

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:

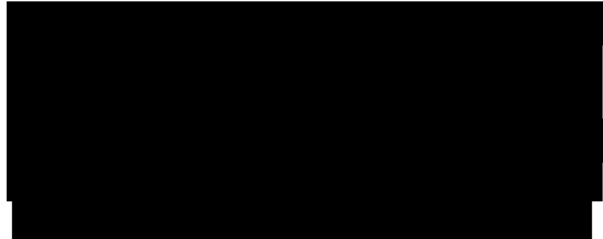


Appeal Decision:	Denied	Appeal Number:	2510184
Decision Date:	09/05/2025	Hearing Date:	08/21/2025
Hearing Officer:	Amy B. Kullar, Esq.		

Appearance for Appellant:

Pro se

Appearances for MassHealth:



Interpreter:



*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:	Waivers; Frail Elder Waiver – Clinical Eligibility
Decision Date:	09/05/2025	Hearing Date:	08/21/2025
MassHealth’s Reps.:	██████████ R.N., <i>et al.</i>	Appellant’s Rep.:	██████████
Hearing Location:	Quincy Harbor South 2 (Telephone)	Aid Pending:	No

Authority

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

Jurisdiction

Through a notice dated June 30, 2025, MassHealth determined that the appellant does not meet the clinical eligibility criteria for the Frail Elder Waiver Program at this time. *See* 130 CMR 456.409 and Exhibit 1. The appellant filed this appeal on July 9, 2025. *See* 130 CMR 610.015(B) and Exhibit 2. This appeal was dismissed by the Board of Hearings on July 10, 2025, because the appellant failed to state a reason for her appeal in her Fair Hearing Request. *See* 130 CMR 610.015(B)(2) and Exhibit 5. The appeal dismissal was vacated by the Director of the Board of Hearings on July 22, 2025, and a fair hearing was scheduled. *See* Exhibits 3 and 5. Clinical eligibility determinations constitute valid grounds for appeal. *See* 130 CMR 610.032.

Action Taken by MassHealth

MassHealth determined that the appellant does not meet the clinical eligibility criteria for the Frail Elder Waiver Program at this time.

Issue

The appeal issue is whether MassHealth properly determined that the appellant does not meet the clinical eligibility criteria for the Frail Elder Waiver Program at this time.

Summary of Evidence

The appellant, an adult living in the community who is over the age of 65, appeared telephonically at the hearing and testified through a Russian interpreter. MassHealth was represented at hearing by four registered nurses, including the Senior Director of Clinical Services (“Senior Director”), from [REDACTED] which is the local Aging Services Access Point (ASAP) that conducted the clinical evaluation of eligibility for the Frail Elder Waiver (FEW) for the appellant.¹ Below is a summary of each party’s testimony and the evidence submitted for hearing:

On June 20, 2025, the appellant, a [REDACTED] woman who lives alone in an apartment in the community, was evaluated at her home for clinical eligibility for the FEW program by one of the registered nurses who was present at the hearing. This R.N./clinical evaluator provided the majority of MassHealth’s testimony. She confirmed that the appellant was assisted by a Russian interpreter throughout the onsite evaluation in June 2025. Testimony. Documentation from the clinical evaluation was submitted by MassHealth prehearing. See Exhibit 6. The written documentation states that on the day of her onsite evaluation, the appellant was observed to be appropriately dressed, and her hygiene was good. Her home was clean and orderly. The appellant “uses no ambulation devices for indoor and outdoor locomotion.” The appellant was oriented to time, place, and people, and the appellant “stated that her memory is normal, but sometimes she is forgetful.” Exhibit 6.

During the evaluation, the appellant reported her current medical issues to include borderline diabetes, arthritis, back pain, vertigo, and chronic migraines. Testimony, Exhibit 6. The appellant’s back pain can become severe at times; this is when the appellant requires assistance with activities of daily living (ADLs) of bathing and dressing, but these episodes do not occur frequently. *Id.* During the evaluation, the clinical evaluator “observed [the appellant] with an independent sit to stand transfer with minimal exertion. RN also observed [the appellant] ambulate from her living room to her kitchen without an assistive device. Her gait

¹ The Frail Elder Waiver (FEW) program, a MassHealth 1915(c) Home and Community Based Services Waiver (HCBS) program operated by the Executive Office of Aging & Independence (AGE), supports individuals who have met Nursing Facility Level of Care and are eligible for MassHealth Standard coverage and who choose to receive their care in the community. Aging Services Access Points (ASAPs) provide initial clinical eligibility determinations for all FEW consumers, ongoing clinical eligibility determinations, and case management for Home Care enrolled FEW consumers. Case management includes coordination of FEW services from a network of providers. See Program Instruction PI-25-02 (<https://www.umassmed.typepad.com/files/pi-25-02-frail-elder-waiver-fewfinal-1.pdf>) Accessed 9/3/2025.

was steady.” Testimony and Exhibit 6. The written documentation from the onsite assessment further states: “[The appellant] denies any difficulty with chewing/swallowing and is continent of bladder/bowel. [The appellant] reported that she is independent with medication management including an injection for migraines which she self-administers. [The appellant] is not receiving skilled services.” Exhibit 6.

The clinical evaluator continued her testimony by explaining the eligibility criteria for the FEW program. To be eligible for the FEW program, a FEW participant must be clinically eligible for nursing facility services in accordance with the MassHealth regulations at 130 CMR 456.409. Testimony. She stated that all FEW participants must have a “need for daily skilled services by a registered nurse or therapist,” which the appellant did not meet. A FEW participant must also require assistance with ADLs such as bathing or dressing; she stated that although the appellant did meet this criterion, the appellant did not meet the last eligibility requirement, skilled nursing services at least three times per week. She explained the third criterion by using an example of the type of services required for FEW eligibility: daily medication management or nursing visits more than three times per week. She explained that the appellant’s medical record states that the appellant only requires a monthly medication injection, which the appellant self-administers; this medication administration can be accomplished through another community-based program such as home health visits or visiting nurses if the appellant is unable to administer her injection herself. Testimony.

The appellant provided testimony in response to MassHealth. The appellant stated that since her evaluation in June 2025, she has experienced a recent decline in her health; her tremors are worsening and she feels that she has more significant mobility issues. She stated that she recently became unable to self-administer her monthly migraine medication injections, and she is now just going to skip them. Testimony. The appellant feels that she needs a visiting nurse more frequently. The appellant needs “more therapy” and she needs help with managing her medications. Testimony. The appellant was frustrated because she had previously received 6 hours weekly in PCA services, but now she is only receiving 2.5 hours in PCA services per week. Testimony. The appellant confirmed that she has not experienced any falls or hospitalizations this year. Testimony.

The Senior Director then clarified for the appellant that this hearing only concerns her current clinical eligibility for the FEW program. [REDACTED] been working with the appellant for over a year to provide her with assistance in the community. The appellant disenrolled herself from the PCA program earlier in 2025, and that is why she is no longer receiving 6 hours of assistance per week. The appellant could be reevaluated at any time for the FEW program if she feels that her needs have increased. Testimony. The Senior Director then stated that the appellant’s case manager at [REDACTED] would be informed of the appellant’s desire to reenroll in the PCA program, and that the appellant would receive assistance with that after this hearing. Testimony. The clinical evaluator then concluded MassHealth’s testimony by emphasizing that the appellant received this FEW denial because the appellant’s need for skilled care does not rise to the “three times per week” threshold required by the

MassHealth regulations. She stated in closing that “eligibility for the Frail Elder Waiver equates to requiring 24/7, or nursing home level, care.” Testimony.

Findings of Fact

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

1. In June 2025, MassHealth conducted an onsite assessment at the appellant’s home to assess her clinical eligibility for the MassHealth Frail Elder Waiver Program (FEW). Testimony and Exhibit 6.
2. One of MassHealth’s testifying nurses was present at the onsite assessment along with a Russian interpreter. Testimony.
3. The appellant is [REDACTED] old and lives in alone in a one-bedroom apartment. Testimony.
4. The appellant’s home was found to be neat and clean with clear pathways for ambulation. Testimony and Exhibit 6.
5. The appellant’s medical history, as reported by the appellant, is significant for borderline diabetes, arthritis, back pain, vertigo, and chronic migraines.
6. The appellant denies any difficulty with chewing/swallowing and is continent of bladder and bowel; the appellant is independent with medication management and can complete daily ADLs. Testimony.
7. The appellant does not require the use of any durable medical equipment (DME). Exhibit 6.
8. The appellant’s gait was noted to be steady. Testimony, Exhibit 6.
9. The appellant is not diagnosed with any cognitive impairments. Exhibit 6.
10. Since the onsite evaluation in June 2025, the appellant is no longer able to self-administer her migraine medication injections. Testimony.

Analysis and Conclusions of Law

The clinical requirements for the MassHealth Frail Elder Waiver program are governed by regulations which are set forth below. As stated therein, the appellant needed to demonstrate

that she meets the specific requirements as set forth in the regulations that she is clinically eligible for nursing facility services. The appellant put forth no evidence that she meets any of the necessary requirements. There is no evidence that she has ever been determined to be permanently and totally disabled in accordance with Title XVI standards or that she requires any assistance with skilled services or nursing services as required by regulation.

The MassHealth regulations governing the Frail Elder Waiver Program, in pertinent parts, state as follows:

(B) Home- and Community-based Services Waiver–frail Elder.

(1) Clinical and Age Requirements. The Home- and Community-based Services Waiver allows an applicant or member who is certified by the MassHealth agency or its agent **to be in need of nursing-facility services** to receive certain waiver services at home if they

(a) are 60 years of age or older and, if younger than 65 years old, is permanently and totally disabled in accordance with Title XVI standards; and

(b) would be institutionalized in a nursing facility, unless he or she receives one or more of the services administered by the Executive Office of Elder Affairs under the Home and Community-based Services Waiver-frail Elder authorized under § 1915(c) of the Social Security Act.

130 CMR 519.007 (emphasis added).

The regulations regarding the clinical eligibility criteria for nursing facility services state as follows:

To be considered clinically eligible for nursing facility services, a member or MassHealth applicant **must require one skilled service listed in 130 CMR 456.409(A) daily, or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C)**, including at least one of the nursing services listed in 130 CMR 456.409(C)...

(A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

- (1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;
- (2) nasogastric-tube, gastrostomy, or jejunostomy feeding;
- (3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;
- (4) treatment and/or application of dressings when the physician or PCP has

prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);

(6) skilled nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);

(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);

(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);

(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and

(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:

- (1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;
- (2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;
- (3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;
- (4) transfers when the member must be assisted or lifted to another position;
- (5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
- (6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. **Nursing services, including any of the following procedures performed at least three times a week**, may be counted in the determination of medical eligibility:

- (1) any physician- or PCP-ordered skilled service specified in 130 CMR 456.409(A);
- (2) positioning while in bed or a chair as part of the written care plan;
- (3) measurement of intake or output based on medical necessity;
- (4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
- (5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental health professional;
- (6) physician- or PCP-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);
- (7) physician- or PCP-ordered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and
- (8) treatments involving prescription medications for uninfected postoperative

or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring.

130 CMR 456.409 (emphases added).

The appellant did not dispute the testimony or findings made by the MassHealth reviewers that were based upon her June 2025 onsite evaluation. The appellant's testimony at hearing was credible; she described her current conditions and limitations, which I found to be consistent with the findings reported by MassHealth. At hearing, the appellant reported a recent need to receive assistance with her monthly medication injection; unfortunately, a monthly medication injection does not meet the criteria outlined in the regulations for FEW eligibility, and the MassHealth representatives explained that her injections could be administered by a monthly visiting nurse.

As attested by both parties at hearing, and as documented by the written record, the appellant does not require one skilled service listed in 130 CMR 456.409(A) daily, nor does she require a combination of at least three services from 130 CMR 456.409(B) and (C), including one nursing service listed in 130 CMR 456.409(C). The record shows that appellant does not presently require any daily "skilled services" as defined by 130 CMR 456.409(A). The appellant requires assistance with ADLs on an infrequent basis. Lastly, the appellant is not currently receiving any nursing services that meet the requirements of 130 CMR 456.409(C). A FEW participant is only clinically eligible for the program if he or she satisfies the requirements of 130 CMR 456.409.

Although I credit the appellant's testimony at hearing regarding the current medical issues that she is experiencing, unfortunately, on this record, the level of assistance and care that the appellant presently requires does not yet rise to the level of clinical eligibility for skilled nursing services. None of the evidence offered by the appellant shows that the appellant meets the criteria for the FEW program pursuant to the applicable MassHealth regulations. The appellant failed to satisfy her burden of proof to establish eligibility for the FEW program. The record shows that MassHealth did not err when it issued the June 30, 2025 notice informing the appellant that she is not presently eligible for the FEW program.

On this record, this appeal is hereby DENIED.²

Order for MassHealth

None.

² Nothing in this decision precludes the appellant from seeking an alternative program for care in the home to manage her monthly medication injection, and/or from reapplying for the FEW program in the future if her needs change.

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.

Amy B. Kullar, Esq.
Hearing Officer
Board of Hearings

[REDACTED]

[REDACTED]

cc: MassHealth Representative: Desiree Kelley, RN, BSN, Massachusetts Executive Office of Elder Affairs, 1 Ashburton Pl., 3rd Floor, Boston, MA 02108