1. If the Applicant has been a member in a Contracted MMCO's MassHealth plan or any other plan offered by a Contracted MMCO within the preceding year, the Applicant will be assigned to the Contracted MMCO in whose plan the Applicant has most recently participated; and
2. Otherwise, the Applicant shall be assigned to a Contracted MMCO in such manner as the Authority may determine.

(4) Notification. The Connector will notify an Enrollee in writing of the name and address of the Enrollee's Contracted MMCO and the Enrollee's enrollment effective date with the Contracted MMCO.

(5) Transfer. The Enrollee may transfer to or from an available Contracted MMCO only during such periods as the Connector may establish.

(6) Disenrollment of Enrollees.

(a) The Connector may disenroll or transfer an Enrollee from a particular Contractor's Plan, upon request of the Contracted MMCO as permitted by the applicable contract. If the Connector approves a request for disenrollment under 956 CMR 3.13(6)(a) it will state the basis for disenrollment in a written notice to the Enrollee.

(b) The Connector may disenroll an Enrollee for failure to pay Enrollee Premium Contribution payments under 956 CMR 3.11 or 3.12.

(c) The Connector may disenroll an Enrollee for Fraud.

3.17: continued

(a) enrollment and plan assignments for Plan Type I members;
(b) disenrollments of Enrollees for failure to pay;
(c) disenrollments of Enrollees based upon the discretion of the Connector;
(d) Enrollee Premium Contributions;
(e) denials of waiver applications; and
(f) co-payment maximum limits.

(3) Enrollees in Plan Type I will continue to remain enrolled in the plans they were enrolled in, and will continue paying their previously-established enrollee premium contributions (if any), at the time of the appealable action, until such time as the Board of Hearings or the Connector makes a decision on the relevant appeal.

3.18: Administrative Information Bulletins

(1) The Connector may issue administrative information bulletins that set out policies that are consistent with the substantive provisions of 956 CMR 3.00. In addition, the Connector may issue administrative information bulletins which specify the information and documentation necessary to implement 956 CMR 3.00. The Connector may also issue administrative bulletins containing interpretations of 956 CMR 3.00 and other information to assist persons subject to 956 CMR 3.00 meet their obligations under 956 CMR 3.00.

(2) MMCOs, Providers, and Eligible Individuals should refer to the Commonwealth Care Rules and Regulations, and other documents published affecting these plans and programs for more detailed information and guidance, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, provider bulletins, MMCO bulletins and other documents as necessary.

3.19: Severability of Provisions

The provisions of 956 CMR 3.00 are hereby declared to be severable. If any such provisions or the application of such provisions or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 3.00 or the applications of such provisions or circumstances other than those held invalid.

REGULATORY AUTHORITY

956 CMR 3.00: M.G.L. chs. 118H and 176Q.

#4

THE COMMONWEALTH OF MASSACHUSETTS

William Francis Galvin

Secretary of the Commonwealth

Notice of Correction

Regulation Filing *To be completed by filing agency*

CHAPTER NUMBER: 956 CMR 3.00

CHAPTER TITLE: Eligibility and Hearings Process for Commonwealth Care

AGENCY: Commonwealth Health Insurance Connector Authority

ORIGINAL PUBLICATION REFERENCE: *Register Number:* 1068 *Date:* 12/29/06

SUMMARY OF CORRECTION:

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Remove these pages:	*Insert these pages:*
22	21,22

TRUE COPY ATTEST

William Francis Galvin

WILLIAM FRANCIS GALVIN
SECRETARY OF THE COMMONWEALTH

DATE 1/12/07 CLERK JY

3.13: continued

(7) Reenrollment. Any Enrollee in Plan Type I who loses Commonwealth Care eligibility and then regains eligibility within one year shall be automatically reenrolled by the Connector with the Contracted MMCO with which the Enrollee was most recently enrolled, if still available, except in the case of reenrollment after disenrollment under 956 CMR 3.13(6)(a), in which case the Connector may make such automatic reenrollment as it deems most appropriate.

3.14: Right to a Hearing

Applicants and Enrollees are entitled to a fair hearing under 956 CMR 3.00 *et seq.* with either the Office of Medicaid Board of Hearings or a hearing with the Connector (depending on factors specified in 956 CMR 3.17) to appeal:

(1) any adverse eligibility decision or determination of income level or initial determination of, or changes in, the amount of Enrollee Premium Contributions;

(2) the Connector's termination of an Enrollee for failure to pay Enrollee Premium Contributions;

(3) the Connector's denial of a financial hardship waiver or renewal of a financial hardship waiver under 956 CMR 3.11(5);

(4) the Connector's disenrollment of an Enrollee for any other reason; or

(5) for Enrollees in Plan Types II-IV, any notice regarding their full payment of co-payments up to the specified maximum limit.

3.15: Notification of the Right to Request a Hearing

(1) Upon being notified of any appealable action as identified and discussed in 956 CMR 3.14 and 3.17 by either the Office of Medicaid or the Connector, the Applicant or Enrollee will be informed in writing of his or her right to a hearing with the appropriate hearings office, of the method by which a hearing may be requested, and of the right to use an Appeal Representative.

(2) If an Applicant or Enrollee indicates disagreement with an appealable action, the acting entity will provide the applicant or Enrollee with an appeal form from the appropriate agency, either the Office of Medicaid or the Connector. The Connector and or its agent/designee may not restrict the Applicant's or Enrollee's freedom to request a hearing.

3.16: Appeal from Contracted MMCO Actions

An Enrollee shall be entitled to appeal any Adverse Determination made by a Contracted MMCO or any representative thereof and to address any Inquiry, Complaint or Grievance through an internal process administered by the applicable Contracted MMCO which complies with 105 CMR 128.000. In addition, an Enrollee shall be entitled to request external review of a Final Adverse Determination issued by a Contracted MMCO through the OPP as set forth in 105 CMR 128.000.

3.17: Hearings

(1) Hearings will be conducted for the Connector by the Board of Hearings within the Office of Medicaid using policies and procedures set forth in 130 CMR 6.10 and those set forth in 956 CMR 3.00, for those appeals that involve initial eligibility determinations as well as reviews of eligibility, including appeals of financial determinations and matching determinations.

(2) Hearings will be conducted for, and by, the Connector using the policies and procedures set forth in 801 CMR 1.00 and those set forth in 956 CMR 3.00, for those appeals that raise the following issues:

3.17: continued

(a) enrollment and plan assignments for Plan Type I members;
(b) disenrollments of Enrollees for failure to pay;
(c) disenrollments of Enrollees based upon the discretion of the Connector;
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REGULATORY AUTHORITY

956 CMR 3.00: M.G.L. chs. 118H and 176Q.