

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2508359
Decision Date:	09/05/2025	Hearing Date:	07/03/2025
Hearing Officer:	Christopher Jones	Record Open to:	07/10/2025

Appearances for Appellant:



Appearance for MassHealth:

Mul Oeur – Taunton Ongoing



*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:	Community Eligibility - over 65; Income
Decision Date:	09/05/2025	Hearing Date:	07/03/2025
MassHealth's Rep.:	Mul Oeur	Appellant's Rep.:	[REDACTED]
Hearing Location:	Telephonic	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 May 22, 2025, MassHealth approved the appellant for the Medicare Savings Program QMB, and calculated a 6-month deductible of \$9,504 for the appellant to be temporarily eligible for Standard coverage. (Exhibit 3; 130 CMR 519.010; 520.002; 520.028.) A hearing was requested telephonically on May 29, 2025, and the Board of Hearings dismissed the appeal for lack of authority. (Exhibit 4; Exhibit 5; see 130 CMR 610.015(B).) On June 2, 2025, the appellant signed a fair hearing request form, and this matter was scheduled for hearing.¹ (Exhibit 6; Exhibit 7.) Termination of assistance is valid grounds for appeal. (130 CMR 610.032.)

The appellant requested that the record be left open following the hearing to allow time to consider her best course of action. The hearing record was left open until July 10, 2025. (Exhibit 11.)

Action Taken by MassHealth

MassHealth terminated the appellant's MassHealth Standard coverage and then approved the appellant for the Medicare Savings Program – QMB, with a 6-month deductible to temporarily qualify for Standard benefits.

¹ The originally scheduled hearing was rescheduled at the appellant's request. (Exhibit 8.)

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 519.005, in determining that the appellant's income is too high to qualify for MassHealth Standard.

Summary of Evidence

MassHealth's representative testified that the appellant completed a renewal application on or around January 22, 2025, and MassHealth requested various verifications. These verifications were due on April 27, 2025. Through a notice dated May 5, 2025, MassHealth terminated the appellant's coverage, effective May 19, 2025, because the requested information had not been received. (Exhibit 1.) The appellant submitted the requested verifications on May 5, 2025, along with Supplement A to the Application for Health Coverage for Seniors and People Needing Long-Term-Care Services (SACA). The verifications were not processed until after the termination notice had been mailed.

The appellant's gross Social Security income had increased to \$2,126 per month. Once the appellant's renewal was processed, she no longer qualified for MassHealth Standard, and MassHealth approved the Medicare Savings Program (MSP) – Qualified Medicare Beneficiaries (QMB) benefit. MassHealth's representative testified that the income limit for MassHealth Standard is only \$1,305 per month. MassHealth's representative confirmed that the appellant's assets were verified as being under \$2,000. MassHealth's representative explained that the appellant could become temporarily eligible for Standard if she met a 6-month deductible. This deductible is calculated by subtracting \$522 from the appellant's countable income. The resulting \$1,584 is listed as a monthly deductible for each month from May through October 2025. MassHealth's representative confirmed that the appellant does not have a disability status on file.

The appellant is over the age of 65, and she resides in an assisted living facility. The appellant's representative explained that the appellant's housing has been covered as part of her Group Adult Foster Care coverage. The appellant's representative testified that the appellant's income increased because she started receiving Social Security Survivor's benefits. The appellant submitted Supplement A to the SACA to request participation in the Frail Elder Waiver. This application was denied on May 14, 2025, because the appellant had not submitted a determination of clinical eligibility for the program. (Exhibit 2.)

The appellant's representative and MassHealth's representative testified that the Frail Elder Waiver is not available for individuals in assisted living. It was confirmed that MassHealth's website includes guidance that Frail Elder Waiver participants "cannot reside in residential settings such as Assisted Living Residences and Rest Homes or in institutional settings such as nursing facilities, except for brief periods when receiving respite services." (<https://www.mass.gov/info-details/frail-elder-waiver-information-for-applicants-and-participants#ii-eligibility-criteria-for-the-frail-elder-waiver> (last visited September 2, 2025).)

The appellant is contemplating converting her Waiver application into a long-term care application, with the anticipation of moving into a long-term care bed at a sister facility. However, no long-term care beds are available, and MassHealth will not approve long-term care benefits until the applicant is in a long-term care setting. The appellant's representative testified that the appellant is incurring about \$2,000 in expenses each month that she was not covered by the Group Adult Foster Care program. It was noted that MassHealth may not cover the assisted-living fees even if the appellant were approved for long-term care benefits.

MassHealth's representative explained that the appellant may be eligible for the CommonHealth benefits, if she were deemed disabled and she worked for 40 hours per month. The appellant was skeptical of her ability to work, but it was explained that she could perform non-traditional work. All that was needed was for someone to sign a letter from the "employer," explaining what task the appellant does, stating that the appellant works for 10 hours per, and identifying a rate of pay, which could be as little as \$1.

Alternately, the appellant could attempt to satisfy her 6-month deductible, which MassHealth had calculated to be \$9,504. MassHealth's representative explained that the deductible expenses had to be incurred between May and October 2025. If the deductible were met, MassHealth would approve Standard coverage for the remainder of the deductible period. The appellant also contemplated rescinding her acceptance of the Social Security Survivor's benefits and hoping that she could have her income go back below the federal poverty level. It was noted that MassHealth may still consider the Survivor's benefits as income, since 130 CMR 520.009(A)(4) counts income "whether or not actually received when failure to receive such income results from the action or inaction of the applicant."

The appellant requested that the hearing record be left open to investigate her options. The hearing record was left open until July 10, 2025, for the appellant to pursue one of the four courses of action identified:

- 1) Convert her application for MassHealth benefits to a long-term-care application.
- 2) Submit an Adult Disability Supplement and a Working Disabled Letter.
- 3) Submit evidence to satisfy the 6-Month Deductible.
- 4) Rescind the Social Security Survivor's Benefits.

The appellant never responded, and the hearing record was closed. On July 29, 2025, the appellant's representative responded that they had been pursuing all of the options and asked to keep the appeal open while they attempted to resolve the appellant's coverage. The appellant's representative alleged that she had submitted a Disability Supplement, but the appellant did not submit a working letter that would allow CommonHealth benefits to be approved if she were found disabled. The appellant's representative did not provide good cause for the untimely

response or indicate how much more time the appellant would need to pursue any of these avenues to coverage.

Findings of Fact

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

- 1) The appellant has a household of one, she is over the age of 65, and she does not have a verified disability. The appellant currently resides in assisted living. (Testimony; Exhibit 9.)
- 2) The appellant recently began receiving Social Security Survivor's benefits, and her gross Social Security income is now \$2,126 per month. (Testimony.)
- 3) The appellant completed a renewal application on or around January 22, 2025, and MassHealth requested verifications that were due back April 27, 2025. (Testimony.)
- 4) The appellant had been covered by MassHealth Standard, through which she was enrolled in the Group Adult Foster Care program. (Testimony; Exhibit 10.)
- 5) MassHealth terminated the appellant's MassHealth Standard coverage, effective May 19, 2025, because she did not return requested verifications. (Exhibit 1.)
- 6) The appellant returned the requested verifications on May 5, 2025, along with Supplement A to the SACA, seeking the Frail Elder Waiver. (Testimony.)
- 7) ON May 14, 2025, MassHealth denied the Frail Elder Waiver application because the appellant did not verify that she was clinically eligible for the program. (Exhibit 2.)
- 8) On May 22, 2025, MassHealth approved the appellant for MSP – QMB and calculated a 6-month deductible of \$9,504. (Exhibit 3.)
- 9) The appellant requested that the hearing record be left open to document that she was pursuing some avenue for becoming eligible for MassHealth Standard. The appellant did not respond by the due date, did not provide good cause for belatedly responding, and did not provide evidence that any of the options were being pursued. (Exhibit 11.)

Analysis and Conclusions of Law

MassHealth annually requires members to reestablish their eligibility. If a member's "continued eligibility cannot be determined based on reliable information contained in his or her account or electronic data match with federal and state agencies, a MassHealth eligibility review form must be completed." (130 CMR 516.007(C)(2).) The member has 45 days to return the completed application, or benefits will be terminated. If the requested renewal application is returned "within

30 days from the date of the termination, a second eligibility determination is made within 15 days.” (130 CMR 516.007(C)(2)(b).) If additional verifications are required, a Request for Information Notice is sent out. (See 130 CMR 516.003(C).) A member is given 90² “days from the receipt of the Request for Information Notice to provide all requested verifications.” (130 CMR 516.003(D)(1).)

MassHealth offers a variety of benefits based upon an individual’s circumstances and finances. To qualify for MassHealth, an individual must fit into a category of eligibility and fall below a certain financial threshold. The financial rules set out at 130 CMR 520.000 explain that all of an individual’s “gross earned and unearned income less certain business expenses and standard income deductions” is countable, and “the countable-income amount is compared to the applicable income standard to determine the individual’s financial eligibility.” (130 CMR 520.009(A)(1)-(2).) There are only two income deductions from a community resident’s unearned income: (1) “a deduction of \$20 per individual or married couple” or (2) a larger deduction if the individual “receiving personal-care attendant services paid for by the MassHealth agency, or have been determined by the MassHealth agency, through initial screening or by prior authorization, to be in need of personal-care attendant services.” (130 CMR 520.013(A)-(B).) If the applicant’s income is over 133% of the federal poverty level prior to the deduction, the applicant must still meet a six-month deductible for Standard coverage. (130 CMR 520.013(C).)

The financial requirements for receiving MassHealth Standard for individuals over 65 who are living in the community are:

519.005: Community Residents 65 Years of Age and Older

(A) Eligibility Requirements. Except as provided in 130 CMR 519.005(C), noninstitutionalized individuals 65 years of age and older may establish eligibility for MassHealth Standard coverage provided they meet the following requirements:

- (1) the countable-income amount, as defined in 130 CMR 520.009: *Countable-Income Amount*, of the individual or couple is less than or **equal to 100 percent of the federal poverty level**; and
- (2) the countable assets of an individual are \$2,000 or less, and those of a married couple living together are \$3,000 or less.

(B) Financial Standards Not Met. Except as provided in 130 CMR 519.005(C), **individuals whose income**, assets, or both **exceed the standards** set forth in 130 CMR 519.005(A) **may establish eligibility for MassHealth Standard by**

² “Effective April 1, 2023, MassHealth [extended] the time that non-MAGI applicants and members will have for verifying eligibility factors and providing corroborative information, from 30 days to 90 days.” (EOM 23-09 (Mar. 2023).) This extended verification timeline was revoked for long-term care applicants effective September 9, 2024. (EOM 25-03 (Feb. 2025).)

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(A)-(B) (emphasis in **bold**).)

“The deductible period is a six-month period that starts on the first day of the month of application or may begin up to three months before the first day of the month of application.” (130 CMR 520.029.) The deductible amount is “determined by multiplying the excess monthly income by six.” Excess monthly income is the difference between the countable income and \$522 (for an individual). (130 CMR 520.030.) A member who establishes “eligibility based upon meeting a deductible is only eligible for MassHealth Standard ... until the end of the deductible period. At the end of the deductible period, the MassHealth agency notifies the member in writing of a new deductible period and amount” (130 CMR 520.031(B).)

Otherwise, individuals over the age of 65 may qualify for MassHealth Standard if they “would be institutionalized in a nursing facility, unless” they received “services ... under the Home-and Community-based Services Waiver-frail Elder” (130 CMR 519.007(B)(1)(b).) If an applicant is found clinically eligible, MassHealth “determines income eligibility based solely on the applicant’s or member’s income regardless of their marital status.” Further, the income threshold is raised to 300% of the federal benefits rate, or \$2,901. (See 130 CMR 519.007(B)(2).) Though not listed as an eligibility requirement in the regulations, MassHealth’s website states that participants “cannot reside in residential settings such as Assisted Living Residences and Rest Homes” (<https://www.mass.gov/info-details/frail-elder-waiver-information-for-applicants-and-participants#ii-eligibility-criteria-for-the-frail-elder-waiver> (last visited September 2, 2025).)

A disabled adult aged 65 or older may qualify for CommonHealth coverage with income in excess of the federal poverty level. However, CommonHealth coverage for individuals over 65 is only for “working disabled adults ... [which] means that eligible applicants must meet the requirements of 130 CMR 505.004(B)(2), (3) and (5) to be eligible for CommonHealth.” (130 CMR 519.012(A)(1).) Those additional criteria are:

(2) be employed at least 40 hours per month, or if employed less than 40 hours per month, have been employed at least 240 hours in the six-month period immediately preceding the month of receipt of the application or MassHealth's eligibility review;

(3) be permanently and totally disabled (except for engagement in substantial gainful activity) as defined in 130 CMR 501.001: Definition of Terms;

... [and]

(5) be ineligible for MassHealth Standard

(130 CMR 519.012(B).)

The appellant timely appealed MassHealth's notices dated May 5, May 14, and May 22. The appellant has presented no reason for overturning any of those notices. The first notice terminated coverage for not providing timely verifications. The appellant concedes that their verifications were late. Once those verifications were submitted, the appellant was over-income for the benefit she had been receiving. The second denial was due to the appellant not submitting a clinical finding that she is eligible for the Frail Elder Waiver. The appellant chose not to submit this clinical paperwork because MassHealth has published guidance that members may not reside in an assisted living facility while on the waiver.³ The appellant does not have a verified disability on file with MassHealth, and the appellant did not verify that she completed a Disability Supplement or submit a working letter, which would also be essential to qualify for CommonHealth benefits even if she were found disabled.

The final notice approved the appellant for MSP-QMB and assessed a 6-month deductible. The appellant's gross income is \$2,126. The federal poverty level is \$1,305 per month. If the \$20 deduction is taken from the appellant's income, their income is equivalent to 161% of the federal poverty level. The deductible amount using this deduction is \$1,584 per month, or \$9,504 for 6 months. MassHealth correctly determined the appellant's eligibility based upon submitted information. Therefore, this appeal is DENIED.

The appellant may be eligible for the larger income deduction under 130 CMR 520.013. The appellant must require some assistance with ADLs in order to be clinically eligible for the Group Adult Foster Care program. However, the larger income deduction is only available when MassHealth has a prior authorization screening confirming that the member requires "personal-care attendant services." The eligibility criteria for personal-care attendant services are not the same as those for Group Adult Foster Care. (Compare 130 CMR 408.506 with 130 CMR 422.403.) Based upon the evidentiary record, it would be premature to adjust the deductible based upon the appellant's need for assistance with personal-care attendant services. Furthermore, this deduction would only reduce her 6-month deductible.

On this record, the 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

³ In the absence of the clinical documentation, it is premature to address the legal question of whether MassHealth may prohibit Frail Elder Waiver members from residing in assisted living facilities.

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 Jones
Hearing Officer
Board of Hearings


MassHealth Representative: Justine Ferreira, Taunton MassHealth Enrollment Center, 21 Spring St., Ste. 4, Taunton, MA 02780