Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Eligibility Letter 135
July 1, 2005

TO: MassHealth Staff

FROM: Beth Waldman, Medicaid Director BW

RE: **Changes to Managed Care Requirements and Appeal Rights for Members for Medicare Part D Low Income Subsidy Determinations**

MassHealth is revising the managed care and fair hearing regulations to implement the provisions of the Balanced Budget Act of 1997 (BBA), 42 U.S.C. § 1396u-2, and to clarify MassHealth policy allowing member choice of a family planning provider.

The revisions include changes to:

- modify fair hearing processes and internal appeals within MassHealth-contracted managed care entities;
- ensure that MassHealth members enrolled in MassHealth-contracted managed care entities may receive family planning services from any MassHealth family planning provider; and
- expressly describe the circumstances under which a MassHealth-contracted managed care entity can request the disenrollment or transfer of a MassHealth member from the MCO.

These regulations are effective July 1, 2005.

In addition, this letter transmits other revisions to the fair hearing regulations. These revisions allow members to appeal an eligibility determination by MassHealth for Medicare Part D Low Income Subsidy benefits.

These emergency regulations are also effective on July 1, 2005.

MANUAL UPKEEP

Insert	Remove	Trans. By
508.000	508.000	E.L. 123
508.001	508.001	E.L. 123
508.002 (1 of 4)	508.002 (1 of 3)	E.L. 123
508.002 (2 of 4)	508.002 (2 of 3)	E.L. 57
508.002 (3 of 3)	508.002 (3 of 3)	E.L. 123
508.002 (4 of 4)	--	--
508.006	508.006	E.L. 116
508.008	508.008 (1 of 2)	E.L. 116
508.009	508.008 (2 0f 2)	E.L. 116
508.010	--	--
610.000 (1 of 2)	610.000 (1 of 2)	E.L. 95
610.001	610.001	E.L. 110
610.004 (1 of 3)	610.004 (1 of 3)	E.L. 95
610.004 (2 of 3)	610.003 (2 of 3)	E.L. 95
610.011	610.011	E. L. 110
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610.013	610.013	E.L. 64
610.015 (1 of 3)	610.015 (1 of 2)	E.L. 95
610.015 (2 of 3)	610.015 (2 of 2)	E.L. 95
610.015 (3 of 3)	--	--
610.016	610.016	E.L. 95
610.026	610.026	E.L. 64
610.031	610.031	E.L. 110
610.032	--	--
610.033	610.033	E.L. 116
610.034	610.034	E.L. 95
610.036	610.036	E.L. 95
610.046	610.046	E.L. 95
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508.001: MassHealth Managed Care Requirement

(A) Member Participation.

(1) MassHealth Standard members described in 130 CMR 505.002(B), (C), (D), (E), and (F), certain MassHealth Family Assistance members described in 130 CMR 505.005(E), and Basic members described in 130 CMR 505.006(B), must enroll in one of the following managed care options unless excluded from participation in 130 CMR 508.004:

(a) the Primary Care Clinician (PCC) Plan; or

(b) a MassHealth-contracted managed care organization (MCO).

(2) MassHealth Family Assistance members described in 130 CMR 505.005(F) and MassHealth Standard members described at 130 CMR 505.002(H) must enroll in the PCC Plan, unless excluded from participation in 130 CMR 508.004.

(3) MassHealth Essential members who have coverage through the purchase of medical benefits described in 130 CMR 505.007(B) and (E) must enroll in the PCC Plan.

(B) Obtaining Services.

(1) Primary Care. When the member selects or is assigned to either a PCC or MCO, that MassHealth managed care provider will deliver the member's primary care, decide if the member needs medical care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services (Excluding Behavioral Health Services).

(a) Service Delivery to Members Enrolled in the PCC Plan. All medical services to members enrolled in the PCC Plan, except those services listed in 130 CMR 450.118(J), require a referral or authorization from the PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(b) Service Delivery to Members Enrolled in an MCO. All medical services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO and family planning services, are subject to the referral requirements of the MCO. MassHealth members enrolled in an MCO may receive family planning services from any MassHealth family planning provider and do not need an authorization or referral in order to receive such services. Members enrolled with an MCO should contact their MCO for information about covered services and referral requirements.

(3) Behavioral Health Services.

(a) Members Enrolled in the PCC Plan. All members who enroll in the PCC Plan receive behavioral health (mental health and substance abuse) services through the MassHealth behavioral health contractor. See 130 CMR 508.003.

(b) Members Enrolled in an MCO.

(i) Members who enroll in a MassHealth-contracted MCO that is under contract to provide behavioral health services receive behavioral health services through that MCO.

(ii) All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services and authorization requirements.

(c) Members with Presumptive or Time-Limited Eligibility, or Fee-for-Service. Members with presumptive or time-limited eligibility, or fee-for-service receive behavioral health services through any qualified participating MassHealth provider.

508.002: Choosing a MassHealth Managed Care Provider

All MassHealth members, except those excluded under 130 CMR 508.004, must enroll with a MassHealth managed care provider. For MassHealth Basic members, described at 130 CMR 505.006(B), and MassHealth Essential members, described at 130 CMR 505.007(B) and (E), services are available only as of the member's enrollment effective date, as established by the MassHealth agency in accordance with 130 CMR 508.002(I), with a MassHealth managed care provider. MassHealth Essential members described in 130 CMR 505.007(E) are also provided services under MassHealth Limited pursuant to 130 CMR 505.007(E) and 505.008.

(A) Selection of a Managed Care Provider.

(1) Procedure. The MassHealth agency notifies the member of the availability of MassHealth managed care providers in the member's service area, and of the member's obligation to select such a provider within the time period specified by the MassHealth agency. The member may select any provider from the MassHealth agency's list of MassHealth managed care providers in his or her service area, if the provider is able to accept new patients.

(2) Member's Service Area. The member's service area is determined by the MassHealth agency based on zip codes. Service area listings may be obtained from the MassHealth agency.

(B) Assignment to a Managed Care Provider. If a member does not choose a managed care provider within the time period specified by the MassHealth agency in a notice to the member, the MassHealth agency assigns the member to a MassHealth managed care provider.

(C) Criteria for Assigning Members.

(1) The MassHealth agency assigns a member eligible to enroll with a managed care provider only if the provider is:

(a) in the member's service area as described in 130 CMR 508.002(A)(2);

(b) physically accessible to the member, if the member is disabled;

(c) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician);

(d) able to communicate with the member directly or through an interpreter, unless there is no medical care available in the member's service area that meets this requirement; and

(e) located in an area to which the member has available transportation.

(2) (a) For MassHealth Standard members only, if the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) is available in the member's service area, the member may:

(i) choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or

(ii) select an available MassHealth managed care provider outside of the member's service area.

(b) Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(i) must obtain any behavioral health services through the MassHealth behavioral health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.

(3) If, after a determination by the MassHealth agency under 130 CMR 508.002(C)(2)(a), the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.002(C)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.002(C)(2)(a)(ii).

(D) Notification. The MassHealth agency will notify a member in writing of the name and address of the member's MassHealth managed care provider, and the member’s enrollment effective date with the provider.

(E) Transfer. The member may transfer to or from an available MassHealth managed care provider at any time.

(F) Out-of-Area Managed Care Provider. A member who seeks to enroll with a MassHealth managed care provider outside of the member's service area must submit a request in writing to the MassHealth agency on forms provided by the MassHealth agency. The MassHealth agency will grant a request for an available out-of-area MassHealth managed care provider where the MassHealth agency determines that:

(1) there is no MassHealth managed care provider available in the member's service area that is able to communicate with the member directly or through an interpreter;

(2) the travel time or distance to the requested out-of-area MassHealth managed care provider is equal to or less than the travel time to a MassHealth managed care provider in the member's service area, or the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by the MassHealth agency, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(G) Disenrollment of Members.

(1) The MassHealth agency may disenroll a member from an MCO, upon request, if the MCO demonstrates to the MassHealth agency's satisfaction that the MCO has made reasonable efforts to provide medically necessary services to the member through available primary care providers or other relevant network providers and, despite such efforts, the continued enrollment of the member with the MCO seriously impairs the MCO's ability to furnish services to either this particular member or other members.

(2) The MassHealth agency may disenroll a member from a PCC's panel, upon request, if the provider demonstrates to the MassHealth agency's satisfaction that:

(a) there is a pattern of noncompliant or disruptive behavior by the member that is not the result of the member's special needs;

(b) the continued enrollment of the member with the provider seriously impairs the provider's ability to furnish services to either this particular member or other members; or

(c) the PCC is unable to meet the medical needs of the member.

(3) If the MassHealth agency approves a request for disenrollment under 130 CMR 508.002(G)(1) and (2), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(11).

(H) Reenrollment. Any member who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled.

(I) Enrollment of MassHealth Basic and MassHealth Essential Members.

(1) After the MassHealth agency sends members a notice of eligibility for the purchase of medical benefits, the MassHealth agency enrolls them with a MassHealth managed care provider. MassHealth Basic members, described at 130 CMR 505.006(B), must enroll in a Primary Care Clinician Plan or with a MassHealth-contracted managed-care organization. MassHealth Essential members, described at 130 CMR 505.007(B) and (E), must enroll in the Primary Care Clinician Plan. Enrollment is accomplished in one of the following ways and within the following time frames.

(a) After the MassHealth agency approves eligibility for the purchase of medical benefits, the member may contact the MassHealth agency directly by telephone at the number indicated on the eligibility notice, or in person, and provide all information needed to enroll the member with a MassHealth managed care provider. If complete information is provided, the MassHealth agency enrolls the member, in accordance with the member's selection, effective no later than 10 business days after the MassHealth agency receives this information.

(b) After the MassHealth agency approves eligibility for the purchase of medical benefits, the MassHealth agency sends the member enrollment materials and a managed care provider selection form. If the member completes and returns this form to the MassHealth agency within the time frame specified by the MassHealth agency, and if the information provided is complete, the MassHealth agency enrolls the member, in accordance with the member's selection, effective no later than 10 business days after the MassHealth agency receives the completed enrollment form. The MassHealth agency considers only such forms that the member sends to the MassHealth agency after the MassHealth agency has approved the member's eligibility.

508.006: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000 et seq. to appeal:

(A) the MassHealth agency's determination that the MassHealth Standard member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001(A);

(B) a determination by the MassHealth behavioral health contractor, by one of the MassHealth managed care organization (MCO) contractors, or by a senior care organization (SCO), as further described in 130 CMR 610.032(B), if the member has exhausted all remedies available through the contractor's internal appeals process;

(C) the MassHealth agency's denial of a request for an out-of-area MassHealth managed care provider under 130 CMR 508.002(F); or

(D) the MassHealth agency's disenrollment of a member from a MassHealth managed care provider under 130 CMR 508.002(G).

(130 CMR 508.007 Reserved)

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:

(1) be aged 65 or older;

(2) live in a designated service area of a senior care organization;

(3) not be diagnosed as having end-stage renal disease;

(4) not be subject to a six-month deductible period under 130 CMR 520.028;

(5) not be a resident of an intermediate care facility for the mentally retarded (ICF/MR); and

(6) not be an inpatient in a chronic or rehabilitation hospital.

(B) Selection of a Senior Care Organization. The MassHealth agency will notify members of the availability of a senior care organization in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any senior care organization in the member's service area. A service area is the specific geographical area of Massachusetts in which a senior care organization agrees to serve its contract with the MassHealth agency and the Centers for Medicare and Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee.

(C) Obtaining Services. When a member chooses to enroll in a senior care organization in accordance with the requirements under 130 CMR 508.008, the senior care organization will deliver the member's primary care and will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, each senior care organization is required to provide evidence of its coverage, including a complete list of participating providers, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to covered services such as specialty, behavioral health, and long-term-care services.

(D) Disenrollment from a Senior Care Organization. A member may disenroll from a senior care organization at any time by submitting a notice of disenrollment to the MassHealth agency or its designee. Disenrollment notices received by the MassHealth agency or its designee by the 20th day of the month will be effective the first day of the following month.

(E) Discharge or Transfer. The MassHealth agency may discharge or transfer a member from a senior care organization where the senior care organization demonstrates to the MassHealth agency's satisfaction a pattern of noncompliant or disruptive behavior by the member or for other good cause. In each case, the MassHealth agency will state the good cause basis for discharge or transfer in a notice to the member.

(F) Other Programs. While voluntarily enrolled in a senior care organization under 130 CMR 508.008, a member may not concurrently participate in any of the following programs:

(1) the Home and Community-Based Services Waiver described in 130 CMR 519.007(B);

(2) the Section 1915 Home and Community-Based Services Waiver for the Mentally Retarded administered by the Department of Mental Retardation;

(3) the Program of All-Inclusive Care for the Elderly (PACE) described in 130 CMR 519.007(C); and

(4) any Medicare+Choice plan or Medicare demonstration program.

508.009: Timely Notice of Appealable Actions

(A) Whenever an MCO, SCO, or the behavioral health contractor reaches a decision that constitutes an appealable action, as described in 130 CMR 610.032(B), it must send a notice to the member within the following timeframes that describes its decision and its internal appeal procedures:

(1) for a standard service authorization decision to deny or provide limited authorization for a requested service, no later than 14 days following receipt of the request for service, unless the timeframe is extended up to 14 additional days because the member or a provider requested the extension or the MCO, SCO, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(2) for an expedited service decision to deny or provide limited authorization for a requested service, where a provider requests, or an MCO, SCO, or behavioral health contractor determines, that following the standard timeframe in 130 CMR 508.009(A) could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, no later than three business days after receipt of the request for service, unless the timeframe is extended up to 14 additional calendar days because the member requested the extension or the MCO, SCO, or behavioral health contractor can demonstrate a need for additional information and how the extension is in the member's interest;

(3) for termination, suspension, or reduction of a previous authorization for a service, at least 10 days before the action, except as provided in 42 CFR 431.213; and

(4) for denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials, which include, but are not limited to, the following:

(a) failure to follow the MCO, SCO, or behavioral health contractor's prior authorization procedures;

(b) failure to follow referral rules; and

(c) failure to file a timely claim.

(B) Whenever an MCO, SCO, or the behavioral health contractor fails to reach a decision on a standard or expedited service authorization within the timeframes described in 130 CMR 508.009(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such timeframe expires.

508.010: Time Limits for Resolving Internal Appeals

(A) MCOs, SCOs, and the behavioral health contractor must resolve standard internal appeals within 45 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.010(C).

(B) Where the MCO, SCO, or behavioral health contractor determines (for a request from the member or the provider, in making the request on the member's behalf) that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, MCOs, SCOs, or the behavioral health contractor must resolve the internal appeal on an expedited basis within three business days after receiving the appeal, unless the timeframes are extended by up to 14 days pursuant to 130 CMR 508.010(C), in which event the MCO, SCO, or behavioral health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, SCO, or behavioral health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, SCO, or behavioral health contractor must resolve the appeal in accordance with the timeframes in 130 CMR 508.010(A) and must make reasonable efforts to give the member prompt, oral notice of the denial and follow up within two calendar days with a written notice. The MCO, SCO, or behavioral health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, SCOs, and the behavioral health contractor may extend the timeframe for resolving internal appeals under the following circumstances, provided that, if the MCO, SCO, or the behavioral health contractor extends the timeframe, it must, for any extension not requested by the member, give the member written notice of the reason for the extension:

(1) if the member requests the extension; or

(2) if the MCO, SCO or the behavioral health contractor shows (to the MassHealth agency's satisfaction, upon request) that there is a need for additional information and how the extension is in the member's interest.

508.011: Timely Notice of Internal Appeal Decisions

(A) MCOs, SCOs, and the behavioral health contractor must provide notice of an internal appeal decision concerning an appealable action, as described in 130 CMR 610.032(B), within the timeframes described in 130 CMR 508.010.

(B) Notice from an MCO, SCO or the behavioral health contractor concerning an internal appeal must be in writing and, for an expedited internal appeal, reasonable efforts must be made to provide oral notice.

(130 CMR 508.012 through 508.015 Reserved)

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610.001: Purpose

The purpose of 130 CMR 610.000 is to set forth procedures that govern the conduct of adjudicatory proceedings whereby dissatisfied applicants, members, and employers seek administrative review of certain actions or inactions on the part of the MassHealth agency or on the part of a managed care contractor. 130 CMR 610.000 also contains provisions under which nursing facility residents may seek review of discharges and transfers by a nursing facility, and where applicants and members seek review of a MassHealth 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 42 CFR Part 423, Subpart P.

610.002: Authority

The authority for the regulations set forth in 130 CMR 610.000 is 42 CFR 431.200 et seq., M.G.L. c. 30A, c. 118E, §§ 12, 20, 47, and 48, and 801 CMR 1.03(7). Pursuant to M.G.L. c. 118E, § 48, the Board of Hearings has exclusive jurisdiction to hear appeals relating to the programs administered by the MassHealth agency.

610.003: Scope

130 CMR 610.000 sets forth the exclusive procedures governing adjudicatory proceedings initiated by applicants, members (or their appeal representatives), and employers under programs administered by the MassHealth agency, and for MassHealth 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. Appeals pursuant to the Executive Office of Elder Affairs Supplementary Rules to the Adjudicatory Rules of Practice and Procedures, 651 CMR 1.00 et seq., 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 are governed by 130 CMR 610.000. Adjudicatory proceedings initiated by medical assistance 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.

610.004: Definitions

For purposes of 130 CMR 610.000, the following terms have the meanings given below unless the context clearly indicates otherwise.

Acting Entity – the MassHealth agency, managed care contractor, or nursing facility responsible for taking an appealable action.

Adequate Notice – a notice concerning an intended appealable action that conforms to the requirements of 130 CMR 610.026.

Appealable Action – certain actions, as further described in 130 CMR 610.032, by the MassHealth agency, managed care contractor, or a nursing facility. No action by a provider will constitute an appealable action, except as otherwise provided herein with regard to a transfer or discharge by a nursing facility.

Appeal Representative – a person who:

(1) is sufficiently aware of the appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;

(2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or

(3) is an eligibility representative meeting the requirements of (1) or (2) above.

Appellant – an applicant, member, resident, or employer requesting a fair hearing.

Applicant – a person or family who has applied or attempted to apply for an assistance program administered by the MassHealth agency.

Application – either a Medical Benefit Request (MBR) (see 130 CMR 501.001) or a Senior Medical Benefit Request (SMBR) (see 130 CMR 515.001).

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

BOH – the Board of Hearings within the MassHealth agency.

Director – the Director of the Board of Hearings.

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.

Division – the Division of Medical Assistance of the Executive Office of Health and Human Services of the Commonwealth of Massachusetts.

Employer – a business, including a self-employed individual, who has applied for or has been receiving payments under the Insurance Partnership.

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

Hearing Officer – an impartial and independent person designated by the Director of the Board of Hearings to conduct hearings and render decisions pursuant to 130 CMR 610.000.

Insurance Partnership – a program administered by the MassHealth agency to help qualified employers offer health insurance.

Interpreter – a person who translates for the appellant, when the appellant's primary language is not English or when the appellant is deaf or hearing-impaired. The interpreter is sworn to make an impartial and accurate translation of the events occurring at the hearing.

Managed Care Contractor – any MassHealth-contracted managed care organization (MCO), senior care organization (SCO), or behavioral health contractor, as defined and described in 130 CMR 508.000.

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' Division of Medical Assistance.

Member – a person or family 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, the respondent to a complaint of coercive behavior, or the MassHealth agency.

Policy Memorandum – a written explanation, 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.

Provider – any entity that furnishes medical services.

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

Resident Record – that portion of a nursing facility's records in which the nursing facility has documented the reason for the 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).

Timely Notice – adequate notice of an intended appealable action by the MassHealth agency that meets the additional requirements set forth in 130 CMR 610.015(A). The MassHealth agency must send a timely notice to the member, except as provided in 130 CMR 610.027.

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

610.011: The Board of Hearings

The 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 will conduct adjudicatory proceedings governing providers pursuant to 130 CMR 450.241 through 450.248, and 130 CMR 450.323. 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 whereby dissatisfied applicants, members, residents, and employers can, upon written request, obtain an administrative determination of the appropriateness of:

(1) certain actions or inactions on the part of the MassHealth agency;

(2) certain actions or inactions on the part of 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) the denial or termination of an employer from the Insurance Partnership;

(6) the amount of an Insurance Partnership payment; or

(7) a decision by a nursing facility to discharge or transfer a resident.

(B) The process is designed to secure and protect the interests of both the appellant and appropriate MassHealth agency 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.

(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 case 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 all parties;

(b) must have no prior involvement in any matter over which he or she conducts a hearing, except in a capacity as a hearing officer; and

(c) must have no direct or indirect financial interest, personal involvement, or bias pertaining to such matter.

(D) The final decision is binding upon the MassHealth agency and managed care contractors, except that appeals may be subject to review as provided in 130 CMR 610.091.

(E) Appeals involving transfers or discharges from nursing facilities are binding only on the facility and the resident.

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

610.013: Methods for Conducting a Fair Hearing

A fair hearing may be conducted:

(A) face-to-face, whether in person or by video conferencing; or

(B) telephonically, if the appellant agrees.

610.014: Compilation of Fair Hearing Decisions

BOH will compile and maintain fair hearing decisions. Copies of decisions will be 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.

610.015: Time Limits

(A) Timely Notice. Before an intended appealable action, the MassHealth agency must send a timely notice to the member except as provided in 130 CMR 610.027. A timely notice is a notice mailed at least 10 days before the action.

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

(1) 30 days after 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 third day after mailing;

(2) unless waived by the 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;

(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 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.):

(i) he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively; or

(ii) he or she was justifiably unaware of the conduct in question; and

(iii) the appeal was made in good faith.

(3) 30 days after a resident receives written notice of a discharge or transfer pursuant to 130 CMR 610.029(A);

(4) 14 days after a resident receives written notice of an emergency discharge or emergency transfer pursuant to 130 CMR 610.029(B);

(5) 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;

(6) 30 days after an employer receives written notice of a denial or termination from the Insurance Partnership or a final written reconciliation determination about the amount of the Insurance Partnership payment;

(7) for appeals of a decision reached by a MassHealth-contracted managed care organization's (MCO's) or a behavioral health contractor's internal appeals process:

(a) for a standard appeal, 30 days after the mailing of the MCO's or behavioral health contractor's final internal appeal decision denying services where the MCO or behavioral health contractor has reached a decision wholly or partially adverse to the member;

(b) if the managed care contractor did not resolve the member's standard appeal of a denial of service within the timeframes described by 130 CMR 508.010(A) and (C), 30 days after the date on which the timeframe for resolving that appeal has expired;

(c) for an expedited appeal, 20 days after the mailing of the MCO's or behavioral health contractor's expedited final internal decision denying services where the MCO or behavioral health contractor has reached a decision wholly or partially adverse to the member, provided that if BOH receives the request for a fair hearing between 21 and 30 days after the mailing of the MCO's or behavioral health contractor's expedited internal appeal decision, BOH will treat such matter as a non-expedited BOH appeal;

(d) if the MCO or behavioral health contractor did not resolve the member's expedited internal appeal of a denial of service within the timeframes described by 130 CMR 508.010(B), 20 days after the date on which the timeframe for resolving that expedited appeal has expired; or

(8) for appeals of an appealable action by a senior care organization (SCO), 30 days after the mailing of the SCO's notice of the appealable action.

(C) Computation of Time. Computation of any period referred to in 130 CMR 610.000 will be on the basis of calendar days except where expressly provided otherwise. Time periods will 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 will be deemed to be the following business day.

(D) Time Limits for Rendering a Decision.

(1) The hearing officer 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; or

(c) a nursing facility-initiated discharge or transfer.

(2) The hearing office 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) The hearing officer 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) 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 includes the advance notice period before scheduled 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 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 or serious illness of the hearing officer that make him or her unable to render a decision, good cause for the extension of the time limits will be deemed to exist.

(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, a hearing will be scheduled to be held 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 10-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). 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). Appeals of discharges or transfers provided under 130 CMR 610.029(B) and (C) will be conducted under the time frames provided in 130 CMR 610.015(E).

(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 timeframe described by 130 CMR 508.010(A).

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

(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 timeframe described by 130 CMR 508.010(B).

(2) The member must submit such a request to BOH within the timeframes described by 130 CMR 610.015(B)(7)(d) or 610.015(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. All documentation required in 130 CMR 610.004 must be submitted at or before the hearing. 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) When an interpreter also acts as the appellant's appeal representative, the appellant will supply a signed written statement to that effect in both English and, where applicable, in the appellant's primary language.

610.017: Auxiliary Aids

BOH will provide reasonable auxiliary aids to appellants who request such aids and who have an impairment that BOH determines would prevent adequate participation of the appellant at the hearing. BOH will inform appellants of the availability of this service. BOH will provide telephonic or, at its option, other interpreter services for an appellant who is deaf or hearing-impaired, or 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.

(130 CMR 610.018 through 610.025 Reserved)

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, notice to the member 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 MassHealth agency mail directed 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 or its agent renders a determination denying or terminating an employer from the Insurance Partnership, or a reconciliation determination regarding the amount of the Insurance Partnership payment;

(G) the MassHealth agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth; or

(H) the MassHealth agency has factual information confirming the death of the member.

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.

(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 the MassHealth agency or its agent notifies an employer in writing that it is being denied or terminated from the Insurance Partnership, or there has been a written reconciliation about the amount of the Insurance Partnership payment, the employer will be informed of its right to a hearing before the MassHealth agency.

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;

(10) the MassHealth agency's denial of an out-of-area provider under 130 CMR 508.002(F);

(11) the MassHealth agency's disenrollment of a member from a managed-care provider under 130 CMR 508.002(G) or 508.008(E);

(12) the MassHealth agency's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442; and

(13) the MassHealth agency 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.

(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;

(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 timeframes for resolution of an internal appeal as described in 130 CMR 508.010; or

(6) a decision by an MCO to deny a request by a member that resides in a rural service area served by only one MCO to exercise his or her right to obtain services outside the MCO'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 MCO'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 MCO's network if the MCO gave the provider the opportunity to participate in the MCO'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 MCO's network does not, because of moral or religious objections, provide the service the member seeks; and

(d) the member's primary care provider or other provider determine 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 MCO's network.

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

(D) Employers have the right to request an appeal of any denial or termination from the Insurance Partnership, or to appeal the amount of the Insurance Partnership payment they receive.

(E) Determinations of temporary eligibility for presumptive coverage or prenatal coverage are not appealable. See 130 CMR 502.008(C).

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 or his or her appeal representative 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 10 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 in writing by the appellant or his or her appeal representative;

(3) the sole issue is one of state or federal law requiring automatic change in assistance for classes of members;

(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; or

(7) the party requesting the hearing is not an applicant, member, resident, appeal representative, or employer as defined in 130 CMR 610.004.

(B) The Director may, 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 the Board of Hearings decides the appeal or, where applicable, the rehearing decision is rendered if the Board of Hearings 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 the Board of Hearings receives the request for the fair hearing within 10 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.

(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.

(130 CMR 610.037 through 610.045 Reserved)

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. At least 10 days' advance written notice will be mailed by the Board of Hearings to all parties involved to permit adequate preparation of the case. However, the appellant or his or her appeal representative 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 name, address, and telephone number of the person in BOH to notify if the appellant cannot attend the scheduled hearing;

(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;

(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 accessible 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 Director or his or her designee concludes that the request does not constitute good cause, the request will be denied.

(3) BOH will inform the parties of the procedures set forth above.

(B) Rescheduling Following Failure to Appear at a Scheduled Hearing. If the appellant fails to appear at the hearing, BOH will notify the appellant in writing (at the address supplied by the appellant) that if he or she fails to request a rescheduled hearing and show good cause for the failure to appear within 10 days of the notice, the appeal will be considered abandoned. If, in the determination of the Director or his or her designee, good cause has not been shown, 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. The Director or his or her designee may at his or her discretion reschedule the hearing to another date at which time the appellant 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 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 or his or her appeal representative. Such request must be received by BOH within 10 days of the date of the dismissal notice. A dismissal will be vacated by the 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 shall 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 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.

(2) In evaluating a party's good cause claim, the hearing officer shall consider 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 the conflicting event;

(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 noncompliance with the fair hearing rules.

(3) If a party will be required to show good cause at the hearing, BOH shall notify that party in advance that the hearing officer will address that issue. The party shall 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.

610.063: Managed Care Contractor and Nursing Facility Rights and Responsibilities

The managed care contractor or nursing facility will:

(A) submit to the hearing office at or before the hearing all evidence on which the decision at issue is based;

(B) designate a staff person or representative to represent the nursing facility at the hearing and arrange for adequate space for the hearing if requested by the MassHealth agency;

(C) have the right to present witnesses;

(D) ensure that the resident record is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;

(E) have the right to introduce into evidence material from the resident record and other pertinent documents that pertain to the issue or issues raised during the hearing;

(F) have the right to present and establish all relevant facts and circumstances by oral testimony and documentary evidence;

(G) have the right to question and refute any testimony and confront and cross-examine adverse witnesses; and

(H) have the right to be represented by legal counsel at 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.

610.071: Evidence

(A) General.

(1) The rules of evidence observed by courts will not apply to fair hearings, but the hearing officer will observe 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 will 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 will be the date on which all eligibility conditions were met, regardless of when the supporting evidence was submitted.

(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 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.

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.

610.083: Content of Decision

(A) The decision of the hearing officer will contain the following:

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

(2) a 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) The hearing officer 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.

610.084: Transmittal of Decision

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) 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.

(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.

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 Director to conduct a rehearing of an appeal. The Director (but not his or her designee) conducts the rehearing, except the Director may appoint another hearing officer to conduct the rehearing if the 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 Director sends a seven days' written notice to all parties, including the date, time, and location of such rehearing, which is held at a site reasonably convenient to the person appealing. After the rehearing, the 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 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. BOH allows such request only when all parties to the appeal agree.

(D) A request for a rehearing or notice of the Medicaid Director's intent to consider a rehearing stays 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.

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).