2010 WL 285201 (Mass.App.Ct.) (Appellate Brief)
Appeals Court of Massachusetts.

Mary TOMASFLLI, Plaintiff-Appellant,
v.
Terrence DOUGHTERY, In His Official Capacity as Interim Director Of The Office Of Medicaid, Defendant-Appellee.

No. 2009-P-1799.
January 14, 2010.

On Appeal from a Judgment of the Essex Superior Court

Brief of the Appellee Interim Director of the Office of Medicaid

Martha Coakley, Attorney General, Annapurna Balakrishna, Assistant Attorney General, Government Bureau, One Ashburton Place, Boston, Massachusetts 02108-1598, (617) 727-2200, ext. 2678, BBO # 655051.

i** ***TABLE OF CONTENTS

TABLE OF AUTHORITIES iii
QUESTIONS PRESENTED 1
STATEMENT OF THE CASE 1
Nature of the Case 1
Course of Proceedings Below 2
Statutory and Regulatory Background 3
1. The Federal Medicaid Act, G.L. c. 118E, and the State Regulatory Scheme 3
2. The Adult Foster Care Regulations 6
a. General terms of the AFC Regulations 6
b. Provision of AFC By A Provider to a Member 7
c. Payment By MassHealth to a Provider for the Provision of AFC to a Member 9
Statement of the Facts 12
1. Relevant Parties and Players 12
2. The Introduction of a New Rate for AFC Care 12
3. Joyce's request to Merrimack for Level II AFC for the Appellant 14
4. The appeal of Merrimack's denial of retroactive payment to Joyce to the Board 18
5. Appellant's G.L.c. 30A, § 14, appeal and the Superior Court's decision affirming the Board 20
STANDARD OF REVIEW 23
***ii** ARGUMENT 24
I. THE BOARD CORRECTLY DISMISSED THE APPELLANT'S APPEAL BECAUSE A MEMBER CANNOT APPEAL AN AFC PROVIDER'S ACTION TO THE BOARD 24
A. The AFC Regulations do not allow the Appellant to appeal an action of Merrimack 25
B. MassHealth's Fair Hearing Rules do not permit the Appellant to appeal Merrimack's challenged action to the Board 26
C. Under the AFC Regulations, the Appellant did not receive AFC, and Joyce was not qualified as an AFC Caregiver, Until August 31, 2007 28
II. THE FACIAL CHALLENGE TO THE AFC REGULATIONS FAILS THE APPELLANT FAILED TO RAISE THE ISSUE BELOW 33
A. A facial challenge to a regulation occurs through a claim for declaratory relief 34
B. The Reasonable Promptness Requirement applies to actions of MassHealth but not to the actions of a Provider 36
C. Sound policy reasons support the decision not to include time standards for Provider action in the AFC Regulations 42
CONCLUSION 43

Addendum

iii** ***TABLE OF AUTHORITIES

Cases

Berrios v. Department of Pub. Welfare, 411 Mass. 587 (1992) 37
Blum v. Yaretsky, 457 U.S. 991 (1982) 28
Borden, Inc. v. Commissioner of Pub. Health, 388 Mass. 707 (1983) 36, 37
Boston Police Superior. Officers Fed'n v. Labor Relations Comm'n, 410 Mass. 890 (1991) 23
Boulet, et al. v. Cellucci, et al., 107 F.Supp. 2d 61 (D. Mass. 2000) 40, 41
Bruggerman ex rel. Bruggerman v. Blagojevich, 324 F.3d 906 (7th Cir. 2003) 38
Century Fire & Marine Ins. Corp. v. Bank of New England-Bristol Cty., 405 Mass. 420 (1989) 33
Coggin v. Massachusetts Parole Bd., 42 Mass. App. Ct. 584 (1997) 23
Consolidated Cigar Corp. v. Department of Pub. Health, 372 Mass. 844 (1977) 37
Massachusetts Fed'n of Teachers v. Board of Educ., 436 Mass. 763 (2002) 37
Merisme v. Board of Appeals on Motor Vehicle Liab. Policies & Bonds, 27 Mass. App. Ct. 470 (1989) 23
Protective Life Ins. Co. v. Sullivan, 425 Mass. 615 (1997) ... 23
Quincy v. Massachusetts Water Resources Auth., 421 Mass. 463 (1995) 37
Sargeant v. Commissioner of Pub. Welfare, 383 Mass. 808 (1981) 31
***iv** *Tarin v. Commissioner of the Div. of Med. Assistance*, 424 Mass. 746 (1997) 3
TBI, Inc. v. Board of Health of N. Andover, 431 Mass. 9 (2000) 36
Town of Falmouth v. Civil Service Commission, 447 Mass. 814 (2006) 35
Westside Mothers v. Olszewski, 454 F. 3d 532 (6th Cir., 2006) 38

Statutes

G.L. c. 30A, § 7 34
G.L. c. 30A, § 14 ..... 2, 11, 20, 21, 23, 34
G.L. c. 118E 3, 6, 34
G.L. c. 118E, § 1 3
G.L. c. 118E, § 8 ..... 3, 6
G.L. c. 118E, § 9 3
G.L. c. 118E, § 12 4
G.L. c. 118E, § 30 ..... 31, 32
G.L. c. 231A, § 1 34
42 U.S.C. § 1396a 38
42 U.S.C. § 1396d 3, 5, 38

Regulations

42 CFR § 435.911 39
42 CFR § 435. 930 39
114.3 CMR 51.00 11
130 CMR 408.402 ..... 7, 8, 29
130 CMR 408.404 12
130 CMR 408.415 ..... 7, 8
***v** 130 CMR 408.416 ..... 9, 10, 11, 25, 26, 30

130 CMR 408.417 ..... 10, 22, 25, 30
130 CMR 408.418 ..... 11, 25
130 CMR 408.419 ..... 10, 29-30, 31
130 CMR 408.431 9
130 CMR 408.431 ..... 8, 9
130 CMR 408.433 ..... 7, 11, 31
130 CMR 408.434 ..... 7, 29, 30
130 CMR 408.435 ..... 6, 7, 27
130 CMR 408.435 27
130 CMR 450.000 et seq 27
130 CMR 450.204 ..... 27, 28
130 CMR 450.241 6
130 CMR 450.323 ..... 6, 11
130 CMR 456.408 19
130 CMR 515.001 ..... 3, 4
130 CMR 515.005 32
130 CMR 515.007 40
130 CMR 516.001 ..... 5, 32
130 CMR 516.004 40
130 CMR 516.005 ..... 31, 32
130 CMR 610.004 3
130 CMR 610.015 11
130 CMR 610.023 19
130 CMR 610.032 26
***vi** 130 CMR 610.035 26
130 CMR 610.082 20
130 CMR 610.085 11
130 CMR 610.092 ..... 4, 35
Rules
Mass. R. Civ. P. 12(c) 21

*1 *QUESTIONS PRESENTED*

WHETHER THE OFFICE OF MEDICAID'S BOARD OF HEARINGS CORRECTLY DETERMINED THAT APPELLANT, A MASSHEALTH MEMBER, HAS NO RIGHT TO APPEAL THE DECISION OF A PROVIDER TO DENY THE APPELLANT'S DAUGHTER'S REQUEST FOR RETROACTIVE PAYMENT FOR CARE THE DAUGHTER PROVIDED TO THE APPELLANT BEFORE THE PROVIDER OBTAINED CLINICAL AUTHORIZATION FOR THE SERVICES.

WHETHER APPELLANT HAS WAIVED A FACIAL CHALLENGE TO MASSHEALTH REGULATIONS BY FAILING TO RAISE IT BELOW.

WHETHER FEDERAL AND STATE MEDICAID LAW REQUIRES THE OFFICE OF MEDICAID TO INCLUDE STRINGENT TIMELINESS REQUIREMENTS IN THE MASSHEALTH PROVIDER REGULATIONS.

STATEMENT OF THE CASE

Nature of the Case

Mary Tomaselli ("Appellant"), appeals from a judgment of the Essex County Superior Court (Whitehead, J.), affirming the decision of the Appellee Office of Medicaid's Board of Hearing ("Board"). In its decision, the Board dismissed, for lack of jurisdiction, the Appellant's claim, on behalf of her daughter, Joyce, for retroactive payment from a private provider of medical services. The care for which Joyce sought reimbursement was rendered *before* Appellant was determined eligible for Adult Foster Care, *before* the provider qualified Joyce as an Adult Foster Caregiver under MassHealth Regulations, and *before* the provider entered into a contract with Joyce for such services.

2** ***Course of Proceedings Below

In November 2007, Joyce, pursuant to a durable power of attorney, requested a fair hearing with the Board on behalf of the Appellant, who has late stage Alzheimer's disease. A. 33. [1] In her hearing request, the Appellant challenged a denial by the **Elder** Services of Merrimack ("Merrimack"), a private provider of adult foster care and other services, of Joyce's request for retroactive payment for personal care services Joyce had provided to the Appellant before August 31, 2007, the date on which the Appellant was determined to be medically eligible for adult foster care services. A. 43. After a hearing, the Board dismissed the. Appellant's claim for lack of jurisdiction because the Appellant. has no right under MassHealth regulations to appeal an action taken by a provider under these circumstances. A. 22-28. The Appellant sought judicial review of the decision pursuant to G.L. c. 30A, § 14. A. 4-7. The Superior Court affirmed the Board's decision, concluding that "the hearing officer was correct in concluding that there was no jurisdiction to hear the appeal. A. 264.

3** ***Statutory and Regulatory Background

1. ***The Federal Medicaid Act, G.L. c. 118E, and the State Regulatory Scheme***.

The Federal Medicaid Act, enacted in 1965 as Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq*., is a cooperative State and Federal program that provides medical assistance to needy individuals. *Tarin v. Commissioner of the Div. of Med. Assistance*, 424 Mass. 746 (1997)(citatios omitted). In Massachusetts, "Medicaid" is the "jointly funded state and federal medical assistance program established pursuant to Title XIX under [G.L, c. 118E, § 9"]." G.L. c. 118E, § 8(c). Under both Federal and State law, "medical assistance" refers to payments by the State agency to a provider of medical services. 42 U.S.C. § 1396d(a); G.L. c. 118E, § 8(d); 130 CMR 515.001 (defining "medical benefits" as "payment for medical services provided" to a member). *See* G.L. c. 118E, § 9 (governing eligibility for Medicaid for commonwealth residents).

The Executive Office For Health and Human Services ("EOHHS") administers Medicaid in the Commonwealth. G.L. c. 118E, § 1, 8. EOHHS is also known as "the MassHealth Agency." 130 CMR 610.004. The Appellee Office of Medicaid, which is an entity ***4** within EOHHS, oversees the payments paid on behalf of MassHealth Members. 130 CMR 515.001. To avoid confusion, this brief will refer to the actions of EOHHS and its entity, the Office of Medicaid, as actions of "MassHealth."

Pursuant to authority granted to it, the EOHHS promulgated regulations at 130 CMR 400.000 - 130 CMR 610.0000 *et seq*. ("MassHealth Regulations"). *See* G.L. c. 118E, § 12. The MassHealth Regulations contain two types' of regulations: Eligibility Regulations, 130 CMR 500.000 *et seq*., which apply to Applicants and Members of the Medicaid program and govern how an Applicant can apply and be eligible for MassHealth benefits (meaning payment for medical services), and Provider Regulations, 130 CMR 400.000 *et seq*., which govern how providers of medical services receive payment from the Office for services provided to Members.

The Eligibility Regulations govern the determination of whether a person is eligible to be a Member. "Members" are "persons determined by the MassHealth Agency to be eligible for MassHealth" benefits." 130 CMR 515.001. MassHealth benefits are not the medical services themselves but rather "payment for medical services." 130 CMR 515.001.

***5** The eligibility process is as follows. First, the person must fill out an application. 130 CMR 516.001(B). If MassHealth approves the application, the person becomes a Member who is eligible to have MassHealth pay for medical services that the Member needs. 130 CMR 516.001 *et seq*.; *see* 42 U.S.C. 1396d(a)("medical assistance" means payments).

In essence, this process is similar to applying for medical insurance: the applicant applies for MassHealth benefits, which is almost like a type of insurance that is paid for by the State and Federal government for those who qualify. Once the person qualifies, that person has the right to have MassHealth pay for the person's necessary medical services. So, when the person

goes to a provider of services, MassHealth pays for the Member's necessary services just like an insurance company covers authorized services for its insured customers.

The Eligibility Regulations, which govern the relationship between MassHealth and its Members, do not contain any provisions under which a Member has to apply for medical services or payment. This is because a Member does not apply to MassHealth for medical services or for payment. To get medical ***6** services, the Member goes to, or is referred to, a provider. At that point, the providers may request that MassHealth pay for services for the Member.

The Provider Regulations list the terms under which providers apply for and receive payment from MassHealth for medical services the provider gives to Members. 130 CMR 400.000 *et seq.* A "Provider" is "any institution, agency, individual, or any other legal entity qualified under the laws of the Commonwealth to perform the medical care and services for which medical assistance and medical benefits are available under G.L. c. 118E." G.L. c. 118E, § 8(f). Providers can appeal certain actions of MassHealth to the Board. 130 CMR 450.241 & 130 CMR 450.323.

This case involves 130 CMR 408.000 *et seq*., (the "AFC Regulations"), which pertain to Providers of Adult Foster Care.

2. *The Adult Foster Care Regulations*

a. *General terms of the AFC Regulations*

"Adult Foster Care ('AFC')" is defined as "services ordered by a physician delivered to a member in a qualified setting as described in 130 CMR 408.435 by a multidisciplinary team and a qualified AFC caregiver[.]" 130 CMR 408.402. Such services ***7** include: assistance with Activities of Daily Living (ADL), which are fundamental personal care tasks such as eating, toileting, and bathing; and Instrumental Activities of Daily Living (IADLs), which includes household management tasks, laundry, shopping, and medication management. *Id*. The components of AFC are:

• A Multidisciplinary Professional team, which is "a team comprising at a minimum, a registered nurse and a care manager who work for the AFC provider." [2] 130 CMR 408.402.

• An AFC Provider, which is "an organization that meets the requirements [of the AFC regulations] and that contracts with MassHealth as the provider of AFC." 130 CMR 408.402.

• An AFC Caregiver, who is "a person who is selected, supervised, and paid by the AFC provider for the provision of direct care in accordance with 130 CMR 408.415(A). [3] 130 CMR 408.402.

• A "Qualified Setting", which a private residence occupied by the AFC Caregiver that is approved by the AFC Provider under 130 CMR 408.435.

b. ***Provision of AFC By A Provider to a Member***

The provision of AFC proceeds as follows. The AFC Provider ensures delivery of direct care to the Member in a Qualified Setting by an AFC Caregiver who ***8** is selected, supervised, and paid for by the AFC Provider. 130 CMR 408.415(A). AFC is ordered by a doctor and delivered by the AFC Caregiver under the supervision of the Multidisciplinary Professional Team in accordance with an "AFC Plan of Care." Id. An AFC Plan of Care is an "individualized written description of activities developed to furnish care that meets the individual's medical, physical, emotional, and social needs based on clinical and psychosocial assessments" and is "prepared by the AFC [P]rovider's registered nurse with input from the AFC care manager,

member, and AFC. [C]aregiver." 130 CMR 408.402. "Clinical Assessments" are evaluations by qualified professionals that determine a member's level of need and serve as the basis of the development of the AFC Plan of Care. *Id*.

When a Member is referred to an AFC Provider, the first step taken by the AFC Providers are Intake and Assessment services. 130 CMR 408.431(A). Before it can provide AFC to a Member, the AFC Provider must: (1) obtain information about the Member; 2) identify potential AFC Caregivers; 3)instruct and train the AFC Caregiver; and 4) submit a request for authorization of MassHealth payment in accordance with the ***9** requirements set forth on 130 CMR 408.416. 130 CMR 408.431(A). After determining that it can provide AFC to a Member, the AFC Provider must: 1) notify Member what the services will be offered through an AFC Plan of Care; and 2) create a Member Record, which includes the doctor's authorization for AFC, the Member's medical history, the past three months' worth of doctor's visits, results of an examination conducted with the past year, and a list of current medications and treatments. 130 CMR 408.431.

c. ***Payment By MassHealth to a Provider for the Provision of AFC to a Member.***

MassHealth authorizes payment to an AFC Provider for AFC for a Member if the Provider satisfies the Payment Criteria set forth in 130 CMR 408.416. To receive payment from MassHealth, the AFC Provider must 1) obtain "Clinical Authorization" [4] that the member ***10** satisfies the Clinical Criteria for AFC that are set forth in 130 CMR 408.417 before the first date of service; and 2) submit a request for payment that includes a designated screening tool completed and signed by a registered nurse as well as a statement documenting its assessment that the AFC Provider can safely and appropriately care for the Member in a Qualified Setting. 130 CMR 408.416. *See also* 130 CMR 408.419(C)(Conditions of Payment). "Clinical Authorization" is the determination by an agent of MassHealth as to whether a Member qualifies for AFC. 130 CMR 408.416 & 408.417. The Clinical Criteria for a Clinical Authorization are: 1) a doctor's order for AFC; 2) a condition requiring daily physical assistance and supervision to complete daily activities such as bathing, toileting, and eating. 130 CMR 408.417.

If the AFC Provider's request for Clinical Authorization for AFC is denied, a Member may appeal the denial to the Board. 130 CMR 408.418(B). In such circumstances, the Member can appeal by requesting a fair hearing from the Board under the procedures set forth in 130 CMR 610.015(B)(2). 130 CMR 408.418(C). The Board's decision is the final decision of ***11** MassHealth and judicial review of that decision occurs pursuant to G.L. c. 30A, § 14, 130 CMR 610.085.

If the AFC Provider's request for Clinical Authorization for Payment is denied, only the AFC Provider may have the right to appeal that decision. *See* 130 CMR 450.323. The AFC Regulations do not permit the Member or an AFC Caregiver to appeal that denial. *See* 130 CMR 400.000 *et seq*. Only the Provider, and not the Member or the AFC Caregiver, receives payment from MassHealth. *See* 130 CMR 408.416. The AFC Caregiver's entitlement to payment derives not from the MassHealth Regulations but instead from the private agreement entered into by the AFC Caregiver with the AFC Provider for provision of direct care. *See* 130 CMR 408.433(B)(b)(iv). [5]

12** ***Statement of the Facts

1. ***Relevant Parties and Players***

The Appellant is a Member. FF. 1; [6] A. 25. She is in her nineties and suffers from end--stage Alzheimer's disease. A. 22; FF 1.

The Appellee Office of Medicaid ("MassHealth") is an entity within the EOHHS that administers MassHealth benefits in Massachusetts.

The **Elder** Services of Merrimack ("Merrimack") is an AFC Provider that has fulfilled the specific requirements to attain that status pursuant to 130 CMR 408. 404. FF 5; A. 22, 27.

Coastline **Elderly** Services ("Coastline") is the agent of MassHealth that performed Clinical Authorization of the Appellant. A. 22, 31.

2. ***The Introduction of a New Rate for AFC Care***.

Through a November 2006 Transmittal Letter (the Letter), MassHealth notified its Providers that, effective December 1, 2006, it would introduce "a new Level II AFC rate, which corresponds to a more extensive level of care provided to eligible MassHealth members who require the higher level of ***13** care." A. 76. The Letter indicated that "for a member who is determined to have met the clinical criteria for MassHealth coverage of AFC, an AFC provider may submit claims for payment at either the Level I or Level II payment rate." A. 76. The Letter also provided that, for "Level. II AFC, certain relatives of a MassHealth member may serve as that member's AFC caregiver" and that the AFC provider must ensure that the qualified caregiver is serving no more than two persons who require Level II AFC in a Qualified Setting. A. 78.

Regulations regarding the new Level II rates were promulgated and became effective in February 2007. A. 36-37. Previously, AFC services had been provided to MassHealth Members for twenty years in accordance with established guidelines. A. 27. The new regulations formalized the provision of AFC to MassHealth members at two levels, Level I and Level II. A. 27, 36-37.

At the time the Letter issued, the Appellant had been receiving services and community-based supports paid for by MassHealth through the Nevins Adult Day Health program and hospice services from Merrimack. FF 2; A. 25. In addition, Joyce had been caring for the Appellant at home. FF 6; A., 26, 36-37.

14 3.** ***Joyce's request to Merrimack for Level II AFC for the Appellant.

Merrimack's file on the Appellant indicated that, in February 2007, one of Appellant's daughters called Merrimack and asked for a call back. A. 104. The Appellant's Case Manager noted that she left the caller a voicemail in response to the call. A. 104.

The next contact between Merrimack and the Appellant's representatives occurred on March 7, 2007, when Joyce called Merrimack to find out whether the Appellant qualified for Level II AFC. A. 104 (noting that "AFC Level II referral received, stamped and logged" at Merrimack). The Intake form completed by Merrimack after that call assessed the situation as: "**Elder** has Alzheimers and requires 24/7 supervision. DTR is primary CG. **Elder** has MassHealth, but DTR does not have # at time of call." A. 80.

The next entry in the Appellant's file occurred on March 15, 2007, when the Appellant's Case Manager noted that the Appellant's daughter called to inform her that the Appellant "needs full assist with dressing, showering, continent care and all IADLs. She cannot be left alone due to her medical Dxs and attends Nevins Alzheimers ADH on a daily basis." A. ***15** 105. The Case Manager further noted that "Appointment arranged for 3/29 at 2 PM at consumers home." A. 105.

For reasons not apparent from the record, the March 29 appointment did not take place. On April 18, 2007, a registered nurse (RN) and a licensed social worker (LSW) attempted to conduct a home visit. A. 105; FF 10. According to the RN, they "were unable to fully complete home safety eval as they had just moved into this rental home and all the moving boxes were crowding halls[.] [W]e told the daughters that we could not assess the house for safety because of this and would have to come back - they will call us." A. 105; *see* FF 10. The RN further noted that "we will • return when the daughters call after house is cleared of moving boxes." A. 105; *see* FF 10.

The next progress note, dated August 13, 2007, indicated that an RN had consulted with the Appellant's Case Manager and that "AFC intake on hold due to previous RN had not completed paperwork." A.105. After speaking with Joyce, the RN recorded that the "family [is] extremely 'upset that approval had not arrived yet.' " *Id*. The RN explained to Joyce that she would follow up. *Id*. The record does not show, and the Appellant does not in her brief indicate, that ***16** her daughters followed up with the RN after the April 18, 2007, visit.

On August 14, 2007, the RN scheduled a home visit for August 16, 2007. A. 105. Before the home visit, the RN mailed the Appellant's medical history to Coastline for Clinical Authorization and "left [a] message with nurse approver to request ASAP review of the case". A. 105-106.

At August 2007 home visit, the RN found that "the family is giving excellent, quality care to the consumer even though the home is cluttered." A. 106; *see* FF 11. During the visit, the Appellant's daughters informed the RN that they had been living in rental properties since the previous winter, when their home in Salisbury had flooded. A. 106. The RN further noted that when she mentioned that this approval may take a couple of weeks, both daughters insisted that, "payment should go back to the date that they were originally seen." A. 106. The RN also noted: "I remind them their mom needs to be clinically approved before payment can be made and they continue to state that payment should be retroactive. I remind that the program is about care and that the money is a ***17** benefit to the program but they continue to be focused on the payment issue." A. 106.

Less than three weeks after receiving the request from Merrimack, on August 31, 2007, Coastline issued a Clinical Authorization for the Appellant. A. 107; FF 3. Merrimack called Joyce to set up an appointment to sign a caregiver contract. A. 107. At the time, "[d]ue to the ongoing issue regarding the date of payment beginning, the family chose not to sign the agreement[.]" A. 108. The family felt that "their signature[s] would be an acceptance of 8/31 as the start date of payment." A. 108.

On October 1, 2007, Merrimack notified Joyce, via letter, that they would not pay her for services rendered before August 31, 2007, A. 24.

By October 16, 2007, however, the family notified Merrimack that they were ready to begin the program. A. 108. Merrimack entered into contracts dated 8/31/2007 and 11/8/07, with Joyce as the AFC Caregiver effective 8/31/2007. A. 112-126. Under the contracts: 1) Merrimack agreed to pay Joyce $50 per day for Personal Care Services; 2) Joyce was required to provide room, board and personal care services to the Appellant pursuant to an AFC Plan of Care and the AFC ***18** Regulations; *and 3)* Merrimack had to provide ongoing. training for Joyce, monthly home visits and monitoring of the home and the Appellant's health, counsel and assistance to Joyce and the Appellant to resolve disputes, an AFC Plan of Care, health and services coordination for the Appellant, respite as specified in MassHealth guidelines, and recordkeeping. FF 15-16; A. 26-27, 112-126.

4. *The appeal of Merrimack's denial of retroactive payment to Joyce to the Board*

On October 16, 2007, Joyce filed an appeal on behalf of the Appellant with the Board to challenge Merrimack's October 1, 2007, refusal to pay Joyce for services rendered before Coastline issued its Clinical Authorization. A. 23, 33. The Board scheduled a hearing for November 9, 2007. A. 41. [7]

At the Board's November 9, 2007, hearing, Joyce and her sister Grace appeared on behalf of the Appellant. A. 20. They stipulated that Appellant did not contest Coastline's Clinical Authorization. FF 4. ***19** Instead, they argued that: 1) that the AFC Regulations violate Federal law because the regulations lack timeliness guidelines for actions of Providers; 2) that 130 CMR 456.408, which provides retroactive payment of three months to a nursing home for long term care should apply to their situation; and 3) that, although the AFC Regulations state that an AFC Provider cannot receive payment prior to the date of Clinical Authorization, the regulations did not indicate that an AFC Caregiver could not be paid prior to the date of Clinical Authorization. A. 25.

Jennifer Bergeron, the Assistant Director of Residential and Adult Day Health Services for the Office of Long Term Care, appeared on behalf of the MassHealth Agency. A. 23. Three Merrimack employees appeared as well. *Id*. Bergeron moved to dismiss on the grounds a determination by a Provider, here, Merrimack, "is not an Appealable Action, as defined in 130 CMR 610.023," which lists the type of actions a Member can bring, and, as such, the Board "is not the appropriate forum, nor is MassHealth the correct party, for this dispute." A. 47.

On November 20, 2007, the Board dismissed the appeal. A. 28. In doing so, the Board concluded that ***20** "[t]he actions of the. AFC provider to qualify appellant and her caregiver for AFC services and to establish a date to begin the services and to pay the caregiver are actions of a MassHealth provider. This appeal is DISMISSED because no provider decision or action ... constitutes an appealable action. (130 CMR 610.035(A)(4))." A. 28. The Board further stated that "the argument that the regulations are deficient by failing to provide timeframes is a challenge to the regulation and not within the jurisdiction of this-hearing officer (130 CMR 610.082(c)(2))." A. 28.

5. ***Appellant's G.L.c: 30A, § 14, appeal and the Superior Court's decision affirming the Board***

After the Board denied her request for a rehearing, the Appellant sought judicial review of the Board decision pursuant to G.L. c. 30A, § 14. A. 4-7. In her Complaint, she alleged that "MassHealth **neglected** to provide policy and regulations that pertain to a family caregiver who is. caring for the sick **elder**/Masshealth member already in the home." A. 6. She requested that the Superior Court "set aside the decision of the Board of Hearings and the Office of Medicaid to order the plaintiff's initial application date in January [2007], for the Enhanced ***21** Adult Foster Care program." A. 6-7. In other words, she asked the Court to determine that Joyce was entitled to payment from Merrimack for the care Joyce provided between January and August 2007. A. 7.

As. its answer, the Appellee submitted a certified copy of the administrative record." A. 9. Further answering, the Appellee stated that, "To the extent the complaint seeks relief unavailable under G.L. c. 30A, § 14, the [Appellant] fails to state a claim upon which relief may be granted." A. 9.

While Appellant filed the Complaint *pro se*, she engaged the services of an attorney to draft, serve, file, and argue her motion for judgment on the pleadings pursuant to Mass. R. Civ. P. 12(c). A. 131-141. In her motion, she argued that: 1) the Board's decision is contrary to Federal and State law requiring that Medicaid services be provided with reasonable promptness, A. 137-138; 2) the dismissal of the appeal is incorrect as a matter of Federal and State law; A. 139-40; and 3) Merrimack should be made to answer for the "delay." A. 140. The Appellee countered by arguing. that: 1) the Board had no jurisdiction over a caregiver's claims, A. 154-156; 2) because the Appellant was not injured by the action, ***22** she was not an aggrieved party entitled to judicial relief; A. 156-57; 3) Merrimack was an AFC Provider and Joyce's complaints are between her and Merrimack, and not MassHealth, A. 159-1.60; and 4) the criteria for Clinical Authorization of MassHealth Payment were not satisfied before August 31, 2007. A. 160.

The Superior Court (Whitehead, J.) affirmed the Board's decision, concluding that the Appellant did not have standing to challenge Merrimack's delay in approving Joyce as an AFC Caregiver. A. 163-64. In doing so, the Superior Court reasoned

[Appellant] styled her appeal as one based on a delayed determination of clinical eligibility. However, the issue that existed between [the Appellant] and [the MassHealth Agency] was never whether she met the criteria for eligibility for AFC services under 130 CMR 408.417. It was whether [Appellant's] daughter qualified as an AFC care giver. It was delay in resolving this issue that resulted in a delay of payment to the provider (and, ultimately, the care giving daughter).There is no suggestion that [the Appellant] desired a caregiver other than her daughter. The issue of who may qualify as an AFC care giver is one that arises between AFC provider, on the one hand, and Masshealth, on the other hand. So far as the Court can ascertain, there is nothing in the statutory or regulatory scheme that confers upon a Masshealth member any rights arising out of the determination of that issue. Since the existence of the right was the premise of [the Appellant's] appeal, her standing to challenge the delay in approving her daughter as a caregiver fails.

A. 163-64. This appeal followed that ruling.

23 *STANDARD OF REVIEW

Under G.L. c. 30A, a Court must affirm an agency decision unless, upon judicial review, it determines that the Appellant's substantial rights were prejudiced because the decision was unsupported by substantial evidence, arbitrary or capricious, or based upon error of law. *Id.* § 14 (7). The party challenging the agency decision bears the burden to prove the agency decision invalid. *Coggin v. Massachusetts Parole Bd.*, 42 Mass. App. Ct. 584, 587 (1997); *Merisme v. Board of Appeals on Motor Vehicle Liab. Policies & Bonds*, 27 Mass.App.Ct. 470, 474 (1989). This is a heavy burden, because Courts also give due weight to an agency's expertise, as required by § 14(7). *See Protective Life Ins. Co. v. Sullivan*, 425 Mass. 615, 618, 682(1997) ("In general, we grant substantial deference to an interpretation of a statute ... by the administrative agency charged with its administration"); *Boston Police Superior Officers Fed'n v. Labor Relations Comm'n*, 410 Mass. 890, 892, (1991) (considerable deference generally accorded agency decision, unless agency commits error of law).

24 *ARGUMENT

I. THE BOARD CORRECTLY DISMISSED THE APPELLANT'S APPEAL BECAUSE A MEMBER CANNOT APPEAL AN AFC PROVIDER'S ACTION TO THE BOARD.

The primary issue in this case boils down to a question of regulatory interpretation: whether the Board erred in interpreting the MassHealth Fair Hearing Rules and the AFC Regulations. Applying those regulations, the Board determined that the Appellant, a Member, had no right to appeal a determination by Merrimack, the AFC Provider, that Joyce. While the Board may hear an appeal brought by the Appellant to challenge an action of either MassHealth or of its agent, here Coastline, neither performed the challenged action in this case.

Before the Board, the Appellant sought review the action of Merrimack, an AFC Provider, to deny of retroactive payment to Joyce. Joyce's entitlement to payment derived not from MassHealth Regulations but rather from Merrimack's agreement to pay for her services. Joyce may have had an independent remedy against Merrimack. The Appellant, however, does not have the right to assert this claim to the *Board* on Joyce's behalf.

***25 A. The AFC Regulations do not allow the Appellant to appeal an action of Merrimack.**

The AFC Regulations do not permit a Member to appeal the action of an AFC Provider to the Board. The regulations provide a Member a right of appeal to the Board pursuant to the Fair Hearing Rules *only* when MassHealth, or its agent, denies a Clinical Authorization requested under 130 CMR 408.416(A). 130 CMR 408.418(B) & (C). In this case, had Coastline denied the Clinical Authorization, the Appellant could have appealed such a denial to the Board. 130 CMR 408.418(C). Here, the Appellant stipulated, however, that she did not challenge Coastline's Clinical Authorization. A. 23.

As the Superior Court astutely recognized, although the Appellant "styled her appeal as one based on a delayed determination of [Clinical Authorization] [,] ... the issue that existed between the [Appellant] and [MassHealth] was never whether she met the criteria for eligibility for AFC services" but rather "whether [Joyce] qualified as an AFC caregiver." A. 163-64. Whether or not a caregiver qualifies as an AFC Caregiver is not among the issues decided during a Clinical Authorization. *See* 130 CMR 408.417 (listing Clinical Criteria to determine a ***26** Member's eligibility). Further, Merrimack does not have the power to issue or deny a Clinical Authorization. *See* 130 CMR 408.416(A) (Clinical Authorization *requested*, but not acted on, by AFC Provider). Therefore, the Board correctly concluded that it did not have the power under the AFC Regulations to hear the Appellant's claim against Merrimack, a provider.

B. MassHealth's Fair Hearing Rules do not permit the Appellant to appeal Merrimack's challenged action to the Board.

In addition, MassHealth's Fair Hearing Rules, 130 CMR 610.000 *et seq.*, also do not permit the Appellant to challenge Merrimack's refusal to pay Joyce for services rendered before Coastline issued the Clinical Authorization. A. 23. The Fair Hearing Rules allow Members to challenge thirteen enumerated actions by MassHealth. *See* 130 CMR 610.032(A). Except for one limited exception not relevant here, "no *provider* decision or action ... constitutes an appealable action" under the Fair Hearing Rules. 130 CMR 610.035(A)(4). Because the challenged action here is Merrimack's denial of retroactive payment to Joyce, and because Merrimack is a Provider, the Board correctly concluded ***27** that the Fair Hearing Regulations do not grant the Board jurisdiction to hear the Appellant's claim.

The Appellant nevertheless attempts to squeeze its claim into a jurisdictional category by insisting that Merrimack is an "agent" of MassHealth so that the actions of Merrimack in its role of an AFC Provider qualify as actions of MassHealth. Appellant's Br. 30-37. To support this misguided argument, the Appellant cites a regulation that does not apply to the situation presented here. Appellant's Br. at 31 (citing to 130 CMR 450.204). The cited regulation, which governs terms under which MassHealth pays Provider for unnecessary services, state that "a provider's opinion or clinical determination that service is not medically necessary does not constitute action by the MassHealth agency." 130 CMR 450.204(C). Citing this inapplicable provision, the Appellant argues that, because Merrimack's challenged action here did not involve medical decision-making, Merrimack cannot be considered an AFC Provider. Appellant's Br. at 31. *Compare* 130 CMR 408.000 *et seq.* (AFC Regulations) *with* 130 CMR 450.200 et. seq. (Administrative and Billing regulations). While the cited regulation eliminates a certain action - namely ***28** a medical determination -from group of actions that qualify as action by MassHealth, one cannot cite that provision to establish the converse (i.e., because Merrimack performs a non-medical service, it cannot be considered a Provider). [8]

C. Under the AFC Regulations, the Appellant did not receive AFC, and Joyce was not qualified as an AFC Caregiver, Until August 31, 2007.

In any event, even if the Board had the power to consider the Appellant's claim against Merrimack, the record does not reflect that Merrimack erred in denying retroactive benefits to Joyce.

The Appellant did not receive AFC, as that term is defined in the AFC Regulations, before August 31, 2007. "AFC" is defined as "services ordered by a physician delivered to a member in a qualified setting as described in 130 CMR 408.435 by a multidisciplinary ***29** team and a qualified AFC caregiver [.]" 130 CMR 408.402. [9] To qualify Joyce as an AFC Caregiver, Merrimack had to, and did in fact: 1) evaluate the prospective caregiver, Joyce, to ensure she met all of the necessary qualifications set forth in 130 CMR 408.434(B); 2) conduct a Criminal Offender Records Information (CORI) check; 3) ensure that Joyce completed a physical examination; 4) independently contract with Joyce; 5) ensure that Joyce was not caring for more than three persons in a qualified setting and 6) ensure that Joyce was properly trained and managed. 130 CMR 408.434 (A)&(B); A. 28. The Appellant does not allege that all of these determinations occurred before August 31, 2007. As such, there is no merit to the claim that Merrimack owed money to Joyce before August 31, 2007.

Further, the AFC regulations permit MassHealth payment for AFC to the AFC Provider only after the later of 1) the date the AFC Provider obtains Clinical Authorization 2) the date AFC actually begins. ***30** 130 CMR 408.419 (G). Under this regulation, the *earliest* date (and, in fact, the actual date) that MassHealth could pay Merrimack for AFC was August 31, 2007. Even if the Appellant received AFC as defined in the regulations before August 31, 2007, MassHealth could not pay Merrimack, and thus Merrimack would not have funds to pay Joyce, before that date.

The Appellant nevertheless complains that she was "clinically eligible" for AFC as on March 7, 2007, because "she was receiving Adult Day Health services as well as hospice service" at that time. Appellant's Br. at 22. She bases this contention on the misguided assumption general eligibility for MassHealth, coupled with specific eligibility for certain medical services,

translates into a general "clinical eligibility" for all services. The AFC Regulations, however, set forth a procedure and criteria for the determination of eligibility for AFC services, which includes Clinical Authorization as well as qualification of the home and the caregiver. *E.g.*,130 CMR 408.416, 408.417, 408.434. Merrimack was not entitled to payment for AFC services until the Clinical Authorization issued on August 31, 2007.

***31** Importantly, the MassHealth Agency does not directly pay the AFC Caregiver. See 130 CMR 408.419(A). Instead, the AFC Provider employs or independently contracts with the AFC Caregiver. 130 CMR 408.434(A)(4). The AFC Program Director, who is part of the Multidisciplinary Professional Team, pays the AFC Caregiver. 130 CMR 408.433 (b)(b)(iv). It is undisputed that Merrimack did not qualify Joyce or the home until August 2007; as such, the contracts between Joyce and Merrimack reflect effective dates of August 31, 2007. A. 112, 121 Joyce's entitlement to payments from Merrimack derived from those contracts, which did not, and could not, cover services provided by Joyce before Clinical Authorization. [10]

Relying on a distorted interpretation of G.L. c. 118E, § 30, and 130 CMR 516.005, the Appellant claims ***32** she was unlawfully denied six months' of benefits because State law allows for three months' of retroactive coverage for services received. Appellant's Br. at 19. Retroactive coverage under the foregoing provisions, however, pertains only to eligibility to become a MassHealth Member. G.L.c. 118E, § 30; [11] 130 CMR 516.005. [12] It is undisputed that the Appellant was eligible for MassHealth benefits at all relevant times and was receiving MassHealth benefits. FF 1-2; A. 28. Thus, the statute and regulation the Appellant cites have no bearing on the issues here, because the Appellant was already a MassHealth Member. There are no requirements, and thus no regulations containing such requirements, stating that a member has to apply to MassHealth for services after becoming eligible. Only the Provider, not the Member, applies to MassHealth for payment for AFC.

***33 II. THE FACIAL CHALLENGE TO THE AFC REGULATIONS FAILS THE APPELLANT FAILED TO RAISE THE ISSUE BELOW.**

Perhaps in recognition that Merrimack, and not MassHealth, made the challenged determination in this case, the Appellant tries to create appealable "action" by MassHealth by further arguing that MassHealth "acted" by "not properly implement[ing] the reasonable promptness requirement [in Federal and State law] by [failing to] require AFC providers to adhere to a time limit for preadmission procedures." Appellant's Br. at 12. [13] This argument appears to be a facial challenge to the AFC regulations. To the extent that the Appellant seeks to present this argument here, she has waived the issue by failing to present it below. *Century Fire & Marine Ins. Corp. v. Bank of New England-Bristol Cty.*, 405 Mass. 420, 421 n. 2 (1989).

***34** Moreover, even if this Court were to consider the Appellant's challenge to the AFC Regulations, the challenge is not meritorious. As discussed below, the Appellant bases her challenges to the regulations on an incorrect interpretation of Federal and State law and precedent. No law mandates MassHealth to require a *Provider* to provide services in an expedited manner. Specifically, Chapter 118E does not grant such authority to MassHealth.

A. A facial challenge to a regulation occurs through a claim for declaratory relief.

In her brief, the Appellant's main argument is essentially that the Appellee failed to enforce Federal and State law by not including in the AFC Regulations a time limit for action by an AFC Provider. Appellant's Br. at 11-19. Although styled as a request for "enforcement," *see* Appellant's Br. at 18, this argument in essence challenges the validity of the AFC Regulations. *See* A. 28 (Board notes same). The Appellant did not, however, assert a facial challenge to the AFC regulations in her Complaint by asserting a claim for declaratory relief pursuant to G.L. c. 231A. A. 4-7. *See* G.L. c. 30A, § 7 ("Unless an exclusive mode of review is provided by law, judicial review of any regulation ... may be had ***35** through an action for declaratory relief in the manner and to the extent provided under chapter two hundred and thirty-one A."). Nor did her counsel amend the Complaint to include this claim before he submitted a motion for judgment on the pleadings on her behalf. Accordingly, the Appellant cannot press this claim for the first time on appeal. [14]

The Appellant may not avoid the burdens of a facial challenge to a regulation by objecting to the manner in which MassHealth has chosen to interpret and apply the regulation. *Town of Falmouth v. Civil Service Commission,* 447 Mass. 814, 822 (2006). Such an " 'argument ignores the principle that [a Court's] deference to an administrative agency extends beyond appropriate instances of statutory interpretation also to include the agency's construction of its own regulations.' " *Id*. (citations omitted).

The only "action" taken by MassHealth with respect to the MassHealth Regulations occurred through ***36** the Board's interpretation and application of those regulations in its decision. As set forth above in Argument Part I.a., the Board reasonably interpreted the AFC Regulations to not permit a Member to appeal the action of a Provider to the Board. *See* Argument Part I.a. This Court should not disturb this choice, which is not patently wrong, unreasonable, arbitrary, whimsical, or capricious. *E.g.*, *TBI, Inc. v. Board of Health of N. Andover,* 431 Mass. 9, 17 (2000).

B. The Reasonable Promptness Requirement applies to actions of MassHealth but not to the actions of a Provider.

The Appellant contends, by not including a timeliness requirement for actions of an AFC Provider in the AFC regulations, MassHealth "ignored" the reasonable promptness requirement set forth in Federal and State law. Appellant's Br. at 18. As the party challenging a regulation, the Appellant bears the burden of proving that the regulation is "illegal, arbitrary, or capricious." *Borden, Inc. v. Commissioner of Pub. Health,* 388 Mass. 707, 722 (1983). As explained below, the Appellant fails to prove that MassHealth's action in doing so violated Federal or State law or was otherwise arbitrary, capricious, or unreasonable.

***37** "A highly deferential standard of review governs a facial challenge to regulations promulgated by a government agency." *Massachusetts Fed'n of Teachers v. Board of Educ.,* 436 Mass. 763, 77.1, (2002). "[A] properly promulgated regulation has the force of law . . . and' must be accorded all the deference due to a statute (citation omitted)." *Borden,* 388 Mass. at 723. While deference does not mean abdication, *Quincy v. Massachusetts Water Resources Auth.,* 421 Mass. 463, 468, (1995) ("regulation that is irreconcilable with an agency's enabling legislation cannot stand"), Courts must "apply all rational presumptions in favor of the validity of the administrative action and not declare it void unless its provisions cannot by any reasonable construction be interpreted in harmony with the legislative mandate." *Consolidated Cigar Corp. v. Department of Pub. Health,* 372 Mass. 844, 855 (1977). *See Berrios v. Department of Pub. Welfare,* 411 Mass. 587, 596 (1992) (enforcement of regulations should be refused only if they are "plainly in excess of legislative power").

The Appellant bases her argument on a summary of Federal and State law that requires a State plan for Medicaid to provide medical assistance to eligible ***38** individuals with "reasonable promptness." Appellant's Br. at 9-19. She reads into such law a requirement that MassHealth require a Provider to act within the same time limits under which MassHealth Agency must act. *Id*. None of the law she cites is susceptible to such an interpretation.

The Appellant first points to the Federal Medicaid statute, which requires that, as a condition of Federal reimbursement, "[a] state plan for medical assistance must ... provide ... that [medical] assistance shall be furnished with reasonable promptness to all eligible individuals." 42 U.S.C. § 1396a(a)(8). "Medical assistance" refers to payments made by the State Medicaid agency, which in Massachusetts is the MassHealth agency." 42 U.S.C. § 1396d(a). This statutory definition mentions payment for, but not the provision of services. *Bruggerman ex rel. Bruggerman v. Blagojevich,* 324 F.3d 906, 910 (7th Cir. 2003)("the statutory reference to 'assistance' appears to have reference to financial assistance rather than to actual medical services"). *See also Westside Mothers v. Olszewski,* 454 F.3d 532m 540 (6th Cir, 2006) (concluding that 42 U.S.C. §§ 1396a(a)(8) does not require the State to provide medical services ***39** promptly but rather only financial assistance). As such, the Medicaid Act only requires the State to pay promptly when presented with a bill. Appellant does not cite to law applying the "reasonable promptness" requirement to' the services of a Provider.

The Appellant also points to Federal regulations, which require that MassHealth "furnish Medicaid promptly to recipients without any delay caused by the agency's administrative procedures", 42 CFR § 435.930(a), and provide that MassHealth "must establish time standards for determining eligibility and inform the applicant of what they are." 42 CFR § 435.911 (a) (noting that

the time standards may not exceed ninety days for disability applicants and 45 days for all other applicants). Again, Appellants do not establish that these regulations govern the actions of a Provider.

The cited portions of the Medicaid Act and accompanying Federal regulations apply only to actions of *MassHealth* in determining eligibility for medical assistance and MassHealth has complied with them. As the Appellant notes, MassHealth inserted time standard requirements for eligibility determinations in the Eligibility Regulations, which apply to the ***40** relationship between MassHealth and its Members. 130 CMR 516.004(A)(for non-disability applicants, determination of general eligibility for MassHealth must be made within 45 days) and 515.007(C)(as a general matter, applicants and Members "have the right to timely provision of benefits").

Despite the Appellant's suggestion to the contrary, *see* Appellant's Br. at 11, the *Boulet* case does not stand for a rule that the "reasonable promptness" requirement in Federal law applies to actions of Providers. *Boulet* involved a group of Medicaid-eligible and disabled plaintiffs, each of whom had languished on a State-run and State-operated waiting list for medically necessary services for three to ten years, who sought class certification on the issue of whether the Commonwealth had failed to provide medical assistance in a reasonably prompt manner by putting them on the waiting list instead of paying for services. *Boulet, et al., v. Cellucci, et al.*, 107 F.Supp. 2d 61, 62 (D. Mass. 2000)(certifying class narrower than one requested and declaring plaintiffs entitled to services, if available, within 90 days).' The "medical assistance" that the Boulet plaintiffs sought was the defendants' payment for ***41** services included in its State plan. *Id.* at 75. All the challenged actions in *Boulet* were attributable to the State; no Provider action was at issue. *Boulet* thus does not stand for the rule that a Provider's actions or inactions are appealable State action for purposes of the "reasonable promptness" requirement.

Unlike *Boulet*, the Appellant's case does not concern actual (as opposed to alleged) delay by MassHealth or any other State actor. The issue in this case involves not the timely payment by the State to the Provider, but instead, whether Merrimack properly paid Joyce, its contracted employee. Finally, in contrast to the facts of *Boulet*, the Appellant did not remain without AFC, despite being clinically eligible, for an extended period of time. Merrimack notified the Appellant of its readiness to start the AFC Plan of Care immediately after obtaining the Clinical Authorization. A. 107-08.

Finally, the Appellant incorrectly argues that the AFC Regulations inappropriately "maintain[] a fiction" that improperly separates intake and assessment from AFC services and that all actions taken by Merrimack pursuant to the AFC Regulations were "reimbursable services" from which she, the ***42** Appellant, had a right of appeal. Appellant's Br. at 20-21. This claim misunderstands the purpose of the AFC Regulations, which, like other regulations in the 400 series, applies to Providers and not to Members. Further, despite her claim to the contrary, the AFC regulations do not "impermissibly limit[] [her] right to appeal the determination of clinical eligibility." Appellant's Br. at 20. The AFC Regulations at 130 CMR 408.418(B) specifically authorize a Member to appeal the denial of Clinical Authorization. The AFC Regulations do not, however, grant a Member the right to appeal the Clinical Authorization of Payment because the issue of payment for services arises between the AFC Provider and MassHealth.

C. Sound policy reasons support the decision not to include time standards for Provider action in the AFC Regulations.

In its decision, the Board noted that "qualifying a setting, selecting and/or investigating a caregiver, obtaining clinically eligibility and training the caregiver involve time elements that would be difficult to quantify." A. 28. As MassHealth argued below, "It is within [the MassHealth] Agency's authority and discretion to decide not to impose such an additional burden on AFC providers, especially ***43** since the effect of the additional burden of a time frame could be to reduce the number of entities that seek to be AFC providers or to reduce the number of MassHealth members that an AFC provider could serve." A. 154-55. Given such policy reasons, it was not unreasonable, arbitrary, or capricious for the Appellee to not include timeliness requirements in the AFC regulations. Accordingly, even if this claim was properly before this Court and not waived, the Court should not disturb the MassHealth's valid exercise of its authority and discretion.

CONCLUSION

For the reasons set forth more fully above, this Court should affirm the decision of the Board.

Footnotes

1 The Record Appendix will be cited as "A. page #" and the Appellant's Brief as "Appellant's Br. at page #."

2 The requirements for the Multidisciplinary Professional Team are set forth in 130 CMR 408.433 (B)

3 The qualifications and responsibilities of an AFC Caregiver appear in 130 CMR 408.434.

4 Confusingly, the title of 130 CMR 408.416 is "Clinical Authorization for MassHealth Payment." This title refers to the determination made by MassHealth as to whether the Payment Criteria listed in the section are satisfied. "Clinical Authorization," which is referred to in 130 CMR 408.416(A) & (B) refers *not* to the payment determination but rather to the determination by an agent acting for the MassHealth as to whether AFC is medically necessary and is made by applying the factors, or Clinical Criteria, set forth in 130 CMR 408.417.

5 The rate of this payment is set by the Division of Health Care Finance and Policy at 114.3 CMR 51.00.

6 The factual findings of the final agency decision, which appears at R. 21-29, will be cited as "FF [#]."

7 Joyce also requested "a fair hearing as an applicant in the capacity as a **caregiver**" and asked if the hearing could be merged with the November 9, 2007, "fair hearing for [the Appellant]." A. 44-45 (emphasis original).

8 The Appellant makes a similar argument later in her brief. Appellant's Br. at 32-33 (arguing that Merrimack's intake and assessment action constitute appealable state action because such services are "non-medical" in nature). The Appellant's logic is flawed. The determination of whether action is State action does not turn on whether the action is medical or non-medical. Just because, in certain cases (i.e. *Blum v. Yaretsky*, 457 U.S. 991 (1982) or under certain regulations (i.e., 130 CMR 450.204), a medical determination *is* not State action, there is no rule, in case or positive law, that all non-medical Medicaid-related action *is* State action.

9 Similarly, there is no merit to the Appellant's argument that Joyce's care of her mother from January 2007 until August 31, 2007, alone qualified as AFC. Appellant's Br. at 25. As the text accompanying this footnote explains, the definition of AFC encompasses much more than direct care from a caregiver.

10 The *Sargeant* case, *see* Appellant's Br. on pp. 27-28, is distinguishable from this case. *Sargeant v. Commissioner of the Dept. of Pub. Welfare*, 383 Mass. 808, 809-10 (1981)(Member had standing to seek payment from Department of Public Welfare(DPW) after DPW advised nurse that, if nurse set up a home for the Members's care, DPW would pay the nurse). The challenged action in *Sargeant* was agency, and not Provider, action. If MassHealth did not pay Merrimack in a timely fashion, the Appellant might have standing under *Sargeant* to sue MassHealth for a failure to provide reasonably prompt medical assistance. That issue is not presented here.

11 G.L. c. 118E, § 30, allows for retroactive payment for eligible services received by an Applicant at the time s/he filed her application for eligibility.

12 Under 130 CMR 516.005, the begin date of MassHealth Standard coverage, which includes AFC, *may* be retroactive to the first day of application, if covered services were received during that period.

13 Appellants also argue that MassHealth "did not approve and provide payment for requested caregiver services within either the 21-day time limit or the 45 day time limit" in MassHealth regulations. Appellant's Br. at 12. As explained above, at page 29, MassHealth does not pay caregivers for AFC. According to the MassHealth regulations, MassHealth pays the AFC Providers for AFC care, which includes direct care by the AFC Caregiver as well as other types of services. The Appellant does not allege, and the record does not show, that MassHealth did not pay Merrimack promptly.

14 The Appellant brought a variant of this claim to the Board and the Board correctly declined to address it because the "hearing officer cannot rule on the legality of regulations" but directed the Appellant to seek judicial review. A. 28(citing 130 CMR 610.092). Despite such notification, the Appellant declined bring a facial challenge to the regulations. A. 6.

End of Document

© 2015 Thomson Reuters. No claim to original U.S. Government Works.