Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Eligibility Letter 212
September 15, 2013

TO: MassHealth Staff

FROM: Kristin L. Thorn, Acting Medicaid Director

RE: **Integrated Care Organizations**

The Executive Office of Health and Human Services (EOHHS) and Centers for Medicare & Medicaid Services (CMS) have contracted with One Care plans (also known as integrated care organizations or ICOs) using a blended global financial arrangement to provide integrated, comprehensive care for those who are eligible for both Medicare and Medicaid ("dually eligible members") who meet the specific eligibility criteria set forth below.

The purpose of the Duals Demonstration is to improve quality of care and reduce health disparities, improve health and functional outcomes, and contain costs for members who participate in the Duals Demonstration by enrolling in a One Care plan.

MassHealth members who are enrolled in a One Care plan will not be covered for most services provided outside the One Care plan and its network of providers.

In order to be eligible to enroll in a One Care plan, a MassHealth member must meet all of the following criteria:

- be aged 21 through 64 at the time of enrollment;
- be eligible for MassHealth Standard as defined in 130 CMR 450.105(A) or MassHealth CommonHealth as defined in 130 CMR 450.105(E);
- be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001; and
- live in a designated service area of a One Care plan.

In addition, Duals Demonstration enrollees eligible for MassHealth Standard may elect to remain in the Duals Demonstration after age 65.

Enrollment in a One Care plan is voluntary. A member may disenroll from a One Care plan at any time by contacting the One Care plan to request disenrollment. Disenrollment becomes effective on the first day of the month following the request to disenroll, provided that the request is made by the last calendar day of the month.

A member may not concurrently participate or be enrolled in any

- programs described at 130 CMR 519.007;
- Medicare Demonstrations or any Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a One Care plan;
- Medicare Demonstrations wherein concurrent participation in the Duals Demonstration is prohibited;
- Employer Group Waiver Plans or other employer-sponsored plans; or
- plans receiving a retiree drug subsidy.

These regulations are effective October 1, 2013.

MANUAL UPKEEP

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501.001: Definition of Terms

The terms listed in 130 CMR 501.001 have the following meanings for the purposes of MassHealth, as described in 130 CMR 501.000 through 508.000.

Access to Health Insurance – the ability to obtain employer-sponsored health insurance for an uninsured family group member where an employer would contribute at least 50 percent of the premium cost, and the health insurance offered would meet the basic-benefit level.

American Indian or Alaska Native – a person who is a member of a federally recognized tribe, band, or group; or an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act, 43 U.S.C. 1601 et seq.

Appeal – a written request, by an aggrieved applicant or member, for a fair hearing.

Appeal Representative – a person who

(1) is sufficiently aware of an 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 130 CMR 501.001: Appeal Representative (1) or (2).

Applicant – a person who completes and submits a Medical Benefit Request.

Basic-Benefit Level (BBL) – benefits provided under a health-insurance plan that are comprehensive and comparable to benefits provided by insurers in the small-group health-insurance market and also meet minimum creditable coverage requirements as defined in 956 CMR 5.03. Health-insurance plans that meet the requirements of 211 CMR 64.00 also meet the BBL.

Blindness – a visual impairment, as defined in Title XVI of the Social Security Act. Generally "blindness" means visual acuity with correction of 20/200 or less in the better eye, or a peripheral field of vision contracted to a 10-degree radius or less, regardless of the visual acuity.

Business Day – any day during which the MassHealth agency's offices are open to serve the public.

Caretaker Relative – an adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Case File – the permanent written collection of documents and information required to determine eligibility and to provide benefits to applicants and members.

Child – a person under age 19.

Complete Medical Benefit Request – a Medical Benefit Request that is received by the MassHealth agency and includes all required information and verifications including, where applicable, a completed disability supplement.

Couple – two persons who are married to each other according to the rules of the Commonwealth of Massachusetts.

Couple Policy – a health-insurance policy that covers a married couple. If an employer does not offer a couple policy, a married couple may be covered under a family policy.

Coverage Date – the date medical coverage begins.

Coverage Types – a scope of medical services, other benefits, or both that are available to members who meet specific eligibility criteria. These coverage types include the following: MassHealth Standard (Standard), MassHealth CommonHealth (CommonHealth), MassHealth Family Assistance (Family Assistance), MassHealth Basic (Basic), MassHealth Essential (Essential), MassHealth Prenatal (Prenatal), and MassHealth Limited (Limited). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105.

Day – a calendar day unless a business day is specified.

Disabled – having a permanent and total disability.

Disabled Working Adult or 18-Year-Old – a person who is engaged in substantial gainful activity but otherwise meets the definition of disabled, as defined in Title XVI of the Social Security Act.

Disability Determination Unit – a unit that consists of physicians and disability evaluators who determine permanent and total disability using criteria established by the Social Security Administration under Title XVI, and criteria established under state law. This unit may be a part of a state agency or under contract with a state agency.

Duals Demonstration Dual Eligible Individual – for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

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

Duals Demonstration Program – the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

Eligibility Process – activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of a MassHealth applicant or member.

Eligibility Representative – a person who

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

(2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:

(a) has provided the MassHealth agency with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or

(b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

Fair Hearing – an administrative, adjudicatory proceeding conducted according to 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to determine the legal rights, duties, benefits, or privileges of applicants and members.

Family – persons who live together, and consist of: (1) a child or children under age 19, any of their children, and their parents; (2) siblings under age 19 and any of their children who live together even if no adult parent or caretaker relative is living in the home; or (3) a child or children under age 19, any of their children, and their caretaker relative when no parent is living in the home. A caretaker relative may choose whether or not to be part of the family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is: (a) pregnant; or (b) a parent. A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children who live with them.

Family Group – a family, couple, or individual.

Family Policy – a health-insurance policy that covers one or more adults, with one or more children. If an employer does not offer a couple policy, or a one-adult with one-child policy, a couple without children, or a family with one adult and one child may be covered by a family policy.

Federal-Poverty Level (FPL) – income standards issued annually in the *Federal Register* to account for the last calendar year's increase in prices as measured by the Consumer Price Index.

Fee-for-Service – a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice.

Gross Income – the total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Health Insurance – coverage of health-care services by a health-insurance company, a hospital-service corporation, a medical-service corporation, a managed-care organization, or Medicare. Coverage of health-care services by MassHealth or Children's Medical Security Plan (CMSP) is not considered health insurance.

Health Safety Net – a source of funding for certain health care under 114.6 CMR 13.00: *Health Safety Net Eligible Services* and 14.00: *Health Safety Net Payments and Funding*.

Individual – an applicant, a member, a spouse who is acting on behalf of the applicant or member, or any person, court, or administrative body with the legal authority to act on behalf of or at the request of the applicant, member, or spouse and may include a trustee, guardian, conservator, or an agent acting under a durable power of attorney.

Individual Policy – a health-insurance policy that covers the policyholder only.

Insurance Partnership Agent (IPA) – the organization under contract with the MassHealth agency to help administer the Insurance Partnership, as described in 130 CMR 650.009: *Insurance Partnership Agent (IPA)*.

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

Interpreter – a person who translates for an applicant or member who has limited English proficiency or a hearing impairment.

Large Employer – an employer that

(1) has more than 50 employees who work 30 or more hours a week;
(2) offers health insurance that meets the basic-benefit level; and
(3) contributes at least 50 percent of the cost of the employees' health-insurance premiums.

Limited English Proficiency – an inadequate ability to communicate in the English language.

Managed Care – a system of primary care and other medical services that are provided and coordinated by a MassHealth managed-care provider in accordance with the provisions of 130 CMR 450.117: *Managed Care Participation* and 508.000: *MassHealth: Managed Care Requirements*.

Managed-Care Organization (MCO) – any entity with which the MassHealth agency contracts to provide and coordinate care and certain other medical services to members on a capitated basis, including a senior care organization (SCO), an integrated care organization (ICO), or an entity that is approved by the Massachusetts Division of Insurance as a health-maintenance organization (HMO), or that otherwise meets the State Plan definition of an HMO.

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

MassHealth Managed-Care Provider – a primary-care clinician or managed-care organization that has contracted with the MassHealth agency to provide and coordinate primary care and certain other medical services to certain MassHealth members.

Medical Benefit Request (MBR) – a form prescribed by the MassHealth agency to be completed by the applicant or an eligibility representative, and submitted to the MassHealth agency as a request for MassHealth benefits.

Medical Benefits – payment for health insurance or medical services provided to a MassHealth member.

Member – a person determined by the MassHealth agency to be eligible for MassHealth.

One-Adult-with-One-Child Policy – a health-insurance policy that covers a family consisting of one adult and one child.

Permanent and Total Disability – a disability as defined under Title XVI of the Social Security Act or under applicable state laws.

(1) For Adults and 18-Year-Olds.

(a) The condition of an individual, aged 18 or older, who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that

(i) can be expected to result in death; or

(ii) has lasted or can be expected to last for a continuous period of not less than 12 months.

(b) For purposes of 130 CMR 501.001, an individual aged 18 or older is determined to be disabled only if his or her physical or mental impairments are of such severity that the individual is not only unable to do his or her previous work, but cannot, considering age, education, and work experience, engage in any other kind of substantial gainful work that exists in the national economy, regardless of whether such work exists in the immediate area in which the individual lives, whether a specific job vacancy exists, or whether the individual would be hired if he or she applied for work. "Work that exists in the national economy" means work that exists in significant numbers, either in the region where such an individual lives or in several regions of the country.

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, of comparable severity to an impairment or combination of impairments that disables an adult, or are of such severity that the child is unable to engage in age-appropriate activities, as defined in Title XVI as in effect on July 1, 1996.

Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

Premium – a charge for payment to the MassHealth agency that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, or the Children's Medical Security Plan (CMSP).

Premium Assistance Payment – an amount contributed by the MassHealth agency toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members.

Presumptive Eligibility – a time-limited period of conditional eligibility for children based on the applicant's declaration of family group gross income.

Primary Care Clinician (PCC) Plan – a managed-care option administered by the MassHealth agency through which enrolled members receive primary care and other medical services. See 130 CMR 450.118: *Primary Care Clinician (PCC) Plan*.

Qualified Employer – a small employer who
(1) purchases health insurance that meets the Basic-Benefit Level;
(2) contributes at least 50 percent of the cost of employees' health-insurance premiums; and
(3) has completed an Employer Application form and been approved by the MassHealth agency or its contractor as a qualified employer pursuant to 130 CMR 650.010(A).

Quality Control – a system of continuing review to measure the accuracy of eligibility decisions.

Senior Care Organization (SCO) – an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers and that integrates all components of care, either directly or through subcontracts. SCOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Small Business – see definition for small employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

Spouse – a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts. Effective for applications and eligibility review forms received on or after October 31, 2008, notwithstanding the unavailability of federal financial participation, no person who is recognized as a spouse under the laws of the Commonwealth will be denied benefits that are otherwise available under M.G.L. c. 118E due to the provisions of 1 U.S.C. § 7 or any other federal nonrecognition of spouses of the same gender. If a member's eligibility changes as the result of updated or corrected information about marital status, the change in eligibility will be effective as of the date the MassHealth agency receives the new information, but no sooner than October 31, 2008.

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508.004: Members Excluded from Participation in Various Managed Care Options

(A) The following MassHealth members are excluded from participation in a MassHealth-contracted managed care organization (MCO):

(1) a member who has Medicare;

(2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;

(3) a member who is aged 65 or older, except such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008;

(4) a member in a nursing facility, chronic disease or rehabilitation hospital, ICF/MR, or a state psychiatric hospital for other than a short-term rehabilitative stay;

(5) a member who is eligible solely for

(a) MassHealth Limited;

(b) MassHealth Prenatal; or

(c) Healthy Start;

(6) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: Emergency Aid to the Elderly, Disabled and Children Program;

(7) a member who has presumptive or time-limited eligibility; and

(8) a member who is a refugee described at 130 CMR 522.002: Refugee Resettlement Program.

(B) The following MassHealth members are excluded from participation in the MassHealth Primary Care Clinician (PCC) Plan:

(1) a member who has Medicare;

(2) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;

(3) a member who is aged 65 or older, except such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008;

(4) a member in a nursing facility, chronic disease or rehabilitation hospital, ICF/MR, or a state psychiatric hospital for other than a short-term rehabilitative stay;

(5) a member who is eligible solely for

(a) MassHealth Limited;

(b) MassHealth Prenatal;

(c) Children's Medical Security Plan (CMSP); or

(d) Healthy Start;

(6) a member who is receiving medical services through the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*;

(7) a member who is receiving hospice care through MassHealth, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less;

(8) a member who has presumptive or time-limited eligibility; and

(9) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program.*

(C) The following MassHealth members aged 65 and older are excluded from participating in a senior care organization (SCO):

(1) a member who has access to other health insurance, with the exception of Medicare, that meets the basic-benefit level as defined in 130 CMR 501.001; *Definition of Terms*;
(2) a member who does not live in the designated service area of a SCO;
(3) a member in a chronic disease or rehabilitation hospital or ICF/MR;
(4) a member who is not eligible for MassHealth Standard;
(5) a member who has presumptive or time-limited eligibility;
(6) a member who is diagnosed as having end-stage renal disease;
(7) a member who is enrolled in a home- and community-based services waiver, except the Home- and Community-Based Services Waiver-Frail Elder as described at 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*; and
(8) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program*.

(D) The following MassHealth members aged 21 through 64 who are enrolled in Medicare Parts A and B and are eligible for Medicare Part D are excluded from participation in an integrated care organization (ICO):

(1) a member who has access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*;
(2) a member in an ICF/MR;
(3) a member who is not eligible for MassHealth Standard or CommonHealth;
(4) a member who has presumptive or time-limited eligibility;
(5) a member who is enrolled in a home- and community-based services waiver; and
(6) a member who is a refugee described at 130 CMR 522.002: *Refugee Resettlement Program.*

508.005: MassHealth Managed Care Providers

(A) Primary Care Clinicians Participating in the PCC Plan. The list of primary care clinicians that the MassHealth agency will make available to members may include any one of the following who is approved as a PCC by the MassHealth agency and who practices within the member's service area:

(1) a physician in one of the following fields of medicine:
  (a) internal medicine;
  (b) family or general practice;
  (c) pediatrics;
  (d) obstetrics;
  (e) gynecology;
  (f) obstetrics/gynecology; or
  (g) physiatry;

(2) a physician specialist who is board-certified or eligible for board certification in internal medicine or pediatrics and who agrees to provide primary care in accordance with MassHealth agency requirements;

(3) an independent nurse practitioner;

(4) a licensed community health center with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1);

(5) an acute hospital outpatient department with one or more practicing physicians who meet the requirements of 130 CMR 508.005(A)(1); or

(6) a group practice with one or more practicing physicians or independent nurse practitioners who meet the requirements of 130 CMR 508.005(A)(1).

(B) Managed Care Organizations. The list of MCOs that the MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency and provide services within the member's service area.

(C) Senior Care Organizations. The list of senior care organizations (SCOs) that the MassHealth agency will make available to members will include those SCOs that contract with the MassHealth agency and provide services within the member's service area.

(D) Integrated Care Organizations. The list of integrated care organizations (ICOs) that the MassHealth agency will make available to members will include those ICOs that contract with the MassHealth agency and provide services within the member's service area.

508.006: Right to a Fair Hearing

Members are entitled to a fair hearing under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* 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, including a senior care organization (SCO) or an integrated care organization (ICO), 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).

508.007: Eligibility and Enrollment in an Integrated Care Organization

(A) Eligibility.
(1) In order to be eligible to enroll in an integrated care organization (ICO), a MassHealth member must meet all of the following criteria, and may not be enrolled or concurrently participate in any of the programs or plans listed in 130 CMR 508.007(F):
(a) be aged 21 through 64 at the time of enrollment;
(b) be eligible for MassHealth Standard as defined in 130 CMR 450.105(A): *MassHealth Standard* or MassHealth CommonHealth as defined in 130 CMR 450.105(E): *MassHealth CommonHealth*;
(c) be enrolled in Medicare Parts A and B, be eligible for Medicare Part D, and have no access to other health insurance that meets the basic-benefit level as defined in 130 CMR 501.001: *Definition of Terms*; and
(d) live in a designated service area of an ICO.
(2) If a member is enrolled in an ICO and turns age 65 and is eligible for MassHealth Standard, he or she may elect to remain in the ICO after age 65.

(B) Selection of an Integrated Care Organization.
(1) The MassHealth agency will notify members
(a) of the availability of an ICO in their service area and how to enroll in an ICO;
(b) that, in any service area with a choice of at least two ICOs, MassHealth will assign eligible members who do not choose an ICO but have not opted out the Duals Demonstration; and
(c) how to opt out of the Duals Demonstration.
(2) An eligible member may enroll in any ICO in the member's service area by making a written or verbal request to MassHealth or its designee. A service area is the specific geographical area of Massachusetts in which an ICO agrees to provide ICO services. Service listings can be obtained from the MassHealth agency or its designee.
(3) MassHealth provides written notice at least 60 days in advance of its assignment of any eligible members to an ICO. The notice includes the ICO to which the member is being assigned, information about how to enroll in a different ICO, and information about how to opt out of the Duals Demonstration Program.

(C) Obtaining Services. When a member is enrolled in an ICO in accordance with the requirements under 130 CMR 508.007(A), the ICO will authorize, arrange, integrate, and coordinate the provision of all covered services for the member. Upon enrollment, the ICO is required to provide evidence of its coverage, the range of available covered services, what to do for emergency conditions and urgent care needs, and how to obtain access to specialty, behavioral-health, and long-term services and supports.

(D) Disenrollment from an Integrated Care Organization. A member may disenroll from an ICO at any time by notifying the MassHealth agency or its designee verbally or in writing. A member who disenrolls from an ICO, but does not select another ICO or opt out of the Duals Demonstration, will be automatically assigned another ICO provided that MassHealth provides a written notice at least 60 days in advance of any auto assignment. The notice includes the ICO to which the member is assigned, information about how to enroll in a different ICO, and information about how to opt out of the Duals Demonstration. Disenrollment requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(E) Disenrollment from the Duals Demonstration. A member may opt out of the Duals Demonstration at any time by notifying the MassHealth agency or its designee verbally or in writing. Requests that are received by the MassHealth agency on the last calendar day of the month will be effective on the first day of the following month.

(F) Other Programs. A member may not be enrolled in an ICO and concurrently participate or be enrolled in any of the following programs or plans:

(1) programs described at 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
(2) Medicare demonstration program or Medicare Advantage plan, except for a Medicare Advantage Special Needs Plan for Dual Eligibles contracted as an ICO;
(3) any Medicare Demonstrations wherein concurrent participation in the Duals Demonstration is prohibited;
(4) Employer Group Waiver Plans or other employer-sponsored plans; or
(5) plans receiving a retiree drug subsidy.

508.008: Voluntary Enrollment in Senior Care Organizations

(A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization (SCO), 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 SCO;
(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: *Eligibility for a Deductible*;
(5) not be a resident of an 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 (SCO) in their service area and of the procedures for enrollment. An eligible member may voluntarily enroll in any SCO in the member's service area. A service area is the specific geographical area of Massachusetts in which a SCO 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 (SCO) in accordance with the requirements under 130 CMR 508.008, the SCO 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 SCO 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 SCO 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 SCO where the SCO 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 (SCO) under 130 CMR 508.008, a member may not concurrently participate in

(1) any program described in 130 CMR 519.007: *Individuals Who Would Be Institutionalized*, except the Home- and Community-Based Services Waiver-Frail Elder described in 130 CMR 519.007(B): *Home- and Community-Based Services Waiver-Frail Elder*;

(2) any Medicare demonstration program or Medicare Advantage plan, except for Medicare Advantage Special Needs Plan for Dual Eligibles contracted as a SCO; or

(3) an ICO described in 130 CMR 508.007.

508.009: Timely Notice of Appealable Actions

(A) Whenever an MCO, SCO, ICO, 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 time frames 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 time frame is extended up to 14 additional days because the member or a provider requested the extension or the MCO, SCO, and ICO, 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, ICO, or behavioral-health contractor determines, that following the standard time frame 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 time frame is extended up to 14 additional calendar days because the member requested the extension or the MCO, SCO, ICO, 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, ICO, 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, ICO, or the behavioral-health contractor fails to reach a decision on a standard or expedited service authorization within the time frames 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 time frame expires.

508.010: Time Limits for Resolving Internal Appeals

(A) MCOs, SCOs, ICOs, 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 provider requests an expedited appeal or the MCO,SCO, ICO, or behavioral-health contractor determines (for a request from the member) that following the standard time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MCO, SCO, ICO, or the behavioral-health contractor must resolve the internal appeal on an expedited basis within 72 hours after receiving the appeal, unless the time frames are extended by up to 14 days pursuant to 130 CMR 508.010(C), in which event the MCO, SCO, ICO, or behavioral-health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, SCO, ICO, or behavioral-health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, SCO, ICO, or behavioral-health contractor must resolve the appeal in accordance with the time frames 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, ICO, or behavioral-health contractor cannot deny a provider's request (on the member's behalf) that an internal appeal be expedited.

(C) MCOs, SCOs, ICOs, and the behavioral-health contractor may extend the time frame for resolving internal appeals under the following circumstances, provided that, if the MCO, SCO, ICO, or the behavioral-health contractor extends the time frame, it must give the member written notice of the reason for the extension:

(1) the member requested the extension;

(2) the MCO, SCO, or the behavioral-health contractor showed (to the MassHealth agency's satisfaction) that there is a need for additional information and how the extension is in the member's interest; or

(3) the ICO showed (to the satisfaction of the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS)) 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, ICOs, 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, a SCO, an ICO, 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)

(2) Pregnancy is verified by a written statement from a competent medical authority certifying the pregnancy.

519.007: Individuals Who Would Be Institutionalized

130 CMR 519.007 describes the eligibility requirements for MassHealth Standard coverage for individuals who would be institutionalized if they were not receiving home- and community-based services.

(A) The Kaileigh Mulligan Program. The Kaileigh Mulligan Program enables severely disabled children under the age of 18 years to remain at home. The income and assets of their parents are not considered in the determination of eligibility.

(1) Eligibility Requirements. Children under the age of 18 years may establish eligibility for the Kaileigh Mulligan Program by meeting the following requirements. They must

(a) (i) meet Title XVI disability standards in accordance with the definition of permanent and total disability for children under the age of 18 years in 130 CMR 515.001 or have been receiving SSI on August 22, 1996; and
(ii) continue to meet Title XVI disability standards that were in effect before August 22, 1996;

(b) have $2,000 or less in countable assets;

(c) (i) have a countable-income amount of $72.80 or less; or
(ii) if greater than $72.80, meet a deductible in accordance with 130 CMR 520.028 et seq.; and

(d) require a level of care equivalent to that provided in a hospital or nursing facility in accordance with 130 CMR 519.007(A)(3) and (4).

(2) Additional Requirements. The MassHealth agency must have determined

(a) that care provided outside an institution is appropriate; and

(b) that the estimated cost paid by the MassHealth agency would not be more than the estimated cost paid if the child were institutionalized.

(3) Level of Care That Must Be Required in a Hospital. To require the level of care provided in a hospital, the child must have a medical need for the following:

(a) direct administration of at least two discrete skilled-nursing services (as defined in 130 CMR 515.001) on a daily basis, each of which requires complex nursing procedures, such as administration of intravenous hyperalimentation, changing tracheotomy tubes, assessment or monitoring related to an uncontrolled seizure disorder, assessment or monitoring related to an unstable cardiopulmonary status, or other unstable medical condition;

(b) direct management of the child's medical care by a physician or provided directly by someone who is under the supervision of a physician on at least a weekly basis;

(c) ongoing use of invasive medical technologies or techniques to sustain life (such as ventilation, hyperalimentation, gastrostomy tube feeding), or dialysis, or both; and

(d) at least one of the following:

(i) assistance in one or more activities of daily living (ADLs), as defined in 130 CMR 515.001: *Definition of Terms*, beyond what is required at an age-appropriate activity level; or

(ii) one or more skilled therapeutic services (occupational therapy, physical therapy, or speech and language therapy), provided directly by or under the supervision of a licensed therapist at least five times a week.

(4) Level of Care That Must Be Required in a Skilled-Nursing Facility. To require the level of care provided in a skilled-nursing facility, the child must be nonambulatory and meet the following requirements.

(a) A child 12 months of age or older must have global developmental skills (as defined in 130 CMR 515.001: *Definition of Terms*) not exceeding those of a 12-month-old child as indicated by a developmental assessment performed by the child's physician or by another certified professional. In addition, the child's developmental skills level must not be expected to improve.

(b) A child less than 12 months of age must have global developmental skills significantly below an age-appropriate level and such skills must not be expected to progress at an age-appropriate rate as indicated by a developmental assessment performed by the child's physician or by another certified professional.

(c) Regardless of age, the child must also require all of the following:

(i) direct administration of at least two discrete skilled-nursing services on a daily basis, each of which requires complex nursing procedures as described at 130 CMR 519.007(A)(3);

(ii) direct management of the child's medical care by a physician or provided directly by someone who is under the supervision of a physician on a monthly basis;

(iii) assistance in one or more ADLs beyond what is required at an age-appropriate activity level; and

(iv) any combination of skilled therapeutic services (physical therapy, occupational therapy, speech and language therapy) provided directly by or under the supervision of a licensed therapist at least five times a week.

(B) Home- and Community-Based Services Waiver-Frail Elder.

(1) Clinical and Age Requirements. The Home- and Community-Based Services Waiver-Frail Elder allows an applicant or member who is certified by the MassHealth agency or its agent to be in need of nursing-facility services to receive certain waiver services at home if he or she

(a) is 60 years of age or older and, if under age 65, is permanently and totally disabled in accordance with Title XVI standards; and

(b) would be institutionalized in a nursing facility, unless he or she receives one or more of the services administered by the Executive Office of Elder Affairs under the Home- and Community-Based Services Waiver-Frail Elder authorized under Section 1915(c) of the Social Security Act.

(2) Eligibility Requirements. In determining eligibility for MassHealth Standard and for waiver services, the MassHealth agency counts the income and assets of only the applicant or member regardless of his or her marital status. The applicant or member must

(a) meet the requirements of 130 CMR 519.007(B)(1)(a) and (b);

(b) have a countable-income amount less than or equal to 300 percent of the federal benefit rate (FBR) for an individual; and

(c) have countable assets of $2,000 or less and have not transferred resources for the sole purpose of obtaining MassHealth as described at 130 CMR 520.018:*Transfer of Resources Regardless of Date of Transfer* and 520.019:*Transfer of Resources Occurring on or after August 11, 1993*.

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610.001: Purpose

(A) MassHealth Decisions. 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 MassHealth managed care contractor. Such actions include, but are not limited to, determinations of eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003, as described in federal regulations 42 CFR Part 423, Subpart P.

(B) Other Decisions. 130 CMR 610.000 also contains provisions under which nursing facility residents may seek review of discharges and transfers by a nursing facility, as well as provisions for individuals applying for or receiving Commonwealth Care, pursuant to M.G.L. c. 118H, to seek administrative review under 130 CMR 610.000 as provided under 956 CMR 3.14: *Right to a Hearing* and 3.17: *Hearings*. 130 CMR 610.000 also contains provisions regarding individuals seeking review of federally mandated Preadmission Screening and Resident Review (PASRR) determinations.

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 Office of Medicaid Board of Hearings has exclusive jurisdiction to hear appeals relating to the programs administered by the MassHealth agency; provided, however, that for certain appeals by an integrated care organization (ICO) or senior care organization (SCO) enrollee concerning covered benefits, the Centers for Medicare & Medicaid Services (CMS) Independent Review Entity (IRE) also has jurisdiction. Pursuant to M.G.L. c. 176Q, §§ 3(a)(6) and 3(m), the Commonwealth Health Insurance Connector Authority may establish procedures for appeals of eligibility decisions for Commonwealth Care through an interdepartmental agreement with the MassHealth agency. Pursuant to 42 U.S.C. 1396r(e)(7) and 42 CFR 483.204, the Office of Medicaid Board of Hearings has authority to hear appeals of PASRR determinations.

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: *Adjudicatory Rules of Practice and Procedure* are governed by the procedures set forth in 130 CMR 610.000. Appeals by residents of a nursing facility who are to be discharged or transferred at the initiation of the nursing facility are governed by 130 CMR 610.000. Adjudicatory proceedings initiated by medical assistance providers are governed by 130 CMR 450.241: *Hearings: Claim for an Adjudicatory Hearing* through 450.248: *Commissioner's Decision* or, with regard to appeals of erroneously denied claims, by 130 CMR 450.323: *Appeals Erroneously Denied or Underpaid Claims*. Appeals pertaining to Commonwealth Care are governed by 130 CMR 610.000 and 956 CMR 3.00: *Eligibility and Hearing Process for Commonwealth Care*. Appeals pertaining to PASRR determinations are governed by 130 CMR 610.000.

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, nursing facility, or the Health Connector responsible for taking an appealable action. Acting entity also includes the Department of Mental Health and the Department of Developmental Services when making a PASRR determination.

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, or the Department of Mental Health or the Department of Developmental Services, or certain actions of the Health Connector as set forth in 956 CMR 3.14: *Right to a Hearing* and 3.17: *Hearings*. 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 Office of Medicaid 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, including individuals who are appealing a PASRR determination.

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

Application – either a Medical Benefit Request (MBR) (see 130 CMR 501.001: *Definition of Terms*) or a Senior Medical Benefit Request (SMBR) (see 130 CMR 515.001: *Definition of Terms*), including authorized electronic applications.

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

BOH – the Office of Medicaid Board of Hearings within the MassHealth agency.

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

Commonwealth Care – the Commonwealth Care Health Insurance Program administered by the Health Connector under M.G.L. c. 118H.

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

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

Director – the Director of the Office of Medicaid 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 Massachusetts Division of Medical Assistance organized under M.G.L. c. 118E, or its agent.

Duals Demonstration Dual Eligible Individual – for purposes of the Duals Demonstration Program, a MassHealth member must meet all of the following criteria:

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

Duals Demonstration Program – the MassHealth state Demonstration to Integrate Care for Duals Demonstration Dual Eligible Individuals.

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.

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

Hearing Officer – an impartial and independent person designated by the Director of the Office of Medicaid 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.

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

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), including a senior care organization (SCO) or an integrated care organization (ICO), or behavioral health contractor, as defined and described in 130 CMR 508.000: *MassHealth: Managed Care Requirements*.

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

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

Member – a person or family who is or had been receiving assistance under a program administered by the MassHealth agency, or an enrollee in Commonwealth Care to the extent the enrollee is affected by decisions appealable to the Office of Medicaid Board of Hearings under 956 CMR 3.17: *Hearings*.

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, the MassHealth agency, the Department of Mental Health, the Department of Developmental Services, or the Health Connector.

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

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

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

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, or a written explanation, issued by the Health Connector or its designee, of the Health Connector's intent and interpretation or application of its regulations under 956 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).

Transfer – movement of a resident from

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

Movement of a resident within the same facility from one certified bed to another bed with the same certification does not constitute a transfer.

(130 CMR 610.005 through 610.010 Reserved)

610.011: The Office of Medicaid Board of Hearings

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

610.012: General Description of the Fair Hearing Process

(A) The fair hearing process is an administrative, adjudicatory proceeding 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) certain decisions or determinations made by the Health Connector as set forth in 956 CMR 3.17: *Hearings*;
(4) actions to recover payment for benefits to which the member was not entitled at the time the benefit was received;
(5) alleged coercive or otherwise improper conduct by a MassHealth agency employee;
(6) the denial or termination of an employer from the Insurance Partnership;
(7) the amount of an Insurance Partnership payment; or
(8) a decision by a nursing facility to discharge or transfer a resident; or
(9) a PASRR determination.

(B) The process is designed to secure and protect the interests of both the appellant and, as appropriate, MassHealth agency or Health Connector 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, the action of a managed care contractor or nursing facility, or the action of the Health Connector.
(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, managed care contractors, and the Health Connector, except that appeals may be subject to review as provided in 130 CMR 610.091. In the case of a decision about an appeal by an ICO or a SCO enrollee concerning the amount, duration, or scope of covered benefits, where both the BOH and the IRE issue a decision, the ICO or SCO is bound by both decisions and will provide the services which are closest to the enrollee's relief requested on appeal.

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

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

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

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

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

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; or
(d) the date of the alleged coercive or otherwise improper conduct, but up to one year from the date of the conduct if the appellant files an affidavit with the 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 he or she was justifiably unaware of the conduct in question; and
(ii) 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 time frames described by 130 CMR 508.010(A) and (C), 30 days after the date on which the time frame 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 nonexpedited BOH appeal; or
(d) if the MCO or behavioral health contractor did not resolve the member's expedited internal appeal of a denial of service within the time frames described by 130 CMR 508.010(B), 20 days after the date on which the time frame for resolving that expedited appeal has expired;

(8) for appeals of an appealable action by a SCO or an ICO, 30 days after the mailing of the SCO's or ICO's notice of the appealable action; or

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

(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;

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

(d) a PASRR determination.

(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 time frame described by 130 CMR 508.010(A).
(2) The member must submit such a request within the time frames described by 130 CMR 610.015(B)(7)(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 time frame described by 130 CMR 508.010(B).
(2) The member must submit such a request to BOH within the time frames described by 130 CMR 610.015(B)(7)(d) or (B)(8), whichever is applicable.
(3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

610.016: Appeal Representative

(A) An appellant has the right to be represented at his or her own expense by an appeal representative as defined in 130 CMR 610.004. 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.

610.018: Appeal Process for Enrollees in an Integrated Care Organization

The Duals Demonstration Program utilizes a coordinated appeals process that provides enrollees with access to both the MassHealth and Medicare appeals processes. If the integrated care organization (ICO) internal appeals process denies a member's requested covered benefits in whole or in part, the member may appeal to either the Centers for Medicare & Medicaid Services (CMS) Independent Review Entity (IRE), the Office of Medicaid Board of Hearings (BOH), or both, as described in 130CMR 610.018(A) through (C).

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

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

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

(130 CMR 610.019 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.

610.028: Notice Requirements Regarding Actions Initiated by a Nursing Facility

(A) A resident may be transferred or discharged from a nursing facility only when:
(1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
(2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;

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.

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), 610.085(C), and 610.091, the following will apply.
(1) The decision of the hearing officer will be final and binding on the acting entity.
(2) The acting entity will not interfere with the independence of the fact-finding process of the hearing officer. Facts found and issues decided by the hearing officer in each case are binding on the parties to that case and cannot be disputed again between them in any other administrative proceeding.

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

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

610.086: Implementation of the Appeal Decision

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

(1) Notification to Appellant. When the decision is issued, BOH will notify the appellant of his or her right to full and prompt implementation of the decision within 30 days, except as provided under 130 CMR 610.091. The notice directs the appellant to notify the appropriate BOH official in writing if there is not full compliance within 30 days.

(2) Responsibility of the MassHealth Agency. The MassHealth agency is responsible for the full and prompt implementation of all fair hearing decisions so that the appellant will receive any benefits due within 30 days of the date of the decision, except as provided under 130 CMR 610.091. No official or any other employee of the MassHealth agency may obstruct the implementation of the fair hearing decision, except as provided under 130 CMR 610.091.

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

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

(B) All Other Decisions.

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

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

(130 CMR 610.087 through 610.090 Reserved)

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).