

Office of Medicaid BOARD OF HEARINGS

Appellant Name and Address:



Appeal Decision: Denied

Appeal Number: 2602616

Decision Date: 6/18/2026

Hearing Date: April 27, 2026

Hearing Officer: Emily T. Sabo

Appearances for Appellant: Pro se and



Appearances for MassHealth: Stacy Reilly, Nursing Director; Amy Baker, R.N., Senior Care, Inc.



*The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, 6th Floor
Quincy, Massachusetts 02171*

APPEAL DECISION

Appeal Decision: Denied

Decision Date: 6/18/2026

Hearing Date: April 27, 2026

Hearing Location: Quincy (Telephone)

MassHealth Representatives: Stacy Reilly and Amy Baker

Appellant Representatives: Pro se and [REDACTED]

Appeal Issue: Frail Elder Waiver

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 January 20, 2026, MassHealth determined that the Appellant is not clinically eligible for participating in the Frail Elder Waiver because he does not meet the level-of-care requirements. Exhibit 1 (citing 130 CMR 519.007(B)). The Appellant filed a timely appeal on February 10, 2026. 130 CMR 610.015(B) and Exhibit 2. Denial of assistance is valid grounds for appeal. 130 CMR 610.032.

Action Taken by MassHealth

MassHealth determined that the Appellant is not clinically eligible for participating in the Frail Elder Waiver.

Issue

The appeal issue is whether MassHealth was correct in determining that the Appellant was not clinically eligible for participation in the Frail Elder Waiver?

Summary of Evidence

The hearing was held by telephone. MassHealth was represented by a registered nurse and the nursing director of Senior Care, an Aging Services Access Point (ASAP). The MassHealth representative testified that she visited the Appellant on January 15, 2026, to perform an assessment. The MassHealth representative testified that the Appellant has no daily skilled nursing needs and that he manages his medications on his own. The MassHealth representative testified that the Appellant manages his activities of daily living independently. The MassHealth representative testified that the Appellant could use supervision to minimal assistance with bathing, but that the Appellant indicated he did not want it. The MassHealth representative testified that Senior Care called the Appellant to follow up after 30 and 60 days, and the Appellant reported that he had not fallen or been hospitalized. The MassHealth representative testified that she performed a follow-up in-person visit on April 13, 2026, and that there was no change in the Appellant's needs. The MassHealth representative testified that the Appellant had been approved for light chore service every other week.¹

The Appellant verified his identity and is [REDACTED] years old. He testified that he does not have formal or informal supports. The Appellant's representative testified that the Appellant needs assistance and supervision with bathing, and that he also could use assistance with cleaning, laundry, and food shopping. The Appellant's representative testified that the Appellant has been missing medical appointments due to the cost of his co-pays. The Appellant testified that when the ASAP nurse came to evaluate him, he was so out of breath going up his stairs, that he was afraid he was having a panic attack. The Appellant testified that he is concerned that two of the individuals who perform the cleaning and chore service broke his sink and that he does not want to get in trouble with his landlord.

Findings of Fact

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

1. The Appellant is [REDACTED] years old. Exhibit 4.

¹ The materials submitted by the ASAP state that the Appellant is "enrolled in the Home Care Basic Non-Waiver program and started receiving Light Chore for two hours twice a week." Exhibit 5 at 1.

2. The Appellant does not have any daily skilled nursing needs. Testimony and Exhibits 5, 6, and 7.
3. The Appellant manages his medications on his own. Testimony and Exhibits 5, 6, and 7.
4. Besides bathing, the Appellant manages his activities of daily living independently. Testimony and Exhibits 5, 6, and 7.
5. The Appellant could use supervision to minimal assistance with bathing, but the Appellant indicated he did not want it. Testimony.
6. By notice dated January 20, 2026, MassHealth determined that the Appellant was not clinically eligible for participating in the Frail Elder Waiver. Exhibit 1.
7. The Appellant filed a timely appeal with the Board of Hearings on February 10, 2026. Exhibit 2.

Analysis and Conclusions of Law

MassHealth regulations provide as follows:

130 CMR 519.007: Individuals Who Would Be Institutionalized

130 CMR 519.007 describes the eligibility requirements for MassHealth Standard coverage for individuals who would be institutionalized if they were not receiving home- and community-based services.

....

(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, are permanently and totally disabled in accordance with Title XVI standards; and

(b) would be institutionalized in a nursing facility, unless they receive one or more of the services administered by the Executive Office of Aging and Independence under the Home- and Community-based Services Waiver—Frail Elder authorized under s. 1915(c) of the Social Security Act.

2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency determines income eligibility based solely on the applicant's or member's income regardless of their marital status. The applicant or member must

- (a) meet the requirements of 130 CMR 519.007(B)(1)(a) and (b);
 - (b) have a countable-income amount less than or equal to 300% of the federal benefit rate (FBR) for an individual; and
 - (c) have countable assets of \$2,000 for an individual and, for a married couple if the initial waiver eligibility determination was on or after January 1, 2014, have assets that are less than or equal to the standards at 130 CMR 520.016(B): *Treatment of a Married Couple's Assets When One Spouse Is Institutionalized*; and
 - (d) not have transferred resources for less than fair market value, as described at 130 CMR 520.018: *Transfer of Resources Regardless of the Transfer Date* and 520.019: *Transfer of Resources Occurring on or after August 11, 1993*.
- (3) Financial Standards Not Met. Individuals whose income, assets, or both exceed the standards set forth in 130 CMR 519.007(B)(2) may establish eligibility for MassHealth Standard by reducing their assets in accordance with 130 CMR 520.004: *Asset Reduction*, by meeting a deductible as described at 130 CMR 520.028 through 520.035, or by both.

130 CMR 450.204: Medical Necessity

The MassHealth agency does not pay a provider for services that are not medically necessary and may impose sanctions on a provider for providing or prescribing a service or for admitting a member to an inpatient facility where such service or admission is not medically necessary.

(A) 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 MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.

(B) 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 the MassHealth agency upon request. (See 42 U.S.C. 1396a(a)(30) and 42 CFR 440.230 and 440.260.)

(C) A provider's opinion or clinical determination that a service is not medically necessary does not constitute an action by the MassHealth agency.

(D) Additional requirements about the medical necessity of MassHealth services are contained in other MassHealth regulations and medical necessity and coverage guidelines.

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

130 CMR 456.408: Conditions for Payment

(A) The MassHealth agency pays for nursing facility services if all of the following conditions are met.

(1) The MassHealth agency or its designee has determined that individuals 22 years of age or older meet the nursing facility services requirements of 130 CMR 456.409 or the multi-disciplinary medical review team coordinated by the Department of Public Health has determined that individuals 21 years of age or younger meet the criteria of 130 CMR 519.006(A): *Eligibility Requirements*.

(2) The MassHealth agency or its designee has determined that community care is either not available or not appropriate to meet the individual's needs.

(3) The requirements for the pre-admission screening and resident review (PASRR) process in 130 CMR 456.410 and as required by sub-regulatory guidance have been met. Failure to follow applicable PASRR rules will result in denial of MassHealth payments to the nursing facility for MassHealth members during the period of noncompliance pursuant to 42 CFR 483.122.

(B) The MassHealth agency pays for nursing facility services beginning with the date of financial eligibility provided that the member shows that they were medically eligible for these services as of the date of financial eligibility. If the member was not medically eligible for nursing facility services as of the first date of financial eligibility, the MassHealth agency will pay for these services beginning on the first date the member is medically eligible, provided that this date is after the first date of financial eligibility. A person may request a determination of medical eligibility at or after application for MassHealth.

(C) Nothing in 130 CMR 456.408 will be construed to prevent MassHealth from taking action, including overpayment and/or sanction action, for failure to meet the requirements of 130 CMR 456.000, of 101 CMR 206.00: *Standard Payments to Nursing Facilities*, or of the applicable requirements for long-term care facilities in 105 CMR 150.000: *Standards for Long-Term Care Facilities*.

(D) 130 CMR 456.408(A) and (B) do not apply to MassHealth members enrolled in any MassHealth affiliated managed care plan or integrated care plan. Providers are responsible for verifying member status on a daily basis. For more information, see 130 CMR 450.117(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 of age 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, MassHealth determined that the Appellant is not clinically eligible for nursing facility services, as required for the Frail Elder Waiver. Based on the testimony and record evidence before me, I agree. 130 CMR 456.408(A)(2); 130 CMR 456.409. As outlined in 130 CMR 456.409, the Appellant has not demonstrated that he is clinically eligible based on a need for a skilled service under subsection (A), or a combination of 3 or more services from subsections (B) and (C), with at least one of the nursing services listed in subsection (C). The only activity in subsection (B) that the Appellant needs supervision and assistance with, is bathing. 130 CMR 456.409. Accordingly, he does not meet the criteria because he does not require 3 or more services from subsections (B) and (C), and he does not require one of the nursing services from subsection (C). Therefore, MassHealth did not err in finding him not clinically eligible for services under the Frail Elder Waiver and the appeal is denied.

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to court in accordance with Chapter 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.

Emily T. Sabo
Hearing Officer
Board of Hearings

cc: MassHealth Representative: Senior Care, Inc., 49 Blackburn Center, Gloucester, MA 01930

cc: MassHealth Frail Elder Waiver Unit