

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied in part; Dismissed in part	Appeal Number:	2515420
Decision Date:	01/09/2025	Hearing Date:	11/21/2025
Hearing Officer:	Scott Bernard		

Appearance for Appellant:
Pro se via telephone

Appearance for Respondent:
Cassandra Horne *via telephone*



*The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171*

APPEAL DECISION

Appeal Decision:	Denied in part; Dismissed in part	Issue:	Managed Care Organization - Denial of Internal Appeal
Decision Date:	01/09/2025	Hearing Date:	11/21/2025
Respondent's Rep.:	Cassandra Horne	Appellant's Rep.:	<i>Pro se</i>
Hearing Location:	Quincy Harbor South	Aid Pending:	N/A

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated June 25, 2025, Commonwealth Care Alliance (CCA), a MassHealth-contracted Managed Care Organization (MCO), issued a Notice of Denial of the appellant's Level One internal appeal concerning her prior authorization request for weekly outpatient psychotherapy with the requested provider for the period January 1, 2025 through December 31, 2025, after determining that the provider was out of network. (See Exhibit (Ex.) 1). The appellant filed this appeal in a timely manner on July 22, 2025. (See 130 CMR 610.015(B); and Ex. 2). A managed care provider's decision regarding a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit, is valid grounds for appeal. (See 130 CMR 610.032(B)(2)).

Action Taken by Respondent

The respondent denied the appellant's request for weekly outpatient psychotherapy with an out-of-network provider after determining that the requested provider was not within the respondent's provider network.

Issue

The issue on appeal is whether the respondent was correct, pursuant to applicable MassHealth managed care regulations, in denying the appellant's request for weekly outpatient psychotherapy with an out-of-network provider.

Summary of Evidence

The respondent was represented by its Operations Manager of Appeals and Grievances (the respondent's representative), and the appellant appeared on her own behalf. All parties attended the hearing by telephone.

The respondent's representative testified first and outlined the procedural history of the appellant's request for services and the subsequent internal appeal. The appellant is under the age of 65 and has been enrolled in the respondent's One Care program since March 1, 2023. (Testimony; Ex. 4; Ex. 7, pp. 1–2, 17). She requested weekly outpatient psychotherapy with an out-of-network provider for the period January 1, 2025 through December 31, 2025. (Testimony; Ex. 7, pp. 4, 17).

The respondent received the prior authorization request on May 13, 2025. (Testimony; Ex. 7, pp. 2, 18–21). After review, the respondent determined that the requested provider was not enrolled as a provider eligible to participate in MassHealth and was not contracted with the respondent's One Care plan as providers eligible to participate in MassHealth and were not contracted with the respondent's One Care plan and further determined that in-network providers could furnish the requested services. (Testimony; Ex. 7, pp. 4–6, 18–19). Based on these determinations, the respondent denied the request on May 16, 2025 and issued written notice of the denial to the appellant. (Ex. 7, pp. 19–21).

The appellant filed a Level One internal appeal on June 2, 2025. (Testimony; Ex. 7, pp. 2, 29–30). Following clinical review, the respondent upheld the denial on June 20, 2025 for the same reasons stated in the initial determination. (Testimony; Ex. 7, pp. 33–35). The respondent issued a written Notice of Denial of Level One Appeal on June 24, 2025, which is the notice appealed in this matter. (Testimony; Ex. 7, pp. 34–35).

The respondent's representative further testified that, under the respondent's One Care Member Handbook, services furnished by an out-of-network provider may be covered only if the provider is eligible to participate in Medicare or Medicaid (MassHealth), and that the respondent may not reimburse providers who are not so enrolled. (Testimony; Ex. 7, pp. 33–35). The representative also testified that the respondent has in-network outpatient psychotherapy providers available to furnish the requested services. (Testimony; Ex. 7, pp. 4–6).

The appellant testified next. Prior to working with the requested provider, she required multiple

episodes of intensive outpatient treatment due to significant mental health conditions, including depression, post-traumatic stress disorder, and suicidal ideation. (Testimony; Ex. 7, pp. 7–10). She has received psychotherapy from the requested provider for approximately three and a half to four years. (Testimony). Continuity of care with her current provider has been critical to her stability, and transitioning to a new therapist would exacerbate her symptoms. (Testimony). Her attempts to locate suitable in-network providers were unsuccessful or distressing. (Testimony). Her therapist has been accepted for enrollment with MassHealth and has contracted with a healthcare services organization but is awaiting issuance of a MassHealth provider identification number. (Testimony).

In response, the respondent's representative testified that, as of the date of the hearing, the requested provider was not enrolled with MassHealth and that the respondent therefore lacked authority to reimburse services furnished by that provider. (Testimony; Ex. 7, pp. 18–19). The documentary evidence confirms that, during the period relevant to the respondent's determinations, the requested provider was enrolled in Medicare but not enrolled with MassHealth. (Ex. 7, pp. 4–5, 18–19). The representative further testified that, if the provider later becomes MassHealth-enrolled but does not contract with the respondent, any future request for services would require prior authorization and would be subject to the respondent's authorization and review requirements. (Testimony).

Findings of Fact

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

1. The appellant is under the age of 65. (Testimony; Ex. 4; Ex. 7, p. 17).
2. The appellant has been enrolled in the respondent's One Care program since March 1, 2023. (Testimony; Ex. 7, pp. 1–2).
3. The appellant requested weekly outpatient psychotherapy with an out-of-network provider for the period January 1, 2025 through December 31, 2025. (Testimony; Ex. 7, pp. 4, 17).
4. The respondent received the appellant's prior authorization request on May 13, 2025 and denied the request on May 16, 2025. (Testimony; Ex. 7, pp. 2, 4–6, 18–21).
5. The respondent determined that the requested provider was not enrolled as a provider eligible to participate in MassHealth, was not contracted with the respondent's One Care plan, and that in-network outpatient psychotherapy providers were available to furnish the requested service. (Testimony; Ex. 7, pp. 2, 4–6, 18–21).
6. The respondent issued written notice of the denial to the appellant on May 16, 2025. (Testimony; Ex. 7, pp. 19–21).

7. The appellant filed a Level One internal appeal on June 2, 2025, which a clinical reviewer reviewed and denied on June 20, 2025 for the same reasons stated in the initial determination. (Testimony; Ex. 7, pp. 2, 29–35).
8. The respondent issued a written Notice of Denial of Level One Appeal on June 24, 2025. (Testimony; Ex. 7, pp. 34–35).
9. The respondent’s One Care Member Handbook states that coverage of services furnished by an out-of-network provider depends on the provider’s eligibility to participate in Medicare or Medicaid (MassHealth). (Testimony; Ex. 7, pp. 33–35).
10. During the period relevant to the respondent’s determinations and as of the date of the hearing, the requested provider was enrolled in Medicare but not enrolled with MassHealth. (Testimony; Ex. 7, pp. 4–5, 18–19).

Analysis and Conclusions of Law

MassHealth members under age 65 receive covered services through the MCO with which they are enrolled. (130 CMR 450.117; 130 CMR 508.001). An Integrated Care Organization (ICO) is a specific type of MCO that contracts with MassHealth to deliver integrated Medicare and MassHealth services to eligible members through the One Care program. (130 CMR 450.117(B)(5); 130 CMR 508.001; 130 CMR 508.007(B)(2)). Members enrolled in an ICO, also known as a One Care plan, receive both MassHealth and Medicare services through that plan in accordance with applicable MassHealth regulations and the plan’s approved member handbook. (130 CMR 450.117(B)(5); 130 CMR 508.007(B)(2), (C)).

Under the MassHealth regulations governing ICOs, a One Care plan is responsible for authorizing, arranging, and coordinating all covered services for its enrolled members, and for informing members about covered benefits, provider networks, prior authorization requirements, and appeal rights. (130 CMR 508.007(C)). Although ICOs operate within the One Care program’s integrated framework, they remain subject to the general managed care principles applicable to MCOs, including the authority to administer benefits through network-based delivery systems. (130 CMR 508.007(C)).

Consistent with that framework, MCOs, including ICOs participating in One Care, may require prior authorization for certain services and may deny or limit coverage based on plan rules governing provider eligibility, network participation, and coverage conditions, so long as those rules comply with MassHealth regulations and the approved member handbook. (130 CMR 450.118(A); 130 CMR 508.007(C)). A MCO’s denial based on provider network status or eligibility therefore constitutes a valid basis for appeal, but not, standing alone, a basis for overturning the plan’s determination. (130 CMR 610.032(B)(2)).

The respondent’s One Care Member Handbook, as reflected in the record, governs coverage

determinations for enrolled members and establishes the conditions under which services may be obtained from in-network and out-of-network providers. (Ex. 7, pp. 4–6, 33–35). The Handbook materials explain that One Care members generally receive covered services from providers within the respondent’s contracted network and that services furnished by out-of-network providers are subject to additional requirements. (Ex. 7, pp. 4–6, 33–35). The Handbook further provides that the respondent may cover services furnished by an out-of-network provider only if the provider is eligible to participate in Medicare or MassHealth and only under circumstances permitted by the plan, such as when no appropriate in-network provider is available. (Ex. 7, pp. 33–35).

The Handbook materials also state that the respondent may not reimburse providers who are not eligible to participate in Medicare or MassHealth and that members may be financially responsible for services furnished by providers who do not meet the plan’s participation requirements. (Ex. 7, pp. 33–35). These provisions reflect the respondent’s authority, under MassHealth regulations, to structure and enforce provider network requirements as part of its administration of covered benefits. (130 CMR 508.007(C); 130 CMR 450.118).

In reviewing an MCO’s denial of a requested service, the Board of Hearings determines whether the respondent correctly applied MassHealth regulations and the governing plan rules to the facts established in the record. (130 CMR 610.036). The appellant bears the burden of proving, by a preponderance of the evidence, that the respondent’s determination was incorrect. (130 CMR 610.015(C)).

Here, the dispositive facts are not in dispute. At the time the respondent reviewed the appellant’s request, the requested provider was not enrolled as a provider eligible to participate in MassHealth and was not contracted with the respondent’s One Care plan as providers eligible to participate in MassHealth and were not contracted with the respondent’s One Care plan. During the same period, the requested provider was enrolled in Medicare but not enrolled with MassHealth. The record also establishes that the respondent had in-network outpatient psychotherapy providers available to furnish the requested services.

Because the respondent’s plan rules prohibit reimbursement to providers who are not eligible to participate in MassHealth, the respondent lacked authority under its One Care plan to reimburse services furnished by the requested provider during the relevant period. The appellant’s preference to continue treatment with that provider, while understandable, does not override the respondent’s obligation to administer benefits in accordance with MassHealth regulations and the approved plan rules.

Accordingly, the appellant has not met her burden of proving that the respondent misapplied the governing regulations or plan provisions. Although the record reflects the appellant’s desire to continue treatment with the requested provider and her concerns about transitioning care to another provider, the respondent remains obligated to administer benefits in accordance with MassHealth regulations and the approved One Care plan rules. Based on the facts established in the record and the applicable regulatory framework, the respondent correctly denied the

appellant's request for weekly outpatient psychotherapy with an out-of-network provider.

The Hearing Officer notes that the prior authorization period at issue has passed and that the appeal may therefore be moot; however, because the respondent issued a denial for that period and the appellant timely filed the appeal, the Hearing Officer has nevertheless addressed the merits of the appellant's dispute concerning the respondent's determination. (130 CMR 610.036).

For the above reasons, the appeal is DENIED as to the respondent's denial of prior authorization for the period at issue and DISMISSED as moot to the extent the appellant seeks prospective relief.

Order for Respondent

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Scott Bernard
Hearing Officer
Board of Hearings

cc: ICO Commonwealth Care Alliance, Attn: Nayelis Guerrero, 30 Winter Street, Boston, MA 02108