



**Commonwealth of Massachusetts**  
**Executive Office of Health and Human Services**  
**Division of Medical Assistance**  
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[www.mass.gov/dma](http://www.mass.gov/dma)

MassHealth  
Eligibility Letter 95  
September 1, 2002

**TO:** Division Staff

**FROM:** Wendy E. Warring, Commissioner 

**RE:** **Authorized Representative Changes for Volumes I and II and Begin Date Changes for Volume II**

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This letter transmits revised regulations changing the name, description, and function of the terms, "authorized representative" and "representative." The Division will no longer use the terms, "authorized representative" and "representative," to describe a person who acts on behalf of a MassHealth applicant or member. As part of our efforts to comply with the Healthcare Insurance Portability and Accountability Act (HIPAA) of 1996, we are establishing the following two types of representatives who may act on behalf of the applicant or member.

- Appeal Representative
- Eligibility Representative

An eligibility representative acts on behalf of an applicant or member during the eligibility process, and an appeals representative acts on behalf of an appellant during the appeals process. They can be the same person. The definitions of these two types of representatives are the same, with one exception. Either type of representative can be:

- designated as such, in writing, by the applicant or member for an eligibility representative, or by the appellant for an appeal representative; or
- appointed under applicable law to act on behalf of the applicant, member, or appellant.

In addition, an eligibility representative (but not an appeal representative) can be established when the eligibility representative certifies that he or she is acting responsibly on behalf of the applicant or member when the applicant or member is not

able to responsibly make a written designation, and when no one has been appointed under other applicable law to represent the applicant or member.

This letter also transmits revised regulations regarding denials due to failure to provide requested information, the date of reapplication, and the begin date for MassHealth Standard, Basic, and Limited coverage for Volume II. These revised regulations clarify, but do not change, current policy.

Minor editorial changes were also made to these regulations for purposes of consistency.

These emergency regulations are effective September 1, 2002.

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501.001: Definition of Terms

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

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

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

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

Appeal Representative – a person who:

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

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

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

Billing and Enrollment Intermediary (BEI) – a health-insurance intermediary, registered with the Massachusetts Division of Insurance pursuant to 211 CMR 66.13(3), that performs billing and enrollment services, and has entered into a contract with the Division to perform the services stated in 130 CMR 650.009.

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

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

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

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

Child – a person under age 19.

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

Couple – two persons who are married to each other, live together, and have no children under the age of 19 living with them.

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

Coverage Date – the date medical coverage begins.

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

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

Disabled – having a permanent and total disability.

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

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

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

Eligibility Representative – a person who:

- (1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:
  - (a) has provided the Division with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or
  - (b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

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

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

Family Group – a family, couple, or individual.

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

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

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

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

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

Individual – any person not included in the definition of a family or couple.

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

Insurance Partnership Agent (IPA) – the organization under contract with the Division to help administer the Insurance Partnership, as described in 130 CMR 650.009. The IPA administers Insurance Partnership payments for those qualified employers who do not obtain employee health-insurance coverage through a BEI or an entity linked to a BEI.

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

Large Employer – an employer that:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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 Division that may be assessed to members of MassHealth CommonHealth or MassHealth Family Assistance.

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

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

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

Qualified Employer – a small employer who:

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

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

Small Business – see definition for small employer.

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

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.

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

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

501.007: Receiving Public Assistance from Another State

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

501.008: Massachusetts Commission for the Blind (MCB)

Blind individuals aged 19 through 64 may submit requests for MassHealth to the Massachusetts Commission for the Blind.

501.009: Rights of Applicants and Members

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

(A) Right to Nondiscrimination and Equal Treatment. The Massachusetts Division of Medical Assistance does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the Division's Affirmative Action Office.

(B) Right to Confidentiality. The confidentiality of information obtained by the Division 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.

(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 eligibility representative, has the right, and must be afforded the opportunity without delay, to apply for MassHealth.

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(F) Right to be Assisted by Others.

(1) The applicant or member has the right to be accompanied and represented by an eligibility representative during the eligibility process, and by an appeal representative during the appeal process. The Division must provide copies of all eligibility notices to an applicant's or member's eligibility representative, and must provide copies of all documents related to the fair hearing process to an applicant's or member's appeal representative.

(2) An application for MassHealth may be filed by an eligibility representative on behalf of a deceased person.

(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 501.001.

(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.

(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 Division. 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 Division will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, the Division will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from the Division has limited English proficiency or sensory impairment and requests interpreter services; or

(2) the Division determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The Division will provide a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard, CommonHealth, or Basic, or a MassHealth health plan under Family Assistance has ended. The Division will issue a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by private insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents will be included on the Certificate.

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501.010: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the Division 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.

(B) Responsibility to Report Changes. The applicant or member must report to the Division, within 10 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 will periodically conduct 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 for the family group.

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 Massachusetts General Laws (M.G.L.) c. 118E § 39 by fines, imprisonment, or both. In all cases of suspected fraud, Division staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

501.012: Recovery of Overpayment of Medical Benefits

The Division has the right to recover payment for medical benefits to which the member was not entitled, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 501.012 will limit the Division's right to recover overpayments.

501.013: Estate Recovery

(A) Introduction.

(1) The Division 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 aged 55 or older.

(2) The estate includes all real and personal property and other assets in the member's probate estate.

(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 under 21 years of age, or a child of any age who is blind or permanently and totally disabled.

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(C) Hardship. For claims presented on or after July 1, 1997, 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) a person 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 person 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 Division;

(b) the person was left an interest in the property under the deceased member's will or inherited the property from the deceased member under the laws of intestacy;

(c) the person is not being forced to sell the property by other devisees or heirs at law; and

(d) at the time the Division first presented its claim for recovery against the deceased member's estate, the person's annual gross income was less than or equal to 200 percent of the applicable federal-poverty-level income standard.

(D) For claims presented between April 1, 1995, and July 1, 1997, that are still outstanding, recovery will be waived only if all requirements under the Division's then existing regulations were met. For claims presented before April 1, 1995, a waiver for hardship did not exist.

501.014: Voter Registration

(A) Voter registration forms will be made available through the Division of Medical Assistance to applicants and members who are:

(1) U.S. citizens; and

(2) aged 18 or older, or who will be aged 18 on or before the date of the next election, in accordance with the National Voter Registration Act of 1993.

(B) Applicants and members will be:

(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, in person or by mail, to the Division of Medical Assistance for transmittal to the proper election offices.

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(C) Division 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 Division of Medical Assistance will be transmitted to the proper local election office for processing within five days of receipt.

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502.001: Medical Benefit Request (MBR)

(A) To apply for MassHealth, a person or his or her eligibility representative must file a Medical Benefit Request (MBR) at a MassHealth Enrollment Center, or Division outreach site. All members of the family group, as defined in 130 CMR 501.001, must be listed on the MBR whether or not they are applying for MassHealth.

(B) The Division requests all corroborative information necessary to determine eligibility. Such information must be provided by the applicant within 60 days of the date of the Request for Information.

(C) If all necessary information is received, except verification of immigration status and/or verification of a person's HIV-positive status, within the 60-day period referenced in 130 CMR 502.001(B), the MBR is considered complete. The completed MBR activates the Division's eligibility process for determining the coverage type that will provide the most comprehensive medical benefits for which the applicant is eligible.

(D) If the necessary information is not received within the 60-day period referenced in 130 CMR 502.001(B), the Division notifies the applicant of the deactivation of the MBR.

502.002: Reactivating the Medical Benefit Request

If all required information is received by the Division after the 60-day period described in 130 CMR 502.001(D), or after a denial of eligibility, the Division reactivates the MBR as of the date the information is received, and the medical coverage date is established in accordance with 130 CMR 502.006. A new MBR must be completed if all required information is not received within one year of receipt of the previous MBR.

502.003: Presumptive Eligibility for Children

(A) The Division may determine a child presumptively eligible for either MassHealth Standard or MassHealth Family Assistance based on the family group's self-declaration of gross income. A child may be presumptively eligible for medical benefits under Family Assistance only if he or she does not have health insurance.

(B) Coverage for services under Presumptive Eligibility begins on the 10<sup>th</sup> day before the date the Division receives the Medical Benefit Request. Presumptive Eligibility coverage ends 60 days from the begin date, or when the Division makes an eligibility determination, whichever is earlier.

(C) A child may receive Presumptive Eligibility only once in a 12-month period.

502.004: Matching Information

The Division initiates information matches with other agencies and information sources when an MBR is received. These agencies and information sources may include, but are not limited to, the following: The Department of Employment and Training, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's

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502.008: Notice

(A) All applicants and members receive a written notice of the eligibility determination for MassHealth. The notice contains an eligibility decision for each member of the family group who has requested MassHealth, and either provides information so the applicant or member can determine the reason for any adverse decision or directs the applicant or member to such information.

(B) Members also receive a notice, in accordance with 130 CMR 610.015, of any loss of coverage, or any changes in coverage type, premium, or premium assistance payments.

(C) The notices described in 130 CMR 502.008(A) and (B) provide information about the applicant's and member's right to a fair hearing, with the exception of notices about eligibility for presumptive coverage as described at 130 CMR 505.002(C)(4) and 505.005(C)(2), and for prenatal coverage as described at 130 CMR 505.003. Information about the appeal process is found at 130 CMR 610.000.

502.009: Voluntary Withdrawal

The applicant or eligibility representative may voluntarily withdraw his or her request for MassHealth.

502.010: Issuance of a MassHealth Card

(A) The Division issues a MassHealth card to a new member, with the exception of those who receive MassHealth Buy-In under 130 CMR 505.007, or premium assistance for children (at 130 CMR 505.005(B)) or adults (at 130 CMR 505.005(C)) under MassHealth Family Assistance.

(B) A temporary card may be issued to a member if there is an immediate need.

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515.001: Definition of Terms

The terms listed in 130 CMR 515.001 have the following meanings for purposes of MassHealth, as described in 130 CMR 515.000 through 522.000.

Activities of Daily Living (ADLs) — self-care activities including, but not limited to, bathing, grooming, dressing, eating, and toileting.

Affidavit — a written or printed statement of fact sworn to or affirmed before a person having legal authority to administer such an oath.

Annuity — a legal instrument that pays a fixed sum in regular, periodic installments for a designated period of time, or for life.

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

Appeal Representative — a person who:

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

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

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

Applicant — a person who completes and submits an application for MassHealth, and is awaiting the decision of eligibility.

Application — see "MassHealth Application."

Asset Limit — the maximum dollar value of assets that can be owned by, or available to, the applicant, member, or the spouse, which if exceeded, results in ineligibility.

Assets — property including, but not limited to, real estate, personal property, and funds. This term has the same meaning as "resources" as defined in 42 U.S.C. 1396p(e)(5).

Available — a resource that is countable under Title XIX of the Social Security Act.

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

Burial Trust — a trust established by an individual solely for funeral expenses, burial expenses, or both.

Business Day — any day during which the Division’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.

Community Resident — a person who lives in a noninstitutional setting in the community.

Competent Medical Authority — a physician or psychiatrist licensed by any state, a psychologist licensed by the Commonwealth of Massachusetts, or both.

Countable Income — the types of income that are considered in the determination of eligibility.

Countable-Income Amount — gross income less certain business expenses and income deductions.

Couple — two persons married to each other according to the rules of the Commonwealth of Massachusetts.

Coverage Date — the date medical coverage begins.

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

Curing of a Transfer — the return, following the transfer for less than fair-market value of a portion of, or the full uncompensated value of, a resource to the individual.

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

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Deductible — the total dollar amount of incurred medical expenses that an applicant whose income exceeds MassHealth income standards at 130 CMR 520.028 et seq. must be responsible for before the applicant is eligible for MassHealth.

Deductible Period — a specified six-month period within which an applicant for MassHealth, whose income exceeds MassHealth income standards, may become eligible if the applicant or the spouse incurs medical bills equaling or exceeding the deductible.

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

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

Eligibility Representative – a person who:

- (1) has, under applicable law, authority to act on behalf of an applicant or member in making decisions related to health care or payment for health care. An eligibility representative may include, but is not limited to, a guardian, conservator, executor, administrator, holder of power of attorney, or health-care proxy; or
- (2) is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made during the eligibility process, and who fulfills at least one of the following two conditions:
  - (a) has provided the Division with written authorization from the applicant or member to act on the applicant's or member's behalf during the eligibility process; or
  - (b) is acting responsibly on behalf of an applicant or member for whom written authorization cannot be obtained.

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

Fair-Market Value — an estimate of the value of a resource if sold at the prevailing price. For transferred resources, the fair-market value is based on the prevailing price at the time of transfer.

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.

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Global Developmental Skills — a child's average developmental skill level, taking into account the physical, psychological, motor, intellectual, emotional, communicative, and social aspects of the child's functional capabilities.

Grantor — an individual or spouse who creates a trust.

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

Guardian — an individual or entity appointed as guardian by the probate and family court under the provisions of M.G.L. c. 201.

Guardianship Fees and Related Expenses — fees for guardianship services and incurred expenses that are essential to enable an incompetent applicant or member to gain access to or consent to medical treatment.

Income Deductions — specified deductions, as described in 130 CMR 520.011 through 520.014, that may be made from the gross income of an applicant or member.

Incompetent Applicant or Member — an applicant or member who has been adjudicated as incompetent and in need of a guardian by the probate and family court under the provisions of M.G.L. c. 201.

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

Institution (Medical) — a public or private facility providing acute, chronic, or long-term care, unless otherwise defined within 130 CMR 515.000 through 522.000. This includes acute inpatient hospitals, licensed nursing facilities, state schools, intermediate-care facilities for the mentally retarded, public or private institutions for mental diseases, freestanding hospices, and chronic-disease and rehabilitation hospitals.

Institutionalization — placement of an individual in one or more medical institutions, where placement lasts or is expected to last for a continuous period of at least 30 days.

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

Irrevocable Trust — a trust that cannot be in any way revoked by the grantor.

Jointly Held Resources — resources that are owned by an individual in common with another person or persons in a joint tenancy, tenancy-in-common, or similar arrangement.

Life Estate — a life estate is established when all of the remainder legal interest in a property is transferred to another, while the legal interest for life rights to use, occupy, or obtain income or profits from the property is retained.

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

Look-Back Period — a period of consecutive months that the Division may review for transfers of resources to determine if a period of ineligibility for payment of nursing-facility services should be imposed.

Lump-Sum Income — a one-time payment, such as an inheritance or the accumulation of recurring income.

MassHealth Application — a form prescribed by the Division that has been completed by the applicant or an eligibility representative, and submitted to the Division as a request for MassHealth benefits. An application ceases to be an application when it is denied and not appealed.

Medical Benefits — payment for medical services provided to a MassHealth member.

Member — a person determined by the Division to be eligible for MassHealth.

Nursing-Facility Resident — an individual who is a resident of a nursing facility, is a resident in any institution, including an intermediate-care facility for the mentally retarded (ICF/MR), for whom payment is based on a level of care equivalent to that received in a nursing facility, is in an acute hospital awaiting placement in a nursing facility, or lives in the community and would be institutionalized without community-based services provided in accordance with 130 CMR 519.007(B).

Patient-Paid Amount — the amount that a member in a long-term-care facility must contribute to the cost of care under the laws of the Commonwealth of Massachusetts.

Period of Ineligibility — the period of time during which the Division denies or withholds payment for nursing-facility services because the individual has transferred resources for less than fair-market value.

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

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

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

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

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

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

(2) For Children Under Age 18. The condition of an individual under the age of 18 who has any medically determinable physical or mental impairment, or combination of impairments, that causes marked and severe functional limitations, as defined in Title XVI of the Social Security Act, and can be expected to cause death or can be expected to last for a continuous period of not less than 12 months. Disability for children eligible for MassHealth CommonHealth under 130 CMR 519.012(B) is determined in accordance with the definition for permanent and total disability for children under the age of 18 in 130 CMR 501.001.

Personal Needs Allowance (PNA) — the designated portion of monthly income that a person in long-term care is allowed to retain for personal expenses. In some instances, the Division pays all or a portion of the PNA to the member. The PNA must not be used for payment of any item included in the daily rate at the long-term-care facility.

Personal Needs Allowance (PNA) Account — an account administered by a long-term-care facility on behalf of a member. Regulations regarding the administration of PNA accounts are contained in 130 CMR 456.000.

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Pooled Trust — A pooled trust is one that meets all the following criteria as determined by the Division.

- (1) The trust was created by a nonprofit organization.
- (2) A separate account is maintained for each beneficiary of the trust, but the assets of the trust are pooled for investment and management purposes.
- (3) The account in a pooled trust was created for the sole benefit of the individual by the individual, the individual's parents or grandparents, or by a legal guardian or court acting on behalf of the individual.
- (4) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the Division for services to the individual. The trust may retain reasonable and appropriate amounts as determined by the Division.
- (5) The individual was disabled at the time his or her account in the pool was created.

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

Reapplication – the Division’s reopening of the application process when the application has been denied pursuant to 130 CMR 516.001(D).

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

Resources — all income and assets owned by the individual or the spouse. For the purposes of determining eligibility, resources include income and assets to which the individual or the spouse is or would be entitled whether or not they are actually received. This term has the same meaning as “assets” as defined in 42 U.S.C. 1396p(e)(1).

Reverse Mortgage — a loan on the equity value of a house paid in installments by a lender to the homeowner who is aged 60 or older.

Revocable Trust — a trust whose terms allow the grantor to take action to regain any of the property or funds in the trust.

Skilled-Nursing Services — the planning, provision, and evaluation of goal-oriented nursing care that requires specialized knowledge and skills acquired under the established curriculum of a school of nursing approved by a board of registration in nursing. Such services include only those services that must be provided by a registered nurse, a licensed practical nurse, or a licensed vocational nurse.

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Special-Needs Trust — a special-needs trust is one that meets all the following criteria as determined by the Division.

- (1) The trust was created for a disabled individual under the age of 65.
- (2) The trust was created for the sole benefit of the individual by the individual's parent, grandparent, legal guardian, or a court.
- (3) The trust provides that the Commonwealth of Massachusetts will receive amounts remaining in the account upon the death of the individual up to the amount paid by the Division for services to the individual.
- (4) When the member has lived in more than one state, the trust must provide that the funds remaining upon the death of the member are distributed to each state in which the member received Medicaid based on each state's proportionate share of the total amount of Medicaid benefits paid by all states on the member's behalf.

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

Stream of Income — income received on a regular basis.

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.

Supplemental Security Income (SSI) Program — a program that provides financial assistance to needy persons who are aged 65 or older, blind, or disabled. This program is established under Title XVI of the Social Security Act and is administered by the Social Security Administration. Such persons automatically receive MassHealth through the Division of Medical Assistance.

Third Party — any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

Trust — a legal device satisfying the requirements of state law that places the legal control of property or funds with a trustee. It also includes, but is not limited to, any legal instrument, device, or arrangement that is similar to a trust, including transfers of property by a grantor to an individual or a legal entity with fiduciary obligations so that the property is held, managed, or administered for the benefit of the grantor or others. Such arrangements include, but are not limited to, escrow accounts, pension funds, and similar devices as managed by an individual or entity with fiduciary obligations.

Trustee — any individual or legal entity that holds or manages a trust.

Uncompensated Value — the difference between the fair-market value of the resource or interest in the resource at the time of transfer less any outstanding debts and the actual amount the individual received for the resource. The Division uses the uncompensated value in the calculation of the period of ineligibility.

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515.005: Receiving Public Assistance from Another State.

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

515.006: Massachusetts Commission for the Blind.

Persons who are blind and aged 65 or older or institutionalized may apply for MassHealth with the Massachusetts Commission for the Blind (MCB).

515.007: Rights of Applicants and Members

The policies of MassHealth 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 Division of Medical Assistance does not discriminate on the basis of race, color, sex, sexual orientation, religion, national origin, disability, or age in admission or access to, or treatment or employment in, its programs or activities. Grievance procedures for resolution of discrimination complaints are administered and applied by the Division's Affirmative Action Office.

(B) Right to Confidentiality. The confidentiality of information obtained by the Division 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 to 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 516.000.

(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 eligibility 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 and represented by an eligibility representative during the eligibility process, and by an appeal representative during the appeal process. The Division must provide copies of all eligibility notices to an applicant's or member's eligibility representative, and must provide copies of all documents related to the fair hearing process to an applicant's or member's appeal representative.

(2) An application for MassHealth may be filed by an eligibility representative on behalf of a deceased person.

(3) An appeal on behalf of a deceased person may be filed by an appeal representative, as defined in 130 CMR 515.001.

(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.

(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 Division. 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 Division will inform applicants and members of the availability of interpreter services. Unless the applicant or member chooses to provide his or her own interpreter services, the Division will provide either telephonic or other interpreter services whenever:

(1) the applicant or member who is seeking assistance from the Division has limited English proficiency or sensory impairment and requests interpreter services; or

(2) the Division determines such services are necessary.

(J) Right to a Certificate of Creditable Coverage Upon Termination of MassHealth. The Division will provide a Certificate of Creditable Coverage to members whose coverage under MassHealth Standard, CommonHealth, or Basic has ended. The Division will issue a Certificate to members within one week of their MassHealth termination, or within one week of the request for a Certificate, as long as the request is made within 24 months of their MassHealth termination. The Certificate may allow members to waive or reduce the length of preexisting-condition waiting periods when they enroll in a new health plan offered by private insurance. If a member's MassHealth termination also terminates the coverage of his or her dependents, the dependents will be included on the Certificate.

515.008: Responsibilities of Applicants and Members

(A) Responsibility to Cooperate. The applicant or member must cooperate with the Division in providing information necessary to establish and maintain eligibility, and must comply with all the rules and regulations of MassHealth, including recovery.

(B) Responsibility to Report Changes. The applicant or member must report to the Division, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, assets, inheritances, gifts, transfers of and proceeds from the sale of real or personal property, distributions from or transfers into trusts, address, the availability of health insurance, and third-party liability.

(C) Cooperation with Quality Control. The Quality Control Division will periodically conduct 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.

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515.009: 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, Division staff will make a referral to the Bureau of Special Investigations, or other appropriate agencies.

515.010: Recovery of Overpayment of Medical Benefits

The Division has the right to recover payment of medical benefits to which the member was not entitled, regardless of who was responsible and whether or not there was fraudulent intent. No provision under 130 CMR 515.011 will limit the Division's right to recover overpayments.

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516.001: Overview

- (A) The eligibility process consists of the activities conducted for the purpose of determining, redetermining, and maintaining eligibility.
- (B) All applicants must file an application for MassHealth at a MassHealth Enrollment Center or outreach site.
- (C) The Division may request additional information or documentation, if necessary, to determine eligibility.
- (1) The Division will send the applicant written notification requesting verifications to corroborate information necessary to determine eligibility, generally within five days of the receipt of the application.
- (2) The notice must advise the applicant that the requested verifications must be received within 30 days of the date of the request, and of the consequences of failure to provide the information.
- (D) If the requested information, with the exception of verification of immigration status, is not provided within 30 days of the date of the request, MassHealth benefits may be denied.
- (1) If the requested information is submitted within 30 days of the denial, the date of receipt of one or more of the verifications will be considered the date of reapplication.
- (2) The date of reapplication replaces the date of the denied application. The applicant's earliest date of eligibility for MassHealth is based on the date of reapplication.
- (3) If a reapplication is subsequently denied and not appealed, the applicant must submit a new written application for benefits to pursue eligibility for MassHealth. The earliest date of application then becomes the date of the new written application.

516.002: Date of Application

- (A) The date of application is the date that a completed application is received at a MassHealth Enrollment Center or outreach site. An application is considered complete when all financially related questions have been answered. If unsigned, the application will be returned for a signature during the verification process.
- (B) If an applicant, aged 65 or older, has been denied SSI in the 30-day period before the date of application for MassHealth, the date of application for MassHealth will be the date the person applied for SSI.

516.003: Matching Information

The Division initiates matches with other agencies when an application for MassHealth is received in order to update or verify eligibility. These agencies and matches may include, but are not limited to, the following agencies: the Department of Employment and Training, Department

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of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and banks and other financial institutions.

516.004: Time Standards for Eligibility Determination

(A) For applicants who do not apply on the basis of a disability, a determination of eligibility must be made within 45 days from the date of receipt of the complete application for MassHealth.

(B) For applicants who apply for MassHealth on the basis of a disability, a determination of eligibility must be made within 90 days from the date of receipt of the complete application, including a disability supplement, if required. If the Division determines unusual circumstances exist, the timeframes for determining eligibility will be extended.

516.005: Coverage Date

The begin date of Standard, Basic, or Limited coverage may be retroactive to the first day of the third month before the month of application, if covered medical services were received during such period, and the applicant or member would have been eligible at the time services were provided. If more than one application has been submitted and not denied, the begin date will be based on the earliest application that is approved.

516.006: Eligibility Determination

(A) The Division will review eligibility at least every 12 months with respect to circumstances that may change. The Division will update the file based on information received as the result of such review. Eligibility may be reviewed:

- (1) as a result of a member's reported changes in circumstances;
- (2) by external matching with other agencies; and
- (3) where matching is not available, through a written update of the member's circumstances on a prescribed form.

(B) If the member fails to provide a written update or information within 30 days of the request, MassHealth coverage may be terminated.

(C) If the requested update or information is submitted within 30 days from the date of the termination, a second eligibility determination will be made within 15 days. Eligibility may be established retroactive to the date of termination, if otherwise eligible.

516.007: Notice

(A) All applicants and members, as well as certain others described below in 130 CMR 516.007, will receive written notice of the determination of eligibility for MassHealth. The notice will contain an eligibility decision for each member who has requested MassHealth, and provide information enabling the applicant or member to determine the reason for any adverse decision.

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(B) Members will also receive a notice of any changes in coverage type or patient-paid amount, or of loss of coverage.

(C) In addition to sending notices to applicants and members, such written notices will be provided to the institution or eligibility representative, as well as the community spouse, as defined at 130 CMR 520.016(B)(1)(c). This may include, in the case of death, the executor, administrator, or legal representative of the deceased individual's estate.

(D) All notices will provide information about the right of the applicant or member to a fair hearing, with the exception of asset assessments described at 130 CMR 520.016. Information about the appeal process is found at 130 CMR 610.000.

516.008: Voluntary Withdrawal

The applicant or eligibility representative may voluntarily withdraw his or her request for MassHealth. An eligibility representative may also withdraw a request for MassHealth on behalf of a deceased applicant.

516.009: Issuance of a MassHealth Card

(A) The Division will issue a MassHealth card to a new member, with the exception of those who receive MassHealth Buy-In coverage.

(B) A temporary card may be issued to a member if there is an immediate need.

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519.007: Individuals Who Would Be Institutionalized

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

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

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

- (a) meet Title XVI disability standards in accordance with the definition of permanent and total disability for children under the age of 18 in 130 CMR 515.001; or have been receiving SSI on August 22, 1996, and continue to meet Title XVI disability standards that were in effect before August 22, 1996;
- (b) have \$2,000 or less in countable assets;
- (c) have a countable-income amount of \$60 or less; or, if greater than \$60, meet a deductible in accordance with 130 CMR 520.028 et seq.; and

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520.006: Inaccessible Assets

(A) Definition. An inaccessible asset is an asset to which the applicant or member has no legal access. The Division does not count an inaccessible asset when determining eligibility for MassHealth for the period that it is inaccessible or is deemed to be inaccessible under 130 CMR 520.006.

(B) Examples of Inaccessible Assets. Inaccessible assets include, but are not limited to:

(1) property, the ownership of which is the subject of legal proceedings (for example, probate and divorce suits); and

(2) the cash-surrender value of life-insurance policies when the policy has been assigned to the issuing company for adjustment.

(C) Date of Accessibility. The Division considers accessible to the applicant or member all assets to which the applicant or member is legally entitled:

(1) from the date of application or acquisition, whichever is later, if the applicant or member does not meet the conditions of 130 CMR 520.006(C)(2)(a) or (b); or

(2) from the period beginning six months after the date of application or acquisition, whichever is later, if:

(a) the applicant or member cannot competently represent his or her interests, has no guardian or conservator capable of representing his or her interests, and the eligibility representative (which may include a provider) of such applicant or member is making a good-faith effort to secure the appointment of a competent guardian or conservator; or

(b) the sole trustee of a Medicaid Qualifying Trust, under 130 CMR 520.022(B), is one whose whereabouts are unknown or who is incapable of competently fulfilling his or her fiduciary duties, and the applicant or member, directly or through an eligibility representative (which may include a provider), is making a good-faith effort to contact the missing trustee or to secure the appointment of a competent trustee.

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- (G) retroactive RSDI and SSI benefit payments; and
- (H) any other income considered noncountable under Title XIX.

520.016: Long-Term Care: Treatment of Assets

130 CMR 520.016 describes the treatment of countable assets when one member of a couple is institutionalized, the post-eligibility transfer of assets, and the allowable income deductions for applicants and members who are residents of a long-term-care facility.

(A) Institutionalized Individuals. The total value of assets owned by an institutionalized single individual or by a member of an institutionalized couple must not exceed \$2,000.

(B) Treatment of a Married Couple's Assets When One Spouse Is Institutionalized.

(1) Assessment.

(a) Requirement. The Division completes an assessment of the total value of a couple's combined countable assets and computes the spousal share as of the date of the beginning of the most recent continuous period of institutionalization of one spouse.

(b) Right to Request an Assessment. When one spouse has entered a medical institution and is expected to remain institutionalized for at least 30 days, either spouse may request the Division to make this assessment, even if the institutionalized spouse is not applying for MassHealth Standard at that time. The period of institutionalization must be continuous and expected to last for at least 30 days.

(c) Right to Appeal. The Division must give each spouse a copy of the assessment and the documentation used to make such assessment. Each spouse must be notified that he or she has the right to appeal the determination of countable assets and the community spouse's asset allowance when the institutionalized spouse (or eligibility representative) applies for MassHealth Standard.

(d) Calculation of the Community Spouse's Asset Allowance. From the couple's combined countable assets, the Division attributes to the community spouse an asset-allowance amount not to exceed \$89,280 even if the assets are held individually. The community spouse's share remains a constant amount for purposes of determining the amount of assets that are used to determine the institutionalized spouse's eligibility.

(2) Determination of Eligibility for the Institutionalized Spouse. At the time that the institutionalized spouse applies for MassHealth Standard, the Division must determine the couple's current total countable assets, regardless of the form of ownership, and the amount of assets allowed for the community spouse as follows. The community spouse's asset allowance is not considered available to the institutionalized spouse when determining the institutionalized spouse's eligibility for MassHealth Standard.

(a) Assign \$2,000 of the current total countable assets to the institutionalized spouse.

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610.001: Purpose

The purpose of 130 CMR 610.000 is to set forth procedures that govern the conduct of adjudicatory proceedings whereby dissatisfied applicants, members, and employers seek administrative review of certain actions or inactions on the part of the Division of Medical Assistance. 130 CMR 610.000 also contains provisions under which nursing facility residents may seek review of discharges and transfers by a nursing facility.

610.002: Authority

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

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 Division. Appeals pursuant to the Executive Office of Elder Affairs Supplementary Rules to the Adjudicatory Rules of Practice and Procedures, 651 CMR 1.00 et seq., are governed by the procedures set forth in 130 CMR 610.000. Appeals by residents of a nursing facility who are to be discharged or transferred at the initiation of the nursing facility are governed by 130 CMR 610.000. Adjudicatory proceedings initiated by medical assistance providers are governed by 130 CMR 450.241 through 450.248 or, with regard to appeals of erroneously denied claims, by 130 CMR 450.323.

610.004: Definitions

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

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

Appealable Action – an action by the Division to deny, reduce, suspend, terminate, or restrict assistance to:

- (1) an individual receiving or seeking assistance from the Division; or
- (2) an employer receiving or seeking payments through the Insurance Partnership.

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.

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Appeal Representative – a person who:

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

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

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

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

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

BOH – the Board of Hearings within the Division of Medical Assistance.

Director – the Director of the Board of Hearings.

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

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

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

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

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

Insurance Partnership – a program administered by the Division of Medical Assistance to help qualified employers offer health insurance.

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

Member – a person or family who is or had been receiving assistance under a program administered by the Division.

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 nursing facility, the respondent to a complaint of coercive behavior, or the Division.

Policy Memorandum – a written explanation, issued by the Commissioner or the General Counsel's office, of the Division's intent and interpretation or application of its regulations under 130 CMR.

Provider – any entity that furnishes medical services.

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

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

Timely Notice – adequate notice that meets the additional requirements set forth in 130 CMR 610.015. Before an intended appealable action, the Division 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 calendar days before the action.

Timely Request – a request for a fair hearing received by BOH within the timely notice period.

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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 will not constitute a transfer.

(130 CMR 610.005 through 610.010 Reserved)

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from the date of the conduct provided the appellant files an affidavit with the Director stating, and can establish at a hearing, that:

- (i) he or she did not know of the right to appeal, and reasonably believed that the problem was being resolved administratively; or
- (ii) he or she was justifiably unaware of the conduct in question; and
- (iii) the appeal was made in good faith.

Failure to substantiate the allegation either before or at the hearing will be grounds for dismissal.

- (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; or
- (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.

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

(D) Time Limits for Rendering a Decision.

- (1) The hearing officer must render a final decision within 45 days of the date of request for a hearing when the issue under appeal is:
  - (a) the denial or rejection of an application for assistance;
  - (b) the failure to act on an application in a timely manner; or
  - (c) a nursing facility-initiated discharge or transfer.

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

(3) The time limits set forth in 130 CMR 610.015(D)(1) and (2) 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 Division 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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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 Division must provide copies of all documents related to the fair hearing process to the appellant and to the appeal representative, if any. An appeal representative may exercise on the appellant's behalf any of the appellant's rights under 130 CMR 610.000.

(B) When an interpreter also acts as the appellant's appeal representative, the appellant will supply a signed written statement to that effect in both English and, where applicable, in the appellant's primary language.

610.017: Auxiliary Aids

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

(130 CMR 610.018 through 610.025 Reserved)

610.028: 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 Division 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 Division 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 Division will provide the applicant or member with an appeal form and, if requested, help complete the form. The Division 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 Division.
- (E) At the time the Division 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 Division.

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 Division 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 Division action to suspend, reduce, terminate, or restrict a member's assistance;
  - (4) individual Division determinations regarding scope and amount of assistance (including, but not limited to, level-of-care determinations);
  - (5) coercive or otherwise improper conduct as defined in 130 CMR 610.033 on the part of any Division employee directly involved in the applicant's or member's case;
  - (6) any condition of eligibility imposed by the Division for assistance or receipt of assistance that is not authorized by federal or state law or regulations;

- (7) the failure of the Division to act upon a request for assistance within the time limits required by Division regulations;
  - (8) the Division's determination that the member is subject to the provisions of 130 CMR 508.000;
  - (9) the Division's denial of an out-of-area provider under 130 CMR 508.002(F);
  - (10) the Division's disenrollment of a member from a managed-care provider under 130 CMR 508.002(G); and
  - (11) a determination by the Division's behavioral health contractor, under 130 CMR 508.003(A), or by one of the Division's managed-care organization (MCO) contractors, under 130 CMR 508.001(B)(2)(b), to deny, reduce, modify, or terminate a covered service, if the member has exhausted all remedies available through the contractor's internal appeals process.
- (B) Nursing facility residents have the right to request an appeal of any nursing facility-initiated transfer or discharge.
- (C) Determinations of temporary eligibility for presumptive coverage or prenatal coverage are not appealable. See 130 CMR 502.008(C).
- (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.

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 Division 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.

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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 Division 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 Division 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 appeal decision 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 Division 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 Division 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 by the Division.

(E) The provisions of 130 CMR 610.036(A) and (B), regarding assistance pending a hearing decision, will not apply to assistance requiring prior authorization where such assistance terminates as the result of the expiration of the specified, finite authorization period, and the member's provider has failed to timely submit a new prior authorization request.

(130 CMR 610.037 through 610.045 Reserved)

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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 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 Division'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 Division 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 the appellant, the appropriate office of the Division, and if applicable, the Division 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:

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.

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

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 Division at the hearing. An appointment must be scheduled in advance with the appropriate MassHealth enrollment center for examination of the case file.

610.051: Adjustment Procedures and Mediation

(A) Division Representative. The Division 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 Division policies and procedures. Ordinarily, complaints may be resolved with an explanation of the regulations by the Division representative. If the Division representative's explanation is not satisfactory, the Division representative's immediate supervisor will be available to respond to the complaint. If the complaint cannot be resolved, the Division will remind the applicant or member of the right to request a fair hearing.

(B) Adjustments Resolving Issues. The Division 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.

610.061: 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 Division 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: Division Rights and Responsibilities

The Division 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 Division representative if the Division is a party at the hearing, and arrange for adequate space for the hearing;
- (C) have the right to present witnesses;
- (D) ensure that the case file is available at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;
- (E) introduce into evidence material from the case file and other pertinent Division documents that pertain to the issue or issues raised during the hearing and that are not otherwise confidential;
- (F) present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (G) have the right to advance any pertinent arguments without undue interference;
- (H) have the right to question and refute any testimony and confront and cross-examine adverse witnesses; and
- (I) have the right to arrange for the appearance at the hearing of a representative of other assistance programs, where appropriate.

610.063: Nursing Facility Rights and Responsibilities

The nursing facility will:

- (A) submit at the hearing all evidence on which the discharge or transfer decision at issue is based;
- (B) designate a staff person or representative to represent the nursing facility at the hearing and arrange for adequate space for the hearing if requested by the Division;
- (C) have the right to present witnesses;
- (D) ensure that the resident record is present at the hearing and that the appellant has adequate opportunity to examine it before and during the hearing;
- (E) have the right to introduce into evidence material from the resident record and other pertinent documents that pertain to the issue or issues raised during the hearing;
- (F) have the right to present and establish all relevant facts and circumstances by oral testimony and documentary evidence;
- (G) have the right to question and refute any testimony and confront and cross-examine adverse witnesses; and
- (H) have the right to be represented by legal counsel at the hearing.

610.064: Division Employee Rights

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

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

610.071: Evidence

(A) General.

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

(2) The hearing officer will not exclude evidence at the hearing for the reason that it had not been previously submitted to the Division, provided that the hearing officer may permit the Division 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

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. 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 Division 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)

610.083: 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), the Division's representatives, and, for appeals held pursuant to 130 CMR 610.032(B), the nursing facility. The appellant, his or her appeal representative and, for appeals held pursuant to 130 CMR 610.032(B), the nursing facility will also be notified in writing of the right of judicial review.

610.085: Finality of the Appeal Decision

(A) Except as otherwise provided under 130 CMR 610.085(B) and 610.091, the following will apply.

- (1) The decision of the hearing officer will be final and binding on the Division.
- (2) The Division 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 Division 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.

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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 Division's final action and the appellant has 30 days from the final action to file a Complaint for Judicial Review.

(D) The Division 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.