



MassHealth  
Transmittal Letter ALL-225 (corrected)  
February 2018

**TO:** All Providers Participating in MassHealth

**FROM:** Daniel Tsai, Assistant Secretary for MassHealth 

**RE:** Revised Administrative and Billing Regulations (New Payment Methodology for Out-of-State Acute Inpatient Hospitals for Long-acting Reversible Contraception (LARC) Devices (LARC Devices))

This letter transmits revisions to MassHealth regulations at 130 CMR 450.000: *Administrative and Billing Regulations*, effective March 1, 2018, to provide for a new payment method for out-of-state acute inpatient hospitals, and also specifies important related billing instructions, as further described below.

### **New Payment Method for Out-of-State Acute Inpatient Hospitals for LARC Devices**

The regulatory amendments provide for separate payment to out-of-state acute inpatient hospitals for Long-Acting Reversible Contraception (LARC) devices (LARC Devices) when MassHealth requirements are met. (See 130 CMR 450.233(D)(1)(a)(1) and (D)(1)(d)). LARC Devices are defined specifically as intrauterine devices and contraceptive implants; the LARC Device does not refer to the procedure itself. Under the amended regulations, payment to out-of-state acute inpatient hospitals for LARC Devices will be in accordance with the fee schedule rates for such devices set forth in EOHHS regulations at 101 CMR 317.00: *Medicine*. These regulatory updates align the out-of-state acute inpatient hospital payment method for LARC Devices with the in-state method that will become effective on the same date.

### **Special Billing Instructions for LARC Devices**

Out-of-State acute inpatient hospitals must bill for LARC Devices through Direct Data Entry (DDE) on a *professional* claim (and not on a facility/institutional claim), and include delay reason code 11 and a copy of the invoice; this will allow the claim to suspend for pricing.

The hospital must *exclude* all costs, charges, and any other claims-based data corresponding to the LARC Device from any facility/institutional claim that the hospital submits for the MassHealth member's stay.

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## **MassHealth Website**

This transmittal letter and attached pages are available on the MassHealth website at [www.mass.gov/masshealth](http://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, email your inquiry to [providersupport@mahealth.net](mailto: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, and 2-25 through 2-36

## **OBSOLETE MATERIAL**

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

### **All Provider Manuals**

Pages ii, and 2-25 through 2-36 — transmitted by Transmittal Letter ALL-224

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450.231: General Conditions of Payments

(A) Except to the extent otherwise permitted by state or federal regulations, no provider is entitled to any payment from MassHealth unless on the date of service the provider was a participating provider and the person receiving the services was a member.

(B) The "date of service" is the date on which a medical service is provided to a member or, if the medical service consists principally of custom-made goods such as eyeglasses, dentures, or durable medical equipment, the date on which the goods are delivered to a member. If a provider delivers to a member medical goods that had to be ordered, fitted, or altered for the member, and that member ceases to be eligible for such MassHealth services on a date before the final delivery of the goods, the MassHealth agency will pay the provider for the goods only under the following circumstances:

- (1) the member must have been eligible for MassHealth on the date of the member's last visit with the provider before the provider orders or fabricates the goods;
- (2) the date on which the provider orders or fabricates the goods occurs no later than seven days after the last visit;
- (3) the provider has submitted documentation with the claim to the MassHealth agency that verifies both the date of the member's last visit that occurred before the provider ordered or fabricated the goods and the date on which the goods were actually ordered or fabricated;
- (4) the provider must not have accepted any payment from the member for the goods except copayments as provided in 130 CMR 450.130; and
- (5) the provider must have attempted to deliver the goods to the member.

(C) For the purposes of 130 CMR 450.231, a provider who directly services the member and who also produces the goods for delivery to the member has "fabricated" an item if the provider has taken the first substantial step necessary to initiate the production process after the conclusion of all necessary member visits.

(D) A provider is responsible for verifying a member's eligibility status on a daily basis, including but not limited to members who are hospitalized or institutionalized. In order to receive MassHealth payment for a covered medical service, the person receiving such service must be eligible for MassHealth coverage on the date of service and the provider must comply with any service authorization requirements and all other conditions of payment. A provider's failure to verify a member's MassHealth status before providing services to the member may result in nonpayment of such services. For payment for services provided before a member's MassHealth eligibility determination, see 130 CMR 450.309(B). For payment to out-of-state providers providing services on an emergency basis, see 130 CMR 450.309(C).

(E) Payments to QMB-only providers as defined in 130 CMR 450.212(D) may be made upon the MassHealth agency's receipt of a claim for payment within the time limitations set forth in provisions, regulations, or rules under Title XVIII of the Social Security Act.

(F) Payment to all providers is made in accordance with the payment methodology applicable to the provider, established by EOHHS, subject to all applicable federal payment limits.

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(G) If under state or federal statute, regulation, billing instructions or other subregulatory guidance, a provider's National Provider Identifier (NPI) is required on a claim submitted to MassHealth, that information must be included on the claim, and that provider must participate in MassHealth for the claim to payable. If the NPI of a provider who is not a MassHealth participating provider is included on a claim for any reason or if an NPI is not provided in accordance with state or federal requirements, that claim may not be payable.

(H) When any participating MassHealth provider orders, refers, or prescribes a service for a MassHealth member, that provider must include his or her individual NPI on such orders, referrals, or prescriptions. Such provider must also provide his or her individual NPI to a servicing billing provider upon request in other circumstances in which the servicing billing provider must include the ordering, referring or prescribing provider's NPI on MassHealth claims.

(130 CMR 450.232 Reserved)

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450.233: Rates of Payment to Out-of-state Providers

(A) Except as provided in 130 CMR 450.233(D) and 435.405(B), payment to an out-of-state institutional provider for any medical service payable by the MassHealth agency is the lowest of

- (1) the rate of payment established for the medical service under the other state’s Medicaid program;
- (2) the MassHealth rate of payment established for such medical service or comparable medical service in Massachusetts; or
- (3) the MassHealth rate of payment established for a comparable provider in Massachusetts.

(B) An out-of-state institutional provider, other than an acute hospital, must submit to the MassHealth agency a current copy of the applicable rate schedule under its state’s Medicaid program.

(C) Payment to an out-of-state noninstitutional provider for any medical service payable by the MassHealth agency is made in accordance with the applicable fee schedule established by EOHHS, subject to any applicable federal payment limit (*see* 42 CFR 447.304).

(D) Payment to an out-of-state acute hospital provider for any medical service payable by the MassHealth agency is made as set forth in 130 CMR 450.233(D)(1) through (3). For purposes of 130 CMR 450.233(D), a “High MassHealth Volume Hospital” means any out-of-state acute hospital provider that had at least 150 MassHealth discharges during the most recent federal fiscal year for which complete data is available as determined by the MassHealth agency at least 90 days prior to the start of each federal fiscal year.

(1) Inpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for inpatient services as specified in 130 CMR 450.233(D)(1)(a) through (c).

(a) Payment Amount Per Discharge.

1. Out-of-state APAD: Out-of-state acute hospitals are paid an adjudicated payment amount per discharge (“out-of-state APAD”) for inpatient services; provided that payment for Long-acting Reversible Contraception (LARC) devices (LARC devices) is as set forth in 130 CMR 450.233(D)(1)(d) and not under 130 CMR 450.233(D)(1)(a). The out-of-state APAD is calculated using the sum of the statewide operating standard per discharge and the statewide capital standard per discharge both as in effect for in-state acute hospitals on the date of admission, which is then multiplied by the MassHealth DRG Weight assigned to the discharge based on the information contained in a properly submitted inpatient acute hospital claim.

- a. “MassHealth DRG Weight” for purposes of 130 CMR 450.233(D) is the MassHealth relative weight determined by the MassHealth agency for each unique combination of APR-DRG and Severity of Illness (SOI).
- b. “APR-DRG” or “DRG” for purposes of 130 CMR 450.233(D) refers to the All Patient Refined Diagnosis Related Group and Severity of Illness (SOI) assigned to a claim by the 3M APR-DRG Grouper.

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2. Out-of-state Outlier Payment: If the calculated cost of the discharge exceeds the discharge-specific outlier threshold, then the out-of-state acute hospital is also paid an outlier payment for that discharge (“out-of-state outlier payment”). The out-of-state outlier payment is equal to the marginal cost factor in effect for in-state acute hospitals on the date of admission multiplied by the difference between the calculated cost of the discharge and the discharge-specific outlier threshold.

a. The “calculated cost of the discharge” for purposes of 130 CMR 450.233(D) will be determined by the MassHealth agency by multiplying the out-of-state acute hospital’s allowed charges for the discharge by the following cost-to-charge ratio:

- i. For a High MassHealth Volume Hospital, the hospital’s inpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.
- ii. For all other out-of-state acute hospitals, the median in-state acute inpatient hospital cost-to-charge ratio in effect on the date of admission based on MassHealth discharge volume, as determined by the MassHealth agency.

b. The “discharge-specific outlier threshold” for purposes of 130 CMR 450.233(D) is equal to the sum of the out-of-state APAD corresponding to the discharge, and the fixed outlier threshold in effect for in-state acute hospitals on the date of admission.

(b) Out-of-state Transfer *Per Diem*. If an out-of-state acute hospital transfers a MassHealth inpatient to another acute hospital, the transferring out-of-state acute hospital is paid for inpatient services provided to that member at a transfer per diem rate (“out-of-state transfer *per diem*”), capped at the sum of the transferring hospital’s out-of-state APAD plus, if applicable, any out-of-state outlier payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by the MassHealth agency. No other payments specified in 130 CMR 450.233(D)(1) apply. The out-of-state transfer *per diem* is equal to the sum of the transferring hospital’s out-of-state APAD plus, if applicable, any out-of-state outlier payment, that would have otherwise applied for the period that the member was an inpatient at the transferring hospital as calculated by the MassHealth agency, divided by the mean in-state acute hospital all-payer length of stay for the particular DRG assigned, as determined by the MassHealth agency.

(c) Out-of-state Psychiatric *Per Diem*. If an out-of-state acute hospital admits a MassHealth patient primarily for behavioral health services, including psychiatric and substance use disorder services, the out-of-state acute hospital will be paid an all-inclusive psychiatric *per diem* equal to the psychiatric *per diem* in effect for in-state acute hospitals on the date of service (“out-of-state psychiatric *per diem*”). No other payments specified in 130 CMR 450.233(D)(1) apply.

(d) Payment for Long-acting Reversible Contraception (LARC) Device (LARC device).

1. A LARC device refers specifically to intrauterine devices and contraceptive implants; it does not refer to the LARC procedure, itself.
2. An out-of-state acute inpatient hospital may be paid for a LARC device separate from the out-of-state APAD, if the following conditions are met:

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- a. the member requests the LARC device while admitted as an inpatient for a labor and delivery stay and, at the time of the procedure, is a clinically appropriate candidate for immediate post-labor and delivery LARC device insertion;
  - b. the practitioner performing the procedure has been properly trained for immediate postpartum LARC device insertion, and performs the procedure immediately after labor and delivery during the same inpatient hospital stay; and
  - c. the hospital satisfies all other conditions for such payment that MassHealth may set forth in other written statements of policy.
3. If the out-of-state acute inpatient hospital qualifies for separate payment of a LARC device, the hospital will be reimbursed for the LARC device according to the fee schedule rates for such devices set forth in 101 CMR 317.00: *Medicine*.
  4. A hospital's charges for a LARC device are excluded in calculating any out-of-state outlier payment under 130 CMR 450.233(D)(1)(a).2.
- (2) Outpatient Services.
- (a) Payment for Outpatient Services. Except as provided in 130 CMR 450.233(D)(3), out-of-state acute hospitals are paid for outpatient services utilizing an adjudicated payment per episode of care payment methodology ("out-of-state APEC") as described in 130 CMR 450.233(D)(2)(b), or in accordance with the applicable fee schedule established by EOHHS for outpatient services for which in-state acute hospitals are not paid the APEC. For purposes of 130 CMR 450.233(D), "APEC-covered services" are outpatient services for which in-state acute hospitals are paid an APEC, and "episode" means all APEC-covered services delivered to a MassHealth member on a single calendar day, or if the services extend past midnight in the case of emergency department or observation services, on consecutive days.
  - (b) Out-of-state APEC. The Out-of-state APEC for each payable episode will equal the sum of the episode-specific total EAPG payment, and the APEC outlier component (*see* 130 CMR 450.233(D)(2)(b)1. and 2.) For proper payment, out-of-state acute hospitals must include on a single claim all of the APEC-covered services that correspond to the episode, and must otherwise submit properly completed outpatient hospital claims.
    1. The "episode-specific total EAPG payment" is equal to the sum of all of the episode's claim detail line EAPG payment amounts, where each claim detail line EAPG payment amount is equal to the product of the APEC outpatient statewide standard in effect for in-state acute hospitals on the date of service, and the claim detail line's adjusted EAPG weight. The 3M EAPG Grouper's discounting, consolidation and packaging logic is applied to each of the episode's claim detail line MassHealth EAPG weights to produce the claim detail line's adjusted EAPG weight used for this calculation. For purposes of 130 CMR 450.233(D)
      - a. EAPG stands for Enhanced Ambulatory Patient Group. EAPG(s) are assigned to claim detail lines containing APEC-covered services based on information contained on a properly submitted outpatient claim by the 3M EAPG Grouper, and refer to a group of outpatient services that have been bundled for purposes of categorizing and measuring casemix.

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- b. 3M EAPG Grouper refers to the 3M Corporation’s EAPG grouper that has been configured for the MassHealth APEC payment methodology.
  - c. MassHealth EAPG weight refers to the MassHealth relative weight developed by the MassHealth agency for each unique EAPG.
2. The “APEC outlier component” is equal to the marginal cost factor in effect for in-state acute hospitals on the date of service multiplied by the difference between the episode-specific case cost and the episode-specific outlier threshold. If the episode-specific case cost is less than the episode-specific outlier threshold, then the APEC outlier component will be \$0.
- a. The “episode-specific case cost” for purposes of 130 CMR 450.233(D) shall be determined by the MassHealth agency by multiplying the sum of the allowed charges for all of the claim detail lines with APEC-covered services in the episode that adjudicate to pay, by the following cost-to-charge ratio:
    - i. For a High MassHealth Volume Hospital, the hospital’s outpatient cost-to-charge ratio, for the most recent complete rate year used for in-state acute hospitals, as determined by the MassHealth agency.
    - ii. For all other out-of-state acute hospitals, the median in-state acute outpatient hospital cost-to-charge ratio in effect on the date of service based on MassHealth episode volume, as determined by the MassHealth agency.
  - b. The “episode -specific outlier threshold” for purposes of 130 CMR 450.233(D) is equal to the sum of the episode-specific total EAPG payment corresponding to the episode, and the fixed outpatient outlier threshold in effect for in-state acute hospitals on the date of service.
  - c. In no case is an APEC outlier component payable if the episode-specific total EAPG payment is \$0.
- (3) Services Not Available in State.
- (a) For medical services payable by the MassHealth agency that are not available in-state as determined by the MassHealth agency, an out-of-state acute hospital that is not a High MassHealth Volume Hospital will be paid the rate of payment established for the medical service under the other state’s Medicaid program (or equivalent) as determined by the MassHealth agency, or such other rate as the MassHealth agency determines necessary to ensure member access to services.
  - (b) For an inpatient service that is not available in-state, as determined by the MassHealth agency, payment to the out-of-state acute hospital under 130 CMR 450.233(D)(3)(a) will also include acute hospital outpatient services that the MassHealth agency determines are directly related to the service that is not available in-state.
  - (c) In order to receive payment under 130 CMR 450.233(D)(3), an out-of-state acute hospital provider must
    - 1. submit to the MassHealth agency a complete list of services that are to be performed, along with their corresponding charges; and
    - 2. coordinate the case with clinical staff designated by the MassHealth agency.

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450.234: Rates of Payment to Chronic Disease, Rehabilitation, or Similar Hospitals with Both Out-of-state Inpatient Facilities and In-state Outpatient Facilities.

Payment to a chronic disease, rehabilitation, or similar hospital with both out-of-state inpatient facilities and in-state outpatient facilities, for any medical service payable by the MassHealth agency is made as follows:

(A) Inpatient Services. For inpatient services, payment is in accordance with 130 CMR 435.405(B).

(B) Outpatient Services.

(1) For outpatient services provided out-of-state, payment is in accordance with 130 CMR 450.233(A) and (B).

(2) For outpatient services provided in-state, payment is the median in-state outpatient hospital cost-to-charge ratio for similar hospitals.

450.235: Overpayments

(A) Overpayments include, but are not limited to, payments to a provider

(1) for services that were not actually provided or that were provided to a person who was not a member on the date of service;

(2) for services that were not payable under MassHealth on the date of service, including services that were payable only when provided by a different provider type and services that were not medically necessary (as defined in 130 CMR 450.204);

(3) in excess of the maximum amount properly payable for the service provided, to the extent of such excess;

(4) for services for which payment has been or should be received from health insurers, worker's compensation insurers, other third-party payers, or members;

(5) for services for which a provider has failed to make, maintain, or produce such records, prescriptions, and other documentary evidence as required by applicable federal and state laws and regulations and contracts;

(6) for services provided when, as of the date of service, the provider was not a participating provider, or was in any breach or default of the provider contract;

(7) for services billed that result in a duplicate payment; or

(8) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.

(B) A provider must report in writing and return any overpayments to the MassHealth agency within 60 days of the provider identifying such overpayment or, for payments subject to reconciliation based on a cost report, by the date any corresponding cost report is due, whichever is later. A provider must include in such written report the reason for the overpayment and use such form and follow such process that may be prescribed by the MassHealth agency.

450.236: Overpayments: Calculation by Sampling

In any action or administrative proceeding to determine or recover overpayments, the

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MassHealth agency may ascertain the amount of overpayments by reviewing a representative sample drawn from the total number of claims paid to a provider during a given period and extrapolating the results of the review over the entire period. The MassHealth agency employs statistically valid techniques in establishing the size and distribution of the sample to ensure that it is a valid and representative sample.

#### 450.237: Overpayments: Determination

The existence and amount of overpayment may be determined in an action to recover the overpayment in any court having jurisdiction. The MassHealth agency may also determine the existence and amount of overpayments. The procedures described in 130 CMR 450.236 and 450.237 do not apply to overpayments resulting from rate adjustments, which are governed by methods described in 130 CMR 450.259.

(A) Overpayment Notice. When the MassHealth agency believes that an overpayment has been made, it notifies the provider in writing of the facts upon which the MassHealth agency bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), the MassHealth agency will so inform the provider. The MassHealth agency may notify the provider by letter, draft audit report, computer printout, or other format.

(B) 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 overpayment notice. The reply must specifically identify and address all allegations in the overpayment notice with which the provider disagrees. With the reply, the provider may submit additional data and argument to support its claim for payment and must include any documentary evidence it wants the MassHealth agency to consider. If the MassHealth agency states in the overpayment notice that the overpayment amount is based on a determination by a federal or state agency (other than the MassHealth agency), a provider may contest only the factual assertion that the federal or state agency made such a determination. The provider may not contest in any proceeding before or against the MassHealth agency the amount or basis for such determination.

(C) Overpayment Determination. The MassHealth agency considers and reviews only information submitted with a timely reply. If, after reviewing the provider's reply, the MassHealth agency determines that the provider has been overpaid, the MassHealth agency will so notify the provider in writing of its final determination, which will state the amount of overpayment that the MassHealth agency will recover from the provider.

(D) Adjudicatory Hearing. If the provider submits a timely reply, the provider may file a claim for an adjudicatory hearing to appeal the MassHealth agency's final determination, in accordance with 130 CMR 450.241 and 450.243.

(E) Consequences of Failure to Submit a Timely Reply. The provider has no right to an adjudicatory hearing or judicial review if it fails to submit a timely reply. The MassHealth agency will take appropriate action to recover the overpayment.

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450.238: Sanctions: General

(A) Introduction. All providers are subject to the rules, regulations, standards, and laws governing MassHealth. The regulations at 130 CMR 450.238 through 450.240 set forth the MassHealth agency's procedures for imposing sanctions for violations of those rules, regulations, standards, and laws. Such sanctions may include, but are not limited to, administrative fines, provider service restrictions, and suspension or termination from participation in MassHealth. The MassHealth agency determines the amount of any fine and may take into account the particular circumstances of the violation. The MassHealth agency may assess an administrative fine whether or not overpayments have been identified based on the same set of facts.

- (B) Instances of Violation. Instances of violation include, but are not limited to
- (1) billing a member for services that are payable under MassHealth, except copayments as provided in 130 CMR 450.130;
  - (2) submitting claims under an individual provider's MassHealth provider number for services for which the provider is entitled to payment from an employer or under a contract or other agreement;
  - (3) billing the MassHealth agency for services provided by someone other than the provider, unless expressly permitted by the applicable regulations;
  - (4) billing the MassHealth agency before delivery of service, unless permitted by the applicable regulations;
  - (5) failing to comply with recordkeeping and disclosure requirements;
  - (6) overstating or misrepresenting services, including submitting separate claims for services or procedures provided as components of a more comprehensive service for which a single rate of payment is established;
  - (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.

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(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, Termination, or Provider Service Restrictions upon Sanction Notice. If the MassHealth agency finds, on the basis of information it has before it, that a provider's continued participation in MassHealth, or in the case of provider restrictions, participation without such restrictions, 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 the provider's MassHealth participation or impose service restrictions on the provider at the same time the sanction notice described in 130 CMR 450.240(A) is sent to the provider. Said suspension, termination, or provider service restriction 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, termination, or provider service restriction, or the Medicaid Director, pursuant to 130 CMR 450.248, issues a final agency decision removing or revising said suspension, termination, or provider service restriction.

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(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 or judicial review 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 regulations, including but not limited to, 130 CMR 450.208(C)(2), 450.209(C)(3), 450.209(D), 450.210(D)(1), 450.211(D)(1), 450.213 (as to provider termination based solely upon a determination of ineligibility by the MassHealth agency), 450.237(D), or 450.240(E), 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, in addition to filing the request for an adjudicatory hearing timely, the provider must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position. A claim is filed on the date actually received by both the Board of Hearings and the MassHealth agency. The failure to either file a timely claim, state the basis of the claim, or file with both the Board of Hearings and the MassHealth agency in compliance with 130 CMR 450.243 will result in implementation of the action identified in the final determination.

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450.242: Hearings: Stay of Suspension or Termination or Provider Service Restriction

A timely claim will stay any suspension or termination or provider service restriction described in the final determination until there has been a final agency action pursuant to 130 CMR 450.243(D) or 450.248; provided, however, that if the MassHealth agency finds on the basis of information it has before it that a provider's continued participation in MassHealth or in the case of provider service restrictions, participation without such restrictions, during the pendency of the administrative appeal could reasonably be expected to endanger the health, safety, or welfare of members or compromise the integrity of MassHealth, the suspension, termination, or provider service restrictions will not be stayed. A timely claim will not stay any withholding of payments under 130 CMR 450.249.

450.243: Hearings: Consideration of a Claim for an Adjudicatory Hearing

(A) A timely claim must specifically identify each issue and fact in dispute and state the provider's position, the pertinent facts to be adduced at the hearing, and the reasons supporting that position.

(B) If a matter has been referred to or is under investigation by the Attorney General's Medicaid Fraud Division or other criminal investigation agency, or if a question of quality of care has been referred to a professional licensing board for investigation, the Board of Hearings, upon notice from the MassHealth agency, will postpone the hearing until the conclusion of such investigation and the final disposition of any criminal complaint, indictment, or order to show cause that ensues, or until the MassHealth agency notifies the Board to schedule the hearing. A provider may not request a postponement of the hearing under 130 CMR 450.243(B).

(C) The Board of Hearings will grant a hearing only if the claimant demonstrates all of the following.

- (1) The claim was filed with the Board of Hearings and the MassHealth agency within the time limits set forth in 130 CMR 450.241.
- (2) There is a genuine and material issue of adjudicative fact for resolution.
- (3) The factual issues can be resolved by available and specifically identified reliable evidence as set forth in M.G.L. c. 30A, § 11(2). A hearing will not be granted on the basis of general allegations or denials or general descriptions of positions and contentions.
- (4) The allegations of the provider, if established, would be sufficient to resolve a factual dispute in the manner urged by the provider. A hearing will not be granted if the provider's submissions are insufficient to justify the factual determination urged, even if accurate.
- (5) Resolution of the factual dispute in the way sought by the provider is relevant to and would support the relief sought.

(D) Failure to comply with the conditions set forth in 130 CMR 450.243(C) will result in dismissal of the claim. Dismissal of a claim is a final agency action reviewable pursuant to M.G.L. c. 30A.