Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
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MassHealth
Transmittal Letter ALL-150
August 2007

TO: All Providers Participating in MassHealth

FROM: Tom Dehner, Medicaid Director TD

RE: All Provider Manuals (Revisions to Regulations – Employee Education about False Claims Laws)

This letter transmits revisions to MassHealth regulations that address federal requirements for all entities receiving or making at least five million dollars in Medicaid payments annually, for state plan and waiver services. Effective January 1, 2007, these entities must educate employees about federal and state laws concerning false claims and whistleblower protections. MassHealth initially notified providers of this federal requirement in All Provider Bulletin 162 (December 2006).

The regulations reference measures MassHealth will take to ensure that providers subject to these federal requirements are, and continue to remain, in compliance. In adding these requirements to the Administrative and Billing regulations, the requirements become incorporated by reference in all MassHealth provider contracts.

These regulations are being issued as emergency regulations and are effective January 1, 2007.

Further information about the federal requirements including the definition of an entity, and how the five million dollar annual threshold is determined, is available on the federal Centers for Medicare and Medicaid Services (CMS) Web site, including:

- State Medicaid Director Letters (SMDL) #06-24, Employee Education about False Claims, dated December 13, 2006, and
- SMDL #07-003, Final Guidance Regarding Employee Education for False Claims Recovery, dated March 22, 2007.

If you have any questions about the information in this transmittal letter please contact MassHealth Customer Service 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 2-3, 2-4, 2-17, and 2-18

OBSOLETE MATERIAL

(The pages listed here are no longer in effect.)

All Provider Manuals

Pages 2-3, 2-4, 2-17, and 2-18 — transmitted by Transmittal Letter ALL-113

(E) Any regulatory or contractual exclusion from payment of experimental or unproven services refers to any service for which there is insufficient authoritative evidence that such service is reasonably calculated to have the effect described in 130 CMR 450.204(A)(1).

450.205: Recordkeeping and Disclosure

(A) The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided to, or prescribed for, members and must provide to the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit on request such information and any other information about payments claimed by the provider for providing services (see 42 U.S.C. 1396a(a)(27) and the regulations thereunder).

(B) All providers must maintain complete patient account records. Patient account records must include complete documentation of charges, indicate the date and amount of all debit and credit transactions, and support the appropriateness of the amounts billed and paid. Institutional providers must, in addition, provide on request all records maintained by or within the institution about services provided to members by other providers. Pharmacy providers must, in addition, keep photocopies of the temporary MassHealth cards referenced when filling prescriptions, if applicable, and must produce a copy of the card on request.

(C) A provider must maintain and disclose any and all financial, statistical, and other information as may be required by the MassHealth agency, the Attorney General's Medicaid Fraud Control Unit, or DHCFP. The required information must include, but is not limited to, ownership and licensure information, cost reports, charge books, audited financial statements, financial records, federal and state tax returns, invoices, general ledgers, trial balances, remittance advices, and explanations of benefits from health insurers and managed care organizations. Such records and documents must be provided within the time period specified by the MassHealth agency, the Attorney General's Medicaid Fraud Control Unit, or DHCFP.

(D) All records, including but not limited to those containing signatures of medical professionals authorizing services, such as prescriptions, must, at a minimum, be legible and comply with generally accepted standards for recordkeeping within the applicable provider type as they may be found in laws, rules, and regulations of the relevant board of registration, professional treatises, and guidelines and other information published, adopted, or promulgated by state or national professional organizations and societies. All accounting records must be maintained in accordance with generally accepted accounting principles. In those instances where MassHealth regulations identify specific recordkeeping requirements for particular types of providers, such regulations constitute an additional standard against which the adequacy of records will be measured for the purposes of 130 CMR 450.205. In no instance will the completion of the appropriate MassHealth claim, the maintenance of a copy of such claim, or the simple notation of service codes constitute sufficient documentation for the purpose of 130 CMR 450.205.

(E) Except as provided under subsection (F), the records and information required to be maintained or disclosed under 130 CMR 450.000 include only those that relate in any manner to services provided to or prescribed for members, provided, however, that disclosure may not be refused on the ground that such records are commingled with records related to persons who are not members. Such records and information must be made available to the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit for examination or copying during reasonable office hours at the provider's place of business or record depository. Alternatively, the MassHealth agency and the Attorney General's Medicaid Fraud Control Unit may each require that the provider submit copies of such records and information.

(F) (1) Providers subject to the federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) must:

(a) provide written certification, on or before June 30 of each year, or such other date as specified by the MassHealth agency, signed under the pains and penalties of perjury, of compliance with the federal requirements;

(b) make available to the MassHealth agency, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. 1396a(a)(68), any employee handbook, and other information as the MassHealth agency may deem necessary to determine compliance; and

(c) initiate corrective actions necessary to comply with such federal requirements.

(2) The MassHealth agency may recover as overpayments any payments made to a provider that the MassHealth agency determines failed to comply with the requirements of 130 CMR 450.205(F)(1) or 42 U.S.C. §1396a(a)(68), and impose sanctions against a provider in accordance with the provisions of 130 CMR 450.000.

(G) Notwithstanding any regulatory or contractual provisions that may provide for a shorter retention period, all records described in 130 CMR 450.204 and 450.205 must be kept for at least six years after the date of medical services for which claims are made or the date services were prescribed, or for such length of time as may be dictated by the generally accepted standards for recordkeeping within the applicable provider type, whichever period is longer. Providers must retain records to substantiate costs listed on a cost report for at least six years following the date of filing of the cost report or for such length of time as may be required by DCHFP regulations, whichever period is longer. In no event may any provider destroy any records while any review, audit, or administrative or judicial action involving such records is pending.

(H) In cases where audits or other reviews reveal provider noncompliance with 130 CMR 450.204 and 450.205, the MassHealth agency may seek to pursue recovery of overpayments and to impose sanctions in accordance with the provisions of 130 CMR 450.000.

(I) (1) The provider, as holder of personal data under M.G.L. c 66A, must comply with all regulatory and statutory requirements applicable to such a holder, including those set forth in M.G.L. c. 66A, and must inform each of its employees having access to such personal data of such requirements and ensure compliance by each employee with such requirements.

(2) The provider must take reasonable steps to ensure the physical security of personal data under its control including, but not limited to:

(a) fire protection;

(b) protection against smoke and water damage;

(c) alarm systems;

(d) locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data;

(e) passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; and

(f) limited access to input and output documents.

(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) 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.

(D) The provider may terminate a provider contract only by written notice to the MassHealth agency and such termination shall 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 shall not constitute the MassHealth agency's specification of or agreement to an earlier effective date.

(E) The provisions of 130 CMR 450.222 and 450.223 apply to any provider contract made on or after the effective date of 130 CMR 450.000, including any extension or renewal of a provider contract made prior to such 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)