

Division of Medical Assistance

Background

The Division of Medical Assistance (Division) is the designated single state agency responsible for administering the program of medical assistance. The Division assumed its responsibilities beginning in fiscal year 1994.

During fiscal year 1998, the Division administered approximately \$5.5 billion in carrying out its program. Federal amounted to approximately \$2.7 billion.

The federal funding to the Division is detailed in the accompanying g Schedule of Expenditures of Federal Awards. The Division's major programs were:

CFDA# Federal Program Description

93.558 Medical Assistance Program

10.551 State Medicaid Fraud Control Units

10.561 State Survey and Certification of Health Care Providers and Suppliers

Findings on Compliance with Rules and Regulations

Finding Number 29: Late Filing of Reports

The Division of Medical Assistance (Division) did not file all of its required Health Care Financing Administration (HCFA) 64 and PMS 272 Reports on time. The HCFA 64 Quarterly Expenditure Reports ensure that all federally-reimbursable expenditures are properly claimed. They are also important because HCFA may decrease the grant awards given to the Division if the Division overspends its grants or if the Division misappropriates its expenditures.

The HCFA 64 Reports must be filed within 30 days after the last day of the reporting period. The reporting periods end on September 30, December 31, March 31, and June 30. The HCFA 64 Reports were filed between 12 and 26 days late for every quarter.

The PMS 272 Quarterly Cash Transaction Reports must be filed within 30 days after the last day of the

reporting period. The reporting periods are the same as for the HCFA 64s. The PMS 272 Reports were filed between 13 and 25 days late for every quarter.

All of these reports were filed late because of delays in obtaining the necessary information from outside sources and the complexity of completing the reports. (*Department of Health and Human Services - Medical Assistance Program 93.778*)

Recommendation:

We recommend that the Division institute policies that ensure the data required for completion of the HCFA 64 and PMS 272 Reports be compiled and submitted in the timeframes required by HCFA guidelines. Gathering this information can become more problematic because the Division is now responsible for reporting the expenditures of Massachusetts Commission for the Blind. Finally, we recommend the Division adopt a policy of notifying HCFA in writing of the delay in filing the reports, the reason for the delay, and an estimated date of actual filing.

Department corrective action plan:

Scrupulously assembling supporting documentation from a medley of people to prepare expenditure reports in a prescribed format for over \$4 billion in annual Medicaid expenditures is a difficult task to accomplish within 30 days without compromising the integrity of the HCFA 64. The current complexities in reporting compounded with new program reporting requirements will likely severely limit the possibility of producing a quality report within the thirty-day time requirement even with our best efforts.

The imposition of the thirty-day time deadline occurred when the reporting requirements for the Medicaid program were simpler and the size of the program was smaller. Nationally, states must now complete the traditional HCFA 64 and a new series of reports for the Title XXI program and Title XIX expansion. Also, the approval of the Division's MassHealth waiver added to the reporting requirements for the traditional HCFA 64. In light of the changes in the program over the years, HCFA should review the timeliness of filing HCFA 64s nationwide and make a determination about the reasonableness of the thirty-day timeline requirements.

With regard to the PMS 272, the late submission of the HCFA 64 impedes the submission of a timely PMS 272 since the reports are intertwined.

In order to address this finding, HCFA will receive a notification letter describing any delays in quarterly reporting. Irrespective of the finding, Richard Turner, Director of Finance, will continue to strive toward the goal of completing the reports within the prescribed deadlines with the overarching goal of producing a quality product.

Finding Number 30: Medicaid Waiver Reports Not Filed

The Division of Medical Assistance (Division) did not file all of its required Health Care Financing Administration (HCFA) 372 Reports for the Home and Community Based Services Waiver for the Mentally Retarded and the Home and Community Based Services Waiver for the Frail Elderly. These waiver programs basically allow Medicaid recipients to receive non-medical benefits in the home or community rather than in an institution. The Department of Mental Retardation (DMR) and the Executive Office of Elder Affairs (ELD) provide the services under the waiver program, through interagency agreements with the Division, for their Medicaid eligible recipients.

Federal regulation, 42 CFR 441.302 (h), requires state agencies to provide HCFA annual reports (HCFA 372) on the waiver program. These reports are to address the waiver's impact on (1) the type, amount and cost of services provided under the State Plan and (2) the health and welfare of the recipients. These reports are important because, according to 42 CFR 441.304 (d), HCFA may terminate the waiver program if the actual costs, for any year of the waiver period, exceed the amount that would be incurred for those individuals in a skilled nursing facility or intermediary care facility.

The HCFA 372 Reports must be filed within 181 days after the last day of the waiver reporting period. The reporting periods ended on June 30, 1996 & 1997 and December 31, 1997 for the DMR and ELD waiver programs, respectively. None of the DMR reports and the December 31, 1997 ELD Report had not been filed as of the end of field work, October 16, 1998, because of delays in obtaining the necessary information which are the result of HCFA required report revisions and subsequent initiation of routine Division procedures in requesting system update orders for required reports. The ELD June 30, 1997 report was filed on April 28, 1998. (*Department of Health and Human Services - Medical Assistance Program 93.778; Fiscal Year 1993; 1997 Single Audit Finding 32*)

Recommendation:

We recommend that the Division institute policies that ensure the data required for completion of the HCFA 372 Reports be compiled and submitted in the timeframes required by HCFA guidelines. In prior years, the Division stated that information could not be obtained from UNISYS in the format necessary to complete the HCFA 372s and we therefore recommended, and continue to recommend, that the Division review its contract with UNYSIS and, where necessary, add agreements that require UNYSIS to provide the facts and figures to complete the HCFA 372 Reports on time.

The delay in the submission of the 372 reports is the result of the dynamic nature of the waivers. The programming for the two waivers is quite complex, utilizing the Division's entire claims database, in addition to the eligibility files. The programs involved take four days to run. Almost yearly, the waivers are amended to include different services and sometimes scope. The DMR waiver for the years in question actually combined two waivers (DMA & MCB) into one.

Although 372 reports are a requirement that HCFA expects, no loss of federal financial participation dollars is in jeopardy. The current cost effectiveness ratios for the two waivers are \$35,800: \$121,700

(community costs vs. institutional costs) for DMR and \$4,204: \$25,453 for the Elderly. Despite the tardiness of the reports, HCFA approved a DMR waiver renewal July 1, 1997 and is actively working with the Division to renew the elderly waiver effective January 1, 1999.

Charles Cook, Director of CommonHealth Plan, will continue to monitor upcoming changes to the waivers and program staff will submit new systems specifications within one month of such changes. The actual programming that generates the reports are done in DMA's Information Services (IS) Unit and priority can be controlled by the Division. The transition from Unisys to ITD will influence the running of future elderly reports, and this situation will have to be monitored closely.

Finding Number 31: Closer Review of Waiver Recipients Case File Documentation Needed

During the review of the Department of Mental Retardation (DMR) Medicaid waiver program, it was noted that, out of the 20 recipient files selected for testing, 14 did not contain evidence that the "Appeal Notification" clause was provided to the recipient, as required by 115 CMR 6.30 to 6.34. Also, one of the 14 files did not have the necessary family member signature on the Individual Support Plan documents.

The Health Care Financing Administration (HCFA) has approved the Division of Medical Assistance (Division) to operate a waiver program that allows Medicaid recipients to receive non-medical benefits in the home or community rather than in an institution. DMR provides the largest segment of the services under the waiver program for the Division. Providers under the waiver program bill DMR for the services they provide to Medicaid eligible recipients, and are required to complete all of the necessary case file documentation for each recipient. This documentation includes an Individual Support Plan (ISP), which outlines the goals and treatment for the recipient for the forthcoming year, and gives the responsible party the opportunity to accept or appeal the ISP.

State regulation, 115 CMR 6.23 (5)(a) states in part that within 30 days following the ISP meeting, the ISP shall be reviewed and mailed to the individual, family, guardian, designated representative, if any, and providers. The service coordinator shall notify the individual and his or her family and guardian, if any, of their right to have, upon request, a meeting with the service coordinator to explain the ISP within 10 days of receipt and of their appeal rights under 115 CMR 6.30 through 6.34.

DMR officials indicate that all ISPs are mailed to the responsible party, and are presumed to have been received within five days, unless DMR is notified otherwise. The cover letter accompanying these mailings notifies the responsible party of the formal appeal option, and cites the attached "Response Sheet" included in the ISP for information regarding the process. Since DMR did not receive any appeals for these cases, they are presumed, by regulation, to have been accepted by the responsible party. However, it was noted that in the copies of the 14 ISPs that were received for testing, the Appeal Notification (Response Sheet) was not included in any portion of the form. Accordingly, the responsible parties may not have been fully aware of their right to appeal in that the Appeal Notifications may have

been inadvertently omitted from the ISP documents sent to the responsible parties.

DMR officials further indicated that each of the 26 area offices have used slightly different forms, some with an Appeal Notification incorporated within the Response Sheet and others with a separate Appeal Notification form. While it is noted that the ISP form has been updated to include the full Appeal Notification within the ISP itself, the recommendation below takes note of the inconsistencies in the use of forms across the state during the audit year in question. (*Department of Health and Human Services – Medical Assistance Program 93.778*)

In three of the 14 cases, it was noted that an ISP meeting did take place and one could reasonably assume that the right to appeal was discussed at this meeting. In the other 11 cases there was no evidence of an ISP meeting or the Appeal Notification. In one of the three cases where an ISP meeting was held, while the ISP meeting attendance sheet was signed, the ISP itself was not. (*Department of Health and Human Services – Medical Assistance Program 93.778*)

Recommendation:

The Division should work with DMR to develop a procedure that would ensure that all ISP forms include the Appeal Notification form as part of the documentation package mailed to the responsible party by the provider. These procedures may include, but not be limited to, the use of a standard ISP form, and a required documentation checklist which would be required to be completed prior to all ISP mailings to assure that all required documentation and signatures are obtained.

Department corrective action plan:

Charles Cook, DMA, and Betsy Youngholm, DMR, are responsible for the following corrective action plan:

1. With the most recent waiver amendment approval, DMA has described a process for annual review of a sample of plans of care. HCFA approved the following:

A random sample of up to 2% of plans of care will be reviewed by DMA once per year beginning January 1999. DMR will generate a random sample of 5 to 10 plans of care per area. For example, the current approved waiver has been approved for up to 11,280 individuals for Year 2 of the waiver. A 2% sample would equal 225 plans of care statewide. As there are 26 areas within the DMR system, a maximum of 260 plans of care will be submitted by DMR to DMA in January of each year of the waiver for desk review.

2. By the end of fiscal year 1999, the new Electronic Individual Support Plan (EISP) will be activated and all service coordinators trained in its use. The EISP provides system-generated letters, reports, forms and checklists which will assure all ISP documents are distributed to appropriate parties. The EISP track dates of distribution and retains copies in electronic format.

Finding Number 32: Documentation of Timely Redeterminations of Eligibility Needs Improvement

In prior year Single Audits, it was reported that the Division of Medical Assistance (Division) did not redetermine the eligibility of all Medicaid recipients in a timely manner.

The redetermination process involves ensuring that the recipient remains eligible for benefits. According to the Medicaid Policy Manual, a redetermination application, interview or automated tape matches are required with respect to items that may change. These procedures are important to assure that only eligible individuals continue to participate in the program. This same information is used to support participation in other programs such as Food Stamps and TANFFDC.

While the Division believes it does comply with all federal regulations, the on-going implementation of MA-21, and the conversion of the Community Elder, and Long-Term Care Cases, and the redetermination of Health Care Reform Cases has taken somewhat longer than anticipated. The Division planned to convert all the cases by June 1998 and then do the redetermination of cases on MA-21. Full conversion is not expected until April 1999. (*Department of Health and Human Services - Medical Assistance Program 93.778; Fiscal Year 1993; 1997 Single Audit Finding 31*)

Recommendation:

The Division should continue its conversion to MA-21 to ensure that all redeterminations of recipient eligibility are completed and documented in a timely manner. This includes ensuring that the case file contains the redetermination application, interview or automated tape match data.

Department corrective action plan:

1. Community Elder and Long-Term Care Cases

In August 1997, the Division established an automated monthly process to select and mail review forms to community elder cases with last review dates equal to or greater than one year. This process included the automatic identification and closing of cases when the review form was not returned within prescribed time frames. Information received in the review process is updated on PACES at the MassHealth Enrollment Centers.

This process was folded into the four month MAOA review process in such a way as to increase annual review compliance of these cases from 39% in August 1997 to 97% compliance in October 1998.

Redetermination of the long-term care portion of the caseload is being approached in a decentralized approach due to the importance and complexity of coordinating redetermination efforts with long-term care facilities and authorized representatives of this member base. Such coordination is critical in

making sure that service delivery is not negatively impacted and to ensure accurate and timely submission of review forms and verifications in the redetermination process. The Division will need to continue its corrective approach with a portion of the caseload until full annual redetermination compliance is achieved.

It is important to note that in the context of Health Care Expansion and other redetermination efforts, redetermination of the long-term care caseload in the traditional sense has not been a priority effort for the following reasons:

1. All eligibility factors for this segment of the caseload are exhaustively examined, assessed, and documented at application.
2. Automatic processes are in place to systemically adjust for social security COLAs, patient paid amounts, and close for death.
3. This segment rarely experiences eligibility factor changes which would render them ineligible for the benefit subsequent to initial approval.
4. The MassHealth Enrollment Centers have ongoing relationships with long-term care facilities they cover which facilitate the updating of case information as changes occur, which makes the formal annual redetermination process less important as a means to insuring correct ongoing eligibility determination while the process is extremely administratively burdensome for all involved parties.

The Division is now at 37% compliance with the annual redetermination of the long-term care caseload. While the Division feels strongly that this is not a good measure of the efforts of the Division in maintaining current eligibility information and correct benefit determinations for this population, the Division will proceed with an aggressive MEC-based program to have redetermination forms sent, completed, and processed for all long-term care cases by the end of fiscal year 1999.

The Division urges that for the reasons cited above, more appropriate measures be employed in the future to assess the Division performance in providing benefits to eligible people only.

2. Health Care Reform Cases which were Established on PACES.

The Division began the massive effort to convert these cases to MA-21 in April 1998. Conversion of these approximately 133,000 cases is being done via a redetermination process using a newly developed review form designed for the MA-21 system. The process includes centralized and automated selection of cases, mailing of the review form, and closing of non-respondents. Selection of cases was done in such a way as to capture overdue redeterminations of Health Care Reform cases from the cash assistance MAOA and Transitional Medical Assistance cases first. In the first two months of the process the Division was able to capture all overdue redeterminations for these types of cases, which are by definition cases which contain eligibility factor changes.

The continuing conversion process will produce redeterminations of these populations as they become

due. The rest of the conversion effort will select Health Care Reform cases from PACES according to oldest review date. All cases selected for conversion will be reviewed, and established on MA-21 with updated eligibility information and determination.

Since April 1998, the Division has processed over 100,000 conversion redeterminations. The conversion process for this portion of the caseload is due to be completed in April 1999.

3. Health Care Reform Cases Established on MA-21

In July 1997, the Division began establishing new Health Care Reform cases on the MA-21 system. In July 1998, those cases became due for redetermination. The Division plans an automated review process which will profile cases according to case characteristics at prescribed intervals not to exceed 12 months.

As this profiling system will not be in place on July 1999, the Division plans to begin redeterminations of this population on time so that redetermination noncompliance does not become an issue. This process will utilize DMA matches with an increasing number of sources, including SSA, DOR, Bureau of Vital Statistics, health insurance companies, etc. to target cases with potential eligibility changes. In order to maintain an annual review rate for all MA-21 cases, the Division would need to review an average of over 15,000 of these cases per month. Given the additional burden of conversion of the 133,000 PACES cases to MA-21, establishing 100% annual review compliance for both these caseload segments is the ambitious and established goal in the fiscal year 1999.

To date, the Division has sent redeterminations to all members due for redetermination in July, August, and September 1998 for whom a DOR match has shown employment that was not reported.

As income was the primary eligibility factor in determining these Health Care Reform cases, the Division believes that this income match information is a most valuable way to prioritize cases for review.

Given the continuing efforts of the Division to expand to uninsured groups, the sheer numbers of people receiving benefits increases at a significant rate. Again, the Division urges consideration of performance measures of the eligibility process which support its efforts to manage these large numbers of cases more efficiently through the use of systems matches, automatic updates, streamlined and targeted update mailings and other methods rather than conventional paper redeterminations to insure the correct provision of benefits to the ongoing caseload.

Thomas DeVouton, Director, MassHealth Enrollment Centers (MEC) is responsible for corrective action plan implementation.

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complexities in reporting compounded with new program reporting requirements will likely severely limit the possibility of producing a quality report within the thirty (30) day time requirement even with our best efforts.

The imposition of the thirty-day time deadline occurred when the reporting requirements for the Medicaid program were simpler and the size of the program was smaller. Nationally, states must now complete the traditional HCFA 64 and a new series of reports for the Title XXI program and Title XIX expansion. Also, the approval of the Division's MassHealth waiver added to the reporting requirements for the traditional HCFA 64. In light of the changes in the program over the years, HCFA should review the timeliness of filing HCFA 64's nationwide and make a determination about the reasonableness of the thirty-day timeline requirements.

With regard to the PMS 272, the late submission of the HCFA 64 impedes the submission of a timely PMS 272 since the reports are intertwined.

In order to address Audit Finding Number 4, HCFA will receive a notification letter describing any delays in quarterly reporting. Irrespective of the finding, Richard Turner, Director of Finance, will continue to strive toward the goal of completing the reports within the prescribed deadlines with the overarching goal of producing a quality product.

Finding Number 33: Lack of Waivers to Pay and Chase Medicaid Claims

The Division of Medical Assistance (Division) still needs to effect system changes to adhere to certain requirements pertaining to prenatal care for pregnant women and preventative pediatric services when absent parents are involved. Regarding care for pregnant women, regulations require that claims pertaining to prenatal care for pregnant women and preventative pediatric services be considered mandatory pay and chase (seek reimbursement) claims if an absent-parent-related obligation is being enforced by the Department of Revenue's Child Support Enforcement Unit (CSE). Previous audits reported that the Medicaid Management Information System (MMIS) could not differentiate between claims that were absent-parent-related and those that were not, and that therefore the system did not allow for the mandatory pay and chase requirement to be fulfilled. Prenatal care and preventative pediatric services were automatically cost-avoided. Moreover, even if MMIS was able to identify absent-parent claims being pursued by CSE, it could not identify whether a specific procedure was for prenatal care. The Division indicated that, by cost avoiding, it was reimbursed 100% on a claim, whereas, if it paid claims and then received reimbursement from a third-party insurer, it would be reimbursed 80%.

Our prior audit further indicated that the Division was developing a new system (MA-21 project version 2) that was going to incorporate system change requests (SUO) to the system that would resolve the issue, but it was terminated. The reason was due to the lengthy development of and cost to continue the project. Thus, the Division stated that they would go ahead and implement the system enhancements to resolve this matter while they worked on the development of the MA-21 project version 1 in order to conform to the requirements set forth in 42 CFR 433.139.

Our follow-up review disclosed the situation to be unchanged because they are waiting for resources to commit to the system enhancements. The Division continued to cost-avoid absent-parent-related claims enforced by CSE pertaining to prenatal care for pregnant women and preventative pediatric services. The Division stated that all system enhancements were put on hold until the MA-21 project version 1 was implemented. (*Department of Health and Human Services - Medical Assistance Program 93.778; Fiscal Year 1992; 1997 Single Audit Finding 34*)

Recommendation:

We recommend that the Division continue to prioritize the system enhancements as high to properly identify cases in which absent parents with related obligations being enforced by CSE.

Department corrective action plan:

The Division's Assistant Director for Third Party Liability, David Phillips, will continue to monitor the status of enhancements to the current MMIS, which are awaiting systems resources, to properly identify cases in which absent-parent-related obligations are being enforced by CSE.

Findings Not Repeated from Prior Years

1. An overpayment was submitted by the Department of Mental Retardation (Department) to the Division of Medical Assistance (Division) for a waiver payment claim. No such overpayments were noted as part of the fiscal year 1998 audit. (*Fiscal Year 1997 Single Audit Finding 33*)

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