Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2413778
Decision Date:	12/9/2024	**Hearing Date:**	11/07/2024
Hearing Officer:	Susan Burgess-Cox		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Patrick George; Sean Brescia
Eileen Cynamon & Yvette Prayor

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:**	Disability; Income; Assets
Decision Date:	12/9/2024	**Hearing Date:**	11/07/2024
MassHealth's Rep.:	Patrick George; Sean Bresca; Eileen Cynamon & Yvette Prayor	**Appellant's Rep.:**	Pro se
Hearing Location:	All Parties Appeard by Telephone	**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 August 21, 2014, MassHealth notified the appellant that they are changing his health benefits from MassHealth Standard to MassHealth CarePlus because of a change in circumstances. (130 CMR 505.000; Exhibit 1). MassHealth noted that the appellant will not get MassHealth Standard after September 4, 2024 because he no longer meets the disability requirements for this benefit. (130 CMR 505.007(F)). Additionally, the appellant's household income is at 101.69% of the federal poverty level (FPL). The appellant filed a timely appeal on September 5, 2024. (130 CMR 610.015).

In the request for hearing the appellant stated that he had "no documents" and "I believe my sleep disorder is a disability as it usually affects my daily life". (Exhibit 2). The Board of Hearings scheduled a hearing for October 10, 2024 with representatives from a MassHealth Enrollment Center (MEC). (Exhibit 3). At that hearing, it was noted that the appellant was challenging the agency's decision regarding his disability status. A representative from the agency's disability evaluation services (DES) department was not present at the hearing. The Board of Hearings rescheduled the hearing for November 7, 2024 with representatives from a MEC and DES. (Exhibit 4).

An agency action to suspend, reduce, terminate, or restrict a member's assistance, and a change in the scope or amount of assistance are valid grounds for appeal. (130 CMR 610.032(A)(3); 130 CMR 610.032(A)(5)).

Action Taken by MassHealth

MassHealth changed the appellant's coverage from MassHealth Standard to MassHealth CarePlus because he no longer meets the disability requirements for MassHealth Standard and his income and assets exceed program limits. (130 CMR 505.000).

Issue

Whether MassHealth was correct in changing the appellant's coverage from MassHealth Standard to MassHealth CarePlus because he no longer meets the disability requirements for MassHealth Standard and his income and assets exceed program limits.

Summary of Evidence

All parties appeared by telephone. MassHealth representatives from the Tewksbury MassHealth Enrollment Center (Tewksbury MEC) and the UMass Disability Evaluation Services (DES) offered testimony regarding the appellant's financial eligibility for MassHealth as well as the evaluation of his disability claims. Documents submitted by MassHealth were incorporated into the hearing record as Exhibit 5 and Exhibit 6.

The Tewksbury MEC had a representative from their unit that worked with members under [redacted] and another who works with those over [redacted] The MEC representative from the [redacted] unit testified that at the time of the decision on appeal, the agency determined that the appellant was eligible for CarePlus as his income was below 133% of the federal poverty level and the agency no longer considered him eligible as a disabled adult. The appellant's income of $1,339 each month from the Social Security Administration placed him at 101.65% of the federal poverty level. Prior to the date of the hearing, the agency determined that the appellant was no longer eligible for CarePlus as they found that he was over the age of [redacted] and CarePlus provides coverage to adults [redacted]

The MassHealth representative from the [redacted] unit testified that the agency issued a notice on November 4, 2024 notifying the appellant that he is eligible for the Medicare Savings Program for Qualified Medicare Beneficiaries (MSP-QMB) as his income is over the limit for MassHealth Standard for individuals over the age of [redacted] and his assets exceed the program limit for MassHealth Standard. Neither party provided a copy of this notice. The MassHealth representative noted that the agency counted a life-insurance policy with a cash-surrender value of approximately $74,000 in

calculating countable assets. The MassHealth representative testified that the appellant met the income and asset requirements for the MSP-QMB. As of the date of the hearing and this notice, the appellant still has the time and opportunity to appeal that decision. This hearing is based upon a request for hearing filed in September 2024.

The appellant did not challenge the asset or income information presented by the representatives from the Tewksbury MEC. The appellant did not have any questions, and the representatives did not have any further testimony or evidence to present. All parties agreed with the decision to dismiss the representatives from the Tewksbury MEC.

The DES representative testified that the appellant was administratively approved for MassHealth as a disabled adult under protocols in effect during the COVID-19 Public Health Emergency (PHE). (Testimony; Exhibit 5; Exhibit 6). These protocols included the agency accepting self-attestation for verification of several eligibility factors including disability status. (MassHealth EOM 20-09). On April 1, 2023, these protocols ended as the PHE was lifted. (MassHealth EOM 23-13). As of April 1, 2023, MassHealth began redetermining eligibility for all members to ensure they still qualify for their current benefits. (MassHealth EOM 23-13). As a result, MassHealth required the appellant to submit a disability supplement. (Testimony; Exhibit 5; Exhibit 6). DES received a disability supplement in January 2024. (Testimony; Exhibit 5; Exhibit 6). The DES representative testified that the medical release forms had missing, incomplete or invalid information so DES could not begin the review process. (Testimony; Exhibit 5; Exhibit 6). DES worked with the appellant and received the necessary documents in February 2024.

As the agency accepted a self-attestation from the appellant regarding his disability during the PHE, in redetermining the appellant's eligibility, they conducted an initial disability evaluation. In making this determination, DES applied the following five-step sequential evaluation process established by the Social Security Act for the purpose of determining eligibility for MassHealth:

Step 1: Is the applicant engaged in substantial gainful activity?

Step 2: Does the applicant have a medically determinable impairment (MDI) or combination of MDIs that is both severe and expected to last for a continuous period of not less than 12 months?

Step 3: Does the impairment meet or equal criteria listing established by the Social Security Administration?

Step 4: Can the applicant retain the capacity to perform past relevant work?

Step 5: If the applicant is not able to perform past work, is the applicant able to perform any other work, considering the applicant's residual functional capacity (RFC), age, education, and work experience?

In performing this review, DES utilized the disability supplement submitted by the appellant, records from the appellant's providers and consultative exams ordered by DES. (Testimony; Exhibit 5; Exhibit 6).

Step 1 is waived for MassHealth eligibility purposes. The DES review progressed to Step 2. The DES representative testified that the appellant listed the following health issues on the supplement: diabetes with symptoms to the eyes, hands and feet; eye issues with floaters; chronic heart disease with chest pain; kidney disease; sleep disorder; left shoulder ache related to a motor vehicle accident in 2016; carpal tunnel "now and again"; memory issues; less upper body strength; and stamina. (Testimony; Exhibit 5 pages 60-64; Exhibit 6).

The appellant graduated from high school, provided a history of working until July 2014 stating that he was not sure if his medical or health condition caused problems at work. (Exhibit 5 pages 62-63). The MassHealth representative testified that the appellant's complaints can be further described with a diagnosis of diabetic peripheral neuropathy, mild non-prolific diabetic retinopathy without macular edema; hypertension; hyperlipidemia; and chronic renal failure without health failure. (Testimony; Exhibit 5; Exhibit 6). The agency determined that the available provider documentation was insufficient to fully evaluate all the appellant's complaints. Therefore, DES ordered a medical consultative exam (CE). The appellant attended the CE on May 14, 2024. (Testimony; Exhibit 5 pages 66-69).

The physician from the medical CE reported that the appellant's sleep disorder/insomnia might have a mental health component and would benefit from a psychiatric evaluation. (Testimony; Exhibit 5 page 67). As the appellant did not have a current provider for which records could be obtained, DES ordered a psychiatric consultative exam. The psychiatric CE was completed in August 2024 as the appointment had to be rescheduled twice. (Testimony; Exhibit 5 page 70). Notes from the psychiatric CE state the appellant did not report any present suicidal ideation; homicidal ideation; hallucination, or delusion. (Exhibit 5 pages 70-74). The psychiatric CE states that during the interview the appellant's affect was regulated by a mildly irritable mood. (Exhibit 5 pages 70-74). The results of the mental status examination indicated normal cognitive functioning. (Exhibit 5 pages 70-74). The psychiatric CE lists a diagnosis of unspecified insomnia disorder. (Testimony; Exhibit 5 pages 70-74). On the disability review form, DES provides the following "Problem List": diabetes; diabetic retinopathy with macular edema; chronic heart disease; kidney disease; carpal tunnel syndrome; diabetic peripheral neuropathy; left shoulder ache; poor memory/cognitive impairment; sleep disorder. (Exhibit 5 page 75). Based upon the information received from the appellant's providers and the CEs, MassHealth determined that the appellant had a combination of MDIs that are both severe and expected to last for a continuous period of not less than 12 months. The evaluation progressed to Step 3.

At Step 3, DES had to determine whether the appellant's impairments met the criteria in the adult listings established by the Social Security Administration (SSA) or are medically equal to a listing for a period of 12 months or more. In their evaluation, DES compared the appellant's visual impairments with the SSA listing at 2.02 for Loss of Central Visual Activity. DES determined that

the appellant's visual impairments did not satisfy the criteria for this listing. DES compared the appellant's reported heart impairments to the SSA listing at 4.02 for Chronic Heart Failure. DES determined that the appellant did not satisfy the criteria for this listing. DES compared the appellant's reported kidney impairments with the SSA listing at 6.05 for Chronic Kidney Disease with Impairment of Kidney Function. DES determined that the appellant did not satisfy the criteria for this listing. DES compared the appellant's reported diabetic peripheral neuropathy to the SSA listing at 11.14 for Peripheral Neuropathy. DES determined that the appellant did not satisfy the criteria for this listing. DES compared the appellant's reported poor memory, cognitive impairment and sleep disorder to the SSA listing at 12.02 - Neurocognitive Disorders for poor memory/cognitive impairment/sleep disorder. DES determined that the appellant did not satisfy the criteria for this listing.

The DES review progressed to Step 4 to determine if the appellant retains the capacity to perform any past relevant work. The appellant reported no work history in more than 5 years. The review progressed to Step 5 to determine if the appellant can perform any other work, considering his residual functional capacity (RFC), age, education and work experience. A physical RFC showed no exertional limitations; no manipulative limitations; no visual limitations; no communicative limitations; some postural limitations involving balance, climbing, stooping, kneeling and crawling; and environmental limitations related to heavy machinery due to potential sugar fluctuations and mild retinopathy. (Exhibit 5 pages 87-89). The physical RFC notes that the appellant has mild neuropathy without treatment needed except for good blood sugar control. (Exhibit 5 pages 87-89). The physical RFC states that no sleep studies were noted in the records. (Exhibit 5 pages 87-89). The physical RFC states that overall there was very little information on any physical limitations and the CE exam was noted as normal. (Exhibit 5 pages 87-89). A mental RFC showed that the appellant was slightly limited in some areas. (Exhibit 5 pages 90-91). The conclusions in the mental RFC note that while the physician found evidence of an insomnia disorder, there was no compelling evidence of significant functional limitations. (Exhibit 5 pages 90-91).

At Step 5, DES concluded that the appellant is capable of performing work as a counter and rental clerk; library assistant, clerical; assembler and fabricator. (Testimony; Exhibit 5 pages 78-93; Exhibit 6). The DES representative testified that the appellant does not meet or equal the high threshold of the adult SSA disability listings. Additionally, the RFCs indicate that the appellant is capable of performing work in the competitive labor market and there are a significant number of jobs in the regional and national economy which the appellant can perform based on his physical and mental capabilities as well as his vocational qualifications. (Testimony; Exhibit 5; Exhibit 6). As a result of this final finding, DES determined that the appellant is not disabled.

The appellant testified that he suffers from insomnia and this impacts his ability to work. The appellant testified that he has lost at least one job due to incidents related to his insomnia. The appellant testified that he can become irritable because he is tired. The appellant testified that he is at risk when he drives or sleeps as he may fall asleep while driving or choke on vomit when sleeping. The appellant testified that he began receiving benefits from the Social Security Administration when he turned [redacted] as he was no longer working and able to receive the benefit

due to his age. The appellant testified that he wakes up 4 or 5 times each night which limits his ability to be able to function at a job. The appellant testified that he sees his primary care to receive treatment for the conditions noted on the disability supplement. The appellant testified that he does not see a neurologist, cardiologist or receive any psychiatric or psychological treatment. The appellant testified that all of his medical issues are associated with insomnia. The appellant has not seen a sleep specialist or undergone a sleep evaluation.

The appellant testified that he sees an ophthalmologist every 8 or 9 months due to issues with his vison. The appellant testified that he does not take any medications or receive any regular treatments related to his vision. The appellant testified that his primary care informed him that his insomnia may be related to his diabetes but did not offer any treatment recommendations. The appellant testified that he does not want to take sleep medications because they can be addictive and he lives alone so if he is in a deep sleep he may not hear a smoke alarm or be able to respond to other incidents. The appellant testified that a worker at an enrollment center informed him that he would likely be deemed disabled by MassHealth.

Findings of Fact

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

1. The appellant is a family group of 1 with monthly income of $1,339.

2. The appellant's countable income is at 101.65% of the federal poverty level.

3. Prior to the eligibility decision on appeal, the appellant was administratively approved for MassHealth Standard as a disabled adult.

4. The administrative approval was based upon protocols in effect during the PHE including acceptance of self-attestation for verification of a disability.

5. Upon lifting of the PHE, MassHealth began performing initial disability evaluations for those deemed disabled through self-attestation during the pandemic.

6. At the time of the eligibility decision on appeal, the appellant was eligible for MassHealth CarePlus as he was under the age of [redacted] and no longer deemed disabled.

7. DES received documents necessary to begin an initial disability evaluation in February 2024.

8. A review of appellant's medical condition was undertaken by DES using a five-step sequential evaluation process established by Title XVI of the Social Security Act for the purpose of determining eligibility for medical assistance.

9. The five-step sequential evaluation process addresses the following:

    Step 1: Is the applicant engaged in substantial gainful activity?

    Step 2: Does the applicant have a medically determinable impairment (MDI) or combination of MDIs that is both severe and expected to last for a continuous period of not less than 12 months?

    Step 3: Does the impairment meet or equal criteria listing established by the Social Security Administration?

    Step 4: Can the applicant retain the capacity to perform past relevant work?

    Step 5: If the applicant is not able to perform past work, is the applicant able to perform any other work, considering the applicant's residual functional capacity (RFC), age, education, and work experience?

10. The appellant graduated from high school.

11. The appellant has not worked in the last 5 years.

12. The appellant appeared at the hearing by telephone and was able to provide testimony on his own.

13. The appellant does not need assistance with any activities of daily living or instrumental activities of daily living.

14. The appellant has no exertional, manipulative, visual or communicative limitations.

15. The appellant has some postural limitations involving balance, climbing, stooping, crawling, kneeling and crawling.

16. The appellant has environmental limitations related to heavy machinery due to potential sugar fluctuations and mild retinopathy.

17. The appellant has been diagnosed with diabetes.

18. The appellant has mild neuropathy without treatment needed except for good blood sugar control.

19. The appellant has a diagnosis of unspecified insomnia disorder.

20. The appellant has not participated in any sleep studies.

21. At a psychiatric consultative exam, the appellant did not report any present suicidal ideation; homicidal ideation; hallucination, or delusion.

22. The appellant has normal cognitive functioning.

23. MassHealth determined that the appellant had a combination of MDIs that are both severe and expected to last for a continuous period of not less than 12 months.

24. The appellant's visual issues did not meet the SSA listing at 2.02 – Loss of Central Visual Activity.

25. The appellant's reported kidney issues did not meet the SSA listing at 6.05 – Chronic Kidney Disease with Impairment of Kidney Function.

26. The appellant's reported heart issues did not meet the SSA listing at 4.02 – Chronic Heart Failure.

27. The appellant's reported memory and cognitive impairments and insomnia did not meet the SSA listing at 12.02 – Neurocognitive Disorders for poor memory/cognitive impairment/sleep disorder.

28. The appellant is capable of performing work as a counter and rental clerk; library assistant, clerical; assembler and fabricator.

Analysis and Conclusions of Law

A disabled adult 21 through 64 years old is eligible for MassHealth Standard if they are permanently and totally disabled as defined in 130 CMR 501.001. (130 CMR 505.002(E)(1)). The regulations define disabled as having a permanent and total disability. (130 CMR 501.001). Disability is established by:

(a) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
(b) a determination of disability by the SSA; or
(c) a determination of disability by the Disability Evaluation Services (DES). (130 CMR 505.002(E)(2)).

The MassHealth Disability Evaluation Services (DES), is a unit that consists of physicians and disability evaluators who determine permanent and total disability of an applicant or member seeking coverage under a MassHealth program for which disability is a criterion. (130 CMR

501.001). In making a disability determination, DES uses the criteria established by the Social Security Administration under Title XVI, and criteria established under state law. (130 CMR 501.001). The Social Security Administration defines disability as:

> the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. (20 CFR 416.905(a)).

Title XVI of the Social Security Act establishes the eligibility standards, and both the five-step sequential evaluation for initial disability determinations, and the eight-step process for ongoing disability determinations. In this case, the five-step process was used because there was no initial review performed by MassHealth or the Social Security Administration. In determining eligibility for MassHealth, Step 1 is waived. At Step 2 DES determined that appellant has severe impairments. The determination was made based on medical documentation from the appellant's providers as well as consultative exams. (Testimony; Exhibit 5; Exhibit 6).

In determining whether the appellant's impairments met a listing established by the Social Security Administration, DES compared the appellant's visual impairments with the SSA listing at 2.02 for Loss of Central Visual Activity. DES determined that the appellant's visual impairments did not satisfy the criteria for this listing. DES compared the appellant's reported heart impairments to the SSA listing at 4.02 for Chronic Heart Failure. DES determined that the appellant's reported heart impairments did not satisfy the criteria for this listing. DES compared the appellant's reported kidney impairments with the SSA listing at 6.05 for Chronic Kidney Disease with Impairment of Kidney Function. DES determined that the appellant's reported kidney impairments did not satisfy the criteria for this listing. DES compared the appellant's reported diabetic peripheral neuropathy to the SSA listing at 11.14 for Peripheral Neuropathy. DES determined that the appellant's condition did not satisfy the criteria for this listing. DES compared the appellant's reported poor memory, cognitive impairment and sleep disorder to the SSA listing at 12.02 - Neurocognitive Disorders for poor memory/cognitive impairment/sleep disorder. DES determined that the appellant's conditions did not satisfy the criteria for this listing.

The physical residual functional capacity worksheet, the mental residual functional capacity worksheet and medical records show that the appellant is able to perform some work. While the appellant testified that his insomnia impacts his functioning during the day, he did not clearly indicate how it impacts his actual ability to work. The appellant has not engaged in a sleep study and testified that he does not take any medications or engage in any active treatment for his insomnia. The appellant did not provide sufficient evidence to demonstrate that he is unable to perform the type of work listed by DES or other unskilled work. The decision made by MassHealth regarding the disability status was correct. This part of the appeal is denied.

The decision on appeal also involves eligibility for MassHealth CarePlus.

130 CMR 505.000 explains the categorical requirements and financial standards that must be met to qualify for a MassHealth coverage type (130 CMR 505.001). As described in 130 CMR 505.001, the MassHealth coverage types are as follows:

1) Standard – for pregnant women, children, parents and caretaker relatives, young adults, disabled individuals, certain persons who are HIV positive, individuals with breast or cervical cancer, independent foster care adolescents, Department of Mental Health members, and medically frail as such term is defined in 130 CMR 505.008(F);
2) CommonHealth – for disabled adults, disabled young adults, and disabled children who are not eligible for MassHealth Standard;
3) CarePlus – for adults 21 through 64 years of age who are not eligible for MassHealth Standard;
4) Family Assistance – for children, young adults, certain noncitizens, and persons who are HIV positive who are not eligible for MassHealth Standard, CommonHealth, or CarePlus;
5) Small Business Employee Premium Assistance – for adults or young adults who
    a) work for small employers;
    b) are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or CarePlus;
    c) do not have anyone in their premium billing family group who is otherwise receiving a premium assistance benefit; and
    d) have been determined ineligible for a Qualified Health Plan with a Premium Tax Credit due to access to affordable employer-sponsored insurance coverage;
6) Limited – for certain lawfully present immigrants as described in 130 CMR 504.003(A), nonqualified PRUCOLs, and other noncitizens as described in 130 CMR 504.003: Immigrants; and
7) Senior Buy-In and Buy-In – for certain Medicare beneficiaries.

The appellant does not have any children and has not been deemed disabled by MassHealth or the Social Security Administration. The only program that the appellant met the categorial requirements for at the time of the decision on appeal is MassHealth CarePlus.

MassHealth CarePlus provides coverage to adults 21 through 64 years of age. (13 CMR 505.008(A)(1)). Persons eligible for MassHealth CarePlus must meet the following conditions:

(a) The individual is an adult 21 through 64 years of age.
(b) The individual is a citizen, as described in 130 CMR 504.002: U.S. Citizens, or a qualified noncitizen, as described in 130 CMR 504.003(A)(1): Qualified Noncitizens.
(c) The individual's modified adjusted gross income of the MassHealth MAGI household is less than or equal to 133% of the federal poverty level.
(d) The individual is ineligible for MassHealth Standard.
(e) The adult complies with 130 CMR 505.008(C). (f) The individual is not enrolled in or eligible for Medicare Parts A or B.

The appellant met the requirements for this coverage at the time of the eligibility decision on appeal. The decision made by MassHealth was correct. This part of the appeal is denied.

The regulations at 130 CMR 515.000 through 522.000 provide the MassHealth requirements for persons who are institutionalized, [redacted] years of age or older, or who would be institutionalized without community-based services in accordance with all applicable laws, including Title XIX of the Social Security Act. (130 CMR 515.002(B)). Representatives from the agency noted that the appellant's coverage changed during the appeal process due to turning [redacted]

The MassHealth representative from the [redacted] unit testified that the agency issued a decision regarding the appellant's eligibility for the Medicare Savings Program on November 4, 2024, three days prior to the hearing. It was not clear at the hearing as to whether the appellant received a copy of that notice or had sufficient time to review and respond to the notice. The appellant can review and respond to that notice should he not agree with that decision. This decision will provide some general information about eligibility for MassHealth for individuals age [redacted] years of age or older for the appellant to consider in making future decisions.

The regulations at 130 CMR 519.005(B) allow individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.005(A) to establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: Asset Reduction, meeting a deductible as described at 130 CMR 520.028: Eligibility for a Deductible through 520.035: Conclusion of the Deductible Process, or both. The MassHealth representative from the over-65 unit testified that the appellant had a life insurance policy with a cash-surrender value of $74,000 making him ineligible for MassHealth Standard as a noninitialized individuals 65 years of age or older must have countable assets of $2,000 or less and the assets reported by the MassHealth representative at hearing exceed that program limit. (130 CMR 519.005(A)).

Countable assets are all assets that must be included in the determination of eligibility. Countable assets include assets to which the applicant or member or his or her spouse would be entitled whether or not these assets are actually received when failure to receive such assets results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf. (130 CMR 520.007). Countable assets include things such as cash, bank accounts and the cash-surrender value of a life-insurance policy. The cash surrender value of a life-insurance policy is the amount of money, if any, that the issuing company has agreed to pay the owner of the policy upon its cancellation. (130 CMR 520.007(E)(1)). An individual may adjust the cash-surrender value of life insurance to meet the asset limit. (130 CMR 520.007(E)(1)). If the total face value of all countable life-insurance policies owned by the applicant, member, or spouse exceeds $1,500, the total cash-surrender value of all policies held by that individual is countable. (130 CMR 520.007(E)(2)). MassHealth does not count the face value of burial insurance and the face value of life-insurance policies not having cash-surrender value (for instance, term insurance) in determining the total face value of life-insurance policies. (130 CMR 520.007(E)(2)). As noted above, the appellant did not appear to have

sufficient time to prepare to respond to that agency decision. These regulatory references are only for informational purposes.

Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.005(A) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: Asset Reduction, meeting a deductible as described at 130 CMR 520.028: Eligibility for a Deductible through 520.035: Conclusion of the Deductible Process, or both. (130 CMR 519.005(B)). The appellant can possibly qualify for MassHealth Standard by spending down assets.

Pursuant to 130 CMR 519.010(A), the Medicare Savings Program for Qualified Medicare Beneficiaries (MSP-QMB) coverage is available to Medicare beneficiaries who:

(1) are entitled to hospital benefits under Medicare Part A;
(2) have a countable income amount (including the income of the spouse with whom he or she lives) that is less than or equal to 190% of the federal poverty level;
(3) Effective until February 29, 2024, have countable assets less than or equal to two times the amount of allowable assets for Medicare Savings Programs as identified by the Centers for Medicare and Medicaid Services. Each calendar year, the allowable asset limits shall be made available on MassHealth's website. Effective March 1, 2024, MassHealth will disregard all assets or resources when determining eligibility for MSP-only benefits; and
(4) meet the universal requirements of MassHealth benefits in accordance with 130 CMR 503.000: Health Care Reform: MassHealth: Universal Eligibility Requirements or 130 CMR 517.000 : MassHealth: Universal Eligibility Requirements, as applicable.

As noted above, MassHealth determined the appellant eligible for the MSO-QMB coverage. This decision appears to be correct. However, the appellant did not appear prepared to address this income- and asset-based eligibility decision. Therefore, if the appellant still does not agree with the November 4, 2024 decision, as it relates to the income and asset determination, he can still appeal that decision.

Under the MSP-QMB, MassHealth pays for Medicare Part A and Part B premiums and for deductibles and coinsurance under Medicare Parts A and B. (130 CMR 519.010(B)). The appellant can always contact the agency to obtain more information about this coverage type and appeal agency actions issued after September 5, 2024 if the appeal is timely. Individuals have 60 days from the date of a decision to file a request for hearing. (130 CMR 610.015).

As noted above, the eligibility decisions within the scope of this appeal regarding the appellant's disability status and eligibility for CarePlus are correct.

This appeal is denied.

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.

Susan Burgess-Cox
Hearing Officer
Board of Hearings

MassHealth Representative: Sylvia Tiar, Tewksbury MassHealth Enrollment Center, 367 East Street, Tewksbury, MA 01876-1957, 978-863-9290