130 CMR 456.000: LONG TERM CARE SERVICES

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456.401: Nursing Facility Services: Introduction

130 CMR 456.000 establishes the requirements for nursing facility services under MassHealth. All nursing facilities participating in MassHealth must comply with the regulations governing MassHealth including, but not limited to, 130 CMR 456.000 and 450.000: *Administrative and Billing Regulations*.

456.402: Definitions

Board of Hearings (BOH). The unit within MassHealth that is responsible for administering the fair-hearing process under 130 CMR 610.000: *MassHealth: Fair Hearing Rules* and claims for adjudication hearings under 130 CMR 450.241: *Hearings: Claim for an Adjudicatory Hearing*, including hearings about transfers and discharges of residents by nursing facilities.

Department of Developmental Services (DDS). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 19B. DDS also serves as the Preadmission and Resident Review (PASRR) authority for intellectual disabilities and developmental disabilities.

Department of Mental Health (DMH). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 19. DMH also serves as the PASRR authority for serious mental illness.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 17.

Discharge. Movement of a resident from a nursing facility to a noninstitutional setting resulting in the cessation of the discharging nursing facility's legal responsibility for the care of that individual. A nursing facility's failure to resume care of or to readmit an individual following hospitalization or other medical leave of absence is considered a discharge.

DPH Multi-disciplinary Medical Review Team (MRT). A multi-disciplinary interagency team, established pursuant to M.G.L. c. 111 § 4J, and authorized to make determinations about nursing facility eligibility for individuals younger than 22 years old.

EOHHS. The Executive Office of Health and Human Services established under M.G.L. c. 6A.

Fair Hearing. An administrative, adjudicatory proceeding conducted pursuant to 130 CMR 610.000: *MassHealth: Fair Hearing Rules* to determine the legal rights, duties, benefits, or privileges of applicants, members, or residents.

Hospital. A facility that is licensed or operated as a hospital by DPH or DMH, and provides diagnosis and treatment on an inpatient basis for patients who have any variety of medical conditions.

Length of Stay. The duration of a member's inpatient hospital stay at a Medicare hospital level of care during a medical leave of absence.

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

MassHealth Agency. The Executive Office of Health and Human Services, which is the state that is designated under the state plan as the Single State Agency responsible for the administration of MassHealth, in accordance with the provisions of M.G.L. c. 118E.

Medical Leave of Absence (MLOA). An inpatient hospital stay for an individual who is a resident of a nursing facility. Medical leave of absence also includes an observation stay.

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Medicare Hospital Level of Care. a level of care that meets all criteria, as determined by the Centers for Medicare & Medicaid Services or its designee, for Medicare payment for hospital care.

Member. A person determined by MassHealth to be eligible for MassHealth.

Mobility System. A manual or power wheelchair or other wheeled device, such as a scooter, including a base, a seating system, its components, accessories, and modifications.

Non-medical Leave of Absence (NMLOA). A temporary absence from the nursing facility for non-medical reasons subject to the requirements in 130 CMR 456.431 and 456.432

Nursing Facility (NF). An institution or a distinct part of an institution that meets the provider-eligibility and certification requirements of 130 CMR 456.404 or 456.405.

Observation Stay. Outpatient hospital services provided anywhere in an acute inpatient hospital to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under order of a physician or PCP, consistent with the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Patient-paid Amount (PPA). The portion of monthly income that a member in a nursing facility must contribute to the cost of care.

Personal Needs Allowance (PNA). The designated portion of monthly income that a member in a facility is allowed to keep for personal expenses.

Personal Needs Allowance Account. An account or accounts administered by a nursing facility on behalf of a member. The account may be used to deposit the PNA and any other money, such as a gift, belonging to the member.

Primary Care Provider (PCP). Any of the following: a physician, a physician assistant, or a nurse practitioner operating within the scope of their licensure and supervision requirements, as applicable.

Resident. An individual receiving care in a nursing facility regardless of whether the individual is a MassHealth member.

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 MassHealth-certified bed;
(4) one nursing facility to another nursing facility; or
(5) a nursing facility to a hospital, or any other institutional setting.

A nursing facility's failure to readmit a resident following hospitalization or other medical leave of absence, resulting in the resident being moved to another institutional setting, is also a transfer. Movement of a resident within the same facility from one certified bed to another bed with the same certification is not a transfer.

Working Days. Monday through Friday except for legal holidays.

456.403: Eligible Members

(A)(1) MassHealth Members. MassHealth pays for nursing facility services only when provided to eligible MassHealth members, subject to the restrictions and limitations in MassHealth regulations. MassHealth's regulations at 130 CMR 450.105: *Coverage Types* specifically state which services are covered and which members are eligible to receive those services.

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(2) Recipients of Emergency Aid to the Elderly, Disabled and Children. For information on covered services for recipients of Emergency Aid to the Elderly, Disabled and Children, *see* 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program.*

(B) For information on verifying member eligibility and coverage type, *see* 130 CMR 450.107: *Eligible Members and the MassHealth Card.*

456.404: Requirements for Provider Participation: In-state

To be eligible to participate in MassHealth, a nursing facility located in Massachusetts must

(A) be licensed by the Massachusetts Department of Public Health to operate such a facility;

(B) be continuously certified by the Massachusetts Department of Public Health as meeting the federal requirements for participation in MassHealth in accordance with Title XIX of the Social Security Act and the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406;

(C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406;

(D) enter into a provider agreement with MassHealth;

(E) accept MassHealth payments as payment in full for nursing facility services pursuant to 130 CMR 450.203: *Payment in Full*; and

(F) agree to periodic inspections, by MassHealth or its designee, that assess compliance with 130 CMR 456.000.

456.405: Requirements for Provider Participation: Out-of-state

To be eligible to participate in MassHealth, an out-of-state nursing facility must

(A) be licensed by the appropriate state licensing authority to operate such a facility;

(B) be continuously certified by the state survey agency as meeting the federal requirements for participation in Medicaid in accordance with Title XIX of the Social Security Act and the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406;

(C) participate in the Medicare program under Title XVIII of the Social Security Act to the extent required under 130 CMR 456.406;

(D) enter into a provider agreement with MassHealth;

(E) accept MassHealth payments as payment in full for nursing facility services pursuant to 130 CMR 450.203: *Payment in Full*; and

(F) agree to periodic inspections, by MassHealth or its designee, that assess compliance with 130 CMR 456.000.

456.406: Medicare Certification Requirement

(A) Nursing facilities must be certified for participation in the Medicare program pursuant to Title XVIII of the Social Security Act, as amended from time to time, and regulations promulgated thereunder.

(B) If a facility or institution has only one unit licensed to provide skilled-nursing care, then that unit must be Medicare certified. A facility with more than one unit licensed to provide skilled nursing care may have one non-Medicare-certified unit.

(C) A facility that is newly enrolling in MassHealth after a change in ownership, has met the conditions in 130 CMR 456.404(A) or 130 CMR 456.405(A) as applicable, and has accepted assignment of the seller's Medicare provider number, may enter into a provider agreement with MassHealth for conditional enrollment pending the facility's Medicare certification for a time period not to exceed nine months from the approval date of the conditional enrollment. At the time that MassHealth receives sufficient documentation from the facility demonstrating that the facility has received Medicare certification, the conditional enrollment will be converted into full enrollment status. If, at the conclusion of the nine-month conditional enrollment, the facility has not yet received Medicare certification, payments to the facility will be suspended until such time as MassHealth receives sufficient documentation from the facility demonstrating that the facility has received Medicare certification.

(D) Penalties.

(1) For a facility that was a MassHealth provider as of October 1, 1990, failure to comply with 130 CMR 456.406(A) or (B) may result in an imposition of an administrative fine by the MassHealth agency or may result in the facility's suspension from participation in MassHealth.

(2) For any facility applying to be a MassHealth provider after October 1, 1990, including facilities built after October 1, 1990, and facilities participating in MassHealth on October 1, 1990, that subsequently changed owners, failure to comply with 130 CMR 456.406 will preclude that facility from participating in MassHealth.

456.407: Clinical Authorization of Nursing Facility Services

(A) Clinical authorization for nursing facility services may be for a specified or indefinite length of stay. Authorizations for an indefinite length of stay may be subject to review by the MassHealth agency or its agent to ensure that conditions for payment continue to be met. A clinical authorization is required

(1) before the first date of service delivery for which the nursing facility is seeking payment from MassHealth;

(2) when a member is transferred from one nursing facility to another nursing facility;

(3) when a member who is hospitalized is to be admitted to a different nursing facility from the one the member resided in before the hospital admission;

(4) when a member who has been hospitalized for over six months seeks to be readmitted to the nursing facility where the member resided before hospital admission; and

(5) when a nursing facility determines that a member has discharge potential, or the member may no longer meet the clinical eligibility criteria described in 130 CMR 456.409.

(B) The MassHealth agency notifies nursing facilities, hospitals, physicians or PCPs, and home health agencies of the identity of the agent responsible for authorizing nursing facility services.

(C) The referring medical provider must submit the request for authorization of nursing facility services to the MassHealth agency or its agent on behalf of the member. For persons who become eligible for MassHealth while residing in a nursing facility, the facility itself must submit the request for authorization. The request for authorization of nursing facility services must be submitted on the forms required by the MassHealth agency and must include documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs.

(D) If the MassHealth agency determines that a member is eligible for nursing facility services, the MassHealth agency will issue a notice that contains the effective date of coverage.

(E) As a prerequisite for payment, nursing facilities must obtain clinical authorization from the MassHealth agency or its designee for each member or MassHealth applicant for whom the nursing facility provider is seeking MassHealth payment.

(F) Clinical authorization determines the medical necessity of nursing facility services as described in 130 CMR 456.409, in accordance with 130 CMR 450.204: *Medical Necessity*. Approval does not establish or waive any other prerequisites for payment, such as the member's financial eligibility for MassHealth.

(G) As part of the clinical authorization process, MassHealth or its designee must assess the member or MassHealth applicant's need for nursing facility services.

456.407: continued

(H) Requests for authorization for nursing facility services must be submitted to MassHealth, or its designee, in the form and format specified by MassHealth or its designee.

(1) A complete authorization request must include all required information, including, but not limited to, documentation of the completed clinical assessment; other nursing, medical, or psychosocial evaluations or assessments; documentation that available alternatives to institutionalization were considered and were deemed inadequate to meet the member's needs; and any other documentation that the MassHealth agency, or its designee, requests in order to complete the review and determination of clinical authorization, including additional assessments of the member.

(2) In making its clinical authorization determination, MassHealth or its designee may require additional assessments of the member or require other necessary information in support of the request for clinical authorization.

456.408: Conditions for Payment

(A) The MassHealth agency pays for nursing facility services if all of the following conditions are met.

(1) The MassHealth agency or its designee has determined that individuals 22 years of age or older meet the nursing facility services requirements of 130 CMR 456.409 or the multi-disciplinary medical review team coordinated by the Department of Public Health has determined that individuals 21 years of age or younger meet the criteria of 130 CMR 519.006(A): *Eligibility Requirements*.

(2) The MassHealth agency or its designee has determined that community care is either not available or not appropriate to meet the individual's needs.

(3) The requirements for the pre-admission screening and resident review (PASRR) process in 130 CMR 456.410 and as required by sub-regulatory guidance have been met. Failure to follow applicable PASRR rules will result in denial of MassHealth payments to the nursing facility for MassHealth members during the period of noncompliance pursuant to 42 CFR 483.122

(B) The MassHealth agency pays for nursing facility services beginning with the date of financial eligibility provided that the member shows that they were medically eligible for these services as of the date of financial eligibility. If the member was not medically eligible for nursing facility services as of the first date of financial eligibility, the MassHealth agency will pay for these services beginning on the first date the member is medically eligible, provided that this date is after the first date of financial eligibility. A person may request a determination of medical eligibility at or after application for MassHealth.

(C) Nothing in 130 CMR 456.408 will be construed to prevent MassHealth from taking action, including overpayment and/or sanction action, for failure to meet the requirements of 130 CMR 456.000, of 101 CMR 206.00: *Standard Payments to Nursing Facilities*, or of the applicable requirements for long-term care facilities in 105 CMR 150.000: *Standards for Long-Term Care Facilities*.

(D) 130 CMR 456.408(A) and (B) do not apply to MassHealth members enrolled in any MassHealth affiliated managed care plan or integrated care plan. Providers are responsible for verifying member status on a daily basis. For more information, *see* 130 CMR 450.117(B).

456.409: Clinical Eligibility Criteria

To be considered clinically eligible for nursing facility services, a member or MassHealth applicant must require one skilled service listed in 130 CMR 456.409(A) daily, or the member must have a medical or mental condition requiring a combination of at least three services from 130 CMR 456.409(B) and (C), including at least one of the nursing services listed in 130 CMR 456.409(C). Additionally, to be considered clinically eligible for nursing facility services, a member or MassHealth applicant younger than 22 years old must also meet criteria as determined by the multi-disciplinary medical review team coordinated by the Department of Public Health.

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(A) Skilled Services. Skilled services must be performed by or under the supervision of a registered nurse or therapist. Skilled services consist of the following:

(1) intravenous, intramuscular, or subcutaneous injection, or intravenous feeding;

(2) nasogastric-tube, gastrostomy, or jejunostomy feeding;

(3) nasopharyngeal aspiration and tracheostomy care, however, long-term care of a tracheotomy tube does not, in itself, indicate the need for skilled services;

(4) treatment and/or application of dressings when the physician or PCP has prescribed irrigation, the application of medication, or sterile dressings of deep decubitus ulcers, other widespread skin disorders, or care of wounds, when the skills of a registered nurse are needed to provide safe and effective services (including, but not limited to, ulcers, burns, open surgical sites, fistulas, tube sites, and tumor erosions);

(5) administration of oxygen on a regular and continuing basis when the member's medical condition warrants skilled observation (for example, when the member has chronic obstructive pulmonary disease or pulmonary edema);

(6) skilled nursing observation and evaluation of an unstable medical condition (observation must, however, be needed at frequent intervals throughout the 24 hours; for example, for arteriosclerotic heart disease with congestive heart failure);

(7) skilled nursing for management and evaluation of the member's care plan when underlying conditions or complications require that only a registered nurse can ensure that essential unskilled care is achieving its purpose. The complexity of the unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the member's recovery and safety;

(8) insertion, sterile irrigation, and replacement of catheters, care of a suprapubic catheter, or, in selected residents, a urethral catheter (a urethral catheter, particularly one placed for convenience or for control of incontinence, does not justify a need for skilled nursing care). However, the insertion and maintenance of a urethral catheter as an adjunct to the active treatment of disease of the urinary tract may justify a need for skilled nursing care. In such instances, the need for a urethral catheter must be documented and justified in the member's medical record (for example, cancer of the bladder or a resistant bladder infection);

(9) gait evaluation and training administered or supervised by a registered physical therapist at least five days a week for members whose ability to walk has recently been impaired by a neurological, muscular, or skeletal abnormality following an acute condition (for example, fracture or stroke). The plan must be designed to achieve specific goals within a specific time frame. The member must require these services in an institutional setting;

(10) certain range-of-motion exercises may constitute skilled physical therapy only if they are part of an active treatment plan for a specific state of a disease that has resulted in restriction of mobility (physical therapy notes showing the degree of motion lost and the degree to be restored must be documented in the member's medical record);

(11) hot pack, hydrocollator, paraffin bath, or whirlpool treatment will be considered skilled services only when the member's condition is complicated by a circulatory deficiency, areas of desensitization, open wounds, fractures, or other complications; and

(12) physical, speech/language, occupational, or other therapy that is provided as part of a planned program that is designed, established, and directed by a qualified therapist. The findings of an initial evaluation and periodic reassessments must be documented in the member's medical record. Skilled therapeutic services must be ordered by a physician or PCP and be designed to achieve specific goals within a given time frame.

(B) Assistance with Activities of Daily Living. Assistance with activities of daily living includes the following services:

(1) bathing when the member requires either direct care or attendance or constant supervision during the entire activity;

(2) dressing when the member requires either direct care or attendance or constant supervision during the entire activity;

(3) toileting, bladder or bowel, when the member is incontinent of bladder or bowel function day and night, or requires scheduled assistance or routine catheter or colostomy care;

(4) transfers when the member must be assisted or lifted to another position;

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(5) mobility/ambulation when the member must be physically steadied, assisted, or guided in ambulation, or be unable to propel a wheelchair alone or appropriately and requires the assistance of another person; and
(6) eating when the member requires constant intervention, individual supervision, or direct physical assistance.

(C) Nursing Services. Nursing services, including any of the following procedures performed at least three times a week, may be counted in the determination of medical eligibility:
(1) any physician- or PCP-ordered skilled service specified in 130 CMR 456.409(A);
(2) positioning while in bed or a chair as part of the written care plan;
(3) measurement of intake or output based on medical necessity;
(4) administration of oral or injectable medications that require a registered nurse to monitor the dosage, frequency, or adverse reactions;
(5) staff intervention required for selected types of behavior that are generally considered dependent or disruptive, such as disrobing, screaming, or being physically abusive to oneself or others; getting lost or wandering into inappropriate places; being unable to avoid simple dangers; or requiring a consistent staff one-to-one ratio for reality orientation when it relates to a specific diagnosis or behavior as determined by a mental health professional;
(6) physician- or PCP-ordered occupational, physical, speech/language therapy or some combination of the three (time-limited with patient-specific goals);
(7) physician- or PCP-ordered nursing observation and/or vital-signs monitoring, specifically related to the written care plan and the need for medical or nursing intervention; and
(8) treatments involving prescription medications for uninfected postoperative or chronic conditions according to physician or PCP orders, or routine changing of dressings that require nursing care and monitoring.

456.410: The Preadmission Screening and Resident Review (PASRR) Process for Intellectual Disability (ID), Developmental Disability (DD), and/or Serious Mental Illness (SMI)

(A) Introduction. Pursuant to 42 U.S.C. 1396r(e)(7) *et seq*. and 42 CFR 483.100 *et seq*., each individual, regardless of payment source, seeking admission to a nursing facility must be screened before admission to a nursing facility to identify individuals who have or are suspected to have ID, DD, and/or SMI.

(B) PASRR Level I Screening.
(1) A Level I screening using the EOHHS PASRR Level I Screening form (Level I Screening Form) must be completed prior to admission for all individuals seeking admission to a nursing facility, regardless of payment source.
(2) The Level I Screening Form must also be completed for resident reviews, upon a significant change in condition, and in any other circumstance required by EOHHS in sub-regulatory guidance. The completed Level I Screening Form must be submitted to the appropriate PASRR authority (DDS or its designee for ID or DD; DMH or its designee for SMI) and be kept in the resident's medical record at the facility.

(C) Referrals for PASRR Level II Evaluation and Resident Review. If the Level I screening indicates that the individual has or is suspected of having ID, DD, and/or SMI, the screener must make the applicable referral or referrals to the appropriate PASRR authority (DDS or its designee for ID or DD; DMH or its designee for SMI) to complete a Level II evaluation and determination in accordance with any applicable sub-regulatory guidance.

(D) PASRR Level II Determination.
(1) Prior to admitting individuals requiring a Level II PASRR evaluation and determination, the nursing facility must receive documentation from the applicable PASRR authority determining that the individual is appropriate for admission to the nursing facility and stating whether or not the individual needs specialized services. The nursing facility must keep such documentation in the resident's record at the facility.

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(2) A determination by the Massachusetts Department of Mental Health (or its designee) or the Department of Developmental Services (or its designee) that admission to the facility is not appropriate supersedes the authorization for services by MassHealth or its agent.

456.411: Review of Need for Continuing Care in a Nursing Facility

(A) When a nursing facility determines during any of the quarterly reviews required by the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) and implemented by regulations at 42 CFR 483.20 that the member has discharge potential, then the facility must notify MassHealth or its agent.

(B) When the nursing facility is notified by MassHealth or its agent that the member no longer meets the conditions for payment criteria under 130 CMR 456.408(A), the nursing facility must initiate the nursing facility's discharge plan for the member in collaboration with MassHealth or its agent. All discharges must be in accordance with the federal requirements found at 42 CFR 483.15(c) and with 130 CMR 456.701 through 456.704.

456.412: Notification and Right of Appeal

(A) MassHealth or its agent will notify the member or applicant and the referral source or nursing facility who submitted the request for institutional services on the member's behalf of the approval or denial of the request for authorization of nursing facility services. If authorization for nursing facility services is denied, the notification will contain the following information:

(1) the reason for the denial;
(2) the explanation of the member's right to appeal; and
(3) a description of the appeal procedure.

(B) If MassHealth or its agent has denied a request for authorization of payment of nursing facility services, the member or applicant may request a fair hearing from the MassHealth Board of Hearings. The request for a fair hearing must be made in writing within 30 days after the date the member receives a written denial notice from MassHealth or its agent. The appeal procedure and hearing will be administered and conducted by the Board of Hearings, in accordance with the regulations set forth in 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(C) An individual who was screened and/or evaluated pursuant to PASRR may request a fair hearing from the Board of Hearings to challenge a determination by the applicable PASRR authority or authorities. The request for a fair hearing must be made in writing within 30 days after the date the individual receives a written notice of the determination from the applicable PASRR authority or authorities. The appeal procedure and hearing will be administered and conducted by the Board of Hearings, in accordance with the regulations set forth in 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

456.413: Resident Rights

A nursing facility must inform any resident or applicant for admission, regardless of payment method, of all rights the person has as a resident of the facility, including but not limited to, the resident rights provided for under 42 CFR 483.10.

456.414: Mobility Systems

A nursing facility is responsible for the provision of mobility systems for members residing in the facility. However, MassHealth will pay a durable medical equipment (DME) provider, in accordance with 130 CMR 409.415(A): *MassHealth Members Residing in Nursing Facilities*, for the purchase, rental, or repair of medically necessary mobility systems and positioning seating systems, except for equipment described in 130 CMR 409.415(A)(1) when being purchased solely for the full-time use of a member while residing in the nursing facility. The nursing facility in which the member resides is responsible for payment to the DME provider for the first $500 towards the purchase of the mobility system unless the member has a written discharge plan in accordance with 130 CMR 409.415(A)(1)(b). For custom positioning seating systems, the nursing facility must check its existing inventory for a wheelchair base that can be used for a customized seating system for the sole use of the member. In circumstances in which the nursing facility has a base, the nursing facility is not responsible for the $500.00.

456.420: Case-mix Classification

(A) MassHealth pays for nursing facility services based on *per diem* rates that correspond to the nursing care needs of members in a facility using a case-mix classification system.

(B) To determine the member's nursing care needs, a nursing facility must complete a case-mix classification assessment to be specified by EOHHS and in accordance with sub-regulatory guidance. Based on the assessment, each member is assigned a case-mix classification rating, which corresponds to a rate of payment established by MassHealth.

(C) MassHealth or its designee may periodically audit medical records to ensure that the nursing facility's documentation supports the *per diem* case-mix classification rating. MassHealth or its designee must be permitted access to the facility's records and the facility's premises for an audit pursuant to 130 CMR 456.420(C).

(D) As part of the review under 130 CMR 456.420(C), if it is determined that the case-mix classification rating is not supported, MassHealth or its designee will notify the nursing facility of any re-classification by MassHealth through the issuance of audit findings. If MassHealth's case-mix classification rating differs from that of the nursing facility, MassHealth's case-mix classification rating will supersede the facility's and the facility must bill for the member's payment cycle at the MassHealth audited case-mix classification *per diem* rate.

(E) If in the course of conducting audits MassHealth determines that any of the regulations, rules, instructions, or procedures of MassHealth have been violated by the nursing facility, MassHealth may implement an overpayment action and/or impose sanctions against the nursing facility in accordance with MassHealth's administrative and billing regulations at 130 CMR 450.000: *Administrative and Billing Regulations*.

456.421: Reconsideration of MassHealth-assigned Case-mix Classification Rating

(A) A nursing facility may request reconsideration of MassHealth's audit findings and of the case-mix classification rating assigned by MassHealth. All requests must state the facility's justification for the request for reconsideration and must contain documentation justifying the request for reconsideration. All documentation must be specific to the individual whose case-mix classification rating is under review. The request for reconsideration must be received by MassHealth within 30 days from the date that the nursing facility receives the audit findings from MassHealth.

(B) If the nursing facility does not submit a request for reconsideration, the audit findings issued pursuant to 130 CMR 456.420(C) will constitute MassHealth's final action. If the nursing facility requests reconsideration but does not comply with the requirements of 130 CMR 456.421(A), then MassHealth will deny the request for reconsideration for failure to make a timely request. In either case, MassHealth's audit findings will constitute MassHealth's final agency action and the nursing facility will have no right to an adjudicatory hearing pursuant to 130 CMR 456.421(C) because of its failure to exhaust its administrative remedies.

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(C) MassHealth will review a request for reconsideration, the accompanying documentation submitted in compliance with the requirements of 130 CMR 456.421(A), and any other documents MassHealth deems relevant and issue a final decision based on its review. The decision by MassHealth will be a determination of whether the nursing facility has met all the criteria for the case-mix classification item or items that are the subject of the reconsideration. The determination will be in writing, state the reasons for the determination, and inform the nursing facility of its right to file a Claim for Adjudicatory Hearing in accordance with 130 CMR 450.241: *Hearings: Claim for an Adjudicatory Hearing*. The Board of Hearings will decide the claim in accordance with 130 CMR 450.248: *Medicaid Director's Decision*.

456.422: Hospice Services in Nursing Facilities

A resident of a nursing facility may elect hospice services and continue to reside in the facility, if the facility is serviced by a hospice provider. When a member elects hospice in accordance with 130 CMR 437.000: *Hospice Services*, MassHealth will not pay for nursing facility services and will not pay the nursing facility for medical leaves of absence while the election is in effect. MassHealth will pay the hospice for room and board and medical leave of absence while the election is in effect and the member remains in the nursing facility. MassHealth may recoup any payment made by MassHealth to the facility for services to the member while a hospice election is in effect.

456.423: Patient-paid Amount

(A) If the MassHealth agency determines that a member is financially eligible for nursing facility services, the MassHealth agency will issue a notice that contains the effective date of coverage and the patient-paid amount.

(B) The patient-paid amount is applied to the nursing facility's *per diem* rate for the member. If the member is discharged from the facility or transferred to another nursing facility, the patient-paid amount is applied up to the last full day of the member's stay and the nursing facility must do the following.

(1) If the member is transferred from one facility to another, the first facility must notify the second facility of the disposition of the patient-paid amount. If the first facility receives a patient-paid amount in excess of the *per diem* rate for the number of days the member was in the facility, then the first facility must issue a check to the second facility for the amount of the balance. The first facility must submit a claim for the member's stay up to, but not including, the day of transfer, even if the claim will not result in any payment by MassHealth to the facility. Submission of this claim is necessary to ensure that the second facility is correctly paid.

(2) If the member is discharged to the community and the facility received a patient-paid amount in excess of the *per diem* rate for the number of days the member was in the facility, then the facility must return the balance of the patient-paid amount to the member.

(3) If the patient dies and the facility has received a patient-paid amount in excess of the *per diem* rate for the number of days the member was in the facility, then the facility must deposit the balance into the member's personal needs account or return the balance to the party who paid the patient-paid amount. *See* 130 CMR 456.614 for the disposition of the personal needs allowance account when a member dies.

456.424: Limitations on Charges to Members

(A) A nursing facility may only charge members for items requested by the member. Before charging the member, the facility must inform the member of the cost of the requested item. The facility must not charge a member for any item or service covered by MassHealth or Medicare.

(B) Items for which the nursing facility must not charge the member, include, but are not limited to, the following:

(1) group activities or entertainment that occur within the facility;

(2) parties organized by the facility;

(3) medically necessary drugs, medical supplies, or medical services;

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(4) funeral expenses;
(5) room and board to the facility;
(6) wheelchair purchase, rental, or repair;
(7) transportation to obtain necessary medical treatment; and
(8) service charges for maintaining the member's personal needs allowance (PNA) account.

456.425: Medical Leave of Absence (MLOA): Introduction

(A) MassHealth pays a nursing facility to reserve a bed for up to 20 consecutive days for a member who is on a medical leave of absence from the nursing facility, if all the conditions of 130 CMR 456.426 and 456.427 are met.

(B) In accordance with federal law, nursing facilities must establish and follow a written policy regarding their bed-hold periods, which must be consistent with the MassHealth bed-hold policy.

(C) Following a medical leave of absence of 20 days or fewer, the nursing facility must allow the member to return to the nursing facility and resume residence unless the member no longer requires the services provided by the nursing facility.

(D) When a member's hospitalization exceeds 20 days or does not meet the requirements of 130 CMR 456.426, the nursing facility must immediately readmit the member to the facility, to the next available bed in a semiprivate room, unless the member no longer requires the services provided by the nursing facility.

456.426: Medical Leave of Absence: Conditions of Payment

(A) When a member is transferred from a nursing facility to a hospital, the nursing facility must
(1) provide the member and the member's authorized or legal representative with notice of the facility's bed-hold policy, including the member's right to return and resume residence in the facility;
(2) provide the member and the member's authorized or legal representative with notice of the transfer that complies with the requirements set forth in 130 CMR 456.701 and 456.702;
(3) document the date and time of the transfer in the member's record;
(4) automatically reserve the same bed and room occupied by the member at the time the absence began for the member until the close of business on the second working day of the member's hospital stay;
(5) contact the admitting hospital and obtain the estimated length of stay by the close of business on the second working day of the member's hospital stay and document the estimated length of stay in the member's medical record;
(6) if the estimated length of stay is 20 consecutive days or fewer, reserve the same bed and room occupied by the member at the time the absence began for the balance of the actual length of stay not to exceed 20 consecutive days from the date of admission to the hospital;
(7) ensure that for each day that a bed is reserved the bed is not occupied; and
(8) if the hospital advises the nursing facility that the estimated length of stay exceeds 20 consecutive days, the nursing facility cannot bill MassHealth for a medical leave of absence from the date of such notification by the hospital.

(B) Notwithstanding 130 CMR 456.426(A), MassHealth does not pay a nursing facility for reserving a bed for a member
(1) after the second working day of the member's stay if the nursing facility has failed to obtain the estimate of the length of stay from the hospital;
(2) if the member has notified the nursing facility in writing that the member does not wish to return to the facility;
(3) for any consecutive medical leave of absence day in excess of the 20 days from the date of transfer from the nursing facility;
(4) the day on which a member is transferred back to a nursing facility or is discharged from the hospital to a non-institutional setting; and

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(5) for any MLOA in cases where the member is transferred from a nursing facility to a hospital and transferred back to the nursing facility on the same calendar day.

(C) When a member is transferred from one inpatient hospital to another inpatient hospital during the medical leave of absence, the nursing facility must continue to reserve for the member the same bed and room occupied by the member at the time the absence began for up to the 20th day of the member's absence from the nursing facility as long as the member continues to require a medical leave of absence and the conditions in 130 CMR 456.426(A) are met. A transfer from one hospital to another continues the 20-day period initiated on the first day the member originally was transferred from the nursing facility for the original medical leave of absence, and does not initiate another 20-day period.

456.427: Medical Leave of Absence: Payment

(A) For billing and payment purposes, the day on which a member is transferred from a nursing facility to a hospital for an inpatient or observation stay is the first day of the medical leave of absence from the nursing facility. The day on which a member is transferred back to a nursing facility or is discharged from the hospital to a noninstitutional setting is not a medical leave of absence day.

(B) MassHealth will only pay a nursing facility for medical leave of absence days at the the leave of absence rate specified by 101 CMR 206.06: *Adjustments to Standard Nursing Facility Rates et seq*.

456.428: Medical Leave of Absence: Readmission

Members who have been authorized for payment of nursing facility services who are admitted to a hospital from a nursing facility may be readmitted to the same facility without a new authorization except when a hospitalization exceeds six months. When a hospitalization exceeds six months, the nursing facility must request a new authorization for nursing facility services before readmitting the member pursuant to 130 CMR 456.407.

456.429: Medical Leave of Absence: Failure to Readmit

(A) When a nursing facility is notified that the member is ready to return to the facility, the nursing facility must readmit the member following a medical leave of absence. If the nursing facility does not allow the member to be readmitted following hospitalization or other medical leave of absence, the nursing facility's failure to readmit the member is deemed a transfer or discharge. If the nursing facility does not readmit, it must provide the member and the member's authorized or legal representative with a notice explaining its decision not to readmit the member at the time such determination is made. The notice must comply with the requirements set forth in 130 CMR 456.701.

(B) A nursing facility that fails to readmit a member who requires nursing facility services or otherwise violates these provisions may be subject to overpayment or sanction action under 130 CMR 450.000: *Administrative and Billing Regulations*.

456.430: Nonmedical Leave of Absence (NMLOA): Introduction

MassHealth seeks the fullest integration possible of members into the community. Wherever possible, coordinated support services will be arranged so a member may return to the community. To prevent members from becoming isolated in nursing facilities, MassHealth will pay the nursing facility to reserve a bed for a member when the member is temporarily absent from the facility for nonmedical reasons subject to the requirements set forth in 130 CMR 456.431 and 456.432.

456.431: Nonmedical Leave of Absence: Limitations

MassHealth pays for temporary absences for nonmedical leave for members in nursing facilities for up to a total of ten days per 12-month period starting with the first day of the nonmedical leave. For the purpose of NMLOA, a day is defined as a continuous 24-hour period. Absences from the nursing facility of less than 24 hours do not constitute a day of absence.

456.432: Nonmedical Leave of Absence: Conditions for Payment

(A) For the facility to obtain payment for a nonmedical absence, the following conditions must be met.

(1) The member must request the nonmedical leave.

(2) A written authorization from the attending physician or PCP must be on file in the member's medical record.

(3) During the period of absence, the nursing facility must hold the same bed and room occupied by the member at the time the absence began and must not admit any other resident in the member's place.

(4) The member's medical record maintained by the facility must document

(a) the home address, telephone number, and relationship of the person responsible for the member while the member is absent from the facility;

(b) the duration of absence;

(c) the physician or PCP's authorization for the absence; and

(d) the member's condition before and after the absence from the facility.

(B) If the member does not return to the facility, for the purpose of payment, MassHealth considers the member to be voluntarily discharged as of the first day of unauthorized absence. The facility cannot bill MassHealth for any days of unauthorized absence. A voluntary discharge is not a discharge under 130 CMR 456.701 through 456.703 or 130 CMR 610.028: *Notice Requirements Regarding Actions Initiated by a Nursing Facility* through 130 CMR 610.030: *Stay of a Transfer or Discharge from a Nursing Facility Pending Appeal*.

456.433: Nonmedical Leave of Absence: Payment

MassHealth will only pay the nursing facility for nonmedical leave of absence days at the leave of absence rate specified by 101 CMR 206.06: *Adjustments to Standard Nursing Facility Rates et seq*.

456.451: Withdrawal by Nursing Facilities from MassHealth: Introduction

A nursing facility participating in MassHealth may cease to participate only in the manner detailed in 130 CMR 456.452 through 456.455. 130 CMR 456.452 through 456.455 continue apply even if the facility is continuing to operate as a nursing facility, is converting to a residential program (including, but not limited to, assisted living), or is closing.

456.452: Notice of Withdrawal

(A) A nursing facility electing to withdraw from MassHealth must give written notice of its intention to withdraw to MassHealth, unless such withdrawal results from an emergency situation beyond the control of the provider such as fire or an act of God. In the instance of alleged emergency withdrawal, the burden of proof will be on the facility. The facility must send the withdrawal notice by certified or registered mail (with return receipt requested) or email to MassHealth's Office of Long-term Services and Supports not less than 90 days before the effective date of withdrawal.

(B) When a decision has been made to close a facility, the nursing facility must promptly complete a Relocation Assessment Form for each member. The forms must be sent to MassHealth's designated nurse reviewer. MassHealth will notify the facility of the results of the assessment.

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(C) A facility must not admit any new MassHealth members after the date on which the withdrawal notice was sent to MassHealth. Residents of the facility who become eligible for MassHealth after the notice of withdrawal, MassHealth members who are hospitalized when the notice was sent, and members who are on nonmedical leaves of absence at the time the notice was sent are not considered new admissions.

456.453: Withdrawal Requirements

(A) On the same date on which the nursing facility sends a withdrawal notice to MassHealth, the facility must give notice, in hand, to all its residents and the residents' authorized or legal representatives, including those residents who have been transferred to hospitals, or who are on nonmedical leave of absence. The notice must advise that any resident who is eligible for MassHealth on the effective date of the withdrawal must relocate to a facility participating in MassHealth to ensure continuation of MassHealth payment of nursing facility services and must also be determined eligible to continue to receive the services.

(B) The notice will also state that the facility will work promptly and diligently to arrange for the relocation of members to MassHealth-participating facilities or, if appropriate, to the community. The nursing facility must give a similar notice to applicants for admission during the period between the date in which the facility sent the withdrawal notice to MassHealth and the effective date of the withdrawal.

(C) After giving notice of intent to withdraw, the facility must promptly begin and diligently sustain efforts to arrange for the relocation of members to facilities participating in MassHealth or to the community.

(D) When it has been determined where a member is to be transferred to, the facility must give the member written notice including the name of the facility to which the member will be transferred and notification of the member's right to appeal such a transfer as provided for in 130 CMR 456.701 and 456.702.

456.454: Administrative Action Regarding Withdrawals

A nursing facility that withdraws from MassHealth must continue to provide services to members until the members are relocated. If the facility fails to provide medical services to a member, the facility is subject to a fine of $1000 for each violation.

456.455: Limitation of Provider Participation

A nursing facility provider that voluntarily withdraws from MassHealth and continues to operate as a nursing facility may not participate as a MassHealth nursing facility provider for up to five years after the date of notice of the intent to withdraw, except to the extent, as determined by MassHealth, that the facility's participation in MassHealth is necessary for the health, welfare, and safety of members. If on the date that the withdrawal was to be effective, the nursing facility is still providing services to MassHealth members, then the facility will continue to be a MassHealth provider with regard to those members but will otherwise be considered withdrawn from the program. In such circumstances, the facility must notify MassHealth of its need to keep its MassHealth provider number.

456.601: Personal Needs Allowance (PNA) Account

MassHealth members have the right to manage their own financial affairs and the nursing facility must not require residents to deposit their personal funds with the facility. However, upon written request by a member, the facility must hold, safeguard, and manage an account for the member's personal funds deposited with the facility as specified in 130 CMR 456.601 through 456.615.

456.602: Management of the PNA Account

If requested by the member, a facility must assume responsibility, that is, become a trustee, for the PNA funds of a member. To do so, the facility must obtain and maintain on file a statement of authorization signed by the member or the member's authorized or legal representative. The authorized or legal representative must not be an employee of the facility or related to an employee of the facility. Once a facility becomes trustee of a member's PNA account, the facility is responsible for the safekeeping of the PNA money and must repay the member for any lost or stolen funds or for any money that cannot be accurately accounted for.

456.603: Autonomy of PNA Account

(A) If the facility assumes responsibility for a member's funds, the facility must deposit funds in excess of $50 into a PNA account, that is, an interest-bearing trustee account separate from any of the facility's operating accounts. A fee may not be charged to the account.

(B) The facility must ensure that a member's PNA funds are not available for any purpose except the personal needs of that member. The funds must not be lent or be used as collateral for a loan for anyone including the facility and may not be less than a zero balance.

456.604: PNA Recordkeeping Requirements

(A) The facility must establish and maintain a system of recordkeeping that ensures a complete and separate accounting of the PNA funds according to generally accepted accounting principles. The system must prevent any commingling of a member's PNA funds with facility funds or with the funds of any other person other than another resident of the facility. If the facility does not manage the PNA funds for any member, it is not required to maintain such records.

(B) Specific Requirements.

(1) The facility must ensure a separate accounting of each member's PNA funds, maintain a written record of all financial transactions involving the PNA funds, and allow the member or the member's authorized or legal representative access to the accounting record.

(2) The bank account statements and the general ledger must be in agreement and reconcilable at all times. All bank statements, canceled checks, and supporting documentation relating to the PNA account must be kept in the facility for no less than required by the recordkeeping requirements at 130 CMR 450.205: *Recordkeeping and Disclosure*.

(3) All checks or cash received by the nursing facility on behalf of the member must be deposited into the PNA account no later than 30 days after the receipt of the money by the facility.

(4) The facility must maintain for each member with a PNA account a record of receipts and disbursements separate from other members' records. The facility must clearly label all PNA receipts and disbursements in the general ledger.

(5) At a minimum, all receipts and disbursements must be recorded in the ledger as follows:

Receipts	Disbursements
1. Date of entry 2. Amount 3. Source 4. Balance	1. Date of entry 2. Specific description (Avoid "misc.", "personal needs", *etc.*) 3. Amount 4. Signature of member or person receiving disbursement 5. Invoice number or date

(6) General ledger records must be updated at least once a month.

(7) The facility must ensure that funds are available to members in the form of actual cash or check for no less than ten hours a week and on no less than three days a week. The facility must inform the members and their authorized or legal representatives of the times when they may receive their money.

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(8) All money disbursed to or on behalf of a member must be at the request of the member or the member's authorized or legal representative. The nursing facility must not make any disbursements on behalf of a member for a service that is covered by either Medicare or MassHealth.

(9) If a facility disburses money to a member by means of a check, or if the member signs petty cash vouchers, the facility does not need to obtain a signature in the ledger.

(10) The facility does not need to itemize cash disbursements to members.

(11) The facility must provide the member or the member's authorized or legal representative every three months and upon the member's request or the member's authorized or legal representative's request with an accounting of all financial transactions made on the member's behalf.

456.605: Petty Cash in the Facility

The facility may, if it chooses, maintain a petty cash fund in order to make direct cash distributions to residents. The total of this petty cash fund must not exceed an amount equal to $5 per member for whom the facility manages a PNA account; however, a maximum of $250 is allowable regardless of the number of residents.

456.606: Assurance of Financial Security

The facility must purchase a surety bond to assure the security of all personal funds of members deposited with the facility. The facility must keep this bond at the facility.

456.607: Availability of PNA Records to MassHealth or it's Designee's Personnel

All PNA records must be kept in the facility at all times and must be available to MassHealth or its designee's personnel upon request.

456.608: Member Signature

If the member cannot sign his or her own name, a staff member or business employee of the facility may sign as witness that the member has received cash from the member's PNA account.

456.609: Notification of Account Balance

(A) The facility must notify each member for whom it has established a PNA account, and his or her authorized or legal representatives, when the balance reaches a total of $1,800, which is $200 less than the maximum countable assets allowed per member. The notification must state that, if the member's countable assets exceed the maximum allowable amount of $2,000, the member may lose MassHealth eligibility.

(B) If the member's balance exceeds the maximum allowable amount, the member may apply the excess to the cost of care in the facility.

456.610: Availability of PNA Records to Members

The facility must, within one working day of a request, allow the member or the member's authorized or legal representative to examine the PNA records of the member.

456.611: PNA Funds of a Member Transferred to Another Facility

If a member is transferred to another nursing facility, all of the member's funds held in trust by the facility must be sent to the new facility within ten days of the transfer date.

456.612: PNA Funds of a Member Discharged to the Community

If a member has been discharged from the facility to the community, the member must receive his or her personal ledger or bank book back from the facility and must receive a check for the balance of the member's PNA account. The amount of the check must reflect both the cash held on behalf of the member by the facility and the bank balance.

456.613: Member Is Transferred to a Hospital and Does Not Return to the Facility

If a member is transferred to a hospital and does not return to the facility, the balance of the PNA account must be sent to the member at his or her new address within ten days after the member leaves the hospital.

456.614: Death of a Member

(A) Upon the death of a MassHealth member, the nursing facility must

(1) render an accounting of the member's PNA funds. The funds must remain at the facility for 30 days after the death of a member to allow for the appointment of an administrator or executor of the estate and for the payment of burial expenses; and

(2) notify the next of kin or the member's authorized or legal representative of any remaining funds, determine whether an executor or administrator has been or will be appointed, and explain to the next of kin or the member's authorized or legal representative how to obtain the funds from the facility.

(a) If there is an outstanding balance due on a funeral bill, the funeral home may submit an itemized funeral bill to the nursing facility and the nursing facility may pay the bill from the PNA funds.

(b) If an executor or administrator is appointed within 30 days after the death of a member, the facility must send the balance of the PNA account and a final accounting of the member's account to the administrator or executor of the member's estate. If any payment has been made to the funeral home under 130 CMR 456.614(A)(2)(a), the final accounting must reflect that payment.

(B) If any funds remain in the PNA account after 30 days after the death of the member, the facility must

(1) send a check for the balance and a final accounting of the member's account to MassHealth or its designee;

(2) notify the next of kin or the member's authorized or legal representative of the amount of the funds and the address to which they are being sent; and

(3) notify the next of kin or the member's authorized or legal representative that they may apply for the funds if they are appointed executor or administrator of the member's estate.

(C) A final accounting of the PNA funds must include any transactions that occurred during the three months prior to and the 30 days following the member's death. If there are no PNA funds, the nursing facility is not required to submit the final accounting; however, the facility must maintain all member records according to 130 CMR 456.604 and 130 CMR 450.205: *Recordkeeping and Disclosure.*

(D) The facility must include with the returned PNA balance and the accounting the following information:

(1) the member's name and MassHealth ID number;

(2) the member's date of birth and date of death;

(3) the name, address, and relationship of the next of kin or the member's authorized or legal representative;

(4) the name, address, and MassHealth provider number of the facility; and

(5) the name and address of the funeral director.

456.615: Annual Accounting to MassHealth of the PNA Balance

(A) An accounting must be made to MassHealth of the balance of each PNA account annually by the deadline specified by EOHHS. If the facility is not a trustee for any member's money, it must report this fact annually to MassHealth by the deadline specified by EOHHS. The accounting to MassHealth must be submitted in accordance with the requirements established by EOHHS in an administrative bulletin or other written issuance.

(B) The accounting must at a minimum consist of the following, as well as any additional information requested by MassHealth:

(1) the member's name;
(2) the member's MassHealth ID number;
(3) the amount of petty cash held in the facility for the member;
(4) the balance held in any individual bank account for the member;
(5) the balance held in the trustee account for the member;
(6) any other money being held by the facility for the member; and
(7) if funds are held in an aggregate trustee bank account, then a copy of the bank statement for that account must be submitted with the accounting.

456.701: Notice Requirements for Transfers and Discharges 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 MassHealth 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 456.701(A)(1) through (4), the resident's clinical record must contain documentation to explain the transfer or discharge. The documentation must be made by

(1) the resident's physician or PCP when a transfer or discharge is necessary under 130 CMR 456.701(A)(1) or (2); and
(2) a physician or PCP when the transfer or discharge is necessary under 130 CMR 456.701(A)(3) or (4).

(C) Before a nursing facility discharges or transfers any resident, the nursing facility must hand-deliver to the resident and mail to the authorized 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 their right to request a hearing before MassHealth's Board of Hearings 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 456.702; and
    (c) the effect of requesting a hearing as provided for under 130 CMR 456.704;
(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.*);

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(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) 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). The nursing facility must issue notice to the resident and an authorized or legal representative in accordance with 130 CMR 456.701(A) through (C), 456.702(C), and 130 CMR 610.029: *Time Frames for Notices Issued by Nursing Facilities*.

456.702: Time Frames for Notices Issued by Nursing Facilities

(A) The notice of discharge or transfer required under 130 CMR 456.701(C) must be made by the nursing facility at least 30 days prior to the date the resident is to be discharged or transferred, except as provided for under 130 CMR 456.702(B).

(B) In *lieu* of the 30-day-notice requirement set forth in 130 CMR 456.702(A), the notice of discharge or transfer required under 130 CMR 456.701(C) must be made as soon as practicable before the discharge or transfer in any of the following circumstances.
(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 or PCP.
(2) The resident's health improves sufficiently to allow a more immediate transfer or discharge and the resident's attending physician or PCP 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 or PCP.
(4) The resident has not resided in the nursing facility for 30 days immediately prior to 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 authorized or legal representative at the time the nursing facility determines that it will not readmit the resident.

456.703: Time Frames for Submission of Requests for Fair Hearings

(A) Appeals of discharges and transfers will be handled by MassHealth's Board of Hearings (BOH) pursuant to 130 CMR 610.000: *MassHealth: Fair Hearing Rules*.

(B) Time Limitation on the Right of Appeal. The date of request for a fair hearing is the date on which BOH receives such a request in writing. BOH must receive the request for a fair hearing within the following time limits:
(1) 30 days after a resident receives written notice of a discharge or transfer pursuant to 130 CMR 456.702(A); or
(2) 30 days after a nursing facility initiates a transfer or discharge or fails to readmit and fails to give the resident notice; or
(3) 14 days after a resident receives written notice of an emergency discharge or emergency transfer pursuant to 130 CMR 456.702(B); or

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(4) 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 a resident following hospitalization or other medical leave of absence.

456.704: 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 456.703(B)(1), 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 456.703(B)(2), and the request is received prior to 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 456.703(B)(2), is received within the applicable time frame but after the transfer, the nursing facility must, upon receipt of an 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 as described in 130 CMR 456.703(B)(3), the nursing facility must, upon receipt of an appeal decision favorable to the resident, promptly readmit the resident to the next available bed in the facility.

456.705: Scheduling by the Board of Hearings

(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 and the nursing facility.

(B) In accordance with 130 CMR 610.015(F): *Expedited Appeals for Discharges and Transfers from a Nursing Facility under 130 CMR 610.029(B) or (C)*, a resident may request an expedited appeal when a nursing facility notifies a resident of a discharge or transfer under the time frames in 130 CMR 456.702(B) or (C).

(C) BOH will 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.

REGULATORY AUTHORITY

130 CMR 456.000: M.G.L. c. 118E, §§ 7 and 12.

(PAGES 613 THROUGH 618 ARE RESERVED FOR FUTURE USE.)