November 5, 2013

Kristin L.Thorn, Medicaid Director
Executive Office of Health and Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Re: proposed changes to MassHealth and Health Safety Net regulations

Submitted electronically to masshealthpublicnotice@state.ma.us

Dear Director Thorn:

The Massachusetts Law Reform Institute (MLRI) and Greater Boston Legal Services (GBLS) are submitting these comments pursuant to the Public Notice issued October 13, 2013, requesting testimony and comments on the proposed changes to MassHealth and Health Safety Net regulations that are intended to conform with the changes to eligibility, benefits, and operational processes that will be implemented in accordance with the Affordable Care Act (ACA) and consistent with the Commonwealth's plans for implementation of the federal Affordable Care Act and related regulations at 42 CFR 433, 435, 440, 447, 457, changes to M.G.L. c. 118E as amended by Chapter 118 of the Acts of 2012 and Chapter 35 of the Acts of 2013, the terms of MassHealth's 1115 Demonstration Projects, and Section 266 of Chapter 224 (State Cost Containment legislation). We appreciate the opportunity afforded us yesterday to testify at the public hearing. We recognize the amount of work on a very tight timetable that it has taken your office to produce these draft regulations. These regulations mean that the Affordable Care Act (ACA) will be implemented here in Massachusetts ensuring that access to affordable health care services will be expanded.

In addition to the comments in this letter we support the comments submitted by the ACT!! Coalition.

101 CMR 613.000 Health Safety Net Eligible Services

Clarify the term "Premium Assistance Payment Program Operated by the Health Connector" in 613.02.
It is not clear if this term refers to the ConnectorCare program only or also includes Advanced Premium Tax Credits for individuals up to 400% FPL. It should only include ConnectorCare, since only individuals enrolled in this program are eligible to receive any kind of cost-sharing assistance. Individuals who only receive assistance with premium costs in the individual market should be able to qualify for HSN Secondary in the same way as individuals whose employers pay a share of premium costs.

Clarify the income methodology that applies to elderly applicants in 613.02.
The proposed rules replace the term Family Income with the term MAGI income as defined in 130 CMR 501.001 and 506.004. However, the MAGI methodology will not apply to individuals age 65 or older who are subject to the non-MAGI methodology in 130 CMR 520.00. We suggest you continue to use the term "Family income" and define it as income determined using the MAGI methodology in 501.001 and 506.004 for individuals under age 65 or otherwise subject to MAGI, and income determined using the methodology at 520.000 for individuals age 65 or older or otherwise not subject to MAGI.

Clarify what constitutes an "application" and when it is received.
613.02 uses the same definition of application as 130 CMR 501.01. As we state in our comments on the MassHealth regulation, defining an "application" as including all verification, including a disability supplement is inconsistent with the way the word application is used in establishing the medical coverage date based on the date an application is received.

Provide some relief to individuals who have been terminated from MassHealth or ConnectorCare for nonpayment of premiums in 613.04(1)(b).
At 613.04(1)(b), the proposed regulations state that people terminated from Premium Assistance Payment Program Operated by the Health Connector due to failure to pay premiums are not considered low-income patients. We urge EOHHS to amend this policy in light of the federal Exchange regulations governing non-payment of premiums. While qualified health plans (QHPs) are required to pay all appropriate claims during the first month of the 90 day grace period, they may pend claims in the second and third months of the grace period. If premiums are not paid by the end of the grace period, the enrollee's coverage is retroactively terminated to the end of the first month of the grace period1. We request that EOHHS allow claims in the second and third months of a grace period to be billed to the HSN for HSN-eligible services in order to compensate the HSN providers obliged to provide services during the grace period, and the patients who may be unable to catch up on an arrearage in such a short time frame. Further, we urge EOHHS to impose some time limit on the lockout period for individuals terminated for nonpayment of premiums; this bar should not last forever. We suggest the HSN limit the premium nonpayment penalty to 12 months from the date of termination of ConnectorCare or MassHealth for nonpayment of premiums.

We support the use of an affidavit for identity verification if no other documentation is available in 613.04(2)(c).
613.04(2)(c) allows for signed affidavit from someone who can attest to the person's identity. This is an important backstop in a safety net program for those individuals who through homelessness, mental illness, undocumented status or other misfortune may be well known to local service providers but unable to supply any documentation. These policies will ensure that people who are indeed eligible for the HSN do not face undue barriers to proving their identity in order to receive HSN services and to compensate the safety net providers who disproportionately serve the poorest of the poor.

We also strongly support the availability of Provisional Eligibility in the Health Safety Net.

Remove the no affordable insurance criteria in 613.04(4)(b)(1).
The Health Safety Net office has spent many years trying to determine if there is a feasible and cost effective way of identifying applicants who have access to affordable insurance. Until the agency has determined that this requirement can be operationalized it should not be in the regulations. We have long considered such a requirement unnecessary in light of the common application process for HSN and other insurance affordability programs and the existence of the individual mandate. With ACA implementation, HSN has even less to gain from attempting to operationalize such a rule.

Provide a limited opportunity for low income patients to waive collection protections for the sole purpose of meeting a CommonHealth deductible in 613.08(3).
We strongly support the collection protections for low income patients in 613.08, but believe there is one very limited situation in which patients could benefit from being able to waive the protections. Adults with disabilities with income over 133% FPL who are not able to work are not eligible for CommonHealth until they meet a one-time deductible amount. Because of the way the deductible is calculated, a person just $1 over the monthly standard will have a deductible amount of over $4000. Often a hospital bill is the only way to meet the deductible. We recommend that the 613.08(3) regulations include a provision that a disabled individual denied CommonHealth until meeting a deductible should be able to waive the collection protections of this section, and that in such a case, the hospital would be able to bill and pursue other collection remedies, but would not be able to seek reimbursement from the HSN for a bill used to meet the CommonHealth deductible. At one time, this procedure was authorized in a set of Frequently Asked Questions, and as far as we know it was never abused.

130 CMR 501.000 – 522.000 MassHealth Eligibility Regulations

501.000 General Policies

501.001 – Definition of Terms

Clarify Definitions and Define Additional Terms
There are a number of terms which should have definitions in this section, but do not. It would improve the overall comprehensibility of these complex regulations, if you added definitions for the additional terms including: Lawfully Present, Certified Application Counselors and Navigators, the Health Insurance Connector Authority, ConnectorCare, Qualified Health Plans, and Premium Tax Credits.

Appeal Representative
While the appeal representative definition is unchanged from the current regulations, except for the substitution of “authorized representative” for “eligibility representative, we recommend some additional changes. As legal advocates who represent MassHealth members in appeals, we find the categories listed do not exactly fit the roles of attorneys and of paralegals that practice in attorney offices.

Section (1) requires an appeal representative to be a person who “is sufficiently aware of the appellant’s circumstances to assume responsibility for the accuracy of the statements made

during the appeal process…." This requirement is not consistent with the role of a legal advocate. It appears to conflict with attorney obligations under the Code of Professional Responsibility. Rule 3.1 requires that "a lawyer shall not bring or defend a proceeding, or assert or controvert an issue therein, unless there is a basis for doing so that is not frivolous, which includes a good faith argument for an extension, modification or reversal of existing law." Rule 3.3 sets out the rules on "candor toward the tribunal." A lawyer shall not knowingly make a false statement of material fact; fail to disclose a material fact to a tribunal when disclosure is necessary to avoid...a fraudulent act by a client…;or offer evidence that the lawyer knows to be false. Further, if the lawyer knows the evidence to be false, the lawyer shall take reasonable remedial measures. The comments to this section outline the lawyer's task: "The advocate's task is to present the client's case with persuasive force. Performance of that duty while maintaining confidences of the client is qualified by the advocate's duty of candor to the tribunal. ***However, an advocate does not vouch for the evidence submitted in a cause*** [emphasis added]; the tribunal is responsible for assessing its probative value." Further, Rule 3.7 provides that lawyers are not typically witnesses in proceedings where they are acting as an advocate. At the MassHealth Board of Hearings, lawyers acting as advocates are not sworn in as witnesses, in recognition of the fact that they are presenting the evidence of witnesses, and legal argument.

Section (2) provides that an appeal representative can be an individual who "has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care." Attorneys do not have the authority to make decisions related to health or payment for such care without further permission from the client. Again, this section does not recognize the situation of attorney/client.

We recommend the addition of language that reflects the nature of the attorney/client relationship, which is different than defined here. The appeal representative definition should include:

> (4) A licensed attorney who notifies the MassHealth Board of Hearings that he or she represents the appellant in an appeal. This shall also include a non-lawyer supervised by a licensed attorney."

An appeal representative should also include an authorized representative. The definition of an authorized representative is someone authorized to act on an individual's behalf throughout the eligibility and enrollment process and this should extend to the authority to file an appeal on behalf of an individual denied eligibility.

Application

An application is defined here as including all required verifications including a completed disability supplement where applicable. We do not think that the definition of an application should include verifications. The application should be defined as the completion of the online application form, telephonic application or the paper "Application for Health Coverage and Help Paying Costs" for a number of reasons: (1) A definition which includes verifications is inconsistent with the use of the term "application" in 502.000, as in general, verifications aren't requested until after an application is filed; (2)The effective date of an application should be the date that it is submitted. Including verifications as part of the application confuses the filing date; (3) The inclusion of a completed disability supplement as part of "the application" is particularly

troubling. We urge you to continue your current practice of determining eligibility for other coverage types while a disability determination is pending. The application date for purposes of coverage should not be delayed until receipt of the disability supplement. Indeed, an individual applying on paper will not even receive a disability supplement until after MassHealth has received the application.

Basic Benefit Level
The Basic benefit level should include at least Essential Health Benefits. Meeting the requirements of 211 CMR 64.00 should be an additional requirement, not an alternative definition of Basic Benefit Level. See our comments concerning 506.012

Case File
The definition of case file should also include any electronic records used to determine eligibility such as data matches and computer screen shots for online applications.

Custodial Parent
This definition is contained in 42 CFR 435.603((f)(2)(iii) for purposes of the Medicaid exception to the MAGI household rules. The definition should state that it is only for the purpose of identifying a noncustodial parent in 506.002(B)(2)(b)(iii). Otherwise the definition may be confused with eligibility criteria for a parent in 505.002 which as we point out in our comment on that sections does not require an inquiry into custody

Deductible
The reference to 130 CMR 506.009 should be deleted from this definition. The income standards in 130 CMR 506.009 are used to calculate the amount of a deductible, but are not the correct standard to use to determine who is subject to a deductible. 130 CMR 505.002 should be substituted.

Deductible Period
We suggest the following rewording: A specified six month period within which an applicant for MassHealth on the basis of disability, whose income exceeds the MassHealth income standards, may become eligible through incurred and/or paid medical expenses of the applicant or any member of the MassHealth Disabled Adult Household as described in 130 CMR 506.009 The One-Time Deductible.

Duals Demonstration Dual Eligible Individual
This definition includes the provision that individuals enrolling in the duals demonstration cannot have "access to other insurance that meets the basic benefit level." This provision is inconsistent with the terms of the MOU which the Commonwealth signed with CMS on August 22, 2013. "Access to other insurance" is defined in these proposed regulations as the ability to obtain employer sponsored insurance meeting specified criteria. There is nothing in the MOU which excludes duals who could obtain employer sponsored insurance. Rather the MOU excludes duals who **have** "other comprehensive private or public health insurance." Moreover, the MOU provides that duals who are "enrolled in a Medicare Advantage plan, Program of All-inclusive Care for the Elderly (PACE), Employer Group Waiver Plans (EGWP) or other Employer-Sponsored Plans, or plans receiving a Retiree Drug Subsidy (RDS), and who meet the eligibility criteria for this Demonstration, may participate in this initiative if they choose to

disenroll from their existing programs." Thus access to employer sponsored insurance should not be listed a criteria excluding participation. This same language is repeated in 130 CMR 508.007(A) (c) and should be deleted from there as well.

Incarceration
The end of the sentence should be revised to read "who is returning to the institution for overnight stays."

Individual
This definition is inconsistent with the way the term individual is used elsewhere in the regulations. See, for example, 130 CMR 506.011(A)(1) concerning premium billing family groups.

Limited English Proficiency
We suggest this definition from the HHS OCR website: Persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language.

Lump Sum Payment
An inheritance is not a good example to use here as an inheritance is not normally taxable and thus not part of adjusted gross income. A lump sum payment is only countable income when it is MAGI income. We suggest the following: "A one-time only payment that represents either a windfall payment, such as gambling winnings, or the accumulation of recurring countable income …. Payments such as gifts, inheritances & personal injury awards, to the extent that they are not included in AGI, are not considered lump sum payments." We also comment on Lump Sum payments in the 506 rules.

Modified Adjusted Gross Income
Section 36B is in the Internal Revenue Code. MAGI is a key concept that we think can be more clearly explained by separately defining Adjusted Gross Income, MAGI as defined by the IRS, and MAGI as further modified by Medicaid. We suggest the following definitions.

> **Adjusted Gross Income** is defined in Section 62 of the Internal Revenue Code (IRC) and means the amount of income reportable on a U.S. Individual Tax Return (line 37 on Form 1040). It includes various types of income to arrive at Total Income, and then deducts certain expenses and pre-tax deductions to arrive at Adjusted Gross Income.
> **Modified adjusted gross income for purposes of the Connector** means Adjusted Gross Income increased by certain foreign earned income, tax exempt interest and nontaxable social security benefits. It is defined in IRC 36(B)(d)(2)(B), and is used to determine countable income for purposes of insurance affordability programs administered by the Health Insurance Connector
> **Modified adjusted gross income for purposes of MassHealth (MAGI)** means MAGI as defined in IRC 36(B)(d)(2)(B) but that counts a lump sum only in the month received, and does not count certain taxable scholarships, awards or grants used for educational purposes and certain taxable income received by American Indians and Alaska Natives It is defined in 42 CFR §435.603(e). This is use of term MAGI throughout these regulations.

Household Income is the sum of the MAGI-based income of every individual included in the applicant's or member's MAGI household or Disabled Adult household with the exception of children and tax dependents who are not expected to be required to file a return. It is defined in 42 CFR §435.603(d).

Parent
Change "adopted" to "adoptive"

Premium Assistance Payment
Add the following sentence to clarify this coverage. Employer-sponsored- health-insurance plans include both "Employer-Sponsored Insurance (ESI) 50% Plans" and "Other Group Insurance Plans" as described in 130 CMR 506.012.

Premium Billing Family Group
You have not previously defined family. This regulation would be clearer if (3) read: "A family making up a PBFG may consist of:… "

Qualified Health Plan
We suggest replacing "Marketplace" with "Massachusetts Health Connector" and omitting the last sentence.

Safe Harbor
This regulation as written is very hard to understand. We suggest quoting directly from the federal regulation 42 CFR 435.603(i) which is somewhat easier to follow: If the household income of an individual determined in accordance with this section results in financial ineligibility for Medicaid and the household income of such individual determined in accordance with 26 CFR 1.36B-1(e) is below 100 percent FPL, Medicaid financial eligibility will be determined in accordance with 26 CFR 1.36B-1(e) . We also suggest this term, once defined, be used in the Financial Eligibility regulations in 506.00.

Spouse
The definition should be revised in accordance with the Supreme Court's Windsor decision and the September 27, 2013 State Medicaid Director's letter. References to "the unavailability of federal financial participation" and to applications received before October 31, 2008 are no longer necessary or appropriate. We suggest that after your first sentence you add: "Massachusetts recognizes couples who are legally married under the laws of the jurisdiction in which the marriage was celebrated as spouses for purposes of MassHealth."

Tax Filer
To distinguish a "tax filer" from a "tax dependent" we suggest you also acknowledge that both spouses are tax filers if they are married filing jointly, and that a dependent who files a return but does not claim an exemption for him or herself and is claimed by another taxpayer is still a tax dependent. We suggest the following definition for a Tax Filer (as distinct from a Tax Dependent) : "Any individual, including his or her spouse if married filing jointly, who intends to file a federal tax return for the year in which a member of the tax household is seeking or receives benefits and who claims an exemption for him or herself. An individual who files a return but is claimed as a dependent by someone else is still a tax dependent. "

501.003 MassHealth Coverage Types

Remove reference to Family Assistance enrollment cap
501.003(C) authorizes enrollment caps in Family Assistance which covers children with family income at 150-300% of poverty, HIV positive individuals at 133-200% of poverty and certain immigrants. This authority should be limited to the Small Business Premium Assistance program not Family Assistance. Only the proposed coverage rules for Small Business Premium Assistance program refer to an enrollment cap, 505.009(C), the Family Assistance rules do not, 505.005. Setting and implementing enrollment caps would require an amendment to the 1115 Demonstration (STC IV, 24).

501.004 Administration of MassHealth

(B) Other Agencies
This section should include an explanation of the role of the Massachusetts Health Connector and explain that applications, eligibility determinations, information, verifications, and appeals are coordinated.

501.009 Rights of Applicants and Members

(A) Right to Nondiscrimination and Equal Treatment
This section should be updated to reference the ADA right to a reasonable accommodation, the Title VI right to language access and the right to be free from gender identity discrimination Chapter 199 of the Acts of 2011prohibits discrimination based upon gender identity in employment, housing, K-12 public education, and credit/lending. While not required here, this law sets the state standard concerning non-discrimination based upon gender identity, and should be adopted here by adding the phrase “gender identity” after the word “sex.”

The regulations should also include a process for requesting a reasonable accommodation and for making a complaint.

(F) Right to Be Assisted by Others
The change in the appeal representative language suggested above is particularly important as this section limits the ability to file appeals to appeal representatives, which should include an attorney acting on behalf of a client. We also recommend that “and appeal representative’s” be added to (4) of this section.

(G) Right to Inspect the MassHealth Case File
Add “including electronic data and information stored on computers” after MassHealth case file. It is important to provide access to information beyond what is kept in a paper file. See our earlier comment concerning the definition of case file.

502.000 The Request for Benefits

Clarify 502.001 and application dates to prevent gaps in coverage
Since the start date of eligibility is based on the date an application is received (see, for example 502.002(P)) clarity as to the receipt date of applications is important. 130 CMR 502.001 raises several questions about the date of application.

As discussed previously, the 501.001 definition of an application as including all required information and verifications including a disability supplement, could significantly postpone the coverage start date. While an eligibility determination may have to await a "complete" application, the date that a paper application form is received, or a telephonic, online or in-person application is submitted should be the application date and should protect retroactive eligibility.

Identity Proofing
The effect of a problem with identity proofing on the application date needs clarification. 502.001(2) provides that someone who is not successful in identity proofing, will be given 15 days to submit documentation proving identity. However, it is not clear whether this attempt to file an application is treated as a protective application filing date or whether the application is not considered filed until after identity proofing has occurred. It is our understanding from the CAC training that the identity proofing process is part of making an online account and the actual application cannot be completed until there has been successful identity proofing. We support treating the identity-proofing attempt as a protective filing date when documentation of identity is provided within 15 days. However, if the application date is not considered to occur until after documentation of identity is provided and the online application is completed, then we question what the purpose of the 15-day period is. We urge you to clarify what day is treated as the application date for purposes of determining the start date for eligibility in the case of a failed attempt at identity proofing. Clear notice should be provided to applicants of what that date is. If a failed attempt at identity proofing does not constitute an application date, then the notice should so inform the applicant and recommend filing a paper or in person application for eligibility that covers the past 10 days. Unless you intend a failed attempt at identity proofing to be a protective filing date, the notice should state that providing proof of identity within 15 days only means that the applicant will not have to start over in creating an online account, but that it will not protect an eligibility start date.

Allow all people applying in person to bypass identity proofing.

502.001(A)(2) states that identity proofing is not required if an applicant submits a paper application or applies in person at a MassHealth Enrollment Center (MEC). We request that MassHealth add that people applying in-person with a Navigator or Certified Application Counselor (CAC) also do not need to complete the identity proofing process. This process should not be needed for CACs and Navigators who are using their own accounts to submit applications. Without this capacity, it will impossible for hospital and health centers to use the on-line application process to obtain payment for the undocumented individuals they serve, and access to care may be restricted.

Incomplete applications
The eligibility filing date in the case of an incomplete application should also be clarified. We recommend adding " and the date that the incomplete application was received will be used to

determine the eligibility start date" to the first sentence in 130 CMR 502.001(A)(3)(c). Also, in this section change the reference to 130 CMR 502.001(E) to 130 CMR 502.001(A)(3)(b).

Disability Application Issues

Applicants who claim disability on an application should not be disadvantaged. Currently a disability determination can be necessary to receive comprehensive MassHealth coverage. With the advent of CarePlus and the ability to access MassHealth Standard through a medically frail designation, that is no longer true. Thus, applicants who allege disability on the application should not receive a lesser benefit while the application is pending. This possibility arises in a number of places for individuals claiming disability who not already been determined disabled by Social Security or MassHealth:

1. Is the completed disability supplement necessary for the application to be considered complete or is the disability supplement treated as a verification. If it is treated as part of an application and is not provided with 15 days, the application should be treated as complete without it and the date of filing should be the date that the application without supplement was filed. In most cases, this applicant will be eligible for some type of MassHealth coverage and thus the eligibility determination should not be delayed. If it is treated as a verification, we again recommend that eligibility be determined without it and that eligibility be upgraded if it is eventually received. Since a determination of disability is not necessary for MassHealth eligibility in most cases, lack of a disability supplement should not delay eligibility.

2. Your regulations indicate MassHealth will not accept a self-declaration of disability for purposes of provisional eligibility. In the case of a self-declaration of disability that is pending a MassHealth disability determination, we recommend that if all other eligibility criteria have been verified, an eligibility determination be made pending the disability determination. If other eligibility criteria require verification, then provisional eligibility should be granted based on the coverage the individual qualifies for without a disability determination.

3. While hospital presumptive eligibility is not available for MassHealth Standard based on disability, to the extent disability has not yet been determined by either SSA or MassHealth, the individual should be given presumptive eligibility for CarePlus.

Failure to Verify Disability, Breast and Cervical Cancer Status, or HIV-positive Status should not Prevent Eligibility for other Coverage

Individuals who allege any of these statuses are likely eligible for other MassHealth coverage. In the event that they do not verify such a status on application or redetermination, rather than being denied for failure to verify to verify, they should be approved for the coverage that they would be eligible for without the status and notified of the ability to upgrade coverage with verification.

Use reliable data to make a determination rather than denying or terminating benefits.

Where reliable data is not reasonably compatible with a self-attestation of income, but would enable the applicant to qualify for MassHealth benefits, and no corroboration of a lower income

amount is supplied on time, a determination should be made. This is the rule that applies to the Connector, 45 CFR 155.315(f)(5), and at continuing eligibility for MassHealth (Proposed 502.007). It would apply for example, if at application, a child's household income was attested to be under 150% FPL, but the data showed income over 150% but still under 300% FPL. Rather than deny the child any coverage, MassHealth should rely on the verified income amount. This is particularly important given the plan to repeal presumptive eligibility for children.

Clarify that verification of residency is only required when MassHealth obtains information that is not consistent with self-attested state residence.

502.003 states that state residence must be verified; this requirement is also in 503.002(E). However, it is our understanding that MassHealth is not requiring a data match verifying that the individual lives where he or she claims to live. Rather, MassHealth will check data sources for information that is inconsistent with the individual's attestation of residence, such as an address in a commercial building, and only then seek documentation to resolve the inconsistency. The rule should state that verification of residence will be required only where MassHealth obtains information inconsistent with the self-attestation of residence.

Clarify when provisional eligibility begins for children in 502.003(E).

For children, provisional eligibility must begin 10 days before the date of application and continue until at least 60 days or longer regardless of whether eligibility is later verified as now provided for in Presumptive Eligibility for Children (502.003 (C) rev. 9/1/2012). Otherwise, the repeal of Presumptive Eligibility for Children would violate the ACA's Maintenance of Effort requirement applicable to children's eligibility until 2019 or the expiration of the current 1115 demonstration in July 2014. The following example shows how certain children who are unable to complete verification on time will be disadvantaged if Provisional Eligibility only begins on the date of decision:

Child enters hospital on Day 1. Parent begin application on Day 3 and completes it on Day 5. The child is discharged on Day 10. MassHealth makes a determination on Day 14 (average processing time was 9 days as of Nov 2, 2013). The family does not submit verification by the deadline for doing so. Under Presumptive eligibility the child is eligible for the entire 10 day hospitalization and for 45 days of aftercare following discharge. Under Provisional eligibility the child is uninsured for the entire 10 day hospitalization period and for the first four days after discharge. The child is insured for 90 days starting after the fourth day of discharge. The family is not eligible for Health Safety Net.

Clarify what the reasonable opportunity period means.

502.003(F)-(G) provide for a reasonable opportunity to submit verification of self-attested US citizenship or an eligible immigration status. However, the rules fail to state that applicants will be found eligible and enrolled based on their self-attested US citizenship or eligible immigration status during the reasonable opportunity period as required by federal law.[1]

[1] 42 USC § 1320b-7(D)(4)(A)(ii) and 42 USC § 1396b(x)(4).

Include Family Assistance children in hospital determined presumptive eligibility.

We believe it was an error to exclude MassHealth Family Assistance children in the list of people who can be determined eligible for MassHealth through hospital determined presumptive eligibility. This population should be included.

Redefine the hospital determined presumptive eligibility period.

The rule misstates the end date of the hospital presumptive eligibility period. Pursuant to the federal rule at 435.1110, hospital determined presumptive eligibility (PE) will follow the same rules as PE for children at 435.1102. The children's PE rule is clear when the PE period ends: for an individual who files an application by the last day of the following month, it ends when the state agency makes a decision, and for an individual who does not file an application by the last day of the following month, it ends on that last day.

Because MassHealth has obtained a waiver of the mandatory Medicaid 3 month retroactive coverage period, it must adjust the start date for the shortened 10 day retroactive period to at least begin with the hospital PE determination. Otherwise patients will be worse off with presumptive eligibility than with regular eligibility. This does not require a waiver of the hospital PE rules which we understand CMS was reluctant to do, but an adjustment to the current waiver of the 3 month retroactive eligibility period. Hospital PE begins on the date the hospital makes the PE determination, but, to be fair, if an application is filed on time and the individual is determined eligible by the agency, eligibility should date back 10 days from the date of the hospital PE determination not the later date of application.

Treat a Hospital Presumptive Eligibility Determination as an Application Date
We are concerned that a hospitals' presumptive eligibility determination could delay the filing of an application. Since the application date is used to determine the eligibility start date and the 10-day retroactive period, any delay in filing an application could result in medical debt for which there is no source of payment. We propose that there be a protective filing date when an application is filed by the end of the month following the month that the hospital determined presumptive eligibility and the applicant is found to be eligible. The hospital's determination of presumptive eligibility should be treated as a protective filing date.

Clarify improvements to Eligibility Reviews.

We strongly support the improvements to the Eligibility Review process at 502.007, such as allowing for automatic renewals maintaining or upgrading benefits based on data matching. However, the rules should clarify the process for downgrading benefits. We assume this will require an opportunity to correct outdated or erroneous data and an advance notice.

We also strongly support the use of prepopulated forms for Eligibility Review Verifications (ERVs). However, the rule is not clear that the beneficiary remains eligible during the second 90 day period referred to in the rule where the ERV is returned on time but verifications are not. It is also not clear that if the ERV is returned after termination but without verifications whether there is still an opportunity for reinstatement back to the date of termination.

Clarify coverage end date in 502.006 (B)
We suggest rewording this to be consistent with the appeal regulations at 130 CMR 610.000. We propose adding the following before for the first sentence of 502.006(B) End Date of Coverage: "Before termination or reduction of benefits, the MassHealth agency must send a timely notice to the member except as provided in 130 CMR 610.027. A timely notice is a notice mailed at least 10 days before the action."

The reference to aid pending appeal should also be revised, as aid pending does not have to be requested but rather is given automatically unless the appellant affirmatively declines it.

We strongly support your decision to continue coverage to the end of the month for individuals who become eligible for premium tax credits.

503.000 Universal Eligibility Requirements

Clarify Residency Verification Requirements in 503.002(E) and (F)
We strongly support the fuller statement of residency requirements in 503.002 (A)-(D). With respect to the verification of residence in (E), we recommend that the language of the rule more closely correspond to the nature of the available electronic data which may be inconsistent with the self-attestation of residence but cannot verify a specific address. We suggest that in (E)(1) instead of saying residency "has been confirmed" by electronic means, the rule say residency "has not been contradicted." In (E) (2) omit the phrase "residency cannot be verified through electronic data matching or" and say instead " if there is conflicting information about residency based on electronic data or other information" the agency may require documentation.
In (F)(10) we recommend that you replace the requirement that an affidavit be notarized with the requirement that the affidavit be signed under pains and penalties of perjury. Affidavits signed under pains and penalties of perjury are acceptable verification of other eligibility factors in MassHealth such as citizenship and identity in 504.005(A)(2)(r), and are generally accepted in Massachusetts courts. Requiring that an affidavit be notarized adds the practical difficulties of locating a notary, persuading the affiant to travel to the notary's office, and possibly having to pay the notary, without increasing the reliability of the document.
We appreciate that the examples of verification of residence recognizes a statement from a homeless shelter and an affidavit. Other examples that it would be helpful to include are: any government issued identification that includes the individual's Massachusetts address such as a current driver's license or any statement from a homeless service provider who can attest that an individual who is living outside lives in Massachusetts.

Clarify Social Security Number Requirement in 503.003
We strongly support the amendment identifying exceptions to the SSN requirement. This should eliminate the problem of lawfully present children who are not eligible for SSNs being erroneously denied or terminated from benefits. However, in (A)(3) we request that you clarify the meaning of a reasonable opportunity period. We make a similar comment on the reasonable opportunity to supply proof of citizenship or eligible immigration status in 502. The rule should make clear that benefits will not be delayed or denied during the reasonable opportunity period.
We also appreciate the helpful clarification of the good cause criteria in 503.004.

Limit assignment to the amounts permitted under federal law
The Supreme Court has recently affirmed and expanded on its earlier holding on the scope of the Medicaid agency's right to recover medical expenses from a beneficiary's award or settlement for a loss. Woe v. E.M.A., U.S. (Mar. 20, 2013); Arkansas DHHS v. Ahlborn, 547 U.S. 286 (2006). The Medicaid agency's right to recover is limited to that portion of the award or settlement which includes payment for medical expenses paid by the Medicaid agency. Medicaid cannot recover from the portion of an award or settlement compensating for other losses or expenses such as lost wages, pain and suffering or property damage. In 503.006(4) the limitation on repayment to MassHealth benefits provided as a result of the accident or incident applies in all cases not just when the individual was already on MassHealth at the time of the accident, and repayment is further limited to that portion of the proceeds compensating the beneficiary for medical expenses paid by MassHealth.

Clarify Potential Sources of Health Care in 503.007
The rule should clarify that an individual must obtain and maintain insurance as condition of remaining eligible for MassHealth "when notified to do so in accordance with 130 CMR 505.000."

504.000 Citizenship and Immigration

504.003 Immigrants

Modify terminology to be less confusing & avoid stigma for ILP and Undocumented non-citizens
Distinguishing the terms Lawfully Present and Immigrant Lawfully Present, both of which are new in MassHealth will be a source of confusion in an already confusing area of law. We suggest using the term "Individual Lawfully Present NonQualified" instead of Immigrant Lawfully Present. While it is admittedly an awkward phrase, it accurately distinguishes the ILP lawfully present immigrants, all of whom are NonQualified, from those who are Qualified and Qualified Barred in a way that Immigrant Lawfully Present does not. It also has the advantage of enabling use of the same initials that we understand are already programmed into the system, ILP. While there may be some confusion between the ILP Nonqualified and the Nonqualified PRUCOL, we think this will be less confusing than that between Lawfully Present Immigrant and Immigrant Lawfully Present. It is helpful that all Qualified immigrants will now be called Qualified, but troubling that people may assume Qualified Barred are Barred from all MassHealth programs and speaks to the need to be very clear in these regulations and other published materials about what this term means.

We also recommend that MassHealth use the term "Other" instead of undocumented. Many undocumented individuals live in fear of discovery and deportation, and having themselves identified in a government system as undocumented will likely deter them from seeking coverage for emergency care and the few safety net programs which provide basic services to pregnant women and children, as well as the Health Safety Net.

CMS appears to be using the term non-citizen in place of immigrant or alien, and we recommend that MassHealth do the same. Many find the connotations of "strangeness" in alien to be offensive, and immigrant is not a good substitute in programs that are now available to individuals with "nonimmigrant" statuses.

Lawfully Present Immigrants 504.003 (A), (B) and (C)

Simplify the language and use examples to clarify the concept of Lawfully Present Noncitizens.

We urge you to revise these regulations in a way that makes them easier to understand. This is how we recommend doing so:

(A) Qualified Noncitizens, Qualified Noncitizens Barred, and Individuals Lawfully Present Nonqualified are considered lawfully present noncitizens. The rule at 504.006 describe the coverage types for which they may be eligible.

(1)There are two groups of Qualified Noncitizens described in section (1): (a) those who are Qualified regardless of when they entered the U.S. or how long they have had a Qualified status, and (b) those who are Qualified based on having had a Qualified status for 5 or more years or meeting an exception to the 5-year bar. Qualified noncitizens may be eligible for MassHealth Standard and other coverage types as described in 504.006.

(a) Noncitizens who are Qualified regardless of when they entered the US or how long they have had a Qualified status are

1. Persons granted asylum under section 208 of the Immigration and Nationality Act(INA);
2. Refugees admitted under section 207 of the INA;

Etc.

[Note in describing Cuban Haitian Entrants change "entered" to "are" since CHE may have been obtained after arrival]

(b) Noncitizens who are Qualified based on having had a Qualified status for 5 or more years or meeting an exception to the 5-year bar are

(1) persons who have one of the three following statuses at the time of application

(i) Persons admitted for legal permanent residence under the Immigration and Nationality Act (LPR or green card holder);

(ii) Persons granted parole for at least one year under section 212(d)(5) of the INA; or

(iii) Persons who are a battered spouse, battered child or child of a battered parent or parent of a battered child who meet the criteria of 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, 8 USC § 1641, and also

(2) satisfy at least one of the three following conditions:

(i) they have had a status in (b)(1) for five or more years;

(ii) they entered the U.S. prior to August 22, 1996, regardless of status at the time of entry, and have been continuously present in the U.S. until attaining a status listed in (b)(1), for this purpose an individual is deemed continuously present who has been absent from the U.S. for no more than 30 consecutive days or 90 nonconsecutive days prior to attaining a status listed in (b)(2), or

(iii) they also have or had a status listed in (a).

Example of (i): Sophia entered the US and married a US citizen who beat her and refused to file an immediate relative petition on her behalf. She left him and filed a petition on her own under the Violence Against Women Act. Her petition was found by USCIS to establish a prima facie case over 5 years ago. She became a legal permanent resident 4 years ago. Sophia is a Qualified Alien. She became a Battered Immigrant when her petition was accepted as establishing a prima facie case. Five years have now passed since her Battered Immigrant status was attained even though she has only been a legal permanent resident for four years.

Example of (ii): John entered the US in 1995 as a tourist and remained living in the US as an undocumented person until last year when he became a legal permanent resident. John is a Qualified noncitizen because he entered the US prior to Aug. 22, 1996 and was continuously present until attaining his LPR status.

Example of (iii). Marie is a Haitian citizen who was paroled into the U.S. after the earthquake in 2010. She became a legal permanent resident last year. Marie is Qualified as a Cuban Haitian Entrant because she is Haitian, and was paroled into the US after 1980. She continues to be a Qualified Noncitizen now that she is a lawful permanent resident; she is not subject to the 5-year bar.

(2) Qualified Noncitizens Barred are persons who have a status listed in (b)(1) (legal permanent resident, parolee for at least one year, or battered immigrant) and do not meet one of the conditions in (b)(2). Qualified Noncitizens Barred, like Qualified Noncitizens, are Lawfully Present Immigrants. Qualified Noncitizens Barred who are under age 21 or pregnant may be eligible for MassHealth Standard and other coverage types as described in 504.006.

(3) Individuals Lawfully Present Nonqualified are not defined as Qualified under PRWORA of 1996, 8 USC § 1641 but are lawfully present. Individuals Lawfully Present Nonqualified who are under age 21 or pregnant may be eligible for MassHealth Standard and other coverage types as described in 504.006. Noncitizens who are Individuals Lawfully Present NonQualified are as follows:

(a) In a valid nonimmigrant status etc.

The rules should provide more explanation about and examples of certain statuses
Some eligible statuses are straightforward and will be readily verified by electronic data matching. Other statuses may not appear in immigration databases at all such as certain American Indians, or Trafficking victims. Still other statuses may appear in immigration data bases as Paroled or Legal Permanent Residents, but more information from other sources will be needed to determine if the individual was a Cuban Haitian Entrant, Amerasian, Veteran, or Battered Immigrant. Application assisters and applicants will all need to better understand these concepts in order to supply the necessary documentary information, and MassHealth workers will need to understand these concepts in order to properly interpret the documents. We urge you to supply more explanatory information than just a citation to a federal statute.

Also some of the lawfully present statuses are new, such as non-immigrants, and more detail will be helpful to explain the variety of nonimmigrant statuses. We urge you to supply more detailed information

Update references to Nonqualified PRUCOL in 504.003(C)
The Medicaid program used the concept of Persons Residing Under Color of Law (PRUCOL) prior to the enactment of PRWORA in 1996. The federal regulations on PRUCOL at 42 CFR 435.408(b)(3), has been repealed. It can still be located of course, but it would be helpful to add after the citation "prior to its repeal and as interpreted by Cruz v. DPW, 395 Mass. 107 (1985)." To make clear that all the examples of PRUCOL are only for individuals not otherwise listed in 504.002(A) and (B) we suggest that the introduction be one sentence as follows:

> "Certain noncitizens who are not described at 130 CMR 504.003(A) or (B) may be permanently residing in the United States under color of law as described in 42 CFR 435.408(b)(3) prior to its repeal and as interpreted by Cruz v. DPW, 395 Mass. 107 (1985). If not otherwise described in 504.003(A) or (B) the following are considered PRUCOL:

Also some of the individuals listed in (C) may be lawfully present if they have employment authorization. We suggest clarification for (5) aliens under supervision and (8) asylum applicants as follows:

> (5) Noncitizens under orders of supervision who do not have employment authorization under 8 CFR 274a.12(c);
>
> (8) Individuals with a pending application for asylum under 8 USC 1158 or for withholding or removal under 8 USC 1231 or under the Convention against Torture who have not been granted employment authorization, or are under the age of 14 and have not had an application pending for at least 180 days;

Finally, we suggest adding an additional example of PRUCOL for "Noncitizens who have filed an application, petition or request to obtain a lawfully present status that has been accepted as properly filed but who have not yet obtained employment authorization and whose departure DHS does not contemplate enforcing."

Clarify that the rules in 504.004 (A) and (B) supersede inconsistent rules at 502.001(D) and 502.003(D)

The Verification rules provide that individuals who are unable to verify US citizenship or an eligible immigration status may still qualify for benefits available regardless of citizenship or status in 504.004. However, the general verification rules at 502.001(D) and 502.003(D) provide that an individual who fails to verify an eligibility factor including citizenship or immigration status will be denied. To make clear that the denial mandated by the 502 regulations does not apply to the specific kinds of benefits for which an individual may be eligible in 504.004, we suggest adding the phrase, "Nothwithstanding the rules in Section 502" to 504.004(A)(2), (A)(3), and (B)(3).

Clarify the reasonable opportunity period in 504.004(C)

As we suggest in our comments on 502.003(F) and (G), the regulations should explain that during the reasonable opportunity period the individual is eligible for MassHealth coverage on the basis of the individual's self-attested US citizenship or eligible immigration status. This is how the term is used in federal law which prohibits benefits from being delayed or denied during a reasonable opportunity period. 42 USC 1320b-7(D)(4)(A)(iii) and 1396b(x)(4).

Clarify that citizens must provide proof of citizenship and identity only if data matching is unable to provide verification in 504.005

In the first instance, MassHealth seeks verification of US citizenship and an eligible immigration status from the federal data hub, individuals are required to provide documentary proof as described in this section only if data matching is not successful. This should be stated in the rule.

Provide examples of acceptable proof of immigration status in 504.005

CMS has released a list of documents in a recent on-line publication at https://www.healthcare.gov/immigration-status-and-the-marketplace/

We suggest at least listing the documents identified by CMS as examples of documents that may be required or used depending on the individual situation:

- Permanent Resident Card, "Green Card" (I-551)
- Reentry Permit (I-327)
- Refugee Travel Document (I-571)
- Employment Authorization Card (I-766)
- Machine Readable Immigrant Visa (with temporary I-551 language)
- Temporary I-551 Stamp (on passport or I-94/I-94A)
- Arrival/Departure Record (I-94/I-94A)

- Arrival/Departure Record in foreign passport (I-94)
- Foreign Passport
- Certificate of Eligibility for Nonimmigrant Student Status (I-20)
- Certificate of Eligibility for Exchange Visitor Status (DS2019)
- Notice of Action (I-797)
- Document indicating membership in a federally recognized Indian tribe or American Indian born in Canada
- Certification from U.S. Department of Health and Human Services (HHS) Office of Refugee Resettlement (ORR)
- Office of Refugee Resettlement (ORR) eligibility letter (if under 18)
- Document indicating withholding of removal
- Administrative order staying removal issued by the Department of Homeland Security
- Alien number or 1-94 number

To be more complete this section could go on to list the following: including but not limited to documents issued by the U.S. Department of State, U.S. Department of Justice (including Executive Office for Immigration Review, Board of Immigration Appeals and former Immigration and Naturalization Service), U.S. Department of Homeland Security (including U.S. Citizenship and Immigration Services, Immigration and Customs Enforcement or Customs and Border Protection), U.S. Department of Health and Human Services, or a federal, state or local government agency with authority to provide certification such as supplement B to an I-914 or I-918.

We strongly support 504.006 on Applicable Coverage Types
Section 504.006 lists coverage options for both lawfully present immigrants and nonqualified PRUCOL. We strongly support the state's decision to honor the principle of equality embodied in our state Constitution by providing comprehensive coverage to all lawfully present and color of law immigrants.

As discussed earlier, we also urge you to replace the term "undocumented" in 504.006(D) with Other Noncitizens including the undocumented

We also suggest that this section should contain some reference to individuals who will be eligible for ConnectorCare or QHPs with Advance Premium Tax Credits through the Health Insurance Connector Authority. We suggest the following:

> All Qualified, Qualified Barred and Individuals Lawfully Present Nonqualified noncitizens who are not eligible for MassHealth Standard, CommonHealth, CarePlus or Family Assistance, may be eligible for assistance paying for private insurance coverage through the Health Insurance Connector Authority.

505.000 MassHealth Coverage Types

Add "certain non-citizens" to Family Assistance description in 505.001 (A)(4)
Certain non-citizens who are NonQualified PRUCOL, and disabled poverty level adults who are Qualified Barred and Immigrant Lawfully Present are also eligible for Family Assistance. The summary should mention them. We suggest just adding the phrase "certain non-citizens."

Clarify MassHealth Standard eligibility 505.002

Remove custody as an eligibility requirement for parents and caretaker relatives in (C)
While not new, the requirement that a separated or divorced parent have custody of a child in addition to living with the child is not consistent with the federal regulations. Federal regulations defining caretaker relatives and parents only require that they be living with the child. 42 CFR 435.4. The current state regulation includes this custody requirement, but no question on the application asks about custody. We recommend the requirement that a separated or divorced spouse also have custody be eliminated. (The concept of custody does arise in determining the MAGI household when a noncustodial spouse claims an exemption for the child, and in our comments on 501 we suggest that the definition of custodial parent be changed to a definition of noncustodial parent for purposes of the MAGI rules).

Clarify that people only need to be eligible for DMH services not receiving them in (I).
The rule provides for eligibility for people receiving services from the Dept. of Mental Health. However, it should describe people eligible for services from DMH whether receiving services or not including those on any wait list.

Allow for Medically Frail to be enrolled directly into Standard in (J).
The rule at (J)(5) requires that a Medically Frail individual first be determined eligible for CarePlus. This wording locks MassHealth into the cumbersome process of first enrolling a person in CarePlus and then allowing them to disenroll and enroll in Standard instead. It should instead say that the person "meets the eligibility criteria for CarePlus and has elected to receive MassHealth Standard benefits." This suggested wording allows flexibility for medically frail individuals to be identified at the time of application and enroll directly into Standard.

Clarify when MAGI household applies to eligibility for Transitional Medical Assistance in (L)(3)(a).
MAGI is used to determine financial eligibility, it is not used for purposes of determining categorical eligibility as a parent or child. For purposes of TMA, the MAGI household is relevant to determining when a parent or caretaker relative with earnings has income that exceeds 133% FPL, but it is not relevant to determining whether there is still a child living with a parent. A child may not be in the parent's MAGI household if claimed by a non-custodial parent, but the family would still be eligible for TMA if the child is living with the parent. Strike "MassHealth MAGI" from (L)(3)(a).

Clarify Medicaid Coverage Dates in (P)(3).
It is not clear how the coverage date rules described in (P)(1) and (2) apply to someone who receives Provisional Eligibility under (P)(3). It would be helpful if the rule explained both when

Provisional Eligibility begins, 90 days from what? And in what circumstances an individual who is initially determined Provisionally Eligible will have a medical coverage date going back 10 days from application as described in (P)(1) or from the receipt of late information as described in (P)(2).

505.004 CommonHealth

Include Nonqualified PRUCOL Young Adults under 150% FPL in 505.004
The proposed rules generally create a new group of 19 and 20 year old Young Adults who have coverage equivalent to children and youth under 19 if family income does not exceed 150% FPL. Based on this new treatment for 19 and 20 year olds, Disabled Young Adults with income under 150% FPL who are Nonqualified PRUCOL, should be eligible for CommonHealth without a one-time deductible like the children and youth under 19. We suggest adding a new subparagraph for Nonqualified PRUCOL Young Adults with income under 150% FPL that does not have either a one-time deductible or work requirement.

The proposed rule includes all Nonqualified PRUCOL Young Adults with income under 150% FPL-- whether working or not-- with Disabled Young Adults in 505.004 (E) who are subject to the one-time deductible. The rule should at least provide CommonHealth without a spenddown for Disabled Working Young Adults who are NonQualified PRUCOL under 150% FPL in 505.004(D).

505.005 Family Assistance

We strongly support the improvements in Family Assistance for children in 505.004(B).
The changes in eligibility for children from 200-300% FPL: eliminating the 6 month crowd out waiting period, and authorizing Premium Assistance for insured children are welcome. These changes should enable more children to get insurance and to remain covered.

Clarify when individuals are required to enroll in private insurance in Standard at 505.002(M) and (N), CommonHealth at 505.004(J) and(K) and CarePlus at 505.008(C)and (D).
Individuals in Standard, CommonHealth cannot be required to enroll in Medicare and in Standard, CommonHealth or CarePlus in private insurance unless there is no added cost either because the other insurance charges no more than the individual would have paid with MassHealth primary or because MassHealth fully reimburses the member for any added cost. The rule does not make this clear. The cross-reference to purchased insurance in accordance with 506.012 in particular falls short because 506.012 requires the member to pay more than the MassHealth required member contribution in 506.012(D)--the amount due if the member had no access to health insurance-- if the estimated premium assistance amount is higher than the cost-effective amount.

The subsection on Potential Health Insurance and Access to ESI in MassHealth Standard at 505.002(M) and (N), CommonHealth at 505.004(J) and (K), and CarePlus at 505.008 (C) and (D), all have the same basic wording and the same problem. All should be amended in similar

ways to make clear that a member cannot be required to enroll in insurance that, after Premium Assistance, will cost more than MassHealth without access to insurance.

In Standard, for example, the rule at 505.002(M) would be more accurate if it said that a person: " must enroll in health insurance, including Medicare, if available at no greater cost than he or she would pay in MassHealth Standard without access to health insurance ; this includes health insurance available at no greater cost after purchase by MassHealth in accordance with 130 CMR 505.002(O) or 506.012.

The same problem exists with reference to the rule on access to employer sponsored insurance at 505.002(N. The following provision should be added to (N)(1)(b) "; provided that:

(c) after MassHealth helps pay for insurance, it will be available at no greater cost than the individual would pay in MassHealth Standard without access to insurance."

Eliminate the requirement that EAEDC recipients be "uninsured" to be eligible for Standard in 505.002(K), CarePlus in 505.008(B) and Family Assistance in 505.005(G).
EAEDC recipients are automatically eligible for MassHealth based on the EAEDC determination by DTA and DTA has no "uninsured" requirement for EAEDC. Further, all EAEDC recipients, if they applied independently for MassHealth, would be eligible without an "uninsured" requirement for children in Standard, adults in CarePlus and certain immigrants in Family Assistance. The requirement that EAEDC recipients must be uninsured should be removed.

505.006 MassHealth Limited

Provisional Eligibility should be available in Limited
There is no mention of Provisional Eligibility in the subsection on Medical Coverage Dates in (D). Provisional Eligibility should be available in Limited –particularly since it is available in the Health Safety Net.

505.008 MassHealth CarePlus.

Clarify and improve the Medically Frail standard at 505.008(F).
The rule does not describe how an individual may be determined medically frail. It should explain that an individual who identifies himself as medically frail at the time of application has made an election for Standard, and if otherwise eligible will be enrolled in Standard. It should not be necessary for an individual to wait to enroll in a type of coverage that will not meet his needs, and then to disenroll and reenroll in the appropriate coverage type . We also address this in our comments on 505.002.

The rule should further provide that an individual determined eligible for CarePlus will be notified of the criteria in 505.008(F) and the process for obtaining a determination that an individual is medically frail. The rule should further provide that if at any time after being determined eligible for CarePlus, an individual is determined medically frail, the person will be offered the opportunity to enroll in Standard.

Also it should be provided that a person who disenrolls from CarePlus based on medical frailty has cause to disenroll pursuant to the managed care rules and should be able to enroll in Standard right away. We make a similar comment on the managed care rules at 508.

The rule should also explicitly provide that individuals who are eligible for EAEDC on the basis of disability are medically frail or persons with special medical needs as defined in this section and will be offered an opportunity to enroll in Standard. To be disabled under the EAEDC standard, an individual must be totally disabled for a period expected to last 60 days or more. In addition, the rule should provide that MassHealth may also identify individuals as medically frail based on a record of high utilization of mental health, substance use or other behavioral or medical health services.

Finally, we note that one rationale given for restricting home nursing services in CarePlus is to better identify the medically frail. While we believe this is not a wise policy, if MassHealth retains restricted home nursing benefits it should specifically recognize that people who need such services are medically frail. Given how narrow the home nursing coverage is in CarePlus this means that the rule should provide that the following individuals are medically frail: Any individual for whom a home nursing visit is medically necessary after discharge from outpatient treatment or a rehabilitation or chronic care hospital or skilled nursing facility or for whom more than 14 days of home nursing are medically necessary after an acute inpatient discharge.

506.000 Financial Requirements

506.001 Introduction

Describe how the MAGI methodology will be applied to current beneficiaries
Pursuant to Section 2002 of the ACA and 42 CFR 435.603(a)(3) the rule should state that in the case of ongoing eligibility for beneficiaries who were determined eligible for MassHealth on or before Dec. 31, 2013, and would lose eligibility based on the application of MAGI methodology, the MAGI methodology described in this section will not be applied until March 31, 2014 or the next regularly scheduled annual review, whichever is later.

506.002 Household Composition

Correct errors in CommonHealth cross-references in 506.002(A).
This section describes which coverage groups are governed by the MAGI Household Composition Rules at (A)(1) or the Disabled Adult Composition Rules at (A)(2). It is our understanding that disabled young adults with income over 150% FPL and disabled adults should be subject to the Disabled Adult Household Composition Rules and young adults with income under 150% FPL, children 1-18, and 18 year olds, should be subject to the MAGI Household Composition Rules. To accomplish this, (A)(1)(b) should strike the reference to 505.004(C) (Disabled Adults), and add a reference to the Non-qualified PRUCOL Young Adults

with income under 150% FPL as described in 505.004(D) and (E).[2] Section 506.002(A)(2) (b) should add a reference to 505.004(B) (Disabled Working Adults), and specify that the reference to 505.004(D)and (E) Young Adults exclude Non-qualified PRUCOL with income under 150% FPL. Also, 506.002(A)(2)(c) refers to the correct section, 505.005(F), but gives it the wrong title.

Clarify definition of tax payer in 506.002(B)(1).
The reference to a tax payer in (1) should say:

(a) The tax payer <u>including the spouse if the tax payers are married and filing jointly regardless of whether they are living together</u>;
(b) The tax payer's spouse, if living with him or her<u>, regardless of filing status</u>;

The Internal Revenue Code (IRC) considers both spouses who file a joint tax return to be tax payers whether or not they live together. IRS Pub. 501. We make a similar point regarding the definition of tax filer in 501.

Clarify that the household in 506.002(C) consists only of those living together.
The description of the members of a Disabled Adult household should specify that the family members in (2)-(4) must be living together with the disabled adult individual.

506.003 Countable Household Income.

Provide a clearer explanation of the basic concept of Countable Household Income using MAGI methodology.
The introduction to this section is not clear. It says that all applicable rules are described in this section, and that the income and deductions are found on the US Tax Return. However, the MAGI-based income methodology is largely defined in federal Medicaid regulations and the Internal Revenue Code, and several provisions in 506.003 are not consistent with the governing federal law as described further below. There are very few state options within the MAGI methodology. Further, the income and deductions on the US Tax Return are modified in MAGI which the reference to "income and deductions found on a US tax return" fails to explain. It is particularly important that the MassHealth rules provide clear and accurate information on MAGI since many MassHealth applicants will have income below tax filing thresholds and will not have a tax return to rely on in identifying taxable income.

We suggest the following introduction to the concept of Countable Household Income using MAGI methodology.

> The rules in 506.003 and 506.004 describing countable income and noncountable income apply to both MassHealth MAGI households and MassHealth Disabled Adult households. Countable income is based on Adjusted Gross Income with modifications as defined in 36(B)(d)(2)(B) of the Internal Revenue Code (IRC) and as further modified in 42 C.F.R. § 435.603(e) for purposes of MassHealth.
>
> Adjusted Gross Income is the amount of income reportable on a U.S. Individual Tax Return. It includes various types of income to arrive at Total Income, and then deducts certain expenses and pre-tax deductions to arrive at Adjusted Gross Income.

[2] 505.004(E)includes a reference to the Nonqualified PRUCOL under 150% FPL; 505.004(D) does not, but should as we note in our comments on that section.

The term "modified adjusted gross income", as defined by the IRC, means Adjusted Gross Income increased by certain foreign earned income, tax exempt interest and nontaxable social security benefits. As further modified for purposes of MassHealth eligibility, MAGI counts a lump sum only in the month received, and is decreased by the amount of certain taxable scholarships, awards or grants used for educational purposes and certain income received by American Indians and Alaska Natives as described in 42 CFR §435.603(e).

A MAGI-based income determination requires determining the household of each individual applying for benefits as described in 130 CMR 506.002. With the MAGI methodology, individuals within a family may be in different MAGI households.

A household's countable income is the sum of the MAGI-based income of every individual included in the individual's household with the exception of children and tax dependents who are not expected to be required to file a return as described in 42 CFR 435.603 and 130 CMR 506.004(K). (Children and tax dependent's whose income is not counted will still be counted in determining family size). A household's countable income is further reduced by 5 percentage points of the Federal poverty level for the applicable family size to determine eligibility under the eligibility group with the highest income standard as described in 506.007.

Countable income includes earned income described in 506.003(A) and unearned income described in 506.003(B) less deductions described in 506.003(C). Countable income does not include noncountable income described in 506.004.

MassHealth will not assess an overpayment against any individual who was correctly determined eligible in accordance with the rules in 506.003 and 506.004 even if these rules are later determined inconsistent with the governing federal rules.

(A) Earned income

Clarify that the earned income of a self-employed person may be a profit or loss.
Currently MassHealth counts income from self-employment as a positive amount or as zero but does not recognize a loss. For tax purposes either a profit *or loss* from self-employment --as determined after application of deductions allowable on schedule C or C-EZ--are included in the calculation of AGI. We suggest the following wording:

(2) Profit or loss from self-employment is the total amount of annual profit or loss from self-employment after deducting business expenses listed or allowable on a US tax return.

We also note that the Application Form section on self-employment income should be amended to indicate that self-employment income may be a loss. Currently, the application form does not suggest that a loss may be recorded or show how to do so.[3]

[3] The Application Form also reflects confusion about self-employed income, possibly related to individuals completing tax forms incorrectly. To address these problems with the Application Form, we suggest that the instructions under the Current Job and Income Information section of the Application Form should instruct self-employed people to also complete the Current Job section "if they receive wages that would be reported on line 7 of Form 1040" not if they "pay themselves wages." Similarly, the parenthetical in the Self-employed Income section

We have not checked the treatment of losses from S-Corporations or Partnerships.

Account for predictable changes in more types of future income than just seasonal income. The seasonal income rule at 506.003(4) is an exception to the general Medicaid rule of counting current monthly income and provides an alternative to churning off and on Medicaid for individuals who have predictable fluctuations in future income based on seasonal employment. The federal regulations at 42 CFR 435.603(h)(3) gives state agencies the flexibility to adopt reasonable methods to pro-rate predictable future increases or decreases in income based on situations other than seasonal income. We urge MassHealth to take advantage of this opportunity to avoid churning by adopting at least the two examples of predictable changes in income described in the federal rule: Individuals who have a contract of employment for only part of the benefit year; and individuals who have a clear history of predictable fluctuations in income.

(B) Unearned income

Clarify the use of veterans' benefits and tax refunds as examples of unearned income. Benefits distributed by the Veterans' Administration that are currently counted as gross income in MassHealth are not counted in Adjusted Gross Income; therefore "veterans' benefits" are not a good example of countable unearned income. Nontaxable veteran's benefits include a VA disability pension, and go beyond the specific types of veteran's benefits listed in 506.004(C). The proposed rule at 506.004 describes only the same veterans' benefits that MassHealth currently excludes. We suggest striking the reference to federal veterans' benefits in 506.003(B)(2), and expanding the description of noncountable veterans' benefits in 506.004(C). The following is from IRS Publication, 525 on Taxable and NonTaxable Income:

> **Veterans' benefits.** Do not include in your income any veterans' benefits paid under any law, regulation, or administrative practice administered by the Department of Veterans Affairs (VA). The following amounts paid to veterans or their families are not taxable.
>
> - Education, training, and subsistence allowances.
> - Disability compensation and pension payments for disabilities paid either to veterans or their families.
> - Grants for homes designed for wheelchair living.
> - Grants for motor vehicles for veterans who lost their sight or the use of their limbs.
> - Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death.
> - Interest on insurance dividends left on deposit with the VA.
> - Benefits under a dependent-care assistance program.
> - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001.

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that now says (Do not include wages and tips), should instead say, (Do not include wages and tips included in the Current Job income section that would be reported on line 7 of Form 1040).

- Payments made under the compensated work therapy program.
- Any bonus payment by a state or political subdivision because of service in a combat zone.

Tax refunds included in AGI generally consist of refunds of state or local taxes for individuals who itemize deductions that included state of local taxes in the previous year. Listing "tax refunds" as an example of unearned income is likely to create the incorrect impression that federal tax refunds are included in countable income. We suggest that you either strike the reference to tax refund, or specify "a state or local tax refund for a tax you deducted in the previous year."

The following is from IRS Publication, 525 on Taxable and NonTaxable Income under Recoveries:

> **Federal income tax refund.** Refunds of federal income taxes are not included in your income because they are never allowed as a deduction from income.
>
> **State tax refund.** If you received a state or local income tax refund (or credit or offset) in 2012, you generally must include it in income if you deducted the tax in an earlier year.

506.004 Noncountable Household Income

Expand the examples of noncountable veteran's benefits in 506.004(C).
See discussion above.

Clarify that the treatment of income received as a lump sum in 506.004(I) only applies to income otherwise included in AGI.
The federal rule that provide for counting a lump sum in the month of receipt and not as prorated annual income was not expanding the definition of what is included in Modified Adjusted Gross Income as defined by the IRC. The lump sum rule only applies to income that is otherwise taxable. 42 CFR 435.603. The definition of lump sum in 501 erroneously lists income that is not included in AGI such as in inheritances or legacies.

The following is from IRS Publication, 525 on Taxable and NonTaxable Income:

> **Gifts and inheritances.** In most cases, property you receive as a gift, bequest, or inheritance is not included in your income. However, if property you receive this way later produces income such as interest, dividends, or rents, that income is taxable to you. If property is given to a trust and the income from it is paid, credited, or distributed to you, that income is also taxable to you. If the gift, bequest, or inheritance is the income from the property, that income is taxable to you.

In addition to correcting the definition of lump sum as we suggest in our comments on 501, we suggest amending 506.004(I) to say: "Taxable amounts received as a lump sum, except in the month received;"

Clarify when children and tax dependents may be required to file a return in 506.004(K).
It will be helpful to provide a brief explanation of when a child or tax dependent may be required to file a return. We suggest: "A tax dependent is required to file a return when his or her earned or unearned income exceeds a certain threshold amount. A tax dependent may choose to file a return in order to claim a refund or for other purposes, but if not required to file, his or her income will not count."

The Application Form asks for each person applying if that person plans to file a return and if that person will be claimed by anyone else as a tax dependent. In accordance with the rule at 506.004(K) and 42 CFR 435.603, persons who will *not* file a return and *are* claimed as tax dependents or are the children of non-filers should not have any of their income counted in the MAGI income for the household. It is our understanding that this is not how HIX-IES has been programmed. This programming error should be corrected as soon as possible.

Add payment to foster care providers as an example of noncountable income.
In most cases payments to foster care providers, including adult foster care providers, will not be taxable income. This is a helpful example to include in the list at 506.004.
The following is from IRS Publication, 525 on Taxable and NonTaxable Income

> **Foster care providers.** Payments you receive from a state, political subdivision, or a qualified foster care placement agency for providing care to qualified foster individuals in your home are not included in your income in most cases. However, you must include in your income payments received for the care of more than 5 individuals age 19 or older and certain difficulty-of-care payments.

We also suggest that you clarify that income in kind is not countable "except when provided as compensation for employment." Certain other examples of income not currently counted in MassHealth may also require limiting language to more accurately reflect MAGI.

Add the safe harbor rule to the 506.004 Regulations
Section 501 includes a definition of the Safe Harbor Rule. In our comments on 501 we suggest ways to clarify the definition. The definition should also be used somewhere in the operative sections of the regulations such as the 504 Regulations on Financial Requirements. We suggest the following language:

In accordance with the Safe Harbor Rule at 42 CFR 435.603(i),an individual will be deemed to have income below 100% FPL when application of the rules in 130 CMR 506 result in a determination of countable income in excess of income standards for any Medicaid coverage type for which the individual would otherwise be eligible, but the Health Insurance Connector has determined that the individual's countable income is below 100% FPL in accordance with the rules at 1.36B of the IRC.

506.005 Verification of Income.

Clarify that an individual must not be required to provide income information in addition to self-attestation unless verification cannot be accomplished electronically.
The regulations at 506.005 do not reflect the clear policy contained in the federal regulations at 435.945 and 435.948 that the agency must *first* attempt to verify income information through data matching before asking the individual for more information. This should be explicitly stated in the introductory paragraph.

Provide more examples of ways to verify income including a statement to explain a discrepancy.
When self-attested information is reasonably compatible with the data, clarify whether the amount of income that will be counted is the self-attested information or the higher or lower amount verified by the data.

Please provide additional examples of ways to verify income including: how many weeks' pay must be verified if it is no longer two, how self-employment income may be verified in the absence of a tax return e.g. through a statement of profit and loss, and how discrepancies between self-attested information and income reported by data sources may be verified e.g. by the individual supplying a "statement that reasonably explains the discrepancy" as required by 42 CFR 435.952(c)(2)(i).

It is also not clear how the deductions from Total Income to arrive at AGI must be verified in households that do not file a tax return or where a current year deduction, like the moving expense deduction, does not appear on a past year's return. Will self-attestation be accepted for these deductions, or must each be verified on paper if electronic data is not available? This is another situation where an applicant's statement to explain the discrepancy (the discrepancy being the absence of electronic data to verify a self-attested deduction) could be used if further verification is needed.

Delete 506.006
The introductory sentence refers to potential sources of income which is addressed elsewhere in the rules and does not seem to belong here. Unless CMS has identified the transfer of income rule set out in 506.006(A) as a further modification to MAGI, it does not appear to be consistent with the MAGI methodology and should be removed. 506.006(B) is confusing and appears to be unnecessary given the verification of income rules at 506.005. We suggest this entire section be struck out.

Clarify application of 5% Federal Poverty Level (FPL) deduction at 506.007.
Final federal rules limit application of the 5% deduction to "the highest income standard" for which the individual is eligible. 42 CFR 435.603(d)(4). It is unclear how this will apply in Massachusetts. Apparently states that had already programmed their systems with an across the board 5% disregard have until 2015 to comply. (78 FR at 42187). If MassHealth is applying the 5% disregard only to the highest income standard in 2014 as 506.007 says, it should explain what this means.

As we understand the federal rules, the 5% disregard should at least apply to the 150% Medicaid income standard and the 300% Separate CHIP income standard for uninsured children. Also since both the parents' standard and the new adult group standard is 133% FPL, and there is no basis to decide which is the higher standard, the 5% disregard should apply to both. (There are several advantages to being treated as a parent including potential eligibility for Transitional Medical Assistance as well as access to the more comprehensive benefits of MassHealth Standard). The Disabled adult standard is not governed by the federal rules but by the 1115 demonstration which states that the 5% deduction will apply to the 133% FPL standard for disabled adults. Further clarification on when the 5% deduction applies should be in the rules.

506.009. The One-Time Deductible

Allow prospective premiums for QHPs to be applied to the deductible.
It is not clear why prospective premiums for Qualified Health Plans, unlike other health insurance premiums cannot be applied toward the deductible. If the concern is that a portion of the premium cost may be reimbursed through a tax credit, the rule can limit the allowable bill to the portion of the premium that is not eligible for a premium tax credit. If the concern is that an individual may use the prospective premiums to meet a deductible and then cancel his or her QHP coverage in favor of CommonHealth, address that in the rule. Since expenses may be incurred by any member of the household, the premium cost of QHP for a nondisabled household member should at least be recognized.

506.011 Premiums.
The first reference to premiums for CMSP members with income over 150% FPL should be deleted. The next sentence correctly states that CMSP premiums are only charged to those over 200% FPL.

Clarify the Premium Billing Family Group (PBFG).
In 506.011 (A)(1)(b) clarify that a married couple in a PBFG must be living together.
With respect to children, the rule provides for equal treatment of all children in the same family in a way that is fair. We think the first sentence in 506.011(A)(4) could be more clearly stated as follows:

> In a family with more than one child, any child with a MAGI household income that does not exceed 300% FPL will have its premium liability determined based on the MAGI household income of the child in the family PBFG with the lowest percentage of the FPL.

With respect to children with household income over 300% and adults (19-64), the rule at 506.011(A) (5) says premiums are calculated using the individual's FPL and corresponding

premium amount. We don't understand what this means. How will the individual's FPL be determined? Will the calculation use the MAGI household or the PBFG? For example, will an unmarried couple with one child who file separate returns be in two MAGI households or one PBFG as a family?

The rule at 506.011 (A)(6) (a) provides that if individuals within a PBFG are in more than one premium billing coverage type, the PBFG is only responsible for the higher premium. However, in some cases this will conflict with the rule applicable to children in (4). We suggest the following clarification:

(6) For individuals within a PBFG that is approved for more than one premium billing coverage type, except where application of 506.011(A)(4) will result in a lower premium for children in the PBFG, the following apply.

Include a table showing the premium formula for Nonqualified PRUCOL Adults 19-64.
The rule at 506.011(B) (5) includes a cross reference to the Connector regulations for the premium formula for nonqualified PRUCOL adults under 300% FPL. However, the Connector does not publish its minimum contribution schedule as a regulation. MassHealth should include a Table corresponding to the other Tables in this section showing the premium formula: 0-150% - 0; Above 150-200% FPL $40; Above 200-250% FPL $80 and Above 250-300% FPL $118.

Clarify Premium Payment Billing in 506.011(C).
The first sentence cross-references to the rule at 504.004(C) on the One-Time Deductible but gives it the wrong title.

In 506.011 (C)(3) it says when a change is reported, the premium will be adjusted in the following month. We suggest that where a member has reported a change in a timely way, a decrease in the premium should take effect in the month it is reported. We also support the rule in 506.011(C)(5) providing relief to individuals who may not have understood a premium may be due.

Provide additional relief for delinquent premiums in 506.011(D) and (E).
The consequences of premium nonpayment are harsh; including loss of even Health Safety Net eligibility. An individual who faces an "extreme financial hardship" and who asks for a waiver of past due premiums should not have benefits terminated until MassHealth has acted on the waiver request. This should be added to the list of actions or circumstances that can prevent termination of benefits in 506.011(D)(1). Similarly the rule at 506.011(E) on reactivating coverage following termination for a past-due balance, should add to the circumstances which allow reactivation after the member "has been granted a waiver of the past-due balance under 506.011(F)."
The rule at 506.011(G) describing the circumstances when premiums may be waived describes the standard as "extreme financial hardship" this is a higher standard than that required in federal regulations which is"undue financial hardship" and that term should be used instead. 42 CFR 447.55(b). In keeping with this change, the grounds for hardship in (d) relating to a significant increase in essential expenses should omit the word "unexpected" or substitute the word "unavoidable" –an increase in expenses may be known beforehand but still not provide any reasonable way to be avoided. We also suggest that the rule clarify that the hardship may have been experienced at the time the premium was incurred for individuals currently receiving

benefits, or at the time the individual is seeking to reactivate benefits for individuals seeking a waiver after benefits have been terminated.

506.011(E)(2) Enables children to reenroll after a 90 day lock-out period after termination for nonpayment of premiums in accordance with federal regulations. Re-enrollment is only "on request." We urge the agency to automatically reinstate children after 90 days, or at least make sure they have clear notice that the lock-out period has expired.

Provide for recalculating the premium annually when the FPL is adjusted.
We understand it is the practice of MassHealth to recalculate premiums when the annual adjustment to the Federal Poverty Level is made. This should be included in the regulation at 506.011(I) to ensure that it will remain the practice.

Exempt former foster children up to age 26 in 506.011(J).
The ACA created a new mandatory coverage group for youth who age out of foster care up to age 26 regardless of income as provided for in 130 CMR 505002(H). The higher age limit equalizes treatment of former foster children with young adults covered under a parents' plan. Since they are eligible regardless of income, like the current group of former foster children up to age 21, it makes sense to also exempt them from income-based premium charges, and we urge MassHealth to add them to the exempt groups listed in 506.011(J).

Allow Premium Assistance for coverage in the individual market at the request of the beneficiary at 506.012.
Federal regulations permit premium assistance for coverage purchased in the individual market in limited circumstances. 42 CFR 435.1015. We are aware that this option poses risks to beneficiaries. However, insurance in the individual market provides certain mandated benefits not generally available in MassHealth such as Applied Behavioral Analysis (ABA) for individuals with Autism Spectrum Disorder (ASD). For families who need such services, there should be an opportunity for them to obtain premium assistance, but, as required by the federal regulations, premium assistance in the individual market must be the choice of the beneficiary. We believe premium assistance will be cost effective in terms of savings in other higher cost MassHealth covered services for children with ASD who now go without needed treatment. Therefore, the cost-effectiveness test in the individual market should be applied individually and not based on average costs as permitted by federal rules. A better solution of course is for MassHealth to include ABA for ASD in all coverage types, but until that change is made, Premium Assistance at least should be available.

506.012 Premium Assistance Payments

Require that eligible insurance include a comprehensive scope of benefits in 506.012(B)(1).
The rule at 506.012 describes the criteria for MassHealth to provide premium assistance in purchasing private insurance, including the criteria that determine whether children in Family Assistance must purchase private insurance instead of direct MassHealth coverage under 505.005(2)(b). As we explained in our comments on the definition of the Basic Benefit Level in 501, the criteria for private insurance should require that the scope of benefits in the private plan include at least Essential Health Benefits in the individual or small group market and at least

Minimum Creditable Coverage as defined by the Health Insurance Connector in the group market. As BBL is now defined it allows for any insurance that either meets MCC *or* can lawfully be sold in Massachusetts under DOI rules. These DOI rules do not require that group insurance provide comprehensive coverage comparable to Family Assistance. Further, while the added costs of private insurance are moderated by the Family Assistance Premium Assistance premium and cost-sharing rules discussed below, the only moderation of a skimpy benefit package is for dental benefits. The ACA has reined in some of the limits in group insurance in terms of pre-existing condition exclusions and life time or annual limits, but it does not apply the Essential Benefit standard to group insurance. A higher state standard is necessary.

Publish the cost effective amount tables in 506.012(E).
MassHeath has calculated cost effective amounts for different groups in different coverage types that is uses in determining the amount of Premium Assistance. These Tables should be published as part of the 506.012 regulations describing the Premium Assistance Payment Calculation.

We also urge MassHealth to include a provision in 506.012(E) providing that a family will not be required to purchase private insurance, or that the requirement may be deferred, where the family's monthly premium cost cannot be reimbursed in time to prevent an immediate hardship to the family.

Are we correct that the difference between the ESI 50% Plan and Other Group Insurance is that the former bases the cost effective amount on the MassHealth cost of covering all individuals in the PBFG household and the latter only considers the cost of household members eligible for MassHealth? Since Other Group Insurance, like coverage in the individual market, may involve no employer contribution, we suggest a similar approach could be used for coverage in the individual market in the circumstances we discuss above.

506.013 Small Business Employee Premium Assistance Program.
The regulation at 506.013(B)(4) refers to the affordability schedule and required member contributions in the Connector regulations at 956 CMR 6.05 and 12.00 but as we explained with reference to the Non-qualified PRUCOL adult premium contributions above, the Connector does not publish either its affordability schedule or premium contributions in its regulations. MassHealth should add a Table with the appropriate amounts to 506.012.

Please clarify whether the rules of this program will assist spouses where an employer offers an employee self-only coverage that is less than 9.5% of household income but coverage for a spouse that is more than 9.5% of income and more than the Connector's affordability schedule? It appears that it will enable the household in this situation to receive up to $300 toward the cost of ESI that covers the spouse. We appreciate the state addressing the so-called "family glitch" even in this limited way as well as providing continued assistance for individuals now receiving premium assistance through the Insurance Partnership.

Clarify the Copayment rules on maximum allowed charges.
The rules on copayments at 506.014 say that members are required to pay certain amounts but they should more accurately say that providers are allowed to charge members certain amounts. For example, the rule in 506.014 will be clearer if it says, "Providers cannot charge members

copayments that exceed the lesser of the maximum copayment described in 506.018, the usual and customary fee, or the MassHealth payment amount less one cent."
Another limitation on copayment charges is when accumulated charges exceed the $250 calendar year maximum or 5% of quarterly household income. The 5% of income cap is new to MassHealth, and we strongly support it. The rule at 506.015(A)(2) does not say 5% of what; it should cross-reference to 506.018 where this is explained.
One consequence of a percentage of income cap on copayments is that individuals with no income should be exempt from copayments. This should be stated in the state regulations and more important should be operationalized through the Pharmacy On Line Payment System at the time of enrollment.

Require notice to Family Assistance children of the Premium Plus Cap.
In Family Assistance, federal rules require that the Medicaid agency must inform beneficiaries of their cumulative premium and cost-sharing maximum amount at the time of enrollment. 42 CFR 457.560(b). This requirement should be set out in the regulations at 506.019, and more important, operationalized so that the agency actually sends such individualized notices to members. As far as we know this is not now done. It is particularly important that members be notified of their individualized cap since MassHealth relies exclusively on reimbursement of overpayments to enforce this rule, despite the federal regulation directing states not to rely primarily on reimbursing overpayments of the 5% of income cap.

508.000 Managed Care Requirements

Clarify transfers for cause in 508.002(E).
The rule says CarePlus transfers to a different managed care plan will take effect on the first of the following month unless the transfer is for cause. It does not state when a transfer for cause takes effect. It should state that a transfer for cause takes effect at any time. Further, the list of causes for a transfer to take effect at any time should include an individual who is determined medically frail electing MassHealth Standard pursuant to 505.008(F) and transferring to a different plan. The rule should also describe what the process is for seeking a transfer for cause.

Clarify the OneCare rule for individuals with "access" to other insurance in 508.004.
Pursuant to the Memo of Understanding with CMS, only dually eligible individuals *enrolled* in other health insurance are ineligible for participation in OneCare. We discuss this in more detail in our comments on the definition of a Duals Demonstration Eligible Individual in 501.

130 CMR 515-522

515.000 General Policies

515.001 Definition of Terms

Appeal Representative
Please see our comment under 501.001.

Disabled
This term is defined as "having a permanent and total disability." Elsewhere the regulations define "permanent and total disability" as the SSI disability standard. If you add to this, "under Title XVI of the Social Security Act or under applicable state law", the definition is clearer.

Case File
This definition should also include any electronic records used to determine eligibility such as date matches and computer screen shots for online application.

Deductible
See comment to 501.001.

Deductible period
See comment to 501.001.

Incarceration
Please see comment to 501.001.

Individual
This definition is used inconsistently with the way the terms is used elsewhere in the regulation. Please see comments at 501.001.

Limited English Proficiency
Please see comment to 501.001

Spouse
The definition of Spouse should be revised as explained in 501.001.

515.004 Administration of MassHealth

515.004(B) Other Agencies
Please see comments at 501.004 B.

515.004(B)(2)
Substitute "Social Security Administration" for "District Social Security offices".

515.007 Rights of Applicants and Members
Please see comments to 501.009.

516.000 The Eligibility Process

516.001 Overview of the Eligibility Process
Please see comment to 502.001. Also we encourage you to develop a way for individuals in need of long term care to apply on-line.

519.000 Coverage Types

519.003 Pickle Amendment cases
The chart at 519.003(B) of SSI MA living arrangements categories showing benefits amounts by category appears to be from 2009, which is out of date. It should be updated to 2014 with the notation that for years after 2014 the information will be updated on the MassHealth web site.

519.010 MassHealth Senior Buy-In
The countable asset limit in 519.010 (A)(3) is out of date. It should be updated to reflect the amounts that are in effect in 2013, or if available the 2014 figures. Language should be added similar to that in 519.011(B)(1)(d)iii to the effect that annual updates will be made available on the MassHealth website.

519.011 MassHealth Buy-In for Qualifying Individuals
519.011(B)(1)(b) requiring that Medicare beneficiaries not be eligible for any other MassHealth coverage type, does not comply with federal requirements and should state instead that they may not be eligible for MassHealth Standard. Individuals who receive CommonHealth coverage can be eligible for Buy-In under the QI benefit if they independently meet the QI eligibility criteria. This issue was directly addressed by the Center for Medicare and Medicaid Services in a letter from Richard R. McGreal, Associate Regional Administrator, to JudyAnn Bigby, M.D., Secretary, Executive Office of Health and Human Services, dated February 22, 2010. MassHealth had been denying QI benefits to persons on CommonHealth relying on §1902(a)(10)(iv) of the Social Security Act which provides that if an individual had medical assistance under the State Plan, he could not qualify for QI. CMS determined that CommonHealth was not part of the State Plan but in fact an expansion group under the 1115 waiver. CommonHealth members should not be excluded from Q-I if otherwise eligible. Most definitively, CMS states "The State must grant QI eligibility to CommonHealth recipients that are otherwise eligible as QIs".

We understand that your computer system has had difficulty processing this dual eligibility in the past due to the differing income methodologies and asset requirements and that "work-arounds" have been needed to provide this benefit to eligible individuals. It was thus limited to individuals who knew enough to ask for it. We see that elsewhere in your regulations at 505.004(L) you propose to provide the equivalent of QI benefits for a subset of CommonHealth members with MAGI income less than 135 % of the federal poverty level. While this encompasses many people who could be independently eligible for QI benefits, it does not include everyone. Thus it remains important that this regulation be amended to accurately state who can be eligible for QI benefits as set forth in the February 22, 2010 CMS letter.

519.011(B)(1)(d)iii also presents outdated countable asset limits, using 2011 and 2012 figures. The regulation should be updated to 2013 figures and ideally 2014 if available before final publication, together with the provision that future years' figures will be posted on the MassHealth web site.

130 CMR403.00 Home Health Agency Services

Ensure MassHealth CarePlus members receive adequate access to home health services. 403.420 restricts home nursing services in CarePlus to individuals discharged after an acute inpatient hospital admission. No other MassHealth coverage type contains this limitation on home nursing services. We urge you not to restrict home nursing for the 300,000 beneficiaries in CarePlus. Not only will the restriction deny medically necessary care for no apparent reason, it may also increase costs. If home nursing is not available to follow up on outpatient treatment or for discharge from a chronic or rehabilitation hospital or skilled nursing facility, it may lead to more inpatient admissions or longer institutional stays which will be more costly for MassHealth as well as imposing more risks and inconvenience on patients.

This limitation on home nursing visits existed in Basic, but Basic did not cover chronic or rehabilitation hospital or skilled nursing facility care and CarePlus does. Basic was also developed over 15 years ago and under the constraints of budget neutrality under the 1115 demonstration. CarePlus covers a population defined in the Medicaid statute for whom the state receives enhanced federal matching funds.

We also note that nothing in the CarePlus MCO procurement described any limitation of this sort in the required home health benefit. Further the language in the regulation stating that home nursing should generally be for a short-time period such as 14 days is inadequate even for an acute hospital discharge. At today's public hearing the Home Health Agency trade organization testified that the average length of home nursing for wound care after an acute discharge is 140 days. Also at today's hearing, the MassHealth representative explained that acupuncture for the treatment of pain, and diagnosis of infertility were added to the benefit package after a review of Essential Health Benefit requirements and the scope of benefits in benchmark plans. If such a review were to consider the scope of home health benefits, it is highly doubtful the limitations in this rule could be sustained.

Conclusion

Thank you for the opportunity to submit these comments. If you have further questions, please contact us.

Sincerely,

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