

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2518920
Decision Date:	2/9/2026	Hearing Date:	2/5/2026
Hearing Officer:	David Jacobs		

Appearance for Appellant:

, Daughter

Appearances for MassHealth:

Yvette Prayor, RN
Gabe Gillis, 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:	Clinical Eligibility
Decision Date:	2/9/2026	Hearing Date:	2/5/2026
MassHealth's Reps.:	Yvette Prayor; Gabe Gillis	Appellant's Rep.:	██████████
Hearing Location:	Board of Hearings (Remote)	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

Through a notice dated 12/1/2025, MassHealth informed the Appellant that based on objective clinical findings he does not meet nursing facility level of care (130 CMR 456.409 and Exhibit 1, pg. 1) On 12/5/2025, the appellant received notice that due to the 12/1/2025 notice his MassHealth Standard benefits would be ending on 12/19/2025 (Exhibit 1, pg. 2). The Appellant filed this appeal in a timely manner on 12/18/2025 (130 CMR 610.015(B) and Exhibit 2). Termination of assistance is valid grounds for appeal (130 CMR 610.032).

Action Taken by MassHealth

MassHealth notified the Appellant that he does not meet nursing facility level of care and thus his MassHealth Standard benefits are ending on 12/19/2025.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CRM 456.409, in determining that the Appellant does not meet nursing facility level of care and is thus ineligible for MassHealth Standard?

Summary of Evidence

MassHealth was represented telephonically by Gabe Gillis and Yvette Prayor for the Disability Evaluation Services (DES). The appellant was represented telephonically by his daughter, [REDACTED].

Gabe Gillis spoke first for MassHealth. He testified that the appellant has been a lawful permanent resident since October 2023, resides in a household of two, and has no income. He then testified to the following timeline of events:

- 10/24/2025: Appellant selected for Family Assistance Long Term Services and Supports (FA LTSS) pathway renewal. A manual renewal notice was sent to the applicant's address on file and Disability Evaluation Services (DES) was contacted to schedule a clinical evaluation at the applicant's home.
- 11/24/2025: Renewal Application received
- 12/1/2025: MassHealth received clinical evaluation from DES which states that the appellant does not meet nursing facility level of care criteria.
- 12/5/2025: Manual decision notice sent to appellant showing MassHealth Standard coverage will end on 12/19/2025 due to the results of the clinical evaluation
- 12/5/2025: A system generated Family Assistance approval notice sent to appellant
- 12/24/2025: Appellant protected on MassHealth Standard pending the results of this appeal

(Exhibit 9)

Mr. Gillis explained that the appellant receives MassHealth Standard as a referral from the Department of Transitional Assistance ("DTA") and directly through MassHealth. The benefits at issue are only the Standard benefits directly through MassHealth. The Standard benefits the appellant receives through the DTA are not subject to clinical eligibility and the appellant will continue to be eligible for MassHealth Standard through the DTA regardless of the results of this hearing. However, when he discussed this matter with the appellant's daughter he became aware that the appellant primarily uses his benefits to pay for an adult day program. Mr. Gillis is not sure how that day program is covered as the appellant has been eligible for MassHealth Standard through both the DTA and directly through MassHealth and the exact benefits may differ between the two. In other words, there remains the possibility that even if the appellant continues to receive MassHealth Standard benefits through the DTA, the adult day program may cease to be covered due to a variation in coverage of MassHealth Standard. Due to this

concern, the hearing officer allowed the hearing to go forward to determine the appellant's clinical eligibility to continue to receive benefits through MassHealth directly.

Yvette Prayor appeared for DES, the department responsible for performing the appellant's clinical assessment. She testified to the following:

"Good morning. My name is Yvette Prayor; I am a Registered Nurse and an Appeals reviewer for Disability Evaluation Services (DES). DES determines whether applicants meet the eligibility criteria for Family Assistance Long-Term Services and Supports (FA LTSS), including both new applicants—such as those residing in hospitals, nursing facilities, or chronic disease and rehabilitation hospitals—and individuals already enrolled who require periodic re-evaluation. Disability and Community-Based Services (DCS), a sister company within ForHealth Consulting, conducts the in-person clinical assessments for FA LTSS participants and submits completed evaluations to DES to support MassHealth eligibility determinations. DES reviews each case to confirm whether the applicant meets the nursing facility level of care (NFLOC) requirements outlined in 130 CMR 456.409 A–C and establishes the appropriate schedule for future assessments. In addition, EOHHS has identified MassHealth members receiving state-funded LTSS in the community who have not previously undergone a clinical eligibility assessment due to the timing of earlier policy implementation. To ensure consistent clinical standards, these members will receive a one-time, time-limited initial assessment to confirm NFLOC, in accordance with EOHHS guidance and 130 CMR 456.409.

[The appellant] is a male [over the age of ■], a participant [sic] of the FA LTSS program and was identified for Re-Evaluation. In accordance with the clinical eligibility criteria the applicant must require one skilled service listed in 130 CMR 456.409 (a) daily or have a medical or mental condition requiring a combination of at least three services from 456.409(B) and (c), including at least one of the nursing services listing in 130 CMR 456.409 (c).

The applicant was sent a LOC Home Visit Scheduling letter on November 7, 2025, for an appointment for November 25, 2025. On this date, DCS RN evaluator Awilda Smith, RN, completed the in-person medical assessment. As part of the evaluation process, the Minimum Data Set–Home Care (MDS-HC) and the Nursing Facility Level of Care Supplemental form were completed, capturing the applicant's medical impairments and current medications.

The applicant's medical health history was listed as the following: Mixed anxiety and depressive disorder, Low back pain, Pain in the right leg, pain in the left leg, Presbyopia, Liver cyst, Motion sickness, Lumbar disc herniated, Hyperlipidemia, (Exhibit 6, pgs. 14, 26, 35). The current medications that are prescribed for the applicant are: Rosuvastatin, Fish Oil (id, pg. 41).

The assessment findings are documented as follows:

- **Section 1: Skilled Services that must be performed by or under the supervision of a registered nurse or therapist. (130 CMR 456.409(A)).**
 - Item (13) marked, indicating the appellant has none of the above needed skilled services.
- **Section 2: Assistance with Activities of Daily Livings (ADLs) (130 CMR 456.409(B)).**
 - Item (7) None of the above.
- **Section 3: Nursing Services which are required for at least 3x/week (130 CMR 456.409(C)).**
 - Item (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.
- **Section 4: Narrative summary of clinical needs**
 - Completed by the RN evaluator indicating the following:
 - Living with spouse, has support of [his] daughter.
 - Independent with Activities of Daily Living (ADLs)
 - Independent with medication management.
 - He does not require a nursing facility level of care.
- **Section 5: Clinical re-evaluation**
 - This section is not applicable N/A – does not meet clinical eligibility.
- **Section 6: Hospitalization**
 - Item marked that this member resides in the community.
- **Section 7: All required supporting clinical documentation**
 - Supplemental clinical documentation from a clinical evaluator:
 - MDS-HC
 - Nursing Facility Level of Care Supplement Form

A final review and endorsement of the NFLOC determination was completed by Physician Advisor (PA), [REDACTED] on December 1, 2025 (page 14). NFLOC Re-Evaluation Denial Notice letter was sent to the appellant on December 1, 2025.

In conclusion, based on the medical assessment completed by DCS on November 25, 2025, and the subsequent review of that documentation by DES on December 1, 2025, the evidence does not support that the appellant meets the NFLOC eligibility criteria. Therefore, the appellant is not eligible for the NFLOC program.”

(Exhibit 10)

The appellant's daughter appeared on behalf of her father. She conceded to all the facts testified to by MassHealth and DES besides the conclusions of the nurse's evaluation. She testified that her father is depressed, suffers from back pain, and requires nursing facility level of care. She testified she made herself familiar with the requirements of 130 CMR 456.409 and believes her father meets those requirements.

The daughter concedes that the appellant likely does not require any of the services under 130 CMR 456.409(A).

However, instead the daughter testified that the appellant requires several services from 130 CMR 456.409(B) as her father suffers back pain and needs help with Activities of Daily Living ("ADLs"). Specifically, he requires help with transfers in and out of the bed, car, and tub due to his back pain which was caused by a slipped disk in his spine. However, he is able to use the toilet without assistance. The daughter testified that the appellant does not take any prescription medication to treat his back pain.

Lastly, DES concedes that the appellant meets the requirements for 130 CMR 456.409(C)(7). The appellant added that she believes subsection 2, "positioning while in bed or a chair as part of the written care plan," also applies. However, she concedes the appellant does not have a written care plan related to positioning in a bed or a chair.

However, DES was unwilling to change its determination based on the daughter's testimony, and the matter went to the hearing officer for decision.

Findings of Fact

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

1. The appellant is a male, over the age of [REDACTED].
2. The appellant has been a lawful permanent resident since October 2023.
3. The appellant resides in a household of two with no income.
4. The following timeline summarizes the events that led to this appeal:
 - 10/24/2025: Appellant selected for Family Assistance Long Term Services and Supports (FA LTSS) pathway renewal. A manual renewal notice was sent to the applicant's address on file and Disability Evaluation Services (DES) was contacted to schedule a clinical evaluation at the applicant's home.
 - 11/24/2025: Renewal Application received

- 12/1/2025: MassHealth received clinical evaluation from DES which states that the appellant does not meet nursing facility level of care criteria.
 - 12/5/2025: Manual decision notice sent to appellant showing MassHealth Standard coverage will end on 12/19/2025 due to the results of the clinical evaluation
 - 12/5/2025: A system generated Family Assistance approval notice sent to appellant
 - 12/24/2025: Appellant protected on MassHealth Standard pending the results of this appeal
5. The appellant is open on MassHealth Standard benefits through DTA.
6. The appellant's medical history is as follows:
- Mixed anxiety and depressive disorder, Low back pain, Pain in the right leg, pain in the left leg, Presbyopia, Liver cyst, Motion sickness, Lumbar disc herniated, Hyperlipidemia.
7. The appellant currently takes the following medications:
- Rosuvastatin, Fish Oil.

Analysis and Conclusions of Law

Qualified non-citizens in need of nursing facility level of care may be eligible to receive MassHealth Standard if they meet the clinical eligibility criteria for nursing facility services (130 CMR 504.006(B)).

130 CMR 456.409 – Clinical Eligibility Criteria

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). Additionally, to be considered clinically eligible for nursing facility services, a member or MassHealth applicant younger than 22 years old must also meet criteria as determined by the multi-disciplinary medical review team coordinated by the Department of Public Health.

(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.

Here, the appellant has failed to meet the criteria. The appellant's condition does not require a service from subsection A, nor does he have a condition that requires three services from subsection B and C.

Subsection A describes skilled services that require the supervision of a skilled nurse or therapist. DES found that the appellant does not meet the requirements for any of the services listed (Exhibit 6). The appellant's daughter concedes that the appellant does not require any services listed in subsection A.

Thus, we move on to discuss if the appellant's condition requires at least three services from

subsections B and C.

Subjection B describes ADL services. DES found that the appellant's condition does not require any of the services listed (Exhibit 6). The appellant's daughter argues that the appellant requires assistance with transfers from the bed, car, and tub due to his back pain. I agree with the daughter's argument. The appellant's diagnoses includes lower back pain, pain in the right leg, pain in the left leg, and a herniated lumbar disc. It is credible that this pain requires the appellant to receive help for transfers in the home. Therefore, 130 CMR 456.409(B)(4) transfers applies. However, no other service under subsection B would apply based on the daughter's testimony and the record. 1 does not apply because the daughter stated that the appellant only needs help getting into the tub, not the entire activity. 2 does not apply as the daughter made no mention that the appellant has difficulty dressing himself. 3 does not apply as the daughter specifically testified that the appellant requires no help with toileting. 5 and 6 do not apply as the daughter did not testify the appellant requires help with ambulation or eating. Moreover, none of the submitted documentation references the appellant's ADL needs. Therefore, it is found that the appellant's condition requires only 130 CMR 456.409(B)(4) transfers.

Lastly, subsection C describes nursing services. DES concedes that the appellant's condition requires (C)(7) observation and vital sign monitoring (Exhibit 6). The appellant's daughter argues that the appellant also meets the requirements of (C)(2) positioning while in bed or a chair as part of the written care plan. However, this cannot be the case as the daughter concedes the appellant has no such written care plan related to positioning for the appellant. The daughter did not argue that any further services under subsection C are required by the appellant condition and based on the record I find the same. Therefore, it is found that the appellant's condition requires only 130 CMR 456.409(C)(7) observation and vital sign monitoring.

As the appellant's condition only requires one service from subsection B and one service from subsection C, the appellant's condition is found to not require at least three services from 130 CMR 456.409(B) and (C) and thus is not clinically eligible for nursing facility services.

The appellant's appeal is DENIED.

Order for MassHealth

Rescind aid pending and proceed with termination set forth on the December 5, 2025 notice.

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.

David Jacobs
Hearing Officer
Board of Hearings

cc:

Quincy MEC

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