Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter ALL-211
November 2014

TO: All Providers Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: *All Provider Manuals* (Revised Regulations about Electronic Health Records)

The regulations that apply to all providers (130 CMR 450.000) have been revised. The amendments set forth a provider's right to review and request an adjudicatory hearing of the agency determination of noneligibility for payments under the Medicaid Electronic Health Records Incentive Payment Program.

These regulations are effective November 21, 2014.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

All Provider Manuals

Pages ii, 2-09 through 2-18, 2-25, and 2-26

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

All Provider Manuals

Page ii — transmitted by Transmittal Letter ALL-209

Pages 2-09, 2-10, 2-13, and 2-14 — transmitted by Transmittal Letter ALL-175

Pages 2-11, 2-12, 2-17, and 2-18 — transmitted by Transmittal Letter ALL-208

Pages 2-15 and 2-16 — transmitted by Transmittal Letter ALL-186

Pages 2-25 and 2-26 — transmitted by Transmittal Letter ALL-201

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(3) MassHealth Agency's Final Determination. The MassHealth agency will review a request for reconsideration and accompanying material submitted in compliance with the requirements of 130 CMR 450.209(C)(2) and will issue a final determination based on such review. The determination will be in writing, state the reasons for the determination, and inform the acute inpatient hospital of its right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241. The claim will be decided by the Office of Medicaid's Board of Hearings in accordance with 130 CMR 450.241 through 450.248.

(D) Resubmission of Claim After Denial or Pending Review. If the acute inpatient hospital resubmits an inpatient claim for payment that, pursuant to 130 CMR 450.209, has either been denied or is pending review, and if that resubmitted claim is paid by the MassHealth agency, the MassHealth agency will void the payment of the claim when it becomes aware of the resubmission. The hospital may file a claim for an adjudicatory hearing pursuant to 130 CMR 450.241 and 450.243 through 450.248 to contest the voiding of the payment.

450.210: Pay-for-Performance Payments: MassHealth Agency Review

(A) Applicability. The provisions set forth in 130 CMR 450.210 establish the MassHealth agency's review process for provider disputes concerning MassHealth pay-for-performance payment amounts for acute hospitals, managed care organizations (MCOs), primary care clinicians (PCCs), and prepaid inpatient health plans (PIHPs). For purposes of 130 CMR 450.210, "pay for performance" means a value-based purchasing program implemented by the MassHealth agency to pay providers to perform activities related to improving the quality of care delivered to MassHealth members.

(B) MassHealth Pay-for-Performance Payment Notice. The MassHealth agency will notify the provider in writing of the agency's determination of the provider's pay-for-performance payment amount for the time period specified in the notice. The notice will identify the aggregate pay-for-performance payment amount calculated for the provider, and may separately identify the amount calculated for components of such payment amount. The MassHealth agency will notify the provider by letter, report, computer printout, electronic transmission, or other format; this notification is the "MassHealth Pay For Performance Payment Notice" referred to in 130 CMR 450.210.

(C) Requesting MassHealth Agency Review of Pay-for-Performance Amounts.

(1) To preserve its right to an adjudicatory hearing and judicial review, a provider must request MassHealth agency review of the provider's pay-for-performance payment amounts specified in the MassHealth Pay for Performance Payment Notice. The request for agency review must be made in writing and be received by the MassHealth agency within 30 calendar days of the date appearing on the MassHealth Pay for Performance Payment Notice. Only those payment amounts specifically identified as in dispute by the provider in its request for agency review are subject to review.

(2) Any request for agency review submitted pursuant to 130 CMR 450.210(C)(1) must

(a) identify with specificity all payment amounts and components of such payment amounts in dispute;

(b) specify in sufficient detail the basis of the provider's disagreement with those amounts as calculated;

(c) identify and address all issues in the MassHealth Pay for Performance Payment Notice with which the provider disagrees; and
(d) include any documentary evidence and information it wants the MassHealth agency to consider.

(D) MassHealth Agency's Final Determination.
(1) The MassHealth agency will review a provider's request for agency review only if it is submitted in compliance with the requirements of 130 CMR 450.210(C)(1) and (2). The MassHealth agency is not obligated to consider any information or documents that the provider failed to timely submit under time deadlines previously imposed by the MassHealth agency. The MassHealth agency will issue a final written determination of contested payment amounts based on its review, which will state the reasons for the determination, and inform the provider of the provider's right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241.
(2) Payment amounts and components of payment amounts specified in the MassHealth Pay For Performance Payment Notice that are not specifically identified as in dispute in a provider's request for agency review will, without further notice, constitute the MassHealth agency's final determination of those amounts. The provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review of such amounts because of the failure to exhaust its administrative remedies.
(3) If the provider does not submit a request for agency review, the MassHealth Pay-for-Performance Payment Notice constitutes the MassHealth agency's final determination of the provider's pay-for-performance payment amounts. If a provider requests agency review but fails to timely comply with the requirements of 130 CMR 450.210(C)(1) and (2), the request for agency review may be denied. In either case, the MassHealth Pay-for-Performance Payment Notice constitutes the MassHealth agency's final determination, and the provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review because of the failure to exhaust its administrative remedies.

450.211: Medicaid Electronic Health Records Incentive Payment Program: Reconsideration and Appeals Process

(A) Applicability. The provisions set forth in 130 CMR 450.211 establish the MassHealth agency's review process for provider disputes concerning the Medicaid Electronic Health Records Incentive Payment Program established pursuant to § 4201 of the American Recovery and Reinvestment Act of 2009, P.L. 111-5 and 42 CFR Part 495.

(B) Medicaid Electronic Health Records Incentive Payment Program Notice. The MassHealth agency will notify the provider in writing of the agency's determination of the provider's Medicaid Electronic Health Records Incentive Payment Program eligibility and payment amount. The notice will identify the provider's eligibility, determination of payment amount, and right to review. The MassHealth agency will notify the provider by letter, report, computer printout, electronic transmission, or other format. This notification is the Medicaid Electronic Health Records Incentive Payment Program Notice referred to in 130 CMR 450.211.

(C) Requesting MassHealth Agency Review of Medicaid Electronic Health Records Incentive Payment Program Determinations.
(1) To preserve its right to an adjudicatory hearing and judicial review, a provider must request MassHealth agency review of the agency's determination specified in the Medicaid

Electronic Health Records Incentive Payment Program Notice. A provider's request for review may be based on either an alleged error in the MassHealth agency's determination of the provider's Medicaid Electronic Health Records Incentive Payment Program eligibility and payment amount or on information that was not initially supplied during the application process. The provider's request for review must be made in writing and be received by the MassHealth agency within 30 calendar days of the date appearing on the Medicaid Electronic Health Records Incentive Payment Program Notice. Only those determinations specifically identified in dispute by the provider in its request for an agency review are subject to review.

(2) A provider's request for review may request reconsideration of the following findings:

(a) the provider's eligibility for incentive payments; and

(b) incentive payment amounts.

(3) Any request for agency review submitted pursuant to 130 CMR 450.211(C)(1) must

(a) identify with specificity all determinations with which the provider disagrees;

(b) specify in sufficient detail the basis for the provider's disagreement with those determinations;

(c) identify and address all issues in the Medicaid Electronic Health Records Incentive Payment Program Notice with which the provider disagrees; and

(d) include any documentary evidence and information that the provider wants the MassHealth agency to consider.

(D) MassHealth Agency's Final Determination.

(1) The MassHealth agency will review a provider's request for agency review only if it is submitted in compliance with the requirements of 130 CMR 450.211(C)(1)through (3). The MassHealth agency is not obligated to consider any information or documents that the provider failed to timely submit under time deadlines previously imposed by the MassHealth agency. The MassHealth agency will issue a final written determination of contested Medicaid Electronic Health Records Incentive Payment Program determinations based on its review, which will state the reasons for the determination, and inform the provider of the provider's right to file a claim for an adjudicatory hearing in accordance with 130 CMR 450.241.

(2) Any findings specified in the Medicaid Electronic Health Records Incentive Payment Program Notice that are not specifically identified as in dispute in a provider's request for agency review will, without further notice, constitute the MassHealth agency's final determination. The provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review of such findings because of the failure to exhaust its administrative remedies.

(3) If the provider does not submit a request for agency review, the Medicaid Electronic Health Records Incentive Payment Program Notice constitutes the MassHealth agency's final determination. If a provider requests agency review but fails to timely comply with the requirements of 130 CMR 450.211(C)(1)through (3), the request for agency review may be denied. In either case, the Medicaid Electronic Health Records Incentive Payment Program Notice constitutes the MassHealth agency's final determination, and the provider has no right to an adjudicatory hearing pursuant to 130 CMR 450.241 or judicial review because of the failure to exhaust its administrative remedies.

450.212: Provider Eligibility: Eligibility Criteria

(A) To be eligible to participate in MassHealth as any provider type, a provider must

(1) meet all statutory requirements applicable to such provider type;

(2) meet all conditions of participation applicable to such provider type under Titles XVIII and XIX of the Social Security Act and regulations promulgated thereunder;
(3) meet all conditions of participation applicable to such provider type. Program regulations applicable to specific provider types appear in 130 CMR 400.000 through 499.000;
(4) be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type;
(5) be registered with appropriate state and federal agencies to prescribe controlled substances, for any provider type that is legally authorized to write prescriptions for medications and biologicals;
(6) never have been subject to any disciplinary action, sanction, or other limitation or restriction of any nature imposed with or without the consent of the provider, by any state or federal agency or board, including but not limited to, revocation, suspension, reprimand, censure, admonishment, fine, probation agreement, practice limitation, practice monitoring, or remedial training or other educational or public service activities;
(7) cooperate with the MassHealth agency during any application, revalidation of enrollment, or other review process, which shall include, but not be limited to, permitting and facilitating, site visits, as determined by the MassHealth agency; and
(8) if the provider is a group practice, ensure that all individual practitioners comprising the group obtain an individual MassHealth provider number, and meet all the requirements of 130 CMR 450.212(A)(1) through (6). In addition, for a group practice to participate in MassHealth, it must file a group practice provider application with the MassHealth agency, and meet all of the following requirements.
(a) It must be a recognized legal entity (for example, partnership, corporation, or trust). A sole proprietorship may not be a group practice.
(b) It must satisfy at least one of the following:
(i) all of the beneficial interest in the group practice must be held by individual practitioners who are members of the group practice serviced by the group practice; or
(ii) all members of the group practice must be employees or contractors of the group practice.
(c) It must not be currently or have previously been suspended from MassHealth participation due to violations of applicable laws, rules, or regulations or have common parties in interest with any provider that is currently under suspension or has been suspended, if such common parties in interest own 50 percent or more of the beneficial interest in both the applicant and the suspended group practice.

(B) A provider who does not meet the requirements of 130 CMR 450.212(A)(6) may, at the MassHealth agency's discretion, participate in MassHealth only if, in the judgment of the MassHealth agency, such participation would neither
(1) threaten the health, welfare, or safety of members; nor
(2) compromise the integrity of MassHealth.

(C) A provider who does not meet the requirements of 130 CMR 450.212(A) is not entitled to a hearing on the issue of eligibility.

(D) A Qualified Medicare Beneficiaries (QMB)-only provider is a provider who provides medical services only to those MassHealth members who are MassHealth Senior Buy-In members described in 130 CMR 450.105(D) and certain MassHealth Standard members described in 130

CMR 450.105(A), and submits claims only for the benefits described in 130 CMR 450.105(D).QMB-only providers are subject to all regulations pertaining to providers participating in MassHealth except as provided in 130 CMR 450.212(D)(1) through (3) or as otherwise specified in 130 CMR 450.000.

(1) QMB-only providers may not bill for medical services other than those specified in 130 CMR 519.010(B): *MassHealth Coverage Types: MassHealth Senior Buy-In*.

(2) QMB-only providers may bill for providing benefits specified in 130 CMR 519.010(B): *MassHealth Coverage Types: MassHealth Senior Buy-In* whether or not the associated medical services are specified in 130 CMR 400.000 through 499.000.

(3) QMB-only providers may bill only for benefits pertaining to medical services that are payable under Title XVIII of the Social Security Act (Medicare).

(E) All individual practitioners comprising the group and the group practice entity are jointly and severally liable for any overpayments owed and are subject to sanctions imposed as a result of any violation of any statute or regulation committed by the individual practitioner that provided the service.

450.213: Provider Eligibility: Termination of Participation for Ineligibility

When a provider fails or ceases to meet any one or more of the eligibility criteria applicable to such provider, the provider's participation in MassHealth may be terminated, subject to 130 CMR 450.212(B) and 450.216. If such termination is based upon a finding, ruling, decision, order, notification, or statement of any nature (including an agreement with the provider) by any federal, state, or quasi-public board, department (other than the MassHealth agency), or other agency that revokes, voids, suspends, or denies the issuance, renewal, or extension of a license, certificate, or other statement of qualification that constitutes a statutory prerequisite or other eligibility criterion, or that takes any action of the nature set forth in 130 CMR 450.212(A)(6), the correctness or validity of the action taken by the issuing agency will be presumed, the termination will be effective as of the earliest date on which the provider failed or ceased to meet any of such criteria, and the MassHealth agency will not afford a hearing as to the correctness or validity of such action. If such termination is based solely upon a determination of ineligibility by the MassHealth agency, the provider will be afforded notice and an opportunity for hearing in substantially the manner set forth in 130 CMR 450.241 through 450.248, and any termination will be effective as of the date of receipt of notice thereof.

450.214: Provider Eligibility: Suspension of Participation Pursuant to U.S. Department of Health and Human Services Order

When a provider is the subject of a notice by the U.S. Department of Health and Human Services (DHHS) requiring the provider's suspension or the denial, termination, or refusal to renew a provider contract pursuant to §1902(a)(39) (42 U.S.C. 1396a(a)(39)) or any other section of the Social Security Act, the provider's participation in MassHealth will be suspended or its provider contract will be denied, terminated, or not renewed in accordance with the DHHS notice, subject, however, to the provisions of 130 CMR 450.216. The MassHealth agency will not afford a hearing to the provider as to the correctness or validity of the action taken by DHHS.

450.215: Provider Eligibility: Notification of Potential Changes in Eligibility

(A) The provider must notify the MassHealth agency in writing, within 14 calendar days of receipt, of any written communication from an issuing agency that expresses an intention, conditionally or otherwise, to alter, revoke, void, suspend, or deny the issuance, renewal, or

extension of any license, certificate, or other statement of qualification that constitutes a provider eligibility criterion, or take any action of the nature set forth in 130 CMR 450.212(A)(6).

(B) The provider must notify the MassHealth agency in writing, within 14 calendar days of sending to an issuing agency, of any communication that expresses an intention or desire to register as an inactive practitioner, resign, surrender, terminate, or substantially modify the conditions of any such license, certificate, or other statement of qualification that constitutes a provider eligibility criterion.

(C) Without limiting the generality of 130 CMR 450.215(A), the provider must notify the MassHealth agency in accordance with 130 CMR 450.215(A) and (B) whenever the provider

(1) has received notice of denial of Medicare or Medicaid certification from the Massachusetts Department of Public Health;
(2) has received notice of a denial of an application for renewal of a license;
(3) has filed application with the Department of Public Health to convert from nursing facility to rest home status;
(4) has received an order to show cause from a board of registration; or
(5) becomes subject to any action of the nature set forth in 130 CMR 450.212(A)(6).

450.216: Provider Eligibility: Limitations on Participation

If termination or suspension of a provider's participation in MassHealth has occurred or is imminent, the MassHealth agency will take such action as may be reasonably necessary or appropriate to prevent or to mitigate injury to members or MassHealth or both, resulting from such termination or suspension. Such action may be taken immediately upon notice to the provider notwithstanding the exercise of such rights as the provider may have to secure administrative or judicial review of the action of the issuing agency, or of the U.S. Department of Health and Human Services, or of the MassHealth agency, or any combination of them. With respect to chronic disease and rehabilitation hospitals and other long-term-care facilities, such action may include an order barring further admissions of members pending final resolution of the issues that prompted such action, or an order that the institution will continue to be paid by the MassHealth agency, for a period specified in the order, for services to members admitted to the facility prior to an order barring new admissions, or prior to such termination. Such action will be reasonably calculated to achieve, so far as possible, the following goals:

(A) protecting the health and safety of members, including present and prospective patients of the provider; and

(B) maximizing federal financial participation in the cost of medical assistance.

450.217: Provider Eligibility: Ineligibility of Suspended Providers

A provider suspended from participation in MassHealth is not eligible to participate during the period of such suspension and until such time as a new application is filed and the provider contract is effective. If the violations resulted in overpayments, the MassHealth agency may deny the participation of such provider until such time as arrangements satisfactory to the MassHealth agency have been made for the restitution of all overpayments.

(130 CMR 450.218 through 450.220 Reserved)

450.221: Provider Contract: Definitions

(A) Defined Terms. For the purposes of 130 CMR 450.222 through 450.228, the following words and expressions have the indicated definitions. These definitions as they are applied in 130 CMR 450.222 through 450.228 are adopted pursuant to the provisions of 42 U.S.C. §§1320a-3, 1320a-5, 1396a(a)(38), 1396b(i)(2), and regulations at 42 CFR 455.100 et seq.

(1) Agent – any person who has been delegated the authority to obligate or act on behalf of a provider.

(2) Convicted – a judgment of conviction has been entered by a federal, state, or local court, regardless of whether an appeal from that judgment is pending.

(3) Disclosing Entity – a provider or fiscal agent.

(4) Other Disclosing Entity – any other disclosing entity and any entity that does not participate in MassHealth, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes

(a) any hospital, nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or managed care organization that participates in Medicare;

(b) any Medicare intermediary or carrier; and

(c) any entity (other than an individual practitioner or group practice that provides, or arranges for the provision of, health-related services for which it claims payment under any plan or program established under Title V or XX of the Social Security Act).

(5) Fiscal Agent – a contractor that processes or pays for provider claims on behalf of the MassHealth agency.

(6) Indirect Ownership Interest – an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

(7) Managing Employee – a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, an institution, organization, or agency.

(8) Ownership Interest – the possession of equity in the capital, the stock, or the profits of the disclosing entity.

(9) Person with an Ownership or Control Interest –

(a) a person or corporation that

(i) has an ownership interest totaling 5 percent or more in a disclosing entity;

(ii) has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

(iii) has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

(iv) owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

(v) is an officer or director of a disclosing entity that is organized as a corporation;

(vi) is a partner in a disclosing entity that is organized as a partnership; or

(vii) owns directly or indirectly an interest of 5 percent or more in any real property leased to a disclosing entity for use as a nursing facility, rest home, or hospital.

(b) For the purpose of this definition, an individual is deemed to own any beneficial interest owned directly or indirectly by or for his or her minor children or spouse.

(10) Significant Business Transaction – any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or five percent of a provider's total operating expenses.
(11) Secretary – the Secretary of the U.S. Department of Health and Human Services or any successor agency.
(12) Subcontractor –
(a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the MassHealth agreement.
(13) Supplier – an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under MassHealth (for example, a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).
(14) Wholly Owned Supplier – a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

(B) Determination of Ownership or Control Percentages. For the purposes of the definitions in 130 CMR 450.221(A), ownership or control percentages will be determined as follows.
(1) Indirect Ownership Interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an eight-percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation that owns five percent of the stock of the disclosing entity, B's interest equates to a four-percent indirect ownership interest in the disclosing entity and need not be reported.
(2) Person with an Ownership or Control Interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to six percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to four percent and need not be reported.

450.222: Provider Contract: Application for Contract

A person or entity may become a participating provider only by submitting an Application for Provider Contract. If approved by the MassHealth agency, the application will be part of any subsequent provider contract between the applicant and the MassHealth agency. Any omission or misstatement in the application will (without limiting any other penalties or sanctions resulting therefrom) render such contract voidable by the MassHealth agency.

450.223: Provider Contract: Execution of Contract

(A) If the provider applicant has filed a complete and properly executed application and meets all applicable provider eligibility criteria and nothing in the application or any other information in the possession of the MassHealth agency reveals any bar or hindrance to the participation of the

provider applicant, the MassHealth agency will prepare and furnish a provider contract. When fully executed by the provider and the MassHealth agency, the contract will take effect as of the effective date determined by the MassHealth agency.

(B) Each MassHealth provider must notify the MassHealth agency in writing within 14 days of any change in any of the information submitted in the application. Failure to do so constitutes a breach of the provider contract. In no event may a group practice file a claim for services provided by an individual practitioner until the individual practitioner is enrolled and approved by the MassHealth agency as a member of the group. At its discretion, the MassHealth agency may require a provider to recertify, at reasonable intervals, the continued accuracy and completeness of the information contained in the provider's application.

(C) The following provisions are a part of every provider contract whether or not they are included verbatim or specifically incorporated by reference. By executing any such contract, the provider agrees

(1) to comply with all laws, rules, and regulations governing MassHealth (see M.G.L. c. 118E, § 36);

(2) that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that:

(a) the medical services for which payment is claimed were provided in accordance with 130 CMR 450.301;

(b) the medical services for which payment is claimed were actually provided to the person identified as the member at the time and in the manner stated;

(c) the payment claimed does not exceed the maximum amount payable in accordance with the applicable fees and rates or amounts established under a provider contract or regulations applicable to MassHealth payment;

(d) the payment claimed will be accepted as full payment for the medical services for which payment is claimed, except to the extent that the regulations specifically require or permit contribution or supplementation by the member;

(e) the information submitted in, with, or in support of the claim is true, accurate, and complete; and

(f) the medical services were provided in compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975;

(3) to keep for such period as may be required by 130 CMR 450.205 such records as are necessary to disclose fully the extent and medical necessity of services provided to or prescribed for members and on request to provide the MassHealth agency or the Attorney General's Medicaid Fraud Control Unit with such information and any other information regarding payments claimed by the provider for providing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder);

(4) that the contract may be terminated by the MassHealth agency if the provider fails or ceases to satisfy all applicable criteria for eligibility as a participating provider;

(5) to submit, within 35 days after the date of a request by the Secretary or the MassHealth agency, full and complete information about:

(a) the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;
(b) any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the five-year period ending on the date of the request; and
(c) any information necessary to update fully and accurately any information that the provider has previously delivered to the MassHealth agency or to the Massachusetts Department of Public Health;

(6) that the MassHealth agency may recoup any sums payable by reason of a retroactive rate increase for any period during which the provider owned or operated part or all of a facility against any sums due the MassHealth agency by reason of a retroactive rate decrease for any periods;
(7) to comply with all federal requirements for employee education about false claims laws under 42 U.S.C. 1396a(a)(68) if the provider is an entity that received or made at least $5 million in Medicaid payments during the prior federal fiscal year;
(8) to furnish to the MassHealth agency its national provider identifier (NPI), if eligible for an NPI, and include its NPI on all claims submitted under MassHealth; and
(9) to permit the Centers for Medicare & Medicaid Services (CMS) and the MassHealth agency, and their agents and designated contractors to conduct unannounced on-site inspections of any and all provider locations.

(D) The provider must terminate a provider contract only by written notice to the MassHealth agency and such termination will be effective no earlier than 30 days after the date on which the MassHealth agency actually receives such notice, unless the MassHealth agency explicitly specifies or agrees to an earlier effective date. Any provision allowing for termination upon written notice does not constitute the MassHealth agency's specification of or agreement to an earlier effective date.

450.224: Provider Contract: Exclusion and Ineligibility of Convicted Parties

The MassHealth agency may terminate, or refuse to enter into or to renew a provider contract if:

(A) the provider, any party in interest in such provider, an agent or managing employee of such provider, or in the case of a group practice, any individual practitioner enrolled as a member of the group, has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the MassHealth agency, the participation of such provider will compromise the integrity of MassHealth; or

(B) the provider or an individual practitioner enrolled as a member of a group practice has been a party in interest, a managing employee, or an agent of a provider that has been convicted of a criminal offense relating to that person's involvement in any program established under Title XVIII, XIX, or XXI of the Social Security Act, or of a crime of such a nature that, in the judgment of the MassHealth agency, the participation of such provider will compromise the integrity of MassHealth.

(130 CMR 450.225 Reserved)

(7) failing to return credit balance funds to the MassHealth agency within 60 days of their receipt;
(8) failing to obtain or provide a physician's order, prescription, or referral when required by the applicable regulations;
(9) failing to comply with MassHealth enrollment, licensure, or certification requirements; and
(10) misapplication or misappropriation of personal needs allowance funds.

450.239: Sanctions: Calculation of Administrative Fine

(A) The MassHealth agency may assess an administrative fine not to exceed the greater of
(1) $100 for each instance of violation of the rules, regulations, standards, or laws governing MassHealth;
(2) $100 for each day of violation of the rules, regulations, standards, or laws governing MassHealth; or
(3) three times the payable amount of each claim, in accordance with 130 CMR 450.239.

(B) In determining the amount of any administrative fine, the MassHealth agency considers the following factors.
(1) Nature and Circumstances of the Claim. The MassHealth agency considers the circumstances to be mitigating if the violations were of the same type and occurred within a short period of time; there were only a few such instances; there was no history of similar types of violations; and the total monetary value of these instances was less than $1,000. Conversely, the MassHealth agency considers the circumstances to be aggravating if the violations were of a single type or several types and occurred over a lengthy period of time; there were many such instances; there was a history of similar types of violations; and the total monetary value of these instances was $1,000 or more.
(2) Prior Offenses. The MassHealth agency may consider the circumstances to be aggravating if the provider previously had been held liable for criminal, civil, or administrative sanctions relating to MassHealth.
(3) Financial Condition and Member-Access Considerations. The MassHealth agency considers the circumstances to be mitigating if the imposition of a full penalty will jeopardize the ability of the provider to continue as a health-care provider and if the provider’s inability to continue as a health-care provider would result in a demonstrable access problem for members in the provider’s geographic region. The provider has the burden of demonstrating such access problem.
(4) Other Factors. The MassHealth agency will consider other mitigating or aggravating circumstances. If there are substantial mitigating circumstances, the MassHealth agency will decrease the administrative fine to be assessed. Conversely, if there are substantial aggravating circumstances, the MassHealth agency will increase the administrative fine to be assessed.

450.240: Sanctions: Determination

(A) Sanction Notice. When the MassHealth agency believes that sanctions should be imposed, the MassHealth agency will notify the provider in writing of the alleged violations and the proposed sanctions. The notice will be sufficiently detailed to reasonably inform the provider of the acts that the MassHealth agency alleges constitute such violations.

(B) Suspension or Termination upon Sanction Notice. If the MassHealth agency seeks to suspend or terminate a provider's participation in MassHealth and finds, on the basis of information it has before it, that a provider's continued participation during the pendency of the administrative process could reasonably be expected to endanger the health, safety, or welfare of its members or compromise the integrity of MassHealth, it may suspend or terminate participation at the same time the sanction notice described in 130 CMR 450.240(A) is sent to the provider. Said suspension or termination will remain in effect until either the MassHealth agency, pursuant to 130 CMR 450.240(D), issues a final determination removing or revising said suspension or termination, or the Medicaid Director, pursuant to 130 CMR 450.248, issues a final agency decision removing or revising said suspension or termination.

(C) Timely Reply. To preserve its right to an adjudicatory hearing and judicial review, the provider must reply in writing to the MassHealth agency and such reply must be received by the MassHealth agency within 30 calendar days of the date on the sanction notice. The reply must specifically identify and address all allegations in the sanction notice with which the provider disagrees and explain any objections to the proposed sanctions. The provider must also include any additional documentary evidence it wants the MassHealth agency to consider.

(D) Sanction Determination. The MassHealth agency will consider and review only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that sanctions should be imposed because the provider has committed one or more violations of any rule, regulation, standard, or law governing MassHealth, the MassHealth agency will notify the provider in writing of its final determination, which will state any sanctions that the MassHealth agency will impose against the provider.

(E) Adjudicatory Hearing. If the provider submits a timely reply, the provider may claim an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243. The MassHealth agency may amend or supplement the sanction notice at any time before the commencement of an adjudicatory hearing as long as any additional findings have been identified in a notice or amended notice. Once an adjudicatory hearing has commenced, the hearing officer may permit amendment of the sanction determination upon proper motion by the MassHealth agency and will permit amendment, where necessary, to conform the sanction determination to the evidence.

(F) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing if it fails to submit a timely reply. The MassHealth agency will take appropriate action to implement the proposed sanctions.

450.241: Hearings: Claim for an Adjudicatory Hearing

A provider may challenge the findings set forth in the MassHealth agency's final determination, issued pursuant to 130 CMR 450.209(C)(3), 450.210(D)(1), 450.211, 450.237(C), or 450.240(D), by filing a claim for an adjudicatory hearing (claim) with the Board of Hearings and the MassHealth agency within 30 calendar days of the date on the final determination, pursuant to 130 CMR 450.243. A claim is filed on the date actually received by both the Board of Hearings and the MassHealth agency. Failure to file a timely claim will result in implementation of the action identified in the final determination.

450.242: Hearings: Stay of Suspension or Termination

A timely claim will stay any suspension or termination described in the final determination