



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

MassHealth
Eligibility Letter 225
December 15, 2017

TO: MassHealth Staff

FROM: Daniel Tsai, Assistant Secretary for MassHealth

A handwritten signature in black ink, appearing to read "D. Tsai".

RE: Revisions to MassHealth Regulations about Payment and Care Delivery Innovation Changes

MassHealth has revised its regulations at 130 CMR 501.000, 508.000, and 610.000 as part of its Payment and Care Delivery Innovation (PCDI) initiative.

Under PCDI, MassHealth is contracting with Accountable Care Organizations (ACOs), entities that are held financially responsible for the cost and quality of care to assigned member populations. There are three types of MassHealth ACOs:

- (1) Accountable Care Partnership Plans;
- (2) Primary Care ACOs; and
- (3) MCO-Administered ACOs.

Revisions to 130 CMR 501.000:

Regulatory changes reflect the new ACOs and their managed care impacts. Specifically, changes include:

- New definitions of ACO, Accountable Care Partnership Plan, behavioral health contractor, MCO-Administered ACO, and Primary Care ACO.
- Modification of the definitions of managed care, MCO, and MassHealth managed care provider.

Revisions to 130 CMR 508.000:

Regulatory changes reflect the incorporation of the new ACOs into the managed care delivery options available to MassHealth members and make associated programmatic changes related to the MassHealth managed care delivery system. Changes include:

- Addition of Accountable Care Partnership Plans and Primary Care ACOs to the list of managed care enrollment options;
- Description of managed care requirements with respect to Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs, including assignment, enrollment, disenrollment, and appeals;
- Reorganization of existing provisions related to assignment, enrollment, and disenrollment for clarity;
- Revision of certain provisions related to enrollment in a managed care provider outside the member's service area;
- Clarification of language related to member assignment to a managed care provider;
- Addition of language regarding copayments for members enrolled in MassHealth's behavioral health contractor and copayment policies for the MassHealth behavioral health contractor, to align language with other managed care provider copayment language.

Revisions to 130 CMR 610.000:

The regulatory changes make necessary changes to accommodate the new ACO program. Specifically, changes include:

- Addition of Accountable Care Partnership Plans to the definition of managed care contractor. As a result, requirements governing appeal of managed care contractor decisions now apply to Accountable Care Partnership Plans.
- Modification of the provision describing time limits for responding to a member's appeal of a managed care contractor decision to conform with federal rules.
- New definitions of ACO, Accountable Care Partnership Plan, behavioral health contractor, managed care organization (MCO), and Senior Care Organization (SCO).
- Conforming changes to the regulations at 130 CMR 508, including the addition of appeal for denial of member's request to transfer out of the member's MCO, Accountable Care Partnership Plan, or Primary Care ACO.
- Revision of appeal for denial of enrollment in an out-of-area provider.
- Clarification of language regarding appealable actions that may be the subject of fair hearing provisions.

These regulations are effective December 18, 2017.

MANUAL UPKEEP

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
501.000	501.000	E.L. 218
501.001 (1 of 10)	501.001 (1 of 10)	E.L. 218
501.001 (2 of 10)	501.001 (2 of 10)	E.L. 218
501.001 (3 of 10)	501.001 (3 of 10)	E.L. 218
501.001 (4 of 10)	501.001 (4 of 10)	E.L. 218
501.001 (5 of 10)	501.001 (5 of 10)	E.L. 218
501.001 (6 of 10)	501.001 (6 of 10)	E.L. 218
501.001 (7 of 10)	501.001 (7 of 10)	E.L. 218
501.001 (8 of 10)	501.001 (8 of 10)	E.L. 218
501.001 (9 of 10)	501.001 (9 of 10)	E.L. 218
501.001 (10 of 10)	501.001 (10 of 10)	E.L. 218
501.002	501.002	E.L. 218
501.003	501.003	E.L. 218
501.005	501.005	E.L. 218
501.006	501.006	E.L. 218
501.007	501.007	E.L. 218
501.009	501.009	E.L. 218
501.010	501.010	E.L. 218
501.012	501.012	E.L. 218
501.013 (1 of 2)	501.013 (1 of 2)	E.L. 218
501.013 (1 of 2)	501.013 (2 of 2)	E.L. 218
501.014	501.014	E.L. 218
501.015	501.015	E.L. 218
508.000	508.000	E.L. 219
508.001	508.001	E.L. 219
508.002 (1 of 2)	508.002 (1 of 2)	E.L. 219
508.002 (2 of 2)	508.002 (2 of 2)	E.L. 219
508.003 (1 of 4)	508.003	E.L. 219
508.003 (2 of 4)	--	--
508.003 (3 of 4)	--	--
508.003 (4 of 4)	--	--
508.004 (1 of 2)	508.004 (1 of 4)	E.L. 219
508.004 (2 of 2)	508.004 (2 of 4)	E.L. 219
--	508.004 (3 of 4)	E.L. 219
--	508.004 (4 of 4)	E.L. 219
508.005	508.005 (1 of 3)	E.L. 219
--	508.005 (2 of 3)	E.L. 219
--	508.005 (3 of 3)	E.L. 219
508.006 (1 of 3)	--	--
508.006 (2 of 3)	--	--

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
508.006 (3 of 3)	--	--
508.007 (1 of 3)	508.007 (1 of 2)	E.L. 219
508.007 (2 of 3)	508.007 (2 of 2)	E.L. 219
508.007 (3 of 3)	--	--
508.008	508.008 (1 of 2)	E.L. 219
--	508.008 (2 of 2)	E.L. 219
508.009	508.009	E.L. 219
508.010	--	--
508.011	508.011	E.L. 219
508.012	508.012	E.L. 219
508.013	508.013	E.L. 219
610.004 (1 of 5)	610.004 (1 of 4)	E.L. 212
610.004 (2 of 5)	610.004 (2 of 4)	E.L. 212
610.004 (3 of 5)	610.004 (3 of 4)	E.L. 212
610.004 (4 of 5)	610.004 (4 of 4)	E.L. 212
610.004 (5 of 5)	--	--
610.011	610.011	E.L. 212
610.013	610.013	E.L. 212
610.015 (1 of 2)	610.015 (1 of 2)	E.L. 212
610.015 (2 of 2)	610.0 (2 of 2)	E.L. 212
610.016	610.016	E.L. 212
610.018	610.018	E.L. 212
610.026	610.026	E.L. 212
610.028	610.028	E.L. 198
610.029	610.029	E.L. 198
610.031	610.031	E.L. 198
610.032	610.032	E.L. 198
610.033	610.033	E.L. 198
610.034	--	--
--	610.035	E.L. 212
610.036	--	--
610.037	610.037	E.L. 198
610.061	610.061	E.L. 198
610.062	610.062	E.L. 198
610.091	610.091	E.L. 212
610.093	610.093	E.L. 198

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.000

TABLE OF CONTENTS

Section

- 501.001: Definition of Terms
- 501.002: Introduction to MassHealth
- 501.003: MassHealth Coverage Types
- 501.004: Administration of MassHealth
- 501.005: Individuals and Families Eligible for or Receiving Medical Assistance on June 30, 1997
- 501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998
- 501.007: Receiving Public Assistance from Another State
- (130 CMR 501.008 Reserved)
- 501.009: Rights of Applicants and Members
- 501.010: Responsibilities of Applicants and Members
- 501.011: Referrals to Investigative Units
- 501.012: Recovery of Overpayment of Medical Benefits
- 501.013: Estate Recovery
- 501.014: Voter Registration
- 501.015: Reimbursement of Certain Out-of-pocket Medical Expenses

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (1 of 10)

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: *Health Care Reform: MassHealth: Managed Care Requirements*. In the event that a definition conflicts with federal law, the federal law supersedes.

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

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

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

American Indian or Alaska Native – a person who

- (1) is a member of a federally recognized tribe, band, or group as defined in Title 25 of U.S.C.;
- (2) is an Eskimo, Aleut, or other Alaska Native enrolled by the Secretary of the Interior, pursuant to the Alaska Native Claims Settlement Act at 43 U.S.C. 1601 *et seq.*; or
- (3) has been determined eligible to receive health care services from Indian Health Care Providers as an Indian pursuant to 42 CFR 136.12 or Title V of the Indian Health Care Improvement Act.

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

Appeal Representative – an Appeal Representative as defined in 130 CMR 610.004: *Definitions*.

Applicant – an individual who completes and submits an application for MassHealth.

Application – a request for health benefits that is received by the MassHealth agency and includes all required information and a signature by the applicant or his or her authorized representative. The application may be submitted at www.MAHealthConnector.org, or the applicant may complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC).

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (2 of 10)

Authorized Representative –

- (1) a person or an organization identified as the authorized representative of an applicant or member in a completed Authorized Representative Designation Form or another form prescribed by the MassHealth agency that has been signed by the authorized representative and, if applicable, the applicant or member and submitted to the MassHealth agency and in which the authorized representative agrees to comply with applicable rules regarding confidentiality and conflicts of interest in the course of representing the applicant or member; provided that such person or organization must be
 - (a) a person or organization designated by the applicant or member in writing to act responsibly on his or her behalf in connection with the eligibility process and other ongoing communications with the MassHealth agency;
 - (b) a person acting responsibly on behalf of the applicant or member and who is sufficiently aware of such applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with the MassHealth agency, such as a family member or friend; provided that the applicant or member in this case cannot provide written designation and does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health care proxy; or
 - (c) a person who has, under applicable law, authority to act on behalf of the applicant or member in making decisions related to health care or payment for health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.
- (2) An authorized representative shall have the authority to complete and sign an application on the applicant's behalf, select a health plan on the applicant's or member's behalf, complete and sign a renewal form on the member's behalf, receive copies of the applicant's or member's notices and other communications from the MassHealth agency (which may include protected health care information, personal data, and financial information), and act on behalf of the applicant or member in all other matters with the MassHealth agency or the Connector, including representing the applicant or member at an appeal provided that, with respect to a person serving as an authorized representative pursuant to 130 CMR 501.001: Authorized Representative (1)(c), authority to act on behalf of the applicant or member is determined by the applicable law or underlying legal document.

Basic-benefit Level (BBL) – benefits provided under a health-insurance plan that include a broad range of medical benefits as defined in the minimum creditable coverage core services requirements in 956 CMR 5.03(1)(a); provided that the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under that plan does not exceed the maximum amounts described at IRC § 223(c)(2) for high deductible health plans.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (3 of 10)

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

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° 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.

Certified Application Counselor (CAC) – an individual who is certified by the MassHealth agency and the Connector to provide assistance in completing applications and renewal forms.

Child – a person younger than 19 years old.

Citizen – see 130 CMR 504.002: *U.S. Citizen*.

Commonwealth Health Insurance Connector Authority or Health Connector or Connector – the entity established pursuant to M.G.L. c. 176Q, § 2.

ConnectorCare – the program administered by the Health Connector pursuant to M.G.L. c. 176Q to provide premium assistance payments and point-of-service cost-sharing subsidies to eligible individuals enrolled in health plans.

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

Coverage Date – the date medical coverage begins.

Coverage Type – a scope of medical services, other benefits, or both that is available to members who meet specific eligibility criteria. MassHealth coverage types include the following: MassHealth Standard (Standard), MassHealth CommonHealth (CommonHealth), MassHealth CarePlus (CarePlus), MassHealth Family Assistance (Family Assistance), Small Business Employee Premium Assistance Program (SBE Premium Assistance Program), and MassHealth Limited (Limited). The scope of services or covered benefits for each coverage type is found at 130 CMR 450.105: *Coverage Types*.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (4 of 10)

Custodial Parent –

- (1) the parent with whom a child's physical custody has been established by a court order or binding separation, divorce, or custody agreement; or
- (2) if no such order or agreement exists, the parent with whom the child spends most nights; or
- (3) if the child spends an equal number of nights with each parent, it is determined by the Internal Revenue Service (IRS) tax rules.

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

Deductible – the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards must be responsible for before the applicant is eligible for MassHealth as described at 130 CMR 506.009: *The One-time Deductible*.

Deductible Period – a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible, on the basis of disability, through incurred and/or paid medical expenses of the applicant or any member of the MassHealth Disabled Adult Household as described in 130 CMR 506.009: *The One-time Deductible*.

Disabled – having a permanent and total disability.

Disabled Adult Household – see 130 CMR 506.002(C): *MassHealth Disabled Adult Household*.

Disabled Working Adult – 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 Evaluation Services (DES) – a unit that consists of physicians and disability evaluators who determine permanent and total disability of an applicant or member seeking coverage under a MassHealth program for which disability is a criterion 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (5 of 10)

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

- (1) be 21 through 64 years of age 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 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.

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

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 Group – a family, couple, or individual.

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.

Filing Status – an Internal Revenue Service term. The five filing statuses are single, married filing a joint return, married filing a separate return, head of household, and qualifying widow(er) with dependent children. The rate at which income is taxed is determined by the filing status.

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, Health Safety Net (HSN), or Children's Medical Security Plan (CMSP) is not considered health insurance.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (6 of 10)

Health Safety Net – a source of funding for certain health care under 101 CMR 613.00: *Health Safety Net Eligible Services* and 614.00: *Health Safety Net Payments and Funding*.

Hospital-determined Presumptive Eligibility – the MassHealth agency will provide time-limited coverage, in accordance with 130 CMR 502.003(H): *Hospital Determined Presumptive Eligibility*, for individuals who are determined to be presumptively eligible by a qualified hospital, as defined at 130 CMR 450.110(B).

Incarceration – the confinement in a penal institution of an individual. An individual is not incarcerated if he or she is on parole, probation, or home release, and does not return to the institution for overnight stays.

Inconsistency Period – the time frame that an individual has to provide verifications needed to determine eligibility for health insurance offered by the Connector.

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.

Lawfully Present Immigrants – see 130 CMR 504.003(A): *Lawfully Present Immigrants*.

Limited English Proficiency – persons who are unable to communicate effectively in English because their primary language is not English and who have not developed fluency in the English language.

Lump-sum Payment – a one-time only payment that represents either a windfall payment, or the accumulation of recurring countable income, such as retroactive unemployment compensation or federal veterans' retirement benefits. Payments such as gifts, inheritances, and personal injury awards, to the extent that they are not included in modified adjusted gross income, are not considered lump-sum payments.

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

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (7 of 10)

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

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

MassHealth MAGI Household – see 130 CMR 506.002(B): *MassHealth MAGI Household Composition*.

MassHealth Managed-care Provider – an MCO, Accountable Care Partnership Plan, Primary Care ACO, or the Primary Care Clinician Plan.

MCO-administered ACO – a type of ACO with which the MassHealth agency contracts under its ACO program and is administered through an MCO.

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

Member – an individual determined by the MassHealth agency to be eligible for MassHealth.

Modified Adjusted Gross Income (MAGI) – modified adjusted gross income as defined in section 36(B)(d)(2) of the Internal Revenue Code with the following exceptions:

- (1) an amount received as a lump sum only counts as income in the month received;
- (2) scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income;
- (3) certain taxable income received by American Indians and Alaska Natives is excluded from income as described in 42 CFR § 435.603(e).

Navigator – an individual who is certified by the Health Care Connector, to assist an applicant with electronic and paper applications to establish eligibility and enroll in coverage through the Health Care Connector. In addition, a navigator provides outreach and education about insurance options offered through the Health Connector.

Nonqualified Individuals Lawfully Present – see 130 CMR 504.003(A)(3): *Nonqualified Individuals Lawfully Present*.

Nonqualified Person Residing under Color of Law (Nonqualified PRUCOLs) – see 130 CMR 504.003(C): *Nonqualified Persons Residing under Color of Law (Nonqualified PRUCOLs)*.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (8 of 10)

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

Other Noncitizen – see 130 CMR 504.003(D): *Other Noncitizens*.

Parent of a Child Younger than 19 Years Old – natural, adoptive, or stepmother or stepfather of a 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 18 Years of Age or Older.

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

1. can be expected to result in death; or
2. 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: Permanent and Total Disability, an individual 18 years of age 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 Younger than 18 Years Old. The condition of an individual younger than 18 years old 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 of the Social Security Act as in effect on July 1, 1996.

Person with Breast or Cervical Cancer – an individual who has submitted verification that he or she has breast or cervical cancer.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (9 of 10)

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 health insurance coverage for certain MassHealth members who meet the criteria in 130 CMR 506.012: *Premium Assistance Payments*.

Premium Billing Family Group (PBFG) – a group of persons who live together.

- (1) The group can be an individual, a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts, or a family.
- (2) Two parents are members of the same premium billing family group if they are mutually responsible for one or more children who live with them.
- (3) A family making up a PBFG may consist of
 - (a) a child or children younger than 19 years old, any of their children, and their parents. A child who is absent from the home to attend school is considered as living in the home;
 - (b) siblings younger than 19 years old and any of their children who live together even if no adult parent or caretaker relative is living in the home; or
 - (c) a child or children younger than 19 years old, any of their children, and their caretaker relative when no parent is living in the home.

Premium Tax Credit (PTC) – payment made pursuant to 26 U.S. C. § 36B on behalf of an eligible individual to reduce the costs of a health benefit plan premium to the individual.

Primary Care ACO – a type of ACO with which the MassHealth agency contracts under its ACO program.

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*.

Protected Noncitizens – see 130 CMR 504.003(B): *Protected Noncitizens*.

Provisional Eligibility – approval for MassHealth benefits when an applicant's certain self-attested circumstances show eligibility for MassHealth benefits but further verification is required for continued eligibility. (See 130 CMR 502.003: *Verification of Eligibility Factors*.)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.001 (10 of 10)

Qualified Noncitizens – see 130 CMR 504.003(A)(1): *Qualified Noncitizens*.

Qualified Noncitizens Barred – see 130 CMR 504.003(A)(2): *Qualified Noncitizens Barred*.

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

Qualified Health Plan (QHP) – a health plan licensed under M.G.L. c. 175, 176A, 176B, or 176G that has received the Commonwealth Health Insurance Connector’s Seal of Approval as meeting the criteria under 45 CFR §155.1000 and is offered through the Health Connector in accordance with the provisions of 45 CFR §155.1010.

Redetermination – a review of a member's circumstances to establish whether he or she remains eligible for benefits.

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 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.

Sibling – natural (full or half-blood), adoptive, or stepbrother or stepsister.

Spouse – a person married to the applicant or member according to the laws of the Commonwealth of Massachusetts.

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.002

Tax Dependent – a qualifying child or qualifying relative, other than the taxpayer or spouse, who entitles the taxpayer to claim a dependency exemption. An individual who files a return but is claimed as a dependent by someone else is still a tax dependent.

Tax Filer – any individual, including his or her spouse if married filing jointly, who intends to file a federal tax return for the year in which a member of the tax household is seeking or receives benefits and who claims an exemption for himself or herself. An individual who files a return but is claimed as a dependent by someone else is still a tax dependent.

Tax Household – all members who are claimed on the tax return, including the tax filer(s) and all dependents.

Third-party – any person, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

Young Adult – an individual 19 or 20 years old.

501.002: Introduction to MassHealth

(A) The MassHealth agency is responsible for the administration and delivery of MassHealth services to eligible low- and moderate-income individuals, couples, and families.

(B) 130 CMR 501.000 through 508.000 provide the MassHealth requirements for children, young adults, parents and caretaker relatives, adults, pregnant women, disabled persons, persons who are HIV positive, individuals with breast or cervical cancer, and certain other individuals or couples who are younger than 65 years old and not institutionalized. These requirements are prescribed in accordance with all applicable laws, including Title XIX and Title XXI of the Social Security Act, and MassHealth's 1115 Medicaid Research and Demonstration Waiver.

(C) 130 CMR 515.000: *MassHealth: General Policies* through 130 CMR 522.000: *MassHealth: Other Division Programs* provide the MassHealth requirements for persons who are institutionalized, 65 years of age or older, or who would be institutionalized without community-based services in accordance with all applicable laws, including Title XIX of the Social Security Act.

(D) The MassHealth agency will determine eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003 and as described in federal regulations at 20 CFR Part 418.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.003

501.003: MassHealth Coverage Types

(A) The MassHealth agency provides access to health care by determining eligibility for the coverage type that provides the most comprehensive benefits for an individual who may be eligible.

(B) MassHealth offers several coverage types: Standard, CommonHealth, CarePlus, Family Assistance, Small Business Employee Premium Assistance, and Limited. The coverage type for which a person is eligible is determined based on the individual's income and circumstances, as described in 130 CMR 503.000: *Health Care Reform: MassHealth: Universal Eligibility Requirements* through 505.000: *Health Care Reform: MassHealth: Coverage Types*, and immigration status, as described in 130 CMR 504.000: *Health Care Reform: MassHealth: Citizenship and Immigration*.

(C) The MassHealth agency may limit the number of people who can be enrolled in MassHealth Family Assistance. When the MassHealth agency imposes such a limit, no new adult applicants (21 years of age or older) subject to these limitations will be added to MassHealth Family Assistance, and current adult members in these coverage types who have lost eligibility for more than 30 days for any reason will not be allowed to reenroll until the MassHealth agency is able to reopen enrollment for adults in MassHealth Family Assistance.

501.004: Administration of MassHealth

(A) MassHealth. The MassHealth agency formulates requirements and determines eligibility for all MassHealth coverage types.

(B) Other Agencies.

(1) Department of Transitional Assistance (DTA).

(a) The Department of Transitional Assistance administers the Transitional Aid to Families with Dependent Children (TAFDC) Program. Persons who meet the requirements of section 1931 of Title XIX (42 U.S.C. § 1396u-1) are automatically eligible for MassHealth Standard coverage.

(b) DTA also administers the Emergency Aid to the Elderly, Disabled and Children (EAEDC) Program. MassHealth provides coverage to those persons receiving EAEDC cash assistance as follows:

1. MassHealth Standard: children younger than 19 years old, young adults 19 and 20 years old who are citizens, qualified noncitizens, qualified noncitizens barred, and nonqualified individuals lawfully present, and parents and caretakers who are citizens or qualified noncitizens;
2. Mass Health CarePlus: adults 21 through 64 years of age who are citizens or qualified noncitizens; and

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.005

3. MassHealth Family Assistance: children younger than 19 years old, young adults 19 and 20 years of age who are nonqualified persons living under color of law (PRUCOLs), parents and caretakers who are qualified noncitizens barred, nonqualified individuals lawfully present, nonqualified PRUCOLs, and adults 21 through 64 years of age who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs.

(2) Social Security Administration (SSA). The Social Security Administration administers the Supplemental Security Income (SSI) program and determines the eligibility of disabled individuals. Individuals receiving SSI are automatically eligible for MassHealth Standard coverage. Individuals without health insurance are provided choices of enrollment in a MassHealth managed care provider, SCO, or ICO in accordance with 130 CMR 508.001 through 508.013.

(3) Health Connector. The Health Connector is Massachusetts's health insurance marketplace where individuals, families, and small businesses can shop among qualified health insurance carriers and choose a health insurance plan. The Health Connector administers Qualified Health Plans (QHP), premium tax credits (PTC), and the ConnectorCare program. The single, streamlined application is used to determine eligibility for both Health Connector and MassHealth programs as described in 130 CMR 502.000: *Health Care Reform: MassHealth: The Eligibility Process*. The Health Connector and MassHealth also coordinate eligibility notices and eligibility appeals.

501.005: Individuals and Families Eligible for or Receiving Medical Assistance on June 30, 1997

(A) Members Who Were Not Subject to a Deductible.

(1) Individuals and families (including caretaker relatives) who were receiving Medical Assistance on June 30, 1997, and whose family group gross income on June 30, 1997, exceeded MassHealth eligibility standards will be provided MassHealth Standard coverage for one year after the date of MassHealth implementation, except in the following circumstances:

- (a) the individual or family no longer lives in Massachusetts;
- (b) the individual enters an institution;
- (c) the individual turns 65 years old;
- (d) the individual or all members of the family are deceased; or
- (e) the individual or family is no longer categorically eligible.

(2) Eligibility for continuing coverage will be reviewed toward the end of this one-year period.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.006

(B) Families Who Have Met a Deductible.

(1) Families (including caretaker relatives) with children younger than 18 years old who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who were denied with a deductible before July 1, 1997, and subsequently meet a deductible on or after July 1, 1997, and whose family group gross income exceeds MassHealth standards will be eligible for MassHealth Standard for one year from the end of the deductible period, except in the following circumstances:

- (a) the individual or family no longer lives in Massachusetts;
- (b) the individual enters an institution;
- (c) the individual turns 65 years old;
- (d) the individual or all members of the family are deceased; or
- (e) the individual or family is no longer categorically eligible.

(2) A determination of eligibility for MassHealth will be made toward the end of the one-year period.

(C) Disabled Individuals Who Have Met a Deductible. Disabled individuals who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who meet a deductible on or after July 1, 1997, will have their continuing eligibility for MassHealth determined in accordance with 130 CMR 506.009: *The One-time Deductible*.

501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998

(A) Eligibility.

(1) Children who were receiving benefits under the Children's Medical Security Plan on August 3, 1998, as well as any siblings in their family, will be treated as a protected status group under MassHealth if they

- (a) have submitted a complete application (formerly known as Medical Benefit Request) as defined in 130 CMR 502.001: *Application for Benefits* by March 31, 1999;
- (b) meet the eligibility requirements of MassHealth; and
- (c) have an income less than or equal to 200 % of the FPL.

(2) Families of children described in 130 CMR 501.006(A)(1) who are determined eligible for MassHealth Family Assistance will have the option of choosing purchase of medical benefits or premium assistance under MassHealth Family Assistance if the MassHealth agency determines the child has access to health insurance from an employer other than the Commonwealth of Massachusetts.

(B) Loss of Protected Status. The protected status of a child described in 130 CMR 501.006(A) will end in the following circumstances:

- (1) the income exceeds 200% of the FPL;
- (2) the family fails to cooperate with the MassHealth eligibility review; or
- (3) the child no longer meets MassHealth requirements.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.007

501.007: Receiving Public Assistance from Another State

Persons who are receiving public assistance from another state are not eligible for MassHealth.

(130 CMR 501.008 Reserved)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.009

501.009: Rights of Applicants and Members

The policies of the MassHealth agency are administered in accordance with federal and state law. Applicants and members must be informed of their rights and responsibilities with respect to MassHealth.

(A) Right to Nondiscrimination and Equal Treatment. The MassHealth agency complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, creed, sexual orientation, or sex (including gender identity and gender stereotyping). A compliance coordinator is designated to administer grievance procedures for discrimination complaints.

(B) Right to Confidentiality. The confidentiality of information obtained by the MassHealth agency during the MassHealth eligibility process is protected in accordance with federal and state regulations. The use and disclosure of information concerning applicants, members, and legally liable third parties is restricted to purposes directly connected with the administration of MassHealth as governed by state and federal law.

(C) Right to Timely Provision of Benefits. Eligible applicants and members have the right to the timely provision of benefits, as defined in 130 CMR 502.000: *Health Care Reform: MassHealth: The Eligibility Process*.

(D) Right to Information. Persons who inquire about MassHealth, either orally or through a written request, have the right to receive information about medical benefits, coverage type requirements, and their rights and responsibilities as applicants and members of MassHealth.

(E) Right to Apply. Any person, individually or through an authorized representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.

(F) Right to Be Assisted by Others.

- (1) The applicant or member has the right to be accompanied by any individual of their choice and the right to be represented by an appeal representative as defined in 130 CMR 610.004: *Definitions* during the appeal process.
- (2) An application for MassHealth may be filed by an authorized representative as described in the definition of authorized representative in 130 CMR 501.001: *Definition of Terms*.
- (3) An appeal of a MassHealth decision, including one brought on behalf of a deceased person, may be filed by an appeal representative if such appeal representative meets the requirements in 130 CMR 610.016: *Appeal Representative*.
- (4) The extent of the authorized representative's and appeal representative's authority to act on behalf of the applicant or member is determined by the applicant or member's delegation of authority, applicable law, or underlying legal document.

(G) Right to Inspect the MassHealth Case File. The applicant or member has the right to inspect information in his or her MassHealth case file and contest the accuracy of the information. The case file may include electronic records used to determine eligibility.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.010

(H) Right to Appeal. The applicant or member has the right to appeal and request a fair hearing as the result of any adverse action or inaction taken by the MassHealth agency. The request will not be granted if the sole issue is a federal or state law requiring an automatic change adversely affecting members.

(I) Right to Interpreter Services. The MassHealth agency provides free aids and services to applicants and members with a disability or limited English proficiency, such as qualified interpreters and written information in other formats or languages, in accordance with the requirements of federal and state law.

501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the MassHealth agency in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery and obtaining or maintaining available health insurance. The MassHealth agency may request corroborative information necessary to maintain eligibility, including obtaining or maintaining available health insurance. The applicant or member must supply such information within 30 days of the receipt of the agency's request. If the member does not cooperate, MassHealth benefits may be terminated.

(B) Responsibility to Report Changes. The applicant or member must report to the MassHealth agency, within ten days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division periodically conducts an independent review of eligibility factors in a sampling of case files. When a case file is selected for review, the member must cooperate with the representative of Quality Control. Cooperation includes, but is not limited to, a personal interview and the furnishing of requested information. If the member does not cooperate, MassHealth benefits may be terminated.

501.011: Referrals to Investigative Units

Intentional false statements or fraudulent acts made in connection with obtaining medical benefits or payments under MassHealth are punishable under M.G.L. c. 118E, § 39 by fines, imprisonment, or both. In all cases of suspected fraud, MassHealth agency staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.012

501.012: Recovery of Overpayment of Medical Benefits

The MassHealth agency has the right to recover payment for medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 501.012: *Recovery of Overpayment of Medical Benefits* will limit the MassHealth agency's right to recover overpayments.

501.013: Estate Recovery

(A) Introduction.

- (1) The MassHealth agency will recover the amount of payment for medical benefits correctly paid from the estate of a deceased member. Recovery is limited to payment for all services provided while the member was 55 years of age or older.
- (2) The estate includes all real and personal property and other assets in the member's probate estate.
- (3) Notwithstanding 130 CMR 501.013(A)(1) and in accordance with 42 U.S.C. 1396p(b)(B), the MassHealth agency will not recover Medicare cost-sharing benefits described at 42 U.S.C. 1396(a)(10)(E) with dates of payment on or after January 1, 2010, for persons who received such benefits under 130 CMR 505.002: *MassHealth Standard*, 505.007: *MassHealth Senior Buy-in and Buy-in*, 519.010: *MassHealth Senior Buy-in*, and 519.011: *MassHealth Buy-in*.
 - (a) The date of payment for Medicare cost-sharing deductibles, coinsurance, and copayments is the date the MassHealth agency received the claim.
 - (b) The date of payment for premium payments is the date the MassHealth agency paid the premium.
- (4) Effective for dates of death on or after December 31, 2016, MassHealth will offset the estate recovery claim by the total of any premiums paid to the MassHealth agency on behalf of the member when the member was 55 years of age or older.

(B) Deferral of Estate Recovery. Recovery will not be required until after the death of a surviving spouse, if any, or while there is a surviving child who is younger than 21 years old, or a child of any age who is blind or permanently and totally disabled.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.013 (1 of 2)

(C) Waiver of Estate Recovery Due to Financial Hardship. For claims presented on or after November 15, 2003, recovery will be waived if

- (1) a sale of real property would be required to satisfy a claim against the member's probate estate; and
- (2) an individual who was using the property as a principal place of residence on the date of the member's death meets all of the following conditions:
 - (a) the individual lived in the property on a continual basis for at least one year immediately before the now-deceased member became eligible for MassHealth or other assistance from the MassHealth agency and continues to live in the property at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate;
 - (b) the individual has inherited or received an interest in the property from the deceased member's estate as defined in 130 CMR 501.013(A)(2) and 515.011(A)(2);
 - (c) the individual is not being forced to sell the property by other devisees or heirs at law; and
 - (d) at the time the MassHealth agency first presented its claim for recovery against the deceased member's estate, the gross annual income of the individual's family group was less than or equal to 133 % of the applicable federal-poverty-level income standard for the appropriate family size.
- (3) The waiver will be conditional for a period of two years from the date the MassHealth agency mails notice that the waiver requirements have been met, or from the date that a court of competent jurisdiction determines that the waiver requirements have been met. If at the end of that period, all circumstances and conditions that must exist for the MassHealth agency to waive recovery still exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), and the real property has not been sold or transferred, the waiver will become permanent and binding. If at any time during the two-year period, the circumstances and conditions for the waiver no longer exist, including meeting the same income standards under 130 CMR 501.013(C)(2)(d), the property is sold or transferred, or the individual does not use the property as their primary residence, the MassHealth agency will be notified and its claim will be payable in full.

(D) Outstanding Claims.

- (1) For claims presented between April 1, 1995, and November 15, 2003, that are still outstanding, recovery will be waived if all requirements under the then-existing MassHealth regulations were met.
- (2) For claims presented before April 1, 1995, a waiver for hardship did not exist.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.013 (2 of 2)

(E) Fair-market Value and Equity Value. If there will be insufficient proceeds from the sale or transfer of the property to satisfy the MassHealth agency's claim in full, the fair-market value and equity value of all real property that is part of the deceased member's estate must be verified prior to the sale or transfer of said property.

(1) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must verify the fair-market value by sending to the MassHealth agency a copy of the most recent tax bill or the property tax assessment that was most recently issued by the taxing jurisdiction, provided that this assessment is not one of the following:

- (a) a special-purpose tax assessment;
- (b) based on a fixed-rate-per-acre method; or
- (c) based on an assessment ratio or providing only a range.

(2) The executor or administrator of the probate estate or, in the case of real property that passes outside the probate estate, the person or entity to whom legal title or interest passed, must also provide a comparable market analysis or a written appraisal of the property value from a knowledgeable source. A knowledgeable source includes one of the following: a licensed real-estate agent or broker, a real-estate appraiser, or an official of a bank, savings and loan association, or similar lending organization. The knowledgeable source must not have any real or apparent conflict-of-interest relationship with the estate.

(3) The MassHealth agency may also obtain an assessment from a knowledgeable source.

(F) Waiver of Estate Recovery Due to Hardship for American Indians and Alaska Natives.

(1) For claims presented on or after July 1, 2009, recovery from the following American Indian and Alaska Natives income, resources, and property will be waived:

- (a) certain income and resources (such as interests in and income derived from tribal land and other resources currently held in trust status and judgment funds from the Indian Claims Commission and the U.S. Claims Court) that are exempt from Medicaid estate recovery by other laws and regulations;
- (b) ownership interest in trust and non-trust property, including real property and improvements

- 1. located on a reservation (any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments) or near a reservation as designated and approved by the Bureau of Indian Affairs of the U.S. Department of the Interior; or
- 2. for any federally recognized tribe not described in 130 CMR 501.013(F)(1)(b)1., located within the most recent boundaries of a prior federal reservation;

(c) income left as a remainder in an estate derived from property protected in 130 CMR 501.013(F)(1)(b), that was either collected by an Indian or by a tribe or tribal organization and distributed to Indians, as long as the individual can clearly trace it as coming from protected property;

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.014

(d) ownership interests left as a remainder in an estate in rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, or fish products, resulting from the exercise of federally protected rights and income either collected by an Indian or by a tribe or tribal organization and distributed to Indians derived from these sources as long as the individual can clearly trace it as coming from protected sources; or

(e) ownership interests in or usage rights to items not covered by 130 CMR 501.013(F)(1)(a) through (d) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional life style according to applicable tribal law or custom.

(2) Protection of non-trust property described in 130 CMR 501.013(F)(1) is limited to circumstances when it passes from an Indian, as defined in § 4 of the Indian Health Care Improvement Act, to one or more relatives (by blood, adoption, or marriage), including Indians not enrolled as members of a tribe and non-Indians, such as spouses or step-children, that their culture would nevertheless protect as family members, to a tribe or tribal organization, or to one or more Indians.

501.014: Voter Registration

(A) Voter registration forms are available through the MassHealth agency to applicants and members who are

- (1) U.S. citizens; and
- (2) 18 years of age or older, or who will be 18 years old on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members are

- (1) informed of the availability of voter registration forms at application, at the time of an eligibility review, and when there is an address change;
- (2) offered assistance in completing the voter registration form unless such assistance is refused; and
- (3) able to submit voter registration forms to the MassHealth agency for transmittal to the proper election offices.

(C) MassHealth agency staff must not

- (1) seek to influence an applicant's or member's political preference or party registration;
- (2) display any political preference or party allegiance to the applicant or member;
- (3) make any statement to an applicant or member or take any action intended to influence the applicant's or member's decision regarding voter registration; or
- (4) make any statement to an applicant or member or take any action intended to lead the applicant or member to believe that the decision to register or not has any bearing on the availability of services or benefits.

(D) Completed voter registration forms that are submitted to the MassHealth agency are transmitted to the proper local election office for processing within five days of receipt.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: GENERAL POLICIES

Chapter 501
Page 501.015

501.015: Reimbursement of Certain Out-of-pocket Medical Expenses

(A) Eligibility Requirements. The following persons shall be entitled to reimbursement for certain medical expenses for which they paid, subject to the provisions of 130 CMR 501.015.

- (1) A member who
 - (a) applied for SSI;
 - (b) was denied SSI benefits by the Social Security Administration; and
 - (c) had his or her initial Social Security Administration denial overturned through a reconsideration process, administrative hearing, appeals counsel review, federal court review, or reopening under the Social Security Administration rules on administrative finality.
- (2) A member who
 - (a) applied for TAFDC or MassHealth;
 - (b) was denied TAFDC by the Department of Transitional Assistance, or was denied MassHealth by the MassHealth agency; and
 - (c) had his or her initial denial overturned by a subsequent decision by DTA, the MassHealth agency, the fair hearing process, or the judicial review process.

(B) Limitations.

- (1) Reimbursement is limited to bills incurred on or after the coverage start date for the applicable coverage type as described in 130 CMR 505.001: *Introduction* through 505.009: *MassHealth Small Business Employee Premium Assistance*, and paid between the date of the erroneous eligibility decision and the date on which the member is notified of MassHealth eligibility. The bill must have been paid by the member, the member's spouse, the parent of a member, or a legal guardian.
- (2) Reimbursement is also limited to amounts actually paid for care or services that would have been covered under MassHealth had eligibility been determined correctly, even if these amounts exceed the MassHealth rate. Before reimbursing a member for care or services that would have required prior authorization, the MassHealth agency may require submission of medical evidence for consideration under the prior-authorization standards. Reimbursement is available even though the medical care or services were furnished by a provider who does not participate in MassHealth.

(C) Verification.

- (1) Applicants or members seeking reimbursement must provide MassHealth with
 - (a) a bill for medical services that includes
 1. the provider's name;
 2. a description of the services provided; and
 3. the date the service was provided; and
 - (b) proof of payment of the bill presented, such as a canceled check or receipt.
- (2) Recipients of SSI must also provide documents from the Social Security Administration establishing the date of application and the date of application denial.

REGULATORY AUTHORITY

130 CMR 501.000: M.G.L. c. 118E, §§ 7 and 12.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.000

TABLE OF CONTENTS

Section

- 508.001: MassHealth Member Participation in Managed Care
- 508.002: MassHealth Members Excluded from Participation in Managed Care
- 508.003: Enrollment with a MassHealth Managed Care Provider
- 508.004: Managed Care Organizations (MCOs)
- 508.005: MassHealth Primary Care Clinician Plan (PCC Plan)
- 508.006: Accountable Care Organizations (ACOs)
- 508.007: Integrated Care Organizations
- 508.008: Senior Care Organizations
- 508.009: Behavioral Health Contractor
- 508.010: Right to a Fair Hearing
- 508.011: Timely Notice of Appealable Actions
- 508.012: Time Limits for Resolving Internal Appeals
- 508.013: Timely Notice of Internal Appeal Decisions

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.001

508.001: MassHealth Member Participation in Managed Care

(A) Mandatory Enrollment with a MassHealth Managed Care Provider. MassHealth members who are younger than 65 years old must enroll in a MassHealth managed care provider available for their coverage type. Members described in 130 CMR 508.001(B) or who are excluded from participation in a MassHealth managed care provider pursuant to 130 CMR 508.002(A) are not required to enroll with a MassHealth managed care provider.

(B) Voluntary Enrollment in a MassHealth Managed Care Provider. The following MassHealth members who are younger than 65 years old may, but are not required to, enroll with a MassHealth managed care provider available for their coverage type:

- (1) MassHealth members who are receiving services from DCF or DYS;
- (2) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program*. Such members may choose to receive all services on a fee-for-service basis;
- (3) MassHealth members who are enrolled in a home- and community-based services waiver. Such members may choose to receive all services on a fee-for-service basis; or
- (4) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance*. Such members may choose to receive all services on a fee-for-service basis.

(C) Senior Care Organizations (SCO). MassHealth members who are 65 years of age or older may enroll in a SCO pursuant to 130 CMR 508.008(A).

(D) Integrated Care Organizations (ICO). MassHealth members who are 21 through 64 years of age at time of enrollment may enroll in an ICO pursuant to 130 CMR 508.007(A).

(E) MassHealth Behavioral Health Contractor.

- (1) MassHealth Standard and CommonHealth members who are younger than 21 years old and who are excluded from participation with a MassHealth managed care provider under 130 CMR 508.002(A)(1) or (2) must enroll with the MassHealth behavioral health contractor.
- (2) MassHealth members who are receiving services from DCF or DYS and who do not choose to enroll with a MassHealth managed care provider must enroll with the MassHealth behavioral health contractor.
- (3) MassHealth members who are enrolled in the Kaileigh Mulligan Program, described in 130 CMR 519.007(A): *The Kaileigh Mulligan Program* and who do not choose to enroll with or a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

Trans. by E.L. 225

Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508

Page 508.002 (1 of 2)

(4) MassHealth members who participate in one of the Money Follows the Person home- and community-based services waiver who are not enrolled with a MassHealth managed care provider or not otherwise enrolled with the behavioral health contractor must enroll with the behavioral health contractor.

(5) MassHealth members who are receiving Title IV-E adoption assistance as described at 130 CMR 522.003: *Adoption Assistance and Foster Care Maintenance* and who do not choose to enroll with a MassHealth managed care provider are enrolled with the MassHealth behavioral health contractor. Such members may choose to receive all services on a fee-for-service basis.

508.002: MassHealth Members Excluded from Participation in Managed Care

(A) MassHealth Managed Care Provider. The following MassHealth members are excluded from participation with a MassHealth managed care provider:

- (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 65 years of age or older. Such member may voluntarily enroll in a senior care organization (SCO) in accordance with the requirements at 130 CMR 508.008(A);
- (4) a member in a nursing facility, chronic disease or rehabilitation hospital, intermediate care facility for individuals with intellectual disabilities (ICF/ID), or a state psychiatric hospital for other than a short-term rehabilitative stay;
- (5) a member who is eligible solely for
 - (a) MassHealth Limited; or
 - (b) Children's Medical Security Plan (CMSP);
- (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 on a fee-for-service basis, or who is terminally ill as documented by a medical prognosis of a life expectancy of six months or less; and
- (8) a member who has presumptive eligibility.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.002 (2 of 2)

(B) SCO. The following MassHealth members 65 years of age 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/ID;
- (4) a member who is not eligible for MassHealth Standard;
- (5) a member who has presumptive 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*.

(C) ICO. The following MassHealth members 21 through 64 years of age 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 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 in an ICF/ID;
- (3) a member who is not eligible for MassHealth Standard or CommonHealth;
- (4) a member who has presumptive 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*.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.003 (1 of 4)

508.003 Enrollment with a MassHealth Managed Care Provider

(A) Member Selection.

(1) In accordance with 130 CMR 508.004 through 508.006, members required or permitted to select a MassHealth managed care provider may select any MassHealth managed care provider from the MassHealth agency's list of MassHealth managed care providers for the member's coverage type in the member's service area, if the provider is able to accept new members.

(2) A member who seeks to enroll with a managed care provider outside of the member's service area must submit a request in writing to the MassHealth agency on forms provided by the MassHealth agency. The MassHealth agency may grant such a request if the out-of-area MassHealth managed care provider is in a service area contiguous to the member's service area and the MassHealth agency determines that:

- (a) The out-of-area MassHealth managed care provider is in a service area contiguous to the member's service area; and
- (b) The MassHealth agency determines either of the following:
 - 1. the member seeks a specific provider who is in the network of the out-of-area MassHealth managed care provider, such requested provider is not in the network of a MassHealth managed care provider in the member's service area, and the travel time or distance to such requested provider is equal to or less than the travel time to, as determined by the MassHealth agency, a comparable provider in the network of a MassHealth managed care provider in the member's service area, or
 - 2. the medical benefit of receiving care from a MassHealth managed care provider in the member's service area is substantially outweighed, as determined by the MassHealth agency, by the medical benefit of receiving care from the out-of-area MassHealth managed care provider requested by the member.

(B) Member Assignment to a MassHealth Managed Care Provider. If a member does not choose a MassHealth managed care provider within the time period specified by the MassHealth agency in a notice to the member or in other circumstances determined appropriate by the MassHealth agency and consistent with applicable laws, the MassHealth agency assigns the member to an available MassHealth managed care provider.

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

- (a) available for the member's coverage type;
- (b) in the member's service area as described in 130 CMR 508.004(A)(1), 130 CMR 508.005(A)(1), 508.006(A)(1)(a), 508.006(B)(1)(a), as applicable;
- (c) physically accessible to the member, if the member is disabled;
- (d) suitable for the member's age and sex (for example, the member is the appropriate age for a pediatrician); and
- (e) located in an area to which the member has available and affordable transportation.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.003 (2 of 4)

(2) If the MassHealth agency determines that no MassHealth managed care provider meeting the criteria of 130 CMR 508.003(B)(1) is available in the member's service area:

(a) The member may

1. choose not to enroll with a MassHealth managed care provider as long as such circumstances prevail; or
2. select an available MassHealth managed care provider outside of the member's service area.

(b) Any MassHealth Standard member who is not enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.003(B)(2)(a)1. must obtain any behavioral health services through the MassHealth behavioral health contractor. All other services for which the member is eligible may be obtained through any qualified participating MassHealth provider.

(c) If, after a determination by the MassHealth agency under 130 CMR 508.003(B)(2), the MassHealth agency determines that a MassHealth managed care provider meeting the criteria of 130 CMR 508.003(B)(1) has become available, the member must enroll with such a provider, unless the member is otherwise enrolled with a MassHealth managed care provider pursuant to 130 CMR 508.003(B)(2)(a)2.

(3) Notification. The MassHealth agency will notify a member in writing of the name and applicable contact information of the member's MCO, Accountable Care Partnership Plan, Primary Care ACO, or PCC, and the effective date of the member's enrollment with the MassHealth managed care provider.

(C) Member Choice to Transfer or Disenroll from a MassHealth Managed Care Provider. Members enrolled with a MassHealth managed care provider may transfer to another available MassHealth managed care provider as provided in this section.

(1) Members enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO may transfer to another available MassHealth managed care provider for any reason during a plan selection period.

(a) For members newly enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO, except for members reenrolled in accordance with 130 CMR 508.003(E), the plan selection period occurs during the first 90 days of the member's enrollment with the MCO, Accountable Care Partnership Plan, or Primary Care ACO.

(b) For all other members, the plan selection period will be a 90-day period that occurs annually.

(c) The MassHealth agency may designate additional plan selection periods at its discretion.

(2) Except as set forth in 130 CMR 508.003(C)(3), a member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO must remain enrolled with the MCO, Accountable Care Partnership Plan, or Primary Care ACO for the fixed enrollment period. For all members, the fixed enrollment period is the period of time when a member is not in a plan selection period. The MassHealth agency will notify members in writing of their disenrollment rights at least annually.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.003 (3 of 4)

- (a) Members enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(1) or who is below one year in age do not have a fixed enrollment period.
- (b) Members voluntarily enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(2) through (4) may disenroll from their MCO, Accountable Care Partnership Plan, or Primary Care ACO at any time. Such members may be enrolled with the behavioral health contractor pursuant to 130 CMR 508.001(E). Members voluntarily enrolled in an MCO, Accountable Care Partnership Plan, or Primary Care ACO pursuant to 130 CMR 508.001(B)(2) through (4) may transfer to another MassHealth managed care provider only in accordance with this 130 CMR 508.003(C).
- (3) During fixed enrollment, a member may only request a transfer out of the member's current MCO, Accountable Care Partnership Plan, or Primary Care ACO for the reasons listed in this 130 CMR 508.003(C)(3).
 - (a) The following reasons defined as cause for disenrollment in 42 CFR 438.56(d)(2):
 - 1. the member moves such that the member's MCO, Accountable Care Partnership Plan, or Primary Care ACO is not available in the member's new service area;
 - 2. the MCO, Accountable Care Partnership Plan, or Primary Care ACO does not, because of moral or religious objections, cover the service the member seeks;
 - 3. the member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk; or
 - 4. other reasons, including but not limited to, poor quality of care, lack of access to services covered, or lack of access to providers experienced in dealing with the member's health-care needs.
 - (b) the MCO or Accountable Care Partnership Plan is no longer contracted with the MassHealth agency to cover the member's service area, or a PCP that participates in the member's Primary Care ACO is not available in the member's service area;
 - (c) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO has not provided access to providers that meet the member's health care needs over time, even after member's request for assistance;
 - (d) the member is homeless, the MassHealth agency's records indicate the member is homeless, and the MCO, Accountable Care Partnership Plan, or Primary Care ACO cannot accommodate the geographic needs of the member;
 - (e) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO substantially violated a material provision of its contract with MassHealth agency;

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.003 (4 of 4)

- (f) the MassHealth agency imposes a sanction on the MCO, Accountable Care Partnership Plan, or Primary Care ACO that specifically allows for members to disenroll from the MCO, Accountable Care Partnership Plan, or Primary Care ACO without cause;
- (g) the member adequately demonstrates to the MassHealth agency that the MCO, Accountable Care Partnership Plan, or Primary Care ACO is not meeting the member's language, communication, or other accessibility needs or preferences; or
- (h) the member adequately demonstrates to the MassHealth agency that the member's key network providers, including PCPs, specialists, or behavioral health providers, leave the MCO, Accountable Care Partnership Plan, or Primary Care ACO network.

(4) The MassHealth agency will determine if the requirements needed for a member transfer pursuant to 130 CMR 508.003(C)(3) have been met within 30 days of MassHealth's receipt of the request. The MassHealth agency's determination is a ground for appeal in accordance with 130 CMR 610.032(A).

(5) Members enrolled in the PCC Plan may transfer from the PCC Plan to another available MassHealth managed care provider at any time.

(D) Other Disenrollment of Member from a MassHealth Managed Care Provider.

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

(2) The MassHealth agency may disenroll a member from a PCC's panel or a Primary Care ACO's Participating PCP's panel, at the PCC's or PCP's request, if the PCC or PCP demonstrates to the MassHealth agency's satisfaction that

- (a) there is a pattern of noncompliant or disruptive behavior by the member that is not the result of the member's special needs;
- (b) the continued enrollment of the member with the provider seriously impairs the provider's ability to furnish services to either this particular member or other members; or
- (c) the PCC or PCP is unable to meet the medical needs of the member.

(3) If the MassHealth agency approves a request for disenrollment under this 130 CMR 508.003(D)(1), (2)(a), or (2)(b), it will state the good cause basis for disenrollment in a notice to the member in accordance with 130 CMR 610.032(A)(10).

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.004 (1 of 2)

(E) Reenrollment. Any member enrolled with a MassHealth managed care provider who loses and then regains managed care eligibility may be automatically reenrolled with the MassHealth managed care provider with which the member was most recently enrolled, if such MassHealth managed care provider is available for the member's coverage type and service area.

(1) A member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO who loses managed care eligibility during a plan selection period will receive a new plan selection period upon regaining eligibility.

(2) A member enrolled with an MCO, Accountable Care Partnership Plan, or Primary Care ACO who loses managed care eligibility during the fixed enrollment period will not receive a new plan selection period upon regaining managed care eligibility; provided, however, that if a member's loss of managed care eligibility causes the member to miss part or all of the member's annual plan selection period, the member will receive a new plan selection period upon regaining managed care eligibility.

508.004: Managed Care Organizations (MCOs)

(A) Enrollment in an MCO.

(1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. The MassHealth agency makes available to the member a list of the MCOs in the member's service area. The list of MCOs that the MassHealth agency will make available to members will include those MCOs that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.

(2) MassHealth members are assigned to MCOs, may transfer from MCOs, may be disenrolled from MCOs, and may be re-enrolled in MCOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(B) Obtaining Services when Enrolled in an MCO.

(1) Primary Care Services. When the member selects or is assigned to an MCO, that MCO will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services. An MCO may provide a member's primary care through an MCO-administered ACO.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.004 (2 of 2)

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

(3) Behavioral Health Services. Members who enroll in an MCO receive behavioral health services through that MCO. All behavioral health services to members enrolled in an MCO, except those services not covered under the MassHealth contract with the MCO, are subject to the authorization and referral requirements of the MCO. Members enrolled with an MCO should contact their MCO for information about covered services, authorization requirements, and referral requirements.

(4) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of “Indians” as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. Such Indian health care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Copayments. Members who are enrolled in MCOs must make copayments in accordance with the MCO’s MassHealth copayment policy. Those MCO copayment policies must

(1) be approved by MassHealth;

(2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;

(3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and

(4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.005

508.005: MassHealth Primary Care Clinician Plan (PCC Plan)

(A) Enrollment in the PCC Plan.

(1) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. To enroll in the PCC Plan, the member must select the PCC Plan and an available primary care clinician (PCC). The MassHealth agency makes available to the member a list of the PCCs in the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency. The list of PCCs that the MassHealth agency will make available to members may include those approved as a PCC by MassHealth in accordance with 130 CMR 450.118: *Primary Care Clinician (PCC) Plan* and who practices within the member's service area.

(2) MassHealth members are assigned to the PCC Plan, may transfer from the PCC Plan, may be disenrolled from a PCC's panel, and may be re-enrolled in the PCC Plan as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(B) Obtaining Services when Enrolled with the PCC Plan.

(1) Primary Care. When the member selects or is assigned to the PCC Plan, the member's selected or assigned PCC will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.

(2) Other Medical Services. All medical services, except those services listed in 130 CMR 450.118(J): *Referral for Services*, require a referral or authorization from the member's PCC. MassHealth members enrolled in the PCC Plan may receive those services listed in 130 CMR 450.118(J), for which they are otherwise eligible, without a referral from their PCC.

(3) Behavioral Health Services. All members enrolled with the PCC Plan receive behavioral health (mental health and substance use disorder) services, except those services not covered under the MassHealth contract with the behavioral health contractor, through the MassHealth behavioral health contractor. Such behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.

(4) Emergency Services. Members enrolled with the PCC Plan may obtain emergency services, including emergency behavioral health services, from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.006 (1 of 3)

(5) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of “Indians” as defined at 42 U.S.C. 1396u-2) or Alaska Natives may choose to receive covered services from an Indian health care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(C) Copayments. MassHealth requires MassHealth members enrolled in the PCC Plan to make the copayments described in 130 CMR 506.014 through 506.018 and 520.036 through 520.040. If the usual and customary fee for the service is less than the copayment amount, the member must pay the amount of the service. Members enrolled in the MassHealth behavioral health contractor must make copayments in accordance with the MassHealth behavioral health contractor’s MassHealth copayment policy. Those MassHealth behavioral health contractor copayment policies must

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.006: Accountable Care Organizations

(A) Accountable Care Partnership Plans.

(1) Enrollment in an Accountable Care Partnership Plan.

(a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. The MassHealth agency makes available to the member a list of Accountable Care Partnership Plans in the member's service area. The list of Accountable Care Partnership Plans that the MassHealth agency will make available to members will include those Accountable Care Partnership Plans that contract with the MassHealth agency to serve the coverage type for which the member is eligible and provide services within the member's service area. The member's service area is determined by the MassHealth agency based on zip codes or geographic area. Service area listings may be obtained from the MassHealth agency.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.006 (2 of 3)

(b) MassHealth members are assigned to Accountable Care Partnership Plans, may transfer from Accountable Care Partnership Plans, may be disenrolled from Accountable Care Partnership Plans, and may be re-enrolled in Accountable Care Partnership Plans as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(2) Obtaining Services when Enrolled in an Accountable Care Partnership Plan.

(a) Primary Care Services. When the member selects or is assigned to an Accountable Care Partnership Plan, that Accountable Care Partnership Plan will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and determine referral requirements for such necessary medical services.

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

(c) Behavioral Health Services. Members who enroll in an Accountable Care Partnership Plan receive behavioral health services through that Accountable Care Partnership Plan. All behavioral health services to members enrolled in an Accountable Care Partnership Plan, except those services not covered under the MassHealth contract with the Accountable Care Partnership Plan, are subject to the authorization requirements and referral requirements of the Accountable Care Partnership Plan. Members enrolled with an Accountable Care Partnership Plan should contact their Accountable Care Partnership Plan for information about covered services, authorization requirements, and referral requirements.

(d) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives who participate in managed care under MassHealth may choose to receive covered services from an Indian health-care provider. Such Indian health care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.006 (3 of 3)

- (3) Copayments. Members who are enrolled in an Accountable Care Partnership Plan must make copayments in accordance with the Accountable Care Partnership Plan's MassHealth copayment policy. Those Accountable Care Partnership Plan copayment policies must
- (a) be approved by MassHealth;
 - (b) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
 - (c) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
 - (d) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

(B) Primary Care ACOs.

(1) Enrollment in a Primary Care ACO.

- (a) Selection Procedure. When a member becomes eligible for managed care, the MassHealth agency notifies the member of the member's obligation to select a MassHealth managed care provider within the time period specified by the MassHealth agency. To enroll in a Primary Care ACO, the member must select a Primary Care ACO and an available PCP that participates with the Primary Care ACO the member has selected. The MassHealth agency makes available to the member a list of PCPs that are participating with each Primary Care ACO. The list of PCPs that the MassHealth agency will make available to members may include those approved as a PCP in accordance with 130 CMR 450.119: *Primary Care ACOs* and who practices within the member's service area.
- (b) MassHealth members are assigned to Primary Care ACOs, may transfer from Primary Care ACOs, may be disenrolled from Primary Care ACOs, and may be re-enrolled in Primary Care ACOs as described in 130 CMR 508.003(B) through 130 CMR 508.003(E).

(2) Obtaining Services when Enrolled in a Primary Care ACO.

- (a) Primary Care. When the member selects or is assigned to a Primary Care ACO, the member's selected or assigned PCP will deliver the member's primary care, determine if the member needs medical or other specialty care from other providers, and make referrals for such necessary medical services.
- (b) Other Medical Services (excluding Behavioral Health). All medical services, except those services listed in 130 CMR 450.119: *Primary Care ACOs* and those provided by providers in a Primary Care ACO's referral circle, require a referral or authorization from the member's primary care provider. MassHealth members enrolled in a Primary Care ACO may receive those services listed in 130 CMR 450.119, for which they are otherwise eligible, without a referral from their PCP.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.007 (1 of 3)

(c) Behavioral Health Services. All members enrolled with a Primary Care ACO receive behavioral health (mental health and substance use disorder) services, except those services not covered under the MassHealth contract with the behavioral health contractor, through the MassHealth behavioral health contractor as follows:

1. Nonemergency Behavioral Health Services. Behavioral health services, except for emergency services, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.
2. Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

(d) Native Americans and Alaska Natives. Individuals who are Native Americans (within the meaning of "Indians" as defined at 42 U.S.C. 1396u-2) or Alaska Natives may choose to receive covered services from an Indian health care provider. Such Indian health-care providers may participate in MassHealth subject to applicable provisions of 130 CMR 450.000: *Administrative and Billing Regulations*.

(3) Copayments. The MassHealth agency requires MassHealth members enrolled in Primary Care ACOs to make the copayments described in 130 CMR 506.014 through 506.018 and 520.036 through 520.040. If the usual and customary fee for the service is less than the copayment amount, the member must pay the amount of the service. Members enrolled in the MassHealth behavioral health contractor must make copayments in accordance with the MassHealth behavioral health contractor's MassHealth copayment policy. Those MassHealth behavioral health contractor copayment policies must

- (a) be approved by MassHealth;
- (b) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (c) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (d) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.007: Integrated Care Organizations

(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):

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.007 (2 of 3)

- (a) be 21 through 64 years of age 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 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 65 years old and is eligible for MassHealth Standard, he or she may elect to remain in the ICO beyond 65 years of age.

(B) Selection Procedure and Assignment to an ICO.

- (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. 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.
- (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.

(C) Obtaining Services When Enrolled in an ICO. 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.007 (3 of 3)

(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, may 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, if available, 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.

(G) Copayments. Members who are enrolled in an ICO must make copayments in accordance with the ICO's MassHealth copayment policy. Those ICO copayment policies must

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.008

508.008: Senior Care Organizations

- (A) Enrollment Requirements. In order to voluntarily enroll in a senior care organization, a MassHealth Standard member must meet all of the following criteria:
- (1) be 65 years of age or older;
 - (2) live in a designated service area of a senior care organization;
 - (3) not be diagnosed as having end-stage renal disease;
 - (4) not be subject to a six-month deductible period under 130 CMR 520.028: *Eligibility for a Deductible*;
 - (5) not be a resident of an intermediate care facility for individuals with intellectual disabilities (ICF/ID); and
 - (6) not be an inpatient in a chronic or rehabilitation hospital.
- (B) Selection Procedure. 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 & Medicaid Services. Service area listings may be obtained from the MassHealth agency or its designee. 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.
- (C) Obtaining Services When Enrolled in a SCO. 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.009

- (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.
- (G) Copayments. Members who are enrolled in a SCO must make copayments in accordance with the SCO's MassHealth copayment policy. Those SCO copayment policies must
- (1) be approved by MassHealth;
 - (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
 - (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
 - (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.009: Behavioral Health Contractor

The following applies to MassHealth members who are not in the PCC Plan or a Primary Care ACO and who receive behavioral health services through MassHealth's behavioral health contractor. (See 130 CMR 508.001(E).)

- (A) Nonemergency Behavioral Health Services. Behavioral health services, except for emergency services and those services not covered under the MassHealth contract with the behavioral health contractor, may be obtained only from a provider that has entered into an agreement with the MassHealth behavioral health contractor. The MassHealth behavioral health contractor is responsible for authorizing or denying behavioral health services based on the member's medical need for those services.
- (B) Emergency Behavioral Health Services. Members may obtain emergency behavioral health services from any qualified participating MassHealth provider as well as any provider that has entered into an agreement with the MassHealth behavioral health contractor.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.010

(C) Copayments. Members enrolled in the MassHealth behavioral health contractor must make copayments in accordance with the MassHealth behavioral health contractor's MassHealth copayment policy. Those MassHealth behavioral health contractor copayment policies must

- (1) be approved by MassHealth;
- (2) exclude the persons and services listed in 130 CMR 506.014: *Copayments Required by MassHealth* and 520.037: *Copayment and Cost Sharing Requirement Exclusions*;
- (3) not exceed the MassHealth copayment amounts set forth in 130 CMR 506.015: *Copayment and Cost Sharing Requirement Exclusions* and 520.038: *Services Subject to Copayments*; and
- (4) include the copayment maximums set forth in 130 CMR 506.018: *Maximum Cost Sharing* and 520.040: *Maximum Cost Sharing*. (See also 130 CMR 450.130: *Copayments Required by the MassHealth Agency*.)

508.010: 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 member is required to enroll with a MassHealth managed care provider under 130 CMR 508.001;
- (B) a determination by the MassHealth behavioral health contractor, by one of the MCOs, Accountable Care Partnership Plans, or SCOs 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 disenrollment of a member under 130 CMR 508.003(D)(1), (D)(2)(a), or (D)(2)(b), or discharge of a member from a SCO under 130 CMR 508.008(E); or
- (D) the MassHealth agency's determination that the requirements for a member transfer under 130 CMR 508.003(C)(3) have not been met.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.011

508.011: Timely Notice of Appealable Actions

(A) Whenever an MCO, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor determines, that following the standard time frame in 130 CMR 508.011(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, Accountable Care Partnership Plan, 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 ten 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, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plan, 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 508.011(A)(1) and (2), whichever is applicable, it must send a notice to the member on the date that such time frame expires.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.012

508.012: Time Limits for Resolving Internal Appeals

(A) MCOs, Accountable Care Partnership Plans, SCOs, ICOs, and the behavioral health contractor must resolve standard internal appeals within 30 days after receiving the appeal, including any extensions pursuant to 130 CMR 508.012(C).

(B) Where the provider requests an expedited appeal or the MCO, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plan, 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 508.012(C), in which event the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor must resolve the appeal within 17 days after receiving the appeal. If the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor denies a member's request for expedited resolution of an internal appeal, the MCO, Accountable Care Partnership Plan, SCO, ICO, or behavioral health contractor must resolve the appeal in accordance with the time frames in 130 CMR 508.012(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, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plans, 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, Accountable Care Partnership Plan, 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, Accountable Care Partnership Plan, 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: MANAGED CARE REQUIREMENTS

Chapter 508
Page 508.013

508.013: Timely Notice of Internal Appeal Decisions

(A) MCOs, Accountable Care Partnership Plans, 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 508.012.

(B) Notice from an MCO, an Accountable Care Partnership Plan, 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.

REGULATORY AUTHORITY

130 CMR 508.000: M.G.L. c. 118E, §§ 7 and 12.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.004 (1 of 5)

610.004: Definitions

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

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

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

Acting Entity – the MassHealth agency, 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.004 (2 of 5)

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 – an application as defined in 130 CMR 501.001: *Definition of Terms* or 130 CMR 515.001: *Definition of Terms*.

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

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

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.

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

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

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.004 (3 of 5)

Duals Demonstration – the MassHealth state Demonstration to Integrate Care for Dual Eligible Individuals, also known as One Care.

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

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 MCO, ACPP, SCO, ICO, or behavioral health contractor.

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

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. §1396a *et seq.*), Title XXI of the Social Security Act (42 U.S.C. §1397aa *et seq.*), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.004 (4 of 5)

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, intellectual disability, or conditions related to intellectual disability. 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).

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.004 (5 of 5)

Senior Care Organization (SCO) – an organization that participates in MassHealth under a contract with the MassHealth agency and Centers for Medicare & Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers 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.

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)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.011

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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.013

(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;

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.015 (1 of 2)

- (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.):
 - 1. he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively or he or she was justifiably unaware of the conduct in question; and
 - 2. the appeal was made in good faith.
- (3) 30 days after a resident receives written notice of 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 managed care contractor:
 - (a) 120 days after the member's receipt of the managed care contractor's final internal appeal decision where the managed care contractor has reached a decision wholly or partially adverse to the member, provided however that if the managed care contractor did not resolve the member's appeal within the time frames described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that appeal has expired;
 - (b) for timing of request for continuation of benefits pending appeal, *see* 130 CMR 610.036.
- (8) for appeals of PASRR determinations, 30 days after an individual receives written notice of his or her PASRR determination. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the 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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.015 (2 of 2)

(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).

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.016

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

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

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

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

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

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

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

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

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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.018

610.018: Appeal Process for Enrollees in an Integrated Care Organization

The Duals Demonstration 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)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.026

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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.028

610.028: Notice Requirements Regarding Actions Initiated by a Nursing Facility

- (A) A resident may be transferred or discharged from a nursing facility only when
 - (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
 - (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;
 - (3) the safety of individuals in the nursing facility is endangered;
 - (4) the health of individuals in the nursing facility would otherwise be endangered;
 - (5) the resident has failed, after reasonable and appropriate notice, to pay for (or failed to have the MassHealth agency or Medicare pay for) a stay at the nursing facility; or
 - (6) the nursing facility ceases to operate.

- (B) When the facility transfers or discharges a resident under any of the circumstances specified in 130 CMR 610.028(A)(1) through (5), the resident's clinical record must be documented. The documentation must be made by
 - (1) the resident's physician when a transfer or discharge is necessary under 130 CMR 610.028(A)(1) or (2); and
 - (2) a physician when the transfer or discharge is necessary under 130 CMR 610.028(A)(4).

- (C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand-deliver to the resident and mail to a designated family member or legal representative a notice written in 12-point or larger type that contains, in a language the member understands, the following:
 - (1) the action to be taken by the nursing facility;
 - (2) the specific reason or reasons for the discharge or transfer;
 - (3) the effective date of the discharge or transfer;
 - (4) the location to which the resident is to be discharged or transferred;
 - (5) a statement informing the resident of his or her right to request a hearing before the MassHealth agency including:
 - (a) the address to send a request for a hearing;
 - (b) the time frame for requesting a hearing as provided for under 130 CMR 610.029; and
 - (c) the effect of requesting a hearing as provided for under 130 CMR 610.030;
 - (6) the name, address, and telephone number of the local long-term-care ombudsman office;
 - (7) for nursing facility residents with developmental disabilities, the address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. § 6041 *et seq.*);
 - (8) for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act (42 U.S.C. § 10801 *et seq.*);
 - (9) a statement that all residents may seek legal assistance and that free legal assistance may be available through their local legal services office. The notice should contain the address of the nearest legal services office; and
 - (10) the name of a person at the nursing facility who can answer any questions the resident has about the notice and who will be available to assist the resident in filing an appeal.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.029

(D) As provided in 130 CMR 456.429: *Medical Leave of Absence: Failure to Readmit*, a nursing facility's failure to readmit a resident following a medical leave of absence will be deemed a transfer or discharge (depending on the resident's circumstances). Upon determining that it will not readmit the resident, the nursing facility must issue notice to the resident and an immediate family member or legal representative in accordance with 130 CMR 456.701(A) through (C), 456.702: *Time Frames for Notices Issued by Nursing Facilities*, and 610.028 through 610.030.

610.029: Time Frames for Notices Issued by Nursing Facilities

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

(B) In lieu of the 30-day-notice requirement set forth in 130 CMR 610.029(A), the notice of discharge or transfer required under 130 CMR 610.028 must be made as soon as practicable before the discharge or transfer in any of the following circumstances, which are considered to be emergency discharges or emergency transfers.

- (1) The health or safety of individuals in the nursing facility would be endangered and this is documented in the resident's record by a physician.
- (2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician documents this in the resident's record.
- (3) An immediate transfer or discharge is required by the resident's urgent medical needs and this is documented in the medical record by the resident's attending physician.
- (4) The resident has not lived in the nursing facility for 30 days immediately before receipt of the notice.

(C) When the transfer or discharge is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, the notice of transfer or discharge, including that which is required under 130 CMR 456.429: *Medical Leave of Absence: Failure to Readmit*, must comply with the requirements set forth in 130 CMR 456.701: *Notice Requirements for Transfers and Discharges Initiated by a Nursing Facility*, and must be provided to the resident and an immediate family member or legal representative at the time the nursing facility determines that it will not readmit the resident.

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

610.030: Stay of a Transfer or Discharge from a Nursing Facility Pending Appeal

(A) If a request for a hearing regarding a discharge or transfer from a nursing facility is received by the Board of Hearings during the notice period described in 130 CMR 610.015(B)(3), the nursing facility must stay the planned discharge or transfer until 30 days after the decision is rendered. While this stay is in effect, the resident must not be transferred or discharged from the nursing facility.

(B) If a hearing is requested, in accordance with 130 CMR 610.015(B)(4), and the request is received before the discharge or transfer, then the nursing facility must stay the planned transfer or discharge until five days after the hearing decision.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.031

(C) If the request for a hearing, in accordance with 130 CMR 610.015(B)(4), is received within the applicable time frame but after the transfer, the nursing facility must, upon receipt of the appeal decision favorable to the resident, promptly readmit the resident to the next available bed in the facility.

(D) In the case of a transfer or discharge that is the result of a nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, if the request for a hearing is received within the applicable time period, in accordance with 130 CMR 610.015(B)(5), the nursing facility must, upon receipt of the appeal decision favorable to the resident, promptly readmit the resident to the next available bed.

610.031: Notification of the Right to Request a Hearing

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

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

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

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

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

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

610.032: Grounds for Appeal

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

- (1) denial of an application or request for assistance, or the right to apply or reapply for such assistance;
- (2) the failure of the MassHealth agency to give timely notice of action on an application for assistance in accordance with the requirements of M.G.L. c. 118E, § 21;
- (3) any MassHealth agency action to suspend, reduce, terminate, or restrict a member's assistance;

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.032

- (4) MassHealth agency actions to recover payments for benefits to which the member was not entitled at the time the benefit was received;
- (5) individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations);
- (6) coercive or otherwise improper conduct as defined in 130 CMR 610.033 on the part of any MassHealth agency employee directly involved in the applicant's or member's case;
- (7) any condition of eligibility imposed by the MassHealth agency for assistance or receipt of assistance that is not authorized by federal or state law or regulations;
- (8) the failure of the MassHealth agency to act upon a request for assistance within the time limits required by MassHealth regulations;
- (9) the MassHealth agency's determination that the member is subject to the provisions of 130 CMR 508.000: *MassHealth: Managed Care Requirements*;
- (10) the MassHealth agency's denial of an out-of-area provider under 130 CMR 508.003(A)(2);
- (11) the MassHealth agency's disenrollment of a member from a managed care provider under 130 CMR 508.003;
- (12) the MassHealth agency's denial of a member's request to transfer out of the member's MCO, ACPP, or Primary Care ACO under 130 CMR 508.003: *Enrollment in a MassHealth Managed Care Provider*;
- (13) the MassHealth agency's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442: *Controlled Substance Management Program*;
- (14) the MassHealth agency's determination of eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003; and
- (15) the MassHealth agency's determination on behalf of the Health Connector as set forth in 956 CMR 3.17: *Hearings*.

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

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

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.033

(5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.012: *Time Limits for Resolving Internal Appeals*;

(6) a decision by a managed care contractor (except a behavioral health contractor) to deny a request by a member who resides in a rural service area served by only one managed care contractor (except the behavioral health contractor) to exercise his or her right to obtain services outside the managed care contractor's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):

(a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the managed care contractor's network;

(b) the provider from whom the member seeks service is the main source of service to the member, except that member will have no right to obtain services from a provider outside the managed care contractor's network if the managed care contractor gave the provider the opportunity to participate in the managed care contractor's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;

(c) the only provider available to the member in the managed care contractor's network does not, because of moral or religious objections, provide the service the member seeks; or

(d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the managed care contractor's network; or

(7) failure to act within the time frames for making service authorization decisions, as described in the information on service authorization decisions provided to members enrolled with the managed care contractor.

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

(D) 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).

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

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.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.034

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

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

610.034: Request for a Fair Hearing

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

(B) Any request for a fair hearing that cites coercive or otherwise improper conduct on the part of a MassHealth agency employee must state the name of the employee and the place, date, and nature of the incident or incidents. If the request lacks the information required by 130 CMR 610.034, BOH will notify the appellant of the requirement. If the appellant then fails to provide the information within 10 days, the appeal will be dismissed.

610.035: Dismissal of a Request for a Hearing

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

- (1) the request is not received within the time frame specified in 130 CMR 610.015;
- (2) the request is withdrawn in writing by the appellant or his or her appeal representative;
- (3) the sole issue is one of state or federal law requiring automatic change in assistance for classes of members;
- (4) the stated reason for the request does not constitute grounds for appeal as set forth in 130 CMR 610.032. Without limiting the generality of the foregoing, except as provided in 130 CMR 610.032(A)(11), no provider decision or action including, but not limited to, a provider determination about whether or the extent to which a service is medically necessary, constitutes an appealable action hereunder;
- (5) the stated reason for the hearing request is outside the scope of 130 CMR 610.000 as set forth in 130 CMR 610.003;
- (6) BOH has conducted a hearing and issued a decision on the same appealable action arising out of the same facts that constitute the basis of the request; or
- (7) the party requesting the hearing is not an applicant, member, resident, appeal representative, or employer as defined in 130 CMR 610.004.

(B) The Director may, at his or her discretion, order a hearing scheduled to allow the appellant the opportunity to contest the dismissal.

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.036

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 BOH decides the appeal or, where applicable, the rehearing decision is rendered if the BOH receives the initial request for the fair hearing before the implementation date of the appealable action. If such appealable action was implemented before a timely request for a hearing, such assistance will be reinstated if the BOH 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.

610.037: Notice Requirements for PASRR Determinations

(A) When DMH or DDS issues a PASRR determination, it must provide written notice of the PASRR determination to the following:

- (1) the evaluated individual and his or her legal representative;
- (2) the admitting or retaining nursing facility;
- (3) the attending physician; and
- (4) the discharging hospital, if the individual is seeking nursing facility admission from a hospital.

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

- (1) whether a Nursing Facility level of service is needed;
- (2) whether specialized services, as defined by 42 CFR 483.120, are needed;
- (3) the placement options available to the individual consistent with the determination and in accordance with 42 CFR 483.130(M);

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.037

- (4) a statement indicating that the individual's PASRR determination is based on the individual's PASRR and evaluation and that the individual was evaluated in accordance with 42 CFR 483.128;
- (5) a statement informing the individual of his or her right to request a fair hearing before the BOH to appeal a PASRR Determination and that provides
 - (a) the address to send a request for a hearing;
 - (b) the time frame for requesting a hearing as provided for under 130 CMR 610.015; and
 - (c) a statement that the individual may represent himself or herself or be represented by legal counsel, a relative, a friend or other spokesperson.

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

(130 CMR 610.038 through 610.045 Reserved)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.061

610.061: Appellant Rights

The appellant must have the right to

- (A) be assisted by an appeal representative as provided in 130 CMR 610.016;
- (B) present witnesses;
- (C) examine and introduce evidence from his or her case file or resident record, if applicable, and examine and introduce any other pertinent MassHealth agency documents;
- (D) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (E) advance any pertinent arguments without undue interference; and
- (F) question or refute any testimony, and confront and cross-examine adverse witnesses.

610.062: Acting Entity Rights and Responsibilities

The acting entity will:

- (A) submit to the hearing officer at or before the hearing all evidence on which any action at issue is based;
- (B) designate a staff person or representative to appear at the hearing, and arrange for adequate space for the hearing if requested by BOH;
- (C) have the right to present witnesses;
- (D) where the acting entity is the MassHealth agency, ensure that the case file is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;
- (E) where the acting entity is a nursing facility, ensure that the appellant's resident record is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;
- (F) where the acting entity is DDS or DMH and the appellant is appealing his or her PASRR determination, ensure that all medical records comprising the PASRR evaluation are present at the hearing and that the appellant or the appellant's representative has adequate opportunity to examine them before and during the hearing;
- (G) introduce into evidence material from pertinent documents that pertain to the issue or issues raised during the hearing and that are not otherwise confidential;

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.062

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

(I) have the right to advance any pertinent arguments without undue interference;

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

(K) have the right to arrange for the appearance at the hearing of a representative of other assistance programs, where appropriate.

(130 CMR 610.063 Reserved)

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.091

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).

Trans. by E.L. 225
Rev. 12/18/17

MASSHEALTH: FAIR HEARING RULES

Chapter 610
Page 610.093

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

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

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

610.093: Access to the Record

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

REGULATORY AUTHORITY

130 CMR 508.000: M.G.L. c. 118E, §§ 7 and 12.