

# Division of Medical Assistance

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## 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 1999, the Division administered approximately \$5.5 billion in carrying out its program. Federal funds amounted to approximately \$2.7 billion.

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

CFDA #	Federal Program Description
93.778	Medical Assistance Program
93.775	State Medicaid Fraud Control Units
93.777	State Survey and Certification of Health Care Providers and Suppliers

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## Findings on Compliance with Rules and Regulations

### Finding Number 21: Lack of Acceptance Signature Noted on Individual Support Plan

During the testing of Department of Mental Retardation (DMR) waiver program, it was noted that one out of twenty selections tested did not have the Individual Support Plan (ISP) form signed by the individual or family member, although there is evidence that both the recipient and her mother were at the ISP meeting.

Massachusetts regulation, 115 CMR 6.23(5)(c), states "the individual, his or her guardian, if any, and any family members who participated in the development of the ISP will be asked to signify, in writing, their approval or appeal of the ISP. If such approval is not received within 20 days of mailing, an attempt will be made by the service coordinator to contact those individuals having a right of appeal to confirm their receipt of the ISP."

A signature was not obtained at the time of the meeting, and DMR officials explained that the recipient's mother did not return the signed ISP sheet mailed to her. However, without formal documentation of ISP acceptance or the attempts made by DMR to obtain the acceptance and approval, neither the DMR nor the Division of Medical Assistance (Division) can be assured that the parties involved accept the ISP as shown in the file or that these persons were adequately informed of their right to appeal the ISP. (*Department of Health and Human Services – Medical Assistance Program 93.778*)

### **Recommendation**

We recommend that DMR implement a policy requiring the family member and/or to sign the ISP document at the end of the meeting, if appropriate, or, at a minimum, provide evidence that the ISP, as presented and tailored at the meeting, is an acceptable plan for support services to be provided to the recipient. Additionally, the DMR should formally document the mailing of the ISP, and, if it is not returned signed within the prescribed timeframe, also formally document the attempt to contact the individual having the right to appeal.

### **Department Corrective Action Plan**

When DMR converted its ISP process to an electronic format in January, 1999, the format included an "ISP Workflow" sheet which guides the service coordinator through the elements of the ISP by providing a sequence for document preparation and prompts entry of a status indication, action information, and date of any action. One of these elements is "Send ISP to individual/family for approval and sign-off". We will continue to emphasize the need to document any follow-up contact attempts with the consumer/family. Betsy Youngholm, Director of Revenue, will monitor the corrective action plan.

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## **Findings on Compliance with Rules and Regulations**

### **Finding Number 22: Lack of Proper Income Documentation Obtained for Medicaid Recipient**

During eligibility testing, one instance out of twenty-five was noted where income documentation was not obtained, as required by 130 CMR 506.005.

130 CMR 506.005(B) states that "Verification of gross monthly unearned income is mandatory and shall include, but not be limited to, the following: a copy of a recent check ...showing gross income from the source [or]...a statement from the income source..."

In submitting her redetermination form for Medicaid eligibility review on August 5, 1998, the applicant declared that her only income was child support. The income should have been verified by the Division of Medical Assistance (Division) by obtaining a copy of the child support check or a statement from the absent parent providing the child support to be included in the recipient's file. However, there was no documentation in the file that income was verified.

Division personnel stated that the documentation for child support income was requested on August

10, 1998 , but was not provided by the recipient. Approximately four months after the date of the original application (December 22, 1998), the recipient informed the Division that the child support payments had ceased. It is the Division's contention that this person would have been eligible because their income level was far below the income guidelines used to determine eligibility. However, this applicant should have been disenrolled within sixty days of the date of the application, due to non-response for additional information.

The lack of proper verification of income could result in the Division improperly providing medical benefits to ineligible persons, possibly at the expense of potentially eligible persons. (*Department of Health and Human Services – Medical Assistance Program 93.778*)

### **Recommendation**

We recommend that the Division improve its follow-up procedures and ensure that all necessary information and documentation be obtained from each applicant. In the event that the necessary information and documentation is not provided, proper steps should be taken to disenroll this recipient within the prescribed time.

### **Department Corrective Action Plan**

Effective September 1999, the Division implemented a systematic disenrollment procedure when applicants or members fail to respond to requests for supporting documentation within sixty days of the eligibility application or review process.

Thomas DeVouton, Director, MassHealth Enrollment Center (MEC) Operations, will monitor the effective implementation of this procedure.

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## **Findings on Compliance with Rules and Regulations**

### **Finding Number 23: 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 shows all federally-reimbursable expenditures claimed. These reports also show if the Division overspends its grant which could result in HCFA decreasing future grant awards.

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 18 and 34 days late for every quarter.

The PMS 272 Quarterly Cash Transaction Reports must be filed within 45 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 4 and 12 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; Fiscal Year 1998 Single Audit Finding 29*)

### **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 time required by HCFA guidelines. Gathering this information may 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**

The Division is continuing to make every effort to complete the PMS 272 and HCFA 64 reports within the prescribed deadlines.

In order to address this finding, on-site HCFA personnel will be notified of any anticipated delays by Gerry Beaudreault, Director, Federal Revenue. The Federal Reporting Unit will continue to strive toward the goal of completing the reports within the prescribed deadlines with the goal of producing a quality product.

Scrupulously assembling supporting documentation from a medley of sources 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 are expected to make the production of a quality report within the thirty-day time requirement more difficult even with our best efforts.

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## **Findings on Compliance with Rules and Regulations**

### **Finding Number 24: Medicaid Waiver Reports not Filed on Time**

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 on time. 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 annual reports (HCFA 372) on the waiver program. These reports 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. 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 were June 30, 1996, June 30, 1997, and June 30, 1998 for DMR waiver programs. The reports were therefore due on December 31<sup>st</sup> each year. The reports due on December 31, 1996 and December 31, 1997 were filed on October 26, 1998. The report due on December 31, 1998 was filed on December 30, 1998. All of the DMR reports have been filed and reporting status is now current.

The ELD reporting periods were December 31, 1996, December 31, 1997, and December 31, 1998. These reports were due on June 30<sup>th</sup> of the following year. The reports due on June 30, 1997 and June 30, 1998 were filed on April 28, 1998 and July 11, 1998, respectively. The report due on June 30, 1999 was filed on August 24, 1999, fifty-five days late. The DMR and ELD Reports had not been filed in a timely manner because of delays in obtaining the necessary information. Some of the delays were the result of HCFA required report revisions, while others resulted from the Division needing to request internal system changes for the reports. *(Department of Health and Human Services - Medical Assistance Program 93.778; Fiscal Year 1993; 1998 Single Audit Finding 30)*

### **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. However, since the information that would have formerly been provided by UNISYS is now being processed by the Commonwealth's Information Technologies Division (ITD), it should facilitate the Division's ability to obtain the facts and figures required to complete the HCFA 372 Reports on time.

### **Department Corrective Action Plan**

The Division is now current with our 372 reporting. Althea Glick, Assistant Director of the CommonHealth program will make every effort to submit future 372 reports in a timely manner.

## **Findings on Compliance with Rules and Regulations**

### **Finding Number 25: 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 match is required for items that may change. This same information is used to support participation in other programs such as Food Stamps and TANF.

While the Division believes it does comply with all federal regulations, the implementation of the new MA-21 system slowed down the redetermination process for a period of time prior to implementation. The new system required the conversion of all community cases under age 65, from the previous system and rather than systematically transfer the cases with existing data it was decided that cases be redetermined as they were converted. This conversion and redetermination of 145,633 households was completed one month ahead of schedule in March 1999. This effort resulted in 36.9% (53,718) households being closed and no longer eligible to receive medical benefits for failure to respond as required by federal regulations.

Currently, three programs have been or are in the process of being redetermined annually as required by federal regulations. All community elders have been redetermined and are now on an annual cycle. Further, it is anticipated that residents of long-term care facilities and health Care Reform cases, will be on an annual review cycle by June 2000.

*(Department of Health and Human Services - Medical Assistance Program 93.778; Fiscal Year 1993; 1998 Single Audit Finding 32)*

### **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**

Effective March, 1999, the Division completed the conversion of all (135,000) household community cases under 65 to its new MA21 system and redetermined those cases as part of the conversion process. Those cases will be subsequently redetermined annually as required by federal regulation.

All community elder cases have been redetermined and are on an annual cycle. It is anticipated that redeterminations for residents of long-term care facilities will be completed statewide by June 2000 (in some areas this has already occurred) and annually thereafter. Finally, new Health Care Reform (HCR) cases as well as the recently converted cases, are part of an automated review process which will profile cases according to case characteristics at prescribed intervals not to exceed twelve months. This process began in fiscal year 1999 when the Division selected cases with unique characteristics from its

Health Care Reform (HCR) population and matched those with the Department of Revenue's files. We have continued this effort with a weekly selection of approximately 5000 cases from the general HCR population as part of the annual review process. The Division's goal is to have reviewed the entire caseload by June 2000 and be on an annual cycle thereafter.

The Division has made steady progress in improving a timely redetermination process and will continue its aggressive efforts to reach full compliance by the end of fiscal year 2000.

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

## Findings on Compliance with Rules and Regulations

### **Finding Number 26: 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. 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. Therefore, the system did not allow the mandatory pay and chase requirement to be fulfilled. Prenatal care and preventative pediatric services were automatically cost-avoided. 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%. 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.

Our prior audit indicated that the Division was developing a new system (MA-21 project version 2) to incorporate system change requests (SUO) that would resolve the issue. However, it was terminated because of lengthy development time and cost to continue the project. The Division stated that they will go ahead and implement the system enhancements to resolve this matter while working 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 the Division is 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; 1998 Single Audit Finding 33*)

### **Recommendation**

We recommend that the Division continue to prioritize the system enhancements to properly identify cases in which absent parent obligations are being enforced by CSE.

### **Department Corrective Action Plan**

As reported last year, due to health care reform and other Division high priority initiatives, implementation of systems enhancements for absent parent obligations has been given a low priority status. The Division's Assistant Director for Third Party Liability, David Phillips, will continue to monitor the status of the MMIS enhancement request and its rank in the project queue monthly.

## Findings not Repeated from Prior Years

1. 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. No such instances were noted during the fiscal year 1999 audit. (*Fiscal year 1998 Single Audit Finding 31*)

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