Volunteer Lawyers Service and Medical Legal Partnership Present:

PRO BONO MANUAL
MASSHEALTH LAW TRAINING

Community Legal Aid
405 Main Street
Worcester, MA 01608

Training Committee:

Vicky Pulos, Esq.
Health Law Attorney, Massachusetts Law Reform Institute
Weayonnoh Nelson-Davies, Esq.
Staff Attorney, Community Legal Aid
Valerie Zolezzi-Wyndham, Esq.
Managing Attorney, Community Legal Aid
Anita Conte, J.D.
Pro Bono Coordinator, Community Legal Aid, Volunteer Lawyers Service
Jena C. Gutierrez, Esq.
Pro Bono Coordinator, Community Legal Aid, Volunteer Lawyers Service

Written and edited by Community Legal Aid, June 2016

Community Legal Aid
Fairness and justice... for all.

UMassMemorial Health Care

Dear Pro Bono Attorney,

Thank you for volunteering with the Medical Legal Partnership - Advocacy for a Healthy Community - a pro bono innovation project.

According to the National Center for Medical-Legal Partnership, there are currently 50,000,000 Americans who face health-harming legal needs which disproportionately affect low-income families, children, the elderly, and people of color. Community Legal Aid and UMass Memorial Health Care have joined to improve the health of low-income families in Central Massachusetts by tackling these unmet health-harming legal needs faced by the system's most vulnerable patients. Your pro bono assistance will enable these families to gain access to stable and affordable housing, education, public benefits, affordable health coverage, and guardianships.

We will support you and provide you with free training seminars on diverse legal topics, discount vouchers for MCLE trainings, access to conference space and telephone interpreters, as well as invitations to recognition events. We also offer mentoring by experienced practitioners and access to online resources.

Thank you for joining us in our efforts to provide low-income individuals access to justice. We are pleased to welcome you to this Medical Legal Partnership project and look forward to working with you.

Yours in Service,

The Medical-Legal Partnership Team

CLA Contact Information

Main: {508} 752-3718
Fax: {508) 752-5918

Anita Conte
Pro Bono Coordinator
aconte@cla-ma.org
Ext: 5354

Jena Gutierrez
Pro Bono Coordinator
jenagutierrez@cla-ma.org
Ext: 5339

Weayonnoh Nelson-Davies
Staff Attorney
Medical-Legal Partnership
wnelsondavies@cla-ma.org
Ext. 5310

Table of Contents

This manual is intended for training purposes only and does not constitute legal advice. Please consult the court websites for current forms and conduct further research for updated cases.

Anatomy of a Case: A Step-by-Step Guide

1. Identifying the Issue(s)

Common Issues

- MassHealth coverage has been denied or terminated;
- MassHealth won't pay for services or a hospital or nursing home stay;
- MassHealth has denied a request for prior approval for services (e.g. PCA services, medical equipment, prescription coverage);
- Client thinks that (s)he might have the wrong MassHealth coverage type;
- Client received a MassHealth notice that (s)he does not understand;
- MassHealth has stopped working without any notice.

Eligibility

MassHealth may deny an application for benefits, change the coverage type or deny benefits if it determines that the client is not a Massachusetts resident, has an ineligible immigration status, is over-income for certain coverage types or does not meet MassHealth disability standard. MassHealth will make a separate decision for each member of the household.

Denials, changes and terminations could also be for administrative reasons such as not responding to a request for additional information or not submitting required verifications. Administrative issues can be resolved by providing the requested information and if this is done within the specified deadline, the client could avoid gaps in coverage (i.e. returning renewal form within 90 days of termination will reinstate benefits back to termination date).

REMEMBER: To review MassHealth notices, documents and relevant regulations for possible procedural errors.

Prior Authorization

The client may be a current MassHealth member but there could be an issue as to whether a particular service or benefit is covered or medically necessary. For example, if your client is having trouble filling a prescription, MassHealth may

need to give prior approval. The provider has to be the one to send in the request for prior approval from MassHealth.

If the provider does not believe that a service is medically necessary then the client could change providers and get a second opinion. If the provider submits a request for prior authorization and the request is denied, the client can appeal MassHealth's decision.

Other insurance

The client may have other insurance in addition to MassHealth. This could create a problem when a provider tries to submit a bill to MassHealth. MassHealth will take the position that the claim should be submitted to the other insurance. If there is evidence that the other insurance information is incorrect, a Third Party Liability Indication (TPLI) Form should be submitted along with documentation verifying the change. http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/tpli.pdf

If the client has recently become Medicare eligible, MassHealth may deny a request to fill prescription. Sometimes, there is a gap period in coverage. Medicare has the Limited Income Newly Eligible Transition Program (LI NET) designed to eliminate gaps in coverage for low income individuals transitioning to Medicare Part D drug coverage. This is temporary until Medicare enrolls individuals in a Standard Medicare Part D plan.

MassHealth Notices

It is important to review all relevant MassHealth notices:

- To determine whether the notice is from MassHealth or the Health Connector programs because there are different rules and procedures
- To review notices sent to each household member because there may be different issues per family member
- To determine the date of the decision, who the decision applies to, the reason for the decision, the regulation on which the decision was based, the eligibility start or end date, next steps and appeal rights

- Contact MassHealth for clarification if notice is not clear, there seems to be an error or there are procedural issues with the notice

2. The Client Interview

See the Sample Initial Client Interview Questions on Page 13 in this Manual for examples of possible interview questions.

REMEMBER: That the appeal request needs to be received by the Board of Hearings ***30 days*** from the date of receipt of the MassHealth notice. When benefits are being reduced or terminated and your client would like to continue receiving benefits while the appeal is pending, the Board of Hearings must receive the appeal ***request before the date of the intended action or within 10 days of the date of notice***.

You or the client should complete and fax the fair hearing request form along with the relevant notice to the Board of Hearings by the deadline even if you think the matter can easily be resolved. If the client had already faxed in the appeal request prior to meeting with you, get a copy of the form and the fax receipt.

Releases

In order to communicate with MassHealth on behalf of your client, you need to submit a Permission to Share Information (PSI) form and/or an Authorized Representative Designation (ARD) form.

The PSI form is useful as it allows you to get information but does not allow you to make changes to eligibility or choose a health plan on behalf of your client. All members of the MassHealth household MUST sign a PSI form or MassHealth may not speak with you about the household's benefits.

The ARD form allows the representative to fill out eligibility or enrollment forms. As an advocate, it can also allow you to report changes in income, address or other circumstances. You could get copies of notices sent to you directly.

Your client should also sign a Health Insurance Portability and Accountability Act (HIPAA) release which would allow you to communicate with medical providers.

Necessary Intake Information

- Make sure to get the MassHealth ID number and date of birth for the client and all members of the household.
- Make sure to get a copy of all relevant MassHealth notices (especially denial and termination notices). It is important to note that the client can get copies of all MassHealth notices and faxes sent to MassHealth online.
- Make sure to get the name of the Primary Care Provider or Health Care Center.
- Make sure that the client, head of household and other members of the household sign either the PSI or ARD form.
- Make sure to have the client sign the HIPAA and any other releases.

3. Navigating MassHealth

REMEMBER: MassHealth will not communicate with you unless there is a PSI or ARD signed by the MassHealth member(s). So, the first step is to fax the PSI and/or ARD form using an original MassHealth Mail/Fax Coversheet to 1-857-323-8300. You cannot use a copy of the Coversheet as the barcode will not work. You can find the Mail/Fax coversheet here: http://www.mass.gov/eohhs/docs/masshealth/provider-services/forms/hc-cs.pdf

See Section V in this Manual for contact information, a tool on navigating MassHealth and copies of some MassHealth forms.

Call the customer service center at 1-800-841-2900 after 24-48 hours to get a general idea of what's going on with the case. Keep in mind that it may take a longer time to process the documents you have submitted. You can direct the customer service representative to proactively search for the documents. They are not MassHealth employees but contractors so they can provide information but cannot make changes.

Call the MassHealth Enrollment Center at 1-888-665-9993 to advocate for an appropriate resolution of the case.

REMEMBER: To file an appeal request with the Board of Hearings simultaneously.

If a change is made and the matter is resolved, MassHealth should send a notice describing the change. If you or the client do not receive the notice, you should contact MassHealth.

If an appropriate resolution cannot be negotiated, prepare for the Fair Hearing.

4. The Appeal

See Section V in this Manual for a more detailed Fair Hearing Checklist which can use as a guide when preparing for the hearing.

REMEMBER: To submit the fair hearing request form and any relevant MassHealth notices to the Board of Hearings within the specified deadline.

You and your client will receive a hearing notice at least 10 days prior to the hearing. The hearing will be held at either one of MassHealth Enrollment Centers (for eligibility issues) or in Quincy (for services or disability issues).

When you are at the hearing and there is evidence presented by MassHealth that you are unaware of, you can ask for a postponement or ask that the record remain open for a certain period of time in order to submit additional information.

If your client receives a favorable hearing decision:

- And obtain coverage for a period that wasn't covered previously, notify providers who delivered covered services to the client during that period that they can now bill MassHealth and receive payment. If services were incurred more than 90 days ago, the provider may need to submit evidence of the reversed decision along with the claim.
- Seek reimbursement for medical expenses personally incurred by the client directly from MassHealth, or from the provider and ask the provider to bill MassHealth.
- If a hearing officer reversed the denial and MassHealth hasn't implemented this decision within 30 days, seek further assistance from the Board of Hearings.

If your client receives an unfavorable hearing decision:

- You could file a request for judicial review in the Superior Court within 30 days from receipt of the fair hearing decision; or
- Request a rehearing with the Director of the Office of Medicaid within 14 days of the date of the hearing decision.
    - If the request isn't granted or if it is granted and again denied, you may file for judicial review within 30 days from that decision.

When the matter is resolved, send a letter to the Office of Medicaid, Privacy and Security Office, 600 Washington Street, Boston, MA 02111 requesting that your office be removed as an organization that is permitted to receive information from MassHealth regarding the client.

Initial Client Interview Questions

1. Did you apply for MassHealth? If so, when and how (in person, by mail, online, with the help of someone else) was the application submitted?

2. Did you receive a MassHealth notice? Ask for a copy of the MassHealth notice(s).

3. Were MassHealth benefits denied, changed or terminated and if so, on what date and why? Ask for a copy of notice(s).

4. Have you ever received MassHealth or prior authorization in the past and if yes, dates of all application(s), coverage period(s), changes(s) in coverage, and reason(s) for changes(s)?

5. Is any other member of the family covered by MassHealth? If yes, who and what program?

6. If a parent is not in the home, where is the absent parent, and does (s)he pay support and/or provide health insurance?

7. What coverage were you getting before denial, change or termination?

8. Has there being any changes that may affect MassHealth coverage (change in income, household size, disability, other insurance)?

9. Have you appealed the MassHealth action and if yes, when and how did you file your appeal?

10. Get basic information such as income, disability, immigration status, and household size to determine for which coverage type the client might be eligible.

Resource Guide

1) ***MassHealth*** website http://www.mass.gov/masshealth

2) ***Massachusetts Health Connector*** where individuals and families can apply for health coverage and shop for health and/or dental plans https://www.mahealthconnector.org/

3) ***2016 Member Booklet*** for MassHealth, the Children's Medical Security Plan, ConnectorCare Plans and Advance Premium Tax Credits, and Health Safety Net http://www.mass.gov/eohhs/docs/masshealth/membappforms/aca-1-english-mb.pdf

4) ***Center for Medicare and Medicaid Services*** (CMS) is a part of the Department of Health and Human Services https://www.cms.gov/

5) ***The Center for Medicaid and CHIP Services*** (CMCS) covers all national program policies and operations of three state based health coverage programs: Medicaid, Children's Health Insurance Plan (CHIP), and Basic Health Plan (BHP) https://www.medicaid.gov/

6) ***Health Reform Beyond the Basics*** is a project of the Center on Budget and Policy Priorities which provides resources and training on health coverage http://www.healthreformbeyondthebasics.org/

7) ***National Health Law Program*** is a national advocacy group www.healthlaw.org

8) ***Health Care for All*** is a non-profit, health advocacy organization in Massachusetts which assists with troubleshooting health care coverage issues https://www.hcfama.org/

9) ***Materials from the April 7, 2016 Health Care Access Program training***, as part of the MLRI/MCLE Basic Benefits Training Series http://www.masslegalservices.org/content/health-care-access-programs-bbt-training

10) ***Mass Legal Services*** is an online poverty law library that offers resources to advocates about legal issues facing low income communities http://www.masslegalservices.org/

11) ***Mass Legal Help*** is a collaboration of the civil legal aid community in Massachusetts to improve access to justice for low income and disadvantaged persons by supporting and educating advocates and the general public http://www.masslegalhelp.org/

12) ***Community Legal Aid Medical-Legal Partnership, Advocacy for a Healthy Community*** provides resources, announcements and training materials for volunteer attorneys http://massprobono.org/cla-medicallegalpartnership/

Federal Law

Medicaid

42 USC § 1396 et seq.

42 CFR Part 430 et seq.

42 USC § 1315 (§ 1115 of Social Security Act)

Visit www.medicaid.gov for more information.

State Laws and Regulations

Statute

Massachusetts General Laws Chapter 118E
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVII/Chapter118E

Regulations

130 CMR: Division of Medical Assistance[1]

http://www.mass.gov/courts/case-legal-res/law-lib/laws-by-source/cmr/100-199cmr/130cmr.html

130 CMR 401: Independent Clinical Laboratory Services

130 CMR 402: Vision Care Services

130 CMR 403: Home Health Agency Regulations

130 CMR 404: Adult Day Health Services

130 CMR 405: Community Health Center Services

130 CMR 406: Pharmacy Services

130 CMR 407: Transportation Services

[1] MassHealth Regulations. Below is a Table of Contents of the different sections. Sections 501-520 regulate eligibility.

130 CMR 408: Adult Foster Care

130 CMR 409: Durable Medical Equipment Services

130 CMR 410: Outpatient Hospital Services

130 CMR 411: Psychologist Services

130 CMR 412: Renal Dialysis Clinic Services

130 CMR 413: Speech and Hearing Center Services

130 CMR 414: Independent Nurse Services

130 CMR 415: Acute Inpatient Hospital Services.

130 CMR 416: Hearing Instrument Specialist Services

130 CMR 417: Psychiatric Day Treatment Center Services

130 CMR 418: Substance Abuse Treatment Services

130 CMR 419: Day Habilitation Program Services

130 CMR 420: Dental Services

130 CMR 421: Family Planning Agency Services

130 CMR 422: Medical Assistance Program: Personal Care Services

130 CMR 423: Freestanding Ambulatory Surgical Services

130 CMR 424: Podiatrist Services

130 CMR 425: Psychiatric Inpatient Hospital

130 CMR 426: Audiologists Manual

130 CMR 427: Oxygen and Respiratory Therapy Equipment

130 CMR 428: Prosthetics Services

130 CMR 429: Mental Health Center Services

130 CMR 430: Rehabilitation Center Services

130 CMR 431: Independent Diagnostic Testing Facilities

130 CMR 432: Therapist Services

130 CMR 433: Physician Services

130 CMR 434: Psychiatric Hospital Outpatient Services

130 CMR 435: Chronic Disease and Rehabilitation Inpatient Hospital Services

130 CMR 436: Radiation Oncology Treatment Centers

130 CMR 437: Hospice Services

130 CMR 439: Chapter 766 Services

130 CMR 440: Early Intervention Program Services

130 CMR 441: Chiropractor Services

130 CMR 442: Orthotics Services

130 CMR 450: Administrative and Billing Regulations

130 CMR 456: Long Term Care Services

130 CMR 484: Abortion Services

130 CMR 485: Sterilization and Hysterectomy Services

130 CMR 501: MassHealth: General Policies

130 CMR 502: Health Care Reform: MassHealth: The Request for Benefits

130 CMR 503: MassHealth: Universal Eligibility Requirements

130 CMR 504: MassHealth: Citizenship and Immigration

130 CMR 505: MassHealth: Coverage Types

130 CMR 506: MassHealth: Financial Requirements

130 CMR 507:Reserved

130 CMR 508: Health Care Reform: MassHealth Managed Care Requirements

130 CMR 515: MassHealth: General Policies

130 CMR 516: MassHealth: The Eligibility Process

130 CMR 517: MassHealth: Universal Eligibility Requirements

130 CMR 518: MassHealth: Citizenship and Immigration

130 CMR 519: MassHealth: Coverage Types

130 CMR 520: MassHealth: Financial Eligibility

130 CMR 521:Reserved

130 CMR 522: MassHealth: Other Division Programs

130 CMR 610: Medical Assistance Program: Fair Hearing Rules

130 CMR 630: Acquired Brain Injury Home- and Community-Based Services Waiver Services

Summary of MassHealth Coverage Types[1]

MassHealth Standard offers a full range of health care benefits.

MassHealth CommonHealth offers health care benefits similar to MassHealth Standard to disabled adults and disabled children who cannot get MassHealth Standard.

MassHealth CarePlus offers a broad range of health care benefits to adults who are not otherwise eligible for MassHealth Standard. This was added in 2014 after the Affordable Care Act.

MassHealth Family Assistance offers benefits to MassHealth residents who are not eligible for MassHealth Standard.

MassHealth Small Business Employee Premium Assistance offers premium assistance to uninsured with income between 133% and 300% of the federal poverty level who work for small employers, and are ineligible for any other MassHealth coverage type and are also ineligible for Advance Tax Credits through the Health Connector.

MassHealth Limited provides emergency health services to people who have an immigration status that keeps them from getting more services.

[1] Information is provided by the 2016 Member Booklet for MassHealth, the Children's Medical Security Plan, ConnectorCare Plus Plans and Advance Premium Tax Credits, and Health Safety Net. http://www.mass.gov/eohhs/docs/masshealth/membappforms/aca-1-english-mb.pdf

MLRI MASSACHUSETTS LAW REFORM INSTITUTE
40 COURT STREET
SUITE 800
BOSTON, MA 02108
617-357-0700 PHONE
617-357-0777 FAX
WWW.MLRI.ORG

Benefits Included in MassHealth by Coverage Type (2016)

This Table compares the benefits included in each of the four main types of direct MassHealth coverage as set out in 130 CMR § 450.105. Additional information on the scope of covered services in MassHealth can be found in MassHealth regulations and Provider Manuals posted at www.mass.gov/masshealth and in the Evidence of Coverage or Summary of Benefits provided by MassHealth Managed Care Plans posted on their websites. The following are the websites of the MassHealth managed care plans and of the Behavioral Health Partnership: bmchp.org (BMC HealthNet Plan); nhp.org (Neighborhood Health Plan); https://tuftshealthplan.com/ (Tufts Health Plan Together); fchp.org (Fallon Community Health Plan); healthnewgland.com/ masshealth (Health New England); celticarehealthplan.com (CeltiCare, CarePlus only); masspartnership.com (Behavioral Health partnership/MassHealth PCC Plan).

		MassHealth Coverage Types			
Services	**MassHealth Regulations 130 C.M.R.**	**Standard**	**Common Health**	**Family Assistance (Direct Coverage)**	**CarePlus**
Total number of services		41	41	33	33
Abortion	§ 484	✔	✔	✔	✔
Acute Inpatient Hospital	§ 415	✔	✔	✔	✔
Adult Day Health	§ 404	✔	✔	No	No
Adult Foster Care	§ 408	✔	✔	No	No
Ambulance	§ 407	✔	✔	✔	✔
Ambulatory Surgery Center	§ 423	✔	✔	✔	✔
Audiologist	§ 426	✔	✔	✔	✔
Behavioral health (mental health & substance abuse)	§§ 411, 417, 418, 425, 429, 434	✔	✔	✔	✔
Chapter 766: Assessments & Team Meetings	§ 439	✔	✔	✔	No
Chiropractor	§ 441	✔	✔	✔	✔
Chronic Disease and Rehabilitation Hospital Inpatient	§ 435	✔	✔	✔	Share of 100 days per year

		MassHealth Coverage Types			
Services	**MassHealth Regulations 130 C.M.R.**	**Standard**	**Common Health**	**Family Assistance (Direct Coverage)**	**CarePlus**
Community Health Center	§ 405	✔	✔	✔	✔
Day Habilitation	§ 419	✔	✔	No	No
Dental Services	§ 420	✔	✔	✔	✔
Durable Medical Equipment and Supplies	§ 409	✔	✔	✔	✔
Early Intervention	§ 440	✔	✔	✔	No
EPSDT (under 21 only)	§450.144	✔	✔	No	No
Family Planning	§ 421	✔	✔	✔	✔
Hearing Aid	§ 416	✔	✔	✔	✔
Home Health	§ 403	✔	✔	✔	✔
Hospice	§ 437	✔	✔	✔	✔
Laboratory	§ 401	✔	✔	✔	✔
Nurse midwife	§ 433.402	✔	✔	✔	✔
Nurse practitioner	§ 433.433	✔	✔	✔	✔
Orthotic	§ 442	✔	✔	✔	✔
Outpatient Hospital	§ 410	✔	✔	✔	✔
Oxygen and Respiratory Therapy Equipment	§ 427	✔	✔	✔	✔
Personal Care	§ 422	✔	✔	No	No
Pharmacy	§ 406	✔	✔	✔	✔
Physician	§ 433	✔	✔	✔	✔
Podiatrist	§ 424	✔	✔	✔	✔
Private Duty Nursing/ Continuous Skilled Nursing	§§ 403, 414	✔	✔	No	No
Prosthetic	§ 428	✔	✔	✔	✔
Rehabilitation Center	§ 430	✔	✔	✔	✔
Renal Dialysis Clinic	§ 412	✔	✔	✔	✔

		MassHealth Coverage Types			
Services	**MassHealth Regulations 130 C.M.R.**	**Standard**	**Common Health**	**Family Assistance (Direct Coverage)**	**CarePlus**
Skilled Nursing Facility[1]	§ 456	✔	✔	No	Share of 100 days per year
Speech and Hearing Center	§ 413	✔	✔	✔	✔
Therapy: Physical, Occupational, and Speech/ Language	§ 432	✔	✔	✔	✔
Transportation (non-emergency)	§ 407	✔	✔	No	✔
Vision Care/ eyeglasses	§ 402	✔	✔	✔	✔
X-ray/ Radiology		✔	✔	✔	✔

[1] Only MassHealth Standard covers *long term* nursing home care.

2016 MassHealth Income Standards and Federal Poverty Guidelines

Family Size	MassHealth Income Standards		100% Federal Poverty Level		5% Federal Poverty Level		120% Federal Poverty Level		133% Federal Poverty Level		135% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$522	$6,264	$990	$11,880	$50	$600	$1,188	$14,256	$1,317	$15,804	$1,337	$16,044
2	$650	$7,800	$1,335	$16,020	$67	$804	$1,602	$19,224	$1,776	$21,312	$1,803	$21,636
3	$775	$9,300	$1,680	$20,160	$84	$1,008			$2,235	$26,820		
4	$891	$10,692	$2,025	$24,300	$102	$1,224			$2,694	$32,328		
5	$1,016	$12,192	$2,370	$28,440	$119	$1,428			$3,153	$37,836		
6	$1,141	$13,692	$2,715	$32,580	$136	$1,632			$3,611	$43,332		
7	$1,266	$15,192	$3,061	$36,732	$154	$1,848			$4,071	$48,852		
8	$1,383	$16,596	$3,408	$40,896	$171	$2,052			$4,532	$54,384		
For each additional person add	$133	$1,596	$347	$4,164	$18	$216			$462	$5,544		

2016 MassHealth Income Standards and Federal Poverty Guidelines

Family Size	150% Federal Poverty Level		200% Federal Poverty Level		250% Federal Poverty Level		300% Federal Poverty Level		400% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$1,485	$17,820	$1,980	$23,760	$2,475	$29,700	$2,970	$35,640	$3,960	$47,520
2	$2,003	$24,036	$2,670	$32,040	$3,338	$40,056	$4,005	$48,060	$5,340	$64,080
3	$2,520	$30,240	$3,360	$40,320	$4,200	$50,400	$5,040	$60,480	$6,720	$80,640
4	$3,038	$36,456	$4,050	$48,600	$5,063	$60,756	$6,075	$72,900	$8,100	$97,200
5	$3,555	$42,660	$4,740	$56,880	$5,925	$71,100	$7,110	$85,320	$9,480	$113,760
6	$4,073	$48,876	$5,430	$65,160	$6,788	$81,456	$8,145	$97,740	$10,860	$130,320
7	$4,592	$55,104	$6,122	$73,464	$7,653	$91,836	$9,183	$110,196	$12,244	$146,928
8	$5,112	$61,344	$6,815	$81,780	$8,519	$102,228	$10,223	$122,676	$13,630	$163,560
For each additional person add	$520	$6,240	$694	$8,328	$867	$10,404	$1,040	$12,480	$1,387	$16,644

Institutional Income Standard $72.80

MassHealth & Other Health Programs: Upper Income Levels, March 1, 2016 to Feb 28, 2017										
Population/ Program	**Seniors (MassHealth Standard)**		**Adults under 65 (MassHealth Standard or MassHealth CarePlus)**		**Children & Young Adults under Age 21 (MassHealth Standard)**		**Pregnant women & infants (MH Standard); HIV+ individuals (MassHealth Family Assistance); All residents (Full Health Safety Net)**		**MassHealth Family Assistance (Children under 19); Small Business Premium Assistance**	
	Not MAGI		**MAGI**		**MAGI**		**MAGI**		**MAGI**	
Percent of poverty	**100%** (plus $20 mo. disregard)		**133%+ 5%**		**150%+5%**		**200%+5%**		**300%+5%**	
	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly
Family Size										
1	$1,010	$233.09	$1,367	$315.49	$1,535	$354.26	$2,030	$468.50	$3,020	$696.98
2	$1,355	$312.72	$1,843	$425.34	$2,070	$477.73	$2,737	$631.66	$4,072	$939.76
3	$1,700	$392.34	$2,319	$535.20	$2,604	$600.97	$3,444	$794.83	$5,124	$1,182.55
4	$2,045	$471.96	$2,796	$645.28	$3,140	$724.67	$4,152	$958.23	$6,177	$1,425.57
5	$2,390	$551.58	$3,272	$755.14	$3,674	$847.91	$4,859	$1,121.39	$7,229	$1,668.36
6	$2,735	$631.20	$3,747	$864.76	$4,209	$971.38	$5,566	$1,284.56	$8,281	$1,911.15
7	$3,081	$711.05	$4,225	$975.08	$4,746	$1,095.32	$6,276	$1,448.42	$9,337	$2,154.86
8	$3,428	$791.14	$4,703	$1,085.39	$5,283	$1,219.25	$6,986	$1,612.28	$10,394	$2,398.80
Each addtl.	$367	$84.70	$480	$110.78	$538	$124.16	$712	$164.32	$1,058	$244.17

For people under 65 in MassHealth, Children's Medical Security Plan (CMSP) & Health Safety Net (HSN), eligibility is based on current monthly Modified Adjusted Gross Income (MAGI); programs that use the new 5% of poverty level income deduction are shown in this table as 5% FPL higher e.g. the 133% standard is shown as 138% .

Monthly amounts are based on the Office of Medicaid 2016 Desk Guide; weekly amounts were calculated by dividing monthly amounts by 4.333.

Add the fetus to the family size of pregnant women in MassHealth & HSN.

For Seniors, eligibility is based on countable monthly income after deductions and there is an asset test, and the $20 per monthly standard disregard is added to the 100% FPL standard in this table; the 5% MAGI deduction does not apply.

The Senior deductible income standard is $522 per mo. for an individual;$650 per mo. for a couple.

The income standard for an institutionalized individual is $72.80 per month.

MassHealth & Other Health Programs: Upper Income Levels

	March 1, 2016 to February 28, 2017			2015 FPLs are used for coverage in Jan - Dec 2016					
				ConnectorCare					
Population/ Program	**Persons with breast/ cervical cancer (MassHealth Standard)**	**All residents (Partial Health Safety Net); Children under 19 (CMSP-subsidized)**		**Plan Type 1**	**Plan Type 2A**	**Plan Type 2B**	**Plan Type 3A**	**Plan Type 3B**	**Qualified Health Plans with Premium Tax Credits**
Percent of poverty	**250% +5%**	**400% + 5%**		**100%**	**150%**	**200%**	**250%**	**300%**	**400%**
	Monthly	Monthly	Weekly	Annual	Annual	Annual	Annual	Annual	Annual
Family Size									
1	$2,525	$4,010	$925.46	$11,770	$17,655	$23,540	$29,425	$35,310	$47,080
2	$3,405	$5,407	$1,247.87	$15,930	$23,895	$31,860	$39,825	$47,790	$63,720
3	$4,284	$6,804	$1,570.27	$20,090	$30,135	$40,180	$50,225	$60,270	$80,360
4	$5,165	$8,202	$1,892.91	$24,250	$36,375	$48,500	$60,625	$72,750	$97,000
5	$6,044	$9,599	$2,215.32	$28,410	$42,615	$56,820	$71,025	$85,230	$113,640
6	$6,924	$10,996	$2,537.73	$32,570	$48,855	$65,140	$81,425	$97,710	$130,280
7	$7,807	$12,398	$2,861.30	$36,730	$55,095	$73,460	$91,825	$110,190	$146,920
8	$8,690	$13,801	$3,185.09	$40,890	$61,335	$81,780	$102,225	$122,670	$163,560
Each addtl.	$885	$1,405	$324.26	$4,160	$6,240	$8,320	$10,400	$12,480	$16,640

For ConnectorCare & Qualified Health Plans with Premium Tax Credits, eligibility is based on expected annual MAGI income with no 5% of poverty level income deduction. 2015 FPL levels are used until the next open enrollment in the fall of 2016.
Children with income over 405% of the poverty level can buy-in to the Children's Medical Security Program (CMSP) at full cost.
There is no income upper limit or deductible for disabled children or disabled working adults in CommonHealth.
The CommonHealth deductible income standard for nonworking adults is $542 per mo. for one person & $670 for a couple
The upper income level for PACE and other home & community based waiver programs is $2199 monthly in 2016.
The 2016 poverty levels were published in the Jan. 25, 2016 Federal Register, 81 Fed. Reg 4036.
The 2016 MassHealth Desk Guide is posted here: http://www.mass.gov/eohhs/docs/masshealth/deskguides/fpl-deskguide.pdf

1

MODIFIED ADJUSTED GROSS INCOME (MAGI)

04-07-2016
Basic Benefit Training: Health Access
Vicky Pulos vpulos@mlri.org
617-357-0700 Ext. 318

2

Financial Eligibility

- Upper income limits –Federal Poverty Guidelines/Level (FPL)
- FPL vary by family size

3

2016 MassHealth Income Standards and Federal Poverty Guidelines

Family Size	MassHealth Income Standards		100% Federal Poverty Level		5% Federal Poverty Level		120% Federal Poverty Level		133% Federal Poverty Level		135% Federal Poverty Level	
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly
1	$522	$6,264	$990	$11,880	$50	$600	$1,188	$14,256	$1,317	$15,804	$1,337	$16,044
2	$650	$7,800	$1,335	$16,020	$67	$804	$1,602	$19,224	$1,776	$21,312	$1,803	$21,636
3	$775	$9,300	$1,680	$20,160	$84	$1,008			$2,235	$26,820		
4	$891	$10,692	$2,025	$24,300	$102	$1,224			$2,694	$32,328		
5	$1,016	$12,192	$2,370	$28,440	$119	$1,428			$3,153	$37,836		
6	$1,141	$13,692	$2,715	$32,580	$136	$1,632			$3,611	$43,332		
7	$1,266	$15,192	$3,061	$36,732	$154	$1,848			$4,071	$48,852		
8	$1,383	$16,596	$3,408	$40,896	$171	$2,052			$4,532	$54,384		
For each additional person add	$133	$1,596	$347	$4,164	$18	$216			$462	$5,544		

06-FPL Rev 02/16

4

MassHealth & Other Health Programs: Upper Income Levels, March 1, 2016 to Feb 28, 2017										
Population/ Program	Seniors (MassHealth Standard)		Adults under 65 (MassHealth Standard or MassHealth CarePlus)		Children & Young Adults under Age 21 (MassHealth Standard)		Pregnant women & infants (MH Standard); HIV+ individuals (MassHealth Family Assistance); All residents (Full Health Safety Net)		MassHealth Family Assistance (Children under 19); Small Business Premium Assistance	
	Not MAGI		MAGI		MAGI		MAGI		MAGI	
Percent of poverty	100% (plus $20 mo. disregard)		133%+ 5%		150%+5%		200%+5%		300%+5%	
	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly	Monthly	Weekly
Family Size										
1	$1,010	$233.08	$1,367	$315.49	$1,535	$354.26	$2,030	$468.50	$3,020	$696.98
2	$1,355	$312.72	$1,843	$425.34	$2,070	$477.73	$2,737	$631.66	$4,072	$939.76
3	$1,700	$392.34	$2,319	$535.20	$2,604	$600.97	$3,444	$794.83	$6,124	$1,182.55
4	$2,045	$471.96	$2,796	$645.28	$3,140	$724.67	$4,152	$958.23	$6,177	$1,425.57
5	$2,390	$551.58	$3,272	$755.14	$3,674	$847.91	$4,859	$1,121.39	$7,229	$1,668.36
6	$2,735	$631.20	$3,747	$864.76	$4,209	$971.38	$5,566	$1,284.55	$8,281	$1,911.15
7	$3,081	$711.05	$4,225	$975.08	$4,746	$1,095.32	$6,276	$1,448.42	$9,337	$2,154.86
8	$3,426	$791.14	$4,703	$1,085.39	$5,283	$1,219.25	$6,986	$1,612.28	$10,394	$2,398.80
Each addit.	$367	$84.70	$488	$110.78	$538	$124.16	$712	$164.32	$1,058	$244.17

For people under 65 in MassHealth, Children's Medical Security Plan (CMSP) & Health Safety Net (HSN), eligibility is based on current monthly Modified Adjusted Gross Income (MAGI); programs that use the new 5% of poverty level income deduction are shown in this table as 5% FPL higher e.g. the 133% standard is shown as 138% .

Monthly amounts are based on the Office of Medicaid 2016 Desk Guide; weekly amounts were calculated by dividing monthly amounts by 4.333.

Add the fetus to the family size of pregnant women in MassHealth & HSN.

For Seniors, eligibility is based on countable monthly income after deductions and there is an asset test, and the $20 per monthly standard disregard is added to the 100% FPL standard in this table; the 5% MAGI deduction does not apply.

The Senior deductible income standard is $522 per mo. for an individual,$650 per mo. for a couple.

The income standard for an institutionalized individual is $72.80 per month.

5

Modified Adjusted Gross Income

- MAGI applies to MassHealth, CMSP & HSN for:
  - Pregnant Women
  - Families with Children
  - Children & Young Adults (under 21)
  - Disabled Adults * (Special rule)
  - Other Adults
- MAGI also applies to everyone seeking subsidized insurance from the Health Insurance Connector

6

Not for today…

Financial eligibility for those applying:

- As age 65 or older,
- For long term care or alternatives to LTC,
- For a Medicare Buy-In, or
- For cash benefits with automatic MassHealth: SSI (including "deemed" SSI), TANF, or EAEDC & some other groups

- BBT Senior Heath & Elder Issues –April 21

7

Why understand MAGI

- To help your clients get better benefits at lower cost by
  - Completing applications more accurately
  - Recognizing incorrect results & referring patients/clients for help
  - Helping to fix incorrect results informally or through an appeal
- To inform applicants how tax related decisions may affect their health benefits

8

When will MAGI apply?

- MAGI rules effective Jan. 1, 2014
- As a practical matter, MAGI was implemented with new hCentive/HIX system that went live Nov. 15, 2014 & applies to people who received eligibility decisions after that date
  - New applicants
  - Current beneficiaries required to reapply as part of 2015 transition or as part of 2015-2016 annual renewal
  - Beneficiaries reporting a change
  - Beneficiaries in HIX up for renewal in 2016 & ongoing

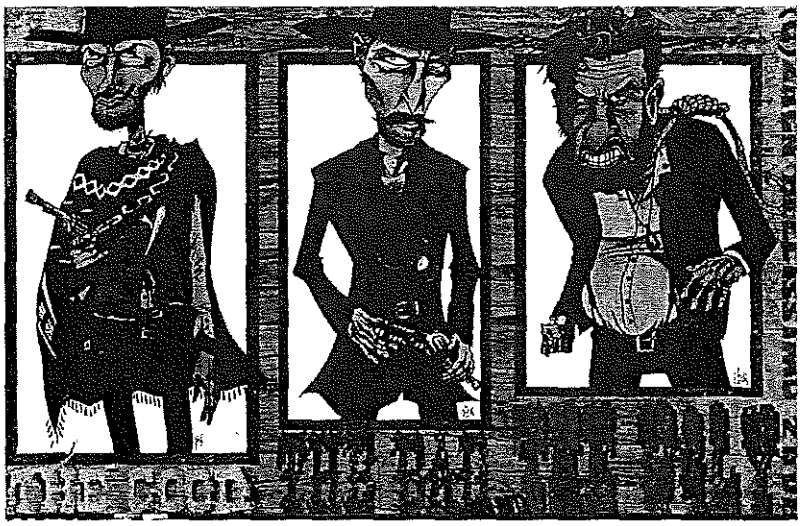
9

MAGI is based on tax rules

- MAGI uses tax rules about tax filers & tax dependents to identify a household
- MAGI uses tax rules about what is included in income & what isn't
  - Same rules apply to nonfilers too
- Tax rules on what counts as income are "modified" for purposes of Connector & MassHealth
- MassHealth has some exceptions to tax rules that do NOT apply to the Connector

10

MAGI-the good, the bad & the ugly



11

MAGI –the good

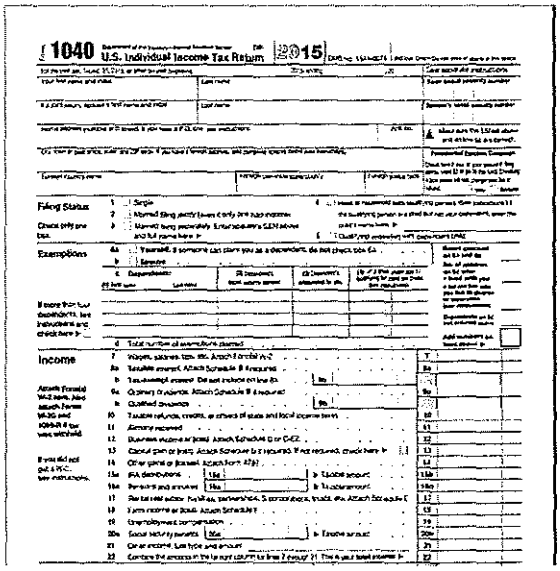
- Many sources of income are no longer counted & new adjustments are available to reduce income
- In MassHealth, there is a standard deduction equal to 5% of the federal poverty level for family size
- More opportunities to bring income under guidelines through pre-tax income
- With less income counted, applicants are more likely to be financially eligible for benefits

Differences in Income Sources: MAGI and 2013 MassHealth Gross Income Rules

Income Source	2013 MassHealth Rules	MAGI Rules
Self-employment income	Counted with deductions for business expenses but losses not counted	Counted with deductions for business expenses, & losses reduce AGI
Salary deferrals (flexible spending, cafeteria and 401(k) plans	Counted	Not counted in Job Income
Child support received	Counted	Not counted
Alimony paid	Not deducted from income	Deducted from income
VA benefits	Counted	Not counted
Workers' compensation	Counted	Not counted
Gifts & inheritances	Counted as lump sum income in month received	Not counted
Child's income	Counted	Only counted if child required to file a return

13

Is income in "Total income" ?



Form 1040 U.S. Individual Income Tax Return 2015

Filing Status

Exemptions

Income

14

IRS.GOV

ication 525, Taxable and Nontaxable Income | 1

IRS

Subscriptions ▾ Language ▾ Information For ▾

Search Q Advanced

Filing Payments Refunds Credits & Deductions News & Events Forms & Pubs Help & Resources for Tax Pros

Publication 525, Taxable and Nontaxable Income

You can receive income in the form of money, property, or services. This publication discusses many kinds of income and explains whether they are taxable or nontaxable. It includes discussions on:

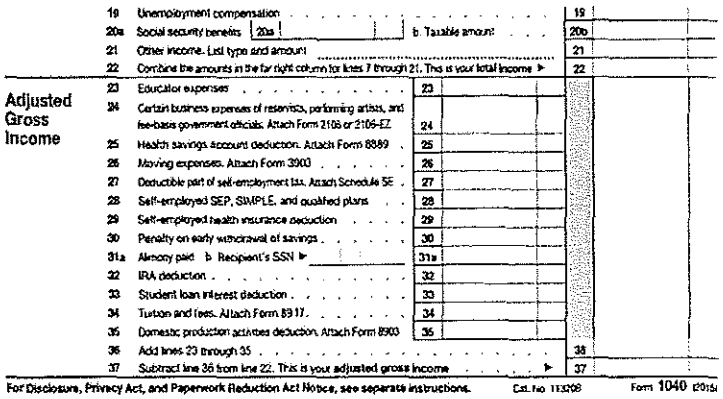
- employee wages and fringe benefits,
- income from bartering, partnerships, S corporations, and royalties,
- disability pensions,
- life insurance proceeds, and
- welfare and other public assistance benefits.

Related Forms

- Form 843, Claim for Refund and Request for Abatement
- Form 982, Reduction of Tax Attributes Due to Discharge of Indebtedness (and Section 1082 Basis Adjustment)
- Form 1040, U.S. Individual Income Tax

15

Are there are any "adjustments"?



	19	Unemployment compensation		19	
	20a	Social security benefits 20a	b Taxable amount	20b	
	21	Other income. List type and amount		21	
	22	Combine the amounts in the far right column for lines 7 through 21. This is your total income ▶		22	
Adjusted Gross Income	23	Educator expenses	23		
	24	Certain business expenses of reservists, performing artists, and fee-basis government officials. Attach Form 2106 or 2106-EZ	24		
	25	Health savings account deduction. Attach Form 8889	25		
	26	Moving expenses. Attach Form 3903	26		
	27	Deductible part of self-employment tax. Attach Schedule SE	27		
	28	Self-employed SEP, SIMPLE, and qualified plans	28		
	29	Self-employed health insurance deduction	29		
	30	Penalty on early withdrawal of savings	30		
	31a	Alimony paid b Recipient's SSN ▶	31a		
	32	IRA deduction	32		
	33	Student loan interest deduction	33		
	34	Tuition and fees. Attach Form 8917	34		
	35	Domestic production activities deduction. Attach Form 8903	35		
	36	Add lines 23 through 35		36	
	37	Subtract line 36 from line 22. This is your adjusted gross income ▶		37	

For Disclosure, Privacy Act, and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 11320B Form 1040 (2015)

16

Adding the "M" to AGI –modified AGI

- Add in the following nontaxable income:
  - Tax exempt interest (line 8b on Form 1040)
  - Non-taxable social security (line 20a less 20b on Form 1040)
  - Tax exempt foreign income (line 45 & 51 IRS Form 2555)

17

Where to find AGI on tax returns

- Form 1040-Line 37
- Form 1040A- Line 21
- Form 1040EZ-Line 4

- MassHealth is still using CURRENT MONTHLY INCOME
  - Most recent year's tax return is only a guide to extent current monthly income is from same source
- IRS rules (with modifications) govern treatment of income for non-filers too

18

5% of FPL Deduction in MassHealth MAGI –(not in Connector)

2016 MassHealth Income Standards and Federal Poverty Guidelines

Family Size	MassHealth Income Standards		100% Federal Poverty Level		5% Federal Poverty Level		120% Federal Poverty Level		133% Federal Poverty Level		Feder
	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Monthly	Yearly	Month
1	$522	$6,264	$990	$11,880	$50	$600	$1,188	$14,256	$1,317	$15,804	$1,3
2	$650	$7,800	$1,335	$16,020	$67	$804	$1,602	$19,224	$1,776	$21,312	$1,8
3	$775	$9,300	$1,680	$20,160	$84	$1,008			$2,235	$26,820	
4	$891	$10,692	$2,025	$24,300	$102	$1,224			$2,694	$32,328	

19

Example of 5% deduction

- Married couple file jointly & claim one child as dependent; Their MAGI is $2300 per mo.
- Income ceiling for MassHealth Standard for a family of 3 (133% FPL) is $2235.
- What is the amount of 5% FPL deduction for them?
- Are they eligible for MassHealth Standard as a family?

20

Income of tax dependents

- Income of a child or other person claimed as a tax dependent is not included in tax filer's income unless dependent is REQUIRED to file a return under IRS rules
- Unmarried dependents under age 65 required to file a return if ANY of
  - Earned income over $6300
  - Unearned income over $1050 (social security doesn't count)
  - Gross income over threshhold
- Also applies to child's income of non-filer parent

21

Example of pre-tax income

- Keisha works and has one child. Her child is on Standard but Keisha's income is $10 over the 133/138% income limit. She is not eligible for ConnectorCare because her employer offers insurance, but the insurance is expensive & has a high deductible. Keisha's employer offers pre-tax withholding for transit but Keisha has never participated. Keisha takes the T to work.
- Are there any choices Keisha can make that will change her eligibility for Standard?

22

MAGI-the bad

- Some sources of income that were not counted now do
  - E.g. Cancellation of a debt
- MAGI household rules create some surprising results
- Some people will not be eligible for ConnectorCare based on tax filing
- One-time income in Connector will be included in annual income that is basis of eligibility
  - In MassHealth it is still only counted in month of receipt

Center on Budget and Policy Priorities

MassHealth Rule for Tax Filers

Household = tax filer and all persons whom taxpayer expects to claim as a tax dependent

- For married couples filing jointly, each spouse is considered a tax filer
- Married couples living together always in same household regardless of filing status
- Anyone pregnant includes fetus(es) in family size

Example: Child Claimed by Non-Custodial Parent

- Lisa lives with her son and files taxes as a single individual
- Non-custodial dad claims son as his only dependent
- Lisa's income is $1500 per mo
- Is Lisa eligible for MassHealth?

25

MAGI-the ugly

- It's Complicated!
  - MAGI household rule can create unexpected results
  - Differences between MassHealth & Connector MAGI rules
  - Figuring out tax treatment of income when past year's return is not available as a guide because
    - New sources of income
    - Income for non-tax filers
  - Figuring out expected tax filing & annual income for people with changeable situations
  - Still defects & workarounds in HIX eligibility system

26

Why household size and composition matter

- Household size affects conversion of income to a federal poverty level percentage

- Who is in household determines whose income *may* count
  - If A is not in B's household, A's income will never count for B
  - If A is in B's household, A's income still may not count for B under tax dependent/child rule

27

Determining Households for Medicaid

- Individual-based determination
  - Members of a family could have different household sizes
- Three categories of individuals
  - Tax filers not claimed as a tax dependent
  - Tax dependents
  - Non-filers *and* not claimed as a tax dependent
- Based on expected tax filing status

Center on Budget and Policy Priorities

MassHealth Rule for Tax Filers

Household = tax filer and all persons whom taxpayer expects to claim as a tax dependent

For married couples filing jointly, each spouse is considered a tax filer

MassHealth rules (not for Connector)

- Married couples living together always in same household regardless of filing status
- Anyone pregnant includes fetus(es) in family size

29

Exemptions on Form1040

Filing Status — Check only one box.

1 ☐ Single
2 ☐ Married filing jointly (even if only one had income)
3 ☐ Married filing separately. Enter spouse's SSN above and full name here. ▶
4 ☐ Head of household (with qualifying person). (See instructions.) If the qualifying person is a child but not your dependent, enter this child's name here. ▶
5 ☐ Qualifying widow(er) with dependent child

Exemptions

6a ☐ Yourself. If someone can claim you as a dependent, do not check box 6a
b ☐ Spouse

c Dependents: (1) First name / Last name	(2) Dependent's social security number	(3) Dependent's relationship to you	(4) ✓ if child under age 17 qualifying for child tax credit (see instructions)
			☐
			☐
			☐
			☐

If more than four dependents, see instructions and check here ▶ ☐

d Total number of exemptions claimed

Boxes checked on 6a and 6b
No. of children on 6c who:
• lived with you
• did not live with you due to divorce or separation (see instructions)
Dependents on 6c not entered above
Add numbers on lines above ▶

Medicaid Rule for Tax Dependents

- Household = household of tax filer claiming the dependent
- 3 exceptions: In these cases, apply the rule for non-filers:
  - Tax dependent who is not a child or spouse of the taxpayer
  - Children living with both parents who are unmarried
  - Children claimed as tax dependent by a non-custodial parent

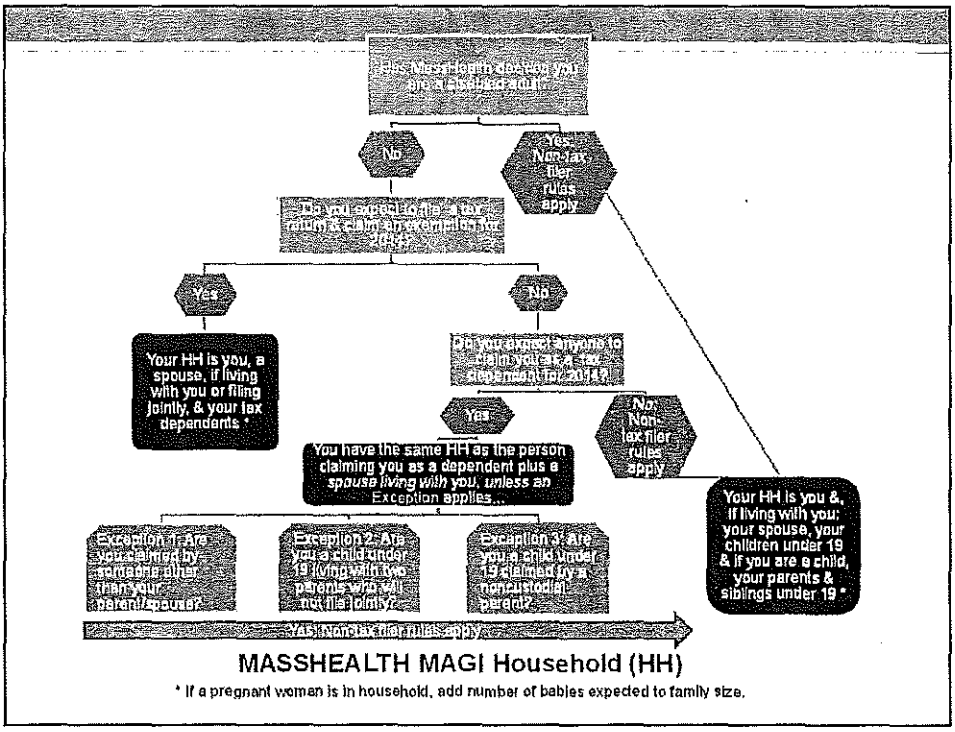
MassHealth Rule for Non-filers Not Claimed as Dependents

- Household = individual plus, if living with individual, spouse and children under 19, and
- For children under 19

  Household also includes, siblings under 19 and parents (including step-parents) living with child

- Similar to 2013 MassHealth gross income rule but not identical

·cbpp.org



MASSHEALTH MAGI Household (HH)

* If a pregnant woman is in household, add number of babies expected to family size.

Example: Non-Married Parents

- Dan and Jen live together with their 2 children, Drew and Mary
- Dan and Jen both have income
- For taxes, Dan claims the children, Jen files on her own

	Counted in HH				HH Size for Medicaid
	Dan	Jen	Drew	Mary	
Dan					?
Jen					?
Drew					?
Mary					?

Example: Non-Married Parents

- Dan and Jen live together with their 2 children, Drew and Mary
- Dan and Jen both have income
- For taxes, Dan claims the children, Jen files on her own

	Counted in HH				HH Size for Medicaid
	Dan	Jen	Drew	Mary	
Dan	✓		✓	✓	3
Jen		✓			1
Drew	✓	✓	✓	✓	4
Mary	✓	✓	✓	✓	4

35

Disabled Adult MAGI Rule

- Massachusetts-specific rule in MassHealth
- Disabled adult will be treated as non-filer even if claimed as dependent
  - Applies to disabled adults 21-64
  - Also applies to disabled young adults 19 and 20 who are not otherwise eligible for MassHealth Standard*
- This prevents disabled adult claimed as a tax dependent from losing eligibility based on income of tax filer

36

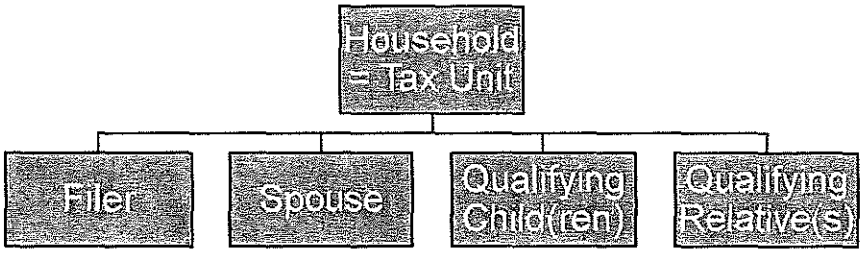
Households for Premium Tax Credits (Connector)

- Household = individuals for whom a taxpayer claims a deduction for a personal exemption
- Taxpayer can claim personal exemption for:
  - Self and spouse (filing jointly)
  - Dependents
    - Children and other relatives who meet certain requirements
    - Person may be a dependent even if he files a tax return (as long as he does not claim his own exemption)

Households for Premium Tax Credits

- Household is based on *expected* tax filing Status & exemptions for tax year in which advance premium tax credit is being claimed
  - Household is <u>not</u> based on previous tax return
  - Life changes will affect household (and credit amount)

Premium Tax Credit MAGI Household



39

Tax filers in the Connector (not MassHealth)

- Application asks if you expect to file taxes. If NO, you will not be eligible for ConnectorCare.
- Application asks if married & planning to file jointly. If NO, you will not be eligible for ConnectorCare.
  - Exceptions: married & unable to file jointly due to abuse or abandonment
    - Workaround-instruction to answer married question NO if this exception applies
  - Head of household filing status "deemed unmarried" by IRS
- Income is expected ANNUAL income

40

FPL in the Connector

- MassHealth updates FPL in March based on federal poverty guidelines released in January of same year
- Connector does not update FPL until start of open enrollment season in same year
  - Nov 1, 2016 -Jan. 31, 2017
  - For determinations of 2017 coverage

More on Connector & ConnectorCare in p.m. session

41

Connector v. MassHealth example

- Maria is a pregnant woman expecting one child in 2017 who lives alone, expects to file as single in 2016 & earns $3000 per mo. ($36,000 per year in 2016)
- Is she eligible for MassHealth?
  - 200% fpl income standard for pregnant women
- Is she eligible for ConnectorCare?
  - 300% fpl income standard

Example: Married Couple with Children (Reyes family)

- Mom and dad file a joint return and claim both children as dependents
- Family's financial situation:

. $800 per mo – Mom's profit from own business

. $2,000 – Dad's gross salary(including $100 pretax retirement contribution)

. $100 per mo current (5,000 per year) – Son's income from weekend and summer jobs

Who is in MassHealth MAGI household for each individual? What is MassHealth MAGI income for each individual in household?

Example: Married Couple with Children (Reyes family)

- Mom and dad file a joint return and claim both children as dependents
- Family's financial situation:

$ 800 – Mom's profit from own business (counted)
$1900 – Dad's $2000 salary (counted) less $100 pretax contribution
$ 0 – Son's income from weekend and summer jobs (not counted)
$2,700 –Household income for tax filing household

. Household income for MassHealth and PTC :

	MassHealth		
	HH	Income	Eligible?
Mom	4	2700	Y
Dad	4	2700	Y
Son	4	2700	Y
Daughter	4	2700	Y

cbpp.org

Example: Non-Married Parents

- Dan and Jen are not married, but live together with their 2 children, Drew and Mary
- Dan claims the children. Jen files on her own
- Family's financial situation:
  - $26,000 ($2,166 mo) – Dan's income
  - $18,000 ($1500 mo) – Jen's income

	MassHealth			Premium Tax Credits		
	HH	Income	Eligible?	HH	Income	Eligible?
Dan	3	?	?	3	?	?
Jen	1	?		1	?	?
Drew	4	?		3	?	?
Mary	4	?		3	?	?

Example: Non-Married Parents

- Dan and Jen are not married, but live together with their 2 children, Drew and Mary
- Dan claims the children. Jen files on her own
- Family's financial situation:
  - $26,000 ($2166 mo)– Dan's income
  - $18,000 ($1500 mo)– Jen's income

	MassHealth			Premium Tax Credits		
	HH	Income	Eligible?	HH	Income	Eligible?
Dan	3	$2166	Y-ST	3	$26,000	n/a
Jen	1	$1500	N	1	$18000	Y-2B
Drew	4	$3666	Y-FA	3	$26,000	n/a
Mary	4	$3666	Y-FA	3	$26,000	n/a

45

More on MAGI

- Federal Regulations
  - 42 CFR 435.603 (Medicaid) and
  - 26 CFR §1.36B-1 (Tax credits)
- State regulations 130 CMR 506 on mass.gov/masshealth
- 1115 Demonstration posted on mass.gov/masshealth

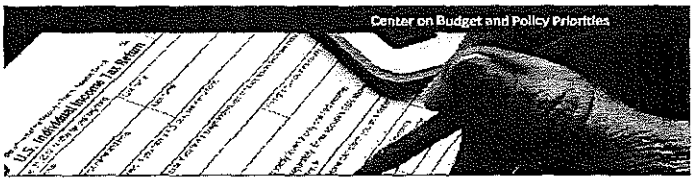
47

Healthreformbeyondthebasics.org

Health Reform: Beyond the Basics

The Health Care Assister's Guide to Tax Rules

Determining Income & Households for Medicaid and Premium Tax Credits



48

Other secondary sources

- National Health Law Program (NHeLP), The Advocate's Guide to MAGI, posted on http://www.healthlaw.org/publications/agmagi#.VvrE1-IrL4Y
- MLRI "Understanding the Affordable Care Act: How MassHealth will count income in 2014" posted at masslegalservices.org

MLRI MASSACHUSETTS LAW REFORM INSTITUTE

99 CHAUNCY STREET
SUITE 500
BOSTON, MA 02111

617.357.0700 PHONE
617.357.0777 FAX
WWW.MLRI.ORG

Understanding the Affordable Care Act in Massachusetts: Eligibility of non-citizens for MassHealth & other subsidized health benefits October 2015

To qualify for comprehensive MassHealth benefits (not just emergency services) and to qualify to purchase insurance through the Massachusetts Health Connector, people must satisfy several financial and non-financial eligibility criteria. Among the non-financial criteria is a requirement that individuals be U.S. citizens or non-citizens who have an eligible immigration status. This paper summarizes the rules that MassHealth and the Connector use to determine when non-citizens have an eligible status.

To be eligible to purchase insurance through the Connector, with or without a premium tax credit, a non-citizen must have an immigration status on the list of statuses considered "Lawfully Present." MassHealth uses additional factors besides Lawful Presence to determine when immigrants have an eligible immigration status. Table 1 summarizes the relationship between the Lawfully Present category and the additional categories used in MassHealth.

MassHealth offers various types of coverage with different benefits based on age, income, health status and other factors. Some immigrants are eligible for MassHealth benefits in the same way as US citizens are. Other immigrants are eligible for some benefits, but not the same benefits for which they would be eligible if they were US citizens. Table 2 summarizes the immigration status and other conditions that affect immigrant eligibility for different types of MassHealth plans.

The Appendices list the various immigration statuses and other conditions that are included in the definitions of the terms used by the Connector and MassHealth

Table 1: Comparing Connector and MassHealth Immigrant Categories

Table 2: Immigrants Eligible for Different Types of MassHealth & the Connector

Appendix 1: Qualified Non-Citizens

Appendix 2: Qualified Barred Non-Citizens

Appendix 3: Lawfully Present Non-Citizens

Appendix 4: Non-qualified PRUCOL Non-Citizens

`

Table 1. Comparing Connector and MassHealth Immigrant Categories			
Connector Category	MassHealth Categories	Code in Computer System	Eligible Immigration Status?
Lawfully Present – Eligible for Connector	Qualified	QLP	Yes
	Qualified Barred	QAB	
	Nonqualified Individual Lawfully Present	ILP	
Not Eligible for Connector	Nonqualified PRUCOL	NQP	
	Other (including undocumented)	UNDOC	No

- "Lawfully Present" adults are eligible for full MassHealth only if they are "Qualified " with two exceptions: 1) Pregnant women who are Lawfully Present need not be Qualified to be eligible for MassHealth Standard, and 2) elderly or disabled poverty level immigrants who are Lawfully Present need not be Qualified to be eligible for MassHealth Family Assistance.
- Lawfully present children and 19 and 20 year old young adults are eligible for MassHealth Standard in the same way as US citizens.
- Immigrants who are "Nonqualified PRUCOL" are not eligible for the Connector but may be eligible for MassHealth Family Assistance, or, for disabled children and young adults, CommonHealth.
- Pregnant women are eligible for MassHealth Standard regardless of status.
- Immigrants who have been receiving MassHealth or CommonHealth continuously since June 30, 1997 or who have been in a nursing home since then are eligible for MassHealth regardless of status. They are "Protected Non-Citizens," see 130 CMR §§ 504.003(B) and 518.003(B).
- Other undocumented non-citizens are only eligible for safety net programs with limited benefits: MassHealth Limited, Health Safety Net and/or the Children's Medical Security Plan.

`

Table 2: Immigrants Eligible for Different Types of MassHealth & the Connector			
Immigration Status	**Other Requirements for MassHealth** (Percent shown is % of federal poverty level)	**MassHealth Eligible Coverage Type**	**Connector Eligible Immigration Status**
Qualified –see Appendix 1 for list of Qualified statuses	Qualified (not barred) immigrants are eligible for all MassHealth benefits in the same way as US citizens	MassHealth Standard, CommonHealth, CarePlus, Family Assistance & Medicare Savings Programs (QMB, SLMB, Q-1)	Yes
Lawfully Present – not included above as Qualified - see Appendix 3 for list of all **Lawfully Present** statuses	Pregnant women & infants ≤200%; children 1-20 ≤150%	MassHealth Standard	Yes
	Children 1-18 >150% ≤300%	Family Assistance	
	Disabled children 0-18 >150%	CommonHealth	
	Elderly & disabled adults ≤100% (asset test for elderly)	Family Assistance	
Nonqualified PRUCOL - see Appendix 4 for list of statuses	Pregnant women ≤200%	MassHealth Standard	No
	Infants ≤200%	Family Assistance	
	Children 1-18 ≤300% FPL	Family Assistance	
	Disabled Children under 19	CommonHealth	
	Disabled young adults 19 & 20 ≤150%	CommonHealth	
	Other adults age 19-64 ≤300% ; elderly ≤100% & asset test	Family Assistance	
Other –including undocumented non US citizens	Pregnant women ≤200%	MassHealth Standard	No
	Infants ≤200%; Children & Young Adults 1-20 ≤150%; Adults 21-64 ≤133%; Adults 65 or older ≤100% & asset test	MassHealth Limited	
	Children under 19	Children's Medical Security Plan (CMSP)	
	All ages, ≤400%	Health Safety Net	
	On MassHealth since 1997 (grandfathered)	Standard or CommonHealth	

`

Appendix 1
Qualified (not barred) Non-Citizens
130 CMR 504.003(A)(1); 504.006(A) (under 65)
130 CMR 518.003(A)(1); 518.006(A) (65 and older)

All Qualified non-citizens are Lawfully Present.

Group A: Individuals who are qualified regardless of date of entry into US or length of time with Qualified Status (never barred):

- Asylee
- Refugee
- Granted withholding of deportation or withholding of removal under immigration laws (but not including CAT)
- Veteran or active duty military and spouse, widow and dependent child/ren
- Cuban/Haitian entrant including a Cuban or Haitian
    - Paroled into US after 1980,
    - Applicant for Asylum, or
    - Subject to a non-final order of exclusion
- American Indian born in Canada or other member of federally recognized tribe
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Conditional entrant granted before 1980

Group B: Individuals with one of the following statuses potentially subject to 5-year bar who are not barred either because 5 years have been met or because they satisfy additional factors that exempt them from the 5-year bar:

- Lawful permanent resident (LPR/Green Card holder),
- Paroled into the U.S. for more than 1 year, or
- Battered spouse and child/ren, or battered child and parent
    - Battered in US by US citizen or Legal Permanent Resident spouse or parent or family member of spouse or parent,
    - No longer living with abuser, and

`

- With an approved or pending petition that will lead to permanent resident status (petition has been found to establish a "prima facie case")

AND

- Had Permanent Resident/Parolee/Battered Immigrant status for 5 or more years or
- Had such status for less than 5 years, but exempt from 5-year bar because:
  - Entered US prior to 8/22/96 (regardless of status at time of entry) & continuously present until becoming Permanent Resident/Parolee/Battered Immigrant,
  - Veteran or Active Duty Military or his/her spouse, widow or dependent child,
  - Iraqi or Afghani Special Immigrant,
  - American Indian born in Canada (or other member of federally recognized tribe),
  - Cuban or Haitian who became a legal permanent resident under certain special laws (not through a family member or employer),
  - Amerasian born in Vietnam during Vietnam War era, or
  - Before becoming a legal permanent resident was an asylee, refugee, granted withholding of deportation, Cuban-Haitian Entrant, or trafficking victim.

Appendix 2

Qualified Barred Non-citizens
130 CMR 504.003(A)(2); 504.006(B) (under 65)
130 CMR 518.003(A)(2); 518.006(B) (65 and older)

All Qualified Barred non-citizens are Lawfully Present.

Individuals with one of the following statuses who have had status for less than 5-years and are not exempt from the 5-year bar (see exemptions to 5 year bar in Appendix 1 Group B):

- Lawful permanent resident (LPR/Green Card holder),
- Paroled into the U.S. for more than 1 year, or
- Battered spouse and child/ren, or battered child and parent

`

Appendix 3

Lawfully Present Non-Citizens

130 CMR 504.003 (A)(1)(2) and (3); 504.006(A) and (B) (under 65)
130 CMR 518.003(A)(1)(2) and (3); 518.006 (A) and (B) (65 & older)
45 CFR §§155.20 and 152.2; proposed § 155.20 and 42 CFR § 435.4 at 78 Fed. Reg. 4594 (Jan. 22, 2013) (definition of lawful presence); 45 CFR §155.305, 956 CMR § 12.05 (Exchange; ConnectorCare)

All Qualified and Qualified Barred Non-Citizens are also Lawfully Present. All Lawfully Present non-citizens are eligible for the Connector in the same way as US citizens. All Lawfully Present Children under 19 at any income level and 19 & 20 year old young adults with income under 150% FPL are eligible for MassHealth in the same way as US citizens.

- *Lawful permanent resident (LPR/Green Card holder)**
- *Asylee**
- *Refugee**
- *Cuban/Haitian entrant**
- *Person paroled into the U.S.**
- *Conditional entrant granted before 1980**
- *Battered spouse, child, or parent**
- *Victim of trafficking and his or her spouse, child, sibling, or parent**
- *Person granted Withholding of Deportation or Withholding of Removal, under the immigration laws* * or under the Convention against Torture (CAT)
- Individual with non-immigrant status (including worker visas, student visas, and citizens of Micronesia, the Marshall Islands, and Palau)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (Deferred Action for Childhood Arrivals (DACA) isn't an eligible immigration status for applying for health coverage.)
- Applicant for:
    - Special Immigrant Juvenile Status
    - Adjustment to LPR Status with an approved visa petition

`

- *Victim of trafficking visa**
- Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days.
- Withholding of Deportation or Withholding of Removal, under the immigration laws or under the Convention against Torture (CAT) who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding removal under the immigration laws or under the CAT pending for at least 180 days.

- Individuals with employment authorization under 8 CFR 274a.12(c) including:
  - Registry applicants
  - Those under an Order of supervision
  - Applicants for Cancellation of Removal or Suspension of Deportation
  - Applicants for Legalization under IRCA
  - Applicants for Temporary Protected Status (TPS)
  - Persons granted legalization under the LIFE Act
- Lawful temporary resident
- Granted an administrative stay of removal by the Department of Homeland Security (DHS)
- *Member of a federally recognized Indian tribe or American Indian born in Canada**

**The kinds of immigration status shown in italic are not only Lawfully Present but also Qualified or Qualified Barred. MassHealth uses the term "Nonqualified Individual Lawfully Present" to describe a non-citizen with a status on this list that is not Qualified or Qualified Barred.*

`

Appendix 4

Nonqualified Persons Residing in US under Color of Law (PRUCOL)

130 CMR 504.003(C); 504.006(C) (under 65)
130 CMR 518.003(C); 518.006(C) (65 and older)

Non-qualified PRUCOL non-citizens are not eligible to purchase insurance through the Connector.

Non-citizens who are not included in the Lawfully Present List in Table 1 and have one of the following statuses/conditions:

- Granted indefinite stay of deportation;
- Granted indefinite voluntary departure;
- Have approved immediate relative petition, entitled to voluntary departure, and whose departure the U.S. Department of Homeland Security (DHS) does not contemplate enforcing;
- Granted voluntary departure by the DHS or an Immigration Judge, and whose deportation the DHS does not contemplate enforcing;
- Living under orders of supervision who do not have employment authorization under 8 CFR 274a.12(c);
- Have entered and continuously lived in the United States since before January 1, 1972;
- Granted suspension of deportation, and whose departure the DHS does not contemplate enforcing;
- Have a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention against Torture who have not been granted employment authorization, or are under the age of 14 and have not had an application pending for at least 180 days;
- Granted Deferred Action for Childhood Arrivals(DACA) or who have a pending application for DACA;
- Have filed an application, petition, or request to obtain a lawfully present status that has been accepted as properly filed, but who have not yet obtained employment authorization and whose departure DHS does not contemplate enforcing; or
- Any noncitizen living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include persons granted Extended Voluntary Departure due to conditions in the noncitizen's home country based on a determination by the U.S. Secretary of State.)

`

Additional Resources

Massachusetts

MassHealth and Connector, Member Booklet, Section 9, US Citizenship and Immigration rules; and Senior Guide to Health Coverage, Part 11, US Citizenship and Immigrations rules (March 2015): http://www.mass.gov/eohhs/gov/laws-regs/masshealth/member-eligibility-lib/applications-and-member-forms.html (last visited 10-19-15)

MassHealth and Connector, Immigration Document Types-description of documents, how to enter codes from different documents and photos of sample documents (link from Getting Started Guide on mahealthconnector.org): https://betterhealthconnector.com/immigration-document-types (last visited 10-19-15)

National

National Immigration Law Center, information about immigrants and access to public benefits: http://nilc.org/access-to-bens.html (last visited 10-19-15)

Send questions or comments to Vicky Pulos, vpulos@mlri.org, 617-357-0700 Ext. 318. For other MLRI papers related to Understanding the Affordable Care Act visit the health section of www.masslegalservices.org

Prior Authorization for Non-Pharmaceutical Services – Frequently Asked Questions

http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/prior-authorization/prior-authorization-for-non-pharmaceutical-srvcs-1.html

1. What is the purpose of prior authorization (PA)?

MassHealth determines the medical necessity of a service or product to be provided to its members through the use of prior authorization (PA) See 130 CMR 450.303. PA determines only the medical necessity of the authorized service and does not establish or waive any other prerequisites for payment (such as a referral or preadmission screening (PAS)). A provider must submit a PA request in accordance with instructions provided by MassHealth for requesting PA in Subchapter 5 of the provider manual.

2. Which services require PA?

The following categories of services require a PA. To access information about these services, you may click on this link,*MassHealth Provider Manuals*, to access all MassHealth provider manuals. You may also click on the service categories below to access specific Subchapter 6 Service Code information for each service.

- physician
- vision care
- therapy (physical, occupational, speech/language)
- audiology
- private duty nursing (independent nursing)
- personal care attendant (PCA)
- durable medical equipment including
- wheelchairs and beds
- orthotics and prosthetics
- oxygen and respiratory

Please note: Dental services are currently administered by Doral.

3. How do I submit a request for PA?

The process for completing a PA request and submitting the required documentation can be found in Subchapter 5 of your provider manual. To reduce the likelihood of a PA request being deferred or denied, it is essential that the PA request form is completed properly and that the necessary attachments are included with the request. **Providers are encouraged to send their PA requests to Mass Health online** via the Provider Online Service Center. PA requests and attachments submitted on paper should be mailed to:

- P.O. Box 9152 - CCM Prior Authorization [Region 31]
- P.O. Box 9153 - Western MA Prior Authorization [Region 32]
- P.O. Box 9154 - Boston Prior Authorization [Region 33]

Hingham, MA 02043

PAs submitted for an MCB member should be sent to the Boston region: P.O.Box 9154.

The PA request form is available on the Provider Online Service Center. Additional MassHealth-generated proprietary attachments will be placed on the site as they are developed. When submitting a PA request for certain services, the provider may also be required to submit a provider-specific form (for example, an invoice) along with any MassHealth proprietary attachments. Please consult your provider manual for specific requirements.

4. What is NewMMIS?

On May 26, 2009, MassHealth launched its New Medicaid Management Information System (NewMMIS) which includes the prior authorization functionality. Providers can easily access the system through the Internet to submit prior authorization requests and attachments electronically. Attachments that consist of photographs or X rays can be submitted electronically, as long as the image is digital. NewMMIS will assign a tracking number to the PA submission. The tracking number (known as GAN number under APAS) is used for tracking purposes only, and consists of nine characters (the tracking number is not the prior authorization number, which consists of one letter followed by nine numbers). While the tracking number is available to the provider immediately, the PA number will not be available until a decision on the PA request has been made.

5. What is the process once the PA request is received?

Providers may submit PAs either online or on paper. Online submission is strongly encouraged. If submitted online, the system performs validation checks to ensure that required fields are completed and certain minimum information such as provider ID, member ID, procedure code, and dates are included and are valid. PAs submitted on paper are keyed into NewMMIS by PA staff and the system performs similar checks. In both cases, the PA is also stamped with the receipt date. The PA is then forwarded to the appropriate consultant for review and decision. After a decision is made, decision letters are mailed to both the provider and the member.

6. Who reviews the PA request?

Consultants with education and experience in the service area review the PA form and supporting documentation. These clinical reviewers include physicians, nurses, and therapists. For example, requests for physical therapy services are reviewed by physical therapists, etc.

7. What standard is used when a decision is made?

The standard is medical necessity. MassHealth will not pay a provider for services that are not medically necessary. A service is medically necessary if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to MassHealth. Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

8. What are the possible decisions?

The consultants may make any of the following decisions on a PA request:

- Approve the request - the request is authorized.
  Deny the request - the request is denied and MassHealth will not reimburse for the service.
- Modify the request - the approval is for a service that is different in quantity or nature than that which was originally requested, but it was determined that the approved item is appropriate to meet the medical needs of the member.
- Defer the request - the request cannot be adjudicated as additional information is needed to make a decision; the provider is asked to submit supporting documentation.

9. Are there time limits that apply to decisions?

MassHealth is required to respond to appropriately completed and submitted requests for PA within the following time periods, in accordance with 130 CMR 450.303(A):

- independent nursing - within 14 calendar days after the date the PA unit receives the request;
- DME - within 15 calendar days after the date the PA unit receives the request;
- for all other services (excluding pharmacy and transportation) - within 21 days after the date the PA unit receives the request.

If a PA is deferred, the adjudication clock stops. Both the provider and member are notified that the PA has been deferred. When the provider submits the additional information to MassHealth, the clock starts again from where it left off.

10. How is the consultant's decision communicated?

Once a decision is made, a notice is sent to the provider through the provider's preferred method of communication and a notice is mailed to the member. The notice advises both parties of the decision and the rationale for the decision. After the decision process is completed, photographs and X rays submitted with the request are returned to the provider. The PA unit does not retain copies of these items. When a PA is submitted via the Provider Online Service Center, the decision can be viewed via the same application. In this way, the provider is aware of the decision in advance of receiving notification via mail, if mail is the provider's preferred method of communication.

11. What if a PA request is deferred?

If a PA is deferred, notification is sent to both the provider and member, explaining the reason for the deferral; typically missing documentation. The provider may submit the additional information needed, either by mail or by attaching it electronically to the online PA request. Once the additional information is received by the PA unit, review and adjudication can continue. Providers have 30 days to respond to a deferral.

12. What if a PA is modified or denied?

If a PA request is modified or denied, the member has a right to appeal. Decision letters detailing the reason for the modification or denial are sent to the provider and the member and an explanation of the member's right to appeal and how to appeal are provided to the member with their packet.

13. Does the member have appeal rights?

The right to appeal the decision made on a PA request belongs to the member. Whenever a PA request is approved, modified, or denied, a letter is sent to the member explaining the decision and providing the reason the decision was made. Also included in the letter is information explaining the member's appeal rights. MassHealth's Board of Hearings is the entity that hears appeals. If needed, interpreter services and/or assistive devices are available to members during the hearing. For questions about the appeals process, call 1-800-862-8341 or 617-727-5550.

14. Who can the provider contact to check on the status of a specific PA?

If 21 days without response from MassHealth has elapsed since the PA was submitted, providers who sent their PA request on paper may call MassHealth Customer Service at 1-800-841-2900 to check on the status of the PA. Providers who submit their request via NewMMIS can simply go online to determine the status of their request.

15. How can I get a provider manual or copies of forms?

To request a provider manual or PA forms, call MassHealth Customer Service at 1-800-841-2900, fax to 617-988-8973, e-mail to publications@mahealth.net, or write to the following address. Forms can also be downloaded from thewww.mass.gov/masshealth/newmmis.

MassHealth Customer Service Center
Attn: MassHealth Forms Distribution
P.O. Box 9162
Canton, MA 02021

Glossary of PA Terms:

NewMMIS terminology

Adjudicated - MassHealth has made a decision on the PA. A notice is sent to the provider through the provider's preferred method of communication and a notice is mailed to the member. The notice describes the results of the adjudication.

Approve - authorization to perform/provide services is granted.

Attachment - documentation accompanying the PA request, which establishes the reason that the service requested is medically necessary. It may also establish the cost of the requested item/service. Attachments may include, but are not limited to: a letter of medical necessity, a prescription, an invoice, a growth chart, etc. Specific required attachments are determined by the service being requested.

Consultant - a clinical professional educated and having experience in a specific clinical field, such as nursing, medicine, or physical therapy.

Defer - adjudication of the PA request is halted due to lack of sufficient documentation to render a decision. Adjudication continues once the provider submits the additional documentation.

Deny - the request for payment of the service is denied.

Medical necessity - A service is medically necessary if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunctions, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and

(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to MassHealth. Services that are less costly MassHealth include, but are not limited to, health care reasonably known by the provider, or identified by MassHealth pursuant to a prior-authorization request, to be available to the member through

sources described in 130 CMR 450.317(C), 503.007, or 517.007. Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Modify - the approval is for a service or product other than what was requested; but it has been determined that the approved item is appropriate to meet the medical needs of the member.

PA number - the number assigned to a PA after it has been reviewed by a consultant and a decision has been made. The PA number is 10 characters long, and is constructed as follows.

PYYJJJNNNN
P = Prior Authorization
YY = the Year
JJJ = Julian date
NNNN = four digit sequence

Tracking Number - a nine-digit number assigned by NewMMIS to a PA request that has been keyed in the system. The tracking number can be used by the provider to ascertain the status of the PA request while it is in process; i.e., not yet adjudicated. Upon adjudication, the provider is notified of the decision and the Prior Authorization number is made available.

NAVIGATING THE MASSHEALTH SYSTEMS[1]

Who to call?

Department	Phone Number	Reason for call
MassHealth Customer Service Center[2]	1-800-841-2900	• To request an application • To apply for or make changes to a subsidized application or health plan • To ask about the status of a case • To discuss billing issues • To report a problem with the Health Insurance Exchange (HIX)
MassHealth Enrollment Centers[3] ▪ Chelsea-45 Spruce Street ▪ Springfield-333 Bridge Street ▪ Taunton-21 Spring Street, Suite 4 ▪ Tewksbury-367 East Street	1-888-665-9993	• To ask about eligibility for subsidized coverage • To ask about the status of a case • To report changes relating to eligibility (i.e. immigration status and income) • To get automated eligibility information (need member ID, SSN, date of birth and sometimes zip code; Press1, 1 and follow directions) • To resolve eligibility issues
Health Connector Customer Service	1-877-623-6765	• To apply for or make changes to a subsidized or unsubsidized application for medical and dental coverage • To ask about the status of a case • To ask for assistance with password or login issues on HIX • To report a problem with HIX • To resolve eligibility issues
Third Party Liability	1-800-462-1120	• To discuss the reason(s) a medical provider cannot bill MassHealth • To update member's record so that proper billing can occur
Board of Hearings	1-617-847-1200 1-800-655-0338	• MassHealth Appeals • Fair Hearings

[1] Information provided by MassHealth. Visit http://www.mass.gov/eohhs/gov/departments/masshealth/contact-masshealth.html for list of telephone numbers for MassHealth & Managed Care Organizations.

[2] The Customer Service Center is staffed by a private company named Maximus under contract with MassHealth. They can provide information but cannot make changes.

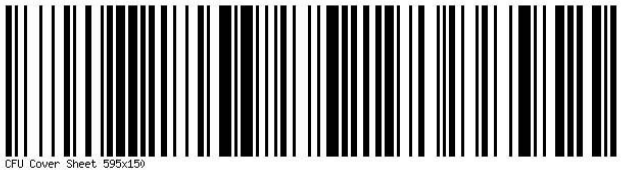
[3] The Enrollment Center is staffed with state employees who can correct errors and assist in resolving issues.

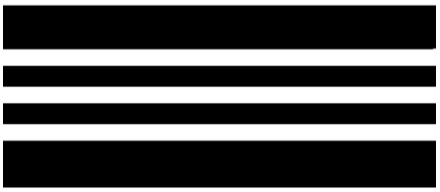
Where to mail/fax?

Mailing Address	Fax Number	Document
Health Insurance Processing Center P.O. Box 4405 Taunton, MA 02780	1-857-323-8300	• New paper Subsidized applications (assistance with paying)-including Health Connector (ConnectorCare plans and those seeking premium tax credits) MassHealth or Health Safety Net coverage • Verification Documents • Permission to Share Information Form • Authorized Representative Designation Form
Massachusetts Health Connector 133 Portland Street, 1st Floor Boston, MA 02114-1707	1-877-623-2155	• New paper applications for unsubsidized (no assistance paying) health insurance through the Health Connector
Massachusetts Health Connector 133 Portland Street, 1st Floor Boston, MA 02114-1707	1-617-887-8745	Identity Proofing Documents-such as: • Driver's license • School Identification card • Voter registration card • U.S. military card or draft record • Identification card issued by the federal, state and local government including a U.S. passport or a Massachusetts ID Or TWO of the following • Birth certificate • Social security card • Marriage certificate • Divorce decree • Employer identification card • High school or college diploma (including high school equivalency diplomas) • Property deed or title
Central Processing Unit P.O. Box 290794 Charlestown, MA 02129	1-617-887-8799	• MassHealth Long-Term Care applications • Supplement A + Buy In applications
Board of Hearings 100 Hancock Street Quincy, MA 02171	1-617-847-1200	• Fair Hearing Request Form • Any documents pertaining to a hearing

TIPS

- ✓ Do not fax documents without the two-page Health Coverage Mail/Fax Cover Sheet.
- ✓ You MUST use the original of the Cover Sheet in order for the bar code to work. DO NOT PHOTOCOPY!
- ✓ Use one Cover Sheet per household.
- ✓ Mail or fax verifications to the address or fax provided in the notice requesting verifications. If you are not sure where to send documents, contact the Customer Service Center at 1-800-841-2900.
- ✓ Make sure to fax a Permission to Share Information (PSI) or Authorized Representative Designation (ARD) form along with applications, verifications or other documents.





Health Coverage Mail/Fax Cover Sheet

Last four digits of Head of Household's Social Security Number: ___ ___ ___ ___ OR

Head of Household initials: __ __ and DOB (MM/DD/YYYY): ____/____/_____

Important Message

Do NOT photocopy the cover sheet containing the barcode. For barcodes to work, the sheet with the barcode must be an original, not a copy. Use a separate two-page cover sheet for each household. Do NOT use the same two-page cover sheet to send items for more than one household.

Always mail or fax verifications to the address or fax on the letter requesting the verifications. If you are not sure where to fax or mail documents, contact the MassHealth Customer Service Center at 1-800-841-2900.

Fax or Mail Information for Health Connector or MassHealth

Type of Document	Where to Send
☐ » New paper applications for **subsidized** (assistance with paying) health coverage, including Health Connector (ConnectorCare plans and those seeking premium tax credits), MassHealth, or HSN coverage » Eligibility verification documents for MassHealth and the Health Connector	**Subsidized** applications and verifications for eligibility should be sent to: **Health Insurance Processing Center** P.O. Box 4405 Taunton, MA 02780 **NEW Fax: 857-323-8300**
☐ » New paper applications for **unsubsidized** (no assistance with paying) health insurance through the Health Connector » Closed Enrollment verification for Health Connector plan	**Unsubsidized** applications and verifications for IDP and Closed Enrollment should be sent to: Massachusetts Health Connector 133 Portland Street, 1st Floor Boston, MA 02114-1707 Fax: 617-887-8745
☐ » MassHealth long-term-care applications and Supplement A + Buy-In applications	These applications should be sent to: Central Processing Unit P.O. Box 290794 Charlestown, MA 02129 Fax: 617-887-8799

Please allow time for the Health Connector or MassHealth to receive your documents and process them. If your benefits have ended and you need medical services, call the MEC at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled).

Health Coverage Mail/Fax Cover Sheet
Applicant/Member Information

Please print clearly. Use this cover sheet **plus the first page containing the barcode** when mailing or faxing documents to the Health Connector or MassHealth.

Head of Household Information

Name: _____

Soc. Sec. No: _____

Date of birth: _____

MassHealth ID No. (if applicable):

_____

Reference ID No. (if applicable):

_____

Applicant/Member:

_____

Sender

Name: _____

Phone No: _____

Name of Facility (if applicable):

_____

Number of pages (including **both** cover sheets): _____

SECTION 7 Signature/Legal guardian

Fill out the following section if this form is being filled out by someone who has the legal authority to act on behalf of the applicant or member (such as the parent of a minor child, an eligibility representative, or a legal guardian).

Printed name of person filling out this form

Signature of person filling out this form

Date

Address

Telephone number

Authority of person filling out this form to act on behalf of the applicant or member:*

** If this form is being filled out by someone who has been appointed by a court as a legal guardian or conservator, or who has power of attorney or health-care proxy, a copy of the applicable legal document must be attached.*

Where to send this form

Please follow the instructions below.

- If you are **applying for health benefits** and wish to submit a PSI, send it to

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

- If you are **already getting health benefits** and wish to submit a PSI, send it to

  MassHealth Enrollment Center
  P.O. Box 1231
  Taunton, MA 02780

- If you are **authorizing only specific information to be shared (such as your claims information or application file)**, and have checked off the second, third, or fourth box in Section 2, send the PSI to

  Privacy Office
  600 Washington Street
  Boston, MA 02111

PSI (Rev. 02/13)

MASSHEALTH

Permission to Share Information (PSI) Form

- **Use this form** if you want MassHealth to share the information we have about you with another person or organization, such as
  - a family member, friend, or other relative;
  - someone who helps take care of you;
  - someone who helps you fill out MassHealth forms; or
  - a social worker, lawyer, or health-care advocacy group.

- **Do not** use this form if you want
  - information about yourself;
  - information about your children under age 18 (You can usually get this without filling out any forms.); or
  - your eligibility and payment information to be shared with your health-care provider. (Your health-care provider can get information about your MassHealth eligibility and payment for services provided to you without you filling out any forms.)

- **Important:** If you decide that you do need to fill out this form, you must fill out all sections completely. Please print clearly.

Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

SECTION 1 Name of MassHealth applicant or member

Permission is given for MassHealth and its representatives to share information listed in **Section 2** about

_____

(name of applicant or member whose information is to be shared)

_____

Street

_____

City/State/Zip

_____

Date of birth **Telephone number**

_____

MassHealth ID number

Please Note: If you do not have a MassHealth ID number, please use your social security number, if one has been issued, unless you are applying for or getting only MassHealth Limited, Children's Medical Security Plan (CMSP), or Healthy Start benefits.

SECTION 2 What information do you want shared?

Check the box or boxes that apply.

☐ I am giving MassHealth permission to share eligibility notices and information about eligibility for, and access to, MassHealth benefits, with the person or organization listed in **Section 3**. Please note such notices may contain financial information. Check this box only if you want the person or organization in **Section 3** to be able to contact MassHealth to get eligibility information and copies of your eligibility notices.

Please Note: Eligibility notices include information about all members of a household. If you check this box, a separate PSI form must be submitted and signed by each member of your household who is 18 years or older. If we do not get forms signed by each member of your household who is 18 years or older, we will not be able to honor your request.

☐ a summary of my MassHealth claims from _____ (month/year) to _____ (month/year)

☐ MassHealth's file containing my applications and related information

☐ other (please be specific):

_____

_____

_____

By giving MassHealth this permission to share information, are you also giving MassHealth permission to share drug and alcohol treatment information?

☐ Yes. Share drug and alcohol treatment information.

☐ No. Do not share drug and alcohol treatment information.

SECTION 3 Whom do you want us to share information with?

List the name of ONLY ONE person or organization in this section. You must fill out another PSI form if you want to name more than one person or organization.

MassHealth may share the information listed in **Section 2** with

_____

Name of person or organization

_____

In care of (name of person in organization to whom mail should be sent)

_____

Street

_____

City/State/Zip

_____

Telephone number

SECTION 4 Why do you want us to share your information?

Tell us why you want to share the information listed in **Section 2**. If you leave this section blank, we will assume you mean "at my request."

_____

SECTION 5 End of permission

This PSI will end in 18 months unless you specify an end date here. _____

SECTION 6 Your signature

I understand the following.

- When the person or organization named in **Section 3** gets this information from MassHealth, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.
- I need to send this PSI to the appropriate address on the back page of this brochure.
- I may cancel this permission at any time by sending a letter to Privacy Office, 600 Washington Street, Boston, MA 02111.
- If I cancel this permission, MassHealth cannot take back any information that it shared when it had my permission to do so.
- If I do not give MassHealth permission to share information, or if I cancel my permission to share information with the person or organization named in **Section 3**, my MassHealth benefits will not be affected in any way.
- In certain circumstances, MassHealth may not honor my request to share information.

_____

Name of applicant or member

_____

Signature of applicant or member **Date**

(*See other side.*)

Authorized Representative Designation Form

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

NOTE: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form) or a sufficiently similar designation document. You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial parent.
You are not required to have a representative in order to apply for or receive benefits.

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B.
2. If, because of a mental or physical condition, you cannot designate an authorized representative in writing, a person (not an organization) who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.
3. An authorized representative can also be someone who has been appointed by law to act on your behalf. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person is lawfully representing you.
4. A person appointed by law to act on behalf of the estate of an applicant or member who has died can also serve as an authorized representative by following the instructions above. An authorized representative under Section III may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant or member's estate will depend on the wording of the legal appointment.

What can an authorized representative do?

An authorized representative may

- fill out your application or eligibility review forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by doing the following.

- Mailing a letter notifying us that the designation has ended to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing a letter notifying us that the designation has ended to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a Section II authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative by doing the following.

- Mailing your form to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Please note: Your social security number (SSN) is required if one has been issued.

Applicant's/Member's Name	SSN (if you have one) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of birth (mm/dd/yyyy)	Applicant's/Member's e-mail address

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature	Date
Authorized representative's name	Authorized representative's phone number

Authorized representative's address (mailing address, city, state, zip)

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date
Authorized representative's printed name	Authorized representative's e-mail address

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date

Printed name of provider, staff member, or volunteer completing form

E-mail of provider, staff member, or volunteer completing form	Authorized representative organization name

SECTION 2 Authorized Representative Designation
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

I certify that I know enough about the applicant or member set forth below to take responsibility for the correctness of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my duties and responsibilities as this person's authorized representative (as explained earlier in this form), and that this person cannot provide written designation. If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's e-mail address

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (as explained earlier on this form). Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's e-mail address

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: If you disagree with the action by MassHealth, you have the right to appeal and ask for a fair hearing before an impartial hearing officer. The Board of Hearings must get your fair hearing request form no later than **30 calendar days** from the date you got MassHealth's official written notice telling you of the action to be taken.

If you want to ask for a fair hearing because MassHealth did not take action on your application or on your request for service, MassHealth did not send you a written notice of the action to be taken, or a MassHealth employee's behavior toward you was coercive or improper, the Board of Hearings must get your fair hearing request form no later than 120 calendar days from the date of your application or your request for service, MassHealth's action, or the MassHealth employee's improper behavior.

How to Appeal: To ask for a fair hearing, fill out the fair hearing request form (be sure to fill out **Section II-Reason for Appeal**) and send one copy with a copy of the MassHealth official written notice to: **Board of Hearings**, **Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171** or fax them to **617-847-1204**. Please keep one copy of the fair hearing request form for your information.

If You Are Now Getting MassHealth: If the Board of Hearings gets your fair hearing request form before the date the action is taken or, if later, within 10 calendar days of the mailing date of MassHealth's written notice to you, you will keep getting MassHealth until a decision is made on your appeal. If you get MassHealth during your appeal, and then lose your appeal, you may have to pay MassHealth back for the cost of MassHealth benefits that you got during this time period. If you do not want to keep getting MassHealth during your appeal, please check **Box A in Section III** on the fair hearing request form. If you do not get MassHealth during your appeal, and then you win your appeal, MassHealth will restore your MassHealth benefits.

Date of Fair Hearing: At least 10 calendar days before the fair hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. This will give you time to get ready for the hearing. If you want to have a fair hearing scheduled as soon as possible, check Box **B in Section III** on the fair hearing request form for an expedited hearing. If you have good cause for not being able to come to the hearing, or if you need a telephone hearing, you must call the Board of Hearings at **617-847-1200** or **1-800-655-0338** before the hearing date. If you do not reschedule or appear on time at the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may represent yourself or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost. To get information about legal service or community agencies, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people with partial or total hearing loss).

If You Need an Interpreter or an Assistive Device: If you do not understand English and/or are hearing or sight impaired, the Board of Hearings will provide an interpreter and/or assistive device for you at the hearing. Please check either **Box C or D, or both, in Section III** on the fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at **617-847-1200** or **1-800-655-0338 at least five business days** before the hearing.

Your Right to Review Your Case File: You and/or your representative can review your MassHealth case file before the hearing. To do this, call a MassHealth Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people with partial or total hearing loss) before the fair hearing. **Your MassHealth case file is not kept at the Board of Hearings**.

Your Right to Ask to Subpoena Witnesses, and Your Right to Question: You or your representative may write to the Board of Hearings to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the fair hearing.

NONDISCRIMINATION NOTICE FOR APPLICANTS AND MEMBERS: Under federal and state law, MassHealth does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age, health status, or handicap.

FAIR HEARING REQUEST FORM

FILL OUT ALL SECTIONS THAT APPLY.
PRINT CLEARLY.

SECTION I: Applicant/Member Information

Name of Applicant or Member: _____

_____

Address: _____

_____

Telephone No.: ( ) _____

MassHealth I.D. or Social Security Number: _____

_____

Cardholder's Name on MassHealth card (if different): _____

_____

SECTION II: Reason for Appeal

I, _____,

want a fair hearing because: _____

_____

_____

_____

_____

Signature: _____

Date: _____

SECTION III: Appeal Information (Check the boxes that apply to you.)

☐ A. I do not want to keep getting MassHealth during the appeal process.

☐ B. I want an expedited hearing.

☐ C. I need an interpreter (what language?: _____) to be provided by the Board of Hearings.

☐ D. I need an assistive device to be provided by the Board of Hearings. (Describe what type of assistive device you need. For example: American Sign Language): _____

_____

SECTION IV: Appeal Representative, if any

My appeal representative is: _____

_____

Title: _____

Address: _____

_____

Telephone No.: ( ) _____

Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

Tel: (800) 841-2900
TTY: (800) 497-4648
Fax: (857) 323-8300

HIPC
P.O. BOX 4405
TAUNTON MA 02780-0968

Reference: [Reference number]

510/T
[Head of Household]
[Mailing Address]
[City, MA, Zip code]

Date: [Date] Notice: [Notice number] SSN: XXX-XX-8765

Dear [Head of Household],

Thank you for submitting your renewal **Massachusetts Application for Health and Dental Coverage and Help Paying Costs**. We have received your application and will process it as soon as possible. Due to the high volume of applications we are receiving, it may take some time until we are able to process your application.

You will keep your current health benefits until we process your application. Once we process your application, we will send a new letter to let you know if you still qualify for MassHealth or other health coverage.

You do not need to take any further action at this time.

Thank you,

MassHealth

Health Insurance Processing Center
P.O. Box 4405
Taunton, MA 02780

[MAIL-TO-NAME]
[blank]
[blank]
[MAILING-STREET-ADDR]
[MAILING-CITY-NAME], [STATE] [ZIP-CODE]

Commonwealth of Massachusetts
Executive Office of Health
and Human Services

You can get this information in large print and Braille. Call **1-800-841-2900** from Monday through Friday, 8:00 a.m. to 5:00 p.m. (**TTY: 1-800-497-4648** for people who are deaf, hard of hearing, or speech disabled).

Date: [DATE]

Dear [MEMBER-FIRST-NAME] [MEMBER-LAST-NAME],

MassHealth has approved the person listed below for MassHealth CarePlus.

- **[Name]** Member ID: **[Member ID]** starting on **January 1, 2014.**

MassHealth CarePlus pays for services such as doctor and clinic visits, hospital stays, prescription medicines, dental services, and transportation to medical appointments, even if it is not an emergency. For a more complete list of services MassHealth CarePlus pays for, please see the *MassHealth Member Booklet*. There is no monthly premium (fee).

Individuals age 21 and over may have a copay for prescriptions and doctor or hospital visits. For more information about copays, see proposed MassHealth regulations at 130 CMR 506.000 in effect as of January 1, 2014, at
http://www.mass.gov/eohhs/docs/masshealth/proposed-regs/130-cmr-506-000.pdf.

What do you need to do next?

- Step 1: Pick a Health Plan
  If you are already enrolled in a health plan through MassHealth, we will keep you with your current plan if it is available. If you are not already enrolled in a health plan through MassHealth and do not have access to other insurance, you must enroll in one of the health plan options in your area. To choose a health plan, call **MassHealth Customer Service at 1-800-841-2900** (**TTY: 1-800-497-4648** for people who are deaf, hard of hearing, or speech disabled). If you do not choose a health plan, MassHealth will choose one for you.
- Step 2: Insurance Cards
  New members will get their MassHealth cards in the mail. If you are already a member of MassHealth and have a MassHealth card, you can continue to use it and don't need a new one. The health plan may also send ID cards for the plan selected. Show these cards to your provider when getting medical services.

How did we make this decision?
MassHealth uses the rules for family size and income to make a decision about your coverage. We also consider pregnancy, disability, immigration status, and breast or cervical cancer or HIV status. We based this decision on information you previously reported to us.

You can get MassHealth CarePlus according to proposed MassHealth regulations at 130 CMR 505.008, in effect as of January 1, 2014. You can find these proposed regulations at **http://www.mass.gov/eohhs/gov/laws-regs/masshealth/masshealth-proposed-regs.**

If you are pregnant or disabled, you may be able to get more benefits, such as personal care attendant services. To find out if you qualify, call **MassHealth Customer Service at 1-800-841-2900** (**TTY: 1-800-497-4648** for people who are deaf, hard of hearing, or speech disabled).

What if you have special health care needs?
You may be able to get more health benefits if you have special health care needs. If you are currently paying for benefits, such as personal care attendants, without assistance from MassHealth, you may also qualify for help paying for these services.

Special health care needs include if you:

- have a medical, mental health, or substance use condition that limits your ability to work or go to school;
- need help with daily activities, like bathing or dressing;
- regularly get medical care, personal care, or health services at home or in another community setting, like adult day care; or
- are terminally ill.

If you have special health care needs, please call MassHealth at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled). You can tell us at any time if you have special health care needs, including if your health changes in the future.

If you tell us about your special health care needs, you may choose to enroll in MassHealth Standard. MassHealth Standard covers all the same benefits that you have now, as well as additional health benefits like personal care attendants, long-term nursing home care, and adult day health programs. Your health plan options in MassHealth Standard may be different than those offered in MassHealth CarePlus. There are no monthly premiums for either MassHealth CarePlus or MassHealth Standard. And with MassHealth Standard, your copays will be the same as what you pay in MassHealth CarePlus.

If you move to MassHealth Standard, there may be some additional steps needed to get some of the added benefits that MassHealth Standard provides. For example, MassHealth may need additional information or may need to check to make sure the benefits are necessary and appropriate for you. Your doctor and MassHealth Customer Service can help explain these additional steps to you. Please call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled) if you have any questions about these additional steps.

Even if you have special health care needs, you can choose to stay enrolled in MassHealth CarePlus instead of moving to MassHealth Standard. If you want to stay in MassHealth CarePlus, you do not have to do anything else.

What else do you need to know?

- The enclosed *MassHealth Member Booklet* explains income rules, premiums, and covered services for MassHealth.

How can you send us information?

You must report any change in your information to MassHealth as soon as possible, but **no later than 10 days**, from the date of the change. This includes any changes to your income, address, phone number, family size, job, or health insurance.

You can submit information in the following ways.

1. **Fax**: **(617) 887-8770**
2. **Mail**: **Commonwealth of Massachusetts**
   Health Insurance Processing Center
   P.O. Box 4405
   Taunton, MA 02780
3. **Call: MassHealth Customer Service at 1-800-841-2900** (**TTY: 1-800-497-4648** for people who are deaf, hard of hearing, or speech disabled)**.**

What if you do not agree with our decision?

You can ask for a hearing if you do not agree with our decision.

Read *How to Ask for a Hearing*, which came with this letter.

What other assistance may be available to you?

For free food and help with healthy eating, call the Women, Infants and Children (WIC) nutrition program. WIC serves pregnant women, children under five, and new mothers. One or more members of your family may be eligible for WIC services. Call the WIC Hotline at 1-800-942-1007.

What if you have questions?

If you have questions or need more information call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Thank you,
MassHealth

EDMC
P.O. BOX 1231
TAUNTON MA 02780-0968

[redacted]

Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

[redacted]

Tel: (800) 332-5545
TTY: (888) 665-9997
Fax: (617) 887-8777

Medicaid ID : [redacted]

[redacted]

Date: 04/02/2014 Notice: [redacted] SSN: [redacted]

Dear [redacted]

Important! This health-care benefits notice tells you the decisions we have made about certain programs that you may be eligible for. Please read the whole notice to find out about your health-care benefits.

MassHealth

MassHealth has decided that the following members of your family are not eligible for MassHealth for the following reasons.

Name	SSN/DOB	Medicaid ID
[redacted]	[redacted]	[redacted]

Reason and Manual Citation
You do not have health insurance; your family's income is too high to get MassHealth Standard or you do not meet MassHealth Standard rules for the cervical or breast cancer treatment program; and you do not meet MassHealth disability rules. 130 CMR 505.005 505.002 501.001

If you get health insurance from your employer, you may be eligible for MassHealth Family Assistance in the future.

continued...

[redacted]

Under MassHealth Family Assistance, we will pay part of your employer-sponsored health insurance premium if you work for a qualified employer that:
(1) offers comprehensive health insurance through a MassHealth approved billing and enrollment intermediary; and
(2) contributes at least 50% toward the cost of the premium.

The MassHealth booklet describes the rules for MassHealth. It explains why members of your family are not eligible. It describes the income standards and other rules for MassHealth.

Call the phone number at the top of this notice if you have any questions about this notice. If you don't have a copy of the MassHealth booklet, please call to request one. It has important information about MassHealth coverage and rules.

For information about appealing our decisions, see the Request for a Fair Hearing page of this notice.

Health Safety Net (formerly Uncompensated Care Pool (UCP))

The Commonwealth of Massachusetts has decided that the Health Safety Net may be able to pay for services that the individual(s) listed below get at a Massachusetts hospital or community health center. If you have other health insurance, that health insurance must be used first before the Health Safety Net will pay for any services you receive at a hospital or community health center. You may be charged copays and deductibles.

Name SSN Medicaid ID	Coverage Type	Family Deductible	Benefit Effective Date
[redacted]	Health Safety Net	n/a	02/01/2014

Please get in touch with your hospital or community health center to find out what services you can get without having to pay bills.

You must tell MassHealth about certain changes that could affect your coverage. These include any changes in income, family size, employment, student status, disability status, health insurance, address, and immigration status. This will let us determine the most complete coverage you can get. Address changes are needed so you will get notices about your benefits. Once a change occurs, please report the change to MassHealth within 10 days or as soon as possible.

If you have questions about this Health Safety Net decision, please call the number at the top of this notice. If you do not agree with this Health Safety Net decision, you may contact the Massachusetts Division of Health Care Finance and Policy, Grievances, Two Boylston Street, Boston, MA 02116, or you can call them at 1-877-910-2100.

[redacted]

Health Connector

Name	SSN/DOB	Medicaid ID
[redacted]	[redacted]	[redacted]

Even though you cannot get MassHealth, you may still qualify for a health insurance plan through the Health Connector. If you want to see if you qualify through the Health Connector, you need to re-apply. Apply online at MAhealthconnector.org. Call Health Connector Customer Service if you have questions at 1-877-MA ENROLL (1-877-623-6765), TTY 1-877-623-7773 if you are deaf, hard of hearing or speech disabled.

Your Right to Appeal: If you disagree with the action by MassHealth, you have the right to appeal and ask for a fair hearing before an impartial hearing officer. The Board of Hearings must get your fair hearing request form no later than **30 calendar days** from the date you got MassHealth's official written notice telling you of the action to be taken.

If you want to ask for a fair hearing because MassHealth did not take action on your application or on your request for service, MassHealth did not send you a written notice of the action to be taken, or a MassHealth employee's behavior toward you was coercive or improper, the Board of Hearings must get your fair hearing request form no later than 120 calendar days from the date of your application or your request for service, MassHealth's action, or the MassHealth employee's improper behavior.

How to Appeal: To ask for a fair hearing, fill out the fair hearing request form (be sure to fill out **Section II-Reason for Appeal**) and send one copy with a copy of the MassHealth official written notice to: **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171** or fax them to **617-847-1204**. Please keep one copy of the fair hearing request form for your information.

If You Are Now Getting MassHealth: If the Board of Hearings gets your fair hearing request form before the date the action is taken or, if later, within 10 calendar days of the mailing date of MassHealth's written notice to you, you will keep getting MassHealth until a decision is made on your appeal. If you get MassHealth during your appeal, and then lose your appeal, you may have to pay MassHealth back for the cost of MassHealth benefits that you got during this time period. If you do not want to keep getting MassHealth during your appeal, please check **Box A in Section III** on the fair hearing request form. If you do not get MassHealth during your appeal, and then you win your appeal, MassHealth will restore your MassHealth benefits.

Date of Fair Hearing: At least 10 calendar days before the fair hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. This will give you time to get ready for the hearing. If you want to have a fair hearing scheduled as soon as possible, check **Box B in Section III** on the fair hearing request form for an expedited hearing. If you have good cause for not being able to come to the hearing, or if you need a telephone hearing, you must call the Board of Hearings at **617-847-1200** or **1-800-655-0338** before the hearing date. If you do not reschedule or appear on time at the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may represent yourself or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost. To get information about legal service or community agencies, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If You Need an Interpreter or an Assistive Device: If you do not understand English and/or are hearing or sight impaired, the Board of Hearings will provide an interpreter and/or assistive device for you at the hearing. Please check either **Box C or D, or both, in Section III** on the fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at **617-847-1200** or **1-800-655-0338 at least five business days** before the hearing.

Your Right to Review Your Case File: You and/or your representative can review your MassHealth case file before the hearing. To do this, call a MassHealth

Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled) before the fair hearing. **Your MassHealth case file is not kept at the Board of Hearings.**

Your Right to Ask to Subpoena Witnesses, and Your Right to Question: You or your representative may write to the Board of Hearings to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the fair hearing.

NONDISCRIMINATION NOTICE FOR APPLICANTS AND MEMBERS: Under federal and state law, MassHealth does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age, health status, or handicap.

Name: [redacted] SSN: [redacted] Medicaid ID: [redacted]
Notice: [redacted] Notice Date: 04/02/2014

*** Keep this copy. ***

FAIR HEARING REQUEST FORM

Fill out all sections that apply. Print clearly.

SECTION I: Applicant/Member Information

Name of Applicant or Member: _____
Address: _____
Telephone No.: ( ) _____
MassHealth I.D. or Social Security Number: _____
Cardholder's Name on MassHealth card (if different): _____

SECTION II: Reason for Appeal

I, _____ want a fair hearing because:
_____
_____
_____
Signature: _____ Date: __/__/__

SECTION III: Appeal Information

(Check the boxes that apply to you.)

( ) A. I do not want to keep getting MassHealth during the appeal process.
( ) B. I want an expedited hearing.
( ) C. I need an interpreter
(what language?: _____)to be provided by the Board of Hearings.
( ) D. I need an assistive device to be provided by the Board of Hearings.
(Describe what type of assistive device you need. For example: American Sign Language): _____

SECTION IV: Appeal Representative, if any

My appeal representative is: _____
Title: _____
Address: _____
Telephone No.: ( ) _____

FHR-1 (Rev. 09/10)

Commonwealth of Massachusetts
Executive Office of Health
and Human Services
Office of Medicaid
www.mass.gov/masshealth

Health Insurance Processing
P.O. Box 4405
Taunton MA 02780-0000

Tel: (800) 841-2900
TTY: 1-800-497-4648
Fax: (617) 887-8770

Medicaid ID : [redacted]

520/MH-UPGR-STD *002440*
WEAYONNOH NELSON DAVIES
c/o CENTRAL WEST JUSTICE CENTER
405 MAIN STREET
WORCESTER MA 01608

Attn: **WEAYONNOH NELSON DAVIES** Re: **Notice sent to** [redacted]

Date: 05/02/2014 Notice: [redacted] SSN: [redacted]

Dear [redacted]

You can get this information in large print and Braille. Call **1-800-841-2900** from Monday through Friday, 8:00 a.m. to 5:00 p.m. (**TTY:** 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Important! The person(s) listed below now qualify for more benefits because of a change in their situation. MassHealth has approved them for MassHealth Standard benefits.

* [redacted], Member ID: [redacted], Date of Birth: [redacted] starting on **02/02/2014**

Members of your family who are not listed above may get another letter about their eligibility.

What does MassHealth Standard pay for?
MassHealth Standard pays for doctor and clinic visits, hospital stays, prescription medicines, some dental services, personal care attendant services, and transportation to medical appointments, even if it is not an emergency. Adults may have a copay for prescriptions and hospital visits. Qualifying American Indians do not have copays or premiums. There is no monthly premium (fee).

continued...

What do you need to do next?

* **Step 1:** If you are required to enroll in a managed care plan, you must choose a health plan through MassHealth. To choose a health plan, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled). If you are already enrolled in a health plan through MassHealth, you can stay with your current plan and you do not need to pick one.

* **Step 2:** New MassHealth members will get their MassHealth cards in the mail. The health plan may also send ID cards for the plan selected. Show these cards to the doctor or pharmacy when getting medical services.

What else do you need to know?

The Member Booklet tells you what services are covered under your coverage type. It explains income rules, premiums, copays and covered services. To get a copy, go to MAhealthconnector.org or call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

How did we make this decision?

MassHealth uses the rules for family size and income to make a decision. We also consider pregnancy, disability, immigration status, and breast or cervical cancer or HIV.

Family size is based on how you and your dependents are claimed on your tax return and who you are related to and live with. If you do not file taxes, family size is based on who you are related to and live with.

To decide your income, we mostly count income taxable by the IRS.

You can get MassHealth Standard according to the MassHealth regulations at 130 CMR 505.002. You can find these regulations at www.mass.gov/eohhs/gov/laws-regs/masshealth/regulations/member-eligibility-regs.html.

If you think you may qualify for more benefits based on pregnancy, disability, a decrease in income or a change in immigration status, call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

We checked to see if you could get tax credits that would help pay for health insurance from the Health Connector. We decided that you do not qualify for the tax credits because you qualify for MassHealth, which has more benefits. This is according to the federal regulations at 45 C.F.R. 155.310(b) and 45 C.F.R. 155.305(f).

How can you send us information?

You must report any change in your information to MassHealth as soon as possible, but **no later than 10 days,** from the date of the change. This includes any changes to your income, address, phone number, family size, job, or health insurance.

continued...

You can also send information in one of the following ways.

1. **Fax:** (617) 887-8770
2. **Mail:** Commonwealth of Massachusetts,
   Health Insurance Processing Center
   P.O. Box 4405
   Taunton, MA 02780-0000
3. **Call:** 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

What if you do not agree with our decision?
You can ask for a hearing if you do not agree with our decision.

* Read **How to Ask for a Hearing** that came with this letter.

What if you have questions?
If you have questions or need more information, go to MAhealthconnector.org or call MassHealth Customer Service at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

Thank you,

MassHealth

HOW TO ASK FOR A FAIR HEARING

Your Right to Appeal: If you disagree with the action by MassHealth, you have the right to appeal and ask for a fair hearing before an impartial hearing officer. The Board of Hearings must get your fair hearing request form no later than **30 calendar days** from the date you got MassHealth's official written notice telling you of the action to be taken.

If you want to ask for a fair hearing because MassHealth did not take action on your application or on your request for service, MassHealth did not send you a written notice of the action to be taken, or a MassHealth employee's behavior toward you was coercive or improper, the Board of Hearings must get your fair hearing request form no later than 120 calendar days from the date of your application or your request for service, MassHealth's action, or the MassHealth employee's improper behavior.

How to Appeal: To ask for a fair hearing, fill out the fair hearing request form (be sure to fill out **Section II-Reason for Appeal**) and send one copy with a copy of the MassHealth official written notice to: **Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171** or fax them to **617-847-1204**. Please keep one copy of the fair hearing request form for your information.

If You Are Now Getting MassHealth: If the Board of Hearings gets your fair hearing request form before the date the action is taken or, if later, within 10 calendar days of the mailing date of MassHealth's written notice to you, you will keep getting MassHealth until a decision is made on your appeal. If you get MassHealth during your appeal, and then lose your appeal, you may have to pay MassHealth back for the cost of MassHealth benefits that you got during this time period. If you do not want to keep getting MassHealth during your appeal, please check **Box A in Section III** on the fair hearing request form. If you do not get MassHealth during your appeal, and then you win your appeal, MassHealth will restore your MassHealth benefits.

Date of Fair Hearing: At least 10 calendar days before the fair hearing, the Board of Hearings will send you a notice telling you the date, time, and place of the hearing. This will give you time to get ready for the hearing. If you want to have a fair hearing scheduled as soon as possible, check **Box B in Section III** on the fair hearing request form for an expedited hearing. If you have good cause for not being able to come to the hearing, or if you need a telephone hearing, you must call the Board of Hearings at **617-847-1200** or **1-800-655-0338** before the hearing date. If you do not reschedule or appear on time at the hearing without documented good cause, your appeal will be dismissed.

Your Right to Be Helped at the Hearing: At the hearing, you may represent yourself or be represented by a lawyer or other representative at your own expense. You may contact a local legal service or community agency to get advice or representation at no cost. To get information about legal service or community agencies, call the MassHealth Customer Service Center at 1-800-841-2900 (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).

If You Need an Interpreter or an Assistive Device: If you do not understand English and/or are hearing or sight impaired, the Board of Hearings will provide an interpreter and/or assistive device for you at the hearing. Please check either **Box C or D, or both, in Section III** on the fair hearing request form if you need an interpreter or assistive device, or call the Board of Hearings at **617-847-1200** or **1-800-655-0338 at least five business days** before the hearing.

Your Right to Review Your Case File: You and/or your representative can review your MassHealth case file before the hearing. To do this, call a MassHealth

Enrollment Center at 1-888-665-9993 (TTY: 1-888-665-9997 for people who are deaf, hard of hearing, or speech disabled) before the fair hearing. **Your MassHealth case file is not kept at the Board of Hearings.**

Your Right to Ask to Subpoena Witnesses, and Your Right to Question: You or your representative may write to the Board of Hearings to ask that witnesses or documents be subpoenaed to the hearing. You or your representative may present evidence and cross-examine witnesses at the hearing. The hearing officer will make a decision based on all evidence presented at the fair hearing.

NONDISCRIMINATION NOTICE FOR APPLICANTS AND MEMBERS: Under federal and state law, MassHealth does not discriminate on the basis of race, color, sex, sexual orientation, national origin, religion, creed, age, health status, or handicap.

Name: **SHELLY HORNING** SSN: **XXX-XX-3236** Medicaid ID: **100028185518**
Notice: **51828432** Notice Date: **05/02/2014**

*** Keep this copy. ***

FAIR HEARING REQUEST FORM

Fill out all sections that apply. Print clearly.

SECTION I: Applicant/Member Information

Name of Applicant or Member: _____
Address: _____
Telephone No.: ( ) _____
MassHealth I.D. or Social Security Number: _____
Cardholder's Name on MassHealth card (if different): _____

SECTION II: Reason for Appeal

I, _____ want a fair hearing because:
_____
_____
_____

Signature: _____ Date: ___/___/___

SECTION III: Appeal Information

(Check the boxes that apply to you.)

( ) A. I do not want to keep getting MassHealth during the appeal process.
( ) B. I want an expedited hearing.
( ) C. I need an interpreter
(what language?: _____)to be provided by the Board of Hearings.
( ) D. I need an assistive device to be provided by the Board of Hearings.
(Describe what type of assistive device you need. For example: American Sign Language): _____

SECTION IV: Appeal Representative, if any

My appeal representative is: _____
Title: _____
Address: _____
Telephone No.: ( ) _____

FHR-1 (Rev. 09/10)

CENTRAL WEST JUSTICE CENTER

An affiliate of Community Legal Aid

Weayonnoh Nelson-Davies
Staff Attorney
wnelsondavies@cwjustice.org

405 MAIN STREET
WORCESTER, MA 01608
(508) 425-2886 • (844) 295-8784
(508) 755-4240 FAX
(508) 755-3260 TTY

OFFICES:
PITTSFIELD
SPRINGFIELD
WORCESTER

April 14, 2014

MassHealth Enrollment Center (MEC)
P.O. Box 1231
Taunton, MA 02780

Re: [redacted], MassHealth ID No. [redacted]; PRUCOL-Family Assistance

To Whom it May Concern:

Please be advised that this office represents Ms. [redacted] in regards to her Medicaid matter. On September 30, 2011, the U.S. Department of Homeland Security (DHS) used its "prosecutorial discretion" and filed a motion with the U.S. Department of Justice, Executive Office for Immigration Review, to administratively close [redacted]'s case. This means that DHS asked the court to close Ms. [redacted]'s case because DHS has decided in its prosecutorial discretion NOT to remove Ms. [redacted] from the United States at this time. I have enclosed the motion filed by DHS and the Immigration Judge's order granting the motion to administratively close this case.

For MassHealth purposes, under 130 CMR 518.003 (C) (11), Ms. [redacted], is a Nonqualified Person Residing under Color of Law (Nonqualified PRUCOL) because she is living in the United States with the knowledge and consent of DHS, and whose departure DHS does not contemplate enforcing. Furthermore, as a Nonqualified PRUCOL 65 years of age and older, she is eligible for Family Assistance, 130 CMR 518.006 (C). I have also enclosed the relevant parts of the regulation.

Based on the above information, **I request that MassHealth adjust Ms. [redacted]'s information to reflect that she is a Nonqualified PRUCOL and apply the appropriate coverage type of Family Assistance**. As you may be aware, Ms. [redacted] has End Stage Renal Disease (ESRD) in which she requires regular course of dialysis and is also in need of a kidney transplant. **So, please expedite this change so that Ms. [redacted] can continue to receive the appropriate medical care**.

If you have any questions or concerns, please contact me directly at 508-425-2878. I appreciate your attention to this matter.

Sincerely,

Weayonnoh Nelson-Davies
Staff Attorney

CC: [redacted]

MassH Igh
3.
77w Commonwerilth nj MassachttlettS
Execleive Office of Health and Haman Services
• (ere of Medicaid
wwW.M4I5'S,RDIOndflhealifl

Member's Name: _____

Member's MassHealth _____

Date of Notice: 02/03/2015

MassHealth Payment Of Nursing-Facility Services

This notice is sent in response to your request for MassHealth payment olnursing-facility services. In order to qualify for MassHealth payment of nursing-facility services, you must be both clinically and financially eligible for services. *This notice is about your clinical eligibility.* You will receive a separate notice about your financial eligibility.

1. MassHealth Assessments

Assessments to determine clinical eligibility for nursing-facility services are conducted by Aging Services Access Point (ASAP). An ASAP nurse reviewed your case in accordance with MassHealth regulations at 130 CMR 456.408, and has determined the following. To view MassHealth regulations, go to www.mass.govimasshealth.

0 You are clinically eligible for MassHealth payment of nursing-facility services on a short-term basis through _____ , because nursing-facility services are medically necessary as required by MassHealth regulations at 130 CMR. 456.409. Your continued clinical eligibility is subject to review. See 130 CMR 456.408.

0 You are clinically eligible for MassHealth payment of nursing-facility services, because nursing facility services are medically necessary as required by MassHealth regulations at 130 CMR 456.409. During your stay, periodic medical reviews may be conducted to determine if nursing-facility services are medically necessary as required by MassHealth regulations. See 330 CMR 456.408.

You are not eligible for MassHealth payment of nursing-facility services for the following reason.

Nursing-theility services are not medically necessary, as required by MassHealth regulations at 130 CMR 456.409.

Ei Your medical needs can be met in the community and services are available. See 130 CMR. 456.408 (A)(2).

Member's Name: _____

2. Appeal Rights

You have the right to appeal this decision. (Please see attached information about your right to appeal through the fair-hearing process.)

OFFICIAL. USE ONLY

Date(s) ., 02/08/2015

ASAP on ',cliff of Mass ealth

Print name. ,RN

a, Worcester, MA

ASAP address

The Commotnvealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/moschcalth

Member's Name: [redacted]

Member's MassHealth No.: [redacted]

Date of Notice: [redacted]

MassHealth Payment ofNursing-Facility Services

This notice is sent in response to your request for MassHealth payment of nursing-facility services, In order to qualify for Masslicalth payment of nursing-facility services, you must be both clinically and financially eligible for services, *This notice is about your clinical eligibility,* You will receive a separate notice about your financial eligibility.

1. Massilealth Assessments

Assessments to determine clinical eligibility for nursing-facility services are conducted by [redacted], Aging Services Access Point (ASAP). An ASAP nurse reviewed your case in accordance with MassHealth regulations at 130 CMR 456.408, and has determined the following. To view MassHealth regulations, go to www.mass.:ov/masshcalth.

E You are clinically eligible for MassHealth payment of nursing-facility services on a short-term basis through 02/02/2015, because nursing-facility services are medically necessary as required by MassHealth regulations at 130 CMR 456,409. Your continued clinical eligibility is subject to review. See 130 CMR 456.408.

❑ You are clinically eligible for MassHealth payment of nursing-facility services, because nursing facility services are medically necessary as required by Masslicalth regulations at 130 CMR 456.409. During your stay, periodic medical reviews may be conducted to determine if nursing-facility services are medically necessary as required by Massl-lealth regulations. *See* 130 CMR 456.408,

❑ You are **not** eligible for Masalealth payment of nursing-facility services for the following reason.

- ❑ Nursing-facility services are not medically necessary, as required by MassHealth regulations at 130 CMR 456.409.
- ❑ Your medical needs can be met in the community and services are available. Sec 130 CMR 456.408 (A)(2).

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171
1-617-847-1200 or 1-800-655-0338
Fax 1-617-847-1204

Weayonnoh Nelson-Davies, Atty.
Central West Justice Center
405 Main Street
Worcester, MA 01608

[redacted]
Worcester, MA [redacted]

Date: March 4, 2015
Appeal No: [redacted]
RE:

The hearing you requested regarding nursing home services will be held on 03/13/15 at 10:00 AM at the Taunton MassHealth Enrollment Center Room 1, 21 Spring Street , Ste. 4, Taunton, MA 02780. This hearing will be conducted pursuant to Massachusetts General Laws, Chapters 30A and 118E and Title 130 of the Code of Massachusetts Regulations, Chapter 610.

Please notify your attorney or appeal representative of the scheduled hearing. If you or your appeal representative fail to appear at the hearing, your appeal will be dismissed. Should your hearing become unnecessary, you must call us at the above number as soon as possible so we may use your scheduled time slot for another appellant.

For good cause, the Board of Hearings may, at the request of a party, reschedule the hearing provided that the request is received before the date of hearing. To reschedule call 1-617-847-1200 and 1-800-655-0338. Allowance of a request to reschedule is within the discretion of the Board of Hearings.

The enclosed sheet describes your rights and responsibilities and the hearing procedures.

cc:
MassHealth Representative [redacted], RN, Executive Office of Elder Affairs - OLTSS, 1 Ashburton Place, Fifth, Boston, MA 02108, 617/222-7420
Appellant Attorney: Weayonnoh Nelson-Davies, Atty., Central West Justice Center, 405 Main Street, Worcester, MA 01608, 508/425-2878
Respondent Representative: [redacted], Worcester, MA [redacted]

CENTRAL WEST JUSTICE CENTER

An affiliate of Community Legal Aid

Weayonnoh Nelson-Davies
Staff Attorney
[redacted]

405 MAIN STREET
WORCESTER, MA 01608
(508) 425-2886 • (844) 295-8784
(508) 755-4240 FAX
(508) 755-3260 TTY

OFFICES:
PITTSFIELD
SPRINGFIELD
WORCESTER

April 25, 2014

MassHealth Enrollment Center (MEC)
P.O. Box 1231
Taunton, MA 02780
Fax: 617-887-8777

Re: [redacted], MassHealth ID No. [redacted] and tax dependent daughter [redacted], MassHealth ID No: [redacted];

To Whom it May Concern:

Please be advised that this office represents Ms. [redacted] and her household in regards to her Medicaid matter.

MassHealth determined that Ms. [redacted]'s MassHealth household is a household of two which includes herself and her son, [redacted]. However, under the new MAGI rules for determining household income, Ms. [redacted] has a household of three. Her daughter, [redacted], is a tax dependent and therefore should be added to her mother's household. I have enclosed copies of Ms. [redacted]'s tax return and a letter stating that [redacted] no longer works at [redacted].

I ask that MassHealth:

1) Adjust its systems to reflect that [redacted] should be added to [redacted]'s household as a tax dependent.
2) Adjust [redacted]'s household composition to reflect a household of three instead of a household of two.
3) Recalculate the income of the household to determine eligibility.

Based on the above information, **I request that MassHealth adjust Ms. [redacted] and her household's income to reflect that she is in a MAGI household of three and apply the appropriate coverage type of MassHealth Standard**. Please expedite this change so that Ms. [redacted] can continue to receive the appropriate medical care.

If you have any questions or concerns, please contact me directly at [redacted]. I appreciate your attention to this matter.

Sincerely,

Weayonnoh Nelson-Davies
Staff Attorney

CC: [redacted]

CENTRAL WEST JUSTICE CENTER

An affiliate of Community Legal Aid

Weayonnoh Nelson-Davies
Staff Attorney
wnelsondavies@cwjustice.org

405 MAIN STREET
WORCESTER, MA 01608
(508) 425-2886 • (844) 295-8784
(508) 755-4240 FAX
(508) 755-3260 TTY

OFFICES:
PITTSFIELD
SPRINGFIELD
WORCESTER

April 14, 2014

MassHealth Enrollment Center (MEC)
P.O. Box 1231
Taunton, MA 02780

Re: [redacted], MassHealth ID No. [redacted]; PRUCOL-Family Assistance

To Whom it May Concern:

Please be advised that this office represents Ms. [redacted] in regards to her Medicaid matter. On September 30, 2011, the U.S. Department of Homeland Security (DHS) used its "prosecutorial discretion" and filed a motion with the U.S. Department of Justice, Executive Office for Immigration Review, to administratively close [redacted]'s case. This means that DHS asked the court to close Ms. [redacted]'s case because DHS has decided in its prosecutorial discretion NOT to remove Ms. [redacted] from the United States at this time. I have enclosed the motion filed by DHS and the Immigration Judge's order granting the motion to administratively close this case.

For MassHealth purposes, under 130 CMR 518.003 (C) (11), Ms. [redacted], is a Nonqualified Person Residing under Color of Law (Nonqualified PRUCOL) because she is living in the United States with the knowledge and consent of DHS, and whose departure DHS does not contemplate enforcing. Furthermore, as a Nonqualified PRUCOL 65 years of age and older, she is eligible for Family Assistance, 130 CMR 518.006 (C). I have also enclosed the relevant parts of the regulation.

Based on the above information, **I request that MassHealth adjust Ms. [redacted]'s information to reflect that she is a Nonqualified PRUCOL and apply the appropriate coverage type of Family Assistance**. As you may be aware, Ms. [redacted] has End Stage Renal Disease (ESRD) in which she requires regular course of dialysis and is also in need of a kidney transplant. **So, please expedite this change so that Ms. [redacted] can continue to receive the appropriate medical care**.

If you have any questions or concerns, please contact me directly at 508-425-2878. I appreciate your attention to this matter.

Sincerely,

Weayonnoh Nelson-Davies
Staff Attorney

CC: [redacted]

Community Legal Aid
Serving Central and Western Massachusetts

MEDHA D. MAKHLOUF
MMAKHLOUF@CLA-MA.ORG

405 MAIN STREET
WORCESTER, MA 01608
(508) 752-3718 • (855) 252-5342
(508) 752-5918 FAX
(508) 755-3260 TTY

OFFICES:
FITCHBURG
GREENFIELD
MILFORD
NORTH ADAMS
NORTHAMPTON
PITTSFIELD
SOUTHBRIDGE
SPRINGFIELD
WORCESTER

August 29, 2013

Kristin Thorn, Acting Medicaid Director
Office of Medicaid
One Ashburton Place
11th Floor
Boston, MA 02108

Re: X
Appeal No. XXXXXXX

Dear Ms. Thorn:

I am writing pursuant to 130 CMR 610.091 to request a rehearing of this MassHealth appeal by Mr. X, a quadriplegic. At issue is the correct application of the MassHealth regulations in determining the number of medically necessary hours of personal care attendant (PCA) services the appellant should receive. The decision denies the appellant's request for additional time for assistance with eating following a tracheotomy because it erroneously categorizes the need for additional time as a need for "supervision," a noncovered service under 130 CMR 422.412(C). A copy of the appeal decision is enclosed.

I am requesting that you allow me until September 16, 2013, to submit additional information and argument in support of this request. The attorney who represented the appellant pro bono at the hearing level is no longer able to do so, and I only recently agreed to represent the appellant. Please permit me this additional time to prepare a brief so that I may familiarize myself with the evidence and testimony submitted thus far.

Thank you for your attention to this matter.

Sincerely,

Medha D. Makhlouf
Staff Attorney

Encl.

THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID
BOARD OF HEARINGS

In re: X	)
Appeal No. XXXXXXX	)

APPELLANT'S MEMORANDUM OF LAW IN SUPPORT OF
PRIOR AUTHORIZATION REQUEST FOR PCA SERVICES

I. INTRODUCTION

This memorandum is submitted in support of X's prior authorization request for Personal Care Attendant (PCA) services, submitted on May 6, 2013. The undersigned counsel did not represent Mr. X at the fair hearing on this issue, but understands that Mr. X testified as to the facts contained herein. To the extent that these facts are not contained in the record of proceedings, counsel offers them in consideration of the request for rehearing and would seek to have this information admitted at the rehearing.

Mr. X is a 36-year-old man who was diagnosed with a spinal cord injury that resulted in full quadriplegia in 1999. In re X, No. XXXXXXX (Office of Medicaid, Aug. 16, 2013) (Test. of X) (hereinafter "X Testimony"). He lives alone and is totally dependent on PCAs for all Activities of Daily Living (ADLs). *Id.* In October 2012, Mr. X was admitted to the hospital for severe gastrointestinal complications. *Id*. Within a day of admission, Mr. X's condition worsened significantly when he developed aspiration pneumonia. *Id*. He spent one month being treated in the Intensive Care Unit (ICU), and an additional month at a rehabilitation hospital. *Id*. During his hospitalization, Mr. X underwent a tracheostomy, which caused scar tissue to form in his throat

and difficulty swallowing. *Id*. This hospitalization represented a major medical setback for Mr. X. *Id*. Upon discharge, Mr. X's physicians directed him to eat slower in order to promote good digestion and to prevent the recurrence of life-threatening aspiration pneumonia. *Id*.; Ex. 5.

On May 21, 2013, MassHealth denied Mr. X's request for an increase in PCA service hours for assistance with eating. Ex.1. Mr. X appealed the decision to the Office of Medicaid Board of Hearings, and attended a hearing before Hearing Officer Susan Burgess-Cox on July 29, 2013. Ex. 2; In re X, No. XXXXXXX (Office of Medicaid, Aug. 16, 2013) (hereinafter "Appeal Decision"). On August, 16, 2013, the Board denied Mr. X's request, reasoning that his need for additional time for assistance with eating could be characterized as a need for "supervision," a non-covered service under the PCA program. Appeal Decision at 7.

Mr. X respectfully requests that the Director of the Office of Medicaid ("the Director") reverse the Hearing Officer's decision and approve the time requested for assistance with eating at each meal, for a total of 45 minutes, three times each day, seven days each week. In the alternative, Mr. X requests that the Director order the Board of Hearings to conduct a rehearing of the appeal on this issue.

II. FACTUAL SUMMARY

In 1999, when Mr. X was 22 years old, he was badly injured when the second-floor, outdoor deck he was standing on collapsed. X Testimony. The resulting spinal cord injury resulted in full quadriplegia. *Id*. For many years, Mr. X has been able to live independently with the assistance of PCAs. *Id*. He is totally dependent on PCAs for all ADLs, including mobility (transfers), assistance with medications, bathing/grooming, dressing and undressing, passive range-of-motion exercises, eating, and toileting. *Id*. He is also totally dependent on PCAs for all

Instrumental Activities of Daily Living (IADLs), including laundry, shopping, housekeeping, meal preparation and cleanup, and transportation to and from medical appointments. *Id*.

In October 2012, Mr. X developed multiple medical problems, including a bowel obstruction, severe distension, and vomiting. X Testimony. He was admitted to HealthAlliance Hospital in Leominster. *Id*. Within a day of his admission, these conditions caused him to aspirate and choke on a mixture of undigested food and vomit. *Id*. Mr. X lost consciousness and had to be resuscitated. *Id*. He developed aspiration pneumonia, a lung infection that occurs when foreign materials (such as food or vomit) are breathed into the lungs or the airways leading to the lungs, and was hospitalized for approximately one month in the ICU. *Id*. After that, he spent an additional month at Whittier Rehabilitation Hospital. *Id*. For most of his hospitalization, Mr. X required a respirator and tracheostomy tube to breathe. *Id*. These events constituted a major setback in Mr. X's overall health, and among the many challenges he faced was the loss of ability to swallow and eat normally. *Id*. Mr. X underwent rehabilitation to learn to swallow all over again, a process he describes as more difficult than after his initial injury in 1999. *Id*.

Upon removal of the tracheostomy tube, Mr. X was left with scar tissue in his throat, and has exhibited dysphagia—difficulty swallowing—ever since. X Testimony. For these reasons, and also to prevent digestive complications that could lead to another incidence of life-threatening aspiration, Mr. X's physicians have recommended that he eat more slowly. *Id*.; Ex. 5. In particular, in order to aid his digestion, it is important that he chews his food adequately, swallows carefully, and does not rush through meals. X Testimony.

III. PROCEDURAL SUMMARY

On May 2, 2013, DZ, R.N., of the Center for Living & Working, Inc., a Personal Care Management (PCM) agency, submitted a PCA Prior Authorization Adjustment Form to

MassHealth on behalf of Mr. X, requesting an increase in his PCA service hours. Attach. 1.[1] Among these was a request for an additional 15 minutes of PCA services for assistance with eating at each meal. *Id*. Mr. X had previously been approved for 30 minutes of PCA assistance with eating at each meal, and this request would increase the PCA hours for this activity to 45 minutes, three times each day, seven days each week. *Id*. Mr. X's Primary Care Physician (PCP) submitted a letter in support of the request, describing the requested adjustments as medically necessary. *Id*.

In a decision dated May 21, 2013, MassHealth modified Mr. X's prior authorization for personal care services, denying *inter alia* the request for additional time for assistance with eating. Ex. 1. The stated reason for the denial was "[T]he time you requested for assistance with eating is longer than ordinarily required for someone with your physical needs." Ex. 1 at 2.

Mr. X appealed the decision to the Board. Ex. 2. He attended the hearing on July 29, 2013, with then-counsel ES, Esq., at Tewksbury MassHealth Enrollment Center. Two of Mr. X's physicians submitted additional letters describing the medical necessity of the requested adjustment. Ex. 5. On August 16, 2013, the Board issued a decision denying the additional time requested for assistance with eating. Appeal Decision at 7. The Board's decision was based on an erroneous characterization of the need for additional time as a need for "supervision," a non-covered service under the PCA program.

On August 30, 2013, with the assistance of undersigned counsel, Mr. X requested a review of the Hearing Officer's decision. Attach. 2. He files this memorandum in support of the prior authorization request for additional time for assistance with eating.

[1] As the undersigned counsel was not present at the fair hearing and does not have a copy of the full record created at that hearing, a copy of Mr. X's prior authorization request is attached hereto. To the extent that this document is not already part of the record, Mr. X would seek to have it admitted at a rehearing, and it is offered to support the Director's consideration of the request for rehearing.

IV. ARGUMENT

A. Applicable Regulations

The regulations governing MassHealth members' eligibility for coverage of personal care services are found at 130 CMR 422.403(C).

> MassHealth covers personal care services provided to eligible MassHealth members who can be appropriately cared for in the home when all of the following conditions are met:.
> (1) The personal care services are prescribed by a physician or a nurse practitioner who is responsible for the oversight of the member's care.
> (2) The member's disability is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance.
> (3) The member, as determined by the personal care agency, requires physical assistance with two or more of the following ADLs as defined in 130 CMR 422.410(A):
> (a) mobility, including transfers;
> (b) medications;
> (c) bathing/grooming;
> (d) dressing or undressing;
> (e) range-of-motion exercises;
> (f) eating; and
> (g) toileting.
> (4) The MassHealth agency has determined that the PCA services are medically necessary and has granted a prior authorization for PCA services.

Pursuant to 130 CMR 422.416, "Prior authorization determines only the medical necessity of the authorized service…." A "medically necessary" service is defined in the regulations as "reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity." 130 CMR 450.204(A).

The PCA Services that MassHealth will cover are defined at 130 CMR 422.402 as "physical assistance with ADLs and IADLs provided to a member by a PCA…." ADLs include, among other activities, "physically assisting a member to eat. This can include assistance with tube-feeding and special nutritional and dietary needs." 130 CMR 422.410(A)(6). The regulations also describe services that MassHealth does not cover as part of the PCA program.

Of relevance in this matter is the service described at 130 CMR 422.412(C): "assistance provided in the form of cueing, prompting, supervision, guiding, or coaching."

MassHealth has not argued that Mr. X does not meet the conditions to receive PCA services, nor has it disputed that Mr. X's need for assistance with eating is medically necessary. Rather, it has argued, and the Board has agreed, that the additional time Mr. X has requested for assistance with eating must be characterized as "supervision," a non-covered service under the PCA program.

B. The Service Requested Can Only Be Characterized as "Physical Assistance with Eating"

In the PCA Prior Authorization Adjustment Request ("the Request"), both the Registered Nurse Evaluator and Mr. X's physicians explained that Mr. X would need additional time for assistance with eating due to changes in his medical condition. Attach. 1; Ex. 5. Essentially, the Request is for *more* time to complete the *same* ADL for which MassHealth has already determined that PCA services are medically necessary—namely, eating three meals per day. The only difference in Mr. X's performance of this ADL pre- and post-hospitalization is the speed at which he must eat.

In the Request, Mr. X has not asked the PCA to perform any "new" service. As a quadriplegic, Mr. X requires physical assistance with every conceivable ADL, including eating. X Testimony. While physically assisting Mr. X to eat, a PCA must use a utensil to bring food to Mr. X's mouth, insert the food, *wait* while Mr. X chews and swallows, and then begin the process all over again. This is a common-sense description of what it means to feed another person. The time it takes a person to chew and swallow food is necessarily incidental to the time it takes to feed that person. It is ludicrous to suggest that a PCA would be performing a fundamentally different task by feeding Mr. X at a slower pace.

Moreover, federal regulations governing medical assistance programs require that "[e]ach service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." 42 C.F.R. § 440.230(b). It is not reasonable for MassHealth to authorize payment for PCA services for assistance with eating without authorizing sufficient time for Mr. X to chew and swallow his food.

C. The Hearing Officer Erred in Characterizing the Service Requested as "Supervision"

In characterizing Mr. X's request for additional time for assistance with eating as a request for supervision, the Hearing Officer incorrectly interpreted the meaning of the term. The decision states: "The appellant's testimony and argument presented by counsel that the PCA needs to 'wait' as the appellant requires additional time to ingest does not indicate that this additional time involves the PCA physically assisting the appellant. Instead, the 'waiting' can also be considered supervision…." Appeal Decision at 7. Both the plain meaning and the dictionary definition of the term "supervision" contradict the Board's interpretation. Generally, to supervise another person is to oversee or direct that person in how to do something. In this context, the PCA would not be overseeing or directing Mr. X while he chews and swallows food—he is capable of performing this function on his own. The dictionary definition of "supervise" supports this argument: "to be in charge of (someone or something); to watch and direct (someone or something)." Merriam-Webster.com, http://www.merriam-webster.com/dictionary/supervise. The PCA is not "in charge of" Mr. X, nor is she watching and directing him while he chews and swallows. Quite simply, she would be feeding him—a task which unequivocally falls within the category of physical assistance with eating. From both a common-

sense and a literal perspective, the service requested by Mr. X cannot reasonably be characterized as "supervision."

D. MassHealth Erred in Denying the Time Requested for Assistance With Eating on the Basis That it is "Longer Than Ordinarily Required"

In order to comply with the Americans with Disabilities Act (ADA), MassHealth must consider Mr. X's individual circumstances when determining the number of hours of physical assistance that he requires to eat.[2] The ADA prohibits public entities from providing services to individuals with disabilities that are "not as effective in affording equal opportunity to obtain the same result [or] to gain the same benefit…as that provided to others." 28 C.F.R. § 35.130(b)(1)(iii). MassHealth agency's original basis for denying the Request was that "the time [Mr. X] requested for assistance with eating is longer than ordinarily required for someone with [his] physical needs." Appeal Decision at 2. It is obvious however that MassHealth did not take into consideration the change in Mr. X's physical needs due to his recent medical problems. Prior to Mr. X's hospitalization in 2012, MassHealth authorized 30 minutes of PCA time for each meal. Attach. 2. After he developed aspiration pneumonia and underwent a tracheostomy procedure and subsequent rehabilitation, Mr. X's physical needs changed, as documented by the PCM agency's Registered Nurse Evaluator and his physicians, who recommended 45 minutes of PCA time for each meal. Testimony; Attach. 1; Ex. 5. MassHealth did not adjust its determination of the number of hours of assistance with eating required to reflect Mr. X's current physical needs.

Furthermore, there is no reason why MassHealth should limit its authorization of PCA time for assistance with eating to 30 minutes per meal. There is no legal or regulatory limit for the number of PCA hours that MassHealth may approve for any particular ADL. The Draft

[2] The regulation at 130 CMR 422.410(C)(3) requires MassHealth to do this precisely when determining the number of hours of physical assistance a member requires for IADLs.

Time-for-Task Guidelines for the MassHealth PCA Program, dated July 19, 2011, provide average time estimates for the amount of PCA time required to perform ADLs and IADLs depending on the level of assistance required by the PCA consumer. Attach. 3. The document explicitly states that "[s]ome consumers may require additional time beyond the time estimates in the guidelines…." *Id.* at 1. For an individual who is totally dependent on his PCA for physical assistance, as Mr. X has been since he was diagnosed with quadriplegia in 1999, the average time estimate for eating is 30 minutes per meal and MassHealth authorized 30 minutes per meal prior to Mr. X's hospitalization in 2012. After his medical ordeal in 2012, MassHealth should have taken into consideration Mr. X's special circumstances and decline in functional ability, which are listed as "common considerations" on the Time-for-Task Guidelines, in determining how much PCA time he requires to eat. Given Mr. X's individual circumstances, MassHealth should approve his request for 45 minutes of PCA assistance with eating for each meal.

V. CONCLUSION

For the reasons stated above, the Director should reverse the Hearing Officer's decision and adjust the prior authorization for PCA services, effective May 6, 2013, to include approval of the time requested for assistance with eating at each meal for a total of 45 minutes, three times each day, seven days each week, increasing the currently authorized PCA services by 315 minutes per week (15 minutes additional time per meal times 3 meals each day times seven days each week). In the alternative, Mr. X requests that the Director order the Board of Hearings to conduct a rehearing of the appeal, granting him the opportunity to submit additional medical evidence in support of the Request, including but not limited to the potentially adverse effects of limiting his PCA hours for assistance with eating.

Respectfully submitted,

X

By his attorney,

Medha D. Makhlouf (BBO# 674050)
COMMUNITY LEGAL AID
405 Main Street
Worcester, MA 01608
(508) 752-3718

Dated: September 16, 2013

APPEAL DECISION

Appeal Decision:	APPROVED	**Issue:**	Premium Assistance Termination – Due Process – Cost Effectiveness of Alternative Insurance
Decision Date:	MAR 10 2014	**Hearing Date:**	11/04/2013 & 12/06/2013
MassHealth Reps.:	N. Mercado & E. Rodriguez	**Appellant Rep.:**	P. Beebe, Esq.
Hearing Location:	Chelsea MassHealth Enrollment Center	**Aid Pending:**	YES

Authority

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

Jurisdiction

Over a two-day span from August 22, 2013 to August 23, 2013, MassHealth sent Appellants AL and SL[1] a total of four eligibility notices, each with appeal rights. The four notices respectively stated that (1) "*MassHealth has information that the employment that was the source of your private health insurance has ended. MassHealth Premium Assistance Unit has stopped paying for this insurance as of 8/22/2013….*" (notice # 49220150, dated 8/22/2013); (2) Appellant AL was eligible for premium assistance, but that MassHealth would pay $0.00 monthly towards the cost of family's health insurance premium (notice #49220174, dated 8/22/13); (3) MassHealth was changing the monthly premium payment required from Appellants to $56.00/month in part because they were no longer eligible to receive Premium Assistance" (notice # 49220175, dated 8/22/2013); and (4) MassHealth coverage for both Appellants would be downgraded to CommonHealth effective 9/6/2013 and that the couple would have to pay a $36.40 premium for this benefits (notice #49236172, dated 8/23/2013). See Exhibit 1 and various regulations cited within those notices.

[1] The Appellants are a married couple and family group of two for all appeal purposes. As of the date of hearing, AL is a 65-year old husband and SL is a 57-year old wife.

The two Appellants both filed multiple timely appeal requests of this series of notices with the Board of Hearings, with the first such appeal request from the couple filed on September 4, 2013. See Exhibits 1, 2 and 130 CMR 610.015(B).

On October 1, 2013, MassHealth sent another appealable notice stating "*MassHealth has information that the employment that was the source of your private health insurance has ended. MassHealth Premium Assistance Unit has stopped paying for this insurance as of 10/1/2013....*" (notice # 49834700). Another appeal request was filed by the couple on October 10, 2013. See Exhibit 3.

Due to the apparent commonality of fact and law, the Board of Hearings consolidated the multiple appeal requests into a single appeal and scheduled the matter for hearing on November 4, 2013. See Exhibit 4. After an initial hearing proceeding,, the Hearing Officer opted to continue the hearing to a second day so that a representative from MassHealth Premium Assistance could be invited. See 130 CMR 610.072; 130 CMR 610.065(A)(1) and (B)(7) and Exhibit 7 and 8.[2]

During the time period between the two hearing dates, Appellant obtained new representation for this matter in the form of Attorney Beebe, who appeared as a successor Appeal Representative. See Exhibits 5 and 9 (containing the appearances of the two lawyers who assisted and appeared on Appellants' behalf on the two different hearing dates).

Also during this same time period between the two hearing dates, MassHealth sent out three new eligibility notices to the two Appellants on November 4, 2013; as described in some greater detail below, all of these notices were generated in response to restoring Appellants' Premium Assistance benefits and level of assistance prior to the August 2013 notices. See Exhibit 10. Because Appellants filed their appeal requests on September 4, 2013 with the Board of Hearings prior to the effective date of downgraded benefits (September 6, 2013, as stated in the August 23, 2013 notice), the two Appellants are entitled to "Aid Pending" protection of their prior benefits and assistance during this appeal process. See Exhibit 1; 130 CMR 610.015(B); and 130 CMR 610.036(A).[3]

On November 15, 2013, the Board of Hearings sent a notice scheduling the second hearing date for December 6, 2013. See Exhibit 8.

---

[2] Shortly after the first Hearing Date, Appellant AL sent correspondence to the Board of Hearings which was received on November 6, 2012. See Exhibit 7. The letter essentially sought the remedy of a default judgment for Premium Assistance's failure to appeal at the first hearing date. As was stated repeatedly during both the first and second hearing date, there was no failure of Premium Assistance to show for the first hearing date, as it was the Board of Hearings (and not MassHealth) who committed an administrative error while processing the multiple appeal requests for the first hearing date, by overlooking the need to include and notice a Premium Assistance Representative. The Appellant's AL request for relief in Exhibit 7 was summarily dismissed at the beginning of the second hearing date.

[3] As described below, there was an administrative issue with providing Appellants with continued assistance in the form of the "Aid Pending" benefits to which they were entitled during this appeal process as a result of their their timely appeal filings in early September 2013.

On November 29, 2013, Appellants filed with the Board of Hearings timely appeal requests of the multiple November 4, 2013 notices related to the protected benefits. See Exhibit 10.

Challenging a MassHealth decision to deny or terminated a level of state medical assistance is a valid ground for appeal to the Board of Hearings. See 130 CMR 610.032.

Actions Taken by MassHealth

Through a series of notices, MassHealth attempted to terminate the eligibility for continued Premium Assistance for the married couple.

Issues

Does MassHealth have grounds to terminate or downgrade the scope of state medical assistance for the couple and, if so, did MassHealth follow all proper due process requirements in its attempt to implement the downgrade in state medical assistance?

Summary of Evidence

Appellants AL and SL are, respectively, a 65-year old husband and a 57-year old wife in a family group of two, consisting solely of a married couple and no children under the age of 19. Prior to 2013, the Social Security Administration (SSA) found each of the two Appellants to be disabled adults who were entitled to receive SSDI benefits prior to turning age 65. Prior to 2013, both Appellants were over the income limit for MassHealth Standard benefits but were both eligible for, and receiving, MassHealth CommonHealth benefits as working disabled adults who work approximately 40 hours/month. The work that both Appellants currently do to qualify for CommonHealth benefits is not related to, or the source of, any private health insurance.

Appellant AL has been disabled since approximately 1999 and has been receiving Medicare Part A benefits since 2002. Appellant AL also has coverage through Medicare Part D. The MassHealth system indicates that Appellant AL may have "Part B" effective June 2013, but Appellant AL indicated that both he and his wife never opted to take Medicare Part B in order to meet the requirements of their private group health insurance through Blue Cross & Blue Shield ("BCBS") offered through a former employer of Appellant AL. Appellant also produced in Exhibit 12 a November 19, 2013 statement from the SSA which stated that Appellant AL is not currently enrolled in Medicare Part B as of that date [4]

[4] Appellant AL turned 65 years of age in June of 2013, which may be one of many factors as to why the MassHealth system has some indication in Exhibit 17 as finding him eligible (or potentially eligible) for some sort of Medicare Part B assistance in that month. Adults found to be disabled by SSA before they turn 65 often, when they subsequently turn 65 years of age, undergo some sort of conversion from disabled to retirement benefits with Social Security, and this may alter or affect their eligibility for Medicare. See Exhibit 15.

Appellant SL has been found to be effectively[5] disabled since approximately February of 2006. She became eligible for Medicare Part A in May of 2013 and also is covered by Medicare Part D.

Evidence in the record (generated primarily from Exhibit 12 from Appellant and Exhibits 16 and 17 from the MEC Representative) indicates that, prior to the August 2013 notices over which this appeal has jurisdiction, Appellants AL and SL received Premium Assistance of $375.97/month towards the private group health insurance he has through his former employer in November of 2012.

This amount was changed to $370.97/month in December of 2012, and then to $352.97/month in January of 2013. On June 4, 2013, Appellants were sent a notice stating that they would no longer be eligible for Premium Assistance due to the end of employment.[6] On June 25, 2013, Appellant turned 65 years of age. Subsequently, on June 26, 2013, Appellants were sent a notice stating that they were eligible for $400.97/month in Premium Assistance. On June 28, 2013, the Premium Assistance amount was lowered to $344.97/month.

In August of 2013, the cycle of notices stating that premium assistance benefits was ending due to the end of employment, found in Exhibits 1 through 9, began to repeat. Premium Assistance was paid in the months of August and September 2013, but not in the month of October 2013 prior to the first hearing date.

At hearing, the Premium Assistance representative submitted a summary (Exhibit 13) which indicated that the agency's position was that it was no longer cost-effective for the state to continue paying for the couple's commercial health insurance. Premium Assistance acknowledged that the couple was only currently receiving Medicare Part A but that the state still felt it was cost-effective. Premium Assistance also stated that, because Appellant AL had turned 65 years of age, he was regulatory no longer eligible for Premium Assistance benefits.

At hearing, Premium Assistance was asked repeatedly by both the Hearing Officer and the Appeal Representative as to how the cost-effectiveness was actually measured for this couple, but no specific mathematical calculation or substantive replies were provided. Questions included how the agency could have found it "cost-effective" to cover the couple earlier in 2013 but not in later 2013, and what changes (if any) led to that decision. Appellant's counsel also questioned whether MassHealth was doing its calculation using the Average Expenditure Projection or the Actual Expenditure process, both of which appear to be the two methods chosen by other states in their formula for cost-effectiveness. Appellant's counsel also expressed concern since cost-effectiveness

---

[5] The term "effectively" is used here because SSA disability determinations are time consuming and often have some retroactive effect with regard to the established disability date. In this appeal there is testimony that SL was found disabled approximately 2 ½ years ago (in 2010) but MassHealth documentation has her as having a disability onset date of February 2006. Testimony indicated that Appellant AL was found disabled in 2002 but has some retroactive Medicare start date in the documentation.

[6] The record is clear that AL's employment, through which the BCBS insurance benefit is provided for the couple, ended many years before 2013 and the notices at issue in this appeal.

was never specifically defined in the MassHealth regulations. At hearing and in memorandum, Appellant's counsel also questioned how cost-effective this decision would be because neither member of the couple had Medicare Part B and they both had extensive outpatient services as disabled adults which would have to be picked up by MassHealth CommonHealth if and when the private insurance ended.

Appellant's counsel also questioned the position of how ineligibility for Appellant AL could be related to age, as, by MassHealth regulation, certain parts of 130 CMR 505.000 and 130 CMR 506.000 applied to his MassHealth eligibility, as incorporated by reference in 130 CMR 519.012, the eligibility rule for MassHealth CommonHealth recipients who are 65 years of age or older. In addition, any presumed ineligibility of Appellant AL would also not necessarily make Appellant SL (who remains under the age of 65) automatically ineligible for continued Premium Assistance.

The parties also discussed how, in 2014, as a result of the new federal health care law (the Affordable Care Act or ACA), premium assistance would no longer be available to any Medicare beneficiaries, regardless of age or income test. See current (2014) version of 130 CMR 506.012(C)(4)(a). [In addition, 130 CMR 507.003 has been effectively repealed as of January 1, 2014.] Appellant's counsel conceded at hearing that such a change was coming, but indicated that the changes which would go into effect in the year 2014 were not part of the regulations that governed the termination action which began with the myriad of notices sent in 2013, and that a future law could not be used to justify the action in question until the law was implemented.

There was also discussion at hearing about how the protection of monthly Premium Assistance benefits to which the couple was temporarily interrupted during the appeal process, even though all parties (and the Board of Hearings) affirmed that the couple was entitled to such protection. The Premium Assistance representative stated that she had taken corrective action to restart Appellants' payments in the month of November 2013, and this including her having taken steps to have sent Appellants payment for the missed month (which would consist of the payment that should have been received during October 2013). Appellant acknowledged recent receipt of two payments prior to the December 6, 2013 hearing date – this included the regular November 2013 payment, as well as a (late) payment for the month of October 2013. The next payment (to be received during the month of December 2013) would be sent shortly after the second hearing date per the Premium Assistance Representative, who also stated that premium assistance payments in the amount of $377.63/month would continue into 2014 until a decision was reached by the Board of Hearings.[7]

In addition to the arguments summarized above, Appellant's memorandum also referred to an argument that the series of confusing and unclear notices sent to the couple since August 2013 were unfair and do not provide a clear and reasonable explanation as to the actual reason why the adverse actions were being proposed for the couple and thus were not adequate or proper notices.

[7] During the hearing, there was some discussion as to whether the parties could reach an agreement to resolve the issue prior to the 2014 change in law, but the Premium Assistance representative indicated that her unit would require and wait for a decision by the Board of Hearings.

Findings of Fact

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

1. The Appellants in this appeal are a married couple and family group of two at all times for eligibility purposes. As of the date of hearing, AL is a 65-year old husband and SL is a 57-year old wife. (Testimony and Exhibits 1, 12, 13 and 17)

2. Over a two-day span from August 22, 2013 to August 23, 2013, MassHealth sent Appellants AL and SL a total of four eligibility notices, each with appeal rights. The four notices respectively stated that (1) "*MassHealth has information that the employment that was the source of your private health insurance has ended. MassHealth Premium Assistance Unit has stopped paying for this insurance as of 8/22/2013....*" (notice # 49220150, dated 8/22/2013); (2) Appellant AL was eligible for premium assistance, but that MassHealth would pay $0.00 monthly towards the cost of family's health insurance premium (notice #49220174, dated 8/22/13); (3) MassHealth was changing the monthly premium payment required from Appellants to $56.00/month in part because they were no longer eligible to receive Premium Assistance" (notice # 49220175, dated 8/22/2013); and (4) MassHealth coverage for both Appellants would be downgraded to CommonHealth effective 9/6/2013 and that the couple would have to pay a $36.40 premium for this benefits (notice #49236172, dated 8/23/2013). (Testimony and Exhibit 1)

3. Appellants first filed timely appeals of these late August 2013 notices on September 4, 2013. (Testimony and Exhibit 1)

4. Multiple other eligibility notices were generated and sent by MassHealth to the couple after August 22, 2013 but prior to the second hearing date, all of which were timely appealed to the Board of Hearings by the Appellants. (Exhibits 3 and 10)

5. Prior to 2013, both Appellants were over the income limit for MassHealth Standard benefits but were both eligible for, and receiving, MassHealth CommonHealth benefits as working disabled adults who work approximately 40 hours/month. The work that both Appellants currently do to qualify for CommonHealth benefits is not related to, or the source of, any private health insurance. (Testimony and Exhibits 16 and 17)

6. At all times relevant, the couple receives health insurance coverage through BCBS, offered through a former employer of Appellant AL. (Testimony and Exhibits 12, 16 and 17)

7. At all times since 2006, both members of the couple have been disabled adults. In May of 2013, Appellant SL became eligible for Medicare Part A. She is also covered by Medicare Part D but does not have Medicare Part B. (Testimony and Exhibits 12, 16, and 17)

8. Appellant AL turned 65 years of age in 2013. Prior to turning 65, he had received SSDI

benefits as well as Medicare Part A and Part D for several years prior to 2013. At no point has Appellant AL been enrolled in Medicare Part B. (Testimony and Exhibits 12, 16, and 17)

9. In November of 2012, the couple received $375.97 in monthly Premium Assistance towards the cost of the premium for their BCBS health insurance. (Testimony and Exhibits 12, 16 and 17)

    a. In 2013, the Premium Assistance amount has fluctuated to $370.97/month in December of 2012, to $352.97/month in January of 2013, to $400.97/month and then later $344.97 in June of 2013, and then $377.63 in November of 2013. (Testimony and Exhibits 12, 16, and 17)

10. All notices sent by MassHealth in 2013 announcing the end of premium assistance indicate that the reason for this action is due to the end of some employment status. (Exhibits 1, 3, 10, and 12)

    a. At hearing, MassHealth argued that the decision was motivated in part by a myriad of factors, including but not limited to some cost-effectiveness determination and the fact that Appellant AL turned 65 years of age in the summer of 2013. (Testimony and Exhibit 13)

Analysis and Conclusions of Law

It is unquestioned that both the state and federal constitutions offer both procedural and substantive due process protections to its citizens. Procedural due process is rife with concerns for fundamental fairness, and I find those concerns make it particularly important for the government, especially when it is attempting to terminating a right to financial assistance, for proper due process to be followed. With regard specifically to this issue and the MassHealth agency, the agency is expected to comply with the relevant Fair Hearing Rules governing notice found in 130 CMR 610.000. By law, MassHealth must always send timely and adequate notice prior to an adverse action, and the Fair Hearing Rule concerning the adequacy of such notice is found in 130 CMR 610.026. That regulation reads as follows:

610.026: Adequate Notice Requirements
(A) ***A notice concerning an intended appealable action must be*** *timely as stated in 130 CMR 610.015, and* ***adequate in that it must be in writing and contain****:*
(1) a statement of the intended action;
(2) ***the reasons for the intended action****;*
(3) ***a citation to the regulations supporting such action****;*
(4) an explanation of the right to request a fair hearing; and
(5) the circumstances under which assistance is continued if a hearing is requested.
(B) Regardless of the provisions of 130 CMR 610.026(A), when a change in either federal or state law requires a change in assistance for a class or classes of members, notice to the member will be considered adequate if it includes a statement of the specific change in law requiring the action to reduce, suspend, or terminate assistance. (Emphasis added.)

In examining the multitude of notices appealed in this case (summarized and reprinted in helpful detail in the Appeal Representative's memorandum in Exhibit 12), it would be a bit understated to say that the notices sent to the couple are a bit confusing and lacking. If one can find the notice that clearly state that Premium Assistance is ending, the only given justification for this action is that "*the employment that was the source of your private health insurance has ended.*" See Exhibits 1, 3, and 12. This is simply factually untrue, and it had the understandable effect of confusing the Appellant AL, whose employment ended many years before.

In addition, the only relevant CMR regulation cited anywhere[8] within the four notices from August 22, 2013 and August 23, 2013 is 130 CMR 506.012, but, as Appellant's counsel points out, the couple was never receiving Premium Assistance benefits through the Family Assistance program discussed at 130 CMR 506.012. Instead, the couple was receiving benefits through the MSCPA program discussed at 130 CMR 507.003.

Presumably having recognized this shortcoming in the notices during the preparation for hearing, the Representative from Premium Assistance attempted to shift the argument or basis for the MassHealth to a decision that was justified in part because of Appellant AL's new age of 65 years old, and because of the cost-effectiveness argument found in 130 CMR 507.003(B). Even if I was to accept that line of argument without regard to the fairness principles inherent in the due process, I would find the explanation at hearing to be inadequate. There was no adequate, detailed explanation of what was meant by cost-effectiveness. Moreover, the agency failed to explain the most intuitive - how was the premium assistance which was found to be cost-effective for the couple in early 2013 found to be not cost-effective in late 2013 when there were no relevant change.

I don't find the argument on age of Appellant AL to be persuasive, due to the fact that Appellant's counsel is correct in that Appellant AL is subject to the Volume I regulations in 130 CMR 501.000 through 130 CMR 508.000 due to the incorporative nature of 130 CMR 519.012. I will also note that MassHealth sent out an approval notice to Appellant AL approving him (and not his wife) for Premium Assistance in July 2013, the month after he turned 65 years of age.

Based on the above, I find all of the Appellant's arguments in Exhibit 12 to be persuasive and worthy of careful consideration. However, ultimately, I find there is enough alone in the agency's failure to send some sort of adequate notice with some clear (or even partially clear) reason or statement for its decision. If MassHealth wants to issue a decision based on the cost-effectiveness of the private BCBS (or an Appellant's age), I conclude that it has an obligation under the law to send much more detailed and adequate notice, particularly when it comes to the termination of regular financial assistance. This appeal is thus APPROVED on procedural grounds due to 130 CMR 610.026.

Due to the change in law that took place in 2014 as a result of the ACA, MassHealth may wish to

[8] I don't find the references to 130 CMR 505.002 or 130 CMR 505.004 in the August 23, 2013 announcing the "downgrade" to CommonHealth benefits to be explanatory in any way for the change.

consult 130 CMR 610.026(B) for guidance if and when it has to send any future notice for this couple regarding their eligibility for continued Premium Assistance due to their Medicare eligibility and the possible change in law in 2014.

Order for MassHealth

Remove the Aid Pending, but continue to pay monthly premium assistance benefits to the Appellants until the agency sends proper, clear, timely, and adequate notice of any such changes to the couple's level of state medical assistance. Any future notice must comply with all parts of the Fair Hearing Rules.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center or the MassHealth Premium Assistance Unit through MassHealth Customer Service. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Christopher S. Taffe
Hearing Officer
Board of Hearings

cc: N. Hazlett, Appeals Coordinator @ Chelsea MEC

K. Johnson-Cheek @ MassHealth Premium Assistance

Appeal Representative
Peter C. Beebe, Esq.
Greater Boston Legal Services
197 Friend Street
Boston, MA 02114

Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

Rehearing Appeal Decision:	Dismissed	**Rehearing Appeal Number:**	
Decision Date:	OCT 16 2013	**Rehearing Date:**	10/21/2013
Hearing Officer:	Kim M. Larkin		

Appellant Representative:
Medha D. Makhlouf, Esq.

MassHealth Representative:
Linda Phillips, RN, BSN, LNC-CSp

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

REHEARING APPEAL DECISION

Rehearing Appeal Decision:	Dismissed	**Rehearing Issue:**	PCA Service Hours
Decision Date:	OCT 16 2013	**Rehearing Date:**	10/21/2013
MassHealth Rep.:	Linda Phillips, RN, BSN, LNC-CSp	**Appellant Rep.:**	Medha D. Makhlouf, Esq.
Hearing Location:	Quincy		

Authority

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

Jurisdiction

Through a notice dated May 21, 2013, MassHealth modified the appellant's interim request for prior authorization (PA) for an increase in personal attendant care (PCA) services because MassHealth determined that the total number of hours requested per week are not medically necessary (see 130 CMR 422.410; 422.412 and 450.204; Exhibit 1). The appellant filed this appeal in a timely manner on June 14, 2013 (see 130 CMR 610.015(B); Exhibit 2). Modification of a request for PA for PCA services is valid grounds for appeal (see 130 CMR 610.032).

On July 29, 2013 a hearing was held and a hearing decision issued on August 16, 2013 dismissing the appeal in part and denying the appeal in part[1] (exhibit 3). On September 3, 2013, the appellant requested a rehearing of Appeal No. (Exhibit 4). On September 27, 2013, the Medicaid

[1] The appellant's interim request was for an additional 30.75 hours of PCA services per week. MassHealth considered the following increase requests: grooming, dressing, undressing, range of motion, eating, laundry, exercise bike, Jacuzzi, AFO's, Bunny boots, Compression boots, Kinesiology taping, hot packs, ice packs and medical appointments. At the original hearing, the parties reached agreement in the following areas: time for grooming (nail care), dressing/undressing, range of motion for lower extremities, laundry, exercise bike, Jacuzzi treatment, AFO, Kinesiology taping, hot/ice packs and medical appointments (decision dismissed in part as to these tasks). The remaining modification was to the increased time requested for eating, which was denied by hearing decision.

[2] "The Medicaid Director may order [] a rehearing...at the appellant's request, **provided that within 14**

Director ordered a rehearing "to determine the medically necessary amount of personal care attendant (PCA) services the member should receive for eating" (Exhibit 5). The parties were notified of the rehearing date, time and place on October 2, 2013 (Exhibit 6). In advance of the rehearing an order issued to the parties to ensure an orderly presentation of the evidence at the rehearing (Exhibit 7).

On October 9, 2013, the Board of Hearings Director was notified by MassHealth that it had adjusted the appellant's interim PA request for PCA services and approved the original time requested for assistance with eating, the only issue for rehearing (Exhibit 9). On October 16, 2013, the appellant withdrew his rehearing request (Exhibit 10).

Pursuant to 130 CMR 610.051(B) where MassHealth makes an adjustment in the matter at issue before or during a hearing and if the parties agree that the adjustment resolves the issue, the hearing officer by written order will dismiss the appeal as to all resolved issues. In the instant rehearing, the sole issue on rehearing was adjusted prior to the rehearing and the appellant requested the rehearing be withdrawn. Therefore, the rehearing is dismissed based on the adjustment and acceptance of the adjustment by the appellant.

Kim M. Larkin
Director
Board of Hearings

cc: Prior Authorization Unit
Barbara Wexler, MassHealth Legal
Medha Makhlouf, Esq.

---

calendar days of the date of the hearing officer's decision, the Medicaid Director receives the appellant's rehearing request" 130 CMR 610.091(B)(2). On a decision dated August 16, 2013, to be timely the rehearing request should have been received by the Medicaid Director on August 30, 2013. A copy of the appellant's rehearing request was submitted with the rehearing order to the Board of Hearing Director and is dated received on September 3, 2013. It appears the request was not timely. The issue need not be addressed, however, because the parties have resolved the issue for rehearing and the rehearing is dismissed on that basis.

Office of Medicaid
BOARD OF HEARINGS

RECEIVED JUL 29 2011

Appellant Name and Address:

Appeal Decision:	APPROVED	**Appeal Number:**	
Decision Date:	JUL 28 2011	**Hearing Date:**	06/02/2011
Hearing Officer:	Kenneth Brodzinski		

Appellant Representative:

Pro Se with
Fran Bakstran - Legal Services

MassHealth Representative:

Christine Carr

APPEAL DECISION

Appeal Decision:	APPROVED	**Issue:**	Eligibility
Decision Date:	JUL 2 8 2011	**Hearing Date:**	06/02/2011
MassHealth Rep.:	Christine Carr	**Appellant Rep.:**	Fran Bakstran
Hearing Location:	Taunton MassHealth Enrollment Center		

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 February 9, 2011, MassHealth informed Appellant that her coverage would terminate on February 23, 2011 because she had failed to file a completed eligibility review form (Exhibit A). Through a second notice dated February 28, 2011, MassHealth informed Appellant that she is eligible for MassHealth Buy-In benefits effective February 1, 2011 (Id). Appellant filed to appeal both actions in a timely manner on March 2, 2011 (see 130 CMR 610.015(B) and Exhibit A). Eligibility determinations constitute valid grounds for appeal (see 130 CMR 610.032).

Action Taken by MassHealth

MassHealth terminated Appellant's MassHealth coverage and subsequently determined that she is eligible for MassHealth Buy-In benefits.

Issue

The appeal issue is whether MassHealth applied accurate facts to the controlling regulations when it terminated Appellant's MassHealth coverage and subsequently determined that she is eligible for MassHealth Buy-In benefits.

Summary of Evidence

The MassHealth representative testified that Appellant is a 65-year-old female who lives alone in the community. Appellant had been receiving MassHealth Standard benefits as a disabled working adult.

Through a notice dated February 9, 2011, MassHealth informed Appellant that her coverage would terminate on February 23, 2011 because she failed to return a completed eligibility review form (Exhibit A).

MassHealth ultimately received the missing review form on February 28, 2011. On February 28, 2011, MassHealth issued a notice to Appellant informing her that as of February 1, 2011 she would be eligible for MassHealth Buy-In benefits (Exhibit A).

The MassHealth representative testified that Appellant's countable income includes $1,045.00 from Social Security and $13 earned income for a total of $1058.00. The MassHealth representative explained that the $13 comes from Appellant working 13 hours per month earning one dollar an hour as a homemaker. The MassHealth representative further testified that Appellant also asserted earned income of $812 per year. MassHealth did not accept this income as earned income because the supporting documentation indicates Appellant is working as a volunteer for the Town of as part of a "senior work off program" which reduces Appellant's annual property taxes by $812.00. The MassHealth representative referred to a letter from the Town of dated January 20, 2010 which states Appellant *"does not receive any direct compensation for said services..... [t]he benefit from the program is a credit off of the property taxes assessed to the individual; the calculation is based on a specific number of volunteer hours"* (Exhibit B). A second letter from the Town of dated January 24, 2011 states that Appellant *"volunteers eight hours per week...."* (Id).

The MassHealth representative testified that in order to be deemed "working disabled" for CommonHealth eligibility, the work cannot be volunteer work. Because the letter from the Town of clearly states that Appellant is a volunteer, MassHealth refuses to credit this time towards the 40 hour monthly minimum needed to be deemed "working disabled" for CommonHealth eligibility purposes.

Appellant appeared on her own behalf by telephone along with a representatives from MetroWest Legal Services.

Appellant asserts that while the Town of might have chosen to use the term "volunteer" it does not negate the fact that she is in fact compensated for her work. Appellant asserted that she is not working for free which would constitute volunteer work. She testified that she is only working to obtain the $812 per year credit off of her property taxes which she believes constitutes compensation. Appellant filed documentation including a W-2 wage and tax statement for federal tax return 2010; an

independent work statement of employment; a copy of IRS instructions for box 1 wages tips another compensation and copies of MassHealth regulations 506.003(A)(1) 519.012(A) and 505.004(B)(2)(3)(4).

Findings of Fact

By a preponderance of the evidence, I find the following:

1. Appellant is a 65-year-old female who lives alone in the community.

2. Prior to February 23, 2011, Appellant had been receiving MassHealth Standard benefits as a disabled working adult.

3. Through a notice dated February 9, 2011, MassHealth informed Appellant that her coverage would terminate on February 23, 2011 because she failed to return a completed eligibility review form (Exhibit A).

4. MassHealth ultimately received the missing review form on February 28, 2011.

5. On February 28, 2011, MassHealth issued a notice to Appellant informing her that as of February 1, 2011 she would be eligible for MassHealth Buy-In benefits (Exhibit A).

6. Appellant's countable income includes $1,045.00 from Social Security and $13 earned income for a total of $1058.00.

7. Appellant works 13 hours per month earning one dollar an hour as a homemaker.

8. Appellant also works for the Town of as part of a "senior work off program" which reduces Appellant's annual property taxes by $812.00.

9. A letter from the Town of dated January 20, 2010 states Appellant *"does not receive any direct compensation for said services..... [t]he benefit from the program is a credit off of the property taxes assessed to the individual; the calculation is based on a specific number of volunteer hours"* (Exhibit B).

10. A second letter from the Town of dated January 24, 2011 states that Appellant *"volunteers eight hours per week...."* (Id).

11. MassHealth did not credit Appellant the hours worked for the Town of for MassHealth CommonHealth eligibility purposes because MassHealth determined the work constitutes volunteer work.

12. Appellant received an IRS W2 wage and tax statement for federal tax return 2010 relative to her work for the Town of .

13. Appellant reports the income earned from her work for the Town of to the IRS for tax purposes.

Analysis and Conclusions of Law

The "working disabled" component of CommonHealth eligibility is governed by regulations 130 CMR 519.012(A) and 505.004(B). Neither section distinguishes volunteer work from compensable work. However, 130 CMR 505.004(B) does use the term "employed" which does support MassHealth's position that the work at issue must be compensable and not volunteer since one is not "employed" when they volunteer.

Nevertheless, in this case, I find that as a matter of fact Appellant is not volunteering her work to the Town of Appellant is working to be compensated by the town. Appellant works for the Town, and the town remunerates her in the form of a property tax reduction; therefore, Appellant is not working for free (as a volunteer would work). Instead, Appellant is, in some manner or degree, employed by the town.

It doesn't make a bit of difference that the Town of chooses to refer to Appellant a volunteer. The controlling fact is that Appellant is compensated financially for the services she provides to the Town. Accordingly, she is not a "volunteer" despite what the Town has chosen to call her.

The $812.00 per year that Appellant is compensated by the Town of for the work she provides to the Town is earned income pursuant to 130 CMR 506.003(A). Appellant's 8 hours per week of work for the Town of [redacted] is countable toward the 40 hours per week needed to be "working disabled" for MassHealth eligibility purposes. Together with the 13 hours per month that Appellant works as a homemaker, Appellant satisfies the "working disabled" requirement of CommonHealth eligibility.

Order for MassHealth

- Rescind notice of February 28, 2011.
- Recognize Appellant's work for the Town of (related to the senior work off program) as "work" for CommonHealth eligibility purposes.
- Reinstate Appellant's CommonHealth eligibility as of February 28, 2011 (the date she filed the eligibility review form).

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings at the address on the first page of this decision.

Kenneth Brodzinski
Hearing Officer
Board of Hearings

cc:

MassHealth Representative: Sherry Anderson
Appellant Attorney: Fran Bakstran

Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Rehearing Appeal Decision:	Approved	**Rehearing Appeal Number:**	0709401.rehearing
Decision Date:	FEB 0 6 2008	**Rehearing Date:**	02/01/2008
Director:	Kim M. Larkin		

Appellant Representatives:
Linda Landry, Esq., Disability Law Center (DLC); [redacted] mother

Witnesses:
Ellen Macasieb, RN, Clinical Director, Family Lives; Kristina M. O'Connell, RN; Karen J. Fitton, RN; Leonel Rodriguez, MD, MS

MassHealth Representatives:
Kay M. George, RN, Assoc. Dir. UMMS Community Case Management (CCM); Julie Meyers, MD, Medical Dir., UMMS, CCM

Witnesses:
Mary Brooks, RN, Case Manager (CM), UMMS, CCM; Jean Hendrix, RN, CM, UMMS, CCM; Jane Ryan, Dir., UMMS, CCM Program

Observing:
Santa Diaz, Appeals Coordinator, UMMS, CCM

Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
Two Boylston Street
Boston, MA 02116

REHEARING DECISION

Rehearing Appeal Decision:	Approved FEB 0 6 2008	**Issue:**	Prior Authorization Continuing Skilled Nursing Services, Complex Case Management
Decision Date:		**Rehearing Date:**	02/01/2008
MassHealth Reps.:	Kay George, RN, Assoc. Dir. UMMS, CCM; Julie Meyers, MD, Med. Dir., UMMS, CCM	**Appellant Rep.:**	Linda Landry, Esq., DLC; Mother
Hearing Location:	China Trade Center	**Aid Pending:**	Yes

Authority

This rehearing was conducted pursuant to 130 CMR 610.091.

Jurisdiction

Through notice dated July 11, 2007, MassHealth through its agent UMMS Community Case Management (CCM) modified the appellant's prior authorization (PA) request for continuous skilled nursing services (CNS) to 136 hours per week for 1 month, then to 124 hours per week of CNS for 1 month and to 112 hours for 8 months (Exhibit 1). The appellant filed this appeal in a timely manner on July 19, 2007 (see 130 CMR 610.015(B); and Exhibit 2). Modification of a request for prior authorization is valid grounds for appeal (see 130 CMR 610.032).

Appellant has been afforded aid pending the outcome of the rehearing (130 CMR 610.091(D)).

The appellant's hearing was held on August 2, 2007 and the hearing decision issued on October 16, 2007 denying the appellant's appeal (Exhibit 3). The appellant made a timely request for a rehearing of Appeal No. 0709401 to the Medicaid Director on November 20, 2007 (Exhibit 4).

On December 21, 2007, the Medicaid Director ordered the Director of the Board of Hearings to

conduct a rehearing of Appeal No. 0709401 (Exhibits 4 & 7). The Medicaid Director's order states the issue for rehearing is the correct application of the MassHealth Early and Periodic Screening, Diagnosis and Treatment (EPSDT) regulations (130 CMR 450.140 *et seq.*), in determining the number of medically necessary hours of private duty nursing services (PDN)[1] the appellant should receive (Id.).

A rehearing was scheduled for January 14, 2008 (Exhibit 8). A prerehearing order issued on December 28, 2007 and the parties complied with the submission of Exhibits 10 & 11. Due to the illness of the director, the rehearing was rescheduled to February 1, 2008 after notice to the parties (Exhibits 12 & 14).

Action Taken by MassHealth

MassHealth, through its designee, UMMS CCM, determined the medically necessary hours for continuous skilled nursing services and modified the appellant's prior authorization request from 136 hours per week to 136 hours per week for one month, 124 hours per week for one month to 112 hours per week for eight months.

Rehearing Issue

The appeal issue is whether MassHealth was correct, in determining the medically necessary hours of continuous skilled nursing services (CNS) the appellant should receive.

Summary of Evidence

MassHealth was represented by the Associate Director of the Community Case Management (CCM) unit through UMMS (Exhibit 10 at Tab A pp. 1-3). The associate director[2] is a registered nurse with multiple years of both clinical and administrative nursing health care experience (Id. at p. 2-3). CCM is a MassHealth program that authorizes and coordinates services for children under the age of 22 that require two or more hours per day of continuous nursing services[3] to remain safely at home. Additionally, CCM provides case management for complex care members, including service coordination (130 CMR 403.412 & 414.411). CCM determines the medical necessity for all long term care services for these children, the most medically fragile children in Massachusetts. CCM has assessed 1035 children for the program since its inception in 2003 and has enrolled 999; there are currently 605 CCM members.

---

[1]Private duty nursing is the term used to describe nurses that provide skilled nursing care either through a home health agency or by an independent nurse (*see specifically,* 130 CMR 403.400 *et seq.* and 130 CMR 414.000 *et seq*). Continuous skilled nursing care services are defined as a nurse visit of more than two continuous hours of nursing services (130 CMR 403.402 – Definitions).

[2]*Curriculum Vitae* Kay M. George, RN, Exhibit 10 at Tab A.

[3] 130 CMR 403.412(A)(1) & 414.411(A)(1).

Enrollment into CCM begins with a needs assessment, an in-person visit, a member focused clinically appropriate service plan that provides a single port of entry for access to community long term care services (CLTC), an expedited prior authorization (PA) process, case management participation in hospital and institutional discharge planning, insurance identification/referral, and case collaboration with other care providers (Testimony). CCM pediatric RN case managers[4], with the support of the CCM multidisciplinary team[5], assess the medical needs of the child and based on each child's unique needs, develops, authorizes and coordinates the long term care services needed to support each child safely in his or her home (Testimony).

CCM received an initial referral for the appellant on April 23, 2004 when the appellant was almost 2 years of age[6] (Exhibit 10, Tab G at p. 1). Appellant's rehearing submissions provided by the parties reveal appellant is a 5 year old female, who resides at home with her parents and two siblings (Exhibit 10 at Tab G p. 15). Appellant was born at 37 weeks gestation by emergency cesarean section after a pregnancy complicated by threatened preterm labor requiring cerclage and bed rest (Exhibit 11 hand numbered document 3 at p. 1). Early on, appellant evidenced problems with feeding and intestinal pseudo-obstruction (Id.). Appellant developed choking with feedings, reflux, severe aspiration, and slow gastric emptying (Id.). At the age of a year and a half, abnormal swallowing studies and failure to thrive required placement of a gastrointestinal tube (g-tube) (Id.). Despite a fundoplication, appellant continued to vomit and aspirate, as well as fail to thrive, necessitating placement of a jejunostomy tube (j-tube) and a central line for the delivery of total parenteral nutrition (TPN) (Id.). Appellant is currently only able to tolerate approximately 2 ½ ounces of j-tube feedings per 24 hours. Over the years appellant has suffered from pancreatitis, gall bladder disease and has an ileostomy (Id.). Appellant was initially noted to have developmental delays and gastrointestinal problems, but her conditions have progressed to include abnormal neurological findings (history of seizures), abnormal respiratory conditions (prolonged hyperventilation and apnea), and abnormal cardiac findings (prolonged QT). Appellant's current medical conditions include mitochondrial dysfunction, complex I and III deficiency, a seizure disorder, chronic intestinal pseudo-obstruction, newly diagnosed Rett syndrome with prolonged QT (Id.). The appellant is alert, non-verbal, non-ambulatory, dependent for nutrition via TPN and through j-tube feedings, incontinent of bladder and is unable to perform activities of daily living

---

[4]Appellant's case manager Mary Brooks, RN, participated in the hearing by telephone. Her resume appears in Exhibit 10 at Tab C.

[5]Ms. George testified to and the program descriptions outlines that the team consists of advanced trained clinicians (both physicians and registered nurses) with experience and expertise in managing complex pediatric patients (*see* Exhibit 10 at Tab E).

[6]Appellant has been eligible for MassHealth Standard coverage since October 1, 2003 and was determined eligible for the Kaileigh Mulligan Program on September 1, 2005 (Exhibit 16 – Copies of MMIS eligibility screen a regulations 130 CMR 519.007; 403.000; 414.000; 450.144; and 450.204). The Kaileigh Mulligan Program is a MassHealth home- and community- base service benefit for individuals who would be institutionalized if they were not receiving home and community based services. The Kaileigh Mulligan Program enables severely disabled children under the age of 18 years to remain at home when care provided outside an institution is appropriate and no more costly that institutional care (130 CMR 519.007). CCM did not challenge that the care through CNS is not appropriate or that there is a less costly comparable alternative (130 CMR 450.204)

(ADL) or instrumental activities of daily living (IADL). She has AFOs for both legs, a wheel chair, tumble chair and a gait trainer (Exhibit 10, Tab L at p. 4). The appellant is currently unable to roll or sit independently she has some motor planning, and is holding her head up, but has noted head lag (Testimony). Appellant receives one hour twice per week of physical therapy (PT) services, one hour twice per week of speech therapy and one hour per week of occupational therapy (OT) services (Testimony). Appellant also has in-home education twice per week and travels for planned MD appointments on Thursday (testimony).

Appellant was initially approved for 56 hours per week of CNS. Appellant's CNS needs increased and in early 2005 she was receiving 112 hours per week of CNS. In December 2005, appellant's condition was complicated by repeated hospitalization and the CNS hours were increased to 136 hours per week. An assessment in May and October of 2006 continued CNS at 136 hours per week due to repeated episodes of sepsis and respiratory problems (prolonged apnea).[7] An annual reassessment was completed on May 5, 2007 and is the plan that is at issue in this rehearing.[8] Appellant's assigned CCM case manager completed a home visit and reassessment and determined the appellant to be eligible for 112 hours per week of continuous skilled nursing and approved 136 hours per week for one month, 124 hours per week for one month and 112 hours per week for eight months (CNS) (Exhibit 10 Tab G at p. 7).

The CCM representative testified that it determines the medical necessity of CNS pursuant to 130 CMR 450.204, utilizing the nursing service regulations (130 CMR 403.00; 414.000), and the early and periodic screening, diagnosis and treatment services regulations. The CCM representatives (the associate director and medical director[9]) also testified that as a policy or guideline, CCM does utilized 112 hours per week when defining the complexity of the individual's need for CNS hours, not as a maximum.[10]

According to the CCM representative, CCM conducts an unbiased medical necessity needs assessment of the appellant for her CCM service plan. The assessment included a review of the appellant's diagnoses, past medical history, prescribed medications, body system by system review, and identification of other service needs (Exhibit 10, Tab G). Nursing notes and requests and justifications were obtained and the appellant's circumstances were presented to the CCM multidisciplinary team that includes nine pediatric RN case managers, a pediatrician, respiratory therapist, physical therapist and a social worker (Id.).[11] CCM reviewed two months of nursing

---

[7] The exact number of nursing hours approved for appellant's CNS over the years was a bit confusing but was ultimately clarified by Jane Ryan, Director, UMMS, CCM program.

[8] Although it was clear that appellant's representative appeal was based on a challenge to the decrease in nursing hours, because the request for CNS hours by the home health agency or independent nurse provider are the hours proposed by CCM's comprehensive plan allows, it was unclear how many hours of CNS per week appellant was requesting. While there was a mention in filings by CCM that appellant was seeking approval for 168 hours per week, after discussion, appellant's representative stated that she believes appellant has demonstrated the medical necessity for 136 hours per week of CNS.

[9] *Curriculum Vitae* Julie Meyers, MD, Exhibit 10 at Tab B.

[10] CCM representatives testified to this position after inquiry by the hearing director.

[11] *See* Exhibit 10 Tabs A-D for professional resumes and/or curricula vitae of CCM staff that testified at

notes, which Ms. George testified provide a good picture of the clinical status of the CCM member.

CCM testified to its review of the appellant's clinical needs after an assessment of appellant's neurological, respiratory, cardiac, gastrointestinal, and musculoskeletal systems and documented nursing needs that flow from the system alterations. It was CCM's determination that appellant's system review reveals that appellant's seizures are managed with medication, appellant is noted to have apnea episodes approximately every 10 seconds that resolve without intervention, she uses 1 liter of oxygen via mask at night and her oxygen saturations are 99% with or without oxygen. Appellant has been receiving nebulizer treatments on an as needed basis. Appellant's cardiac status reveals appellant has a history of hypotension that is treated with IV fluid replacement, but none was needed in recent months. Appellant's nursing hours were increased for a period of 24 hours to allow continuous monitoring when medication was trialed for the newly diagnosed prolonged QT. Appellant's representative testified that a defibrillator is now in the home. CCM was aware of a prescription for the defibrillator, but not its delivery. Appellant's GI status review revealed appellant is not taking anything by mouth, she receives TPN 18 hours per day, lipids three times per week, IV NS bolus 4x/day (200 cc over 2 hours), and Vivonex 37.5 cc via the j-tube twice per day. Appellant requires frequent venting of her g-tube and approximately 2 days per week she tolerates the feedings, 5 days per week she does not. Appellant has an ileostomy, the pouch is vented and emptied several times per day and the pouch is changed twice per week.

CCM's determination was that the appellant met the criteria for CNS and the CCM program per MassHealth regulations (130 CMR 403.000; 414.000; and 450.204). CCM testified that while the appellant is a medically fragile child with multiple medical conditions, the nursing notes evidenced that past CNS hours were increased and approved because of appellant's unstable GI status (frequent episodes of sepsis, poor progression in j-tube feeding tolerance), unstable respiratory status (apnea) and neurological status (seizure activity) that have since improved to a point where appellant requires fewer and/or less frequent nursing interventions. CCM also noted that the number of hospitalizations had decreased from 12 emergency room visits and 7 inpatient admissions to two inpatient admissions in the last year. CCM determined appellant evidences the medical need for 112 hours per week of CNS and drafted a plan to decrease the CNS hours from 136 to 124 then to 112. CCM contacted appellant's physician, Dr. Fox, who noted his objections to a decrease in nursing hours and CCM completed a second review and presentation to the CCM team, who again confirmed the service plan.

CCM testified that the goal of the CCM program is to assist families to keep their complex medically fragile child at home. And while appellant indeed has many nursing needs, her current number of hours provide for 19 ½ hours per day of CNS with the family responsible for 4 ½ hours of care per day. It is CCM's determination after its assessment and members of the CCM team reviewing the appellant's status during home visits, that 112 hours per week of CNS is medically necessary. CCM testified that appellant demonstrates fewer skilled nursing intervention needs as she has demonstrated some improvement and that 112 hours per week will reasonably prevent the worsening of her condition. CCM noted that if there is a change in appellant's condition, the hours

---

hearing.

can be increased to address that change (just like an increase was approved for the medication trial in treatment of the newly diagnosed prolonged QT).

CCM attached a summary of the appellant's daily and weekly schedule that was submitted at the original hearing.[12] It is a summary of activities appellant requires related to accessing the double lumen central line for medication administration, dressing changes, TPN/lipid infusions, saline boluses, and blood draws; j-tube feedings, j-tube and g-tube care; oxygen administration; bathing; ileostomy pouch changes; PT, OT and speech schedule, MD appointment schedules; monitoring vital signs; and infection control.

Appellant was represented by her mother accompanied by legal counsel. They offered the testimony of 2 treating registered nurses, one nursing service provider manager and one of her treating physicians. Appellant's attorney argues that the appellant has received approval from CCM for CNS hours above a maximum of 112 hours by meeting the emergency short term criteria and has not had an evaluation that applies the CNS regulations in compliance with EPSDT regulations[13] to determine how many hours of CNS are medically necessary (Exhibit 4). Appellant's mother offered that she has been educated and trained to provide care for a number of appellant's complex needs. However, she lacks the assessment skills to determine what the appellant may or may not need to address many clinical situations that could be life threatening to the appellant. For example she often is unable to obtain a blood pressure reading and can therefore not make a determination on the need for fluid replacement. She has not been trained and is not clear on the use of a defibrillator or the potential for having to perform straight catheterizations to address her daughter's persistent and increase in urinary tract infections. She argues that she is addressing her daughter's needs to the extent she is able and believes to safely continue to have her daughter at home and a part of the family, the CNS must continue at the current level.

Appellant's counsel argues specifically that the appellant has demonstrated the need for 136 hours of CNS because the number of CNS hours allows active treatment and prevention, and are responsible for some of appellant's stability as compared to one year ago, and the hours are responsible for preventing hospitalizations (Id.). The appellant's physicians argue that the appellant is one of the most severely affected children with the diagnoses she carries, has complex medical needs and is at risk for life threatening events such as aspiration, seizures, infection (particularly of concern because of the central line) and dysautonomic phenomena (cardiac and/or respiratory arrest) (Id.). Additionally, the appellant's testifying physician noted that appellant's disease processes have unfortunately progressed and there is no noted improvement (Testimony of Dr. Rodriguez). Dr. Rodriguez noted that appellant's disorders result in metabolic and immune dysfunction. In fact, Dr. Rodriguez offered "appellant has chronic conditions that will not improve", and that in his "medical opinion [appellant] meets both requisites of the definition [of medical necessity] her current care is necessary to '...prevent, diagnose, prevent worsening of,

[12] It is unclear who created the document or from where the information was obtained.

[13] Federal Medicaid provisions related to EPSDT regulations allow for services that have been determined to be medically necessary to be provided without regard to any quantitative limits in state regulations (*see* 42 USC §1396d(r)(5)). Massachusetts has codified the federal provision in 130 CMR 450.144(A)(1)(b)).

alleviate conditions in the member that endanger life, threaten to cause or aggravate a handicap or result on (sic) [in illness or] infirmity.... and any decrease on (sic) her services will cause complications and also on the other important requisite of 'no site or service comparable in effect, available and suitable for the member' unless we return to the frequent acute hospitalizations that she had in the previous years" (Exhibit 11 at hand numbered document 1 at p. 1). The only change in appellant's condition is that she had a decrease in the number of inpatient admissions and that may be due in part to the creation of the ileostomy and decrease in the number of episodes of sepsis, as well as the skilled care she is receiving. A decrease in the number of hospitalizations does not however change appellant's skilled needs. According to Dr. Rodriguez, appellant's respiratory problems are a direct result of her brain driving this erratic pattern, her GI and neurological issues are a presentation of her conditions as is the newly diagnosed cardiac difficulties; all currently unstable.

Appellant's mother argued that a review of two months of nursing notes is not sufficient to get a true picture of appellant's conditions. That in fact, appellant's condition has not stabilized and she demonstrates significant nursing needs in all systems.

Appellant's treating registered nurses testified to the appellant's current skilled nursing needs by presenting a systems review and disputed some of the assessment by CCM. Appellant's treating day nurse testified that appellant's neurological status is not at all clear. There are times when appellant appears not to respond and/or has noted periods of increased seizure activity compared to her last review. This recent change has not been defined well and there is concern regarding the amount of antiseizure medication absorption. As to the respiratory status, appellant's prolonged persistent periods of apnea have increased, with an increase in respiratory distress requiring oxygen blow by and use of oxygen via mask for periods of time other than at night. Appellant's most recent hospitalization was due to acute respiratory distress and appellant is now ordered for CPT 6 times per day around the clock, and is receiving Atrovent and Flovent 4x, and 2x per day respectively (they used to be administered as needed) and saline nebulizer (due to the appellant's prolonged QT, she cannot tolerate the nebulizer with Albuterol). Appellant's GI status has also not improved. Appellant is arguably able to tolerate 2 ½ ounces of j-tube feedings per 24 hours. The number of times that her g-tube is vented has increased and the number of days per week that appellant tolerates the feedings without vomiting is only 2. A trial of decreasing the TPN to potentially increase tolerance of j-tube feedings failed with appellant sustaining rapid weight loss (also raising concern over her ability to absorb). While the problem of hospitalizations for sepsis has improved since the creation of the ileostomy, appellant has had continued GI issues related to poor or no ileostomy output (mechanical obstruction that must be manipulated by MD) or high output (requiring a calculation for fluid replacement). Appellant's cardiac status is not stable, the interventions for management of the newly diagnosed prolonged QT are not defined and the presence of a defibrillator in the home is evidence of the risk from this newly diagnosed cardiac problem. Appellant has unfortunately lost mobility and even in the past two weeks is evidencing fewer abilities in purposeful movement particularly rolling and sitting. Appellant has a history of biting tubing and manipulating equipment and must be supervised at all times.

Appellant's attorney argued that appellant has identified the need for 136 hours of CNS and that

appellant has skilled nursing service needs that must be provided by a registered nurse due to the complexity of the appellant's conditions (*citing*, 130 CMR 403.420(B)(1-6)). Appellant's skilled care involves both nursing interventions and skilled assessments to provide correct interventions and prevent or minimize possible exacerbations and crises, a component of MassHealth's medical necessity standard (Exhibit 4 at pp. 4-5). Dr. Rodriguez testified that while he was not aware of exact number of hours of CNS he is acutely aware of his increased ability to manage the appellant's needs at home and decrease the number of acute hospitalizations and does not support a decrease in the CNS service plan and would find it detrimental to the appellant.

Findings of Fact

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

1. MassHealth's CCM program received an initial referral for the appellant on April 23, 2004 (Testimony).

2. Appellant is a 5 year old female, who resides at home with her parents and two siblings. (Exhibit 10 Tab G at p. 15).

3. Appellant was born at 37 weeks gestation by emergency cesarean section after a pregnancy complicated by threatened preterm labor requiring cerclage and bed rest (Exhibit 11 hand numbered document 3 at p. 1).

4. Early on, appellant evidenced problems with feeding and intestinal pseudo-obstruction (Exhibit 11). Appellant developed choking with feedings, reflux, severe aspiration, and slow gastric emptying (Id.). At the age of a year and a half, abnormal swallowing studies and failure to thrive required placement of a gastrointestinal tube (g-tube) (Id.). Despite a fundoplication appellant continued to vomit and aspirate, as well as fail to thrive, necessitating placement of a jejunostomy tube (j-tube) and a central line for the delivery of total parenteral nutrition (TPN) (Id.).

5. Over the years appellant has suffered from pancreatitis, gall bladder disease and underwent bowel surgery and the creation of an ileostomy (Exhibit 11.).

6. Appellant has developmental delays with abnormal neurological findings (history of seizures, inability to sit, roll, ambulate), abnormal respiratory conditions (intermittent hyperventilation and apnea, with recent respiratory distress), and cardiac findings (prolonged QT) (Exhibit 11).

7. Appellant's medical conditions include mitochondrial dysfunction, complex I and III deficiency, seizure disorder, chronic intestinal pseudo-obstruction, newly diagnosed Retts syndrome and prolonged QT (Id.).

8. The appellant is alert, non-verbal, non-ambulatory, dependent for nutrition via TPN and through j-tube feedings, incontinent of bladder and is unable to perform activities of daily

living (ADL) or instrumental activities of daily living (IADL).

9. The CCM program determined the appellant to be eligible for CCM program services and completed a service plan initially approving 56 hours per week of CNS in 2004.

10. From 2004 to the winter of 2005, appellant's CNS hours increased from 56 hours per week to 136 hours per week.

11. Prior to the current evaluation of May 5, 2007, the appellant was receiving 136 hours of CNS paid for by MassHealth and her care needs had last been reviewed in August 2006. The current plan at issue demonstrates a gradual reduction in CNS from 136 to 112 hours over a 2 month period.

12. CCM utilized two months of nursing records, medical records, CCM to appellant physician contact and presentation to the CCM team (twice) to determine appellant demonstrates the medical necessity for 112 hours per week of CNS.

13. CCM determined appellant's medical condition, particularly her respiratory and gastrointestinal system issues had improved or stabilized and appellant required fewer nursing interventions to support its determination.

14. Appellant's neurological status is impaired with a history of developmental delays, frequent seizures and delay/loss of developmental milestones. Appellant's neurological status is assessed for an increase in seizure activity and loss of function. Appellant's treating nurse reports it is difficult to assess if appellant is suffering a seizure or a dysautonomic event and intervention planning can be critical and difficult.

15. Appellant experiences frequent prolonged breath holding and persistent prolonged periods of apnea. This is a direct result of her disease. In the past, appellant's respiratory medications and CPT were ordered as needed. For the 2 month period CCM reviewed appellant's nursing records, CCM determined appellant required no as-needed nebulizer treatments or CPT. Appellant's oxygen saturations were in the 99% range with or without oxygen and no specific intervention was required for the apnea episodes.

16. Appellant's period of breath holding and apnea have increased and over the period from the last review to the date of rehearing, appellant has required oxygen during the day as well as at night, her most recent hospitalization was due to acute respiratory distress and her respiratory regime has changed from as-needed to administration of inhalers 2 to 4 times per day, CPT 6 times per day around the clock and saline nebulizer treatments. Appellant's newly diagnosed cardiac condition, prolonged QT limits the respiratory medication appellant can receive.

17. Appellant has newly diagnosed prolonged QT (can result in a severe arrhythmia and instant death). A medication trial was started and the medicine discontinued based on appellant's complex medical diagnoses. A defibrillator has been delivered to appellant's home and a

process for use will be established.

18. Appellant's mitochondrial disorder can be characterized as a disorder of metabolism and immunity.

19. Appellant has recently lost some developmental gains and is no longer able to roll, she is unable to sit independently, although she has motor planning skills, she is unable to ambulate and while she can hold up her head she has head lag.

20. Appellant will pull and bite on tubes, etc. and requires constant supervision.

21. Appellant receives PT for 1 hour twice per week, OT for one hour once per week and speech therapy for 1 hour twice per week.

22. Appellant has educational services at home for two hours twice per week.

23. Appellant has AFOs for her lower extremities, a wheel chair, tumble chair, and a gait trainer.

24. Appellant takes no food by mouth, receives TPN 18 hours per day, lipids 3x per week, via a double lumen central line and is currently tolerating 2 ½ ounces of j-tube feedings per day. Appellant's GI distress continues with a noted increase in g-tube venting and tolerance of j-tube feedings 2 out of 7 days.

25. Appellant's medications are delivered via the central line or j-tube.

26. Appellant receives four 200 cc NS boluses per day and can require additional fluid replacement depending on her BP and ileostomy output.

27. The appellant has limited unskilled needs that can be met by an educated adult (e.g., assistance with bathing, grooming, and mouth care).

28. The appellant has the need for assistance with the use of and adjustment of her durable medical equipment (wheel chair, stander, etc.) and AFOs. These are unskilled needs that can be met by an educated adult.

29. Appellant's skilled needs arise from her neurological, respiratory, cardiac, gastrointestinal, urinary and muscular skeletal systems.

30. Appellant's skilled nursing needs include nursing intervention and assessment of (1) breathing, breathing patterns, periods of apnea, breath sounds, performance of CPT, administration of respiratory medications including the nebulizer, obtaining and assessing oxygen saturation, the administration of oxygen; (2) measuring blood pressure, fluid volume, heart rate and rhythm, use of defibrillator; (3) monitoring bowel sounds, g-tube and j-tube care, monitoring weight, caloric intake, TPN prep, lipid prep, blood draw, evaluation of blood

results, aspiration precautions; (4) urinary monitor output, color, odor, culture, and the question of a need for intermittent catherization; and (5) PT, OT and speech, monitoring skin integrity. Appellant's skilled needs also include sterile central line dressings, g-tube and j-tube dressings, ileostomy pouch care and infection control.

31. Appellant's nursing service providers have built into appellant's plan of care education and training of her parents.

Analysis and Conclusions of Law

Pursuant to 130 CMR 403.410 and 130 CMR 414.408(B), for nursing services to be authorized by MassHealth, there must be a clearly identifiable, specific medical need for nursing services. To establish eligibility for continuous nursing, the member must have a medical condition requiring continuous skilled nursing care that includes documentation of assessment, intervention, the teaching of the member and/or family members or other caregivers who are caring for the member and evaluation of clinical outcomes (130 CMR 414.409(E)). A MassHealth member, under the age of 22 at enrollment, whose medical needs, as determined by MassHealth or its designee, are such that he or she requires a nurse encounter of more than two continuous hours of nursing services to remain in the community is a complex care member (130 CMR 403.402; 414.402). Enrollment in CCM is automatic for members under the age of 22 who require a nurse encounter of more than two continuous hours of nursing (130 CMR 403.412(A); 414.411(A)(1)). The elements of the comprehensive needs assessment are set forth at 130 CMR 403.412(A)(2) and 414.411(A)(2). For complex care members, MassHealth or its designee, in this instance CCM, provides case management that includes service coordination with home health agencies as appropriate (130 CMR 403.412; 414.412((B)).

MassHealth's regulatory mandate for case management is to ensure that complex care members are provided with a coordinated community long term care service (CLTC) package that meets the member's individual needs and ensures that MassHealth pays for home health and other CLTC services only if they are medically necessary in accordance with 130 CMR 403.410 and 414.408. Pursuant to 130 CMR 450.204, a service is medically necessary if:

> (1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
> (2) there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the Division. Services that are less costly to the Division include, but are not limited to, health care reasonably known by the provider, or identified by the Division pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.

(130 CMR 450.204(A)(1)(2)).

Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality. A provider must make those records, including medical records, available to MassHealth upon request (See 42 USC 1396a(a)(30) and 42 CFR 440.230 and 440.260).

MassHealth pays for nursing services based only on the nursing care needs of the member and not on the availability or unavailability of the member's family or primary care giver unless the exceptions of 130 CMR 414.409(L)(2) or 414.416 are met.[14] When a family member or other caregiver is providing services that adequately meet the member's needs, it is not medically necessary for an independent nurse to furnish such services (130 CMR 414.409(H)).

MassHealth through its designee CCM is required to assess and approve the amount of nursing services based on the level of skilled nursing care it determines to be medically necessary for the member (*see specifically*, 130 CMR 403.420(B), 414.408). CCM determined that 112 hours per week of CNS are medically necessary to treat appellant's conditions in accordance with 130 CMR 414.409(D) and 130 CMR 450.204. CCM's determination that a reduction in CNS hours from 136 to 112 is appropriate appears to be based on an improvement in the appellant's condition that CCM measured by a decrease in hospital visits/hospitalizations and a decrease in the need for skilled nursing interventions. However, while there is no evidence that CCM disregarded appellant's skilled nursing needs, the number of hours approved fails to adequately address the skill level required for both this child's skilled nursing intervention and assessment needs. CCM did not contest what the appellant's needs are, and made only a slight reference to whom should provide the appellant's care in the absence of skilled nursing. Additionally, CCM failed to proffer any reasonable medical necessity support. While there was testimony as to the

[14] 130 CMR 403.410(I)(1) and 414.409(K)(2) states MassHealth members may be eligible for on a short-term basis, not to exceed three months, nursing services over the maximum amount [112 hours per week] if such additional services are determined to be medically necessary by the MassHealth agency or its designee, and at least one of the listed criteria is met. As stated at the rehearing, the maximum does not apply to children if there are medically necessary hours above any regulatory maximum and would be covered pursuant to the EPSDT regulations (*see specifically*, 130 CMR 450.144(A)). The CCM representatives testified its reference to 112 hours case is not being used to determine a maximum number of hours rather CCM uses 112 hours as a guideline or policy to denote the complexity level of the needs of a particular CCM member. While I do not have a sufficient factual basis to rule on appellant's counsel's arguments that CCM has been using the regulatory maximum and approving hours above the maximum when appellant meets the criteria for an increase and that CCM has not rendered a determination of what hours are actually medically necessary, without concluding in support of appellant's arguments it is somewhat concerning that even as a guide or policy, the question of whether a maximum number of hours is utilized in a medical necessity determination would appear not to be in compliance with the EPSDT mandate.

first prong of the medical necessity standard, again CCM hinted at, but did not articulate how the second prong of the standard was or was not met. Thus leaving open the question of how the medical necessity determination was reached and supported.

The appellant has several chronic debilitating diseases. Additionally the record overwhelmingly evidences that the extent of or possible medical complications/conditions that have and/or can result from appellant's chronic diseases have presented as acute life threatening events over a period of years and result not only in a change in the amount or type of skilled nursing interventions, but also the level of expertise needed in assessment.

Appellant challenged the CCM determination of the number of medically necessary CSN hours by articulating the clinical facts with the requirements of MassHealth's CNS and medical necessity regulations. First, appellant argued that she meets the clinical criteria for nursing services because of the complexity of the appellant's condition and that there is no current evidence that the services needed by the appellant can be safely and effectively managed by a nonmedical individual without direct supervision of a registered or licensed nurse. While appellant's nursing services providers have included education and training of appellant's caregivers in the plan of care, and appellant's mother demonstrates proficiency in a number of care needs, does not negate the need for direct care and supervision by skilled nursing professionals. Appellant's registered nurse witnesses explained the detailed skilled nursing interventions and clinical assessment needs of the appellant and appellant's testifying physician articulated a solid understanding of the clinical facts when applied to the medical necessity standard. CCM did not dispute the testimony of any of appellant's witnesses.

In conclusion, the appellant has demonstrated the medical necessity for 136 hours per week of CNS. She has met the burden of proof that the CCM determination of medical necessity for a decrease from 136 hours per week to 112 hours per week is not correct and she has demonstrated by a preponderance of the evidence that 136 hours per week is medically necessary. In this unique situation where unfortunately due to the acute presentation of impairments from her multiple chronic medical conditions, skilled nursing services that monitor and assess multiple system functions are diagnosing and preventing the worsening of appellant's condition and while appellant's family members can provide some direct care, there is the need for direct skilled nursing supervision and thus there is no site or service that is comparable (130 CMR 450.204).

The appellant's appeal is APPROVED. Pursuant to 130 CMR 610.091(C) & (D), the rehearing decision supersedes the original hearing decision.

Rehearing Order for MassHealth

Rescind the service plan that calls for a decrease in the number of CNS from 136 to 112 hours per week and approve a service plan for 136 hours of CNS per week.

Implementation of this Decision

If this rehearing decision is not implemented within 30 days after the date of this decision, you should contact CCM. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Office of Medicaid, Board of Hearings, at the address on the first page of this decision.

Kim M. Larkin
Director
Board of Hearings

cc: Thomas Dehner, Medicaid Director
Judy Karp, MassHealth Legal
Appeals Coordinator, PA Unit
Linda Landry, DLC

A CHECKLIST WHEN PREPARING FOR A MASSHEALTH FAIR HEARING

- ✓ The Board of Hearings MUST receive the fair hearing request form within 30 days of the date of receipt of the MassHealth notice.

- ✓ If benefits are terminated or changed and the client would like benefits to continue while the appeal is pending, the appeal MUST be received before the date of action or within 10 days of the date of notice.

- ✓ If there is no notice, the appeal deadline is 120 days from the date of action.

- ✓ The appeal form must be signed by the client, a lawyer or someone with authority to act on behalf of the client.

- ✓ Briefly state the reason for the appeal, indicate whether the client needs an interpreter or any form of accommodations and include a copy of the notice of action.

- ✓ Fax your request for a hearing to 1-617-847-1204 and call within a day or two to confirm receipt.

- ✓ You and/or your client have a right to review the file and any evidence that MassHealth will be using at the hearing.

- ✓ Call MassHealth Enrollment Center at 1-888-665-9993 to review the file.

- ✓ You may also have to contact other agencies, MCO or MassHealth Prior Authorization Unit to get a copy of hearing materials prior to

the hearing. If you are not sure how to obtain a copy contact the Board of Hearings.

- ✓ If needed, request that the Board of Hearings subpoena necessary witnesses.

- ✓ A hearing notice is mailed at least 10 days prior to the hearing. It will give you the date, time and place of the hearing. The notice will also include the name of the MassHealth representative.

- ✓ MassHealth hearings are usually in person but a telephonic hearing can be requested.

- ✓ The hearing is informal and tape recorded.

- ✓ At the hearing, MassHealth will present its case. You will have an opportunity to review documents and cross-examine the MassHealth representative and any witnesses.

- ✓ You will then present your client's case. Your evidence will include documents and witnesses. Witness testimony by phone is allowed.

- ✓ You can ask the hearing officer to leave the record open to submit more evidence or a hearing memo.

- ✓ If your client is successful at the hearing and there was no aid pending, the order will go back to the date of the incorrect decision.

- ✓ MassHealth should notify providers to bill MassHealth for the past period.

- ✓ Your client should be reimbursed for any out of pocket expense while the appeal was pending.

- ✓ If you are unsuccessful at the hearing, you could request a rehearing 14 days from the date of the hearing decision or file a request for judicial review 30 days from the date of receipt of the fair hearing decision or denial of rehearing.

Case Study #1: Person Residing Under the Color of Law (PRUCOL)

Who: The client had End Stage Renal Disease (ESRD) and was in the United States at the discretion of the U.S. Department of Homeland Security (DHS) through a motion to administratively close her deportation case. The provider had concerns about whether MassHealth would pay for services and decided to remove the client from the kidney transplant list until the issue was resolved.

Efforts to get the appropriate coverage: The attorney sent a letter to MassHealth explaining that the client met the criteria for PRUCOL under MassHealth regulations. Based on the client's PRUCOL status, she was eligible for Family Assistance which covers kidney transplants. The appropriate coverage would get the client back on the kidney transplant list.

Resolution: After a couple of advocacy calls with MassHealth Enrollment Center, MassHealth agreed that the client had PRUCOL status and appropriately enrolled her into MassHealth Family Assistance. The attorney then worked with the provider to obtain a guarantee from MassHealth that all services would be covered. The client was put back on the kidney transplant list and had a successful transplant.

Case Study #2: Modified Adjusted Gross Income (MAGI)

Who: The client and her two children were all receiving MassHealth Standard. When her daughter turned 19 years old, MassHealth removed the daughter as a member of the MassHealth household. MassHealth then assessed coverage for the client based on income of a household of two. MassHealth sent her a notice stating that she was no longer eligible for MassHealth because she was over income.

Efforts to get the appropriate coverage: The attorney sent a letter to MassHealth explaining that under the new MAGI rules, the client was financially eligible for MassHealth Standard because her MassHealth household remained a household of three. Under the new rules, the client's 19 year old daughter was a member of the MassHealth household because she was a tax dependent. An appeal was also filed at the same time.

Resolution: MassHealth agreed that it had erred by not applying the new MAGI rules and made the appropriate adjustment. MassHealth then sent a notice approving the client for MassHealth Standard benefits. The appeal request was withdrawn as the matter had been resolved.

Case Study #3: Hearing Decision on Due Process and Premium Assistance[1]

Issue(s): Does MassHealth have grounds to terminate or downgrade the scope of premium assistance for the couple and, if so, did MassHealth follow all proper due process requirements in its attempt to implement the downgrade?

Facts: The appellants were a disabled 65 year old husband and his disabled 57 year old wife. Within two days, MassHealth had sent four different eligibility notices: (1) it had information that employment had ended and therefore the MassHealth Premium Assistance Unit had stopped paying the premium; (2) the husband was eligible for premium assistance but MassHealth would pay $0.00 towards the premium; (3) MassHealth was changing the monthly premium payments to $56.00 because they were no longer eligible for assistance; (4) MassHealth coverage would be downgraded to CommonHealth and they were required to pay $36.40 monthly premium.

There were a few more eligibility notices sent to the couple prior to the hearing. All the notices sent by MassHealth were in regards to a change in the rules as to who was entitled to premium assistance. The couple submitted multiple appeal requests for each notice received but the Board of Hearings consolidated all of the requests into one appeal.

Decision: The hearing officer found that the MassHealth notices were inadequate and did not have a clear reason for the decision to terminate and/or downgrade the premium assistance received by the couple. He ordered MassHealth to continue to pay monthly premium assistance benefits and that any future notice must comply with the Fair Hearing Due Process rules.

[1] See Section V(c)(1) in this Manual for the Hearing Decision.