956 CMR 3.00: ELIGIBILITY AND HEARING PROCESS FOR COMMONWEALTH CARE

Section

3.01: Authority
3.02: Purpose
3.03: Scope
3.04: Definitions
3.05: Eligibility for Commonwealth Care
3.06: Matching Information
3.07: Time Standards for an Eligibility Determination
3.08: Eligibility Review
3.09: Eligibility Requirements
3.10: Responsibilities of Applicants and Enrollees
3.11: Enrollment, Transfer and Disenrollment
3.12: Commonwealth Care Enrollee Premium Contributions
3.13: Choosing a Contracted MMCO: Reserved
3.14: Right to a Hearing
3.15: Times and Methods for Filing Requests for Hearings
3.16: Appeal from Health Plan Actions
3.17: Hearings
3.18: Administrative Information Bulletins
3.19: Severability of Provisions

3.01: Authority

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

3.02: Purpose

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

3.03: Scope

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

3.04: Definitions

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

Abuse. Physical or verbal abuse which poses a threat to health care providers or other insureds of the Health Plan and which is unrelated to the Enrollee's physical or mental condition.

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

Appeal Representative. A person who:

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

3.04: continued

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

Appealable Action. Any of the actions listed in 956 CMR 3.14.

Applicant. A person who completes and submits an application for Commonwealth Care.

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

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

Commonwealth. The Commonwealth of Massachusetts.

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

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

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

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

Covered Services. The range of medical services required to be provided by a Health Plan under Commonwealth Care.

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

Eligible Individual. An individual who is a resident of the Commonwealth and who is eligible to participate in Commonwealth Care in accordance with M.G.L. c. 118H and 956 CMR 3.09.

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

Enrollee. An Eligible Individual enrolled by the Connector or its designee in a Health Plan, either by choice or assignment.

Enrollment. The selection of a Health Plan, either by choice of the Eligible Individual or by assignment.

Enrollment Effective Date. The first day of the calendar month following the completion of the Enrollment Process.

Enrollment Process. The process in which an Eligible Individual chooses a Health Plan, or is assigned to a Health Plan by the Connector.

Family. Persons who live together, and consists of:

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

3.04: continued

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

1. pregnant; or
2. a parent.

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

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

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

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

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

Health Plan. Any managed care organization or carrier that is contracted with the Connector to provide covered services to Commonwealth Care Enrollees.

Hearing. An administrative, adjudicatory proceeding pursuant to 801 CMR 1.02 to determine the legal rights, duties, benefits or privileges of Applicants (in certain, limited circumstances) and Enrollees pertaining to enrollment and plan assignments, disenrollments of Enrollees for failure to pay, disenrollments of Enrollees based upon the discretion of the Connector; Enrollee Premium Contributions and co-payment maximum limits; and denials of waiver requests.

Non-premium-paying Plan Type. A Plan Type for which an Enrollee is not required to pay an Enrollee Premium Contribution under the Premium schedule established by the Board pursuant to 956 CMR 3.12(8). In the event that one Plan Type includes both premium-paying and non-premium-paying Enrollees depending on the Enrollees' income, regulations applicable to non-premium-paying Plan Types will apply only to the Enrollees in the Plan Type who are not required to pay Enrollee Premium Contributions.

Plan Type. A type of coverage for Enrollees with income within a certain range.

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

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

3.04: continued

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

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

3.05: Eligibility for Commonwealth Care

(1) Eligibility for Commonwealth Care is determined by the Commonwealth's Office of Medicaid, under authorization of the Connector and consistent with the Connector's regulations regarding eligibility. The eligibility determination includes a determination of both

(a) whether, based on individual or family household income, the individual is financially eligible for Commonwealth Care and

(b) whether the individual meets other eligibility requirements, including residence and uninsured status, as set forth in 956 CMR 3.04 and 3.09.

(2) The Office of Medicaid will use the same methods as are used for MassHealth to determine individual or family household income level and Resident status. The financial eligibility for various Commonwealth Care Plan Types is determined by comparing the individual or family group's monthly Gross Income with the applicable income standard for the specific Coverage Type. In determining monthly Gross Income, the Office of Medicaid multiplies average weekly income by 4.333.

(3) Included in the financial eligibility determination will be a determination of the Plan Type to which an Eligible Individual should belong based on individual or family household income. Covered Services, Premium Contributions and Co-payments will vary among Plan Types, as determined by the Board. The following are the different levels of such income for each Plan Type:

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

(b) Plan Type II- more than 100% but not in excess of 200% of Federal Poverty Level, except that persons below 150% of Federal Poverty Level will be in Plan Type IIA, and those between 150% and 200% of Federal Poverty Level will be in Plan Type IIB.

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

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

(a) Divide the annual Federal Poverty Level income standard as it appears in the Federal Register by 12.

(b) Multiply the unrounded monthly income standard by the applicable Federal Poverty Level standard.

(c) Round up to the next whole dollar to arrive at the monthly income standards.

3.06: Matching Information

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

3.07: Time Standards for an Eligibility Determination

In making an eligibility determination for Commonwealth Care, the Office of Medicaid will require an applicant to complete an application and provide the information requested in that application. Based on the information supplied in that application, additional information may be requested to determine eligibility status. The eligibility determination will be made within 45 days from the date of receipt of the information requested during the determination process.

3.08: Eligibility Review

(1) The Connector or its designee may review eligibility every 12 months. Eligibility may also be reviewed more frequently as a result of an Enrollee's change in circumstances, or a change in Commonwealth Care eligibility rules. The Connector or its designee updates the case file based on information received as the result of such review. The Connector reviews eligibility:

(a) by information matching with other agencies, health insurance carriers, and information sources as set forth in 956 CMR 3.06;

(b) through a written update of the Enrollee's circumstances on a prescribed form; and

(c) based on information in the Enrollee's case file.

(2) The Connector determines, as a result of this review, if:

(a) the Enrollee continues to be eligible for Commonwealth Care; or

(b) the Enrollee's current circumstances require a change in Plan Type or Premium Contribution.

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

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

3.09: Eligibility Requirements

(1) An uninsured individual who is a resident of the Commonwealth shall be eligible to participate in Commonwealth Care in accordance with M.G.L. c. 118H if:

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

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

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

(d) the individual has not accepted a financial incentive from his employers to decline his or her employer's subsidized health insurance plan; and

(e) the individual is eligible to receive federally funded benefits under §§ 401, 402 and 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, for fiscal year 2010.

3.09: continued

(2) Persons shall not be deemed uninsured for purposes of determining eligibility for Commonwealth Care if such persons are eligible for other government programs that cover hospitalization and physician services including, but not limited to, one of the following programs:

(a) TRICARE, the Department of Defense's managed health care program for active duty military, active duty service families, retirees and their families, and other beneficiaries, established pursuant to 10 U.S.C. § 1073;

(b) student health insurance programs available to full-time or part-time students enrolled in a public or independent institution of higher learning located in the Commonwealth pursuant to M.G.L. c. 15A, § 18; and

(c) the Massachusetts Division of Unemployment Assistance's Medical Security Program, which provides health insurance assistance for residents of the Commonwealth who are receiving unemployment insurance benefits, pursuant to M.G.L. c. 151A.

(3) Persons shall be deemed uninsured for purposes of determining eligibility for Commonwealth Care if:

(a) such persons are insured solely under a health benefit plan for which they pay the full premium obtained pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) at 29 U.S.C. § 1161 or the Small Group Health Insurance Continuous Coverage Act at M.G.L. c. 176J, § 9 or obtained as an individual in the non-group insurance commercial market; or

(b) if and to the extent such persons are in a waiting period prior to becoming eligible under an employer-provided health benefit plan for which the employer covers at least 20% of the annual premium cost of a family health benefit plan or at least 33% of an individual health benefit plan.

3.10: Responsibilities of Applicants and Enrollees

(1) Responsibility to Cooperate. The Applicant or Enrollee must cooperate with the Connector or its designee in providing information necessary to establish and maintain eligibility and to bill and collect Enrollee Premium Contributions, and must comply with all the rules and regulations of the Connector or its designee. An Applicant's failure to provide information requested during the eligibility determination process may result in a delay in the eligibility determination, or a denial of eligibility.

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

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

3.11: Enrollment, Transfer and Disenrollment

(1) Enrollment. Following a determination of eligibility, Eligible Individuals will be instructed to contact the Connector to enroll in Commonwealth Care. Eligible Individuals will be permitted to choose a Health Plan from among those that operate in their Service Area, except that the Connector may in its discretion assign Eligible Individuals in Plan Type I to a Health Plan in their Service Area or provide Eligible Individuals in Plan Type I with a limited choice of fewer than all of the Health Plans that operate in their Service Area, unless such Eligible Individuals had previously been enrolled through M.G.L. c. 118E or 118H in a different Health Plan within a time period determined by the Connector, which shall be no less than 90 days. Eligible Individuals who are required to pay a premium must pay the first month's premium on or before a due date set by the Connector in order to complete the enrollment process. In the event that

3.11: continued

a Health Plan ceases operation in a Service Area, the Connector shall assign Eligible Individuals who had been enrolled in that Health Plan to another Health Plan in their Service Area, unless the Connector in its discretion permits such Eligible Individuals to choose from among the Health Plans that operate in their Service Area.

(2) Automatic Assignment to a Health Plan. If an Eligible Individual who is eligible for Plan Type I does not contact the Connector within the time period specified by the Connector in a notice to the Eligible Individual in accordance with 956 CMR 3.11(1), the Connector may automatically assign that Eligible Individual to a Health Plan determined by the Connector. The Connector will assign that individual to a Health Plan available in that individual's Service Area unless the individual had previously been enrolled through M.G.L. c. 118E or 118H in a different Health Plan within a time period determined by the Connector, which shall be no less than 90 days, in which case the individual shall be re-assigned to the same Health Plan. The Connector will assign Eligible Individuals only to Health Plans that operate in the Service Areas where the Eligible Individuals reside.

(3) Enrollment Effective Date. Eligible Individuals must complete the Enrollment process in order to receive Covered Services. Coverage will begin on the Enrollment Effective Date, which is the first date of the month following the completion of Enrollment.

(4) Premium Contributions. Premium Contributions paid by Enrollees within the same Plan Type may vary depending on the Health Plan selected. The differentials in Premium Contributions for Health Plans will be determined by the Connector based on the difference in cost to the Connector of the Health Plans. There will be at least one Health Plan available to Plan Type I and Plan Type IIA members that has no Premium Contribution. There will be at least one Health Plan available to Plan Types IIB and III members that will cost the minimum Premium Contribution set by the Board in the accordance with 956 CMR 3.12(7).

(5) Notification. The Connector will notify an Enrollee in writing of the name and address of the Enrollee's Health Plan and Enrollment Effective Date.

(6) Transfer. The Enrollee may transfer from a Health Plan to another Health Plan in that Enrollee's Service Area within 60 days after the Enrollment Effective Date and during any open enrollment periods established by the Connector, except that an Enrollee who has been assigned to a Health Plan or given a limited choice of Health Plans by the Connector pursuant to 956 CMR 3.11(1) or (2) may only transfer during a subsequent open enrollment period. Notwithstanding the foregoing, during any open enrollment periods established by the Connector, Enrollees in Plan Type I who do not comply with the procedures established to choose a Health Plan may be assigned to a Health Plan in their Service Area determined by the Connector and will only be permitted to transfer during a subsequent open enrollment period. Enrollees may transfer from a Health Plan outside of any open enrollment periods established by the Connector only for one of the following reasons:

(a) the Enrollee has moved and the new residential address is outside the Service Area in which the Enrollee's Health Plan operates;

(b) the Enrollee demonstrates to the Connector that:

1. the Enrollee has a medical condition and continued enrollment in the current Health Plan will result in a lack of continuity of care, and

2. the current Health Plan has not provided the Enrollee with access to health care providers that meet the Enrollee's health care needs over time, even after the Enrollee has asked the Health Plan for help;

(c) the Enrollee's primary care provider is no longer a contracted provider with the current Health Plan's network;

(d) the Enrollee's health care access has been adversely affected by a significant change in the current Health Plan's network of providers, which may include, without limitation, the loss of a contract with a hospital, health center, physician group or specialty provider group;

(e) the Enrollee has an eligibility change in Plan Types;

(f) the Enrollee is homeless and that status has been reported to the MassHealth eligibility system; or

(g) the enrollment materials sent to the Enrollee were returned without being delivered.

3.11: continued

(7) Disenrollment of Enrollees.

(a) The Connector may disenroll or transfer an Enrollee from a particular Health Plan, upon request of the Health Plan, if the Health Plan has established that the Enrollee has committed Fraud or Abuse.

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

(c) The Connector may disenroll an Enrollee from Commonwealth Care for Fraud or Abuse.

(d) If the Connector disenrolls an Enrollee pursuant to 956 CMR 3.11(7), it will provide the enrollee with written notice stating the reason for the action.

(8) Re-enrollment. Persons who lose Commonwealth care eligibility and then regain eligibility are required to re-enroll before coverage becomes effective. The first month's premium, if applicable, and any outstanding premium balance from any prior enrollment, if applicable, must be received on or before the payment due date set by the Connector before re-enrollment is effective unless such overdue amounts have been waived or the person enters into a payment plan with the Connector. In the case of re-enrollment after disenrollment under 956 CMR 3.11(7)(a), the Connector may make such health plan assignment as it deems most appropriate. Other than as provided in 956 CMR 3.11(8), re-enrollment will occur in accordance with 956 CMR 3.11(1) and 3.11(2).

3.12: Commonwealth Care Enrollee Premium Contributions

(1) Enrollee Premium Contribution Payments. Enrollees who are assessed an Enrollee Premium Contribution are responsible for monthly payments that must be paid on or before a due date set by the Connector. The Connector will establish and maintain at least one convenient payment method for Enrollees.

(2) Delinquent Enrollee Premium Contribution Payments.

(a) If the Connector or its designee has billed an Enrollee for a payment, and on the day following the payment due date the Enrollee has an unpaid balance of at least two months premiums, the Connector will terminate the Enrollee at the end of that month, except as provided below. The Enrollee will be sent a notice of termination at least 14 days before the date of termination. The Enrollee's coverage will not be terminated if, on or before the payment due date, the Enrollee:

1. submits an application for a financial hardship waiver pursuant to 956 CMR 3.12(5); or
2. establishes a payment plan acceptable to the Connector.

(b) After such a payment plan has been established, the Connector will bill the Enrollee for:

1. payments in accordance with the payment plan; and
2. monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan. If the Enrollee does not make payments on or before the due dates set by the Connector for both the payment plan payments and any monthly Enrollee Premium Contributions due subsequent to the establishment of the payment plan, the Enrollee's eligibility is terminated.

(3) Reactivating Coverage Following Disenrollment.

(a) An Eligible Individual who has been disenrolled for failure to pay Enrollee Premium Contributions or for any other reason, other than a disenrollment under 956 CMR 3.11(7)(c) will be re-enrolled in Commonwealth Care if capacity exists. Prior to re-enrollment, the Eligible Individual must pay in full all payments due unless such overdue amounts have been waived, or establish a payment plan with the Connector. Individuals disenrolled under 956 CMR 3.11(7)(c) will be re-enrolled at the Connector's discretion.

(b) If no capacity exists in Commonwealth Care, there will be a waiting list for individuals seeking to re-enroll. Re-enrollment will not occur until the Connector is able to reopen enrollment for those placed on the waiting list. When the Connector is able to open enrollment for those on the waiting list, Eligible Individuals on the waiting list will be processed in the order they were placed on the waiting list.

3.12: continued

(4) Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship.

(a) Extreme financial hardship means that the Enrollee has shown to the satisfaction of the Connector that the Enrollee:

1. is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice; or
2. has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or sole telephone); or
3. within the 24 month period immediately preceding the date of the waiver application, incurred non-cosmetic medical and/or dental out-of-pocket expenses for the Enrollee and/or Enrollee's household members (exclusive of premium and co-payments), that are not subject to payment by a third party, and that totaled more than 7.5% of the Enrollee's gross family income during that time period. (In this case "non-cosmetic medical and/or dental out-of-pocket expenses" must be incurred by the individual or family for services rendered while enrolled in a Commonwealth Care plan or during a gap period of no more than nine months between periods of enrollment in Commonwealth Care and/or another state-subsidized health program, provided that the gap was not caused by an Enrollee's choice, by an Enrollee's re-determination of income, or by an Enrollee's non-compliance with Commonwealth Care rules or regulations; or
4. has incurred a significant, unexpected increase in essential expenses within the last six months resulting directly from the consequences of:
   a. domestic violence;
   b. the death of a spouse, family member, or partner with primary responsibility for child care;
   c. the sudden need to provide full-time care for self, for an aging parent or for another family member, including a major, extended illness of a child that requires a working parent to hire a full-time caretaker for the child;
   d. a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee; or
5. has filed for bankruptcy within the last six months.

(b) If the Connector determines that the requirement to pay an Enrollee Premium Contribution or arrears results in extreme financial hardship for the Enrollee, the Connector may waive payment of such Contribution or arrears; or reduce the amount of such Contribution or arrears assessed to a particular individual.

(c) An Applicant who has been found eligible for Commonwealth Care may request a premium waiver prior to enrollment, although the filing of such request does not entitle such Applicant to enroll while the request is pending.

(d) If the Connector determines, in the case of an Enrollee who is in a Non-premium-paying Plan Type that the payment of any Co-payment results in extreme financial hardship for such Enrollee, the Connector may waive any Co-payment incurred by such Enrollee. Enrollees in a Non-premium paying Plan Type who are homeless and have reported that status to the MassHealth enrollment center will be granted a six-month Co-payment Waiver without the requirement of submitting a Co-payment Waiver Application and that waiver will be renewed at the Enrollee's request, as long as the homeless status is still reflected in the MassHealth Enrollment Center records.

(e) Hardship waivers will be authorized for up to 12 months. The waiver period begins in the month after a documented hardship waiver is granted. An Enrollee who is granted a hardship waiver will be assigned to the lowest cost Health Plan available in that Enrollee's Service Area. At the end of the waiver period, the Enrollee may submit another request. Requests for Enrollee Premium Contribution or Co-payment relief should be addressed to the Connector.

(f) Enrollees who have filed a premium waiver or reduction request on or before the payment due date will not be required to pay Enrollee Premium Contributions while the request is under consideration. Enrollees who have filed a copayment waiver request will not be required to pay Co-payments while the request is under consideration. If the Connector receives a request to waive or reduce Enrollee Premium Contributions from an Enrollee who has received a notice of termination for non-payment of Enrollee Premium Contributions, the filing of that request will stay the termination of the Enrollee while the request is under consideration, provided that the Connector receives the request more than five business days before the effective date of that termination. If the hardship waiver request is denied, the Enrollee will be required to resume paying Enrollee Premium Contributions or Co-payments, even if the Enrollee files an appeal pursuant to 956 CMR 3.14.

3.12: continued

(g) Notwithstanding the provisions of 956 CMR 3.12(4)(f), if the waiver or reduction request is the second or subsequent such request made by the Enrollee, and the previous request was unsuccessful, the Connector will require the payment of Enrollee Premium Contributions and Co-payments, and, if applicable, proceed with a termination while the waiver or reduction request is under consideration.

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

(6) Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes in income, family group size, or health-insurance status, and may be changed whenever the cost to the Connector of contracting with a Health Plan changes or as a result of a change in a Health Plan's Service Area.

(7) Minimum Monthly Commonwealth Care Enrollee Premium Contribution Schedule. The Board shall determine annually the minimum monthly Premium Contributions for each Plan Type. The Premium Contributions shall be set forth in a schedule that will be published annually.

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

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

(3.13: Choosing a Contracted MMCO: Reserved)

3.14: Right to a Hearing

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

(1) any adverse eligibility decision based on income level or other MassHealth eligibility regulations at 130 CMR 501.000 *et seq.*;

(2) any adverse eligibility decision based on an Applicant's access to government-sponsored or employer-subsidized insurance;

(3) any determination that an Enrollee is not permitted to transfer from a current Health Plan because the Enrollee has not satisfied the requirements established by the Connector pursuant to 956 CMR 3.11(6);

(4) the Connector's disenrollment of an Enrollee for failure to pay Enrollee Premium Contributions or for any other reason other than loss of eligibility;

(5) the Connector's denial of a financial hardship waiver or renewal of a financial hardship waiver under 956 CMR 3.12(5); or

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

3.15: Times and Methods for Filing Requests for Hearings

(1) The Applicant or Enrollee will receive a notice in writing of an Appealable Action identified in 956 CMR 3.14 from either MassHealth or the Connector. That notice will also include notice of the right to a hearing with the appropriate hearings office, of the method by which a hearing may be requested, and of the right to use an Appeal Representative. The notice will also include a form for appealing the action.

(2) The request for an appeal must be received within the following time limits:
(a) 30 days after the receipt of the notice of the Appealable Action. (In the absence of evidence to the contrary, it will be presumed that the notice was received on the third day after mailing.);
(b) 120 days from the date of a request for an eligibility determination, a transfer from a Health Plan or a financial hardship waiver or reduction when the MassHealth agency or the Connector fails to act on that request; or
(c) 120 days from the date of an Appealable Action if the MassHealth agency or the Connector fails to send written notice of such action.

(3) The time periods in 956 CMR 3.15(2) will expire on the last day of such periods unless the day falls on a Saturday, Sunday, or legal holiday, in which event the last day of the time period will be deemed to be the following business day.

(4) Upon request by an Applicant or Enrollee, the Connector will provide the Applicant or Enrollee with a form to bring an appeal. The Connector and or its agent/designee may not restrict the Applicant's or Enrollee's freedom to request a hearing.

3.16: Appeal from Health Plan Actions

Any inquiries, complaints or grievances by an Enrollee against a Health Plan, or any appeal by an Enrollee from an adverse determination by a Health Plan shall be subject to the review and appeal procedures contained in M.G.L. 176O, including appeals to the Office of Patient Protection within the Commonwealth's Department of Public Health, as set forth in 105 CMR 128.000.

3.17: Hearings

(1) Fair hearings will be conducted for the Connector by the Board of Hearings within the Office of Medicaid using policies and procedures set forth in 130 CMR 610.00 and those set forth in 956 CMR 3.00, for those appeals brought under 956 CMR 3.14(1).

(2) Hearings for all other appeals will be conducted by the Connector using the policies and procedures for informal hearings set forth in 801 CMR 1.02, as well as the procedures set forth in 956 CMR 3.00 or in any administrative bulletins issued by the Connector.

(3) The Connector may dismiss any request for hearing if:
(a) it is not received within the time periods specified in 956 CMR 3.15;
(b) it does not state a valid ground for appeal under 956 CMR 3.14;
(c) the appeal is withdrawn by the Appellant or Appeal Representative; or
(d) for any reason stated in 801 CMR 1.02.

(4) The Connector may designate a hearing officer to hear any appeals. The hearing officer may, at the request of a party or on his or her own initiative, order that the hearing be conducted by telephone.

3.17: continued

(5) The decision of the hearing officer designated by the Connector will be final, except that within 14 days of the issuance of the hearing officer's decision, the Director of the Appeals Unit for the Connector, or his designee, may, for good cause, and at the request of the appealing party or on his or her own initiative, order a re-hearing. In the event that the Director or the Director's designee orders a re-hearing, the Director will give notice in writing to all parties of the date, time, and location of the re-hearing. The re-hearing will be conducted before the Director or another hearing officer whom he designates. Within 30 days after the order requiring re-hearing, the Director or designated hearing officer will conduct the re-hearing and will either issue a superseding decision or decide not to issue a superseding decision. A request for re-hearing stays the initial decision of the hearing officer, and that initial decision will not be deemed final for purposes of the filing of an action for judicial review under M.G.L. c. 30A, § 14, until the Director or his designee issues a superseding decision or decides not to supersede the initial decision.

(6) Enrollees who have brought an appeal must continue to pay all required Enrollee Premium Contributions during the pendency of the appeal. Persons who are appealing a disenrollment because of non-payment of Enrollee Premium Contributions or for any other reason will remain disenrolled during the pendency of the appeal unless they obtain re-enrollment under the provisions of 956 CMR 3.12(3). Persons who are appealing a denial of a premium waiver-reduction application or a copayment waiver application must pay Enrollee Premium Contributions and Co-payments while the appeal is pending.

3.18: Administrative Information Bulletins

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

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

3.19: Severability of Provisions

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

REGULATORY AUTHORITY

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