Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2410624
Decision Date:	09/26/2024	**Hearing Date:**	08/15/2024
Hearing Officer:	Kimberly Scanlon		

Appearances for Appellant:

[redacted]

Appearances for Fallon:
John A. Shea, Esq.
Michelle Malkoski, Senior Director, Summit ElderCare PACE Nursing and Quality

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:**	PACE; Denial of Request for LTC Services
Decision Date:	09/26/2024	**Hearing Date:**	08/15/2024
Fallon Reps.:	John A. Shea, Esq.; Michelle Malkoski, Senior Director	**Appellant Reps.:**	[redacted]
Hearing Location:	Tewksbury MassHealth Enrollment Center	**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

On June 26, 2024, Fallon Health (Fallon) notified the appellant of its decision to uphold its decision to deny her request for long-term care services (Exhibit 1). The appellant filed a request for hearing on July 8, 2024 (Exhibit 2). A managed care contractor's decision to deny authorization of a requested service is a valid basis for appeal (130 CMR 610.032(B)).

Action Taken by Fallon

Fallon upheld its decision to deny the appellant's request for long-term care services.

Issue

The appeal issue is whether Fallon's decision to deny the appellant's internal appeal denying her request for long-term care services is supported by regulation.

Summary of Evidence

Fallon was represented by an attorney who testified by telephone.[1] Fallon's representatives referenced the following chronology: On October 1, 2019, the appellant, a female then in her [redacted] was enrolled into Summit ElderCare, Fallon's PACE program. The appellant was recently admitted to a skilled nursing facility at a "respite level" after completing short-term rehabilitation. On June 18, 2024, Fallon received a request for long-term care services on behalf of the appellant (Exhibit 9, p. 6). On June 24, 2024, Fallon denied the request on the basis that it believed that there were community options that could be explored (Exhibit 9, p. 8). On June 24, 2024, the appellant's stepdaughter internally appealed this decision on the appellant's behalf on an expedited basis (Exhibit 9, p. 19). Fallon summarized the reasons for the appeal as follows:

> [Stepdaughter] contacted the Fallon Health Member Appeals and Grievances Department on behalf of [the appellant] to appeal the denied authorization for long term care facility services. [Stepdaughter] stated that [appellant] has been living in the community and has advanced dementia, approximately [redacted] years diagnosed into the disease. [Stepdaughter] stated that in [appellant's] home, her granddaughter was caretaking upon the passing of [appellant's] spouse [redacted] years ago. [Stepdaughter] stated that in the past 6 months, [appellant] has declined in that she has become a fall risk and more fragile and safety is a big issue. [Stepdaughter] stated that the past month has brought [appellant] to recement [sic] scenario. [Stepdaughter] stated that [appellant] has had 3 hospitalizations in 2 months and had 2 falls in 1 month that has caused hospitalizations. [Stepdaughter] stated that [appellant] has suffered a syncopal episode resulting in a loss of consciousness in rehab, and also suffered an MI while at an offsite doctor's visit resulting in a compromised cardiac system. [Stepdaughter] stated that they couldn't intervene due to comorbidities. [Stepdaughter] stated that this is just to summarize as [appellant] is a 24 hour and incontinent of urine and bowels. [Stepdaughter] stated that it's not safe without assistance. [Stepdaughter] has requested reconsideration of the denied authorization in question (Exhibit 9, p. 19).

On June 26, 2024, Fallon notified the appellant it was upholding its initial decision to deny her

[1] Another Fallon representative, the Senior Director of Nursing and Quality for Summit ElderCare, Fallon's Program of All-Inclusive Care for the Elderly (PACE) program, was also present at the hearing (by telephone).

request for long-term care services. The basis of the decision was that the appellant does not need long-term care services and that she has not exhausted all community options including assisted living facilities, memory care facilities, and adult foster care (Exhibit 1; Exhibit 9, p. 20). On July 8, 2024, the appellant filed an external appeal with the Board of Hearings (Exhibit 2).

By way of background, Fallon's attorney explained that its PACE program provides comprehensive health care services to frail, older adults living in the community. Fallon's attorney noted that the PACE program is governed by 42 CFR §460 *et seq*. Citing to 42 CFR §460.4, the attorney spoke to the PACE program's purpose and noted that its objectives are to enhance the quality of life and autonomy for frail, older adults, maximize dignity of, and respect for, older adults, enable frail, older adults to live in the community as long as medically and socially feasible, and to preserve and support the older adult's family unit. Citing to 42 CFR §460.92, he noted that the PACE benefit package for all participants must include all Medicare-covered services, all Medicaid-covered services, and other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status. Decisions by the interdisciplinary team to provide or deny services must be based on an evaluation of the participant that considers his or her current medical, physical, emotional, and social needs; and current clinical practice guidelines and professional standards of care.

Fallon's attorney explained that the PACE program is structured as a "team" approach to maintaining elders in their community. The whole concept of the team involves multiple disciplines, all of whom are required to be part of an interdisciplinary team. Citing to 42 CFR §460.102, he noted that a PACE organization must establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each participant. For each participant, the interdisciplinary team is responsible for the initial assessment, periodic reassessments, and plan of care, as well as ordering, approving, or authorizing all necessary care. Fallon's attorney explained that in this case, the interdisciplinary team performed its required duties under the federal regulations; it performed all necessary assessments and determined that the appellant could be safely cared for in the community setting.

Fallon's attorney referenced a provider evaluation for long-term care services that took place on June 21, 2024 at the skilled nursing facility where the appellant had been temporarily residing (Exhibit 9, pp. 35-41). He noted some of the findings from that evaluation, including that at the time of the visit, the appellant was feeding herself lunch. Per nursing staff, the appellant has been at her baseline. She is awake and alert during the day, eating meals, coloring, participating in activities and following direction. Because of her cognitive impairment and poor safety awareness, she is unable to be left alone at any time as she has such poor balance and safety awareness and requires supervision with all tasks involving mobility (Exhibit 9, p. 35). The appellant's chronic conditions were listed as stable (Exhibit 9, pp. 35-36). The physical exam findings were normal (Exhibit 9, p. 40). The appellant's dementia, seizures, spondylosis, cataracts, overactive bladder, and major depressive disorder are all listed as stable (Exhibit 9, pp. 40-41).

Fallon's attorney cited a physical therapy assessment that took place on June 21, 2024, related to the appellant's request for long-term care services. The physical therapist noted that the appellant was seated in an armchair and was alert, pleasant, and oriented to person. The appellant reported no pain. She demonstrated the ability to follow verbal and visual cues and demonstrated active movement in all four extremities. Staff reported that the appellant is supervised with all bed mobility, transfers and ambulates using a two-wheel walker with contact guard for occasional need to re-direct walker position. At the assessment, the appellant was observed transferring sit to stand without assist using walker and ambulated 25 feet with close supervision in the activity room. The physical therapist stated that the appellant requires supervision during all mobility due to poor memory and safety insight, and that she tolerates walking distances up to 150 feet per staff report. The physical therapist's recommendations/goals included a setting able to accommodate a walker and able to provide close supervision/contact guard during all mobility activities (Exhibit 9, p. 42).

Fallon's attorney referenced an occupational therapy assessment that took place on June 21, 2024, related to the appellant's request for long-term care services. The occupational therapist stated that the appellant requires an assist of one for bathing, dressing, grooming, toileting, and functional mobility. The appellant is able to feed herself after set up. She ambulates short distances with a rolling walker. The appellant is generally continent of bowel and bladder and does seek out assist for toileting. She is not consistent and does make attempts to toilet herself. She does have occasional urinary incontinence. The appellant is oriented to self and familiar caregivers and surroundings; she can follow commands but unable to initiate and complete self-care tasks without assist. The occupational therapist's recommendations/goals included a living environment where a 24-hour caregiver is available, as well as an assist of one with all activities of daily living (ADLs) and functional mobility (Exhibit 9, p. 43).

Fallon's attorney cited a home care progress note prepared by a nurse on June 21, 2024, related to the request for long-term care services. The nurse notes that the appellant is alert and forgetful. She can ambulate with walker and supervision. She lives with her granddaughter who reported that she is no longer willing to care for her. The appellant would do well in ALF memory care unit (Exhibit 9, p. 44).

Fallon's attorney referenced a semi-annual assessment that took place on March 8, 2024. At this assessment, the appellant's chronic conditions were all described as stable (Exhibit 9, p. 65). The assessment sets forth, in part, the following:

> PPt is [redacted] widower, enrolled in PACE on 10/2019, attend Summit 5x/week, transported by SWT. PPt resides with her grand stepdaughter who is her primary care giver, in PPt's own home since the passing of PPt's spouse > [redacted]. PPt receives all her medical services at PACE with the exception of outside referral services which PPt's transported by her family.

COGNITION: PPt's awake, alert, verbally responsive and pleasantly confused. PPt's oriented to self and family member, able to follow simple instructions, commands and able to make her basic needs known. Last Moca score 15/30, (10/2019). No further MoCA testing. HCP activated.

ACTIVITIES OF DAILY LIVING: PPt requires assist of 1 with all care. Able to attend to her BR needs and manage her clothing without any issues. Continent of B/B with occasional incontinence of bowels in the setting of chronic diarrhea. Ambulates independently with rolling walker (Exhibit 9, p. 64).

Fallon's attorney noted the appellant's Long Term Care Assessment Tool completed on June 24, 2024 (Exhibit 9, pp. 76-80). The case summary provides in relevant part as follows:

[Appellant] is a [redacted] widowed female who lives in her own home in Worcester with her step granddaughter who has been an intermittent caregiver. [Appellant] has been a member of Summit since Oct 1, 2019. [The appellant] ambulates with a walker and needs supervision with her eating but is able to feed herself. Dx's include: Dementia, Overactive Bladder, Chronic Low [sic] Pain and Hyperlipidemia. . . . She is alert and oriented x 1. She continues to require support and cueing for ADLs. . . . [Appellant] has had continued and expected decline in relation to progression of dementia.

[Appellant] had social respite [redacted] due to caregiver burnout. On [redacted] [appellant] had weakness requiring ER admission. Later transitioning to Lutheran [redacted] for short term rehab. On [redacted] [appellant] exhibited weakness and had an abnormal EKG and was at the ER. On [redacted] had a fall at Lutheran and returned to ER. On [redacted] had a fall/NSTEMI. [redacted] at Lutheran and became respite on [redacted]. [Appellant] has had continued and expected decline in relation to progression of dementia. She does not present with any mood or behavioral concerns. [Appellant] is prescribed donepezil, trazadone and sertraline. . . .

[Appellant] receives HHA and HMKR services to assist with ADLs and IADLs. There are no reported concerns regarding housing or finances. [Appellant's] step-granddaughter is caregiver and lives with [appellant]. Support provided to family related to caregiver stress and information provided on alternate living though family goal is for [appellant] to remain in her own home but now feels related to falls and dementia she can no longer be taken care of at home. [Appellant] has attended SE five times a week and benefits from memory care activities. Protective services closed out case in April. . . .

Stepdaughter declines referrals to AFC and Supportive Housing. Daughter also toured Colony, SW reviewed supportive housing and memory care assisted living

> on several occasions. Daughter also reviewed with team her thoughts regarding all of the alternative care at the family meeting on 6/18/24. . . . Daughter would like her to remain at Lutheran for LTC (Exhibit 9, pp. 76-77).

The assessment lists alternatives considered, including rest home, assisted living facility, additional home care, respite, and family member's home (Exhibit 9, p. 77). Under the section describing barriers and solutions, the team identified that a caregiver not always at home when the aide is scheduled to leave; the solution is described as having a willing and able caregiver to provide needed care, and a more supportive environment (Exhibit 9, p. 78). The interdisciplinary team's rationale for its final decision to deny long-term care services is described as "not all community-based options have been explored" (Exhibit 9, p. 80).

The Senior Director of Nursing and Quality for Summit ElderCare also provided testimony. She testified that during the enrollment process, PACE staff explained to the family that the PACE team considers the individual's care needs and explores all available community-based options prior to considering long-term care coverage. She explained that prior to PACE enrollment, MassHealth requires a Minimum Data Set (MDS) assessment to determine whether an individual requires nursing facility level of care (a PACE requirement). If an individual meets this level of care, their PACE enrollment represents a choice to live in the community, with PACE program support. The MDS assessment, completed in April 2019, did indicate that she had bowel and bladder incontinence, and needed physical assistance with ADLs including meal preparation, bathing, dressing, household tasks etc. At the time of enrollment, the appellant could not live independently. Some of the medical issues noted included dementia and chronic low back pain with compression fractures. She does have osteoporosis. Many of her diagnoses are chronic and stable and were present at the time that she enrolled in the PACE program.

The Senior Director explained that enrollment in the PACE program is voluntary, and disenrollment is always an option if desired. Once disenrolled, a new MassHealth application would be required. She noted that less than 10% of Summit ElderCare enrollees reside in a skilled nursing facility. Those that do are individuals who are medically complex and typically require clinical nursing assessments more than one time per day. Most enrollees, like the appellant, require custodial care and assistance with ADLs, and thus can be safely cared for in the community.[2] She clarified that the appellant is not obligated to reside with her granddaughter; there are other community options that would be appropriate for someone with the appellant's needs. Those options include a memory care facility, assisted living, adult foster care, and a supportive housing arrangement (such as a studio or senior housing apartment) with 24-hour health aides on site. These community options are less costly than skilled nursing facility care and would meet the appellant's needs. Summit ElderCare would

[2] The Senior Director noted that the appellant is a fall risk but indicated that her risk assessment results (performed every six months) have remained mostly consistent for the past five years. She noted that the appellant's arthritic pain has increased, necessitating the use of a pain patch and Tylenol.

contribute to the cost of assisted living and would cover adult foster care. The appellant has declined to trial these options and has not demonstrated that she meets the PACE program requirements for long-term care services.

Two of the appellant's stepdaughters appeared at the hearing and testified on behalf of the appellant. They submitted a letter in support of the appeal, which mirrors the testimony provided at the hearing. That letter provides in relevant part as follows:

> In discussing [appellant's] potential future needs upon enrolling in Summit 5 years ago, it was confirmed from the team that if [appellant] became in need of long-term care as a Summit client this would be provided as long as it was in one of the Summit contracted facilities. At the time we enrolled, however, we wished to keep [appellant] in the home. There were other more immediate assistive services that we have appreciated throughout the years that have helped us do just that.
>
> However, [appellant's] health has declined in the past couple of months, making it impossible to continue to keep her in the home safely. . . .
>
> [Appellant] has suffered from dementia for over 12 years. Our father . . . was [appellant's] primary caregiver until just before his passing in [redacted] A few months before he passed, [appellant's] (step) granddaughter moved into their home to help care for them both. . . . Without this commitment, [appellant] would have needed long term care at this juncture event [sic].
>
> It was our dad's wish that [step granddaughter] remain to assist with [appellant's] care as she needed a live-in caregiver due to her advanced Alzheimer's dementia as well as progressing incontinence and healthcare needs. The family and [step granddaughter] supported this decision.
>
> [Stepdaughters] and especially [step granddaughter] have worked daily affording [appellant] the security, safety, comforts and means to remain at home during her progressing healthcare needs. We have added cameras that oversee her safety, ensure all the bills are paid, groceries and other comforts provided, have the safety aids in place in all her areas, stay in contact with all healthcare teams. And of course, have [step granddaughter] living with [appellant] for her overall care and supervision now for[redacted]. There have been many healthcare events, hospitalizations and rehab stays that have all concluded with [appellant] returning to her home. We have always made keeping [appellant] in her home a priority.
>
> [Appellant's] health has sharply declined recently. She has had **3 hospitalizations**

in one month.
[redacted] – hospitalization – fall at home – new T2 and L5 spinal fractures – intractable pain.
[redacted] syncopal episode w unresponsiveness at rehab while in bathroom – witnessed – stabilized – not transferred.
[redacted] – hospitalization – MI – while rehab resident.
[redacted] – hospitalization – unwitnessed fall with unresponsiveness at rehab – admitted for UTI and dehydration.
[redacted] syncopal episode at rehab - family not informed until next day – not transferred.

[Appellant's] cognitive status has greatly diminished with her advanced Alzheimer's dementia. She has virtually no short-term memory. She is oriented to self only.
She has constant **fatigue and increasing weakness**.
She has become **nutritionally challenged**. New finding of aspiration risk and requires ground diet and assistance to sufficiently take in food. Disinterest in food.
She is a **High fall risk**.
Her cervical, thoracic and lumbar spine has new and old acute and chronic compression fractures. She is in constant risk of debilitating pain and chronic immobility.

She is now **24/7 supervision**. Cannot ambulate independently. With walker she requires cues and assistance for safety. She is at increased risk with her mobility status d/t her insistence to try to do for herself. She will attempt to move about alone if she does not have cues to wait for assistance.

She is **incontinent of both urine and bowel**. Chronic UTI's. . . .

Due to [appellant's] increasing needs in the past year and even before, we have considered other community options suggested . . . [and] none of them would be a fit for [appellant]. . . .

Memory care option is financially impossible for the family. And this is not a Summit option. The only memory care option they have offered to the family to investigate is in Leominster, a community too far from family. And her healthcare needs are too great for this facility. Incontinence, dysphasia. She is intellectually disabled, diagnosed with chronic diseases and was an inpatient at rehab center at time of investigating this option.

Foster care is not an option. If [appellant] would be safe in a home setting she

would be in her own home with her own relative caregiver. Also, see Supporting Document – Criteria for Foster Care from the Mass Assisted Living site. [Appellant] clearly does not fit this criteria. "Individuals who are intellectually disabled, are diagnosed with chronic diseases…do not qualify." She is intellectually disabled, diagnosed with chronic diseases and was an inpatient at rehab center at time of investigating this option.

Her own home setting is not longer safe for [appellant], there are too many safety concerns. The risk for fall is too high. Prior to April, [appellant] could safely get herself up and walk around with her walker. That is not possible any longer without assistance and if she attempts to get up without assistance, it is highly likely she will fall. It has already happened. It is not possible to watch her 24x7 in the home. The last time [appellant] fell, [step granddaughter] left the room for a moment to get the laundry. That's all the time it took for [appellant] to fall. It is also not possible to get a wheelchair into the downstairs bathroom, it is too small. The incontinence care is constant, skin breakdown risk [sic]. Nutrition challenges with required ground food and aspiration risk with eating now require supervision. Hospitalist at last admission and case manager both stated home setting was no longer a safe option for [appellant]. **Our history** with adding services requests has proven Summit does not have the staff to increase services to cover the needs of [appellant] in the home.

Assisted living is below the level of care she needs. This would be clearly unsafe. They have explained to use that though they offer care in the general facility 24x7, [appellant] would be alone in her apartment for long stretches of time. This puts her at the same risk as living at home without someone with her 24x7. [Appellant] was considered for the Assisted Living option at Lutheran Home and did not qualify. See Supporting Documents – Lutheran rejection for their assisted living. She is intellectually disabled, diagnosed with chronic diseases and was an inpatient at a rehab center at the time of investigating this option.

Supportive housing cannot provide the level of care and consistency of supervision [appellant] requires. Her condition and abilities have declined greatly over past month and her risks have greatly increased. **Supportive housing** cannot provide [appellant] the supervision and safety measures she requires. Too high safety and skin breakdown risk, aspiration risk, elopement risk. . . .

Based on the promise from Summit when we signed up for that [appellant] would be taken care of should the need for long-term care ever arise, the family is choosing at this time not to disenroll from Summit to pursue other options. The family took all information and stated benefits into consideration to choose Summit.

> [Appellant] has been in Lutheran House Rehab Worcester for this past month and a half and according to PT report has plateaued at her set goals at 24 hour supervision with all activity level. This facility is a summit [sic] contracted facility and has offered [appellant] a long term bed.
>
> Understanding that this is a rare and fleeting opportunity, the family is very eager for Summit to approve this. Lutheran has proven to be a very safe, clean and well-run facility that we can trust with the daily care for our step-mom. A rare find indeed. . . .
>
> We are appealing to this board to consider the obvious with both [appellant's] current health status as well as accelerating declining conditions and approve this request by the family (Exhibit 9, pp. 25-28).

Findings of Fact

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

1. The appellant is a female in her early [redacted].

2. On October 1, 2019, the appellant was enrolled in Fallon's PACE program, Summit ElderCare; the appellant continues to meet the clinical eligibility requirements of this program.

3. The appellant was recently admitted to a skilled nursing facility at a "respite level" after completing short-term rehabilitation. As of the date of hearing, the appellant was still at the skilled nursing facility.

4. On June 18, 2024, Fallon received a request for long-term care services on behalf of the appellant.

5. On June 24, 2024, Fallon denied the request on the basis that there were community options that could be explored.

6. On June 24, 2024, the appellant's stepdaughters internally appealed this decision on the appellant's behalf on an expedited basis.

7. On June 26, 2024, Fallon notified the appellant it was upholding its initial decision to deny her request for long-term care services. The basis of the decision was that the appellant does not need long-term care services and that she has not exhausted all community

options including assisted living facilities, memory care facilities, and adult foster care. All these options are less costly than long-term care services.

8. On July 8, 2024, the appellant filed an external appeal with the Board of Hearings.

9. The appellant has multiple chronic conditions including Alzheimer's disease, dementia, complex partial seizure disorder, spondylosis of lumbar region, cataracts of both eyes, overactive bladder, and major depressive disorder. All these conditions have been recently described as stable.

10. The appellant ambulates with a walker and the assistance of a contact guard. Because of her cognitive impairment and poor safety awareness, she is unable to be left alone due to poor balance and lack of safety awareness. She requires supervision with all tasks involving mobility.

11. The appellant requires an assist of one with all ADLs.

12. The appellant is generally continent of bowel and bladder but has occasional episodes of incontinence.

13. The appellant is a fall risk, but her risk assessment results have remained mostly consistent for the past five years; the appellant's arthritic pain has increased, necessitating the use of a pain patch and Tylenol.

14. The appellant's care needs are mostly custodial; she does not have significant clinical nursing needs.

15. The Summit ElderCare Enrollment Agreement provides the following regarding coverage of nursing home care:

    - Nursing home care (when community-based care is not feasible or reasonable as determined by the Summit ElderCare Care Team)
        - Semi-private room and board
        - Physician and nursing services
        - Custodial care when the Team cannot develop and support a community-based living arrangement
        - Personal care and assistance
        - Drugs and biologicals
        - Physical, speech and occupational therapies
        - Social services
        - Medical supplies and appliances (Exhibit 9, p. 140).

Analysis and Conclusions of Law

The PACE program is a comprehensive health program that is designed to keep frail, older individuals who are certified eligible for nursing-facility services living in the community (130 CMR 519.007(C)(1)). The MassHealth regulations set forth the following regarding PACE:

> (a) A complete range of health-care services is provided by one designated community-based program with all medical and social services coordinated by a team of health professionals.
> (b) The MassHealth agency administers the program in Massachusetts as the Elder Service Plan (ESP).
> (c) Persons enrolled in PACE have services delivered through managed care
> 1. in day-health centers;
> 2. at home; and
> 3. in specialty or inpatient settings, if needed.

In determining PACE eligibility, the applicant or member must meet all the following criteria:

> (a) be 55 years of age or older;
> (b) meet Title XVI disability standards if 55 through 64 years of age;
> (c) be certified by the MassHealth agency or its agent to be in need of nursing-facility services;
> (d) live in a designated service area;
> (e) have medical services provided in a specified community-based PACE program;
> (f) have countable assets whose total value does not exceed $2,000 or, if assets exceed these standards, reduce assets in accordance with 130 CMR 520.004: *Asset Reduction*; and
> (g) have a countable-income amount less than or equal to 300% of the federal benefit rate (FBR) for an individual.

(130 CMR 519.007(C)(2)).

The PACE program is also governed by federal regulations. As set forth above, the PACE program offers medical and social services that are coordinated by a team of health professionals. Per 42 CFR §460.102, PACE must establish an interdisciplinary team with the following responsibilities:

> Interdisciplinary Team.
> (a) Basic Requirement. A PACE organization must meet the following requirements:
> (1) Establish an Interdisciplinary team at each PACE Center to

comprehensively assess and meet the individual needs of each participant.

(2) Assign each participant to an interdisciplinary team functioning at the PACE Center that the participant attends. . . .

(d) Responsibilities of interdisciplinary team**.**

(1) The interdisciplinary team is responsible for the following for each participant:

(i) Assessments and plan of care**.** The initial assessment, periodic reassessments, and plan of care.

(ii) Coordination of care**.** Coordination and implementation of 24-hour care delivery that meets participant needs across all care settings, including but not limited to the following:

(A) Ordering, approving, or authorizing all necessary care.

(B) Communicating all necessary care and relevant instructions for care.

(C) Ensuring care is implemented as it was ordered, approved, or authorized by the IDT.

(D) Monitoring and evaluating the participant's condition to ensure that the care provided is effective and meets the participant's needs.

(E) Promptly modifying care when the IDT determines the participant's needs are not met in order to provide safe, appropriate, and effective care to the participant.

Per 42 CFR §460.92, PACE must provide the following services:

Required Services. The PACE benefit package for all participants, regardless of the source of payment, must include the following:

(a) All Medicare-covered items and services.

(b) All Medicaid-covered items and services, as specified in the State's approved Medicaid Plan.

(c) Other services determined necessary by the interdisciplinary team to improve and maintain the participant's overall health status.

Per 42 CFR §460.98, the scope of PACE services is described as follows:

(a) Access to services. A PACE organization is responsible for providing care that meet the needs of each participant across all care settings, 24 hours a day, every day of the year, and must establish and implement a written plan to ensure that care if appropriately furnished.

(b) Provision of services.

(1) The PACE organization must furnish comprehensive medical, health and social services that integrate acute and long-term care.
(2) These services must be furnished in at least the PACE Center, the home, and in-patient facilities.
(3) The PACE organization may not discriminate against any participant on the delivery of required PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, or source of payment.

(c) Minimum services furnished at each PACE center. At a minimum, the following services must be furnished at each PACE Center:
(1) Primary care, including physicians and nursing services.
(2) Social services.
(3) Restorative therapies, including physical therapy and occupational therapy.
(4) Personal care and supportive services.
(5) Nutritional counseling.
(6) Recreational therapy.
(7) Meals.

In this case, the Fallon determined that the appellant is not eligible for long-term care services because there are community housing options that will meet her needs. The appellant disputes this determination and argues that a skilled nursing facility is the only setting that is appropriate for her at this time. On this record, the appellant has not demonstrated that she meets Fallon's eligibility requirements for long-term care services.

Fallon pays for services that are 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: *Potential Sources of Health Care*, or 517.007: *Utilization of Potential Benefits*.

(130 CMR 450.204(A)).

As noted above, the PACE organization must furnish comprehensive medical, health and social services that integrate acute and long-term care, and these services must be furnished in at least the PACE Center, the home, and in-patient facilities (42 CFR §460.98). Per Fallon's policy as outlined in Summit ElderCare's Enrollment Agreement, nursing home care is covered "when community-based care is not feasible or reasonable as determined by the Summit ElderCare Care Team" (Exhibit 9, p. 140). Fallon argues that here, the appellant's needs are primarily custodial in nature, and that because she does not have significant clinical nursing needs, she can be safely cared for in a less costly community setting. Fallon provided examples of appropriate community housing options, including a memory care facility, assisted living, adult foster care, and a supportive housing arrangement (such as a studio or senior housing apartment) with 24-hour health aides on site.

The appellant argues that none of these options is feasible. The appellant argues that she can no longer live in her own home due to safety concerns and the need for constant supervision. The appellant's representatives noted the appellant's recent falls as evidence that this living arrangement is no longer safe. Similarly, they argue that the appellant cannot participate in adult foster care or live in basic assisted living facility or supportive housing for the same reasons. They argue that the appellant would be alone for long stretches of time, putting her at risk for falls, skin breakdown, and aspiration. They feel that the support available in some of these settings, such as the health aides on site in a supportive housing setting, would be helpful but not the 24/7 supervision needed to keep the appellant safe. The record provides some support for these arguments (Exhibit 9, pp. 48-63). Importantly, however, Fallon has suggested additional home care support and has recommended that the appellant continue her weekday day program attendance (Exhibit 9, p. 30). Without evidence that these additional supports have been trialed, the appellant has not demonstrated that these community options will not safely meet her medical needs.

Further, the appellant also rejected the memory care facility option on the basis that it is too expensive and too far away. These factors may certainly present logistical challenges. There is no evidence, however, that this community option is unsafe or will not meet the appellant's medical needs. This setting, which is also less costly than long-term care at a skilled nursing facility, is specifically geared toward those living with dementia.

On this record, the appellant has not provided sufficient evidence to conclusively establish that there is no medically appropriate community housing setting that is available to her. The appeal is denied.

Order for Fallon

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.

Kimberly Scanlon
Hearing Officer
Board of Hearings

cc: [redacted]

Fallon Health
Member Appeals and Grievances
10 Chestnut Street
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[redacted]

[redacted]