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**MASSHEALTH
FAIR HEARING RULES**

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610.001: Purpose

(A) MassHealth Decisions. The purpose of 130 CMR 610.000 is to set forth procedures that govern the conduct of adjudicatory proceedings whereby dissatisfied applicants, members, and employers seek administrative review of certain actions or inactions on the part of the MassHealth agency or on the part of a MassHealth managed care contractor. Such actions include, but are not limited to, determinations of eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003, as described in federal regulations 42 CFR Part 423, Subpart P.

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

610.002: Authority

The authority for the regulations set forth in 130 CMR 610.000 is 42 CFR 431.200 et seq., M.G.L. c. 30A, c. 118E, §§ 12, 20, 47, and 48, and 801 CMR 1.03(7). Pursuant to M.G.L. c. 118E, § 48, the Office of Medicaid Board of Hearings has exclusive jurisdiction to hear appeals relating to the programs administered by the MassHealth agency; provided, however, that for certain appeals by an integrated care organization (ICO) or senior care organization (SCO) enrollee concerning covered benefits, the Centers for Medicare & Medicaid Services (CMS) Independent Review Entity (IRE) also has jurisdiction. Pursuant to M.G.L. c. 176Q, §§ 3(a)(6) and 3(m), the Commonwealth Health Insurance Connector Authority may establish procedures for appeals of eligibility decisions for Commonwealth Care through an interdepartmental agreement with the MassHealth agency. Pursuant to 42 U.S.C. 1396r(e)(7) and 42 CFR 483.204, the Office of Medicaid Board of Hearings has authority to hear appeals of PASRR determinations.

610.003: Scope

130 CMR 610.000 sets forth the exclusive procedures governing adjudicatory proceedings initiated by applicants, members (or their appeal representatives), and employers under programs administered by the MassHealth agency, and for MassHealth determinations of eligibility for low-income subsidies under Medicare Part D, as set forth in the Medicare Prescription Drug and Improvement and Modernization Act of 2003. Appeals pursuant to the Executive Office of Elder Affairs Supplementary Rules to the Adjudicatory Rules of Practice and Procedures, 651 CMR 1.00: *Adjudicatory Rules of Practice and Procedure* are governed by the procedures set forth in 130 CMR 610.000. Appeals by residents of a nursing facility who are to be discharged or transferred at the initiation of the nursing facility are governed by 130 CMR 610.000. Adjudicatory proceedings initiated by medical assistance providers are governed by 130 CMR 450.241: *Hearings: Claim for an Adjudicatory Hearing* through 450.248: *Commissioner's Decision* or, with regard to appeals of erroneously denied claims, by 130 CMR 450.323: *Appeals Erroneously Denied or Underpaid Claims*. Appeals pertaining to Commonwealth Care are governed by 130 CMR 610.000 and 956 CMR 3.00: *Eligibility and Hearing Process for Commonwealth Care*. Appeals pertaining to PASRR determinations are governed by 130 CMR 610.000.

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610.004: Definitions

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

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

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

Appealable Action – certain actions, as further described in 130 CMR 610.032, by the MassHealth agency, managed care contractor, or a nursing facility, or the Department of Mental Health or the Department of Developmental Services, or certain actions of the Health Connector as set forth in 956 CMR 3.14: *Right to a Hearing* and 3.17: *Hearings*. No action by a provider will constitute an appealable action, except as otherwise provided herein with regard to a transfer or discharge by a nursing facility.

Appeal Representative – a person who

- (1) is sufficiently aware of the appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has provided the Office of Medicaid Board of Hearings with written authorization from the appellant to act on the appellant's behalf during the appeal process;
- (2) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (3) is an eligibility representative meeting the requirements of (1) or (2) above.

Appellant – an applicant, member, resident, or employer requesting a fair hearing, including individuals who are appealing a PASRR determination.

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

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

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

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

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

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

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

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

Director – the Director of the Office of Medicaid Board of Hearings.

Discharge – the removal from a nursing facility of an individual who is a resident where the discharging nursing facility ceases to be legally responsible for the care of that individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Nursing Facility – a Medicare- or Medicaid-certified nursing facility, or certified unit within a nursing facility, that is licensed by the Department of Public Health to operate in Massachusetts.

Party – the appellant, the managed care contractor, the nursing facility, the respondent to a complaint of coercive behavior, the MassHealth agency, the Department of Mental Health, the Department of Developmental Services, or the Health Connector.

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

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

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

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Policy Memorandum – a written explanation, issued by the Medicaid Director or the General Counsel's office, of the MassHealth agency's intent and interpretation or application of its regulations under 130 CMR, or a written explanation, issued by the Health Connector or its designee, of the Health Connector's intent and interpretation or application of its regulations under 956 CMR.

Provider – any entity that furnishes medical services.

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

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

Rural Service Area – any geographic area other than an urban area, as that term is defined in 42 CFR 412.62(f)(ii).

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

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

Transfer – movement of a resident from

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

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

(130 CMR 610.005 through 610.010 Reserved)

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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.

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(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;

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- (2) unless waived by the Director or his or her designee, 120 days from
 - (a) the date of application when the MassHealth agency fails to act on an application;
 - (b) the date of request for service when the MassHealth agency fails to act on such request;
 - (c) the date of MassHealth agency action when the MassHealth agency fails to send written notice of the action; or
 - (d) the date of the alleged coercive or otherwise improper conduct, but up to one year from the date of the conduct if the appellant files an affidavit with the Director stating the following, and can establish the same at a hearing (Failure to substantiate the allegation either before or at the hearing will be grounds for dismissal.):
 - (i) he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively or he or she was justifiably unaware of the conduct in question; and
 - (ii) the appeal was made in good faith.
- (3) 30 days after a resident receives written notice of a discharge or transfer pursuant to 130 CMR 610.029(A);
- (4) 14 days after a resident receives written notice of an emergency discharge or emergency transfer pursuant to 130 CMR 610.029(B);
- (5) 14 days after a resident receives written notice of a transfer or discharge that is the result of a nursing facility's failure to readmit the resident following hospitalization or other medical leave of absence;
- (6) 30 days after an employer receives written notice of a denial or termination from the Insurance Partnership or a final written reconciliation determination about the amount of the Insurance Partnership payment;
- (7) for appeals of a decision reached by a MassHealth-contracted managed care organization's (MCO's) or a behavioral health contractor's internal appeals process
 - (a) for a standard appeal, 30 days after the mailing of the MCO's or behavioral health contractor's final internal appeal decision denying services where the MCO or behavioral health contractor has reached a decision wholly or partially adverse to the member;
 - (b) if the managed care contractor did not resolve the member's standard appeal of a denial of service within the time frames described by 130 CMR 508.010(A) and (C), 30 days after the date on which the time frame for resolving that appeal has expired;
 - (c) for an expedited appeal, 20 days after the mailing of the MCO's or behavioral health contractor's expedited final internal decision denying services where the MCO or behavioral health contractor has reached a decision wholly or partially adverse to the member, provided that if BOH receives the request for a fair hearing between 21 and 30 days after the mailing of the MCO's or behavioral health contractor's expedited internal appeal decision, BOH will treat such matter as a nonexpedited BOH appeal; or
 - (d) if the MCO or behavioral health contractor did not resolve the member's expedited internal appeal of a denial of service within the time frames described by 130 CMR 508.010(B), 20 days after the date on which the time frame for resolving that expedited appeal has expired;
- (8) for appeals of an appealable action by a SCO or an ICO, 30 days after the mailing of the SCO's or ICO's notice of the appealable action; or
- (9) for appeals of PASRR determinations, 30 days after an individual receives written notice of his or her PASRR determination. In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the third day after mailing.

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(C) Computation of Time. Computation of any period referred to in 130 CMR 610.000 will be on the basis of calendar days except where expressly provided otherwise. Time periods will expire on the last day of such periods unless the day falls on a Saturday, Sunday, legal holiday, or other day on which BOH is closed, in which event the last day of the time period will be deemed to be the following business day.

(D) Time Limits for Rendering a Decision.

(1) The hearing officer must render a final decision within 45 days of the date of request for a hearing when the issue under appeal is

- (a) the denial or rejection of an application for assistance;
- (b) the failure to act on an application in a timely manner;
- (c) a nursing facility-initiated discharge or transfer; or
- (d) a PASRR determination.

(2) The hearing office must render a final decision within 45 days of a request for a fair hearing about appealable actions by managed care contractors, except where the internal appeal was expedited pursuant to 130 CMR 610.015(G) and (H).

(3) The hearing officer must render a final decision within 90 days of the date of request for a hearing for all other appeals.

(4) The time limits set forth in 130 CMR 610.015(D)(1) and (3) may be extended for good cause as follows.

- (a) When delays are caused by the appellant or his or her appeal representative, the time limits may be extended by the total number of days of such delays, which includes the advance notice period before scheduled hearing dates. Such delays include the appellant's delay in the submission of evidence, briefs, or other statements, rescheduling or continuances granted at the request or for the benefit of the appellant, and any other delays caused by the actions of the appellant or his or her appeal representative.
- (b) When delays occur due to acts of nature or serious illness of the hearing officer that make him or her unable to render a decision, good cause for the extension of the time limits will be deemed to exist.

(E) Expedited Appeals for Denied Acute Hospital Admissions. When the MassHealth agency denies prior authorization for an elective hospital admission of a member, the member may request an expedited hearing. When such request is made, a hearing will be scheduled to be held as soon as possible, but no later than seven days from the date BOH receives the request. The hearing officer must render a final decision as soon as possible, but no later than seven days from the date of the hearing. These time limits may be extended pursuant to 130 CMR 610.015(D). A request for an expedited hearing under 130 CMR 610.015(E) automatically waives the requirement for 10-day advance notice of the hearing under 130 CMR 610.046(A). The appellant will be contacted, orally when possible, at least 48 hours before the hearing.

(F) Expedited Appeals for Discharges and Transfers from a Nursing Facility Under 130 CMR 610.029(B). A resident may request an expedited appeal when a nursing facility notifies a resident of a discharge or transfer under the time frames of 130 CMR 610.029(B) or (C). Appeals of discharges or transfers provided under 130 CMR 610.029(B) and (C) will be conducted under the time frames provided in 130 CMR 610.015(E).

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- (G) Expedited Hearings on Adverse Managed Care Contractor Internal Appeals Decisions.
- (1) A member may request an expedited hearing at BOH with respect to an appealable action after exhausting the managed care contractor's expedited appeals process (if required) where the managed care contractor reached a decision on the member's expedited internal appeal wholly or partially adverse to the member within the time frame described by 130 CMR 508.010(A).
 - (2) The member must submit such a request within the time frames described by 130 CMR 610.015(B)(7)(c) or 610.015(B)(8), whichever is applicable.
 - (3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.
- (H) Expedited Hearings on Untimely Managed Care Contractor Internal Appeals Decisions.
- (1) A member may request an expedited hearing at BOH with respect to an appealable action if the managed care contractor's internal appeals process did not resolve the member's expedited internal appeal within the time frame described by 130 CMR 508.010(B).
 - (2) The member must submit such a request to BOH within the time frames described by 130 CMR 610.015(B)(7)(d) or (B)(8), whichever is applicable.
 - (3) The hearing officer must take final administrative action as expeditiously as the member's health condition requires, but no later than three business days after BOH receives from the managed care contractor the case file and information for any such appeal.

610.016: Appeal Representative

- (A) An appellant has the right to be represented at his or her own expense by an appeal representative as defined in 130 CMR 610.004. All documentation required in 130 CMR 610.004 must be submitted at or before the hearing. The MassHealth agency must provide copies of all documents related to the fair hearing process to the appellant and to the appeal representative, if any. An appeal representative may exercise on the appellant's behalf any of the appellant's rights under 130 CMR 610.000.
- (B) When an interpreter also acts as the appellant's appeal representative, the appellant will supply a signed written statement to that effect in both English and, where applicable, in the appellant's primary language.

610.017: Auxiliary Aids

BOH will provide reasonable auxiliary aids to appellants who request such aids and who have an impairment that BOH determines would prevent adequate participation of the appellant at the hearing. BOH will inform appellants of the availability of this service. BOH will provide telephonic or, at its option, other interpreter services for an appellant who is deaf or hearing-impaired, or whose English proficiency is limited, unless such appellant provides his or her own interpreter or such appellant knowingly and voluntarily signs a waiver of such services.

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610.018: Appeal Process for Enrollees in an Integrated Care Organization

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

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

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

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

(130 CMR 610.019 through 610.025 Reserved)

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Rev. 10/01/13**610.026: Adequate Notice Requirements**

(A) A notice concerning an intended appealable action must be timely as stated in 130 CMR 610.015, and adequate in that it must be in writing and contain:

- (1) a statement of the intended action;
- (2) the reasons for the intended action;
- (3) a citation to the regulations supporting such action;
- (4) an explanation of the right to request a fair hearing; and
- (5) the circumstances under which assistance is continued if a hearing is requested.

(B) Regardless of the provisions of 130 CMR 610.026(A), when a change in either federal or state law requires a change in assistance for a class or classes of members, notice to the member will be considered adequate if it includes a statement of the specific change in law requiring the action to reduce, suspend, or terminate assistance.

610.027: Timely Notice Exceptions

The MassHealth agency need not send a timely notice, as defined at 130 CMR 610.015(A), but must send an adequate notice, as defined in 130 CMR 610.026, no later than the date of an appealable action when:

(A) the MassHealth agency receives a clear written statement signed by the member that:

- (1) the member no longer wishes to receive assistance; or
- (2) gives information that requires termination or reduction of services and indicates that termination or reduction of services must be the result of supplying that information;

(B) the member has been admitted or committed to an institution and he or she is not eligible for further payments or service under any category of assistance;

(C) the member has been placed in a nursing facility or chronic hospital;

(D) a member's whereabouts are unknown and MassHealth agency mail directed to the member has been returned by the Postal Service indicating there is no known forwarding address;

(E) the MassHealth agency renders a decision on a request for prior authorization of services;

(F) the MassHealth agency or its agent renders a determination denying or terminating an employer from the Insurance Partnership, or a reconciliation determination regarding the amount of the Insurance Partnership payment;

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

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

610.028: Notice Requirements Regarding Actions Initiated by a Nursing Facility

(A) A resident may be transferred or discharged from a nursing facility only when:

- (1) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the nursing facility;
- (2) the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility;

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- (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.
- (D) As provided in 130 CMR 456.429, 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, 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, must comply with the requirements set forth in 130 CMR 456.701, 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.

(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;
 - (4) MassHealth agency actions to recover payments for benefits to which the member was not entitled at the time the benefit was received;
 - (5) individual MassHealth agency determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations);
 - (6) coercive or otherwise improper conduct as defined in 130 CMR 610.033 on the part of any MassHealth agency employee directly involved in the applicant's or member's case;
 - (7) any condition of eligibility imposed by the MassHealth agency for assistance or receipt of assistance that is not authorized by federal or state law or regulations;
 - (8) the failure of the MassHealth agency to act upon a request for assistance within the time limits required by MassHealth regulations;
 - (9) the MassHealth agency's determination that the member is subject to the provisions of 130 CMR 508.000;
 - (10) the MassHealth agency's denial of an out-of-area provider under 130 CMR 508.002(F);

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- (11) the MassHealth agency's disenrollment of a member from a managed-care provider under 130 CMR 508.002(G) or (E);
- (12) the MassHealth agency's determination to enroll a member in the Controlled Substance Management Program under the provisions of 130 CMR 406.442;
- (13) 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
- (14) the MassHealth agency's determination on behalf of the Health Connector as set forth in 956 CMR 3.17.

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

- (1) failure to provide services in a timely manner, as defined in the information on access standards provided to members enrolled with the managed care contractor;
- (2) a decision to deny or provide limited authorization of a requested service, including the type or level of service;
- (3) a decision to reduce, suspend, or terminate a previous authorization for a service;
- (4) a denial, in whole or in part, of payment for a service where coverage of the requested service is at issue, provided that procedural denials for services do not constitute appealable actions. Notwithstanding the foregoing, members have the right to request a fair hearing where there is a factual dispute over whether a procedural error occurred. Procedural denials include, but are not limited to, denials based on the following:
 - (a) failure to follow prior-authorization procedures;
 - (b) failure to follow referral rules; and
 - (c) failure to file a timely claim;
- (5) failure to act within the time frames for resolution of an internal appeal as described in 130 CMR 508.010;
- (6) a decision by an MCO to deny a request by a member who resides in a rural service area served by only one MCO to exercise his or her right to obtain services outside the MCO's network under the following circumstances, pursuant to 42 CFR 438.52(b)(2)(ii):
 - (a) the member is unable to obtain the same service or to access a provider with the same type of training, experience, and specialization within the MCO's network;
 - (b) the provider from whom the member seeks service is the main source of service to the member, except that member will have no right to obtain services from a provider outside the MCO's network if the MCO gave the provider the opportunity to participate in the MCO's network under the same requirements for participation applicable to other providers and the provider chose not to join the network or did not meet the necessary requirements to join the network;
 - (c) the only provider available to the member in the MCO's network does not, because of moral or religious objections, provide the service the member seeks; and
 - (d) the member's primary care provider or other provider determines that the member needs related services and that the member would be subjected to unnecessary risk if he or she received those services separately and not all of the related services are available within the MCO's network; or
- (7) failure to act within the 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.

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- (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.

(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.

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610.035: Dismissal of a Request for a Hearing

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

610.036: Continuation of Benefits Pending Appeal

- (A) When the appealable action involves the reduction, suspension, termination, or restriction of assistance, such assistance will be continued until the Board of Hearings decides the appeal or, where applicable, the rehearing decision is rendered if the Board of Hearings receives the initial request for the fair hearing before the implementation date of the appealable action. If such appealable action was implemented before a timely request for a hearing, such assistance will be reinstated if the Board of Hearings receives the request for the fair hearing within 10 days of the mailing of the notice of the appealable action. If the hearing officer's decision is adverse to the appellant, the appealable action will be implemented immediately, except as provided in 130 CMR 610.091.
- (B) When a change affecting the member's assistance occurs while the hearing decision is pending, the MassHealth agency will take appropriate action to implement the subsequent change affecting assistance, subject to the advance notice requirements and the right to assistance pending a hearing decision.
- (C) Assistance pending a hearing will not be granted if the MassHealth agency has granted assistance on a presumption of eligibility and subsequently determines that the member is ineligible, and such determination is the subject of a hearing request.
- (D) Assistance continued pending an appeal in accordance with 130 CMR 610.036(A) is subject to recoupment.
- (E) The provisions of 130 CMR 610.036(A) and (B), regarding assistance pending a hearing decision, will not apply to assistance requiring prior authorization where such assistance terminates as the result of the expiration of the specified, finite authorization period, and the member's provider has failed to timely submit a new prior authorization request.

610.037: 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);
- (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)

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610.046: Notification of Hearing

(A) The time, date, and place of the hearing will be arranged so that the hearing is accessible to the appellant. At least 10 days' advance written notice will be mailed by the Board of Hearings to all parties involved to permit adequate preparation of the case. However, the appellant or his or her appeal representative may request less advance notice to expedite the scheduling of the hearing.

(B) The notice will contain the following:

- (1) the date, time, and location of the hearing;
- (2) the name, address, and telephone number of the person in BOH to notify if the appellant cannot attend the scheduled hearing;
- (3) an explanation of the MassHealth agency's hearing procedures, including the appellant's right to representation at the appellant's expense;
- (4) a statement that the appellant or appeal representative may examine the case file (or resident record, as applicable) before the hearing; and
- (5) a statement to the appellant indicating that the MassHealth agency will dismiss the hearing request if the appellant or his or her appeal representative fails to appear for the hearing without good cause.

610.047: Scheduling

(A) Upon receipt of a request for a fair hearing, BOH will register the appeal, set a date for a hearing and so notify:

- (1) the appellant;
- (2) the appropriate office of the MassHealth agency and the managed care contractor or nursing facility; and
- (3) if applicable, the MassHealth agency employee against whom allegations of coercive or otherwise improper conduct have been made.

(B) BOH will further designate a site for the hearing accessible to the appellant. If the appellant has a handicap or disability that reasonably prevents his or her appearance at the designated site, he or she may request that the hearing be held by telephone or video conferencing, or at an accessible location.

610.048: Procedures and Requirements for Rescheduling**(A) Rescheduling Before the Day of the Hearing.**

- (1) BOH may change the date, time, and location of the hearing upon due notice to the parties involved.
- (2) For good cause shown as defined in 130 CMR 610.048(D), BOH may, at the request of any party to a hearing, reschedule the hearing provided that the request is received before the date of the hearing. If the Director or his or her designee concludes that the request does not constitute good cause, the request will be denied.
- (3) BOH will inform the parties of the procedures set forth above.

(B) Rescheduling Following Failure to Appear at a Scheduled Hearing. If the appellant fails to appear at the hearing, BOH will notify the appellant in writing (at the address supplied by the appellant) that if he or she fails to request a rescheduled hearing and show good cause for the failure to appear within 10 days of the notice, the appeal will be considered abandoned. If, in the determination of the Director or his or her designee, good cause has not been shown, the appeal will be dismissed subject to the procedures set forth in 130 CMR 610.048(C) and aid pending, if any, will be discontinued. The Director or his or her designee may at his or her discretion reschedule the hearing to another date at which time the appellant will be required to establish good cause for the failure to appear. A finding by the hearing officer that good cause has not been shown will result in dismissal of the appeal.

(C) Procedures for Vacating a Dismissal.

- (1) The appellant will be informed by written notice of the dismissal and of the procedures for requesting that the dismissal be vacated.
- (2) A request to vacate a dismissal must be in writing and must be signed by the appellant or his or her appeal representative. Such request must be received by BOH within 10 days of the date of the dismissal notice. A dismissal will be vacated by the Director or his or her designee upon a finding that the appellant has shown good cause for
 - (a) failure to appear at a scheduled hearing; and
 - (b) failure to inform BOH before the date of a scheduled hearing of his or her inability to appear at that hearing.

(D) Good Cause.

- (1) The following circumstances constitute good cause subject to 130 CMR 610.048(D)(2):
 - (a) a death in the family;
 - (b) a personal injury or illness that reasonably prevents the party from attending the hearing;
 - (c) a sudden and serious emergency that reasonably prevents the party from attending the hearing;

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- (d) an obligation or responsibility that a reasonable person in the conduct of his or her serious affairs would conclude takes precedence over attendance at the hearing; or
 - (e) the need for additional time to produce evidence or witnesses or obtain legal assistance.
- (2) In evaluating a party's good cause claim, the hearing officer considers the following factors:
- (a) the amount of time during which the party had advance notice of the hearing;
 - (b) the party's ability to anticipate the circumstances that resulted in his or her inability to appear for the hearing;
 - (c) the party's ability to reschedule the conflicting event;
 - (d) delay by the party in notifying BOH of his or her inability to attend the hearing; and
 - (e) previous rescheduling requests or failure to appear for scheduled hearings that indicate a pattern of noncompliance with the fair hearing rules.
- (3) If a party will be required to show good cause at the hearing, BOH will notify that party in advance that the hearing officer will address that issue. The party will also be notified that the party may bring documentation and witnesses in support of the good cause claim and that failure to demonstrate good cause may result in dismissal of the appeal.

610.049: Dismissal for Failure to Prosecute

When the record discloses the failure of the appellant to file documents required by 130 CMR 610.000, to respond to notices or correspondence, or to comply with orders, or when the appellant otherwise indicates an intention not to continue with the prosecution of his or her appeal, BOH may issue an order requiring the appellant to show cause why the matter should not be dismissed for lack of prosecution. The show cause determination will be made by the Director; however, in cases where the hearing has been scheduled and a hearing officer has been designated to conduct the hearing, the determination will be made by the hearing officer. If the appellant is found to have failed to show such cause, the appeal will be dismissed with prejudice.

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610.050: Right to Examine Case File and Documents, or "Discovery"

(A) Appeals of MassHealth/Health Connector Determinations. The appellant and his or her appeal representative will have reasonable opportunity to examine the entire contents of the appellant's case file, as well as all documents and records to be used by the MassHealth agency or the Health Connector at the hearing. An appointment must be scheduled in advance with the appropriate MassHealth Enrollment Center (MEC) for examination of the case file.

(B) Appeals of PASRR Determinations. The appellant and his or her appeal representative will have reasonable opportunity to examine the appellant's PASRR evaluation, including all documents and records used in performing the evaluation, as well as all documents and records to be used at the hearing by the department that issued the PASRR determination. An appointment to examine the documents must be scheduled in advance with the department that issued the PASRR determination.

610.051: Adjustment Procedures and Mediation

(A) MassHealth Agency or Health Connector Representative. The MassHealth agency or Health Connector representative is primarily responsible for dealing with complaints from applicants or members. Dissatisfaction on the part of applicants or members may result from a lack of knowledge or understanding of the regulations that govern MassHealth or Health Connector policies and procedures. Ordinarily, complaints may be resolved with an explanation of the regulations by the representative. If the representative's explanation is not satisfactory, the representative's immediate supervisor will be available to respond to the complaint. If the complaint cannot be resolved, the MassHealth agency or the Health Connector will remind the applicant or member of the right to request a fair hearing.

(B) Adjustments Resolving Issues. The MassHealth agency or the Health Connector may make an adjustment in the matters at issue before or during a hearing. If the parties agree that the adjustment resolves one or more of the issues in dispute, the hearing officer, by written order, will dismiss the appeal as to all resolved issues, noting as the reason for such dismissal that the parties have reached agreement. BOH will not delay a fair hearing because a possible adjustment is under consideration unless the appellant requests or agrees to such a delay.

(C) Mediation. BOH may offer to the parties the opportunity to resolve one or more of the appeal issues in dispute through mediation, and such mediation may proceed only if, and as long as, both parties agree to such mediation that will be conducted substantially in accordance with M.G.L. c. 233, § 23C. If such mediation resolves one or more of the issues in dispute, the hearing officer, by written order, will dismiss the appeal, without prejudice, as to all resolved issues, noting as the reason for such dismissal that the parties have reached agreement. Either party may elect to terminate mediation at any time and proceed to a fair hearing that BOH will schedule accordingly. Any party may request that a different hearing officer be assigned to conduct such fair hearing.

610.052: Subpoenas

(A) A subpoena under this chapter is a document that commands a witness to appear at a given time to give testimony at an administrative proceeding. A subpoena can also require the witness to produce for the administrative proceeding any books, documents, papers, or records in his or her possession or control.

(B) Right to Subpoena. Any party to a hearing and BOH on its own have the right to request a subpoena requiring the attendance and testimony of witnesses and the production of any evidence including books, records, correspondence, or documents relating to any matter in question at the hearing. Any party may submit to BOH a written request for the issuance of such subpoena. If, in its discretion and in accordance with 130 CMR 610.065(B), BOH allows such request, a subpoena will be issued within three business days of receipt of such request.

(C) Petition to Vacate Subpoena. Any witness subpoenaed may petition BOH to vacate or modify a subpoena.

(1) BOH gives the party who requested the issuance of the subpoena notice of such petition orally or in writing. The notice contains or quotes the contents of the petition and indicates that the party may oppose the petition orally or, if time permits, in writing to BOH. If time does not permit a party to respond to the request to vacate, the hearing will be postponed long enough to permit the party to respond to the petition. This procedure is not be construed to require a hearing or adjudicatory proceeding.

(2) After such investigation as BOH considers appropriate, BOH may grant the petition in whole or in part upon a finding that:

- (a) the testimony or the evidence whose production is required does not relate with reasonable directness to any matter in question;
- (b) the subpoena is unreasonable or unduly burdensome; or
- (c) the subpoena has not been issued a reasonable period in advance of the time when the evidence is requested.

(3) Unless BOH finds that at least one of the conditions in 130 CMR 610.052(C)(2)(a) through (c) exists, BOH will deny the petition.

(D) Failure to Comply with a Subpoena. If any person fails to comply with a properly issued subpoena, BOH (or the party who requested the subpoena) may petition the Superior Court for an order requiring compliance with the terms of the subpoena.

(130 CMR 610.053 through 610.060 Reserved)

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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;
- (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;

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(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)

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610.064: MassHealth Agency Employee Rights

Any MassHealth agency employee against whom allegations of coercive or otherwise improper conduct have been made may present his or her own case and will have the right to

- (A) be assisted by a representative of his or her choice at his or her own expense;
- (B) bring witnesses or subpoena witnesses upon request to BOH;
- (C) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (D) advance any pertinent arguments without undue interference;
- (E) question or refute any testimony and confront and cross-examine adverse witnesses; and
- (F) examine and introduce any pertinent evidence, including material from the case file.

610.065: Powers and Duties of the Hearing Officer

- (A) The hearing officer has the following duties:
 - (1) to administer the oath or affirmation to anyone who will testify at the hearing and to an interpreter/translator;
 - (2) to assist all those present in making a full and free statement of the facts in order to elicit all the information necessary to decide the issues involved and to ascertain the rights of the parties;
 - (3) to ensure an orderly presentation of the evidence;
 - (4) to ensure that all parties have a full opportunity to present their claims orally or in writing and to secure witnesses and evidence to establish their claims;
 - (5) to receive, rule on, exclude, or limit evidence;
 - (6) to introduce into the record by reference or production any regulations, statutes, memoranda, or other materials he or she believes relevant to the issues at the hearing;
 - (7) to ensure a record is made of the proceedings;
 - (8) to render a fair, independent, and impartial decision based on the issues and evidence presented at the hearing and in accordance with the law, including the MassHealth agency's rules, regulations, and Policy Memoranda, and to order MassHealth agency action if appropriate; and
 - (9) to inform appellants who are not fluent in English of the right to a full and accurate interpretation by their own interpreter, or by a MassHealth agency-provided interpreter. The hearing officer will conduct the bilingual hearing in accordance with the guidelines for conducting hearings through interpretation in the *Hearing Officer Manual*. The purpose of the guidelines is to enable non-English speaking appellants to understand and to participate in the entire hearing as fully as if the appellants were fluent in English. To achieve this end, all statements, including questions, answers, and comments, of the appellant, hearing officer, witnesses, and any other persons participating in the hearing, will be fully translated without alteration of such statements, such as by changing from the first person to the third person.

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- (B) The hearing officer has the following powers:
- (1) to limit attendance at the hearing, at his or her discretion;
 - (2) to change the date, time, or location of the hearing on his or her own motion or at the request of any party, upon due notice to the parties;
 - (3) to request a statement of the issues and define the issues, and, to accomplish this purpose, to request the parties' participation in prehearing activities, including, but not limited to, a prehearing conference or conferences;
 - (4) to regulate the presentation of evidence and the participation of the parties for the purpose of ensuring an adequate and comprehensive record of the proceedings;
 - (5) to issue subpoenas on his or her own motion or upon request of any party to secure the presentation of evidence or testimony;
 - (6) to examine witnesses and ensure that relevant evidence is secured and introduced;
 - (7) to continue the hearing to a subsequent date to permit either party to produce additional evidence, witnesses, or other materials;
 - (8) when appropriate, to direct the MassHealth agency to pay for the costs of an independent medical examination;
 - (9) to rule on any requests that may be made during the hearing;
 - (10) to reconvene the hearing at his or her discretion at any time before the rendering of the decision in accordance with 130 CMR 610.081; and
 - (11) to order, at his or her discretion, written briefs to be submitted provided that all parties are notified of the submission of the briefs and have opportunity to answer.

(130 CMR 610.066 through 610.070 Reserved)

610.071: Evidence

(A) General.

(1) The rules of evidence observed by courts will not apply to fair hearings, but the hearing officer will observe the rules of privilege recognized by law. Evidence may be admitted and given probative effect only if it is the kind of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. Unduly repetitious or clearly irrelevant evidence may be excluded.

(2) The hearing officer will not exclude evidence at the hearing for the reason that it had not been previously submitted to the acting entity, provided that the hearing officer may permit the acting entity representative reasonable time to respond to newly submitted evidence. The effective date of any adjustments to the appellant's eligibility status will be the date on which all eligibility conditions were met, regardless of when the supporting evidence was submitted.

(B) Presentation at Hearing. Except as the hearing officer may otherwise order within his or her discretion in accordance with 130 CMR 610.081 and 610.082, any evidence on which a decision is based must be presented at the hearing. Copies of any evidence not submitted at the hearing will be provided to all other parties who will then have the opportunity to respond.

(C) Oral Testimony. Oral testimony will be given under oath or affirmation. Witnesses will be available for examination and cross-examination.

(D) Regulations, Statutes, and Memoranda. Regulations and statutes may be submitted into evidence by reference to the citation or by submitting a copy of the regulations. Memoranda and other materials may be put into evidence by submission of the original or copy thereof.

(E) Stipulations. Stipulations of facts or stipulations as to the testimony that would have been given by an absent witness may, if agreed upon by the parties, be used as evidence at the hearing.

(F) Additional Evidence. The hearing officer may in any case require either party, with appropriate notice to the other party, to submit additional evidence on any relevant matter.

610.072: Continuance

Once a hearing has been opened, it may be continued at the discretion of the hearing officer. All parties will be notified as to the time, date, and location of the continued hearing.

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610.073: Consolidated Hearings

(A) BOH may respond to a series of individual requests for hearings by conducting a single group hearing. BOH may consolidate cases when:

- (1) the applicable state or federal law is common to all such cases; and
- (2) the issues of fact are undisputed, or are common to all such cases. In all group hearings, the regulations governing individual hearings must be followed.

(B) Each appellant must be permitted to present his or her own case or have the case presented by an appeal representative.

610.074: The Record

(A) All documents and other evidence offered and taken will become part of the record. The record will further contain electronic or stenographic recordings of the proceedings or transcripts of such recordings, if produced, and all exhibits and documents introduced at the hearing and, wherever applicable, medical documents obtained to resolve medical issues. The record will be the exclusive source of the hearing officer's decision. For purposes of judicial review, the record will include the decision, but will not include recordings or transcripts of the proceedings unless requested by the appellant. If the appellant requests a recording or transcript, the appellant will bear the cost of producing such recording or transcript unless such cost is waived by the MassHealth agency or the court.

(B) All evidence and testimony at the hearing will be recorded either electronically or stenographically.

(C) At the discretion of the hearing officer, any party may record the hearing.

(D) Regardless of whether an appellant intends to file a Complaint for Judicial Review, transcripts or duplicate tapes of the proceedings will be supplied, upon request by the appellant, at his or her expense. The record will be open for inspection by any party or his or her appeal representative during the regular business hours of BOH.

(130 CMR 610.075 through 610.080 Reserved)

610.081: Reopening Before Decision

After the close of the hearing and before a decision, the hearing officer may reopen the record or, if appropriate, the hearing if he or she finds need to consider further testimony, evidence, materials or legal rules before rendering his or her decision. If the hearing officer decides to reopen the record, he or she shall notify all parties accordingly and all parties shall have the opportunity to submit such additional testimony, evidence, materials, or legal argument as the hearing officer may describe in such notice and within such time period that the hearing officer may so establish. All such additional submissions shall be sent to the other party or parties who shall have the opportunity to respond to such submissions within such time period as the hearing officer may establish. If the hearing officer decides to reopen the hearing, he or she must send seven days' written notice to all parties of the reopening and his or her reasons therefore, including the date, time, and location of the resumed hearing, which shall be held at a location accessible to the appellant. Before a hearing decision, any party to a hearing may request in writing that the hearing officer exercise his or her power hereunder, which request shall become part of the record.

610.082: Basis of Fair Hearing Decisions

(A) The hearing officer's decision is based upon evidence, testimony, materials, and legal rules, presented at the hearing, including the MassHealth agency's or the Connector's interpretation of its rules, policies, and regulations. Any evidence, testimony, materials, legal rules, or arguments presented after the close of the hearing will be excluded unless the record or hearing is reopened by the hearing officer pursuant to 130 CMR 610.081, or the parties stipulate procedures for response, or the parties otherwise waive the right to respond.

(B) The decision shall be based upon a preponderance of evidence.

(C) The decision must be rendered in accordance with the law.

(1) The law includes the state and federal constitutions, statutes, and duly promulgated regulations, as well as decisions of the state and federal courts.

(2) Notwithstanding 130 CMR 610.082(C)(1), the hearing officer shall not render a decision regarding the legality of federal or state law including, but not limited to, the MassHealth or Connector regulations. If the legality of such law or regulations is raised by the appellant, the hearing officer shall render a decision based on the applicable law or regulation as interpreted by the MassHealth agency or the Connector. Such decision shall include a statement that the hearing officer cannot rule on the legality of such law or regulation and shall be subject to judicial review in accordance with 130 CMR 610.092.

(3) The hearing officer shall give due consideration to Policy Memoranda and any other MassHealth agency or Connector representations and materials containing legal rules, standards, policies, procedures, or interpretations as a source of guidance in applying a law or regulation.

610.083: Content of Decision

- (A) The decision of the hearing officer will contain the following:
- (1) a statement of the issues involved in the hearing;
 - (2) a summary of evidence;
 - (3) findings of fact on all relevant factual matters;
 - (4) rulings of law on all relevant legal issues, with citations to supporting regulations or other law;
 - (5) conclusions drawn from the findings of fact and rulings of law if appropriate; and
 - (6) the hearing officer's order for appropriate action.
- (B) The hearing officer will notify the appellant of his or her right to full and prompt implementation of the decision in accordance with 130 CMR 610.086. The appellant will be further notified of this right to judicial review in accordance with 130 CMR 610.092.

610.084: Transmittal of Decision

Copies of the decision will be forwarded to the appellant, the appellant's appeal representative, the appellant's interpreter (if requested), and representatives of the acting entity, as applicable. The appellant, his or her appeal representative and, for appeals held pursuant to 130 CMR 610.032(C), the nursing facility will also be notified in writing of the right of judicial review.

610.085: Finality of the Appeal Decision

- (A) Except as otherwise provided under 130 CMR 610.085(B), 610.085(C), and 610.091, the following will apply.
- (1) The decision of the hearing officer will be final and binding on the acting entity.
 - (2) The acting entity will not interfere with the independence of the fact-finding process of the hearing officer. Facts found and issues decided by the hearing officer in each case are binding on the parties to that case and cannot be disputed again between them in any other administrative proceeding.
- (B) A hearing decision that directs the MassHealth agency or managed care contractor to authorize or pay for a medical service will have no effect if the appellant has not scheduled or received such medical service within one year from the date of the hearing decision.
- (C) In the case of a decision affecting a member enrolled in an ICO, where both the BOH and the IRE have issued a ruling, the ICO is bound by the rulings and will provide the services which are closest to the enrollee's relief requested on appeal.

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610.086: Implementation of the Appeal Decision

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

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

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

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

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

(B) All Other Decisions.

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

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

(130 CMR 610.087 through 610.090 Reserved)

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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).

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(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.