Assisted Living Services [Specialized Personal Assistance (SPA)] Necessity Guideline

Medical Necessity Guideline (MNG) Title: Assisted Living Services [Specialized Personal Assistance (SPA)]		
MNG #: 068	**☒ CCA Senior Care Options (HMO D-SNP) (MA)** **☒ CCA One Care (Medicare-Medicaid) (MA)**	**Prior Authorization Needed?** **☒ Yes (always required)** **☐ Yes (only in certain situations. See this MNG for details)** **☐ No**
Benefit Type: **☐ Medicare** **☐ ☒ Medicaid**	**Approval Date:** 5/6/2021;	**Effective Date:** 08/21/2021, 12/12/24; 12/23/2025
Last Revised Date: 8/10/2023; 12/12/24; 12/23/2025	**Next Annual Review Date:** 5/6/2022; 8/10/2024; 12/12/25; 12/23/2026	**Retire Date:**

OVERVIEW:

Assisted Living Services (ALS) - A residential service that provides personal care and support services (homemaker, chore, personal care services, and meal preparation) for elderly or disabled persons in a home like environment. Assisted living residences (ALRs) includes 24-hour on-site response capability to meet scheduled or unpredictable resident needs and to promote the health of individuals by offering a combination of housing, meals, and personal care services to adults. ALRs may also include assistance with medication and offer social and recreational programs. ALRs do not provide medical or nursing services and they are not designed for adults who need serious medical care on an ongoing basis. The member pays the cost of room and board, usually through an income subsidy known as Supplemental Security Income ("SSI") (See Department of Transitional Assistance regulation at 106 CMR 327.220.)

DEFINITIONS:

Activities of Daily Living (ADLs): Fundamental personal-care tasks performed daily as part of an individual's routine of self-care. ADLs include, but are not limited to, eating, toileting, dressing, bathing, transferring, mobility and ambulation

Adult Day Health (ADH: Health care and supervision, restorative services, and socialization for elders who require skilled nursing or therapy, or assistance with Activities of Daily Living, nutrition, and personal care

Assisted Living Residence or Residence: Any entity certified by Elder Affairs under 651 CMR 12.00, however organized, whether conducted for profit or not for profit, which meets all of the following criteria:

- provides room and board; and

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- provides, directly by its employees or through arrangements with another organization which the entity may or may not control or own, Personal Care Services for three or more adults who are not related by consanguinity or affinity to their care provider; and
- collects payments or third-party reimbursements from or on behalf of Residents to pay for the provision of assistance with the Activities of Daily Living, or arranges for the same

Assisted Living Services: services consist of personal care and supportive services (for example, homemaker, chore, personal care services, meal preparation) that are furnished to participants who reside in an assisted living residence (ALR) that meets all applicable requirements of 42 CFR441.301(c)(4) (Home and Community-based Settings Rule), and include 24-hour, on-site response capability to meet scheduled or unpredictable resident needs and to provide supervision, safety ,and security. Services may also include social and recreational programs, and medication assistance (consistent with ALR certification and to the extent permitted under State law). Nursing and skilled therapy services are incidental rather than integral to the provision of Assisted Living Services. Intermittent skilled nursing services and therapy services may be provided to the extent allowed by applicable regulations

Chore: Services to maintain the home in a clean, sanitary and safe manner, including but not limited to minor home repairs, general maintenance, and heavy household chores such as washing floors, windows, and walls, and moving heavy items of furniture to provide safe access and egress

Clinical Assessment: The comprehensive screening process of documenting a member's need using the Minimum Data Set (MDS) tool to form the basis for prior authorization

Companion Services: nonmedical care, supervision, and socialization provided to a participant. Companions may assist or supervise the participant with such light household tasks as meal preparation, laundry, and shopping

Grocery Shopping/Delivery Services: Ordering groceries, shopping for groceries, delivering groceries, and assisting with storage of groceries as needed

Home Delivered Meals (HDM): Meals provided to Consumers to maintain optimal nutrition and health status

Homemaker Services: Services to assist a client with Instrumental Activities of Daily Living provided in accordance with homemaker standards issued by Elder Affairs

Instrumental Activities of Daily Living (IADLs): certain basic environmental tasks required for daily living, including the ability to prepare meals, do housework, laundry, and shopping, get around outside, use transportation, manage money, and use the telephone

Member: a person who is enrolled in the CCA once care (ICO) or CCA Senior Care Options (SCO) plan

Medical necessity guidelines (MNGs): Medical policies that are developed to publish what services are covered and to provide a better understanding of the basis upon which coverage decisions are made. MNGs are only developed for select preventive, therapeutic, or diagnostic services that have been found to be safe and proven effective for a defined population or in specific clinical circumstances.

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Not Medically Necessary: Items and services that do not meet the definition of medical necessity. According to CMS, Medicare does not pay for medically unreasonable and unnecessary services and supplies to diagnose and treat a Medicare patient's condition. This includes, but not limited to the following:

- Hospital-provided services that, based on the patient's condition, could have been provided in a lower-cost setting, like the patient's home or nursing home; *or*
- Hospital services exceeding Medicare length of stay limits; *or*
- Evaluation and management services exceeding those considered medically reasonable and necessary; *or*
- Excessive therapy or diagnostic procedures; *or*
- Unrelated screening tests, exams, and therapies where the patient has no symptoms or diagnoses, except certain screening tests, exams, and therapies; *or*
- Unnecessary services based on the patient's diagnosis.

Prior Authorization: Prior assessment that must be conducted to evaluate whether the service requested is deemed medically necessary and meets the specific requirements outlined in the health plan's documents. It is based on information provided (e.g., letter of medical necessity, medical records, etc.) to determine whether the proposed services meet the clinical requirements for medical necessity, which includes appropriateness, effectiveness, and level of care.

Personal Care Service: Assistance with one or more of the Activities of Daily Living and Self-administered Medication Management (SAMM), either through physical support or supervision. Supervision includes reminding or observing residents while they perform activities

Provider: An organization that meets the requirements of 651 CMR 12.00 and contracts with MassHealth as the provider for ALS

Respite Services: services provided to individuals unable to care for themselves; furnished on a sort-term basis because of the absence or need for relief of unpaid caregivers

Room and Board: the term room means shelter-type expenses, including all property-related costs, such as rental or purchase of real estate, maintenance, utilities, and related administrative services. The term board means up to three meals a day or any other full nutritional regimen

Self-administered Medication Management (SAMM): A process which includes reminding Residents to take medication, opening containers for Residents, opening prepackaged medication for Residents, reading the medication label to Residents, and observing Residents while they take the medication.

DECISION GUIDELINES:

Clinical Coverage Criteria:

1. Commonwealth Care Alliance (CCA) may cover Assisted Living Services [Specialized Personal Assistance (SPA)**]** when all the following criteria are met:
    a. The member has a physical, cognitive or mental health condition that requires daily assistance with at least **one** of the Activities of Daily Living (ADLs) described below*. Such

assistance must be either:

1. Hands-on (physical) assistance, or
2. Cueing and supervision throughout the entire ADL.

*Qualifying ADLs include the following: Bathing, Dressing, Toileting, Transfers, Mobility, (ambulation/locomotion) or Eating

DETERMINATION OF NEED:

Prior Authorization:

1. There are two payment rates for Assisted Living Services, Basic and Special Care/Memory Care Unit. CCA will determine the payment rate based upon the clinical criteria. Providers may request the level of payment assuming the clinical documentation submitted with the prior authorization demonstrates the following:
    a. Basic Payment- For a member to qualify for Basic payment:
        i. the member must need assistance with at least one of the Qualifying ADLs described in the Clinical Criteria section above
    b. Special Care/Memory Care Unit. For a member to qualify for Special Care/Memory Care Unit payment:
        i. the member must need assistance with at least one of the Qualifying ADLs as described in the Clinical Criteria section above; AND
        ii. The member must reside in a certified ALS Special Care/Memory Care unit

2. Requests for prior authorization must be submitted to CCA as outlined in the CCA Provider Manual

3. As a prerequisite for payment of Assisted Living Services, prior authorization must be obtained before the first date of service delivery and at various intervals. CCA may take up to 14 days to process a request

4. Prior Authorization requests must be submitted at the following intervals:
    a. Initial Authorization –Before the first date of service delivery; services will not be approved retroactively
    b. Re-authorization – For members with an existing prior authorization a new authorization request should be submitted at least 14 calendar days before the existing authorization end date

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Prior Authorization Documentation:

1. Documentation of medical necessity for Assisted Living Services must include, at a minimum, the following:

a) The member has a physical, cognitive, or mental health condition that requires daily assistance with at least one of the Qualifying ADLs; and
b) CCA Standardized Prior Authorization Request Form; and
c) CCA Clinical Assessment (MDS) to support eligibility; and
d) CCA Personal Care Plan; and
e) ALS Service Plan or Preadmission assessment, and
f) Other documentation to support the medical necessity review including but not limited to: Clinical documentation evaluations, ALS Individualized Service Plan, primary care provider notes, hospital paperwork or other clinical assessment.

EXCEPTIONS/LIMITATIONS/EXCLUSIONS:

Exceptions:

1. Personal Care Agency, Home Health Aide, or Supportive Home Care Aide may be authorized in addition to ALS if the CCA clinician determines that the member's ADL assistance needs exceed what the ALR can fully provide. Such services may not be provided for the purpose of supervising the member.
2. PERS may be authorized if the Assisted Living Residence does not have a call system and the use of PERS has been approved by the Executive Office of Elder Affairs as part of its certification review.
3. Members receiving ALS may also attend an ADH up to 2 days per week.
4. CCA typically does not combine ALS with the following services unless there are unique member-specific needs requiring consideration and those other services do not duplicate services. In these circumstances, the ALRs are expected to provide:
    - Adult Foster Care (AFC) or Group Adult Foster Care (GAFC)
    - Chore
    - Companion
    - Grocery Shopping and Delivery Service
    - Homemaker
    - Home Delivered Meals (HDM)
    - Laundry
    - Home Modifications/Adaptations
    - Personal Care Attendant (PCA)
    - Respite

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Limitations:

1. Coverage will be only for SCO members who meet Nursing Home Certified rating category.
2. Agency Personal Care, Home Health Aide, and Supportive Home Care Aide may be provided (see below), but only by an outside agency.
3. The costs of room, board or deposits are not covered

3. Exclusions: CCA does not pay for ALS in the following circumstances:

1. The member is not living in an Assisted Living Facility
2. The member is inpatient of a hospital, nursing facility
3. The ALS provider has not received prior authorization from CCA
4. When ALS is requested for emergency shelter

CODING:

When applicable, a list(s) of codes requiring prior authorization is provided. This list is for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment.

HCPCS Codes	Description
T2031	Assisted living; waiver, per diem
T2031/Modifier TG	Use TG for Assisted Living Special Care/Memory Care Unit)

References:

1. 106 CMR 327.00: Eligibility requirements for State Supplement Program (SSP). Accessed December 1. 2024. https://www.mass.gov/regulations/106-CMR-32700-eligibility-requirements-for-state-supplement-program-ssp
2. 130 CMR 408.00 Adult Foster Care Program Regulations. Accessed December 1. 2024. https://www.mass.gov/regulations/130-CMR-408000-adult-foster-care
3. Home-and-Community-Based Waiver Services. Accessed December 1, 2024. https://www.mass.gov/regulations/130-CMR-630000-home-and-community-based-services-waiver-services
4. 130 651 CMR 3.00 Home Care Program. Accessed December 1, 2024. https://www.mass.gov/regulations/651-CMR-300-home-care-program
5. 651 CMR 12.00: Certification Procedures and Standards for Assisted Living. Accessed December 1, 2024. https://www.mass.gov/regulations/651-CMR-1200-certification-procedures-and-standards-for-assisted-living-residences

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Disclaimer

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual© criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists. Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

This Medical Necessity Guideline is not a rigid rule. As with all CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity [supporting literature (full text preferred) should be attached to the request], or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

required.

REVISION LOG:

REVISION DATE	DESCRIPTION
12/12/24	Template updated. Updates to assessment requirements. MDS added. HCPCS code definitions added.

7/28/2023	Revised Title of MNG, Overview section, Added Definitions section, Added Criteria to the title of Clinical Coverage and Eligibility under the Decision Guidelines and added sub sections – Prior Authorization and Prior Authorization Documentation sections, revised Limitations/Exclusion section, added Exceptions to Limitations/Exclusion section, removed Key Care Planning Section, update Regulatory Notes Section and Revised Related References

APPROVALS:

Jeffrey Sedlack	Senior Medical Director Utilization Review and Medical Policy
CCA Clinical Lead	**Title**
	12/23/2025
Signature	**Date**
CCA Senior Operational Lead	**Title**
Signature	**Date**
CCA CMO or Designee	**Title**