

130 CMR: DIVISION OF MEDICAL ASSISTANCE

130 CMR 610.000: MASSHEALTH: FAIR HEARING RULES

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610.001: Purpose

(A) MassHealth Determinations.

- (1) 130 CMR 610.000 sets out the process for requesting and participating in a fair hearing that allows dissatisfied applicants, members, or nursing facility residents to have administrative review of certain actions or inactions on the part of the MassHealth agency and of determinations by a MassHealth managed care contractor.

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(2) Such actions include, but are not limited to, determinations of eligibility for MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, MassHealth Limited, MassHealth Senior Buy-In, MassHealth Buy-In, MassHealth CarePlus, MassHealth Small Business Employee Premium Assistance, Children's Medical Security Plan, Refugee Resettlement Program, low-income subsidies under Medicare Part D (as set forth in the *Medicare Prescription Drug and Improvement and Modernization Act* of 2003, as described in federal regulations 42 CFR Part 423, Subpart P), and requests for services that require prior authorization.

(B) Other Determinations. 130 CMR 610.000 also contains rules for nursing facility residents who want to appeal a discharge, transfer, or failure to readmit initiated by a nursing facility. 130 CMR 610.000 contains provisions for individuals seeking an appeal of federally mandated Preadmission Screening and Resident Review (PASRR) determinations.

610.002: Authority

The authority for 130 CMR 610.000 is set out in 42 CFR 431.200 *et seq.*, M.G.L. c. 30A, c. 118E, §§ 12, 20, 47, and 48, and 801 CMR 1.03(4). Pursuant to M.G.L. c. 118E, § 48, the Board of Hearings (BOH) has exclusive jurisdiction to hear appeals relating to the programs administered by the MassHealth agency; provided, however, that for certain appeals by an integrated care organization (ICO) or senior care organization (SCO) enrollee concerning covered benefits, the Centers for Medicare & Medicaid Services (CMS) Independent Review Entity (IRE) also has jurisdiction. Pursuant to 42 U.S.C. 1396r(e)(7) and 42 CFR 483.204, the BOH has authority to hear appeals of PASRR determinations. BOH has authority to hear financial eligibility appeals, clinical eligibility appeals, and service plan appeals for the following 1915(c) home- and community-based services waivers: Traumatic Brain Injury (TBI), Acquired Brain Injury — Nonresidential Habilitation (ABI-N), Acquired Brain Injury — Residential Habilitation (ABI-RH), Moving Forward Plan — Community Living (MFP-CL), and Moving Forward Plan — Residential Supports (MFP-RS). BOH has authority to hear financial eligibility appeals and clinical eligibility appeals of the following 1915(c) home- and community-based services waiver: Frail Elder. BOH has authority to hear the financial eligibility appeals of the following 1915(c) home- and community-based services waivers: Young Children with Autism, Persons with an Intellectual Disability — Intensive Supports, Persons with an Intellectual Disability — Community Living, and Persons with an Intellectual Disability — Adult Supports.

610.003: Scope

130 CMR 610.000 sets out the processes for fair hearing requests and proceedings started by applicants or members to review certain actions or inactions by the MassHealth agency or a MassHealth managed care contractor relating to programs administered by the MassHealth agency, including determinations of eligibility for low-income subsidies under Medicare Part D (as set forth in the *Medicare Prescription Drug and Improvement and Modernization Act* of 2003, as described in federal regulations at 42 CFR Part 423, Subpart P). In addition, appeals pursuant to the Executive Office of Elder Affairs Supplementary Rules to the Adjudicatory Rules of Practice and Procedures, 651 CMR 1.00: *Adjudicatory Rules of Practice and Procedure* are governed by the procedures set forth in 130 CMR 610.000. Appeals by residents of a nursing facility who are to be discharged or transferred at the initiation of the nursing facility, appeals regarding a nursing facility's failure to readmit, and appeals pertaining to PASRR determinations are also governed by 130 CMR 610.000. Adjudicatory proceedings initiated by MassHealth providers are governed by 130 CMR 450.241 through 450.248 or, with regard to appeals of erroneously denied claims, by 130 CMR 450.323: *Appeals of Erroneously Denied or Underpaid Claims*.

610.004: Definitions

For purposes of 130 CMR 610.000, the following terms are defined as follows:

610.004: continued

Accountable Care Organization (ACO) — an entity that enters into a population-based payment model contract with EOHHS as an accountable care organization, wherein the entity is held financially accountable for the cost and quality of care for an attributed or enrolled member population. ACOs include Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs.

Accountable Care Partnership Plan (ACPP) — a type of ACO with which the MassHealth agency contracts under its ACO program to provide, arrange for, and coordinate care and certain other medical services to members on a capitated basis and is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO) and is organized primarily for the purpose of providing health care services.

Acting Entity — the MassHealth agency, a MassHealth managed care contractor, or a nursing facility responsible for making a determination that can be appealed. The acting entity also includes the Department of Mental Health and the Department of Developmental Services when making a PASRR determination. The acting entity includes the Department of Developmental Services for purposes of denial, suspension, reduction, modification, or termination of services or for failure to act on a waiver participant's request for services for the following HCBS Waiver Programs: Acquired Brain Injury — Residential Habilitation (ABI-RH) and Moving Forward Plan — Residential Supports (MFP-RS). The acting entity includes the Massachusetts Rehabilitation Commission for purposes of denial, suspension, reduction, modification, or termination of services or for failure to act on a waiver participant's request for services for the following HCBS Waiver Programs: Acquired Brain Injury — Nonresidential Habilitation (ABI-N), Moving Forward Plan — Community Living (MFP-CL), and Traumatic Brain Injury (TBI).

Adequate Notice — a notice concerning an intended appealable action that states the intended action by the MassHealth agency; the reason or reasons for the intended action; the MassHealth regulation supporting the action; an explanation of the right to request a fair hearing; and the circumstances under which assistance is continued as set out in 130 CMR 610.026.

Appealable Action — certain actions or inactions, as further described in 130 CMR 610.032, by the MassHealth agency, a MassHealth managed care contractor, a nursing facility, the Department of Mental Health, or the Department of Developmental Services.

Appeal Representative —

- (1) a person or an organization who agrees to comply with applicable rules regarding confidentiality and conflicts of interest in the course of representing an applicant or member, provided such person or organization
 - (a) has provided the BOH with written authorization from the applicant or member to act responsibly on his or her behalf during the appeal process; or
 - (b) has, under applicable law, authority to act on behalf of an applicant or member at an appeal or otherwise in making decisions related to health care or payment for health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy; or
- (2) a person or organization who has been designated an authorized representative, as defined in 130 CMR 610.004: Authorized Representative, pursuant to a valid Authorized Representative Designation Form.

Appellant — an applicant, member, or nursing facility resident requesting a fair hearing, including individuals who are appealing a PASRR determination. An appellant may also include a community spouse of an institutionalized applicant when the community spouse is exercising a fair hearing appeal right that he or she has under 130 CMR 520.016: *Long-term-care: Treatment of Assets* or 130 CMR 520.017: *Right to Appeal the Asset Allowance or Minimum-monthly-maintenance-needs Allowance*.

Applicant — a person, including a waiver applicant, who has applied or attempted to apply for an assistance program administered by the MassHealth agency.

Application — an application as defined in 130 CMR 501.001: *Definition of Terms* and 130 CMR 515.001: *Definition of Terms*.

610.004: continued

Assistance — any medical assistance or benefits provided to a member by the MassHealth agency.

Authorized Representative — an authorized representative as defined in 130 CMR 501.001: *Definition of Terms* and 130 CMR 515.001: *Definition of Terms*.

Behavioral Health Contractor — the entity contracted with EOHHS to provide, arrange for, and coordinate behavioral health care and other services to members on a capitated basis.

Board of Hearings (BOH) — the designated hearing unit within the Executive Office of Health and Human Services (EOHHS) Office of Medicaid.

Department of Mental Health (DMH) — the state agency organized under M.G.L. c. 19, or its agent.

Department of Developmental Services (DDS) — the state agency organized under M.G.L. c. 19B, or its agent.

Director — the Director of BOH (also known as BOH Director).

Discharge — the removal from a nursing facility of an individual who is a resident where the discharging nursing facility ceases to be legally responsible for the care of that individual.

Dual Eligible Individual — for purposes of the Duals Demonstration Program, a MassHealth member who meets all of the following criteria:

- (1) is 21 through 64 years of age at the time of enrollment in the Duals Demonstration Program;
- (2) is eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;
- (3) is enrolled in Medicare Parts A and B, is eligible for Medicare Part D, and has no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
- (4) lives in a designated service area of an ICO.

Duals Demonstration Program — the MassHealth state demonstration to integrate care for Dual Eligible Individuals, also known as One Care.

Fair Hearing — the process for appeals conducted according to 130 CMR 610.000 to determine the legal rights, duties, benefits, or privileges of applicants, members, or nursing facility residents.

Fair Hearing Regulations — the regulations at 130 CMR 610.000.

Health Connector — the Commonwealth Health Insurance Connector Authority established under M.G.L. c. 176Q.

Hearing — a fair hearing.

Hearing Officer — an impartial and independent person designated by the BOH Director to conduct hearings and render decisions pursuant to 130 CMR 610.000.

Home- and Community-based Services (HCBS) Waiver Program — one of the following programs established pursuant to 42 USC 1396n: Acquired Brain Injury — Residential Habilitation (ABI-RH); Acquired Brain Injury — Nonresidential Habilitation (ABI-N); Young Children with Autism; Persons with an Intellectual Disability — Intensive Supports; Persons with an Intellectual Disability — Community Living; Persons with an Intellectual Disability — Adult Supports; Frail Elder Waiver (FEW); Moving Forward Plan — Residential Supports (MFP-RS); Moving Forward Plan — Community Living (MFP-CL); and Traumatic Brain Injury (TBI).

610.004: continued

Integrated Care Organization (ICO, also known as a One Care Plan) — an organization with a comprehensive network of medical, behavioral health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) and been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrolled members with the full continuum of Medicare- and MassHealth-covered services.

Independent Review Entity (IRE) — the external review entity for the Centers for Medicare & Medicaid Services (CMS) appeals.

Interpreter — a person who is either a Qualified Interpreter for an Individual with Limited English, or a Qualified Interpreter for an Individual with a Disability as defined in 130 CMR 610.004.

Managed Care Contractor — any MassHealth-contracted managed care organization (MCO), including a SCO or an ICO, or behavioral health contractor.

Managed Care Organization (MCO) — any entity with which the MassHealth agency contracts under its MCO program to provide arrange for, and coordinate care and certain other medical services to members on a capitated basis, and is approved by the Massachusetts Division of Insurance as a health maintenance organization (HMO) and is organized primarily for the purpose of providing health care services.

Massachusetts Rehabilitation Commission (MRC) — the state agency organized under M.G.L. c. 6, § 74, or its agent.

MassHealth — the medical assistance and benefit programs administered by the MassHealth agency pursuant to Title XIX of the Social Security Act (42 U.S.C. § 1396), Title XXI of the Social Security Act (42 U.S.C. § 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Agency — the Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

Member — a person who is or had been receiving assistance under a program administered by the MassHealth agency.

Nursing Facility — a Medicare- or Medicaid-certified nursing facility or certified unit within a nursing facility that is licensed by the Department of Public Health to operate in Massachusetts.

Party — the appellant, the managed care contractor, the nursing facility as respondent in a nursing facility initiated transfer, discharge, or failure to readmit the respondent to a complaint of coercive behavior, the MassHealth agency, DMH, MRC, or DDS.

PASRR Determination — a determination, made by DMH or DDS, that an individual does or does not require the level of services provided by a nursing facility or that the individual does or does not require specialized services as defined by 42 CFR 483.120.

PASRR Evaluation — the medical review of an individual for mental illness, developmental disability, or conditions related to developmental disability and conducted pursuant to 42 CFR 483 Subpart C.

Policy Memoranda — written explanations issued by the Medicaid director or the General Counsel's office, of the MassHealth agency's intent and interpretation or application of its regulations under 130 CMR, or a written explanation, issued by the Health Connector or its designee, of the Health Connector's intent and interpretation of its regulations under 956 CMR.

Preadmission Screening and Resident Review (PASRR) — a federally mandated program for screening individuals seeking admission to and residents of Medicaid-certified nursing facilities for mental illness, developmental disability, or conditions related to developmental disability. The federal requirements for PASRR are provided at 42 CFR 483 Subpart C and 42 U.S.C. 1396r(e)(7).

610.004: continued

Provider — any entity that furnishes medical services to MassHealth members.

Qualified Interpreter for an Individual with a Disability —

- (1) A qualified interpreter for an individual with a disability is an interpreter who *via* a remote interpreting service or an on-site appearance
 - (a) adheres to generally accepted interpreter ethics principles, including client confidentiality; and
 - (b) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.
- (2) For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

Qualified Interpreter for an Individual with Limited English Proficiency — an interpreter who *via* a remote interpreting service or an on-site appearance

- (1) adheres to generally accepted interpreter ethics principles, including client confidentiality;
- (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
- (3) is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Record Open — a period of time determined by the hearing officer that, if allowed by the hearing officer within his or her discretion, permits either party to a fair hearing the opportunity to submit post-hearing documentation, relevant evidence, or legal arguments.

Resident — an individual who lives in a nursing facility, regardless of whether he or she is a MassHealth member.

Resident Record — that portion of a nursing facility's records in which the nursing facility has documented the reason for an intended discharge or transfer of a resident.

Rural Service Area — any geographic area other than an urban area, as that term is defined in 42 CFR 412.62(f)(ii).

Senior Care Organization (SCO) — a managed care organization that participates in MassHealth under a contract with the MassHealth agency to provide coordinated care and medical services through a comprehensive network to eligible members 65 years of age or older. SCOs are responsible for providing enrolled members with the full continuum of MassHealth-Medicare-covered services.

Timely Notice — adequate notice of an intended appealable action by the MassHealth agency that meets the requirements set forth in 130 CMR 610.015(A).

Timely Request — a request for a fair hearing received by BOH within the timely notice period set forth in 130 CMR 610.015(B).

Transfer — except for the movement of a resident within the same facility from one certified bed to another bed with the same certification, a transfer is the 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.

Waiver Applicant — a person who submits an application for enrollment in a HCBS Waiver Program.

Waiver Participant — a member who is enrolled in a HCBS Waiver Program.

610.011: The Office of Medicaid Board of Hearings

The Office of Medicaid Board of Hearings (BOH) is responsible for administering the fair hearing process in accordance with 130 CMR 610.000, holding hearings, and rendering decisions. At the MassHealth agency's discretion, BOH also conducts adjudicatory proceedings governing providers pursuant to 130 CMR 450.241 through 450.248, and 130 CMR 450.323: *Appeals of Erroneously Denied or Underpaid Claims*. BOH is administered by a Director who is appointed by the Medicaid Director, and who is responsible for ensuring that the fair hearing process and decisions comply with the requirements of 130 CMR 610.000.

610.012: General Description of the Fair Hearing Process

(A) The fair hearing process is an administrative, adjudicatory proceeding where dissatisfied applicants, members, and nursing facility residents can, upon written request, obtain an administrative determination of the appropriateness of

- (1) certain actions or inactions by the MassHealth agency;
- (2) certain actions or inactions by a managed care contractor;
- (3) actions to recover payment for benefits to which the member was not entitled at the time the benefit was received;
- (4) alleged coercive or otherwise improper conduct by a MassHealth agency employee;
- (5) a notice of intent or failure to give notice of intent by a nursing facility to discharge, transfer, or readmit a resident; or
- (6) a PASRR determination.

(B) The hearing process is designed to secure and protect the interests of both the appellant and, as appropriate, the MassHealth agency or its personnel and to ensure equitable treatment for all involved.

(C) A hearing is conducted by an impartial hearing officer of BOH.

- (1) The decision of the hearing officer is based only on those matters that are presented at the hearing or during a record open period.
- (2) The hearing officer examines the facts, the applicable law, the MassHealth agency's rules, regulations, contracts, and *Policy Memoranda*, and the other circumstances of the appeal presented by the parties to determine the legality and appropriateness of the MassHealth agency's or MassHealth agency employee's action, or the action of a managed care contractor or nursing facility.
- (3) The hearing officer is impartial in that he or she
 - (a) attempts to secure equitable treatment for the parties;
 - (b) has had no prior involvement in any matter over which he or she conducts a hearing, except in a capacity as a hearing officer; and
 - (c) has had no direct or indirect financial interest, personal involvement, or bias pertaining to such matter.

(D) The final hearing decision is binding upon all parties to the hearing, except that appeals may be subject to review under the rehearing process described in 130 CMR 610.091. In the case of a decision about an appeal by an ICO or a SCO enrollee concerning the amount, duration, or scope of covered benefits, where both the BOH and the IRE issue a decision, the ICO or SCO is bound by both decisions and will provide the services that are closest to the enrollee's requested relief in the appeal.

(E) Appeals involving transfers, discharges, or failure to readmit initiated by nursing facilities are binding only on the facility and the resident.

(F) Appeals involving PASRR determinations are binding on DMH and DDS.

(G) Final decisions of the hearing officer are subject to judicial review in accordance with 130 CMR 610.092.

(H) Final decisions of the IRE are subject to administrative review and judicial review in accordance with federal law.

(I) An ICO is bound by decisions as referenced in 130 CMR 610.012(G) and (H).

610.013: Methods for Conducting a Fair Hearing

- (A) A fair hearing may be conducted
- (1) face-to-face, whether in person or by video conferencing; or
 - (2) telephonically, if the party appearing telephonically agrees to such an appearance and notifies the BOH in advance of hearing of such a request.
- (B) Hearings may be consolidated and/or a single hearing may be conducted on multiple requests for fair hearings for the same application, at the discretion of the hearing officer, and provided all parties agree.

610.014: Compilation of Fair Hearing Decisions

BOH compiles and maintains fair hearing decisions. Copies of decisions are available to the public at BOH after deletion of personal data, including the appellant's name and address, in order to protect the confidentiality of personal information. To view fair hearing decisions, an appointment must be made with the BOH in advance. Requests for appointments shall be addressed as expeditiously as possible.

610.015: Time Limits

- (A) Timely Notice. Before an intended appealable action, the MassHealth agency must send a written timely notice to the member except as provided in 130 CMR 610.027. A timely notice is a notice mailed at least ten days before the action. Such notice must include a statement of the right of appeal and the time limit for appealing.
- (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) 60 days after an applicant or member receives written notice from the MassHealth agency of the intended action. Such notice must include a statement of the right of appeal and the time limit for appealing. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the fifth day after mailing;
 - (2) unless waived by the BOH Director or his or her designee, 120 days from
 - (a) the date of application when the MassHealth agency fails to act on an application;
 - (b) the date of request for service when the MassHealth agency fails to act on such request;
 - (c) the date of MassHealth agency action when the MassHealth agency fails to send written notice of the action; or
 - (d) the date of the alleged coercive or otherwise improper conduct, but up to one year from the date of the conduct if the appellant files an affidavit with the BOH Director stating the following, and can establish the same at a hearing (failure to substantiate the allegation either before or at the hearing will be grounds for dismissal):
 1. he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively or he or she was justifiably unaware of the conduct in question; and
 2. the appeal was made in good faith.
 - (3) 30 days after a resident receives written notice of an intent to discharge or transfer pursuant to 130 CMR 610.029(A);
 - (4) 30 days after a nursing facility initiates a transfer or discharge or fails to readmit and fails to give the resident notice;
 - (5) 14 days after a resident receives written notice of an emergency intent to discharge or emergency transfer pursuant to 130 CMR 610.029(B);
 - (6) 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 the resident following hospitalization or other medical leave of absence;
 - (7) for appeals of a decision reached by a managed care contractor:
 - (a) 120 days after the member's receipt of the managed care contractor's final internal appeal decision where the managed care contractor has reached a decision wholly or partially adverse to the member, provided however, that if the managed care contractor did not resolve the member's appeal within the time frames described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that appeal has expired;
 - (b) for timing of request for continuation of benefits pending appeal, *see* 130 CMR 610.036.

610.015: continued

(8) for appeals of PASRR determinations, 30 days after an individual receives written notice of his or her PASRR determination. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the fifth day after mailing.

(C) Computation of Time.

(1) Computation of any period referred to in 130 CMR 610.000 is on the basis of calendar days, except where expressly provided otherwise. Time periods expire on the last day of such periods, unless the day falls on a Saturday, Sunday, legal holiday, or other day on which BOH is closed, in which event the last day of the time period is deemed to be the next day on which BOH is open.

(2) In the absence of evidence or testimony to the contrary, it will be presumed that a notice was received by an appellant on the fifth day after the date of the notice, regardless of whether the fifth day after the date of the notice falls on a Saturday, Sunday, legal holiday, or other day on which the BOH is closed. If an appellant dies on or prior to the date of presumed receipt, then for the purposes of determining whether an appeal request is timely, the appealable notice is still presumed to have been received no later than the fifth day after the date of the notice.

(D) Time Limits for Rendering a Decision.

(1) BOH must render a final decision within 45 days of the date of request for a hearing when the issue under appeal is

- (a) the denial or rejection of an application for assistance;
- (b) the failure to act on an application in a timely manner;
- (c) a nursing facility-initiated discharge or transfer; or
- (d) a PASRR determination.

(2) BOH must render a final decision within 45 days of a request for a fair hearing about appealable actions by managed care contractors, except where the internal appeal was expedited pursuant to 130 CMR 610.015(G) and (H).

(3) BOH must render a final decision within 90 days of the date of request for a hearing for all other appeals.

(4) The time limits set forth in 130 CMR 610.015(D)(1) and (3) and 130 CMR 610.015(E) and (F) may be extended for good cause as follows.

- (a) When delays are caused by the appellant or his or her appeal representative, the time limits may be extended by the total number of days of such delays, which may include the advance notice period before any rescheduled hearing dates. Such delays include the appellant's delay in the submission of evidence, briefs, or other statements, rescheduling or continuances granted at the request of or for the benefit of the appellant, and any other delays caused by the actions of the appellant or his or her appeal representative.
- (b) When delays occur due to acts of nature, serious illness, or other issues beyond the control of BOH that make a hearing officer unable to render a timely decision, good cause for the extension of the time limits will be deemed to exist.
- (c) The hearing officer will document in the hearing record and notify the applicant of any delay that the hearing officer determines is excluded from the time limits set forth under 130 CMR 610.015(D)(1) and (3) and 130 CMR 610.015(E) and (F).

(E) Expedited Appeals for Denied Acute Hospital Admissions. When the MassHealth agency denies prior authorization for an elective hospital admission of a member, the member may request an expedited hearing. When such request is made, BOH will schedule a hearing as soon as possible, but no later than seven days from the date BOH receives the request. The hearing officer must render a final decision as soon as possible, but no later than seven days from the date of the hearing. These time limits may be extended pursuant to 130 CMR 610.015(D). A request for an expedited hearing under 130 CMR 610.015(E) automatically waives the requirement for ten-day advance notice of the hearing under 130 CMR 610.046(A). The appellant will be contacted, orally when possible, at least 48 hours before the hearing.

(F) Expedited Appeals for Discharges and Transfers from a Nursing Facility under 130 CMR 610.029(B) or (C). A resident may request an expedited appeal when a nursing facility notifies a resident of a discharge or transfer under the time frames of 130 CMR 610.029(B) or (C). When such a request is made, BOH will schedule a hearing as soon as possible, but no later than seven days from the date BOH receives the request. The hearing officer must render a final decision as soon as possible, but no later than seven days from the date of the hearing. These time limits may be extended pursuant to 130 CMR 610.015(D). Appeal requests made under 130 CMR 610.015(F) automatically waive the requirement for ten-day advance notice of the scheduled hearing date under 130 CMR 610.046(A).

610.015: continued

(G) Expedited Hearings on Adverse Managed Care Contractor Internal Appeals Decisions.

(1) A member may request an expedited hearing at BOH with respect to an appealable action after exhausting the managed care contractor's expedited appeals process (if required) where the managed care contractor reached a decision on the member's expedited internal appeal wholly or partially adverse to the member within the time frame described by 130 CMR 508.010(A).

(2) The member must submit such a request within the time frames described by 130 CMR 610.015(B)(7)(a).

(3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

(H) Expedited Hearings on Untimely Managed Care Contractor Internal Appeals Decisions.

(1) A member may request an expedited hearing at BOH with respect to an appealable action if the managed care contractor's internal appeals process did not resolve the member's expedited internal appeal within the time frame described by 130 CMR 508.010(B).

(2) The member must submit such a request to BOH within the time frames described by 130 CMR 610.015(B)(6)(d), (B)(7), or (B)(8), whichever is applicable.

(3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

610.016: Appeal Representative

(A) An appellant has the right to be represented at his or her own expense by an appeal representative as defined in 130 CMR 610.004. If the person filing the appeal is not the appellant, all documentation required to demonstrate that the person requesting the appeal is an appeal representative in accordance with 130 CMR 610.004 must be submitted either at the time the hearing is requested or before the hearing is scheduled. The MassHealth agency must provide copies of all documents related to the fair hearing process to the appellant and to the appeal representative, if any. An appeal representative may exercise on the appellant's behalf any of the appellant's rights under 130 CMR 610.000.

(B) If a timely request for a hearing is filed but the applicant or member has died prior to the filing, BOH must be informed of the death of the applicant or member at the time of a request for a hearing by the person filing the appeal. In addition, the filing of the appeal on behalf of such a deceased individual must be accompanied by one of the following:

(1) (a) written proof that the person filing the appeal is a personal representative of the applicant's or member's estate with a current and valid appointment from a court of proper jurisdiction; or

(b) if there is no such personal representative, then written proof of a currently pending petition, docketed in a court of proper jurisdiction, which seeks the appointment of such a personal representative. In addition, the person filing the appeal must notify BOH in writing of the status of the pending petition every 30 days and, once a personal representative with a current and valid appointment has been established, the personal representative must submit written proof of such authority and a desire to pursue the appeal to BOH, within ten days of the appointment.

(2) Failure to comply with all of the requirements in 130 CMR 610.016(B) may constitute grounds for dismissal.

(C) When an appeal representative also acts as an interpreter for the appellant, the appellant must give sufficient verbal consent on the hearing record. The purpose of this guideline is to enable appellants with limited English proficiency to understand and to participate in the entire hearing as fully as if the appellant was fluent in English.

610.017: Reasonable Accommodations

BOH provides reasonable accommodations in accordance with the *Americans with Disability Act* (ADA) to appellants who request such accommodations. BOH informs appellants of the availability of this service. In addition, BOH will provide telephonic or, at its option, other interpreter services for an appellant whose English proficiency is limited, unless such appellant provides his or her own interpreter or such appellant knowingly and voluntarily signs a waiver of such services.

610.018: Appeal Process for Enrollees in an Integrated Care Organization

The Duals Demonstration Program uses a coordinated appeals process that provides enrollees with access to both the MassHealth and Medicare appeals processes. If the ICO internal appeals process denies a member's requested covered benefits in whole or in part, the member may appeal to either IRE, BOH, or both, as described in 130CMR 610.018(A) through (C).

(A) If the member's appeal is denied in whole or in part, the ICO must automatically forward an external appeal about Medicare services to the IRE. The member may simultaneously appeal the ICO decision to the BOH.

(B) Services that are not covered by Medicare fee-for-service may only be appealed to the BOH. The ICO must notify the member if the service is not covered by Medicare and that the member has the right to appeal to the BOH.

(C) If the BOH or the IRE decides in the member's favor, the ICO must provide or arrange for the service in dispute as expeditiously as the member's health condition requires, but no later than 72 hours from the date the ICO receives the notice of the BOH or the IRE decision.

610.026: Adequate Notice Requirements

(A) A notice concerning an intended appealable action must be timely as stated in 130 CMR 610.015 and adequate in that it must be in writing and contain

- (1) a statement of the intended action;
- (2) the reasons for the intended action;
- (3) a citation to the regulations supporting such action;
- (4) an explanation of the right to request a fair hearing; and
- (5) the circumstances under which assistance is continued if a hearing is requested.

(B) Regardless of the provisions of 130 CMR 610.026(A), when a change in either federal or state law requires a change in assistance for a class or classes of members, a notice will be considered adequate if it includes a statement of the specific change in law requiring the action to reduce, suspend, or terminate assistance.

610.027: Timely Notice Exceptions

The MassHealth agency need not send a timely notice, as defined at 130 CMR 610.015(A), but must send an adequate notice, as defined in 130 CMR 610.026, no later than the date of an appealable action when

- (A) the MassHealth agency receives a clear written statement signed by the member that
 - (1) the member no longer wishes to receive assistance; or
 - (2) gives information that requires termination or reduction of services and indicates that termination or reduction of services must be the result of supplying that information;
- (B) the member has been admitted or committed to an institution and he or she is not eligible for further payments or service under any category of assistance;
- (C) the member has been placed in a nursing facility or chronic hospital;
- (D) a member's whereabouts are unknown and the mail from the MassHealth agency to the member has been returned by the Postal Service indicating there is no known forwarding address;
- (E) the MassHealth agency renders a decision on a request for prior authorization of services;
- (F) the MassHealth agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or
- (G) the MassHealth agency has factual information confirming the death of the member.

610.028: Notice Requirements Regarding Actions 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 MassHealth agency 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 610.028(A)(1) through (5), the resident's clinical record must be documented. The documentation must be made by
- (1) the resident's physician when a transfer or discharge is necessary under 130 CMR 610.028(A)(1) or (2); and
 - (2) a physician when the transfer or discharge is necessary under 130 CMR 610.028(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, if the resident has made such a person known to the facility, a notice written in 12-point or larger type that contains the following, in a language the member understands:
- (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 MassHealth agency, 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 610.029; and
 - (c) the effect of requesting a hearing as provided for under 130 CMR 610.030;
 - (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. § 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. § 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.
- (D) As provided in 130 CMR 456.429: *Medical Leave of Absence: Failure to Readmit*, a nursing facility's failure to readmit a resident following a medical leave of absence will be deemed a transfer or discharge (depending on the resident's circumstances). Upon determining that it will not readmit the resident, the nursing facility must issue notice to the resident and an immediate family member or legal representative, if the resident has made such a person known to the facility, in accordance with 130 CMR 456.701(A) through (C), 456.702: *Time Frames for Notices Issued by Nursing Facilities*, and 130 CMR 610.028 through 610.030.

610.029: Time Frames for Notices Issued by Nursing Facilities

(A) The notice of discharge or transfer required under 130 CMR 610.028 must be made by the nursing facility at least 30 days before the date the resident is to be discharged or transferred, except as provided for under 130 CMR 610.029(B) and (C).

(B) In lieu of the 30-day-notice requirement set forth in 130 CMR 610.029(A), the notice of discharge or transfer required under 130 CMR 610.028 must be made as soon as practicable before the discharge or transfer in any of the following circumstances, which are considered to be 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 lived in the nursing facility for 30 days immediately before 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: *Medical Leave of Absence: Failure to Readmit*, must comply with the requirements set forth in 130 CMR 456.701: *Notice Requirements for Transfers and Discharges Initiated by a Nursing Facility*, and must be provided to the resident and an immediate family member or legal representative, if such a person is known to the nursing facility, at the time the nursing facility determines that it will not readmit the resident.

(D) Appeals of discharges and transfers listed in 130 CMR 610.029(B) and (C) are handled under the expedited appeals process described in 130 CMR 610.015(F).

610.030: 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 BOH during the notice period described in 130 CMR 610.015(B)(3), 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 610.015(B)(4), and the request is received before 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, in accordance with 130 CMR 610.015(B)(4), 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, in accordance with 130 CMR 610.015(B)(5), the nursing facility must, upon receipt of the appeal decision favorable to the resident, promptly readmit the resident to the next available bed.

610.031: Notification of the Right to Request a Hearing

(A) Upon being notified of any appealable action, the applicant or member will be informed in writing of his or her right to a hearing, of the method by which a hearing may be requested, and of the right to use an appeal representative (*see* 130 CMR 610.016).

(B) If an applicant or member indicates disagreement with an appealable action, the acting entity will provide the applicant or member with an appeal form and, if requested, help complete the form. The MassHealth agency may not restrict the applicant's or member's freedom to request a fair hearing.

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(C) If there is an individual or organization that provides free legal representation, the person requesting a hearing will be informed of the availability of that service.

(D) At the time that a nursing facility notifies a resident that he or she is to be discharged or transferred, the nursing facility must inform the resident that he or she has the right to request a hearing before the MassHealth agency.

(E) At the time that DMH or DDS notifies an individual of the individual's PASRR determination, the acting entity must inform the individual that he or she has the right to request a hearing before BOH.

610.032: Grounds for Appeal

(A) Applicants and members have a right to request a fair hearing for any of the following reasons:

- (1) denial of an application or request for assistance, or the right to apply or reapply for such assistance;
- (2) the failure of the MassHealth agency to give timely notice of action on an application for assistance in accordance with the requirements of M.G.L. c. 118E, § 21;
- (3) any MassHealth agency action to suspend, reduce, terminate, or restrict a member's assistance;
- (4) MassHealth agency actions to recover payments for benefits to which the member was not entitled at the time the benefit was received;
- (5) individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations);
- (6) coercive or otherwise improper conduct as defined in 130 CMR 610.033 on the part of any MassHealth agency employee directly involved in the applicant's or member's case;
- (7) any condition of eligibility imposed by the MassHealth agency for assistance or receipt of assistance that is not authorized by federal or state law or regulations;
- (8) the failure of the MassHealth agency to act upon a request for assistance within the time limits required by MassHealth regulations;
- (9) the MassHealth agency's determination that the member is subject to the provisions of 130 CMR 508.000: *MassHealth: Managed Care Requirements*;
- (10) the MassHealth agency's denial of an out-of-area provider under 130 CMR 508.003(A)(2);
- (11) the MassHealth agency's disenrollment of a member from a managed care provider under 130 CMR 508.003: *Enrollment with a MassHealth Managed Care Provider*;
- (12) the MassHealth agency's denial of a member's request to transfer out of the member's MCO, ACPP, or Primary Care ACO under 130 CMR 508.003: *Enrollment with a MassHealth Managed Care Provider*;
- (13) the MassHealth agency's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442: *Controlled Substance Management Program*; and
- (14) the MassHealth agency's determination of eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003 as described in federal regulations at 42 CFR Part 423, Subpart P.

(B) Members enrolled in a managed care contractor have a right to request a fair hearing for any of the following actions or inactions by the managed care contractor, provided the member has exhausted all remedies available through the managed care contractor's internal appeals process (except where a member is notified by the managed care contractor that exhaustion is unnecessary):

- (1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;
- (2) a decision to deny or provide limited authorization of a requested service, including the type or level of service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

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- (3) a decision to reduce, suspend, or terminate a previous authorization for a service;
- (4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following:
 - (a) failure to follow prior-authorization procedures;
 - (b) failure to follow referral rules; and
 - (c) failure to file a timely claim;
- (5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010: *Time Limits for Resolving Internal Appeals*;
- (6) a decision by a managed care contractor to deny a request by a member who resides in a rural service area served by only one managed care contractor to exercise his or her right to obtain services outside the managed care contractor's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):
 - (a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the managed care contractor's network;
 - (b) the provider, from whom the member seeks service, is the main source of service to the member, except that member will have no right to obtain services from a provider outside the managed care contractor's network if the managed care contractor gave the provider the opportunity to participate in the managed care contractor's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;
 - (c) the only provider available to the member in the managed care contractor's network does not, because of moral or religious objections, provide the service the member seeks; or
 - (d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the managed care contractor's network; or
- (7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

(C) Nursing facility residents have the right to request an appeal of any nursing facility-initiated transfer or discharge.

(D) Hospital-determined presumptive eligibility as defined in 130 CMR 502.003(H): *Hospital Determined Presumptive Eligibility* is appealable. See 130 CMR 502.008(C).

(E) Individuals have the right to request an appeal of their PASRR determination.

(F) Waiver applicants applying to one of the following HCBS Waiver Programs have a right to request a fair hearing for any of the following actions by the MassHealth agency:

- (1) denial of an application due to financial ineligibility for any HCBS Waiver Program;
- (2) denial of an application due to clinical ineligibility for the following HCBS Waiver Programs:
 - (a) Acquired Brain Injury — Nonresidential Habilitation (ABI-N);
 - (b) Acquired Brain Injury — Residential Habilitation (ABI-RH);
 - (c) Frail Elder Waiver (FEW);
 - (d) Moving Forward Plan — Community Living (MFP-CL);
 - (e) Money Follows the Person — Residential Supports (MFP-RS); and
 - (f) Traumatic Brain Injury (TBI).

(G) Waiver participants enrolled in one of the following HCBS Waiver Programs have the right to request a fair hearing for any of the following actions or inactions by the acting entity:

- (1) disenrollment from an HBCS Waiver Program due to financial ineligibility for any HCBS Waiver Program;
- (2) disenrollment from an HBCS Waiver Program due to clinical ineligibility for the following HCBS Waiver Programs:
 - (a) Acquired Brain Injury — Nonresidential Habilitation (ABI-N);
 - (b) Acquired Brain Injury — Residential Habilitation (ABI-RH);

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- (c) Frail Elder Waiver (FEW);
 - (d) Moving Forward Plan — Community Living (MFP-CL);
 - (e) Moving Forward Plan — Residential Supports (ABI-RS); and
 - (f) Traumatic Brain Injury (TBI);
- (3) denial, suspension, reduction, modification, or termination of services, including failure to provide choice of available provider, for waiver participants enrolled in the following HCBS Waiver Programs:
- (a) Acquired Brain Injury — Nonresidential Habilitation (ABI-N);
 - (b) Acquired Brain Injury — Residential Habilitation (ABI-RH);
 - (c) Moving Forward Plan — Community Living (MFP-CL);
 - (d) Moving Forward Plan — Residential Supports (MFP-RS); and
 - (e) Traumatic Brain Injury (TBI); and
- (4) failure to act on a waiver participant's request for a HCBS Waiver Program service within 30 days of receiving such request for waiver participants enrolled in the following HCBS Waiver Programs:
- (a) Acquired Brain Injury — Nonresidential Habilitation (ABI-N);
 - (b) Acquired Brain Injury — Residential Habilitation (ABI-RH);
 - (c) Moving Forward Plan — Community Living (MFP-CL);
 - (d) Moving Forward Plan — Residential Supports (ABI-RS); and
 - (e) Traumatic Brain Injury (TBI).

610.033: Coercive or Otherwise Improper Conduct

(A) Definitions.

- (1) Coercive conduct means knowingly compelling an applicant, member, or former member by force, threat, intimidation, or other abuse of position to take action that is injurious to his or her best interest and that he or she would not otherwise have done.
- (2) Improper conduct means reckless and unreasonable abuse of authority that interferes with the applicant's, member's, or former member's exercise of rights under MassHealth.

(B) Remedies. When a hearing officer has found coercive or otherwise improper conduct on the part of any MassHealth agency employee directly involved in the applicant's, member's, or former member's case at a fair hearing, the enrollment center director will

- (1) assign a different worker; and
- (2) initiate appropriate personnel action including the insertion of a written reprimand and a copy of the written findings, if any, in the worker's personnel file.

610.034: Request for a Fair Hearing

(A) A request for a fair hearing is defined as a written statement by the appellant that asks for administrative review of an appealable action. The request for a fair hearing must be received by BOH within the time limits set forth in 130 CMR 610.015.

(B) Any request for a fair hearing that cites coercive or otherwise improper conduct on the part of a MassHealth agency employee must state the name of the employee and the place, date, and nature of the incident or incidents. If the request lacks the information required by 130 CMR 610.034, BOH will notify the appellant of the requirement. If the appellant then fails to provide the information within ten days, the appeal will be dismissed.

610.035: Dismissal of a Request for a Hearing

(A) BOH will dismiss a request for a hearing when

- (1) the request is not received within the time frame specified in 130 CMR 610.015;
- (2) the request is withdrawn by the appellant;
- (3) the sole issue is one of state or federal law requiring automatic change in assistance for classes of members;

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- (4) the stated reason for the request does not constitute grounds for appeal as set forth in 130 CMR 610.032. Without limiting the generality of the foregoing, except as provided in 130 CMR 610.032(A)(11), no provider decision or action including, but not limited to, a provider determination about whether or the extent to which a service is medically necessary, constitutes an appealable action hereunder;
- (5) the stated reason for the hearing request is outside the scope of 130 CMR 610.000 as set forth in 130 CMR 610.003;
- (6) BOH has conducted a hearing and issued a decision on the same appealable action arising out of the same facts that constitute the basis of the request;
- (7) the party requesting the hearing is not an applicant, member, or resident as defined in 130 CMR 610.004;
- (8) BOH learns of an adjustment or action that resolves all of the issues in dispute between the parties;
- (9) BOH learns that the applicant or member has passed away before or after the date of filing and there is no full compliance with 130 CMR 610.016(B) within ten days of a BOH request;
- (10) BOH learns that the applicant or member has passed away prior to the date of filing and scheduling of the hearing and is not informed until the date of the hearing and there is no full compliance with 130 CMR 610.016(B); or
- (11) the appellant fails to appear at a scheduled hearing.

(B) 130 CMR 610.048(C) contains the procedure for BOH notices of dismissals and attempts to vacate such dismissals. The BOH Director may also, at his or her discretion, order a hearing scheduled to allow the appellant the opportunity to contest the dismissal.

610.036: Continuation of Benefits Pending Appeal

(A) When the appealable action involves the reduction, suspension, termination, or restriction of assistance, such assistance will be continued until BOH decides the appeal or, where applicable, the rehearing decision is rendered if BOH receives the initial request for the fair hearing before the implementation date of the appealable action. If such appealable action was implemented before a timely request for a hearing, such assistance will be reinstated if BOH receives the request for the fair hearing within ten days of the mailing of the notice of the appealable action. If the hearing officer's decision is adverse to the appellant, the appealable action will be implemented immediately, except as provided in 130 CMR 610.091(D).

(B) When a change affecting the member's assistance occurs while the hearing decision is pending, the MassHealth agency will take appropriate action to implement the subsequent change affecting assistance, subject to the advance notice requirements and the right to assistance pending a hearing decision.

(C) Assistance pending a hearing will not be granted if the MassHealth agency has granted assistance on a presumption of eligibility and subsequently determines that the member is ineligible, and such determination is the subject of a hearing request.

(D) Assistance continued pending an appeal in accordance with 130 CMR 610.036(A) is subject to recoupment.

(E) The provisions of 130 CMR 610.036(A) and (B), regarding assistance pending a hearing decision, will not apply to assistance requiring prior authorization where such assistance terminates as the result of the expiration of the specified, finite authorization period, and the member's provider has failed to timely submit a new prior authorization request.

610.037: Notice Requirements for PASRR Determinations

- (A) When DMH or DDS issues a PASRR determination, it must provide written notice of the PASRR determination to the following:
- (1) the evaluated individual and his or her legal representative;
 - (2) the admitting or retaining nursing facility;

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- (3) the attending physician; and
- (4) the discharging hospital, if the individual is seeking nursing facility admission from a hospital.

(B) Notice of the PASRR determination must include the following:

- (1) whether a nursing facility level of service is needed;
- (2) whether specialized services, as defined by 42 CFR 483.120, are needed;
- (3) the placement options available to the individual consistent with the determination and in accordance with 42 CFR 483.130(M);
- (4) a statement indicating that the individual's PASRR determination is based on the individual's PASRR and that the individual was evaluated in accordance with 42 CFR 483.128;
- (5) a statement informing the individual of his or her right to request a fair hearing before the BOH to appeal a PASRR Determination and that provides
 - (a) the address to send a request for a hearing;
 - (b) the time frame for requesting a hearing as provided for under 130 CMR 610.015; and
 - (c) a statement that the individual may represent himself or herself or be represented by legal counsel, a relative, a friend or other spokesperson.

(C) Notice must be mailed no later than the date of the PASRR determination.

610.046: Notification of Hearing

(A) The time, date, and place of the hearing will be arranged so that the hearing is accessible to the appellant. Advance written notice will be mailed by BOH to all parties involved at least ten days prior to the hearing date in order to permit adequate preparation of the case. However, the appellant may request less advance notice to expedite the scheduling of the hearing.

(B) The notice will contain the following:

- (1) the date, time, and location of the hearing;
- (2) the address and telephone number for BOH to allow for notification if a party cannot attend the scheduled hearing and needs to submit a request for rescheduling in accordance with 130 CMR 610.048;
- (3) an explanation of the MassHealth agency's hearing procedures, including the appellant's right to representation at the appellant's expense;
- (4) a statement that the appellant or appeal representative may examine the case file (or resident record, as applicable) before the hearing; and
- (5) a statement to the appellant indicating that the MassHealth agency will dismiss the hearing request if the appellant or his or her appeal representative fails to appear for the hearing without good cause.

610.047: Scheduling

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

- (1) the appellant and any appeal representative or authorized representative;
- (2) the appropriate office of the MassHealth agency and the managed care contractor or nursing facility; and
- (3) if applicable, the MassHealth agency employee against whom allegations of coercive or otherwise improper conduct have been made.

(B) BOH will further 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 alternative location.

610.048: Procedures and Requirements for Rescheduling

(A) Rescheduling before the Day of the Hearing.

- (1) BOH may change the date, time, and location of the hearing upon due notice to the parties involved.
- (2) For good cause shown as defined in 130 CMR 610.048(D), BOH may, at the request of any party to a hearing, reschedule the hearing provided that the request is received before the date of the hearing. If the BOH Director or his or her designee concludes that the request does not constitute good cause, the request will be denied.
- (3) If a party does not request to reschedule or is denied a request to reschedule and fails to attend the hearing, the appeal will be dismissed.
- (4) BOH will inform the parties of the procedures set forth in 130 CMR 610.048(A)(1) through (3).

(B) Rescheduling following Failure to Appear at a Scheduled Hearing. If a party fails to request or requests, but does not receive approval, to reschedule a hearing and fails to appear at the hearing, BOH will notify the party and any appeal representative in writing (at the address supplied by the party) that, if the party fails to demonstrate good cause within ten days of the notice, the appeal will be considered abandoned by such party. If the party who does not appear is an appellant and if, in the determination of the BOH Director or his or her designee, good cause, as defined in 130 CMR 610.048(D), has not been timely shown by such appellant, the appeal will be dismissed subject to the procedures set forth in 130 CMR 610.048(C), and aid pending, if any, will be discontinued. If the party who fails to appear is a respondent and not an appellant, BOH will issue an appropriate order. The BOH Director or his or her designee may at his or her discretion reschedule a hearing to another date at which time the party who failed to appear at the scheduled hearing will be required to establish good cause for the failure to appear. A finding by the hearing officer that good cause has not been shown will result in dismissal of the appeal.

(C) Procedures for an Appellant to Request Vacating a Dismissal.

- (1) The appellant will be informed by written notice of the dismissal and of the procedures for requesting that the dismissal be vacated.
- (2) A request to vacate a dismissal must be in writing and must be signed by the appellant. Such request must be received by BOH within ten days of the date of the dismissal notice. If the dismissal is for failure to appear at a hearing, such a dismissal will be vacated by the BOH Director or his or her designee upon a finding that the appellant has shown good cause for
 - (a) failure to appear at a scheduled hearing; and
 - (b) failure to inform BOH before the date of a scheduled hearing of his or her inability to appear at that hearing.

(D) Good Cause.

- (1) The following circumstances may constitute good cause subject to 130 CMR 610.048(D)(2):
 - (a) a death in the family;
 - (b) a personal injury or illness that reasonably prevents the party from attending the hearing;
 - (c) a sudden and serious emergency or act of nature that reasonably prevents the party from attending the hearing;
 - (d) an obligation or responsibility that a reasonable person in the conduct of his or her serious affairs would conclude takes precedence over attendance at the hearing; or
 - (e) the need for additional time to produce evidence or witnesses or obtain legal assistance; or
 - (f) for the purposes of 130 CMR 610.048(A) only, the agreement of the parties to reschedule.
- (2) In evaluating a party's good cause claim, the BOH Director or his or her designee considers the following factors:
 - (a) the amount of time during which the party had advance notice of the hearing;
 - (b) the party's ability to anticipate the circumstances that resulted in his or her inability to appear for the hearing;
 - (c) the party's ability to reschedule any conflicting event;

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- (d) delay by the party in notifying BOH of his or her inability to attend the hearing; and
 - (e) previous rescheduling requests or failure to appear for scheduled hearings that indicate a pattern of delay or noncompliance with the fair hearing rules.
- (3) If a party will be required to show good cause at the hearing, BOH will notify that party in advance that a hearing officer will address that issue. The party will also be notified that the party may bring documentation and witnesses in support of the good cause claim and that failure to demonstrate good cause may result in dismissal of the appeal.

610.049: Dismissal for Failure to Prosecute

When the record discloses the failure of the appellant to file documents required by 130 CMR 610.000, to respond to notices or correspondence, or to comply with orders, or when the appellant otherwise indicates an intention not to continue with the prosecution of his or her appeal, BOH may issue an order requiring the appellant to show cause why the matter should not be dismissed for lack of prosecution. The BOH Director will make the show cause determination; however, in cases where the hearing has been scheduled and a hearing officer has been designated to conduct the hearing, the hearing officer will make the determination. If the appellant is found to have failed to show such cause, the appeal will be dismissed with prejudice.

610.050: Right to Examine Case File and Documents, or "Discovery"

(A) Appeals of MassHealth Determinations. The appellant will have reasonable opportunity to examine the entire contents of the appellant's case file, as well as all documents and records to be used by the MassHealth agency at the hearing. An appointment must be scheduled in advance with the appropriate MassHealth Enrollment Center (MEC) or MassHealth agency unit for examination of the case file.

(B) Appeals of PASRR Determinations. The appellant will have reasonable opportunity to examine the appellant's PASRR evaluation, including all documents and records used in performing the evaluation, as well as all documents and records to be used at the hearing by the department that issued the PASRR determination. An appointment to examine the documents must be scheduled in advance with the department that issued the PASRR determination.

610.051: Adjustment Procedures and Mediation

(A) MassHealth Agency. The MassHealth agency is primarily responsible for dealing with complaints from applicants or members. Dissatisfaction on the part of applicants or members may result from a lack of knowledge or understanding of the regulations that govern MassHealth policies and procedures. Ordinarily, complaints may be resolved with an explanation of the regulations by the representative. If the MassHealth representative's explanation is not satisfactory, the representative's immediate supervisor will be available to respond to the complaint. If the complaint cannot be resolved, the MassHealth agency will remind the applicant or member of the right to request a fair hearing.

(B) Adjustments Resolving Issues. The MassHealth agency or the acting entity may make an adjustment in the matters at issue before or during an appeal period. If the parties' adjustment resolves one or more of the issues in dispute in favor of the appellant, the hearing officer, by written order, may dismiss the appeal in accordance with 130 CMR 610.035 as to all resolved issues, noting as the reason for such dismissal that the parties have reached agreement in favor of the appellant. BOH will not delay a fair hearing because a possible adjustment is under consideration, unless the appellant requests or agrees to such a delay.

(C) Mediation. BOH may offer to the parties the opportunity to resolve one or more of the appeal issues in dispute through mediation, and such mediation may proceed only if, and as long as, both parties agree to such mediation that will be conducted substantially in accordance with M.G.L. c. 233, § 23C. If such mediation resolves one or more of the issues in dispute, the hearing officer, by written order, will dismiss the appeal, as to all resolved issues, noting as the reason for such dismissal that the parties have reached agreement. Either party may elect to terminate mediation at any time and proceed to a fair hearing that BOH will schedule accordingly. Any party may request that a different hearing officer be assigned to conduct such fair hearing.

610.052: Subpoenas

(A) A subpoena under 130 CMR 610.000 is a document that commands a witness to appear at a given time to give testimony at an administrative proceeding. A subpoena can also require the witness to produce for the administrative proceeding any books, documents, papers, or records in his or her possession or control.

(B) Right to Subpoena. Any party to a hearing and BOH on its own have the right to request a subpoena requiring the attendance, testimony of witnesses, and the production of any evidence including books, records, correspondence, or documents relating to any matter in question at the hearing. Any party may submit to BOH a written request for the issuance of such subpoena. If, in its discretion and in accordance with 130 CMR 610.065(B), BOH allows such request, a subpoena will be issued within three business days of receipt of such request.

(C) Petition to Vacate Subpoena. Any witness subpoenaed may petition BOH to vacate or modify a subpoena.

(1) BOH gives the party who requested the issuance of the subpoena notice of such petition orally or in writing. The notice must contain the contents of the petition and indicates that the party may oppose the petition orally or, if time permits, in writing to BOH. If time does not permit a party to respond to the request to vacate, the hearing will be postponed long enough to permit the party to respond to the petition. This procedure is not be construed to require a hearing or adjudicatory proceeding.

(2) After such investigation as BOH considers appropriate, BOH may grant the petition in whole or in part upon a finding that:

- (a) the testimony or the evidence whose production is required does not relate with reasonable directness to any matter in question;
- (b) the subpoena is unreasonable or unduly burdensome; or
- (c) the subpoena has not been issued in a reasonable period in advance of the time when the evidence to be produced is requested.

(3) Unless BOH finds that at least one of the conditions in 130 CMR 610.052(C)(2)(a) through (c) exists, BOH will deny the petition.

(D) Failure to Comply with a Subpoena. If any person fails to comply with a properly issued subpoena, BOH (or the party who requested the subpoena) may petition the Superior Court for an order requiring compliance with the terms of the subpoena.

610.061: Appellant Rights

The appellant must have the right to

(A) be assisted by an appeal representative of his or her choice as provided in 130 CMR 610.016;

(B) present witnesses;

(C) examine and introduce evidence from his or her case file or resident record, if applicable, and examine and introduce any other pertinent documents of the MassHealth agency or other party;

(D) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;

(E) advance any pertinent arguments without undue interference; and

(F) question or refute any testimony, and confront and cross-examine adverse witnesses.

610.062: Acting Entity Rights and Responsibilities

The acting entity will

(A) submit to the hearing officer, at or before the hearing, all evidence on which any action at issue is based;

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- (B) designate a staff person or representative to appear at the hearing, and arrange for adequate space for the hearing if requested by BOH;
- (C) have the right to present witnesses;
- (D) where the acting entity is the MassHealth agency, ensure that the case file is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;
- (E) where the acting entity is a nursing facility, ensure that the relevant portions of an appellant's resident record are present at the hearing and that the appellant has adequate opportunity to examine such records before and during the hearing upon reasonable request;
- (F) where the acting entity is DDS or DMH and the appellant is appealing his or her PASRR determination, ensure that all medical records comprising the PASRR evaluation are present at the hearing and that the appellant or the appellant's representative has adequate opportunity to examine them before and during the hearing;
- (G) introduce into evidence material from pertinent documents that pertain to the issue or issues raised during the hearing and that are not otherwise confidential;
- (H) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (I) have the right to advance any pertinent arguments without undue interference;
- (J) have the right to question and refute any testimony and confront and cross-examine adverse witnesses;
- (K) have the right to arrange for the appearance at the hearing of a representative of other assistance programs, where appropriate; and
- (L) where the acting entity is a managed care contractor, ensure that the relevant paperwork is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing.

610.064: MassHealth Agency Employee Rights

Any MassHealth agency employee against whom allegations of coercive or otherwise improper conduct have been made may present his or her own case and will have the right to

- (A) be assisted by a representative of his or her choice at his or her own expense;
- (B) bring witnesses or subpoena witnesses upon request to BOH;
- (C) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (D) advance any pertinent arguments without undue interference;
- (E) question or refute any testimony and confront and cross-examine adverse witnesses; and
- (F) examine and introduce any pertinent evidence, including material from the case file.

610.065: Powers and Duties of the Hearing Officer

- (A) The hearing officer has the following duties:
 - (1) to administer the oath or affirmation to anyone who will testify at the hearing and to an interpreter/translator;

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- (2) to assist all those present in making a full and free statement of the facts in order to elicit all the information necessary to decide the issues involved and to ascertain the rights of the parties;
- (3) to ensure an orderly presentation of the evidence;
- (4) to ensure that all parties have a full opportunity to present their claims orally or in writing and to secure witnesses and evidence to establish their claims;
- (5) to receive, rule on, exclude, or limit evidence;
- (6) to ensure a record is made of the proceedings;
- (7) to render a fair, independent, and impartial decision based on the issues and evidence presented at the hearing and in accordance with the law, including the MassHealth agency's rules, regulations, and *Policy Memoranda*, and to order MassHealth agency action if appropriate; and
- (8) to inform appellants who are not fluent in English of the right to a full and accurate interpretation by their own interpreter, or by a MassHealth agency-provided interpreter. The hearing officer will conduct the bilingual hearing in accordance with the guidelines for conducting hearings through interpretation in the Hearing Officer Manual. The purpose of the guidelines is to enable non-English speaking appellants to understand and to participate in the entire hearing as fully as if the appellants were fluent in English. To achieve this end, all statements, including questions, answers, and comments, of the appellant, hearing officer, witnesses, and any other persons participating in the hearing, will be fully translated without alteration of such statements, such as by changing from the first person to the third person.

(B) The hearing officer has the following powers to:

- (1) limit attendance at the hearing, at his or her discretion;
- (2) change the date, time, or location of the hearing on his or her own motion or at the request of any party, upon due notice to the parties;
- (3) request a statement of the issues and define the issues, and, to accomplish this purpose, to request the parties' participation in prehearing activities including, but not limited to, a prehearing conference or conferences;
- (4) regulate the presentation of evidence and the participation of the parties for the purpose of ensuring an adequate and comprehensive record of the proceedings;
- (5) issue subpoenas on his or her own motion or upon request of any party to secure the presentation of evidence or testimony;
- (6) examine witnesses and ensure that relevant evidence is secured and introduced;
- (7) introduce into the hearing record by reference or production any regulations, statutes, *memoranda*, or other materials he or she believes relevant to the issues at the hearing;
- (8) continue the hearing to a subsequent date to permit either party to produce additional evidence, witnesses, or other materials;
- (9) when appropriate, direct the MassHealth agency to pay for the costs of an independent medical examination;
- (10) rule on any requests that may be made during the hearing;
- (11) reconvene the hearing at his or her discretion at any time before the rendering of the decision in accordance with 130 CMR 610.072 and 130 CMR 610.081; and
- (12) order, at his or her discretion, written briefs to be submitted, provided that all parties are notified of the submission of the briefs and have opportunity to answer.

610.071: Evidence(A) General.

- (1) The rules of evidence observed by courts do not apply to fair hearings, but the hearing officer observes the rules of privilege recognized by law. Evidence may be admitted and given probative effect only if it is the kind of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. Unduly repetitious or clearly irrelevant evidence may be excluded.
- (2) The hearing officer may not exclude evidence at the hearing for the reason that it had not been previously submitted to the acting entity, provided that the hearing officer may permit the acting entity representative reasonable time to respond to newly submitted evidence. The effective date of any adjustments to the appellant's eligibility status is the date on which all eligibility conditions were met, regardless of when the supporting evidence was submitted.

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(B) Presentation at Hearing. Except as the hearing officer may otherwise order within his or her discretion in accordance with 130 CMR 610.081 and 130 CMR 610.082, any evidence on which a decision is based must be presented at the hearing. Copies of any evidence not submitted at the hearing will be provided to all other parties who will then have the opportunity to respond.

(C) Oral Testimony. Oral testimony will be given under oath or affirmation. Witnesses will be available for examination and cross-examination.

(D) Regulations, Statutes, and Memoranda. Regulations and statutes may be submitted into evidence by reference to the citation or by submitting a copy of the regulations. *Memoranda* and other materials may be put into evidence by submission of the original or copy thereof.

(E) Stipulations. Stipulations of facts or stipulations as to the testimony that would have been given by an absent witness may, if agreed upon by the parties, be used as evidence at the hearing.

(F) Additional Evidence. The hearing officer may in any case require either party, with appropriate notice to the other party, to submit additional evidence on any relevant matter.

(G) Format and Length. 130 CMR 610.071(G) applies to all submissions to the hearing record, unless otherwise directed by the hearing officer. Motions, *memoranda* of law, and other papers, except for exhibits, submitted to the hearing record should be on 8½" by 11" paper and, except for exhibits, typed in no less than 12-point type. Unless a request is made to the hearing officer in advance of submitting a document and all *memoranda* of law should be limited to 20 pages, and any reply *memoranda* limited to ten pages. If a party wants to submit motions, *memoranda* of law, or other papers in excess of the pages outlined above, a party (appellant or respondent) shall make the request in writing to the hearing officer assigned to the appeal, with a copy to the other party, stating the number of pages the party anticipates desiring and a description of why the recommended length cannot be achieved within the applicable page limit. Any opposition to a request to exceed the page limit should be made in writing to the assigned hearing officer with a copy to the other party.

610.072: Continuance

Once a hearing has been opened, it may be continued at the discretion of the hearing officer. All parties will be notified as to the time, date, and location of the continued hearing in accordance with 130 CMR 610.081.

610.073: Consolidated Hearings

(A) BOH may respond to a series of individual requests for hearings by conducting a single group hearing. BOH may consolidate cases when

- (1) the applicable state or federal law is common to all such cases; and
- (2) the issues of fact are undisputed, or are common to all such cases.

(B) In all group hearings, the regulations governing individual hearings must be followed and each appellant must be permitted to present his or her own case or have the case presented by an appeal representative.

610.074: The Record

(A) All documents and other evidence offered and taken become part of the record. The record further contains electronic or stenographic recordings of the proceedings or transcripts of such recordings, if produced, and all exhibits and documents introduced at the hearing and, wherever applicable, medical documents obtained to resolve medical issues. The record is the exclusive source of facts for the hearing officer's decision. For purposes of judicial review, the record includes the decision, but does not include recordings or transcripts of the proceedings, unless requested by the appellant. If the appellant requests a recording or transcript, the appellant bears the cost of producing such recording or transcript, unless such cost is waived by the MassHealth agency or the court.

610.074: continued

(B) All evidence and testimony at the hearing are recorded either electronically by the hearing officer or stenographically.

(C) At the discretion of the hearing officer, any party may record the hearing, so long as the request to record is made to the hearing officer and the other party before the recording commences.

(D) Regardless of whether an appellant intends to file a complaint for judicial review, transcripts or duplicate tapes of the proceedings are supplied, upon request by the appellant, at his or her expense. The record is open for inspection by any party during the regular business hours of BOH. To review the record, an appointment must be made with BOH in advance. Requests for appointments shall be addressed as expeditiously as possible.

610.081: Reopening before Decision

After the close of the hearing and before a decision, the hearing officer may reopen the record or, if appropriate, the hearing if he or she finds need to consider further testimony, evidence, materials or legal rules before rendering his or her decision. If the hearing officer decides to reopen the record, he or she must notify all parties accordingly and all parties will have the opportunity to submit such additional testimony, evidence, materials, or legal argument as the hearing officer may describe in such notice and within such time period that the hearing officer may so establish, unless the party waives the right at hearing to receive a copy of and respond to such submission. All such additional submissions must be sent to the other party or parties who will have the opportunity to respond to such submissions within such time period as the hearing officer may establish. If the hearing officer decides to reopen the hearing in the form of a continuance according to 130 CMR 610.071, he or she must send written notice, at least seven days in advance of the resumed hearing, to all parties of the reopening. Such written notice must include the date, time, and location of the resumed hearing and must be held at a location accessible to the appellant. Before a hearing decision is rendered, any party to a hearing may request in writing that the hearing officer exercise his or her power hereunder, and such request will become part of the record.

610.082: Basis of Fair Hearing Decisions

(A) The hearing officer's decision is based upon evidence, testimony, materials, and legal rules, presented at the hearing, including the MassHealth agency's interpretation of its rules, policies, and regulations. Any evidence, testimony, materials, legal rules, or arguments presented after the close of the hearing will be excluded, unless the record or hearing is reopened by the hearing officer pursuant to 130 CMR 610.081, or the parties stipulate procedures for response, or the parties otherwise waive the right to respond.

(B) The decision must be based upon a preponderance of evidence.

(C) The decision must be rendered in accordance with the law.

(1) The law includes the state and federal constitutions, statutes, and duly promulgated regulations, as well as decisions of the state and federal courts.

(2) Notwithstanding 130 CMR 610.082(C)(1), the hearing officer must not render a decision regarding the legality of federal or state law including, but not limited to, the MassHealth regulations. If the legality of such law or regulations is raised by the appellant, the hearing officer must render a decision based on the applicable law or regulation as interpreted by the MassHealth agency. Such decision must include a statement that the hearing officer cannot rule on the legality of such law or regulation and must be subject to judicial review in accordance with 130 CMR 610.092.

(3) The hearing officer must give due consideration to *Policy Memoranda* and any other MassHealth agency representations and materials containing legal rules, standards, policies, procedures, or interpretations as a source of guidance in applying a law or regulation.

610.083: Content of Decision

(A) Unless subject to 130 CMR 610.083(C), the hearing decision will contain the following:

- (1) statement of the issues involved in the hearing;
- (2) summary of evidence;
- (3) findings of fact on all relevant factual matters;
- (4) rulings of law on all relevant legal issues, with citations to supporting regulations or other law;
- (5) conclusions drawn from the findings of fact and rulings of law if appropriate; and
- (6) the hearing officer's order for appropriate action.

(B) Unless subject to 130 CMR 610.083(C), the hearing decision will notify the appellant of his or her right to full and prompt implementation of the decision in accordance with 130 CMR 610.086. The appellant will be further notified of this right to judicial review in accordance with 130 CMR 610.092.

(C) If all the appeal issues between the parties have been resolved in accordance with 130 CMR 610.051, then the hearing decision may consist of a statement which sufficiently identifies the appeal issues and states the resolution and any future action agreed upon by the parties.

610.084: Transmittal of Decision

Unless waived, copies of the decision will be forwarded to the appellant, the appellant's appeal representative, the appellant's interpreter (if requested), and representatives of the acting entity, as applicable. The appellant, his or her appeal representative and, for appeals held pursuant to 130 CMR 610.032(C), the nursing facility will also be notified in writing of the right of judicial review.

610.085: Finality of the Appeal Decision

(A) Except as otherwise provided under 130 CMR 610.085(B), 610.085(C), and 610.091, the following will apply.

- (1) The decision of the hearing officer will be final and binding on the acting entity.
- (2) The acting entity will not interfere with the independence of the fact-finding process of the hearing officer. Facts found and issues decided by the hearing officer in each case are binding on the parties to that case and cannot be disputed again between them in any other administrative proceeding nor used as binding precedent by other parties in other proceedings.

(B) A hearing decision that directs the MassHealth agency or managed care contractor to authorize or pay for a medical service will have no effect if the appellant has not scheduled or received such medical service within one year from the date of the hearing decision.

(C) In the case of a decision affecting a member enrolled in an ICO, where both the BOH and the IRE have issued a ruling, the ICO is bound by the rulings and will provide the services which are closest to the enrollee's relief requested on appeal.

610.086: Implementation of the Appeal Decision

(A) Decisions When the MassHealth Agency Is the Acting Entity.

- (1) Notification to Appellant. When the decision is issued, BOH must notify the appellant of his or her right to full and prompt implementation of the decision within 30 days, except as provided under 130 CMR 610.091. The notice directs the appellant to notify the appropriate BOH official in writing if there is not full compliance within 30 days.
- (2) Responsibility of the MassHealth Agency. The MassHealth agency is responsible for the full and prompt implementation of all fair hearing decisions so that the appellant will receive any benefits due within 30 days of the date of the decision, except as provided under 130 CMR 610.091. No official or any other employee of the MassHealth agency may obstruct the implementation of the fair hearing decision, except as provided under 130 CMR 610.091.

610.086: continued

(3) Procedure for Monitoring Implementation. The MassHealth agency monitors approved and denied appeal decisions to ensure implementation and compliance within 30 days of the decision, except as provided under 130 CMR 610.091.

(4) Expedited Appeals for Denied Acute Hospital Admission. When a member requests an expedited appeal of a denial of prior authorization for an elective hospital admission, pursuant to 130 CMR 610.015(E), the MassHealth agency will comply with the decision of the hearing officer as soon as possible, but no later than seven days from the date of the decision, except as provided under 130 CMR 610.091. The hearing officer's decision pertaining to such appeal establishes whether the MassHealth agency will approve the admission and, if applicable, determines the length of stay. However, the hearing officer's decision does not establish whether medical care provided following the admission is medically necessary.

(B) All Other Decisions.

(1) Notification to Appellant. When the decision is issued, BOH must notify the appellant of his or her right to full and prompt implementation of the decision. The notice must direct the appellant to notify the appropriate BOH official in writing if there is not full compliance within 30 days.

(2) Responsibility of the Acting Entity. The acting entity is responsible for the full and prompt implementation of the fair hearing decision. No official or any other employee of the acting entity may obstruct the implementation of the fair hearing decision.

610.091: Review of Hearing Officer Decisions

(A) The Medicaid director (but not his or her designee) may, for good cause shown, send an order for the BOH Director to conduct a rehearing of an appeal. Good cause is defined in regard to the rehearing of long-term care eligibility decisions at 130 CMR 610.091(E)(3). The BOH Director (but not his or her designee) conducts the rehearing, except the BOH Director may appoint another hearing officer to conduct the rehearing if the BOH Director:

- (1) is unable to conduct the rehearing due to a conflict of interest;
- (2) was the hearing officer at the original hearing for which the rehearing is requested; or
- (3) is ill or unavailable and an extended delay would be prejudicial to any of the parties.

(B) An order to conduct a rehearing is not to be construed, for any purpose, as indicating any position by the Medicaid director on the merits of the appeal. The Medicaid director may order such a rehearing on his or her own initiative or at the appellant's request, provided that within 14 calendar days of the date of the hearing officer's decision

- (1) the Medicaid director receives the appellant's rehearing request; or
- (2) the Medicaid director notifies the appellant of his or her intent to consider a rehearing.

(C) The BOH Director must send written notice, seven days in advance of the rehearing, to all parties, including the date, time, and location of such rehearing, which is held at a site reasonably convenient or agreeable to the person appealing. After the rehearing, the BOH Director may issue a superseding decision no later than 30 days after the order to conduct a rehearing. Any party to an appeal may request the BOH to treat an order to conduct a rehearing as an order to remand the appeal for further consideration by the hearing officer who rendered the original decision. The BOH allows such request only when all parties to the appeal agree.

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(D) A request for a rehearing or notice of the Medicaid director's intent to consider a rehearing stays implementation or effect of the appeal decision until such request is denied or the Medicaid director otherwise decides not to order a rehearing, or the superseding rehearing decision is issued.

(E) Review of Hearing Officer Decisions – Long-term Care Eligibility Decisions. The following provisions apply only to the review of the hearing officer's decisions regarding the appellant's eligibility for long-term care.

(1) If the Medicaid director does not act upon a timely request for rehearing within 45 days, the request for rehearing is deemed denied, unless the appellant advises the Medicaid director in writing before the expiration of the 45-day deadline that they do not want the request to be deemed denied if it is not acted on within 45 days.

(2) If a request for rehearing has been denied by the Medicaid director or deemed denied because the Medicaid director has not acted upon it within 45 days of the request, the appellant may immediately proceed to judicial review of the BOH's decision under M.G.L. c. 30A.

(3) Good cause for a rehearing of a hearing officer decision exists if the Medicaid director determines that the appellant has satisfactorily demonstrated that the appellant's BOH decision is directly inconsistent with a previous BOH decision or binding appellate precedent concerning the same trust language or law. To establish good cause for a rehearing to be ordered by the Medicaid director, the appellant must:

(a) attach a copy of the BOH decision the appellant is challenging;

(b) attach copies of the inconsistent prior decisions from the BOH or the appellate court or both;

(c) identify and explain the inconsistencies between the decisions and the identity of facts and law; and

(d) provide any prior BOH decisions that are consistent with the treatment provided to appellant on the identical facts and law.

(4) Any rehearing of a long-term care eligibility decision will be confined to the specific consistency issues identified in the rehearing request. The hearing officer or the BOH Director conducting the rehearing will issue a decision that contains:

(a) a statement of the issues involved in the hearing;

(b) a summary of evidence;

(c) findings of fact on all relevant factual matters;

(d) rulings of law on all relevant legal issues, with citations to supporting regulations or other law;

(e) conclusions drawn from the findings of fact and rulings of law if appropriate; and

(f) an order for appropriate action.

610.092: Judicial Review

(A) If the appellant is dissatisfied with the final decision of the hearing officer, he or she may exercise the further right of judicial review in accordance with M.G.L. c. 30A. The right to such judicial review is also available to a nursing facility regarding a final decision in a hearing instituted under 130 CMR 610.032(C).

(B) A party seeking judicial review must file a complaint with the Superior Court in the county where that party lives or has its principal place of business, or in Suffolk County, within 30 days after receipt of the fair hearing decision.

(C) If the appellant timely requests a rehearing or remand, in accordance with 130 CMR 610.091, then the decision following the rehearing or remand, or the denial of the request for the rehearing or remand, is the MassHealth agency's final action and the appellant has 30 days from the final action to file a complaint for judicial review.

(D) The MassHealth agency must notify the appellant and his or her appeal representative of the appellant's right to seek judicial review and of the time limits for seeking such review.

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610.093: Access to the Record

The record of the fair hearing is provided to the appellant within the appropriate time limits after filing a complaint for judicial review. BOH provides access to the record of the hearing in accordance with 130 CMR 610.074. Such access may be accomplished by allowing the appellant to examine all the documentary evidence and to listen to the recording, or to review the hearing with the stenographer, if applicable and appropriate.

REGULATORY AUTHORITY

130 CMR 610.000: M.G.L. c. 118E, §§ 7 and 12.

NON-TEXT PAGE