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456.401: Nursing Facility Services: Introduction

130 CMR 456.000 establishes the requirements for nursing-facility services under MassHealth. All nursing facilities participating in MassHealth must comply with the regulations governing MassHealth including, but not limited to, the regulations set forth in 130 CMR 456.000 and 130 CMR 450.000.

456.402: Definitions

Board of Hearings — the unit within MassHealth that is responsible for administering the fair-hearing process under 130 CMR 610.000 and claims for adjudication hearings under 130 CMR 450.241, including hearings about transfers and discharges of residents by nursing facilities.

Discharge — the removal from a nursing facility to a noninstitutional setting of an individual who is a resident where the discharging nursing facility ceases to be legally responsible for the care of that individual; this includes a nursing facility's failure to readmit following hospitalization or other medical leave of absence.

Fair Hearing — an administrative, adjudicatory proceeding conducted pursuant to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants and members, or residents.

Hospital — an inpatient facility that is licensed as a hospital by the Massachusetts Department of Public Health.

Length of Stay — the duration of a member's inpatient hospital stay at a Medicare hospital level of care during a medical leave of absence.

Medical Leave of Absence — an inpatient hospital stay at a Medicare level by a member who is a resident of a nursing facility. MassHealth pays a nursing facility for up to 10 consecutive medical leave of absence days in a hospital.

Medicare Hospital Level of Care — a level of care that meets all criteria, as determined by the Centers for Medicare and Medicaid Services or its agent, for MassHealth payment for hospital care.

Member — a person determined by MassHealth to be eligible for MassHealth.

Mobility System — any manual or motorized wheelchair or other wheeled device, such as a scooter, including its components, accessories, and modifications, that is prescribed by a physician.

Nursing Facility — an institution or a distinct part of an institution that meets the provider-eligibility and certification requirements of 130 CMR 456.404 or 456.405. For requirements related to the transfer and discharge of residents, the term nursing facility also includes a nursing facility participating in Medicare, whether or not it participates in MassHealth.

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Patient-Paid Amount — The portion of monthly income that a member in a nursing facility must contribute to the cost of care.

Personal Needs Allowance (PNA) — the designated portion of monthly income that a member in a facility is allowed to keep for personal expenses.

Personal Needs Allowance (PNA) Account — an account or accounts administered by a nursing facility on behalf of a member. The account may be used to deposit the PNA and any other money, such as a gift, belonging to the member.

Resident — an individual receiving care in a nursing facility regardless of whether the individual is a MassHealth member.

Transfer — movement of a resident from:

- (1) a Medicaid- or Medicare-certified bed to a noncertified bed;
- (2) a Medicaid-certified bed to a Medicare-certified bed;
- (3) a Medicare-certified bed to a Medicaid-certified bed;
- (4) one nursing facility to another nursing facility; or
- (5) a nursing facility to a hospital, or any other institutional setting.

A nursing facility’s failure to readmit a resident following hospitalization or other medical leave of absence, resulting in the resident being moved to another institutional setting is also a transfer. Movement of a resident within the same facility from one certified bed to another bed with the same certification is not a transfer.

Unit-Dose Packaging — an individual drug product container usually consisting of foil, molded plastic, or laminate with indentations for a single solid oral dosage form, with any accompanying materials or components, including labeling. Each individual container fully identifies the drug and protects the integrity of the dosage. For purposes of 130 CMR 456.000, an assemblage of multiple, unlabeled single doses (traditional “bingo cards” or “bubble packs”) is not unit-dose packaging.

Working Days — Monday through Friday except for legal holidays.

456.403: Eligible Members

- (A) (1) MassHealth Members. MassHealth pays for nursing-facility services only when provided to eligible MassHealth members, subject to the restrictions and limitations in MassHealth regulations. MassHealth regulations at 130 CMR 450.105 specifically state which services are covered and which members are eligible to receive those services.
- (2) Recipients of Emergency Aid to the Elderly, Disabled and Children. For information on covered services for recipients of Emergency Aid to the Elderly, Disabled and Children, see 130 CMR 450.106.

- (B) For information on verifying member eligibility and coverage type, see 130 CMR 450.107.

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456.404: Requirements for Provider Participation: In State

To be eligible to participate in MassHealth, a nursing facility located in Massachusetts must:

- (A) be licensed by the Massachusetts Department of Public Health to operate such a facility;
- (B) be certified by the Massachusetts Department of Public Health as meeting the federal requirements for participation in MassHealth under Title XIX of the Social Security Act; and
- (C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406.

456.405: Requirements for Provider Participation: Out of State

To be eligible to participate in MassHealth, an out-of-state nursing facility must:

- (A) be licensed by the appropriate state licensing authority to operate such a facility;
- (B) be certified by the state survey agency in accordance with 42 U.S.C. 1396a(a)(33)(b);
- (C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406; and
- (D) participate in the medical assistance program of its own state.

456.406: Medicare Certification Requirement

Nursing facilities must be certified for participation in the Medicare program pursuant to Title XVIII of the Social Security Act, as amended from time to time, and regulations promulgated thereunder. If a facility or institution has only one unit licensed to provide skilled-nursing care, then that unit must be Medicare certified. A facility with more than one unit licensed to provide skilled-nursing care may have one non-Medicare-certified unit. For a facility that was a MassHealth provider as of October 1, 1990, failure to comply with this requirement may result in an imposition of an administrative fine by the Division, or may result in the facility's suspension from participation in MassHealth. For any facility applying to be a MassHealth provider after October 1, 1990, including facilities built after October 1, 1990, and facilities participating in MassHealth on October 1, 1990, that subsequently changed owners, failure to comply with this requirement will preclude such facility from participating in MassHealth.

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456.407: Clinical Authorization of Nursing-Facility Services

(A) Clinical authorizations for nursing-facility services may be for a specified or indefinite length of stay. Authorizations for an indefinite length of stay may be subject to review by the Division or its agent to ensure that conditions for payment continue to be met. New clinical authorizations are required when:

- (1) a member is transferred from one nursing facility to another nursing facility;
- (2) a member who is hospitalized is to be admitted to a different nursing facility from the one the member resided in before the hospital admission;
- (3) a member who has been hospitalized for over six months seeks to be readmitted to the nursing facility where the member resided before hospital admission; and
- (4) a member has discharge potential as provided for in 130 CMR 456.411.

(B) The Division notifies nursing facilities, hospitals, physicians, and home-health agencies of the identity of the agent responsible for authorizing nursing-facility services in accordance with 130 CMR 456.000.

(C) The referring medical provider must submit the request for authorization of nursing-facility services to the Division or its agent on behalf of the member. For persons who become eligible for MassHealth while residing in a nursing facility, the facility itself must submit the request for authorization. The request for authorization of nursing-facility services must be submitted on the forms required by the Division and must include documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs.

(D) If the Division determines that a member is eligible for nursing-facility services, the Division will issue a notice that contains the effective date of coverage and the patient-paid amount. This notice is confirmation to the facility that the Division has authorized payment of nursing-facility services for the member.

456.408: Conditions for Payment

(A) The Division pays for nursing-facility services if all of the following conditions are met.

- (1) The Division or its agent has determined that individuals aged 22 and older meet the nursing-facility services requirements of 130 CMR 456.409 or that the medical review team coordinated by the Department of Public Health has determined that individuals aged 21 or younger meet the criteria of 130 CMR 519.006(A)(4).
- (2) The Division or its agent has determined that community care is either not available or not appropriate to meet the individual's needs.
- (3) The requirements for preadmission screening at 130 CMR 456.410 have been met.

(B) The Division pays for nursing-facility services beginning with the date of financial eligibility provided that the member shows that he or she was medically eligible for these services as of the date of financial eligibility. If the member was not medically eligible for nursing-facility services as of the first date of financial eligibility, the Division will pay for these services beginning on the first date the member is medically eligible, provided that this date is after the first date of financial eligibility. A person may request a determination of medical eligibility at or after application for MassHealth.

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(C) 130 CMR 456.408(A) and (B) do not apply to MassHealth members enrolled with a senior care organization. Enrollment in a senior care organization is voluntary and subject to change. Providers are responsible for verifying member status on a daily basis. For more information, see 130 CMR 450.117(D).

456.409: Services Requirement for Medical Eligibility

To be considered medically eligible for nursing-facility services, the member or 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 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;

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(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 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-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-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);

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- (7) physician-ordered licensed registered 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 orders, or routine changing of dressings that require nursing care and monitoring.

456.410: Screening for Mental Illness and Mental Retardation

(A) The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) established a requirement that individuals be screened before admission to a nursing facility to determine if the individual has a major mental illness, mental retardation, or developmental disabilities. The federal requirements are contained in 42 U.S.C. 1396r(e)(7). The Division of Medical Assistance implements this requirement under the terms of 130 CMR 456.410.

(B) The nursing facility must complete a Preadmission Screening Level I form for all admissions. The completed form must be kept in the resident's medical record. If it is determined that the individual has a major mental illness, mental retardation, or a developmental disability, then the Department of Mental Health or its agent or the Department of Mental Retardation or its agent, as appropriate, must perform Level II screening, unless one of the conditions of 130 CMR 456.410(C) applies.

(C) A Level II referral and screening is not required when:

- (1) the individual is to be admitted to the nursing facility directly from a hospital provided that the placement is expected to last for 30 days or less;
- (2) a physician has certified that the individual has a terminal illness and the prognosis is six months or less;
- (3) the individual is comatose or functioning at brain-stem level;
- (4) the individual has a mental illness and one of the following primary diagnoses:
 - (a) Alzheimer's disease or other dementia documented by a neurological examination;
 - (b) severe and debilitating Parkinson's disease;
 - (c) severe and debilitating Huntington's disease;
 - (d) severe and debilitating amyotrophic lateral sclerosis;
 - (e) severe and debilitating congestive heart failure; or
 - (f) severe and debilitating chronic obstructive pulmonary disease.

(D) To admit individuals requiring a Level II review, the nursing facility must receive documentation from the Massachusetts Department of Mental Health, the Department of Mental Retardation, or both, as appropriate, certifying that the individual is eligible for admission to the nursing facility and whether or not the individual needs specialized services. The nursing facility must keep such documentation in the resident's record at the facility. A determination by the Massachusetts Department of Mental Health or the Department of Mental Retardation that admission to the facility is not appropriate supersedes the authorization for services by the Division or its agent.

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456.411: Review of Need for Continuing Care in a Nursing Facility

(A) When a nursing facility determines during any of the quarterly reviews required by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and implemented by regulations at 42 CFR 483.20 that the member has discharge potential, then the facility must complete and send a Long Term Care Assessment form to the Division or its agent.

(B) When the nursing facility is notified by the Division or its agent that the member no longer meets the conditions for payment criteria under 130 CMR 456.408(A), the nursing facility must initiate the nursing facility's discharge plan for the member in collaboration with the Division or its agent. All discharges must be in accordance with the federal requirements found at 42 CFR 483.12 and with 130 CMR 456.701 through 456.704.

456.412: Notification and Right of Appeal

(A) The Division or its agent will notify the member or applicant and the referral source or nursing facility who submitted the request for institutional services on the member's behalf of the approval or denial of the request for authorization of nursing-facility services. If authorization for institutional services is denied, the notification will contain the following information:

- (1) the reason for the denial;
- (2) the explanation of the member's right to appeal; and
- (3) a description of the appeal procedure.

(B) If the Division or its agent has denied a request for authorization of payment of nursing-facility services, the member or applicant may request a fair hearing from the Division. The request for a fair hearing must be made in writing within 30 days after the date the member receives a written denial notice from the Division or its agent. The appeal procedure and hearing will be administered and conducted by the Board of Hearings, in accordance with the regulations set forth in 130 CMR 610.000.

(C) If the Department of Mental Retardation or its agent or Department of Mental Health or its agent, or both, determine in accordance with 130 CMR 456.410(D) that an individual is not eligible for admission to a nursing-facility or that specialized services are or are not needed, then the individual may request a fair hearing as provided for in 130 CMR 456.412(B).

456.413: Resident Rights

A nursing facility must inform any resident or applicant for admission, regardless of payment method, of all rights the person has as a resident of the facility, including but not limited to, the resident rights provided for under 42 CFR 483.10.

456.414: Mobility Systems

A nursing facility is responsible for the provision of mobility systems for members residing in the facility. However, the Division will pay a durable medical equipment (DME) provider, in accordance with 130 CMR 409.433, for the purchase of a Special Adaptive Mobility System (see 130 CMR 456.402) furnished for the exclusive full-time use of a member residing in a nursing facility provided, however, that the nursing facility in which the member resides is responsible for payment to the DME provider for the first \$500 of any such purchase.

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456.420: Management Minutes Questionnaire

(A) The Division pays for nursing-facility services based on per diem rates that correspond to the nursing-care needs of members in the facility. The Division of Health Care Finance and Policy establishes the rates for nursing-facility services.

(B) To determine the member's nursing-care needs, a nursing facility must complete a Management Minutes Questionnaire (MMQ) in accordance with the Division's instructions. Based on the questionnaire, each member is assigned a Management Minutes Category (MMC), which corresponds to a rate of payment established by the Division of Health Care Finance and Policy. The facility must bill the Division at the MMC determined by the completion of the MMQ.

(C) The facility must submit the completed MMQ to the Division in the following instances:

- (1) on the admission of any MassHealth member;
- (2) on notice that a resident of the nursing facility is eligible for MassHealth; and
- (3) quarterly on a schedule assigned by the Division.

(D) A nursing facility must transmit completed MMQ information to the Division electronically in accordance with the Division's specifications and instructions or in such other format as may be designated by the Division.

(E) The Division may periodically audit medical records to ensure that the MMQs have been properly completed and the MMCs have been properly assigned. As part of the review, the Division may complete an MMQ and assign an MMC to the member. The Division will notify the nursing facility of any assignment by the Division of a new MMC through the issuance of audit findings. If the Division's MMC differs from that of the nursing facility, the Division's MMC will supersede the facility's and the facility must bill for the audited quarter at the assigned MMC.

(F) If in the course of conducting audits the Division determines that any of the regulations, rules, instructions, or procedures of the Division have been violated by the nursing facility, the Division may impose fines on the nursing facility in accordance with the Division's administrative and billing regulations at 130 CMR 450.000.

456.421: Reconsideration of Assigned Management Minutes Category

(A) A nursing facility may request reconsideration of the Division's audit findings and of the Management Minutes Category (MMC) assigned by the Division in accordance with 130 CMR 456.420(D). All requests must state the facility's justification for the request for reconsideration and must contain documentation justifying the request for reconsideration. All documentation must be specific to the individual whose MMC is under review. The request for reconsideration must be received by the Division within 30 days from the date that the nursing facility receives the audit findings from the Division.

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(B) If the nursing facility does not submit a request for reconsideration, the audit findings issued pursuant to 130 CMR 456.420(D) will constitute the Division’s final action. If the nursing facility requests reconsideration but does not comply with the requirements of 130 CMR 456.421(A), then the Division will deny the request for reconsideration for failure to make a timely request. In either case, the Division’s audit findings will constitute the Division’s final agency action and the nursing facility will have no right to an adjudicatory hearing pursuant to 130 CMR 456.421(C) because of its failure to exhaust its administrative remedies.

(C) The Division will review a request for reconsideration, the accompanying documentation submitted in compliance with the requirements of 130 CMR 456.421(A), and any other documents the Division deems relevant and issue a final decision based on its review. The Division’s decision will be a determination of whether the nursing facility has met all the criteria for the management minute item or items that are the subject of the reconsideration. The determination will be in writing, state the reasons for the determination, and inform the nursing facility of its right to file a Claim for Adjudicatory Hearing in accordance with 130 CMR 450.241. The Board of Hearings will decide the claim in accordance with 130 CMR 450.248.

456.422: Hospice Services in Nursing Facilities

A resident of a nursing facility may elect hospice services and continue to reside in the facility, if the facility is serviced by a hospice provider. When a member elects hospice in accordance with 130 CMR 437.000, the Division will not pay for nursing-facility services and will not pay the nursing facility for medical leaves of absence while the election is in effect. The Division will pay the hospice for room and board and medical leave of absence while the election is in effect and the member remains in the nursing facility. The Division may recoup any payment made by the Division to the facility for services to the member while a hospice election is in effect.

456.423: Patient-Paid Amount

The patient-paid amount is applied to the nursing facility’s per diem for the member. If the member is discharged from the facility or transferred to another nursing facility, the patient-paid amount is applied up to the last full day of the member’s stay and the nursing facility must do the following.

(A) If the member is transferred from one facility to another, the first facility must notify the second facility of the disposition of the patient-paid amount. If the first facility receives a patient-paid amount in excess of the per diem rate for the number of days the member was in the facility, then the first facility must issue a check to the second facility for the amount of the balance. The first facility must submit a claim for the member’s stay up to, but not including, the day of transfer, even if the claim will not result in any payment by the Division to the facility. Submission of this claim is necessary to ensure that the second facility is correctly paid.

(B) If the member is discharged to the community and the facility received a patient-paid amount in excess of the per diem rate for the number of days the member was in the facility, then the facility must return the balance of the patient-paid amount to the member.

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(C) If the patient dies and the facility has received a patient-paid amount in excess of the per diem rate for the number of days the member was in the facility, then the facility must deposit the balance into the member's personal needs account or return the balance to the party who paid the patient-paid amount. See 130 CMR 456.614 for the disposition of the personal needs account when a member dies.

456.424: Limitations on Charges to Members

(A) A nursing facility may only charge members for items requested by the member. Before charging the member, the facility must inform the member of the cost of the requested item. The facility must not charge a member for any item or service covered by MassHealth or Medicare.

(B) Items for which the nursing facility must not charge the member include, but are not limited to, the following:

- (1) group activities or entertainment that occur within the facility;
- (2) parties organized by the facility;
- (3) medically necessary drugs, medical supplies, or medical services;
- (4) funeral expenses;
- (5) room and board to the facility;
- (6) wheelchair purchase, rental, or repair;
- (7) transportation to obtain necessary medical treatment; and
- (8) service charges for maintaining the member's personal needs allowance (PNA) account.

456.425: Medical Leave of Absence: Introduction

(A) MassHealth pays a nursing facility to reserve a bed for up to 10 consecutive days for a member who is on a medical leave of absence from the nursing facility, if the conditions of 130 CMR 456.426 and 456.427 are met.

(B) In accordance with federal law, a nursing facility must establish and follow a written policy regarding its bed-hold period, which must be consistent with the MassHealth bed-hold policy. Following a medical leave of absence of 10 days or fewer, the nursing facility must allow the member to return to the facility and resume residence unless the member no longer requires the services provided by the nursing facility. When a member's hospitalization exceeds 10 days or does not meet the requirements of 130 CMR 456.426, the nursing facility must immediately readmit the member to the facility, to the next available bed in a semiprivate room, unless the member no longer requires the services provided by the nursing facility.

456.426: Medical Leave of Absence: Conditions of Payment

- (A) When a member is transferred from a nursing facility to a hospital, the nursing facility must:
- (1) provide the member and an immediate family member or legal representative with notice of the facility's bed-hold policy, including the member's right to return and resume residence in the facility;
 - (2) provide the member and an immediate family member or legal representative with notice of the transfer that complies with the requirements set forth in 130 CMR 456.701 and 456.702;

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- (3) document the date and time of the transfer in the member's record;
- (4) automatically reserve a bed for the member until the close of business on the second working day of the member's hospital stay;
- (5) contact the admitting hospital and obtain the estimated length of stay by the close of business on the second working day of the member's hospital stay and document the estimated length of stay in the member's medical record;
- (6) if the estimated length of stay is 10 consecutive days or fewer, reserve a bed for the balance of the actual length of stay not to exceed 10 consecutive days from the date of admission to the hospital;
- (7) if the hospital advises the nursing facility that the estimated length of stay exceeds 10 consecutive days, not bill MassHealth for a medical leave of absence from the date of such notification by the hospital; and
- (8) ensure that for each day that a bed is reserved, the bed is not occupied.

- (B) Notwithstanding 130 CMR 456.426(A), MassHealth does not pay a nursing facility for reserving a bed for a member:
- (1) after the second working day of the member's stay if the nursing facility has failed to obtain the estimate of the length of stay from the hospital;
 - (2) if the member has notified the nursing facility in writing that he or she does not wish to return to the facility; or
 - (3) for any consecutive medical leave of absence day in excess of the 10 days from the date of transfer from the nursing facility.

(C) When a member is transferred from one inpatient hospital to another inpatient hospital during the medical leave of absence, the nursing facility must continue to reserve a bed for the member for up to the 10th day of the member's absence from the nursing facility as long as the member continues to require a medical leave of absence and the conditions in 130 CMR 456.426(A) and (B) are met. A transfer from one hospital to another continues of the 10-day period initiated on the first day the member originally was transferred from the nursing facility for the original medical leave of absence, and does not initiate another 10-day period.

456.427: Medical Leave of Absence: Payment

(A) The day on which a member is transferred from a nursing facility to a hospital for an inpatient stay is the first day of the medical leave of absence from the nursing facility. The day on which a member is transferred back to a nursing facility or is discharged from the hospital to a noninstitutional setting is not a medical leave of absence day.

(B) MassHealth pays a nursing facility for medical leave of absence days at the facility's lowest payment rate.

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456.428: Medical Leave of Absence: Readmission

If a member is hospitalized, the nursing facility must readmit the member to the next available bed in a semiprivate room, the member continues to require nursing-facility services. Members who have been authorized for payment of nursing-facility services who are admitted to a hospital from a nursing facility may be readmitted to the same facility without a new authorization except when a hospitalization exceeds six months. When a hospitalization exceeds six months, the nursing facility must request a new authorization for nursing-facility services before readmitting the member.

456.429: Medical Leave of Absence: Failure to Readmit

(A) When a nursing facility is notified that the resident is ready to return to the facility, the nursing facility must readmit the resident following a medical leave of absence. If the nursing facility does not allow the resident to be readmitted following hospitalization or other medical leave of absence, the nursing facility's failure to readmit the resident is deemed a transfer or discharge. The nursing facility must then provide the resident and an immediate family member or legal representative with a notice explaining its decision not to readmit the resident. The notice must comply with the requirements set forth in 130 CMR 456.701, and must be provided to the resident and an immediate family member or legal representative at the time such determination is made.

(B) A nursing facility that fails to readmit a member who requires nursing facility services or otherwise violates these provisions may be subject to administrative action.

456.430: Nonmedical Leave of Absence: Introduction

MassHealth seeks the fullest integration possible of aged and disabled members into the community. Wherever possible, coordinated support services will be arranged so a member may return to the community. To prevent residents from becoming isolated in nursing facilities and to encourage families to care for members at home, MassHealth will pay the nursing facility to reserve a bed for a member when the member is temporarily absent from the facility for nonmedical reasons subject to the requirements set forth in 130 CMR 456.431 and 456.432.

456.431: Nonmedical Leave of Absence: Limitations

MassHealth pays for temporary absences for nonmedical leave for members in nursing facilities for up to a total of 10 days per 12-month period starting with the first day of the nonmedical leave. A day is defined as a continuing 24-hour period. Absences from the nursing facility of less than 24 hours do not constitute a day of absence.

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456.432: Nonmedical Leave of Absence: Conditions for Payment

(A) For the facility to obtain payment for a nonmedical absence, the following conditions must be met.

- (1) The member must request the nonmedical leave.
- (2) A written authorization from the attending physician is on file in the member's medical record.
- (3) During the period of absence, the nursing facility must hold the same bed and room for the member and must not admit any other resident in the member's place.
- (4) The member's medical record maintained by the facility must document:
 - (a) the home address, telephone number, and relationship of the person responsible for the member while the member is absent from the facility;
 - (b) the duration of absence;
 - (c) the physician's authorization for the absence; and
 - (d) the member's condition before and after the absence from the facility.

(B) If the member does not return to the facility, MassHealth considers the member to be voluntarily discharged as of the first day of unauthorized absence. The facility cannot bill billing MassHealth for any days of unauthorized absence. A voluntary discharge is not a discharge under 130 CMR 456.701 through 456.703 or 610.028 through 610.030.

456.433: Nonmedical Leave of Absence: Payment

MassHealth pays the nursing facility for nonmedical leave of absence days at the facility's lowest payment rate.

(130 CMR 456.434 through 456.450 Reserved)

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456.451: Withdrawal by Nursing Facilities from MassHealth: Introduction

A nursing facility participating in MassHealth may cease to participate only in the manner detailed in 130 CMR 456.452 through 456.455. 130 CMR 456.452 through 456.455 apply whether the facility is continuing to operate as a nursing facility, is converting to a residential program such as assisted living, or is closing.

456.452: Notice of Withdrawal

(A) A nursing facility electing to withdraw from MassHealth must give written notice of its intention to withdraw to the Division, unless such withdrawal results from a situation beyond the control of the provider such as fire or an act of God. In the instance of alleged emergency withdrawal, the burden of proof will be on the facility. The facility must send the withdrawal notice by certified or registered mail (return receipt requested) to the Division's Delivery Systems Long-Term-Care and Rehabilitation Services Unit and must be given not less than 90 days before the effective date of withdrawal.

(B) When a decision has been made to close a facility or when the facility has received a notice of jeopardy closure by the Department of Public Health, the nursing facility must promptly complete a Relocation Assessment Form for each member. The forms must be sent to the Division's designated nurse reviewer. The Division will notify the facility of the results of the assessment.

(C) A facility must not admit any new MassHealth members after the date on which the withdrawal notice was sent to the Division. Residents of the facility who become eligible for MassHealth after the notice of withdrawal, MassHealth members who are hospitalized when the notice was sent, and members who are on nonmedical leaves of absence at the time the notice was sent are not considered new admissions.

456.453: Withdrawal Requirements

(A) On the same date on which the nursing facility sends a withdrawal notice to the Division, the facility must give notice, in hand, to all its residents and the resident's authorized representatives, including those residents who have been transferred to hospitals, or who are on nonmedical leave of absence. The notice must advise that any resident who is eligible for MassHealth on the effective date of the withdrawal must relocate to a facility participating in MassHealth to ensure continuation of MassHealth payment of nursing-facility services and must be determined eligible to continue to receive the services.

(B) The notice will also state that the facility will work promptly and diligently to arrange for the relocation of members to MassHealth-participating facilities or, if appropriate, to the community. The nursing facility must give a similar notice to applicants for admission during the period between the date in which the facility sent the withdrawal notice to the Division and the effective date of the withdrawal.

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(C) After giving notice of intent to withdraw, the facility must promptly begin and diligently sustain efforts to arrange for the relocation of members to facilities participating in MassHealth or to the community.

(D) When it has been determined where a member is to be transferred to, the facility must give the member written notice including the name of the facility to which the member will be transferred and notification of the member's right to appeal such a transfer as provided for in 130 CMR 456.701.

456.454: Administrative Action Regarding Withdrawals

A nursing facility that withdraws from MassHealth must continue to provide services to members until the members are relocated. If the facility fails to provide medical services to a member, the facility is subject to a fine of \$1000 for each violation.

456.455: Limitation of Provider Participation

A nursing-facility provider that voluntarily withdraws from MassHealth and continues to operate as a nursing facility may not participate as a MassHealth nursing-facility provider for up to five years after the date of notice of the intent to withdraw, except to the extent, as determined by the Division, that the facility's participation in MassHealth is necessary for the health, welfare, and safety of members. If on the date that the withdrawal was to be effective, the nursing facility is still providing services to MassHealth members, then the facility will continue to be a MassHealth provider with regard to those members but will otherwise be considered withdrawn from the program. The facility must notify the Division of its need to keep its MassHealth provider number.

(130 CMR 456.456 through 456.600 Reserved)

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456.601: Personal Needs Allowance Account

MassHealth members have the right to manage their own financial affairs and the nursing facility must not require residents to deposit their personal funds with the facility. However, upon written request by a member, the facility must hold, safeguard, manage, and account for the member's personal funds deposited with the facility as specified in 130 CMR 456.601 through 456.615.

456.602: Management of the PNA Account

If requested by the member, a facility must assume responsibility for the PNA funds of a member. To do so, the facility must obtain and maintain on file a statement of authorization signed by the member or the member's authorized representative, such as a guardian, conservator, relative, or other responsible person acting on the member's behalf. The "other responsible person" must not be an employee of the facility or related to an employee of the facility in any way. Once a facility is trustee of a member's PNA account, it is responsible for the safekeeping of this money and must repay the member for any lost or stolen funds or for any money that cannot be accurately accounted for.

456.603: Autonomy of PNA Accounts

(A) If the facility assumes responsibility for a member's funds, the facility must deposit funds in excess of \$50 into a PNA account, that is, an interest-bearing trustee account separate from any of the facility's operating accounts.

(B) The facility must ensure that PNA accounts are not available for any purpose except the personal needs of the member. The funds must not be lent or be used as collateral for a loan for anyone including the facility.

456.604: PNA Recordkeeping Requirements

(A) The facility must establish and maintain a system of recordkeeping that ensures a complete and separate accounting of the PNA funds according to generally accepted accounting principles. The system must prevent any commingling of the members' PNA funds with facility funds or with the funds of any other person other than another resident of the facility. If the facility does not manage the PNA funds for any member, it is not required to maintain such records.

(B) (1) The facility must ensure a separate accounting of each member's PNA funds, maintain a written record of all financial transactions involving the PNA funds, and allow the member or the member's authorized representative access to the accounting record.

(2) The bank-account statements and the general ledger must be in agreement and reconcilable at all times. All bank statements, canceled checks, and supporting documentation relating to the PNA account must be kept in the facility for at least four years from the date of the transaction.

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- (3) All checks or cash received on behalf of the member must be deposited into the PNA account no later than 30 days after the receipt of the money by the facility.
- (4) The facility must maintain for each member with a PNA account a record of receipts and disbursements separate from other members' records. The facility must clearly label all PNA receipts and disbursements in the general ledger.
- (5) At a minimum, all receipts and disbursements must be recorded in the ledger as follows:

Receipts	Disbursements
1. Date of entry	1. Date of entry
2. Amount	2. Specific description (Avoid "misc.," "personal needs," etc.)
3. Source	3. Amount
4. Balance	4. Signature of member or person receiving disbursement
	5. Invoice number or date

- (6) General ledger records must be updated at least once a month.
- (7) The facility must ensure that funds are available to members in the form of actual cash or check for no less than 10 hours a week and on no less than three days a week. The facility must inform the members of the times when they may receive their money.
- (8) All money disbursed to or on behalf of a member must be at the request of the member or the member's representative. The nursing facility may not make any disbursements on behalf of a member for a service that is covered by either Medicare or MassHealth.
- (9) If a facility disburses money to a member by means of a check, or if the member signs petty cash vouchers, the facility does not need to obtain a signature in the ledger.
- (10) The facility does not need to itemize cash disbursements to members.
- (11) The facility must provide the member or the member's representative every three months and upon the member's request with an accounting of all financial transactions made on the member's behalf.

456.605: Petty Cash in the Facility

The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to residents. The total of this petty-cash fund must not exceed an amount equal to \$5 per member for whom the facility manages a PNA account; however, a maximum of \$250 is allowable regardless of the number of members.

456.606: Assurance of Financial Security

The facility must purchase a surety bond to assure the security of all personal funds of members deposited with the facility. The facility must keep this bond at the facility.

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456.607: Availability of PNA Records to Division Personnel

All PNA records, including the accompanying bank statements, canceled checks, and supporting documentation, must be kept in the facility at all times and must be available to Division of Medical Assistance personnel upon request. The request may be made by telephone, in person, or by mail.

456.608: Member Signature

If the member cannot sign his or her own name, a staff member or business employee of the facility may sign as witness that the member has received cash from his or her PNA account.

456.609: Notification of Account Balance

(A) The facility must notify each member for whom it has established a PNA account when the balance reaches a total of \$1800, which is \$200 less than the maximum countable assets allowed per member. The notification must state that, if the member's countable assets exceed the maximum allowable amount of \$2000, the member may lose MassHealth eligibility.

(B) If the member's balance exceeds the maximum allowable amount, the member may apply the excess to the cost of care in the facility.

456.610: Availability of PNA Records to Members

The facility must, within one working day of a request, allow the member or the member's authorized representative to examine the PNA records of the member.

456.611: PNA Funds of a Member Transferred to Another Facility

If a member is transferred to another nursing facility, all of the member's funds held in trust by the facility must be sent to the new facility within 10 days of the transfer date.

456.612: PNA Funds of a Member Discharged to the Community

If a member has been discharged from the facility to the community, he or she must receive his or her bank book back from the facility or receive a check for the balance of his or her PNA account. The amount of the check must reflect the cash held on behalf of the member by the facility plus the bank balance.

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456.613: Member Is Transferred to a Hospital and Does Not Return to the Facility

If a member is transferred to a hospital and does not return to the facility, the balance of the PNA account must be sent to the member at his or her new address within 10 days after he or she leaves the hospital.

456.614: Death of a Member

- (A) Upon the death of a MassHealth member, the nursing facility must:
- (1) render an accounting of the member's PNA funds. The funds must remain at the facility for 30 days after the death of a member to allow for the appointment of an administrator or executor of the estate and for the payment of burial expenses; and
 - (2) notify the next of kin or the person who served as the member's representative in official business with the facility of any remaining funds, determine whether or not an executor or administrator has been or will be appointed, and explain to the next of kin or the member's representative how to obtain the funds from the facility.
 - (a) If there is an outstanding balance due on a funeral bill, the funeral home may submit an itemized funeral bill to the nursing facility and the nursing facility may pay the bill from the PNA funds.
 - (b) If an executor or administrator is appointed within 30 days after the death of a member, the facility must send the balance of the PNA account and a final accounting of the member's account to the administrator or executor of the member's estate. If any payment has been made to the funeral home under 130 CMR 456.414(A)(2)(a), the final accounting must reflect that payment.
- (B) If any funds still remain in the PNA account after 30 days, the facility must
- (1) send a check for the balance and a final accounting of the member's account to the
Division of Medical Assistance; and
 - (2) notify the next of kin or the member's representative of the amount of the funds
and
the address to which they are being sent and tell them they may apply for the funds, if they are appointed executor or administrator of the member's estate.
- (C) A final accounting of the PNA funds must include any transactions that occurred during the previous three months and for the 30 days following the member's death. If there are no PNA funds, the nursing facility is not required to submit the final accounting; however, the facility must maintain all member records according to 130 CMR 456.604.
- (D) The facility must include with the returned PNA balance and the accounting the following information:
- (1) the member's name and social security number;
 - (2) the member's date of birth and date of death;
 - (3) the name, address, and relationship of the next of kin or the member's representative ;
 - (4) the name, address, and MassHealth provider number of the facility; and
 - (5) the name and address of the funeral director.

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456.615: Annual Accounting to the Division of the PNA Balance

(A) Annually, at least by each June 1, an accounting must be made to the Division of the balance of each PNA account. If the facility is not a trustee for any member's money, it must report this fact by each June 1 to the Division. The accounting to the Division must be submitted on the Statement of MassHealth Member's Personal Needs Account (PNA-1) and must be dated and signed under the pains and penalty of perjury by the administrator of the facility and mailed to the Division.

(B) The accounting must consist of the following:

- (1) the member's name;
- (2) the member's social security number;
- (3) the amount of petty cash held in the facility for the member;
- (4) the balance held in any individual bank account for the member;
- (5) the balance held in the trustee account for the member;
- (6) any other money being held by the facility for the member; and
- (7) if funds are held in an aggregate trustee bank account, then a copy of the bank statement for that account must be submitted with the accounting.

(130 CMR 456.616 through 456.620 Reserved)

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456.621: Return of Unused Unit-Dose Drugs

(A) Returnable Drugs.

(1) Requirement. The nursing facility must return to the dispensing pharmacy unused drugs in unit-dose packaging that are listed in Appendix F of the *Nursing Facility Manual* and that were dispensed to a MassHealth member, when the use of the drug for that member is discontinued. Such returns allow the pharmacy to credit the Division for unused doses, which reduces pharmaceutical waste. The nursing facility must return such drugs that meet the requirements of 130 CMR 456.621(A)(2), unless they are excluded under 130 CMR 456.621(B). The nursing facility must return such drugs as soon as possible, but no later than 30 days after the date that the drug is discontinued for the member, and no less than 90 days before the earliest expiration date printed on the drug's label.

(2) Returnable Drugs. Drug products that are returned must comply with all applicable state and federal requirements, including those related to the safety, labeling, handling, and storage of drugs.

(B) Excluded Drugs. Of the drugs described in 130 CMR 456.621(A), the following unit-dose-packaged drugs may not be returned to the pharmacy for credit to the Division:

- (1) drugs that were dispensed to a member whose other insurance paid for part or all of the prescription;
- (2) unused quantities of a prescription that are less than the minimum quantity identified in Appendix F of the *Nursing Facility Manual*;
- (3) drugs prescribed to a member who has been discharged or transferred to another facility when a physician, physician's assistant, or nurse practitioner has authorized the release of the drug to the patient or an authorized custodian upon discharge; and
- (4) drugs with an expiration date of less than 90 days from the date of the discontinuation of the drug.

(C) Dosage Changes. When the prescriber changes the dosage of any drug described in 130 CMR 456.621(A), and the previously prescribed dosage of the drug can be used to accommodate the new dosage, the nursing facility must:

- (1) use up existing supplies of the drug dispensed to the member instead of returning the drug to the pharmacy;
- (2) document the dosage change in the member's record; and
- (3) apply a change-of-directions sticker over the directions on the pharmacy prescription label.

(D) Preparation of Manifest. The nursing facility must prepare a manifest of all drugs listed in Appendix F of the *Nursing Facility Manual* that are being returned to the pharmacy. This manifest must accompany the returned drugs to the pharmacy, account for drugs that have been destroyed because the integrity of the drug has been compromised, and must include:

- (1) the name of the member to whom the drugs were originally dispensed;
- (2) the date that the unused drugs were returned to the pharmacy;
- (3) the prescription number under which the unused drugs were originally dispensed;
- (4) the name and strength of the unused drugs;
- (5) the quantity of unit doses returned; and
- (6) if the drug was destroyed, the quantity, reason, and date of destruction; along with the initials of the person preparing the manifest.

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(E) Recordkeeping Requirements. The nursing facility must establish tracking and recordkeeping systems for all unit-dose-packaged drugs returned pursuant to 130 CMR 456.621. The records must reflect sound standard business accounting practices; be available for review by the Division upon request; and be kept for at least seven years from the date of the return. The records must include:

- (1) a copy of the manifest described in 130 CMR 456.621(D) of each shipment of unused unit-dose-packaged drugs that has been returned to the pharmacy;
- (2) for unit-dose-packaged drugs that are not returned pursuant to 130 CMR 456.621(B), the reason that the drugs are not being returned; and
- (3) for unit-dose-packaged drugs that were destroyed, the quantity, reason, and date of destruction, along with the initials of the person who destroyed the drugs.

(130 CMR 456.622 through 456.700 Reserved)

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456.701: Notice Requirements for Transfers and Discharges Initiated by a Nursing Facility

- (A) A resident may be transferred or discharged from a nursing facility only when:
- (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
 - (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;
 - (3) the safety of individuals in the nursing facility is endangered;
 - (4) the health of individuals in the nursing facility would otherwise be endangered;
 - (5) the resident has failed, after reasonable and appropriate notice, to pay for (or failed to have the Division or Medicare pay for) a stay at the nursing facility; or
 - (6) the nursing facility ceases to operate.
- (B) When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 456.701(A)(1) through (5), the resident's clinical record must contain documentation to explain the transfer or discharge. The documentation must be made by:
- (1) the resident's physician when a transfer or discharge is necessary under 130 CMR 456.701(A)(1) or (2); and
 - (2) a physician when the transfer or discharge is necessary under 130 CMR 456.701(A)(3) or (4).
- (C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand deliver to the resident and mail to a designated family member or legal representative a notice written in 12-point or larger type that contains, in a language the member understands, the following:
- (1) the action to be taken by the nursing facility;
 - (2) the specific reason or reasons for the discharge or transfer;
 - (3) the effective date of the discharge or transfer;
 - (4) the location to which the resident is to be discharged or transferred;
 - (5) a statement informing the resident of his or her right to request a hearing before the Division's Board of Hearings including:
 - (a) the address to send a request for a hearing;
 - (b) the time frame for requesting a hearing as provided for under 130 CMR 456.702; and
 - (c) the effect of requesting a hearing as provided for under 130 CMR 456.704;
 - (6) the name, address, and telephone number of the local long-term-care ombudsman office;
 - (7) for nursing-facility residents with developmental disabilities, the address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. s. 6041 et seq.);
 - (8) for nursing-facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act (42 U.S.C. s. 10801 et seq.);
 - (9) a statement that all residents may seek legal assistance and that free legal assistance may be available through their local legal-services office. The notice should contain the address of the nearest legal-services office; and
 - (10) the name of a person at the nursing facility who can answer any questions the resident has about the notice and who will be available to assist the resident in filing an appeal.

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(D) A nursing facility's failure to readmit a resident following a medical leave of absence shall be deemed a transfer or discharge (depending on the resident's circumstances). The nursing facility must issue notice to the resident and an immediate family member or legal representative in accordance with 130 CMR 456.701(A) through (C), 456.702(C), 610.028, and 610.029.

456.702: Time Frames for Notices Issued by Nursing Facilities

(A) The notice of discharge or transfer required under 130 CMR 456.701(C) must be made by the nursing facility at least 30 days prior to the date the resident is to be discharged or transferred, except as provided for under 130 CMR 456.702(B).

(B) Instead of the 30-day-notice requirement set forth in 130 CMR 456.702(A), the notice of discharge or transfer required under 130 CMR 456.701 must be made as soon as practicable before the discharge or transfer in any of the following circumstances, which are emergency discharges or emergency transfers.

- (1) The health or safety of individuals in the nursing facility would be endangered and this is documented in the resident's record by a physician.
- (2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician documents this in the resident's record.
- (3) An immediate transfer or discharge is required by the resident's urgent medical needs and this is documented in the medical record by the resident's attending physician.
- (4) The resident has not resided in the nursing facility for 30 days immediately prior to receipt of the notice.

(C) When the transfer or discharge is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, the notice of transfer or discharge, including that which is required under 130 CMR 456.429, must comply with the requirements set forth in 130 CMR 456.701 and must be provided to the resident and an immediate family member or legal representative at the time the nursing facility determines that it will not readmit the resident.

456.703: Time Frames for Submission of Requests for Fair Hearings

(A) Appeals of discharges and transfers will be handled by the Division's Board of Hearings (BOH).

(B) Time Limitation on the Right of Appeal. The date of request for a fair hearing is the date on which BOH receives such a request in writing. BOH must receive the request for a fair hearing within the following time limits:

- (1) 30 days after a resident receives written notice of a discharge or transfer pursuant to 130 CMR 456.702(A); or
- (2) 14 days after a resident receives written notice of an emergency discharge or emergency transfer pursuant to 130 CMR 456.702(B); or
- (3) 14 days after a resident receives written notice of a transfer or discharge that is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence.

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456.704: Stay of a Transfer or Discharge from a Nursing Facility Pending Appeal

(A) If a request for a hearing regarding a discharge or transfer from a nursing facility is received by the Board of Hearings during the notice period described in 130 CMR 456.703(B)(1), the nursing facility must stay the planned discharge or transfer until 30 days after the decision is rendered. While this stay is in effect, the resident must not be transferred or discharged from the nursing facility.

(B) If a hearing is requested, in accordance with 130 CMR 456.703(B)(2), and the request is received prior to the discharge or transfer, then the nursing facility must stay the planned transfer or discharge until five days after the hearing decision.

(C) If the request for a hearing is received within the applicable time frame but after the transfer, the nursing facility must, upon receipt of the appeal decision favorable to the resident, promptly readmit the resident to the next available bed in the facility.

(D) In the case of a transfer or discharge that is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, if the request for a hearing is received within the applicable time period as described in 130 CMR 456.703(B)(3), the nursing facility must, upon receipt of the appeal decision favorable to the resident, promptly readmit the resident to the next available bed.

456.705: Scheduling by the Board of Hearings

(A) Upon receipt of a request for a fair hearing, BOH will register the appeal, set a date for a hearing, and so notify the appellant and the nursing facility.

(B) BOH will designate a site for the hearing accessible to the appellant. If the appellant has a handicap or disability that reasonably prevents his or her appearance at the designated site, he or she may request that the hearing be held by telephone or video conferencing, or at an accessible location.

REGULATORY AUTHORITY

130 CMR 456.000: M.G.L. c. 118E, §§ 7 and 12.