Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied in part; Dismissed in part	**Appeal Number:**	2419088
Decision Date:	3/7/2025	**Hearing Date:**	01/23/2025
Hearing Officer:	Emily Sabo		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Chanthy Kong, Tewksbury MEC

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 in part; Dismissed in part	**Issue:**	Community Eligibility—under 65
Decision Date:	3/7/2025	**Hearing Date:**	01/23/2025
MassHealth's Rep.:	Chanthy Kong	**Appellant's Rep.:**	Pro se
Hearing Location:	Tewksbury MassHealth Enrollment Center (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 October 30, 2024, MassHealth notified the Appellant that he was not eligible for MassHealth, because he did not complete his annual eligibility review within the allowed time. 130 CMR 502.007(C)(2) and Exhibit 1. The Appellant filed this appeal in a timely manner on December 13, 2024. 130 CMR 610.015(B) and Exhibit 2. Denial of assistance is valid grounds for appeal. 130 CMR 610.032.

Action Taken by MassHealth

MassHealth notified the Appellant that he was not eligible for MassHealth because he did not complete his annual eligibility review within the allowed time.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 502.007(C), in finding that the Appellant was not eligible for MassHealth because he did not complete his annual

eligibility review within the allowed time.

Summary of Evidence

The notice appealed is dated October 30, 2024, and states that the Appellant does not qualify for MassHealth, Health Safety Net, or the Children's Medical Security Plan. Exhibit 1. It states that the Appellant does not qualify because he "did not complete the annual eligibility review within the allowed time. Based on available federal and state data sources, they do not qualify for MassHealth. If the person completes the annual eligibility renewal withing 90 days from the coverage ending date below, we will reconsider their eligibility 130 CMR 502.007(C)(2)." *Id.*

The hearing was held by telephone. The MassHealth representative testified that MassHealth notified the Appellant on April 4, 2024, that his MassHealth benefit was downgraded from CarePlus to the Health Connector, as of June 1, 2024.[1] The MassHealth representative testified that the Appellant does not have a disability. The MassHealth representative testified that based on available federal and state data sources, the Appellant has a monthly income of $4,783.65 and is not financially eligible for MassHealth benefits. The MassHealth representative testified that MassHealth sent the Appellant a notice on September 5, 2024, that he had to complete an annual renewal, and that his failure to respond is what generated the October 30, 2024, notice. The MassHealth representative testified that the Appellant's benefit, after June 1, 2024, was a Connector Care plan.

The Appellant verified his identity. The Appellant testified that he agreed with the MassHealth October 30, 2024, notice that his coverage was ending November 13, 2024. The Appellant testified that he did not receive a renewal notice or the April 4, 2024, MassHealth notice. The Appellant testified that his work is seasonal, that he was laid off in August 2024, and that the income only pertained to when he worked over the summer and so did not reflect his actual monthly income averaged over twelve months of the year. The Appellant testified that he found new employment in September 2024, and that he currently has employer-sponsored health insurance. The Appellant testified that based on the October 30, 2024, notice, he thought he had MassHealth coverage through November 13, 2024, which is why he filed the appeal. The Appellant testified that he has called the Health Connector and been told MassHealth is responsible for his benefit, and when he has called MassHealth, he has been told that the Health Connector is responsible for his benefit.

Findings of Fact

[1] I do not have jurisdiction over the April 4, 2024 MassHealth notice, and there is no evidence in the Board of Hearings appeals database that this decision was timely appealed by the appellant. *See also,* 130 CMR 610.015(B).

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

1. On April 4, 2024, MassHealth notified the Appellant that his CarePlus benefit was downgraded to the Health Connector as of June 1, 2024. Testimony.

2. The Appellant is under the age of 65. Exhibit 4.

3. The Appellant does not have a disability. Testimony.

4. Based on available federal and state data sources, the Appellant has a monthly income of $4,783.65. Testimony.

5. After June 1, 2024, the Appellant's benefit was a Connector Care plan. Testimony.

6. On October 30, 2024, MassHealth notified the Appellant that he does not qualify for MassHealth, Health Safety Net, or the Children's Medical Security Plan because he "did not complete the annual eligibility review within the allowed time. Based on available federal and state data sources, they do not qualify for MassHealth." Exhibit 1.

7. On December 13, 2024, the Appellant filed an appeal with the Board of Hearings. Exhibit 2.

8. Beginning in September 2024, the Appellant began a new job, where he has employer-sponsored health insurance. Testimony.

Analysis and Conclusions of Law

MassHealth regulations state that

502.007: Continuing Eligibility

. . . .

(C) Eligibility Reviews. MassHealth reviews eligibility in the following ways.

(1) Automatic Renewal. Households whose continued eligibility can be determined based on electronic data matches with federal and state agencies will have their eligibility automatically renewed.

(a) If the data match results in no change in benefits or in a more comprehensive benefit for all members of the household, the MassHealth agency will notify the head of household that eligibility has been reviewed using the automatic renewal process.

(b) In addition, if the member's coverage type changes to a more comprehensive benefit, the member will be sent a notice informing him or her of the start date for the

new coverage. The start date of the new coverage is described at 130 CMR 502.006, except that premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month that the insurance deduction begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(2) Prepopulated Renewal Application. Households whose continued eligibility cannot be determined based on electronic data matches with federal and state agencies and households whose eligibility would change to a less comprehensive benefit for at least one member of the household as a result of the data matches will be required to complete a prepopulated renewal application.

(a) The MassHealth agency will notify the head of household of the need to complete the renewal application.

(b) The head of household will be given 45 days from the date of the request to return the paper prepopulated renewal application, log onto their MAHealthConnector.org account to complete the renewal application online, or call the MassHealth agency to complete the renewal application telephonically.

1. If the renewal application is completed within 45 days, eligibility will be determined using the information provided by the individual with verification confirmed through electronic data matches if available. If verification through electronic data match is unsuccessful, the MassHealth agency will request required verifications as described in 130 CMR 502.003 and the individual continues to receive benefits pending verification.

2. If the renewal application is not completed within 45 days, the MassHealth agency will

a. use information received from electronic sources, if available, and redetermine eligibility; or

b. if information is not available from electronic sources, terminate MassHealth coverage as described at 130 CMR 502.006(B).

3. If the individual submits the prepopulated renewal application within 90 days of the termination date, as described in 130 CMR 502.007(C)(2)(b)2., and is determined eligible for a MassHealth benefit, the date of coverage for MassHealth is determined by the coverage type for which the individual is now eligible, in accordance with 130 CMR 502.006(A). The begin date of MassHealth coverage may be retroactive to the date of the termination if the individual requests retroactive coverage and has incurred covered medical services since the date of the termination.

4. If the prepopulated renewal application is returned, but the required verifications are not submitted with the form, a second 90-day period starts on the date that the prepopulated form is returned.

5. If the prepopulated renewal application is not submitted within 90 days of the previous termination date, a new application is required.

(c) If the member's coverage type changes, the start date for the new coverage type is

determined as follows.

1. If the member's coverage type changes, the start date for the new coverage type is effective as described in 130 CMR 502.006(A).

2. However, premium assistance payments under MassHealth Family Assistance begin in the month of the MassHealth agency's eligibility determination or in the month the insurance begins, whichever is later in accordance with 130 CMR 506.012(F)(1)(d).

(3) Periodic Data Matches. The MassHealth agency matches files of MassHealth members with other agencies and information sources as described in 130 CMR 502.004 to update or verify eligibility.

(a) If the electronic data match indicates a change in circumstances that would result in potential reduction or termination of benefits, the MassHealth agency will notify the member of the information that was received through the data match and require the member to respond within 30 days of the date of the notice.

1. If the member responds within 30 days and confirms the data is correct, eligibility will be determined using the confirmed data from the electronic data match.

2. If the member responds within 30 days and provides new information, eligibility will be determined using the information provided by the member. Additional verification from the member will be required.

3. If the member does not respond within 30 days, eligibility will be determined using available information received from the electronic data sources. If information necessary for eligibility determination is not available from electronic data sources, MassHealth coverage will be terminated.

(b) If the electronic data match indicates a change in circumstances that would result in an increase or no change in benefits, the MassHealth agency will automatically update the case using the information received from the electronic data match and redetermine eligibility. If the member's coverage type changes to a more comprehensive benefit, the member will be sent a notice informing them of the start date for the new benefit. The effective date of the more comprehensive benefit is determined in accordance with 130 CMR 502.006(A).

130 CMR 502.007(C).

505.008: MassHealth CarePlus

(A) Overview.

(1) 130 CMR 505.008 contains the categorical requirements and financial standards for MassHealth CarePlus. This coverage type provides coverage to adults 21 through 64 years old.

(2) Persons eligible for MassHealth CarePlus Direct Coverage are eligible for medical benefits, as described in 130 CMR 450.105(B): MassHealth CarePlus and 130 CMR 508.000:

MassHealth: Managed Care Requirements and must meet the following conditions.

(a) The individual is an adult 21 through 64 years old.

(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.

. . . .

(C) Use of Potential Health Insurance Benefits. All applicants and members must use potential health insurance benefits in accordance with 130 CMR 503.007: Potential Sources of Health Care and must enroll in health insurance, if available at no greater cost to the applicant or member than they would pay without access to health insurance, or if purchased by MassHealth in accordance with 130 CMR 505.008(D) or 130 CMR 506.012: Premium Assistance Payments. Members must access those other health insurance benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are provided.

130 CMR 505.008(A), (C).

The MassHealth regulations at 130 CMR 501.001 define the federal poverty level as, "income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index." For 2024, the *Federal Register* states that the federal poverty level for a household of one is $1,255 monthly. Therefore, 133% of the federal poverty level is $1,670/month.[2] The Appellant's income of $4,783.65 exceeds that amount. 130 CMR 505.008(A)(2)(c). Additionally, the Appellant did not dispute that he did not respond to MassHealth's request for information. 130 CMR 502.007(C)(3). Accordingly, MassHealth did not err in determining that the Appellant is not eligible for MassHealth, Health Safety Net, or the Children's Medical Security Plan, and that part of the appeal is denied.

The MassHealth Fair Hearing Rules regulations state:

610.032: Grounds for Appeal

(A) Applicants and members have a right to request a fair hearing for any of the following reasons:

(1) denial of an application or request for assistance, or the right to apply or reapply for such assistance;

[2] Even using the updated 2025 FPL figures issued by the federal Centers for Medicare and Medicaid Services, 133% of the FPL for a household of one in 2025 is $1,734.32 monthly income, and the Appellant's income of $4,783.65 exceeds this figure. See, Federal Poverty Guidelines - 2025 | Mass Legal Services.

(2) the failure of the MassHealth agency to give timely notice of action on an application for assistance in accordance with the requirements of M.G.L. c. 118E, § 21;
(3) any MassHealth agency action to suspend, reduce, terminate, or restrict a member's assistance;
(4) MassHealth agency actions to recover payments for benefits to which the member was not entitled at the time the benefit was received;
(5) individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations);
(6) coercive or otherwise improper conduct as defined in 130 CMR 610.033 on the part of any MassHealth agency employee directly involved in the applicant's or member's case;
(7) any condition of eligibility imposed by the MassHealth agency for assistance or receipt of assistance that is not authorized by federal or state law or regulations;
(8) the failure of the MassHealth agency to act upon a request for assistance within the time limits required by MassHealth regulations;
(9) the MassHealth agency's determination that the member is subject to the provisions of 130 CMR 508.000: *MassHealth: Managed Care Requirements*;
(10) the MassHealth agency's denial of an out-of-area provider under 130 CMR 508.003(A)(2);
(11) the MassHealth agency's disenrollment of a member from a managed care provider under 130 CMR 508.003: *Enrollment with a MassHealth Managed Care Provider*;
(12) the MassHealth agency's denial of a member's request to transfer out of the member's MCO, ACPP, or Primary Care ACO under 130 CMR 508.003: *Enrollment with a MassHealth Managed Care Provider*;
(13) the MassHealth agency's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442: *Controlled Substance Management Program*; and
(14) the MassHealth agency's determination of eligibility for low-income subsidies under Medicare Part D, as set forth in the *Medicare Prescription Drug and Improvement and Modernization Act* of 2003 as described in federal regulations at 42 CFR Part 423, Subpart P.

130 CMR 610.032(A).

<u>610.035: Dismissal of a Request for a Hearing</u>

(A) BOH will dismiss a request for a hearing when
(1) the request is not received within the time frame specified in 130 CMR 610.015;
(2) the request is withdrawn by the appellant ;
(3) the sole issue is one of state or federal law requiring automatic change in assistance for classes of members;

(4) the stated reason for the request does not constitute grounds for appeal as set forth in 130 CMR 610.032. Without limiting the generality of the foregoing, except as provided in 130 CMR 610.032(A)(11), no provider decision or action including, but not limited to, a provider determination about whether or the extent to which a service is medically necessary, constitutes an appealable action hereunder;
(5) the stated reason for the hearing request is outside the scope of 130 CMR 610.000 as set forth in 130 CMR 610.003;
(6) BOH has conducted a hearing and issued a decision on the same appealable action arising out of the same facts that constitute the basis of the request;
(7) the party requesting the hearing is not an applicant, member, or resident as defined in 130 CMR 610.004;
(8) BOH learns of an adjustment or action that resolves all of the issues in dispute between the parties;
(9) BOH learns that the applicant or member has passed away before or after the date of filing and there is no full compliance with 130 CMR 610.016(B) within ten days of a BOH request;
(10) BOH learns that the applicant or member has passed away prior to the date of filing and scheduling of the hearing and is not informed until the date of the hearing and there is no full compliance with 130 CMR 610.016(B); or
(11) the appellant fails to appear at a scheduled hearing.

130 CMR 610.035(A).

According to MassHealth's testimony, the Appellant no longer had MassHealth benefits after June 1, 2024, and his coverage was downgraded to Connector Care. *See also* Exhibit 4 (benefit plan designations). To the extent that the Appellant is appealing the termination of his Connector Care coverage on November 13, 2024, I do not have jurisdiction over that issue because Connector Care determinations are not listed as a ground for appeal under 130 CMR 610.032. Therefore, I dismiss that aspect of the appeal under 130 CMR 610.035(A)(4).

Thus, the appeal is denied in part and dismissed in part.

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.

Emily Sabo
Hearing Officer
Board of Hearings

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