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 142
February 15, 2006

TO: MassHealth Staff

FROM: Beth Waldman, Medicaid Director BW

RE: **Revision to Fair Hearing Regulations**

MassHealth is revising the fair hearing regulations about grounds for an appeal.

Members who are enrolled with managed care contractors will be able to request a fair hearing if the managed care contractor failed to act within the timeframes for making service authorization decisions that are mandated by the Balanced Budget Act of 1997 (BBA) and described to members in the member handbooks provided by the managed care contractors.

These regulations are effective March 1, 2006.

MANUAL UPKEEP

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(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;

(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 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 MCO's network; or

(7) failure to act within the timeframes 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) 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.