Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	DENIED	**Appeal Number:**	2200899
Decision Date:	6/1/2022	**Hearing Date:**	03/11/2022
Hearing Officer:	Christopher Taffe	**Record Open to:**	04/14/2022

Appearance for Appellant:
Appellant, pro se (by telephone)

Appearance for MassHealth:
Fabienne Jenniton (BERS from the Tewksbury MassHealth Enrollment Center); and Katie Mullen (Representative from MassHealth Premium Assistance) (both by phone)

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	DENIED	**Issue:**	Premium Assistance – Responsibility to Cooperate
Decision Date:	6/1/2022	**Hearing Date:**	03/11/2022
MassHealth's Rep.:	F. Jenniton & K. Mullen	**Appellant's Rep.:**	Appellant, pro se
Hearing Location:	Tewksbury MassHealth Enrollment Center	**Aid Pending:**	No

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated January 20, 2022, MassHealth informed Appellant that the agency has stopped Premium Assistance benefits. See Exhibit 1; 130 CMR 506.012. Appellant filed a timely request for an appeal with the Board of Hearings on February 7, 2022. See 130 CMR 610.015(B) and Exhibit 1. Challenging a MassHealth agency determination terminating or restricting the scope of medical assistance is a valid ground for appeal to the Board of Hearings. See CMR 610.032.

After the end of the March 11, 2022 hearing, the record was left open until, initially, March 31, 2022, to allow the parties time to exchange and review documentation. See 130 CMR 610.081 and Exhibit 4. The record open period was subsequently extended and closed on April 15, 2022. See Exhibits 4 through 9.

Action Taken by MassHealth

MassHealth terminated Appellant's Premium Assistance benefits.

Issue

The appeal issue is whether Appellant has complied with all requirements to verify his eligibility for continued premium assistance benefits and, if so, is the MassHealth decision to terminate benefits for this insurance proper and justified under current state law.

Summary of Evidence

Appellant is a father of a [redacted] daughter; the daughter has been a MassHealth member since at least April 2020 who currently receives MassHealth Standard benefit, which is the highest form of MassHealth medical assistance. The daughter is disabled and receives health insurance and various state services while living in a community setting. Since some point in 2020, the Appellant has received monthly checks in the amount of $1,314/month in the form of MassHealth Premium Assistance benefits, which is the maximum amount allowed by the state for a disabled individual like Appellant's daughter; these cash benefits are sent to Appellant as Premium Assistance (PA) under the theory that they would in turn be used towards the cost of a family plan under Appellant's employer-sponsored health insurance (ESHI). Appellant's daughter will then continue to be enrolled and covered primarily by Appellant's personal health insurance benefit through his employment and ESHI, with the MassHealth benefit as a secondary form of health insurance. In such a case, per state and federal law, the MassHealth insurance or Medicaid benefit is the insurance payor of last resort. Because of the presence and use of the primary ESHI, this should reduce some of the cost or burden on the Medicaid program.

The appealable action notice of January 20, 2022, which was appealed and led to this hearing, was generated in response to MassHealth Premium Assistance receiving certain updated health plan information ,earlier January 12, 2022, on the renewal form for PA benefits. The MassHealth Premium Assistance Representative ("MH PA Rep") stated that the documents the agency received on the ESHI held by the policyholder indicated that the annual deductible under the ESHI would be $3,000 for an individual and $6,000 for a family. To qualify for PA, the ESHI must meet the Basic-Benefit Level as defined by 130 CMR 501.001. [Insurance benefits through a Basic-Benefit Level (BBL) plan typically must meet some requirements, including but not limited to conditions such as an adequate form of "Minimum Creditable Coverage" (MCC).] The MH PA Rep testified to 130 CMR 506.012(B) which stated this requirement and also read in part that *"Instruments including but not limited to Health Reimbursement Arrangements, Flexible Spending Arrangements…or Health Savings Accounts, as described at IRC §223(c)(2), cannot be used to reduce the health insurance deductible in order to meet the basic-benefit level requirement."* The MH PA Rep also testified that, currently, the maximum deductible allowed by the MassHealth agency for a BBL plan would be $2,850 for an individual deductible and $5,700 for the deductible for a family plan. During this hearing, the MH PA Rep stated that these figures were $2,500 and $5,000 respectively a few years ago, but they have since been periodically adjusted and/or increased yearly due to a regulatory formula used by the agency.[1]

[1] The specific regulation or formula was neither identified nor provided by the agency during the appeal. However, it appears to be a reference to the Commonwealth Health Insurance Connector Authority's regulations found at 956

As a result, on January 20, 2022, MassHealth sent Appellant a notice informing Appellant that it would stop the Premium Assistance payments. The notice states *"MassHealth has determined that you or your family member no longer has health insurance or the health insurance no longer meets MassHealth Rules for Premium Assistance. This is according to MassHealth regulations at 130 CMR 506.012."* See Exhibit 1.

Regardless of whether Appellant receives Premium Assistance payment or not, the daughter will still have MassHealth Standard as a secondary form of health insurance. The question in this appeal is whether there will be monetary Premium Assistance given to the Appellant to help pay the cost of the ESHI.

Although a health reimbursement arrangement is technically not permitted to be factored into this math by the MassHealth regulation per the text of 130 CMR 506.012(B), the MH PA Rep stated that certain arrangements involving health reimbursement, where the employer contributes the cost (instead of the employee) to such arrangement, may be permittable and allow for a recalculation and see if the end result falls under the appropriate monetary limit.[2] In this case, the Appellant's paperwork indicated to MassHealth that Appellant's insurance benefit through his work had some sort of Health Savings Account where the employer contributed to some of the cost of that benefit, and MassHealth stated that in cases like this, the MassHealth agency works together with the Massachusetts Health Connector (the Connector)[3] to have the Connector review the details of employer-sponsored health insurance plans and determine whether such alternative arrangements satisfy any additional MCC requirements that would allow MassHealth to continue premium assistance payments.

The MH PA Rep stated that if Appellant could have his employer fill out and submit a certain form to the Connector,[4] and if the Connector indicated the Appellant's ESHI plan qualified for the above-referenced "exception" to the rule, then the MassHealth Premium Assistance Unit would not only reinstate the monthly payments, but they would also provide reimbursement for any months missed.

Appellant submitted paperwork prior to hearing indicating that the overall deductible of his ESHI is less than $8,000, which is less than some current federal standard.[5] Appellant also argued that his

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CMR 5.03(2)(b) and its subparts.

[2] For examples, in some companies, "Health Savings Accounts" are funded by the employee while in another company it may be funded by the employer, or some combination of both. In addition, the term "Health Savings Account" is a phrase used by many in either a more generic sense, or it is sometimes conflated with other similar accounts or terms which may be related for health care costs and/or create certain taxable benefits and burdens (like a Flexible Spending Account FSA health benefit, or a Health Reimbursement Account, or a Health Reimbursement Arrangement).

[3] The Health Connector is the state-based insurance marketplace that not only assists individuals, families, and small businesses with shopping for health and dental coverage, but also works on many issues involving whether insurance plans meet certain state and federal coverage standards. These standards include many related to or issued since the passage of the federal Affordable Care Act (ACA) in 2010.

[4] The form, provided post-hearing and found in Exhibit 4, is titled *"MCC Certification Application for Plan Years Beginning On or After 1/1/2022"*.

[5] It is noted here that being less than $8,000 does not automatically mean it is less than the $5,700 testified to by the MH PA Rep at hearing. It is also unclear if this $8,000 figure includes the aggregate of not only the deductible, but

ESHI was a High Deductible Health Plan (HDHP) and that there were various relevant state and federal regulations which meant that all HDHP should satisfy the necessary MCC requirements. Appellant also submitted various pages from the IRS.gov website, mass.gov, and some federal tax publications in support of this position. See Exhibits 1 and 3.

The MH PA Rep pointed out that she believed the IRC documents submitted by the Appellant had more to do with some qualification or categorization of a Health Savings Account or the effect of such an HSA, as opposed to an entire insurance plan. She wanted to defer to the Connector's process so the most proper legal review of the plan and whether it met the relevant MCC standard could be done.

On the March 11, 2022 hearing date, post-hearing, the MH PA Rep sent Appellant the form needed to be filled out by his employer and sent to the Connector. See Exhibit 4. Appellant responded on March 11, 2022 with an email that stated in part and concluded with *"...From what I understand, the plan is already certified as MCC eligible (at least that's what my employer says) and hence a duplicate submission does not make sense."* See Exhibit 5.

The MH PA Rep responded on that date, stating *"I would recommend sending the documents they have stating it meets MCC along with the completed form. If the Health Connector approves, they will stamp the form and then Premium Assistance will be able to continue payments."*

On the hearing date, the Hearing Officer initially allowed a Record Open deadline of March 31, 2022 for the Appellant to submit the form from his employer (Verista) and for the MH PA Rep to respond as to any new information she learned from the Connector. On March 31, 2022, the MH PA rep reported that the agency's Premium Assistance Unit had not received anything from the Connector yet, and she had sent an email inquiring on the status of any such form to the Connector. The Hearing Officer extended the record until April 8, 2022. See Exhibit 7.

On April 1, 2022, the Appellant replied with an email saying the following in part:

"...Sorry for the delay since I am OO country on vacation.

I did send the form to my Employer and they discussed with our insurance agency. The Insurance Agency confirmed that the current plan meets MA MCC standard and hence they do not need to submit this form. I am attaching the response here..." See Exhibit 8.

The response referred to within, from the Insurance Broker (from a company named AON based in Louisville Kentucky), states in part the following as to the document that the MH PA Rep asked Appellant to fill out:

***"…[The document MassHealth is asking Appellant to fill out] is** a document that the employer completes for the annual attestation for creditable coverage. It is not meant for individuals covered on the plan. BCBS MA or Anthem are also required under the ACA to meet minimum coverage*

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other out-of-pocket costs, such as co-insurance, or copayments.

standards. Both the HPP and Verista plans would meet the criteria (60% actuarial value to meet the "Bronze" level standard required by the state of MA is the same as the ACA requirement).

Do you have the individual employee documents for the state subsidy for a disabled dependent? I have looked, but so far, I have not found what appears to be the correct documents."
See Exhibit 8.[6]

On April 5, 2022, the Hearing Officer extended the Record Open period to April 13, 2022. In that April 5, 2022 correspondence, the Hearing Officer stated that the appeal record didn't need the insurance agency's opinion as to confirm MassHealth compliance, but that instead the MassHealth agency needed to confirm the plan's compatibility and eligibility in order to allow for a benefit like Premium Assistance to continue and be approved. The Hearing Officer also directly informed Appellant in this April 5, 2022 correspondence of Appellant's obligation under the MassHealth regulation at 130 CMR 501.010 to provide corroborative information related to establishing eligibility for state medical assistance. The Hearing Officer closed his correspondence by indicating to Appellant that he would give Appellant the until April 13, 2022 to obtain and submit the information. See Exhibit 9.

On Thursday April 14, 2022, the Appellant replied saying, in part, that "*Since my Employer is convinced that the plan conform to MCC* (sic)*, they would not send the form to reapply for MCC. I will leave it to you to write the decision...*" See Exhibit 9.

The MCC Certification form, found in multiple places within the record, but first in Exhibit 4 with the emails of March 11, 2022, consists of 8 pages. Section A consists of "*Contact Information*" and Section B consists of "*Health Benefit Plan Information"*. Page 3 of the 8-page form is titled "*Section C – Deviations*" and has an introductory section that reads verbatim:

> *"**Please identify the plant's deviation(s) from the MCC requirements listed in** 956 CMR 5.03(2) and (3) **for in-network services only. You must answer these questions. You cannot answer by simply referring to the attached schedule/summary of benefits. Failure to identify any deviation below will result in the application being considered incomplete and it will NOT be processed. You may attach a separate document(s) to explain any issues further**."*

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[6] It is unclear how Appellant goes from these statements to the conclusion that "*The Insurance Agency confirmed that the current plan meets MA MCC standard and hence they do not need to submit this form.*"
In an earlier email between Appellant and his employer and the broker found within Exhibit 8, the Appellant himself wrote on March 11, 2022 (after the hearing) to the Verista Manager of Human Resources, stating the following and referring to the difference between HRA and HSA for this particular ESHI:

> *"…This has a minor personal ramification on me, but more than that, it will impact all Massachusetts employees who purchased this (or the one with even higher deductible) plan because we will need to pay additional Tax at end of year for not carrying a state approved insurance. Ideally employer contribution to an HRA is taken into account to reduce the Deductible threshold, but they said that the Employer Contribution (to HSA) that we have might be considered if we apply. Can you check with our legal and/or insurance if we have MCC Certification? If we have can you send me a copy. If we are not MCC certified and intend to get certified, they sent me a form that need* (sic) *to be completed by the employer. This is not an individual level application, but for the entire plan."* See Exhibit 8.

(Bolded, non-bolded, CAPITALIZED, and underlined emphases as found in original. See Exhibit 4.)

Section C then offers 12 possible "deviations" with a box to check if applicable. The most relevant "deviations" to this appeal are # 2 and 3, which read verbatim as follows:

"2. The health benefit plan has a **combined** (if applicable) **annual deductible** for **in-network** covered core services that is **more than**

□ $**2,750** for individual coverage and/or more than □ **$5,500** for family coverage
Note: If the health Benefit plans deductible is more than $2,750 for individual coverage or more than $5,500 for family coverage but the employer funds a Health Reimbursement Arrangement (HRA) that results in a net deductible that is not more than $2,750 for individual coverage and not more than $5,500 for family coverage, then the combined coverage satisfies the MCC deductible requirement. For example, a health benefit's plan's deductible is $4,000 for individual coverage and $8,000 for family coverage and the employer funds an HRA that providers $1,250 for an individual employee coverage and $2,500 for family coverage. This results in a net deductible of $2,750 for individual coverage and $5,500 for family coverage, and, therefore this combination satisfies the MCC deductible requirement and you would NOT need to check the corresponding box(es) above. If, on the other hand, a health benefit's plan deductible is $4,000 for individual coverage and $8,000 for family coverage and the employer funds an HRA that provides $500 for an individual employee coverage and $1,000 for family coverage, then this combination results in a net deductible of $3,500 for individual coverage and $7,000 for family coverage and this combination would NOT satisfy (thereby deviating from) the MCC deductible requirement and you would need to check the corresponding box(es) above and answer question 1 on page 5.

3. The health benefit plan has an **out-of-pocket maximum** for **in-network** covered core services that is **more than** □ **$8,700** for individual coverage and/or more than □ **$17,400** for family coverage."

(Bolded, non-bolded, CAPITALIZED, and underlined emphases as found in original. See Exhibit 4, page 3 of 8 of the MCC form [page 5 of the entire Exhibit 4].)[7]

Section D of the MCC form has questions related to, and is titled, "*Plan Benefit Information*" and Section E involves "*Actuarial Attestation/Certification*". Section F is titled "Applicant's Summary and Signature" and requires a signature under the pains and penalty of perjury. See Exhibit 4.

[7] Although the MH PA Rep's testimony referred to deductible figures of $2,850 for an individual and $5,700 for a family plan, it is noted that her testimony occurred in 2022, likely after another annual adjustment required by 956 CMR 5.03, and this form from the Connector is from July 2021, and is likely the Connector's most current form with albeit with some 2021 calendar year dollar figures, and that explains the discrepancy.
In addition, the 3rd possible deviation was included as that seemed to be the issue that Appellant was more predominantly focused on in his submissions (in Exhibits 1 and 3) regarding the sum total of the deductible and out of pocket expenses. However, the form makes it clear that there are potential deviation or compliance questions with just the deductible, which may be separate from the issue regarding the total of such deductibles and out of pocket expenses.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. Appellant is the father of a [redacted] MassHealth member who is receiving MassHealth Standard benefits as a disabled adult. (Testimony)

2. Starting in or around 2020, Appellant has been receiving monthly checks of approximately $1,314 from the MassHealth program as a Premium Assistance benefit for his daughter. These checks are expected to be used towards contributions for the Appellant's cost of a family plan available through his employer's ESHI. (Testimony)

3. In January 2022, MassHealth sent a notice to Appellant stating that the agency would stop Premium Assistance benefits. (Testimony and Exhibit 1)

    a. MassHealth sent this notice because there were questions as to whether the ESHI plan met MassHealth rules for continued Premium Assistance payments. (Testimony)

4. Appellant's ESHI has an individual plan deductible of $3,000 and a family plan deductible of $6,000. (Testimony and Exhibits 1 and 3)

    a. Any ESHI that has an individual plan deductible of more than $2,850 for an individual plan and $5,700 for a family plan has a "deviation" that may need to be reviewed under Massachusetts law to see if it meets certain MCC and BBL criteria required by the MassHealth program regarding the plan's deductible limit. (Testimony and Exhibit 4)

    b. Appellant's ESHI benefits has some sort of alternative Health Reimbursement Arrangement that may involve additional funding from the employer in the form of a Health Savings Account or some other similar arrangement and account. (Testimony and Exhibit 4

5. After the hearing held on March 11, 2022, the MH PA Rep sent Appellant a copy of the *"MCC Certification Application for Plan Years Beginning On or After 1/1/2022"* form. (Exhibit 4)

6. MassHealth informed Appellant that if he wanted to be considered for continued Premium Assistance benefits, he would have to work with his employer and have them submit information to the Connector in order to allow the Connector to review the plan and see if it satisfied the necessary regulations which would allow MassHealth to provide this monetary benefit. (Testimony and Exhibit 4)

7. Through the use of the Record Open period, the Appellant had more than 30 days to have the MCC-related form completed and submitted to the Connector. (Exhibits 4 through 9)

8. Appellant did not submit the MCC-related form to the Connector during the Record Open period. (Exhibits 8 and 9).

    a. Despite being informed of the need to cooperate and corroborate information, Appellant stated that he and his employer would not complete and send the form to the Connector for review, as the Appellant stated that his employer believes the insurance conforms with the relevant MCC requirements so there is no need to send the form to the Connector. (Exhibits 8 and 9)

Analysis and Conclusions of Law

As the Summary contains in detail, the question of eligibility for MassHealth Premium Assistance, especially when it involves Employer-Sponsored Health Insurance, is relatively complicated and fact-intensive as far as Medicaid appeals go. It is not just a simple matter of comparing an income level of an applicant and seeing whether the income is over or below a certain figure determined of the Federal Poverty Level (as the agency did in the past when determining the financial eligibility test for Appellant's daughter per 130 CMR 505.002(E)(1)(b) to see if she qualifies for MassHealth Standard benefits).

Instead, eligibility for MassHealth Premium Assistance component of benefits can require analysis that looks at many different factors and regulations, including but not limited to, 130 CMR 506.012(B) **and** (C) (referencing definitions at 130 CMR 501.001 and how different types of ESHI may or may not qualify); 130 CMR 501.001 (incorporating portions of 956 CMR 5.00 as well as federal regulations); and 956 CMR 5.01 to 956 CMR 5.05. Clearly there are multiple options that private and employer-sponsored health insurance may have, as one regulation lists some of the regulations (*Health Reimbursement Arrangements, Flexible Spending Arrangements…or Health Savings Accounts*). See 130 CMR 506.012(B). A close review of the detail of the many subsections within those regulations shows various terms and a need for significant analysis to be done to determine compliance. This need for factual analysis is further confirmed by the MCC Certification form found in Exhibit 4, which is promulgated per the Connector regulations in 956 CMR 5.00, and which in turn has two extensive pages regarding all the possible "deviations" that certain ESHI may have. Knowing whether a health plan has such deviations, and whether the deviation is allowable or falls within an exception, may determine whether an insurance is compliant with certain state standards.

In this matter, there was some general information and allusions to Appellant's ESHI benefit, but no detailed information was provided at hearing as to the health arrangements that Appellant may have through his ESHI. On its face, the Appellant's insurance does not comply with 956 CMR 5.03(2)(b)(2) due to the deductible amounts of the plan which exceed not only the regulatory text but also the purported increased dollar figures for such deductible figures. However, MassHealth explained that while this was a sign of a possible deviation,[8] it was not necessarily the end of the

[8] This analysis can take no position on whether Appellant's ESHI is MCC compatible or not. The ESHI very well may be compliant, but to verify that, **further information had to be provided by Appellant**. Had the Appellant submitted information and had MassHealth indicated it would not result in continued PA benefits, the parties may

matter and that Appellant may be able to obtain relief for the deviation. The MH PA Rep offered and explained how a form could be filled out, reviewed by the state, and how this form could be used to more fully determine whether Appellant's ESHI is compliant with the relevant state law, which may have allowed for reconsideration of the decision and perhaps the continuation of the PA benefits.

Because the MassHealth agency is charged with properly administering and disbursing a lot of state resources, the MassHealth agency is obligated and within its rights to have steps in its eligibility process to require corroboration, particularly in the case where the distribution of a non-nominal and regular cash benefit, like the Premium Assistance benefits at stake in this case. See 130 CMR 502.001(B) (requiring corroborative information to be timely provided); 130 CMR 502.007 (stating that the timeframe for completing an eligibility review for MassHealth members may be as short as 30 days). In this matter, Appellant was sent the form and given instructions as to how the form could be returned. Ample time of more than a month since the hearing date was given and allowed for the Appellant to respond and, if there was a delay caused by circumstances beyond the Appellant (such as a delay caused by the employer), more time could have been requested and given per 130 CMR 610.081. However, not only was the form never returned, but Appellant also indicated that it would not be done, even if more time was given. See Exhibit 9.

The MassHealth regulation at 130 CMR 501.010(A) reads as follows:

501.010: Responsibilities of Applicants and Members
*(A) Responsibility to Cooperate. **The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility** and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance. **The MassHealth agency may request corroborative information necessary to maintain eligibility**, including obtaining or maintaining available health insurance. **The applicant or member must supply such information within 30 days of the receipt of the agency's request. If the member does not cooperate, MassHealth benefits may be terminated**.*
(**Bolded** emphasis added.)

In this case, Appellant was given sufficient time to provide corroborative information and chose to not do so. The main reason appears to be because the Appellant would rather rely on the opinion and unsubstantiated and somewhat vague conclusions of his employer's insurance broker about MCC instead of the opinion of the Connector on the to see whether the payment arrangements complies with Massachusetts and Medicaid law.[9] The desire of MassHealth member to not file a

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have been called back and/or the record would have been further developed to decide whether the MassHealth decision on continued PA benefits was proper.
It is unclear why Appellant and his HR director in their emails in the week after the hearing talked about how Appellant's claim was "rejected" and that the plan "does not meet minimum creditable coverage". That is not what MassHealth said. If it was "rejected" why would MassHealth offer the form and a chance for relief? MassHealth is allowed to have the insurance arrangement reviewed to see how the ESHI fits within regulatory framework before disbursing a constant cash benefit.
[9] Medicaid law, which may allow for Premium Assistance payments from the MassHealth program, may (or may

form but still receive a benefit is not necessarily permitted by the regulations and it is certainly not a choice to which a member is entitled. To qualify for a cash benefit, the Appellant must file the form.

Based on the above analysis, I conclude that there is no evidence in the record which can allow me to grant Appellant the relief he seeks in the form of continued Premium Assistance benefits. This appeal is therefore DENIED. Appellant can choose to file the form or take further appropriate action in the future to see if he and/or his daughter qualify for a PA benefit that starts or is reinstated in the future, but there are no further appeal rights over the benefits terminated.

If Appellant disagrees with this interpretation or believes there is an entitlement to past benefits due to a conflict between federal and state law, he has a right to bring that issue and appeal that to the more appropriate forum of the Superior Court. See 130 CMR 610.092; 130 CMR 610.082.[10]

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not) have different standards than the IRS or the Commonwealth's DOR does with regard to compliance with MCC and the federal and state health insurance mandates. See e.g. 130 CMR 506.012(C)(1) and (C)(2) (laying out certain PA eligibility rules for plans where the employer contributes 50% or more of the cost, and slightly different rules for those where the contribution is less than 50%.)

[10] 130 CMR 610.082(C) reads in relevant part as follows:

610.082: Basis of Fair Hearing Decisions

...

(C) The decision must be rendered in accordance with the law.

(1) The law includes the state and federal constitutions, statutes, and duly promulgated regulations, as well as decisions of the state and federal courts.

(2) Notwithstanding 130 CMR 610.082(C)(1), the hearing officer must not render a decision regarding the legality of federal or state law including, but not limited to, the MassHealth regulations. ***If the legality of such law or regulations is raised by the appellant, the hearing officer must render a decision based on the applicable law or regulation as interpreted by the MassHealth agency. Such decision must include a statement that the hearing officer cannot rule on the legality of such law or regulation and must be subject to judicial review in accordance with 130 CMR 610.092.***

(3) The hearing officer must give due consideration to Policy Memoranda and any other MassHealth agency representations and materials containing legal rules, standards, policies, procedures, or interpretations as a source of guidance in applying a law or regulation."

(**Bolded** emphasis added.)

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Christopher Taffe
Hearing Officer
Board of Hearings

cc: Appeals Coordinator @ Tewksbury MEC

Appeals Coordinator @ Premium Assistance