Massachusetts Health Care Training Forum
April 2014 Questions & Answers

**** Please Be Advised ****
The answers to these questions speak in general terms and are not intended to be case specific

Click on any link below to access a Question and Answer section.

MASSHEALTH UPDATES

Is PT-1 just for MassHealth Standard or CarePlus?
PT-1 is used for any coverage type that allows medical transportation. You should check with your doctor as they are the one that completes the form and sends it in.

Is there a fax number for expecting processing of ARD's?
Customer Service 1-800-841-2900.

I was told ERV's are on hold right now. Do you know when they will resume? Will there be a new form or process?
The eligibility review forms have not been revised yet but eventually revisions will be made to comply with the Affordable Care Act.

Should all supporting documentation/verifications for applications be faxed to 617-887-8770 or a different number?
Yes, that is the correct fax number.

How long should we keep voter declination forms on file?
22 months.

What happens when a person refuses to sign the Voter Reg., whether or not they are a voter or not eligible?
A person has the right to refuse to register to vote; the Certified Application Counselor should keep records of this.

Should we be asking non-qualified alien if they are registered to vote?
You must be a US citizen to register to vote in Massachusetts.

The PSI slide says that PSIs should "only be completed upon an applicant's request". Does this mean we cannot offer the PSI to people? How would an applicant even know that this form exists?
You should explain the purpose of the PSI and then allow the applicant/member to decide if they want to sign the form.

Online requests for information after submission "during session", where do these documents go?
The assumption is that if you have questions following the MTF where do they go? If sent directly to the MTF folks they will disseminate it accordingly to the proper folks to answer such as Mass Health, the Connector, HSN, etc.

When calling to report income changes, some workers tell clients they must send verifications, others do not. Why is there a difference?
Sometimes we can match income with the Department of Revenue so no further verification would be necessary from the member.

Can we get a copy of the March 2014 OneCare pharmacy flyer? Is it online anywhere?
All available One Care materials can be downloaded from their website which is www.mass.gov/masshealth/onecare

When will the provider portal be available?
Being worked on as we speak with hopes of later this year but no definitive date.

Could indicate "Temporary Coverage" be missing a restrictive message?
Check with Provider Services to see if Appendix Y is being revised to include a message for temporary coverage.

We have a patient approved for Buy-in, but she does not have MediCare. Who do we call?
Customer Service 1-800-841-2900.

For patients that have CarePlus and/or Standard for coverage, but are NOT active in MA21, what can we do for them to be added in MA21 in order for DES to process the Disability Supplement?
Disability supplements should be sent directly to DES. The address is Disability Evaluation Services 333 South Street Shrewsbury, MA 01545. They have a process that ensures the supplements are getting processed and the decisions are being entered into the correct computer system.

Who can we contact to correct discrepancy of information showing in MAP and EVS?
When there is a case issue for a member the MEC should be the one's contacted. 1-888-665-9993.

How long is it taking for patients over 65 to process their bills to meet deductibles for upgrade to MH?
Case maintenance is processed in the order it is received. If the member has an urgent medical need they should call customer 1-800-841-2900 and ask to have their case expedited.

Who can we call for discrepancy of patient's approval?
Customer Service at 1-800-841-2900. An appeal can also be filed. The appeal instructions are included in the approval mailing.

For discrepancies on demographics who is the right person to contact?
Customer Service 1-800-841-2900.

How do we access EVS? Years ago we were able to access REVs but can only access MAP for client eligibility information.
If you had VG access previously you should still have it unless your circumstances have changed. You may want to call the VG Helpdesk at 1-800-421-0938.

Will the new cover sheet be applicable to other community organizations? i.e. ASAPs
Yes.

Disabled prior to 65, turn 65 are losing their access to standard or CommonHealth; they're not accordingly coded.
If they continue to have the disabling condition and are "Working" then there is potential to continue on with CommonHealth even after the 65th birthday. If there is a problem the MEC should be contacted for any correction to the case.

On POSC system, eligibility shows CarePlus when member has Medicare or group BCBS as primary. Is this correct? Can CarePlus be a secondary? One member was previously CommHealth and switched to CarePlus.
There were some initial issues with the computer which I believe have been resolved and these cases corrected. If you are still having issues please call the MEc for resolution.

Where are the review forms that were sent back in October and November? And if found, are they going to be backdated when we submit an ACA?
A call would need to be made to Customer Service at 1-800-841-2900 to inquire about these specific cases.

What is causing the long delay in processing SMBR applications and redeterminations? OneCare members who are then placed in one of the three MCOs must fill Specialty Meds form that plan design?
Applications are processed in the order they are received. Regulations for time standards for processing applications are in the MassHealth regulations. Generally, MassHealth has 45 days to process an application, although it can take longer depending on certain circumstances.

We have been receiving denial letters for clients telling them to reapply due to over income. Why are they not being told they are eligible for Connector Care? They have already re-applied with us.

Many of these issues were during transition early in the year and have been worked out since. Members should call the Connector helpdesk about their Commonwealth Care continuance at 1-877-623-6765.

Applications submitted since December for incarcerated individuals leaving jail within 90 days, are we still going through and customer service reps continue to insist that people cannot be found eligible prior to their release. What is going on?
We have been working diligently with the Department of Corrections to resolve these cases and have processes in place to get these folks covered prior to leaving. They should apply within 30 days of release, not 90.

If a person who is head of household with kids goes to jail and thus loses coverage, will their kids also lose it as part of the overall household?
Only the parent loses MassHealth.

How does a member end up with two ID numbers to an MCO and only have one ID number with MassHealth? How do we "fir" this?
Both ID numbers are linked to the MH ID#. Old number is NIF and wiped out in the MCO system.

Are we still sending review forms even though ACA new applications have been submitted?
Most reviews are currently on hold but there are still certain one's that go out such as folks transitioning off of the TAFDC program, people turning 65, etc.

Why are the over 65 apps also taking so long to process?
Applications are processed in the order they are received. Regulations for time standards for processing applications are in the MassHealth regulations. Generally MassHealth has 45 days to process an application although it can take longer depending on certain circumstances.

Are ERV's that are sent out for under 65 populations supposed to be sent back or should a HIX be completed instead?
Depends why the ERV was sent out; there are certain ERV's that do need completion so I would suggest checking with the MEC.

Are applications for undocumented able to be submitted electronically yet? They were receiving error messages regarding not being able to verify information.
The error message was because there was no Social Security number so I would suggest using paper for now.

What causes the error that the social security number is already used in individuals who have not completed an application in the new system yet?
Unsure of your question but if someone else is using the same number the system will reject it causing what we know to be a shared "RID", Recipient Identification Number.

What needs to happen for those individuals whose applications were submitted prior to December and were incorrectly categorized for unsubsidized instead of subsidized?
Depending on potential eligibility, Connector or MH, it may have required a new application. At this time it should not be an issue any longer.

Are electronic applications not showing in the current My Accounts Page?

There is a new system being developed at this time and it may take a while to identify. Paper is definitely showing on MAP.

Verification document should be sent to whom? Portland Street, Worcester walk-in office or Taunton office?
Verifications should be sent to the Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780.

Do paper applications override the electronic applications?
No they don't override but it may be the way to go for a temporary time frame.

Are declination forms required for all of the individuals we meet with, even non-citizens?
Voter Declination forms are mandatory but the good thing is that you hold them at your facility and don't require faxing.

What do we need to do with the declination forms, will we need to report numbers or just have those available to be reviewed?
You hold them at your facility and have them available if necessary to review.

Can we get the list of hospitals that accept which MCO? We only have the Commonwealth Care one from before.
Most acute hospitals in the state accept the MH MCO's you can check with the Connector for their products and availability.

Applications submitted; shows as processed on MAPs but their coverage has not changed.
Call customer service 1-800-841-2900 and a determination can be made if a coverage change was supposed to happen.

What is the true back log? We were told there is none, however, we still have people who have not been processed for temporary coverage; 15 individuals who are listed as not eligible or not found.
The backlog is in processing the final decision on the cases. There are cases being batched daily for Temporary Coverage so in essence there is no backlog because the cases are in our system and are being worked on every minute of every work day and if we can't make a full determination timely the case goes to Temp Coverage.

What do we do when someone is approved incorrectly?

- **I have one person who was given Connector Care then MH Standard and she has full ESI that is affordable.**
- **I have 3 that show up as QHP only with no subsidy and they are all unemployed with no income.**
- **I have 6 that show as still covered by HSN even though they appear to be eligible for other things and at minimum should have temporary coverage.**

The simple answer is to call the Mass Health Enrollment Center to identify and resolve the issue. Customer Service cannot complete the necessary case work to resolve many of these issues.

We have submitted PSI's for all of the clients that we serve. However, when we call MassHealth to get information about one of our clients, we are told that the PSI is not on file. What can we do to insure that the PSI's that we are sending are being recorded?
PSI's should be sent or faxed to the Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780. They are scanned into the computer and processed in the order they are received by enrollment staff.

If a member receives an ERV, what do they do? What is the official application date: date submitted or date processed?
If the review is received timely they need to complete it and send it in by the date indicated on the letter.

Can we assist patients from other states fill out MassHealth applications? Ex: NH app.
People living in other states, countries, etc are not eligible for Mass Health; you must be residing and have intent to reside in Massachusetts to qualify.

Will phone applications be viewable for those who assist with "online" applications? As of now it is hard to track down the phone applications. Is there something in place for the near future? Patients are coming in saying that they have started the application over the phone.
When an application is done over the phone, they help the applicant create an account with a user ID and password. The applicant can use that to lookup the application.

With loss of coverage d/t separation from military, what documentation is required and is there anything different about this type of change of circumstance?
Not sure what d/t is but it should not require any special documentation. Submit the application and if more information is necessary the worker will request it.

What do we do if an application was submitted in November and does not show as received?
Call customer service 1-800-841-2900. Be prepared to show proof of application submission.

I am having trouble checking on member's application status. When I go to the MEC website, I could not see the status. Either the member needed to submit more proof or their eligibility status. Any suggestions for this situation?
You can call Customer Service and see if they can assist you but make sure you have a PSI on file or the member with you.

If a child receives Social Security under a disabled parent, where should we put that income on the paper ACA application?
In the "Money from other sources" section.

Mixed households under and over age 65, under 65 needs insurance, over 65 does not. Which application do we submit: ACA-2 or SACA-2? We have been given conflicting information from customer service.
We will tend to use the SACA-2 only because we may need assets in the near future and it will all be there when the other person turns 65 or the person that is 65 now wants to apply.

ACA LEARNING SERIES

Young adults 19 years old, do they still have to apply on their own? What if the parents are claiming their 19 year old in their taxes?
A student can apply separately from their parents, but if they are still claimed on their parent's taxes, we will look at the family's MAGI to determine what that student would qualify for.

A client has been approved for CarePlus and at the same time she has Commonwealth Care. Both programs are open. What should the client do? Should she drop the Commonwealth Care?
Once this client has received confirmation that they are enrolled in a CarePlus plan, then they should stop paying their Commonwealth Care premium. There is logic in the system that automatically unenrolls a CommCare member when they become enrolled in CarePlus.

When a member shows up with CarePlus, not MassHealth Standard, does that mean they do not have temporary coverage? Nothing shows up for coverage; underneath the message is member is unenrolled, needs to pick plan. MassHealth repos are saying member is covered.
CarePlus is not MH Standard and the message you see is requiring the person to choose a Managed Care Plan. So the person should call 800-841-2900 and choose a plan ASAP.

Now if that person is "medically fail", having certain medical conditions that may require more attention than the person can call the MH Enrollment Center and request to be escalated to MH Standard due to these conditions. The number would be 888-665-9993.

If patient now eligible for CarePlus begins getting social security, which changes income bracket, what coverage would they receive and when will it be in effect?
All MassHealth members should report change in circumstances, such as change in incomes, to MassHealth Customer Service. With changes in circumstances, a member would be re-determined eligible for MassHealth and based on their circumstances may be eligible for other MassHealth coverage.

A patient called MassHealth and declared herself "medically frail" (cancer patient). Does the patient still need to complete MassHealth Disability Supplement as this upgrade is only a "protection" in place until 12/31/14? Also can ARD make this declaration on behalf of the patient?
An individual in CarePlus can self-declare "medically frail" and does not need to complete a disability supplement. The individual will need to speak with MassHealth by calling 1-888-665-9993 (TTY: 1-888-665-9997) to declare "medically frail."

This is regarding the employer sponsored insurance. If a person states that his family plan is way too high to purchase for his family, but the individual lowest cost for health insurance meets to 9.5% rule, can this person take just an individual plan and apply for assistance for other family members?
The employee can definitely take the individual coverage. However, because the family technically has access to coverage that would be deemed affordable, they would not be able to shop. Children of this family may be eligible for MassHealth.

If someone is approved for coverage and wants to purchase dental coverage how do they do that without losing the subsidized insurance they currently have?
Purchasing dental is a completely separate purchase and can be done only over the phone by calling 1-877-MA-ENROLL. It will have no effect on their subsidies.

I have a client who has Medicare and previously MassHealth Basic (DMH only) now has HSN. I thought he would be receiving an upgrade in coverage. Is there something I can help him to do or is this the correct transition?
Individuals with Medicare looking to apply for MassHealth coverage will need to complete an Application for Health Coverage for Seniors and People Needing Long-Term-Care Services.

If an individual states he/she is married but they are separated (not legally) do you include the spouse on the application?
Applicants for subsidized health coverage must tell us about all members in their household in order to determine eligibility for MassHealth, ConnectorCare, and tax credits based on MAGI rules. Include:

- *Yourself*
- *Your spouse*
- *Your natural, adoptive, or step children under age 19*
- *Your unmarried partner if you have children together who are under age 19*
- *Your unmarried partner's children who live with you and who are under age 19, if you include your unmarried partner*
- *Anyone you include on your tax return (even if they do not live with you) **
- *Anyone your unmarried partner included on his or her tax return (even if they do not live with you), if you include your unmarried partner*
- *Anyone else under age 19 who you live with and take care of*

You do not have to include:

- *Your unmarried partner, unless you have children together*
- *Your unmarried partner's children, unless they live with you*
- *Your parents who you live with and who file their own taxes (if you are aged 19 or older)*
- *Other adult relatives who you do not claim as a tax dependent*

Do people have to pay back any temporary given status? i.e. What if they qualify for a plan, but they have used the temporary status for an emergency?
Any individual in temporary coverage will not be responsible for any payments (other than the nominal co-pays they are charged in that coverage) of services provided once we are able to make a final eligibility determination. Prior to an eligibility determination, individuals on temporary coverage will be provided a broad array of health care services that are at least as comprehensive as what applicants would receive if they were enrolled in a Health Connector plan or MassHealth. These services include doctors and clinic visits, hospital stays, prescription medicines, mental health, family planning and laboratory services. Visit bettermahealthconnector.org/temporary-coverage for a complete list of covered services for individuals receiving temporary coverage.

In regards to Celticare, Network Health, BMC and NHP, what hospitals take these insurance plans and which ones do not? Is there a letter that has this information for the patient, so that they can make the right choice for them in the area?

Members seeking assistance selecting a MCO can call the toll-free telephone number that is in the enrollment package and talk to a Customer Service Representative. The Customer Service Representative is trained to help make the choice that is best for our members and their household.

More information about choosing a health plan through MassHealth can be found in the MassHealth regulations at 130 CMR 508.000.

On the question "Are you offered health insurance" on the ACA application, if a person is part time, but they are offered insurance at their job, if they are full time only, can we just answer "No" to this question?
Yes, they are not offered health insurance because of their part-time status, so they should answer no.

Would Commonwealth Care patients now on temporary coverage need to call the Connector to cancel CommCare?
We suggest having patients stay on Commonwealth Care.

Why are Commonwealth Care members still receiving notices to enroll, although they cannot?
We've stopped sending enrollments postcards for the Commonwealth Care program. Please provide example notices if available.

Clients up for review, should they complete a new ACA?
*Members should complete an eligibility review **ONLY** if they receive a request by mail from MassHealth. We will be in touch with members and assistors on the next steps individuals up for renewals will need to take.*

Where do we call to follow up on dental applications? We have completed apps and clients are receiving notices. When we call the number on the letter, no one is able to see these determinations or know what we are talking about.
For Health Connector Dental plans, members should continue to call the Health Connector Customer Service Center at 877-MA-ENROLL (877-623-6765)

Clients denied for MassHealth, but eligible for ConnectorCare, how and when will this happen?
Right now those individuals, who will most likely be eligible for ConnectorCare will be on Temporary Coverage until a program determination for ConnectorCare can be made and we have the systems in place to support their enrollment.

Please provide written guidance re: people transitioning out of jail or prison as when/if this is a qualifying event?
For MassHealth coverage, individuals are applying 30 days prior to their release from incarceration throughout the state with the intent of obtaining health insurance at release.

For the Health Connector, individuals who are released from prison meet a qualifying event because they experienced a loss of health insurance as a result of no longer being incarcerated. However, an individual needs to be released before they can apply. (This policy may change to align more with MassHealth, but right now, this is how it works.) Unlike MassHealth, individuals who are confined but not convicted are eligible for coverage through the Health Connector.

What do you mean by "one time" qualifying event?
The Health Connector, like the Federally Facilitated Marketplaces, established a special one-time qualifying event that allowed individuals to shop from April 1-April 15, 2014 if they had had trouble with the website.

A person over 65 completed a Virtual Gateway application in November 2013 because the new HIX system was not yet operating correctly. Then the individual did a HIX online application in March 2014; they received MA from Feb 2014. Why did they not receive deny coverage (retro) from application received date?
Persons over 65 should complete the Application for Health Coverage for Seniors and People Needing Long Term Care Services (SACA-2), which is found at the: http://www.mass.gov/eohhs/gov/departments/masshealth/applications-and-member-forms.html.

The person should call the Mass Health Enrollment Center to have the case reviewed and may have to appeal to have the decision changed based on receipt of the original application. This is usually very case specific and not all are the same.

What would an individual do if they had CommCare, lost their job in November before they submitted their ACA application? They cannot afford the premiums while they await the decision.
They should call the Health Connector's customer service at 1-877-623-6765.

A pregnant enrollee signed up for a QHP back in January, but has not yet received a determination. In the Interim, she has been given temporary MassHealth coverage. The issue is that the member sees a provider who does not accept MassHealth, and now the member is ready to deliver. Are there any other options than to switch a provider who accepts Masshealth? Is there a way to expedite these applications?
Pregnant women are eligible to receive richer benefits and should call the MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

A same sex couple married with children can they apply together for MassHealth? How long will it take to receive a temporary coverage letter after they apply?
The Supreme Court ruled on June 26, 2013 that DOMA is unconstitutional. Therefore, same-sex marriages in states that recognize them will now be looked at the same as opposite-sex marriages and the same MAGI household composition rules will apply.

Can someone approved for QHP through CommCare enroll?
Not yet.

What happens to an individual who purchases insurance through the Connector and ends up moving to another state? Do you have any information related to out of state coverage / systems?
They would need to purchase a health plan in the state in which they are moving to. All states have either a state based marketplace or the federally facilitated marketplace. They should also cancel their Massachusetts coverage (MassHealth or QHP).

Can you please explain any changes to MassHealth Premium Assistance for individuals who have a private, non-group health insurance plan that is not employer-sponsored? The person

becomes eligible for MassHealth Family Assistance. Will Premium Assistance help with private, non-group insurance plan premium?
Eligibility for MassHealth premium assistance is determined by the individual's coverage type and the type of private health insurance the individual has or has access to. MassHealth has two categories of health insurance for which it may provide premium assistance: 1) Employer-Sponsored Insurance or 2) Group Insurance Plans (i.e. employer-sponsored health-insurance plans, COBRA, or other group health insurance). The individual will pay for a direct purchase plan for any individuals under the age of 19.

Individuals currently on temporary coverage will need to be program determined for their ACA coverage type before premium assistance is applied.

If an individual gets approved for MH Standard when (temp) in nursing home, will h/she get ERF when discharged? If so, how long after discharge or will the client be able to keep MassHealth Standard?
I believe you are speaking to the Eligibility Review form and Mass Health is mandated to complete one annually on each case. When a discharge from a NH occurs the NH sends MH an SC-1 form, Status of Change, and MH adjusts the case accordingly.

MassHealth CommonHealth member for past year, February 2, 2014 was approved for MassHealth Standard review form was requested and stated that if not returned would be terminated. What do we do? MEC did not know and have been advised differently each time we called.
If the member is receiving any type of requests by mail from MassHealth to verify information or provide additional documents, please send all necessary information to ensure undue delays and coverage gaps.

What if any communications/messaging are planned for unsubsidized populations (especially current CommCare members), between now and the end of June?
*On Thursday June 12th, the Commonwealth announced that we have received approval to extend both the Commonwealth Care (CommCare) and Temporary Coverage (through MassHealth FFS Standard and Limited) programs through **December 31, 2014**. Members currently enrolled in these health insurance programs will begin receiving notification of this extension by mail. Mailing was done in batches and was completed on June 30th.*

Can you please explain what the exemptions are for American Indians that are not eligible for MassHealth? Ex: deductibles, co-pays through the Health Connector.
There are certain Federal rules for American Indians /Alaskan Natives (AI/AN) when applying for health insurance through the Health Connector. AI/AN's are not subject to Open Enrollment restrictions, those who have Indian status are also eligible for additional subsidies, including special cost-sharing assistance at Indian Health Services centers. For more detailed information on Policies for American Indians please visit the Health Connector's Policy Center at www.MAhealthconnector.org.

Eligible to receive services from an Indian Health Services, do tribal members actually have to be seen or get services from Indian Health Services or through referral?
If you are an American Indian/Alaskan Native (AI/AN) and have ever gotten services from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from

one of those programs, you will not have to pay any out-of-pocket costs at the time you get care and will not have to pay any MassHealth premiums.

If you are an American Indian who has never gotten a service from the Indian Health Service, a tribal health program, or urban Indian health program or through a referral from one of those programs but are eligible for such services, you will not have to pay any MassHealth premiums.

Can any person get or just buy dental coverage through the exchange? Which website is most appropriate? Medicare person?
Yes, anyone can purchase a dental plan. They should call 1-877-MA-ENROLL

If someone is over 65, not a citizen, has lived here over 10 years and has not worked enough quarters to qualify for SS or Medicare, are they eligible for a Connector Care plan regardless of assets? What is the bar? 5 years with green card? Or given card application.
Yes, they are eligible for coverage through the Health Connector, including ConnectorCare. There are no restrictions on the immigration status or status award date as long as they are considered Lawfully

Will there be outreach to state colleges and universities listing the local CACs and Navigators organizations and locations? Is this something the Health Connector will consider?
Before June and prior to students pay tuition. We are in very close contact with all the state colleges and universities and will definitely be working with them to give students their choices.

Does having a Certificate of Blind auto-quality an individual as disabled?
Yes.

Why are MH 2014 and HC 2013 using different FPLs?
The federal regulations require that the Health Connector use the FPL table that is in effect as of the first day of open enrollment for a coverage year for the entire coverage year; since the 2013 table was in effect on 10/1 when open enrollment started, we have to use it for all applications for 2014 coverage. Otherwise, the people who apply during open enrollment will be measured against a different income standard than the people who come in mid-year for some reason.

Since MassHealth is always looking at the individuals circumstances at the time of the determination, they can change throughout the year without consequence.

Why can't we see HC letters in MAPs?
MAP was never set up to see Health Connector letters and unfortunately, we don't have any easy way to make it work now.

Members/patients that have CarePlus for coverage, do they need ACA applications?
Unless they receive instructions requesting they do so, CarePlus is a new MassHealth coverage type for individuals ages 21- 64 who are at or below 133% FPL.

We are being told that some members that came up as having either Standard and/or CarePlus are NOT active in MAPS? Why is this? What can we do to get these members active in MAPS?
Providers should continue using the EVS to verify for MassHealth CarePlus or Temporary Coverage members' eligibility.

When checking MAPs, it does not indicate when the next review date is. What can we do and how can we tell if an ACA is needed?
Eligibility review forms for most members under the age of 65 are being delayed during the ACA transition. As for transitional review, forms are being sent to members 64 years of age who are turning 65. Members should complete an eligibility review only if they receive a request by mail from MassHealth.

Can CarePlus be secondary to Medicare?
No, per our regulations at 505.008, MassHealth CarePlus members cannot be enrolled in or eligible for Medicare Parts A or B. Individuals with Medicare looking to apply for MassHealth coverage will need to complete an Application for Health Coverage for Seniors and People Needing Long-Term-Care Services

For the Hospital Determined Presumptive Eligibility, who are the certain individuals that the hospital can approve? Does it include those with an income that would fall in the range where a Home and Community Based Waiver (HCBW) is needed for eligibility?
Eligibility for Home and Community Based Services Waivers cannot be determined presumptively through HPE. Individuals must be determined both financially and clinically eligible through the full application process, including establishing financial eligibility through submission of a full SACA Application (asset information is required), and conducting a clinical/functional assessment to determine that the applicant's level of need meets waiver requirements.

HPE can be used to determine presumptive eligibility for certain individuals as follows:

- *Children aged 0-18 and young adults aged 19-20 eligible for MassHealth Standard*
- *Pregnant women eligible for MassHealth Standard*
- *Former foster care youth up to age 26 eligible for MassHealth Standard*
- *Adults aged 21-64 eligible for MassHealth CarePlus*
- *Parents or other caretaker relatives eligible for MassHealth Standard*
- *Uninsured individuals with breast or cervical cancer eligible for MassHealth Standard*
- *HIV positive individuals eligible for MassHealth Standard or HIV-Family Assistance*
- *Children who are non-qualified permanent residents under color of law (PRUCOLs) eligible for MassHealth Family Assistance*

Parents who have 50/50 custody of child and child lives with the mom, but dad claims him, but legal custody is 50/50. Who should apply for the child?
Both parents may need to claim the child on their applications. It depends on the situation. First I want to be clear about equal custody. According to the ACA, the parent who has the right to claim custody is the parent defined by the court or if no court documents, it is the parent the child spends the most nights with. If the child resides with each parent for an equal amount of nights per the year & the parents cannot agree on who has custody, the IRS says it is the parent who makes more money.(seems wrong about the money issue) So after that is settled, here is what should happen. If the custodial parent & the parent who claims the child on their tax return in the year they are seeking MH or QHP w/PTC are the same parent then only that parent should list the child on the application. If the custodial parent & the parent who claims the child on the tax return for the year they are seeking MH or QHP w/PTC, then both parents should list the child on their application. The child would only be eligible for MH in the household the custodial parent's home & only eligible for QHP w/PTC in the household of the parent who claims them on their tax

return. The system should figure out which is the highest benefit & only award the child one subsidized benefit.(MH or QHP w/PTC) Please note the child may only be eligible for unsubsidized QHP based on how the FPL% come out.(I think this will be rare) If the noncustodial parent who claims the child on their tax return list the child on the application, this does not mean this parent is eligible for Standard as a parent. The definition of parent for MH states the child must be living with the member in order to be categorically eligible as a parent. In this case the noncustodial parent would list on the application that the child does not live at the same address. The reason to list the child in both households is for household compositions & FPL% for both the child & parents.

If an appeal will need to be done on a patient's eligibility, will the application and fax communication showing the date that it was submitted to Masshealth be sufficient back-up?
Saving and providing copies of all documentation will be helpful and may decrease delay during the appeals process.

Where do we send the Senior applications? At the meeting we were told to fax to the regular fax number: (617) 887-8770. In the past, when I had spoken to a supervisor, they told me not to fax to that number, but to fax to CPU in Charlestown, as we would not want the SACA-2's to get piled up with all of the other applications. Was the info at the meeting, when we were told to fax the SACA-2's to the same number as the ACA-2's correct?
Send your filled-out Senior Application to:

MassHealth Enrollment Center
Central Processing Unit
P.O. Box 290794
Charlestown, MA 02129-0214;

HPE – This is only for members with 133%. How will hospitals benefit since these ones are already getting CarePlus or Temporary Standard – Only for folks who don't have a benefit.
So that the provider does not lose time (getting paid). HPE isn't intended to be used for individuals who already have comprehensive MassHealth coverage established. If an individual has MassHealth Standard, CarePlus, or Family Assistance, they already have comprehensive MassHealth coverage and are ineligible for a determination through HPE.

HPE is intended to help certain individuals who do not have sufficient coverage and need coverage effective immediately. However, the coverage is only effective for a limited period of time, and the individual must submit a full MassHealth application in order to be considered for continuing coverage.

HEALTH SAFETY NET

Did HSN produce a SENDS Application that functions on Windows7? It seems to be working but would like to confirm function ability; drop-down to send file does not seem to be working.
Yes, SENDS is compatible with Windows7. For specific questions or concerns related to SENDS please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Documenting that an HSN partial patient with $0.00 deductible has met their deductible? How to bill? Audit protection?

If a patient with HSN Partial has no deductible, the provider can print a copy of the EVS screen displaying no deductible or a copy of the patient's eligibility determination which will also show no deductible. Bills can be submitted indicating that the patient has met their deductible.

Will there be a review form?
The Eligibility Reviews are currently being held for all patients, including HSN, other than the Traditional population. If a patient is not sent a review form then they do not need to fill one out.

Status of dental 2330 & 2331?
These dental codes have been restored for both MassHealth and Commonwealth Care Plan Type 1 patients. Providers should have received a letter from DentaQuest informing them of this update for Commonwealth Care. MassHealth and Commonwealth Care will cover these codes for patients going back to January 1, 2013.

Claims rejected incorrectly are requiring a resubmit, why is there a resubmit and waiver requirement?
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

Why does HSN skip a month in payment process? MassHealth does not.
Typically, claims which are submitted in a given month are processed in the month following submission and paid in the month following processing. However, in some cases there are exceptions to this schedule. For specific claim examples please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

We have claims sent on a spreadsheet to HSN months ago, no status yet. Why? We have also sent files over a year old and also no status yet.
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us

Also claims with corrections are not getting paid at all.
The HSN cannot address this question without reviewing specific claim examples. Please contact the HSN Help Desk at (800) 609-7232 or hsnhelpdesk@state.ma.us.

We have case(s) where members are now (April) being determined eligibility for HSN/HSNP going back to our application dates in December and prior, but they are not OTL to bill (0/90 days). Will there be any considerations made on these submitted claims?
When a patient is determined eligible for the Health Safety Net after services are provided, claims may be submitted within 90 days of the date of determination. If the claim cannot be billed within 90 days of the date of service, the provider may submit a 90-day waiver request in accordance with HSN billing instructions.

When will 837P claims be able to track on MMIS?
The HSN claims migration process to MMIS will take place through several stages. This functionality is expected to become available in a future stage, but a timeline has not been established at this time.

D9450 – Partial payment of only 80%, incentive to health center only. This should be paid at 100%.

For patients with HSN Partial, the HSN pays 80% of the full payment rate for the claim.

When revs says "Elig for ComCare", member must choose plan – not eligible for HSN; should be eligible for dental HSN because they cannot choose a plan now?
A patient who is eligible but unenrolled and beyond their 100 days of temporary HSN gap eligibility is not eligible for HSN services, including dental. The individual should fill out an ACA-2 application.

If someone applied for coverage and is seeking HSN retro from the date of service and got temporary coverage will they get the appropriate retro from date of application even though they are getting temporary coverage now? (January and February temp coverage, and temp coverage for those with affordable coverage.)
Yes, if the patient is ultimately eligible for Health Safety Net or a MassHealth program which has HSN Retro eligibility, the presence of a MassHealth Temporary segment will not block the HSN Retro eligibility. For example, if the patient applied January 15 and is placed into Temporary Coverage starting February 1st, and is ultimately found eligible for HSN, provided all documentation was received on time, they would have HSN starting January 15 with 6 months of retroactive coverage.

ONE CARE (DUALS DEMONSTRATION)

What are the dates and locations for the One Care Shared Learning Conference sessions in June?

The dates and locations are:

June 3, 2014
7:30 A.M. – 1:00 P.M.
Springfield Marriott
2 Boland Way,
Springfield, MA 01103

June 10, 2014
7:30 A.M. – 1:00 P.M.
Best Western Royal
Plaza – Marlborough
181 Boston Post Rd. W,
Marlborough, MA 01752

June 18, 2014
7:30 A.M. – 1:00 P.M.
Four Points by
Sheraton – Norwood
1125 Boston Providence Turnpike,
Norwood, MA 02062

To register for one of these sessions or to get more information, please visit the One Care Learning Website, https://onecarelearning.ehs.state.ma.us/