

**Office of Medicaid  
BOARD OF HEARINGS**

**Appellant Name and Address:**

[REDACTED]

<b>Appeal Decision:</b>	Denied	<b>Appeal Number:</b>	2517282
<b>Decision Date:</b>	02/13/2026	<b>Hearing Date:</b>	01/15/2026
<b>Hearing Officer:</b>	Christopher Jones		

**Appearance for Appellant:**

[REDACTED]

**Appearance for CHA:**

[REDACTED] PT, DPT  
[REDACTED], Program Director  
[REDACTED] Director of Operations



*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

<b>Appeal Decision:</b>	Denied	<b>Issue:</b>	Waivers; Program of All-Inclusive Care for the Elderly (PACE)
<b>Decision Date:</b>	02/13/2026	<b>Hearing Date:</b>	01/15/2026
<b>PACE Reps.:</b>	[REDACTED]	<b>Appellant's Reps.:</b>	[REDACTED]
<b>Hearing Location:</b>	Telephonic	<b>Aid Pending:</b>	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 letter dated November 10, 2025, Cambridge Health Alliance (CHA), a Program of All-Inclusive Care for the Elderly (PACE) plan, denied the appellant's internal appeal for continuation of short-term rehabilitation services. (Exhibit 1.) The appellant filed this appeal in a timely manner on November 21, 2025. (Exhibit 1; 130 CMR 610.015(B).) A managed care contractor's decision to limit requested services is grounds for appeal (130 CMR 610.032(B)), and a PACE plan must allow for external review of its coverage decisions (42 CFR § 460.124).

### Action Taken by Cambridge Health Alliance

CHA denied the appellant's request for continued short-term rehabilitation and recommended a transition to long term care.

### Issue

Whether CHA appropriately assessed and documented the appellant's need for a transition to long term care, pursuant to 130 CMR 519.007 and 42 CFR 460.000, et seq.

## Summary of Evidence

The appellant has been participating in CHA's PACE plan since December 2020. (Exhibit 4, p. 35.) The appellant was hospitalized in the summer of [REDACTED] due to worsening wounds and cellulitis. The appellant has been in either a skilled nursing facility or a hospital since this admission. (Exhibit 4, p. 36.) Even prior to this admission, the appellant was bed bound with poor mobility due to right hip [REDACTED] causing overuse of and distortion of the left ankle. (Exhibit 4, p. 68.)

The appellant's left ankle was found to have a bone infection, and he underwent surgery for osteomyelitis with an exposed bone in [REDACTED]. (Exhibit 4, p. 64.) The appellant testified that after the surgeon removed a bone from his ankle, they attached a fixator to straighten the ankle. CHA's nurse practitioner who reviewed the appellant's case described the purpose of the fixator as "reducing skin tension to aid in healing." (Exhibit 4, p. 64.) The appellant testified that the surgeon had told him that they could either remove the foot or remove the ankle bone and attempt to reconstruct the foot with the goal of it being weightbearing. The appellant testified that the fixator was just recently removed, and he is awaiting future surgery to insert a metal pin. The appellant would not be able to begin rehabilitation to achieve weightbearing on that foot until after this future surgery has been done and he has healed from it. CHA's nurse practitioner described the possibility of future weightbearing as "uncertain and ambulation is not likely." (Exhibit 4, p. 68.)

CHA's representatives testified that the decision was a medical one based upon the appellant's medical condition. In October 2025, an interdisciplinary team reviewed the appellant's medical history and current prognosis. Their determination was that the appellant required 24/7 support including 2 people to assist him with many of his ADLs. (Exhibit 4, pp. 45-47.) The appellant's family had reported at that time that they were unable to provide needed care in the community. (Exhibit 4 pp. 47, 63.)

The reason why the decision needed to be made is that the appellant is MassHealth member. Broadly, CHA tries to keep aligned with MassHealth and Medicare's eligibility criteria, though they are able to provide some flexibility around these rules. There is a MassHealth eligibility rule that once a member has been in a nursing facility for 6 months that they must convert to a long-term status. CHA's representatives explained that the appellant is welcome to remain a member of the PACE, and that CHA would continue to review requests for therapies in the future.

The long-term care conversion would largely be a financial change whereby MassHealth would review the appellant's finances and determine a patient-paid amount. CHA does not handle the financial eligibility, that determination would need to be made by MassHealth. Because the appellant has a community spouse, she could be eligible to keep some of his income as a spousal maintenance allowance. If the appellant has more questions about this process, he will need to speak with a long-term care worker at MassHealth.

The appellant felt that the decisions around whether he could go home have been confusing. At first, the problem was that his wife was not home all the time. Now the appellant's daughter had moved into his community home, so there would be additional family support. The appellant acknowledged that he still could not engage in any independent mobility, so it would not be appropriate to go home right now. However, the appellant's family was planning to set up a bed for him on the first floor to help with his ability to stay at his home. CHA's representatives testified that the ankle surgery and external fixator were an escalation of care since the decision to stop short-term services. The appellant agreed that he was not in a position to return home to the community in the immediate future.

## Findings of Fact

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

- 1) The appellant is over the age of 65, and he has been enrolled in CHA's PACE plan since March 2020. (Testimony by PACE representatives; Exhibit 4, p. 35.)
- 2) The appellant suffers multiple chronic conditions, and he was bed bound with poor mobility due to [REDACTED] causing overuse of and distortion of the left ankle, even when he resided in the community. (Testimony by PACE representatives; Exhibit 4, p. 68.)
- 3) In the summer of [REDACTED], the appellant was hospitalized for worsening wounds and cellulitis. (Testimony by PACE representatives; Exhibit 4, p. 36.)
- 4) Since this initial hospitalization, the appellant has not returned to a community setting. (Testimony by PACE representatives; testimony by the appellant.)
- 5) In October 2025, an interdisciplinary team at CHA reviewed the appellant's case and determined that the appellant required 24/7 support including 2 people to assist him with many of his ADLs. As such, they decided that a long-term care setting was the best place for the appellant. (Exhibit 4, pp. 45-47.)
- 6) In October 2025, the appellant's family was unable to provide needed care in the community. (Exhibit 4 pp. 47, 63.)
- 7) The appellant had surgery in [REDACTED] related to a left ankle bone infection. The appellant was informed that his choices were to remove the foot or remove the ankle bone and attempt to reconstruct the ankle. (Exhibit 4, p. 64; testimony by the appellant.)
- 8) The appellant still requires further surgery to place a pin in the ankle, and only after he has healed from that would he be able to attempt to begin rehabilitation. (Testimony by the appellant.)

## Analysis and Conclusions of Law

The Programs of All-Inclusive Care for the Elderly is one of several Medicaid waiver programs that allow state Medicaid agencies, such as MassHealth, to experiment with different reimbursement methods for providing care to frail and elderly populations. (See Centers for Medicare and Medicaid Services, Programs of All-Inclusive Care for the Elderly (PACE) Manual, CMS Pub. 100-11 [“PACE Manual”], Ch. 1, § 10 (Rev. 2, June 9, 2011) (available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf> (last visited February 11, 2026)).)

PACE provides participants all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team (IDT), as well as additional medically necessary care and services not covered by Medicare and Medicaid. There are no limitations or condition as to amount, duration or scope of services and there are no deductibles, copayments, coinsurance, or other cost sharing that would otherwise apply under Medicare or Medicaid. The IDT assesses the participant’s needs and develops a comprehensive care plan that meets the needs of its participants across all care settings on a 24 hour basis, each day of the year.

(PACE Manual at § 30.3; see also 42 USC § 1395eee.)

A PACE “benefit package for all participants” must include access to all Medicare- and Medicaid-covered services and may also include “[o]ther services determined necessary by the interdisciplinary team to improve and maintain the participant’s overall health status.” (42 CFR 460.92(a) (Jan. 19, 2021).) A PACE organization must “[e]stablish an interdisciplinary team ... at each PACE center to comprehensively assess and meet the individual needs of each participant.” (42 CFR § 460.102(a)(1) (Mar. 22, 2021).) This interdisciplinary team must be comprised of at least 11 different participants representing various caregiver roles. (See 42 CFR § 460.102(b)(1)-(11).)

The interdisciplinary team is responsible for assessing and meeting the member’s individual needs. (42 CFR § 460.102(a)(1).) However, the interdisciplinary team has wide latitude regarding medical decision-making, so long as decisions are based upon “all relevant information ... including findings and results of any reassessments required” when a specific service is requested. (42 CFR § 460.121(g); see also 42 CFR § 460.92(b).) These decisions and the recommendations underlying them must be thoroughly documented. (42 CFR § 460.210(b).)

MassHealth’s regulations do not provide additional guidance regarding how an IDT is to review a participant’s request for services or how an IDT’s decision should be reviewed. (See 130 CMR 519.007(C).) Medicare generally only covers 30 days of rehabilitation services following hospitalization, and Medicare has a maximum coverage of 100 days of rehabilitation services. (Exhibit 4, pp. 116-117.) MassHealth will automatically convert a beneficiary from short-term care to long-term care after six months from their initial admission to a nursing facility. (See 130 CMR 520.026(D).)

