Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2176569
Decision Date:	01/26/2022	**Hearing Date:**	12/01/2021
Hearing Officer:	Rebecca Brochstein		

Appearances for Appellant:
[redacted]

Appearances for Comm. Care Alliance
Cassandra Horne, Appeals & Grievances Sup.

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

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	MCO Prior Approval
Decision Date:	01/26/2022	**Hearing Date:**	12/01/2021
MCO's Rep.:	Cassandra Horne	**Appellant's Rep.:**	Pro se
Hearing Location:	Board of Hearings (Remote)		

Authority

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

Jurisdiction

Through a notice dated July 28, 2021, Commonwealth Care Alliance, a managed care organization (MCO) that contracts with MassHealth, notified the appellant that it had denied her Level 1 Appeal regarding her request for home-delivered meals (Exhibit 4). The appellant filed a timely appeal with the Board of Hearings on August 27, 2021 (130 CMR 610.015(B); Exhibit 2). On September 1, 2021, the Board of Hearings dismissed the appeal for failure to submit a copy of the Level 1 denial notice[1] from MassHealth; the Board of Hearings sent a second dismissal letter dated September 29, 2021, citing the same reason (Exhibit 3). The appellant subsequently sent a copy of the Level 1 denial, and the dismissal was vacated (Exhibits 4 and 5). Denial of a request for services is a valid basis for appeal (130 CMR 610.032).

Action Taken by MCO

Commonwealth Care Alliance denied the appellant's request for home-delivered meals for the period of July 24, 2021, to January 31, 2022. CCA then denied her Level 1 Appeal of that initial denial.

Issue

The appeal issue is whether Commonwealth Care Alliance was correct in denying the appellant's request for prior authorization of home-delivered meals.

[1] The appellant had sent a copy of the original denial, dated June 24, 2021. See Exhibit 1.

Summary of Evidence

The Commonwealth Care Alliance (CCA) appeals and grievances supervisor appeared at the hearing, which was held telephonically. She testified that the appellant has been a CCA One Care participant since April 2019. She was previously approved for home-delivered meal (HDM) services. On June 24, 2021, CCA denied the appellant's request to continue HDM services between July 24, 2021, and January 31, 2022. The June 24 notice includes the following explanation:

> We denied the request for the medical services/items listed above because: You had an assessment of your care needs on April 20, 2021. Our records show that you live [sic] you need help with meals and shopping. You live with your spouse. Your spouse is expected to help with these shared tasks. A service to deliver meals is not needed. For these reasons, coverage of Home Delivered Meal (HDM) Service will stop on July 24, 2021. (Exhibit 1)

On June 28, 2021, the appellant filed an internal (Level 1) appeal with CCA. The record indicates that she was appealing because she has no income to afford to buy food, she does not get food stamps, and "she is going to starve to death if she doesn't get the meals." See Exhibit 6 at 18.

On July 28, 2021, CCA upheld the original denial. The notice of the Level 1 denial states that HDM is provided only when neither the member nor anyone else in the household is capable of providing for them, and that if the member lives with a relative or other caregiver, it is expected that shopping and meal preparation will include the needs of the member. As the appellant lives with family who can assist with shared household tasks, a service to deliver meals is not needed. See Exhibit 4. The appellant filed a Level 2 appeal with the Board of Hearings on August 27, 2021.

The CCA representative testified that the appellant was previously approved for HDM in December 2020 because she had suffered an injury that prevented her from preparing meals. She stated that this was approved as an exception even though her spouse was in the home. She argued that there is no evidence that the appellant is at nutritional risk at this time.

The appellant appeared at the hearing telephonically and testified on her own behalf. She testified that she only receives $850 per month and that she should be entitled to continue receiving meals. She complained that the woman who lives upstairs from her receives meals even though she has more income and owns a new car. The appellant stated that the meals were convenient for her because she could just "pop them in the microwave." She argued that her husband "is not [her] slave" and "doesn't have to cater to [her]," adding that he does make her lunch. The appellant complained that CCA did not assign her a nurse as she was promised, and that they have taken a long time to answer her questions.

The CCA representative responded that the appellant has a care partner through CCA, not a nurse. She stated that CCA has been timely with its responses to this request. She also testified that CCA does not provide HDM services based on financial need.

Findings of Fact

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

1. The appellant has been enrolled in the Commonwealth Care Alliance One Care program since April 2019.

2. In December 2020, the appellant was approved for home-delivered meal (HDM) services.

3. On June 24, 2021, CCA denied the appellant's request to continue HDM for the period of July 24, 2021, and January 31, 2022. The reason for the denial is the appellant lives with her spouse, who is expected to help her with shared household tasks.

4. On June 28, 2021, the appellant filed a Level 1 appeal with CCA. The basis of her appeal was financial hardship.

5. On July 28, 2021, CCA upheld the original denial.

6. On August 27, 2021, the appellant filed a Level 2 appeal with the Board of Hearings.

Analysis and Conclusions of Law

Under 130 CMR 508.006, MassHealth members who are enrolled in MassHealth-contracted managed care plans are entitled to a fair hearing under 130 CMR 610.000*: MassHealth: Fair Hearing Rules* to appeal:

> (A) the MassHealth agency's determination that the MassHealth member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);
>
> (B) a determination by the MassHealth behavioral-health contractor, by one of the MassHealth managed care organization (MCO) contractors, or by a senior care organization (SCO), as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;
>
> (C) the MassHealth agency's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or
>
> (D) the MassHealth agency's disenrollment of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

The Fair Hearing regulations at 130 CMR 610.032(B) describe in greater detail the bases for appeal:

(B) Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):

(1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;

(2) a decision to deny or provide limited authorization of a requested service, including the type or level of service;

(3) a decision to reduce, suspend, or terminate a previous authorization for a service;

(4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following: (a) failure to follow prior-authorization procedures; (b) failure to follow referral rules; and (c) failure to file a timely claim;

(5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010;

(6) a decision by an MCO to deny a request by a member who resides in a rural service area served by only one MCO to exercise his or her right to obtain services outside the MCO's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):

(a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the MCO's network;

(b) the provider from whom the member seeks service is the main source of service to the member, except that member will have no right to obtain services from a provider outside the MCO's network if the MCO gave the provider the opportunity to participate in the MCO's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;

(c) the only provider available to the member in the MCO's network does not, because of moral or religious objections, provide the service the member seeks; and

(d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the MCO's network; or

(7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

Under 130 CMR 450.204, the MassHealth agency will 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 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, or 517.007. 130 CMR 450.204(A)

The CCA Decision Support Tool (DST) for home delivered meals include the following guidelines:

DECISION GUIDELINES:
Clinical eligibility: In order to be eligible to receive HDMs, the member must have a medical, cognitive, or behavioral-health related disability that impairs the member's ability to access community resources and shop, cook, or feed him/herself. The care team must identify the condition or syndrome that underlies the disability, as well as the nature of the functional impairment.

Determination of need: In order to receive HDM, the authorizing clinician must determine that the member is at nutritional risk, and that the guidelines for limitations and exclusions have been met. Nutritional risk may be present if, for example, the member:

- Has, without wanting to, gained or lost 10 pounds or more in the previous six months
- Eats fewer than two meals per day
- Eats few fruits or vegetables or milk products
- Takes three or more different medications per day
- Has a condition or illness that necessitates and change in diet
- Has tooth or mouth problems that make it difficult to eat

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LIMITATIONS/EXCLUSIONS:

- If the member receives daily HDM, he/she must be home to receive the meal. HDM is provided only when neither the member nor anyone else in the household is capable of providing for them. If the member lives with a relative or other caregiver, it should be determined if shopping and meal preparation will include the needs of the member. If household is unable to assume member's meal preparation and shopping needs, sufficient documentation should be provided.
- HDMs are not provided as an income support.
- 1 meal a day is recommended for members who require supplemental nutrition to improve the quality of their diet or who are unable to prepare multiple or nutritionally complex meals independently.
- 2 meals a day may be provided for members who are unable to prepare any meals due to physical/mental impairment or are at a very high nutritional risk (e.g. receiving chemotherapy).
- If 3 meals a day are being considered, the requestor must thoroughly consider and document the member's clinical and nutritional needs, especially as 2 HDM per day can generally satisfy the caloric and nutritional values recommended for most adults.

At issue in this case is a denial by Commonwealth Care Alliance, a MassHealth-contracted managed care program, of the appellant's request for continued coverage of home-delivered meals. CCA denied the request because it determined that the appellant's spouse, who lives with her, is able to prepare meals for her. The appellant contends that her husband should not be responsible for preparing her meals and that she does not have enough income to purchase her own food.

CCA's decision to deny HDM services is consistent with the guidelines and regulations above. There is no documentation that the appellant's spouse is unable to assist with her meal preparation. Further, the guidelines make clear that a determination of need for this service is unrelated to the member's financial circumstances. While the appellant has understandably found HDM services to be convenient and financially beneficial in the past, the record does not indicate that she meets the criteria for HDM at this time.

This appeal is denied.

Order for CCA

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.

Rebecca Brochstein
Hearing Officer
Board of Hearings

cc: Cassandra Horne, Appeals & Grievances Supervisor
Commonwealth Care Alliance SCO
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