

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or recipient's case file; and

(2) All documents and records to be used by the State or local agency or the skilled nursing facility or nursing facility at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

[44 FR 17932, Mar. 29, 1979, as amended at 57 FR 56506, Nov. 30, 1992]

**§ 431.243 Parties in cases involving an eligibility determination.**

If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the agency that is responsible for determining eligibility must participate in the hearing.

**§ 431.244 Hearing decisions.**

(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

(b) The record must consist only of—

(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

(2) All papers and requests filed in the proceeding; and

(3) The recommendation or decision of the hearing officer.

(c) The applicant or recipient must have access to the record at a convenient place and time.

(d) In any evidentiary hearing, the decision must be a written one that—

(1) Summarizes the facts; and

(2) Identifies the regulations supporting the decision.

(e) In a *de novo* hearing, the decision must—

(1) Specify the reasons for the decision; and

(2) Identify the supporting evidence and regulations.

(f) The agency must take final administrative action as follows:

(1) Ordinarily, within 90 days from the earlier of the following:

(i) The date the enrollee filed an MCO or PIHP appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing; or

(ii) If permitted by the State, the date the enrollee filed for direct access to a State fair hearing.

(2) As expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, from the MCO or PIHP, the case file and information for any appeal of a denial of a service that, as indicated by the MCO or PIHP—

(i) Meets the criteria for expedited resolution as set forth in § 438.410(a) of this chapter, but was not resolved within the timeframe for expedited resolution; or

(ii) Was resolved within the timeframe for expedited resolution, but reached a decision wholly or partially adverse to the enrollee.

(3) If the State agency permits direct access to a State fair hearing, as expeditiously as the enrollee's health condition requires, but no later than 3 working days after the agency receives, directly from an MCO or PIHP enrollee, a fair hearing request on a decision to deny a service that it determines meets the criteria for expedited resolution, as set forth in § 438.410(a) of this chapter.

(g) The public must have access to all agency hearing decisions, subject to the requirements of subpart F of this part for safeguarding of information.

[44 FR 17932, Mar. 29, 1979, as amended at 67 FR 41095, June 14, 2002]

**§ 431.245 Notifying the applicant or recipient of a State agency decision.**

The agency must notify the applicant or recipient in writing of—

(a) The decision; and

(b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

**§ 431.246 Corrective action.**

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if—