

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	DENIED	Appeal Number:	2507337; 2507335
Decision Date:	09/04/2025	Hearing Date:	06/16/2025
Hearing Officer:	Sharon Dehmand	Record Open to:	09/08/2025

Appearance for Appellant:



Appearance for MassHealth:

Jenny Chan, Quincy MEC



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

APPEAL DECISION

Appeal Decision:	DENIED	Issue:	Long Term Care; Verifications
Decision Date:	09/04/2025	Hearing Date:	06/16/2025
MassHealth's Rep.:	Jenny Chan	Appellant's Rep.:	[REDACTED]
Hearing Location:	Remote	Aid Pending:	No

Authority

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

Jurisdiction

Through notices dated March 12, 2025, MassHealth denied both appellants' applications for MassHealth long-term care services because MassHealth determined that the appellants did not provide necessary information MassHealth requires to decide the appellants' eligibility within the required time frame. See 130 CMR 515.008 and Exhibit 1A-B. The appellants filed this appeal in a timely manner on May 9, 2025. See 130 CMR 610.015(B) and Exhibit 2A-B. Denial of assistance is valid grounds for appeal before the Board of Hearings. See 130 CMR 610.032(A)(1).

Action Taken by MassHealth

MassHealth denied the appellants' applications for long-term-care services in a nursing facility.

Issue

Whether MassHealth was correct in denying the appellants' applications for MassHealth long-term care benefits pursuant to 130 CMR 515.008.

Summary of Evidence

All parties participated telephonically. MassHealth was represented by a worker from the Quincy MassHealth Enrollment Center. The appellants were represented by their son as their appeal representative who confirmed their identities. The following is a summary of the testimony and evidence provided at the hearing:

The MassHealth representative testified that long-term care applications on behalf of both members of the household were submitted on November 13, 2024. Requests for information were issued on November 26, 2024, which were due back on December 26, 2024. No verifications were submitted. On January 2, 2025, denial notices based on failure to submit the requested verifications were issued by MassHealth. On January 30, 2025, the case was “re-apportioned” and new requests for verifications were sent out. MassHealth received some of the outstanding verifications. Through notices dated March 12, 2025, MassHealth denied both appellants’ applications for MassHealth long-term care services because MassHealth determined that the appellants did not provide necessary information MassHealth requires to decide the appellants’ eligibility within the required time frame. The MassHealth representative stated that the following verifications remain outstanding as of the hearing date:

- 1) Genworth long term care insurance policy effective date/coverage date and daily benefits amount for both appellants;
- 2) ██████████ bank statements for account ending in ██████████ from May 20, 2024 to December 6, 2024 including copies of all cancelled checks for both appellants;
- 3) A current ██████████ insurance policy reflecting the current cash surrender value for the wife;
- 4) A current ██████████ insurance policy reflecting the face value of the policy for the husband;
- 5) A copy of the personal needs allowance (PNA) statement;
- 6) The notification of admission to a nursing facility;
- 7) The nursing facility Screening.

She explained that the last three items would be submitted by the nursing facility.

The appellants’ representative testified that his parents have not been admitted to a nursing facility. He stated that although his mother suffers from advanced dementia, it is ultimately his father’s decision if and when she will be admitted to a nursing facility. He explained that his intent in filing the applications was to secure MassHealth approval for long-term care coverage for both his parents in advance of any admission. He expressed frustration that despite submitting financial documents in good faith and attaching explanatory notes, MassHealth has neither reviewed nor credited his explanations. He believed that the hearing would provide him with an opportunity to demonstrate the efforts he had already made and to obtain a decision, rather than to revisit or discuss what he still had to submit to MassHealth. He stated that his parents have limited resources, that his father’s ██████████ life insurance policy has no cash surrender value, and that

the face value of the policy has consistently been \$50,000. He urged MassHealth to apply common sense, asserting that life insurance policies do not change from year to year and that there should not be a need for updated statements. He reiterated his confusion and frustration with the MassHealth process.

The MassHealth representative responded that even if all available verifications are submitted, the system will issue denial notices because the final three verifications must come directly from the nursing facility after admission. She explained that typically applicants will apply for long term care coverage once they are admitted to a nursing facility. She stated that MassHealth regulations require both financial eligibility and clinical eligibility before approval can be issued. Financial eligibility requires assets not to exceed \$2,000, and clinical eligibility requires admission to a nursing facility and completion of associated forms upon admission. Only when both criteria are satisfied will the system generate approvals. She further clarified that although applicants may file before admission and satisfy the financial eligibility criterion, the system will still generate a denial. They will then have six months to be admitted or else they must reapply. She added that eligibility must be renewed annually, though the renewal process is typically simpler. With respect to the Prudential life insurance policy, she stated that MassHealth regulations require updated documentation, including verification of the current face value, regardless of whether the amount has remained the same.

The appellants' representative agreed to provide the requested verifications. The record was held open until July 18, 2025, for the appellants to submit the missing verifications, and until August 1, 2025, for MassHealth to review and respond. See Exhibit 6, p. 1. On July 8, 2025, the appellants submitted some of the requested verifications. See Exhibit 7. On July 9, 2025, the appellants' representative requested additional time to submit the outstanding items. See Exhibit 8. An extension to the record open period was allowed to August 18, 2025, for the appellant and until September 8, 2025, for MassHealth. See Exhibit 6, p. 3. The appellants submitted additional verifications. The last three items listed on the record open remained outstanding. Through an email on July 28, 2025, MassHealth responded to the appellants' submissions and stated the following:

I have reviewed the check copies and verified bank account ending in [REDACTED]. At the time of the hearing, MassHealth [] stated that the total asset[s] for each applicant cannot exceed \$2,000 when both spouses are applying for long term care. Asset limit for the spouse not entering a long-term care facility is \$157,920.

At this time both applicants' asset[s] exceeded the \$2,000 asset limit. MassHealth will need confirmation if both applicants are applying for long-term care. If one of the applicants is not applying, MassHealth will need a long-term care application withdrawal letter from the applicant. See Exhibit 9, p. 1.

Through an email on July 30, 2025, the appellants' representative responded that he has "spoken

with [his] Dad. [They] will move forward with Mom’s eligibility and forego Dad[‘]s application. Can you please tell me the next process steps?...” See Exhibit 9, p. 2. On the same day, MassHealth representative responded and requested that the appellants “...submit a letter stating the long care term application withdrawal for [the] father. Once [MassHealth has] received the withdrawal letter [it] will process... and a determination will be issued. If the Personal Needs Allowance (PNA), the notification of admission to facility (SC-1) and the Nursing Facility Screening Notification (Screen) are the only outstanding verifications, [you will] receive a deny notice. You will have 6 months from the date of the notice to submit the PNA, SC-1 and Screen to MassHealth. Also after the admission to the facility, you will need to submit the Genworth Long Term care documentation verifying the start of receiving the benefit payments.” See id.

Through an email on July 31, 2025, the appellants’ representative expressed confusion regarding a denial and the requirement for admission into a nursing facility prior to an approval. He expressed dissatisfaction with the rules and requested clarification. See Exhibit 9, pp. 4, 7. No other submissions were received by MassHealth.

Findings of Fact

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

1. The appellants are a married couple, over the age of 65, and live in the community. (Testimony).
2. On November 13, 2024, long-term care applications on behalf of both members of the household were submitted. (Testimony and Exhibit 4).
3. Requests for information were issued on November 26, 2024, which were due back on December 26, 2024. No verifications were submitted. On January 2, 2025, denial notices based on failure to submit the requested verifications were issued by MassHealth. (Testimony and Exhibit 4).
4. On January 30, 2025, the case was “re-applied” and new requests for verifications were sent out. Not all verifications requested were received. (Testimony).
5. Through notices dated March 12, 2025, MassHealth denied both appellants’ applications for MassHealth long-term care services because MassHealth determined that the appellants did not provide necessary information MassHealth requires to decide the appellants’ eligibility within the required time frame. (Testimony and Exhibit 1A-B).
6. MassHealth determined that the following verifications remained outstanding: 1) Genworth long term care insurance policy effective date/coverage date and daily benefits amount for both appellants; 2) ██████████ bank statements for account ending in ████████ from May

20, 2024 to December 6, 2024 including copies of all cancelled checks for both appellants; 3) a current [REDACTED] policy reflecting the current cash surrender value for the wife; 4) a current [REDACTED] insurance policy reflecting the face value of the policy for the husband; 5) a copy of the personal needs allowance (PNA) statement; 6) the notification of admission to a nursing facility; 7) the nursing facility Screening. (Testimony and Exhibit 4).

7. The appellant filed this appeal in a timely manner on May 9, 2025. (Exhibit 2A-B).
8. As of the hearing on June 16, 2025, the appellants had not provided the outstanding verifications enumerated by MassHealth. (Testimony).
9. The record was held open until August 1, 2025, for the appellants to submit the missing verifications and for MassHealth to respond to the submissions. (Exhibit 6).
10. On July 9, 2025, the appellants' representative requested additional extension of time to the record open period which was granted. (Exhibit 6 and Exhibit 8).
11. The record was held open until September 8, 2025, for the appellants to submit the missing verifications and for MassHealth to respond to the submissions. (Exhibit 6).
12. A number of verifications were submitted by the appellants' representative. (Exhibit 7).
13. Through an email on July 28, 2025, MassHealth representative stated:

I have reviewed the check copies and verified bank account ending in [REDACTED]. At the time of the hearing, MassHealth [] stated that the total asset[s] for each applicant cannot exceed \$2,000 when both spouses are applying for long term care. Asset limit for the spouse not entering a long-term care facility is \$157,920.

At this time both applicants' asset[s] exceeded the \$2,000 asset limit. MassHealth will need confirmation if both applicants are applying for long-term care. If one of the applicants is not applying, MassHealth will need a long-term care application withdrawal letter from the applicant. (Exhibit 9).

14. Through an email on July 30, 2025, the appellants' representative responded that he has "spoken with [his] Dad. [They] will move forward with Mom's eligibility and forego Dad['s] application. Can you please tell me the next process steps?..." (Exhibit 9).
15. On July 30, 2025, MassHealth representative responded and requested that the appellants "...submit a letter stating the long care term application withdrawal for [the] father. Once [MassHealth has] received the withdrawal letter [it] will process... and a determination will be issued. If the Personal Needs Allowance (PNA), the notification of admission to facility (SC-1)

and the Nursing Facility Screening Notification (Screen) are the only outstanding verifications, [you will] receive a deny notice. You will have 6 months from the date of the notice to submit the PNA, SC-1 and Screen to MassHealth. Also[,] after the admission to the facility, you will need to submit the Genworth Long Term care documentation verifying the start of receiving the benefit payments.” (Exhibit 9).

16. No other submissions were received by MassHealth.
17. The last three items enumerated in the record open remain outstanding since the appellants have not been admitted to a nursing facility, namely: a copy of the personal needs allowance (PNA) statement; the notification of admission to a nursing facility; and the nursing facility Screening.

Analysis and Conclusions of Law

MassHealth administers and is responsible for delivery of healthcare benefits to MassHealth members. See 130 CMR 515.002. Eligibility for MassHealth benefits differs depending on an applicant’s age. Regulations 130 CMR 515.000 through 522.000 (referred to as Volume II) provide the requirements for non-institutionalized persons aged 65 or older, institutionalized persons of any age, persons who would be institutionalized without community-based services, and certain Medicare beneficiaries. See 130 CMR 515.002(B).

In this case, the appellants are non-institutionalized persons aged 65 or older. As such they are subject to the requirements of the provisions of Volume II. See 130 CMR 515.002.

In order to determine an appellant’s eligibility, it is incumbent upon an applicant to cooperate with MassHealth and provide necessary information for a determination:

515.008: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining other health insurance.

(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within ten days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, assets, inheritances, gifts, transfers of and proceeds from the sale of real or personal property, distributions from or transfers into trusts, address, availability of health insurance, immigration status, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated.

See 130 CMR 515.008.

Here, there is no dispute that MassHealth required additional information to determine eligibility. Despite the request for additional information, ultimately MassHealth did not receive the information required to make a determination. See 130 CMR 516.001(B); Exhibit 1. Notices of denial were sent to the appellants in accordance with the regulations. See 130 CMR 516.001 (C); Exhibit 1A-B.

During the hearing held on June 16, 2025, the MassHealth representative testified that the following items were still outstanding: 1) Genworth long term care insurance policy effective date/coverage date and daily benefits amount for both appellants; 2) ██████████ bank statements for account ending in ██████ from May 20, 2024 to December 6, 2024 including copies of all cancelled checks for both appellants; 3) a current ██████████ insurance policy reflecting the current cash surrender value for the wife; 4) a current ██████████ insurance policy reflecting the face value of the policy for the husband; 5) a copy of the personal needs allowance (PNA) statement; 6) the notification of admission to a nursing facility; 7) the nursing facility Screening. See Exhibit 1A-B and Exhibit 4.

The record was left open until September 8, 2025, for the appellants to submit the outstanding verifications and for MassHealth to respond to the submissions. See 130 CMR 610.004(record open is a period of time determined by the hearing officer that, if allowed by the hearing officer within his or her discretion, permits either party to a fair hearing the opportunity to submit post-hearing documentation, relevant evidence, or legal arguments); Exhibit 6.

During the record open period, the appellants' representative submitted the requested financial verifications. However, since the appellants are not institutionalized, the appellants were unable to submit the last three verifications that would only be generated by a nursing facility. See 130 CMR 456.403(MassHealth pays for nursing facility services only when provided to eligible MassHealth members, subject to the restrictions and limitations in MassHealth regulations); See also 130 CMR 456.407.¹

¹ 456.407: Clinical Authorization of Nursing Facility Services (A) Clinical authorization for nursing facility services may be for a specified or indefinite length of stay. Authorizations for an indefinite length of stay may be subject to review by the MassHealth agency or its agent to ensure that conditions for payment continue to be met. A clinical authorization is required (1) before the first date of service delivery for which the nursing facility is seeking payment from

MassHealth; (2) when a member is transferred from one nursing facility to another nursing facility; (3) when a member who is hospitalized is to be admitted to a different nursing facility than the one the member resided in before the hospital admission; (4) when a member who has been hospitalized for over six months seeks to be readmitted to the nursing facility where the member resided before hospital admission; and (5) when a nursing facility determines that a member has discharge potential, or the member may no longer meet the clinical eligibility criteria described in 130 CMR 456.409. (B) The MassHealth agency notifies nursing facilities, hospitals, physicians or PCPs, and home health agencies of the identity of the agent responsible for authorizing nursing facility services. (C) The referring medical provider must submit the request for authorization of nursing facility services to the MassHealth agency or its agent on behalf of the member. For persons who become eligible for MassHealth while residing in a nursing facility, the facility itself must submit the request for authorization. The request for authorization of nursing facility services must be submitted on the forms required by the MassHealth agency and must include documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs. (D) If the MassHealth agency determines that a member is eligible for nursing facility services, the MassHealth agency will issue a notice that contains the effective date of coverage. Commonwealth of Massachusetts MassHealth Provider Manual Series Subchapter Number and Title 1. Program Regulations (130 CMR 456.000) Page 4-6 Nursing Facility Manual Transmittal Letter NF-63 Date 10/01/23 (E) As a prerequisite for payment, nursing facilities must obtain clinical authorization from the MassHealth agency or its designee for each member or MassHealth applicant for whom the nursing facility provider is seeking MassHealth payment. (F) Clinical authorization determines the medical necessity of nursing facility services as described in 130 CMR 456.409, in accordance with 130 CMR 450.204: Medical Necessity. Approval does not establish or waive any other prerequisites for payment, such as the member's financial eligibility for MassHealth. (G) As part of the clinical authorization process, MassHealth or its designee must assess the member or MassHealth applicant's need for nursing facility services. (H) Requests for authorization for nursing facility services must be submitted to MassHealth, or its designee, in the form and format specified by MassHealth or its designee. (1) A complete authorization request must include all required information, including, but not limited to, documentation of the completed clinical assessment; other nursing, medical, or psychosocial evaluations or assessments; documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of clinical authorization, including additional assessments of the member. (2) In making its clinical authorization determination, MassHealth or its designee may require additional assessments of the member or require other necessary information in support of the request for clinical authorization.

As such, the appellants have failed to provide MassHealth with all verifications needed to determine eligibility simply because they are not yet admitted to a nursing facility. See 130 CMR 515.008(A). An Appellant must provide corroborative information for MassHealth to determine eligibility. See generally 130 CMR 516.001. Accordingly, I find that MassHealth correctly determined that the appellant did not provide the necessary information required to decide eligibility within the required time frame.

For the foregoing reasons, this appeal is DENIED.²

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

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

Sharon Dehmand, Esq.
Hearing Officer
Board of Hearings

cc:

[REDACTED]

MassHealth Representative: Quincy MEC, Attn: Appeals Coordinator, 100 Hancock Street, 6th Floor, Quincy, MA 02171

² Any subsequent MassHealth notices will carry their own separate appeal rights.