Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2406366
Decision Date:	5/23/2024	**Hearing Date:**	04/29/2024
Hearing Officer:	Alexandra Shube	**Record Open to:**	05/02/2024

Appellant Representatives:

[redacted]

MassHealth MCO Representatives:
Health New England, via telephone:
James Farrell, Complaints & Appeals Mgr.
Angeline Brault, Clinical Reviewer Case Mgr.
Dr. Crystal Whittcopp, Medical Director
Maggie Perracchio, UM Director
Robert Azeez, Behavioral Health Mgr.

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:**	MCO; Medical Necessity; Custodial Care Criteria
Decision Date:	5/23/2024	**Hearing Date:**	04/29/2024
MCO Health New England's Reps.:	James Farrell, et al.	**Appellant's Reps.:**	[redacted]
Hearing Location:	Charlestown MassHealth Enrollment Center, 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 a notice of denial of an expedited internal appeal dated March 22, 2024, Health New England (HNE), a Managed Care Organization (MCO) contracted with MassHealth, denied the appellant's internal appeal of a denial for custodial care (Exhibit 1). The appellant filed this appeal in a timely manner on April 22, 2024 (see 130 CMR 610.015(B) and Exhibit 2). Denial of assistance is valid grounds for appeal (see 130 CMR 610.032). An MCO's decision to deny authorization of a requested service is grounds for appeal (see 130 CMR 610.032(B)).

The record was briefly held open until May 2, 2024 while this hearing officer obtained additional information from parties via email.

Action Taken by MCO

HNE denied the appellant's request for custodial care at [redacted] at Holyoke, a long-term care facility.

Issue

The appeal issue is whether HNE was correct, pursuant to 130 CMR 456.409, in determining that the appellant does not meet the criteria for custodial level of care.

Summary of Evidence

All parties appeared at hearing via telephone. The Managed Care Organization, Health New England, was represented at hearing by the Complaints and Appeals Manager, the Case Manager and Clinical Reviewer, the Medical Director, the Utilization Management (UM) Director, and the Behavioral Health Manager. The appellant was represented at hearing by the following team from the facility, [redacted] (hereinafter, the facility): the Administrator, the Business Office Manager, the Social Worker, and the Assistant Administrator.

HNE's UM Director provided the following case summary: the appellant, who is [redacted] years old, was admitted to the facility on [redacted] after a hospitalization due to fall and traumatic subdermal hematoma with loss of consciousness. Ex. 5 at 22. Additionally, he was hospitalized for extended neurobehavioral care related to chronic but variable psychiatric and cognitive-behavioral issues, as well as deficits in mobility. *Id*. He was admitted under the skilled nursing facility post-acute waiver.[1] Ex. 7. Under the waiver, HNE would cover the initial seven days of the skilled nursing facility or acute rehabilitation stay and conduct a retrospective and concurrent review during that time to determine the appropriateness of the level of care. Ex. 5 at 22. On January 30, 2024, HNE reviewed the appellant's clinical records and determined that he no longer met the inpatient level of care for a skilled nursing facility. He did not meet criteria and the required number of skilled needs for skilled nursing level of care. According to the Medical Director, but for the waiver, he never would have met the initial admission criteria for skilled nursing facility admission. At the time of the review on [redacted] the appellant was medically stable and mostly independent with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). *Id*. at 23. He was independent with bed mobility, transfers, and ambulation of 150 feet. *Id*. He could ambulate independently with a walker and needed to be cued occasionally to remember to use it. *Id*. at 22. He was compliant, eating and drinking well, and there were no behavioral issues. *Id*. at 23. His main barriers to discharge were sobriety, lack of income, lack of housing, and cognitive deficits. *Id*. The medical reviewer stated that it was not medical necessity for him to remain in a skilled setting. *Id*. Unfortunately, social issues do not qualify as a skilled need. *Id*.

[1] In a memorandum dated January 9, 2024 and in response to "severe capacity challenges as we navigate through the winter months with record hospital occupancy levels," the Executive Office of Health and Human Services (EOHHS) requested and Massachusetts Associations of Health Plans (MAHP) agreed to waive prior authorization beginning January 9, 2024 and ending on April 1, 2024 for admissions from acute care hospitals to sub-acute care facilities and rehabilitation facilities across commercial, Medicaid, Medicare, and Medicare Advantage lines of business. This waiver does not include custodial or long-term care admissions. Ex. 7.

On February 13, 2024, HNE received a request for custodial care with a start date of January 31, 2024. A review of his clinical records showed that the appellant required supervision for bathing as well as minimum assistance for hygiene. *Id*. The appellant also needed nursing oversight for medicine administration and monitoring that required a registered nurse to monitor the dosage, frequency, and adverse reactions. *Id*. at 24. HNE determined that under 130 CMR 456.409(B) and (C) the appellant met the criteria level of care. The appellant was approved for custodial care beginning January 31, 2024.

On February 28, 2024, after a review of the appellant's clinical records, HNE determined that he no longer met the criteria for custodial level of care because he no longer required assistance with three ADLs and he only needed some assistance with medication management. *Id*. Records showed that the appellant was alert and oriented x3 and was independent with gait and not requiring any assistive device; independent with stairs; independent with all functional mobility; independent with feeding, grooming, bathing, toileting hygiene, dressing; and did not require assistance with continence issues. *Id*. He was also independent with laundry and meal preparation. *Id*. at 24-25. He did not meet the criteria for custodial level of care, but there was no disposition plan at the time because the appellant was homeless.

On March 8, 2024, a reviewing doctor overturned the denial because the appellant was homeless. *Id*. at 26. On March 11, 2024, HNE requested updated clinical records in response to the overturning. *Id*. The updates indicated independence with bed mobility, gait, ambulation, up 22 stairs, feeding, grooming, bathing, and dressing. *Id*. He has some occasional incontinence with needing verbal cues on the night shift, but is independent with clean up after. *Id*. Continued barriers to discharge are all social determinants: lack of income, homelessness, sobriety, cognitive issues. *Id*. He only needs verbal cues for medication management of oral medications and toileting. *Id*. at 28. As a result, on March 11, 2024, HNE recommended to deny continued stay at sub-acute nursing facility at the custodial level of care pursuant to 130 CMR 456.409. *Id*. There was an Expedited Internal Appeal on March 21, 2024. *Id*. There was no new information since March 1, 2024 and the Internal Appeal was denied. *Id*. On March 22, 2024, HNE issued the Notice of Denial of Expedited Internal Appeal, which is the notice under appeal here.

According to HNE's Member Handbook which was provided after hearing, HNE will cover chronic, rehabilitation hospital or skilled nursing facility services "for all levels of care…provided at either a nursing facility, chronic or rehabilitation hospital, or any combination thereof, for 100 days per the Contract Year per Enrollee." Ex. 9 at 58. The Member Handbook specifies that HNE shall use the MassHealth admission/coverage criteria found at 130 CMR 456.409 and "may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts the 100-day limitation at either a nursing facility, chronic or rehabilitation hospital for that Contract Year." At hearing, HNE also testified that it used [redacted] criteria to determine the appellant's

eligibility.[2]

HNE explained that the term "custodial care" is interchangeable with the term "long-term care," but different than skilled care. HNE testified that, under 130 CMR 456.409, to be considered clinically eligible for nursing facility services, a MassHealth member must require one skilled service listed in 130 CMR 456.409(A) or the member must have a medical or mental condition that requires 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). 130 CMR 456.409(A) are skilled services and the appellant does not have any skilled needs. 130 CMR 456.409(B) lists ADLs and 130 CMR 456.409(B) lists nursing services. Based on the most recent clinical records submitted, the appellant no longer meets these criteria. He is independent with all ADLs; no longer requires any assistance with hygiene or bathing; and only needs some verbal cueing for toileting and medication management of oral medications. These needs are no different than the majority of their patients who live in the community.

HNE Behavioral Health Manager explained that there are supports available in the community that HNE can help set up with its various partners. HNE provides complex care coordination in the community, and there is the LTSS program.

The appellant's representatives explained that the facility is a specialized neurobehavioral facility that deals with such issues as traumatic brain injuries, acquired brain injuries, and dementia secondary to substance abuse. The facility takes individuals that are deemed hard to place and gets a special rate for its services through a contract with the state. He agreed with HNE's assessment that the appellant is independent with ADLs, but felt strongly that the assessment was missing a major clinical piece. The appellant is severely impaired with his executive functioning due to the subdural hematoma.

When the appellant first entered the facility, he scored a 20 out of 50 on the Brief Cognitive Assessment Tool (BCAT) on January 22, 2024. *Ex*. 5 at 45. A score of 37 or less is indicative of a high likelihood of dementia. He had deficits in orientation, visual recognition, attention, abstraction, language, executive function, visuospatial design, visual recall, story-telling, and recall and recognition. *Id*. The BCAT was repeated on February 15, 2024, and he scored a total of 39 out of 50 with improvements in all areas except visual and verbal recall and executive functioning. *Id*. At hearing, the facility testified that the appellant most recently scored a 45 out of 50 on the BCAT, which is still considered impaired and would minorly impact decision making (whereas before, the appellant could not even make decisions). Clinical notes on March 1, 2024 indicate the following barriers: executive skills related to self-monitoring, planning, organization, impulsivity and task perseveration with problem solving, mental flexibility, and management of cognitive load. *Id*. at

[2] After hearing, HNE provided the hearing officer and the appellant's representatives with the InterQual criteria used. HNE stated it used the Acute Neurological Skilled Nursing Facility criteria set for the initial review and the Medical Management criteria set for subsequent reviews. Both InterQual criteria sets state: "This subset is not appropriate for patients who reside in a SNF for long-term care or those who require custodial care."

60.

The facility testified that the appellant has no income to be able to afford an assisted living facility or a rest home, but the facility has filed for Social Security for him and has been looking for rest home-type placements for him. Due to his impulsivity and substance abuse history, he would be vulnerable in the community. *Id*. at 45. He only has five to six months of sobriety and his cognitive deficits in executive functioning would impact his ability and willingness to stay sober in the community. *Id*.

The facility explained that the appellant's incontinence has improved, but he still sometimes needs prompting to go to the bathroom. He has difficulty disengaging from activities and will have accidents as a result. He feels the same reasons for admission still exist now. The facility emphasized that the appellant has cognitive issues that would put him at risk in the community.

The facility argued that sometimes it appears that their residents, like the appellant, do not qualify for nursing home level of care, but they need the structure and supervision plus neurological rehabilitation to be successful back in the community and to avoid death and/or rehospitalization. Ex. 8 at 1. He provided two examples of MassHealth patients of the facility that were approved for long-term care and for which the facility received its specialized neuro-behavioral rate.[3] *Id*. The facility was looking for approval for the appellant and to receive its specialized rate, including the homeless payment.[4]

Findings of Fact

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

1. The appellant, who is [redacted] years old, was admitted to the facility on [redacted] after a hospitalization due to fall and traumatic subdermal hematoma with loss of consciousness.

2. He was admitted under a waiver that waived the prior authorization for admissions from acute care hospitals to sub-acute care facilities.

3. On January 30, 2024, HNE determined that the appellant did not meet the criteria for the inpatient level of care for a skilled nursing facility.

4. The appellant was approved for custodial level of care beginning January 31, 2024.

[3] In both these sample cases, the clients were found to have met the criteria necessary for nursing home level of care in 130 CMR 456.409. Ex. 8 at 34 and 76.

[4] See 130 CMR 206.11 Rates for Severe Mental and Neurological Disorder Services and 130 CMR 206.10(13) Homeless Rate Add-On. Ex. 8 at 146-154.

5. On February 28, 2024, HNE determined that the appellant no longer required assistance with three ADLs and did not meet the criteria for custodial level of care.

6. The appellant is independent with all ADLs and only needs some verbal cueing with toileting and medication management of oral medications. He is also independent with meal preparation and laundry.

7. The appellant has a history of substance abuse and homelessness. Lack of income, homelessness, sobriety, and cognitive issues are barriers to discharge.

8. While a reviewing doctor at HNE initially overturned the denial for a continued stay at the custodial level of care, on March 11, 2024 upon reviewing updated clinical records, HNE determined that the denial of the stay was appropriate because the appellant did not meet the criteria for custodial level of care pursuant to 130 CMR 456.409.

9. HNE's Member Handbook specifies that HNE shall use the MassHealth admission/coverage criteria found at 130 CMR 456.409 which requires that the member must have a medical or mental condition that requires 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).

10. There was an expedited internal appeal on March 21, 2024 which prompted the denial notice dated March 22, 2024 currently under appeal before the Board of Hearings.

11. On April 22, 2024, the appellant timely appealed the March 22, 2024 denial notice.

Analysis and Conclusions of Law

MassHealth members younger than 65-years-old must enroll in a Managed Care Organization available for their coverage type, unless they are excluded from such participation. 130 CMR 508.001(A); 130 CMR 508.002(A). The MCO is responsible for delivering "the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services." 130 CMR 508.004(B)(1); see also 130 CMR 450.105; 130 CMR 508.001(A). "All medical services to members enrolled in an MCO … are subject to the authorization and referral requirements of the MCO." 130 CMR 508.004(B)(2); see also 130 CMR 450.105(A)(3).

Whenever an MCO makes a coverage decision, it must provide notice to the affected member. 130 CMR 508.011. An MCO has 30 days to resolve any internal appeals, and the member then has 120 days to request a fair hearing from the Board of Hearings. See 130 CMR 508.012; 130 CMR 610.015(B)(7).

The MassHealth definition of "medical necessity" is:

> (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, or 517.007.

(130 CMR 450.204(A))

This appeal considers whether HNE correctly determined that the appellant did not meet the criteria for custodial care and applied the appropriate standards, policies, and regulations in doing so. Pursuant to the Member Handbook, HNE will cover chronic hospital, rehabilitation hospital, or skilled nursing facility services for all levels of care in accordance with state requirements for 100 days per contract year. The Member Handbook states the following:

> [HNE] shall use the following MassHealth admission/coverage criteria for admission into a chronic hospital, rehabilitation hospital and nursing facility, and may not request disenrollment of any Enrollee who meets such coverage criteria until the Enrollee exhausts the 100-day limitation at either a nursing facility, chronic or rehabilitation hospital for the Contract Year. For the applicable criteria, see 130 CMR 456.408, 456.409, 456.410…

130 CMR 456.409 states the following in relevant part regarding clinical eligibility criteria for long-term care services:

> 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.

(Emphasis added)

While the facility has clearly provided a valuable service to the appellant, he does not meet the criteria in 130 CMR 456.409 to qualify for custodial care. As testified by both parties at hearing, the appellant does not 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). He needs some verbal cueing for incontinence, particularly when he is engaged in activities, but does not require routine, scheduled assistance with toileting. He is independent with the other ADLs listed in 130 CMR 456.409, which includes bathing, dressing, transfers, mobility/ambulation, and eating. He needs some verbal cueing with medication management of oral medications, but no other ADLs or nursing services. The appellant's representatives from the facility offered no evidence that the appellant required assistance with his ADLs, but argued that his cognitive deficits required him to stay in the facility. Unfortunately, that does not meet the criteria for long-term or custodial care pursuant to the applicable MassHealth regulations. The appellant failed to satisfy his burden of proof to establish eligibility for custodial level of care.

As the appellant does not meet the criteria in 130 CMR 456.409 for custodial care, HNE's determination was correct and this appeal is denied.[5]

Order for MCO

None.

[5] Pursuant to 130 CMR 456.408, MassHealth will only pay for nursing facility services when MassHealth has determined that the individual meets the nursing facility services requirement of 130 CMR 456.409; community care is not available or not appropriate; and the pre-admission screening and resident review (PASRR) process has been met. As the appellant does not meet the nursing facility services requirement, the facility is not eligible for payment and the regulations for payment rates at 130 CMR 206.11 and 130 CMR 206.10(13) cited by the facility are irrelevant.

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.

Alexandra Shube
Hearing Officer
Board of Hearings

cc: Health New England, Attn: James Farrell, Complaints & Appeals, One Monarch Place, #1500, Springfield, MA 01144-1500

[redacted]