Commonwealth of Massachusetts
Office of the State Auditor
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Making government work better

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Office of the State Auditor—Annual Report
Medicaid Audit Unit

For the period March 15, 2019 through March 14, 2020

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OFFICE OF THE STATE AUDITOR

MEDICAID AUDIT UNIT

March 15, 2019 through March 14, 2020

Introduction

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit (the Unit) for the purposes of preventing and identifying fraud, waste, and abuse in the MassHealth system and making recommendations for improved operations. The state's fiscal year 2020 budget (Chapter 41 of the Acts of 2019) requires that OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 14, 2020 that includes (1) "all findings on activities and payments made through the MassHealth system;" (2) "to the extent available, a review of all post-audit efforts undertaken by MassHealth to recoup payments owed to the commonwealth due to identified fraud and abuse;" (3) "the responses of MassHealth to the most recent post-audit review survey, including the status of recoupment efforts;" and (4) "the unit's recommendations to enhance recoupment efforts."

For fiscal year 2020, the appropriation for the Unit was $1,234,674. This amount represents an approximately 3% increase over the Unit's fiscal year 2019 appropriation of $1,198,713. OSA submits all costs (direct and indirect) associated with running the Unit to the Executive Office of Health and Human Services (EOHHS) to be included in its in quarterly filings with the Centers for Medicare & Medicaid Services for federal cost sharing. In federal fiscal year[1] 2019, OSA submitted a total of $1,470,381 to EOHHS for consideration for the state's program integrity, allowing the state to obtain a 50%, or $735,190, reimbursement of these costs.

This report, which is being submitted by OSA in accordance with the requirements of Chapter 41, provides summaries of three performance audits of MassHealth involving the following:

- billing methods and treatment plans for methadone and buprenorphine users
- payments for prescription refills
- management of accounts receivable

1. The 2019 federal fiscal year is October 1, 2018 through September 30, 2019.

It also provides summaries of five MassHealth provider audits involving the following:

- a provider of day habilitation services (one audit)
- a provider of physical therapy (one audit)
- providers of adult day health services (two audits)
- a provider of vision care (one audit)

The report also summarizes OSA's objectives for MassHealth audits that are currently underway. Finally, it details the corrective measures and related outcomes reported by the auditees, including MassHealth, in relation to our findings and recommendations for six audits.

This report details findings that identified improper payments totaling $1,901,051, as well as deficiencies in MassHealth's administration of millions of dollars in uncollectible accounts receivable and treatment for members with opioid use disorders. It also describes corrective actions MassHealth is taking as a result of six audits whose findings were issued at least six months ago for which follow-up surveys have been completed and MassHealth has taken actions, including recouping funds. MassHealth and its providers reported action or planned action on approximately 15 (52%) of our 29 audit recommendations, which will improve operational efficiency and effectiveness.

Background

EOHHS administers the state's Medicaid program, known as MassHealth, which provides access to healthcare services annually to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2019, MassHealth paid more than $16 billion to healthcare providers, of which approximately 50% was Commonwealth funds. Expenditures, including administration costs, for the Medicaid program represent approximately 39% of the Commonwealth's total annual budget of approximately $42 billion.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the United States Government Accountability Office (GAO) placed the US Medicaid program on its list of government programs that are at "high risk" of fraud, waste, abuse, and mismanagement. GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Based on these concerns, OSA began conducting audits of Medicaid-funded programs and, as part of its fiscal year 2007 budget proposal, submitted a request to establish a Medicaid Audit Unit within its Division of Audit Operations dedicated to detecting fraud,

waste, and abuse in the MassHealth program. With the support of the state Legislature and the Governor, this proposal was acted upon favorably and has continued in subsequent budgets. Since that time, OSA has maintained ongoing independent oversight of the MassHealth program and its contracted service providers. Audit reports issued by OSA have continued to identify weaknesses in MassHealth's controls to prevent and detect fraud, waste, abuse, and mismanagement in the Massachusetts Medicaid program as well as improper claims for Medicaid services.

OSA uses data mining in all audits conducted by the Unit. By so doing, our auditors can identify areas of high risk, isolate outlier providers, and in many cases perform reviews of 100% of the claims under audit, thus significantly improving the efficiency and effectiveness of our audits. Moreover, in many cases, data mining has enabled the Unit to fully quantify the financial effects of improper payments, whether they involve one claim or 10 million. The use of data-mining techniques has enabled the Unit to (1) identify greater cost recoveries and savings, (2) isolate weaknesses in MassHealth's claim-processing system, and (3) make meaningful recommendations regarding MassHealth's system and program regulations to promote future cost savings, improve service delivery, and make government work better.

COMPLETED AUDITS

(March 15, 2019 through March 14, 2020)

During this reporting period, the Office of the State Auditor (OSA) released eight audit reports on MassHealth's administration of certain aspects of the state's Medicaid program and on selected Medicaid service providers' compliance with state and federal laws, regulations, and other applicable authoritative guidance. These reports identified $1,901,051 in improper payments, as well as deficiencies in MassHealth's administration of certain program services and other operational activities, and made a number of recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work.

1. Office of Medicaid (MassHealth)—Review of Counseling Provided to MassHealth Members Receiving Medication-Assisted Treatment for Opioid Use Disorders

Audit Number	2016-1374-3M13
Audit Period	January 1, 2011 through December 31, 2015
Issue Date	March 21, 2019
Number of Findings	3
Number of Recommendations	4
Total Improper Payments	N/A—operational issues identified
MassHealth Recouping Payments	N/A

Background/Reason for Audit

Given the significant increase in reported incidents of opioid misuse both nationally and within the Commonwealth, OSA had concerns as to whether individuals who were receiving treatment for opioid use disorders (OUDs) had access to, and were receiving, counseling as part of their treatment programs. Our audit focused on OUD counseling provided to MassHealth members who received buprenorphine under any brand or generic name as part of their medication-assisted treatment (MAT)[2] for OUDs.

2. According to the federal Substance Abuse and Mental Health Services Administration, medication-assisted treatment for OUDs consists of a combination of prescription medication and outpatient OUD counseling to provide patients with behavioral coping skills to treat their disorders.

Summary of Findings and Recommendations

OSA reported three findings in this audit:

1. Twenty-seven percent of MassHealth members who were treated for OUDs did not receive, and/or may not have had access to, recommended counseling.
2. Some MassHealth members did not receive OUD counseling from healthcare professionals who either were certified or specialized in addiction treatment.
3. Five prescribers wrote a total of 72 prescriptions for 6 members (for a total of $22,733 paid to pharmacies by MassHealth) for which they did not keep any kind of documentation, such as prescriptions issued or medical services provided.

Our recommendations to MassHealth to address these problems were as follows:

1. MassHealth should take additional measures to better ensure that prescribers effectively facilitate member participation in OUD counseling.
2. MassHealth should further investigate the reasons that were provided to OSA during this audit for members' not having access to counseling and take whatever measures it can to minimize these barriers to access.
3. MassHealth should collaborate with the Department of Public Health to ensure that OUD counselors have the proper training, skills, and knowledge to provide effective OUD counseling.
4. MassHealth should conduct a review of the medical documentation of those who prescribe buprenorphine and recover any payments for services that were not properly documented.

MassHealth's Comments: Implementation of Recommendations

MassHealth agreed with our first finding about the importance of best practices and the need to ensure that members with OUDs receive quality comprehensive care. MassHealth also stated,

> *MassHealth will continue to invest in behavioral health services, including support for best practices for individuals with OUD and efforts to ensure access to all medically necessary behavioral health services. Furthermore, MassHealth agrees prescribers should offer referrals and follow-up to appropriate behavioral health outpatient counseling services for members who receive MAT services.*

However, MassHealth said it disagreed that members should be required to obtain counseling as a condition of obtaining MAT. It also disagreed that specific measures were necessary to address rates of engagement in counseling, as defined by OSA, for members with OUDs who were prescribed buprenorphine.

Regarding our second finding, MassHealth said it agreed that practitioners providing counseling and other services to members with OUDs should be qualified and well trained, but disagreed with our conclusion that some members were not receiving OUD counseling from healthcare professionals who specialized or were certified in addiction treatment. MassHealth did not indicate that it would take any measures to address this problem.

Regarding the third finding, MassHealth stated that it agreed with OSA's recommendation that an additional review of these five prescribers was warranted based on the apparent lack of medical documentation.

2. Office of Medicaid (MassHealth)—Review of Claims Paid for Pharmacy Drugs

Audit Number	2018-1374-3M1
Audit Period	January 1, 2015 through June 30, 2017
Issue Date	August 29, 2019
Number of Findings	1
Number of Recommendations	1
Total Improper Payments	$982,535
MassHealth Recouping Payments	N/A—significant operational issues identified

Background/Reason for Audit

The MassHealth Pharmacy Program is administered by Commonwealth Medicine, a division of the University of Massachusetts Medical School, pursuant to an Interdepartmental Service Agreement that the Executive Office of Health and Human Services entered into on behalf of MassHealth. Commonwealth Medicine also manages the Pharmacy Online Processing System (POPS), which, during our audit period, was provided under contract with Conduent State Healthcare LLC (formerly Xerox State Healthcare LLC) and was MassHealth's system for processing pharmacy drug claim data. Drug prescriptions are orders written by state-licensed prescribers and filled by state-licensed pharmacies.

During the audit period, January 1, 2015 through June 30, 2017, MassHealth paid pharmacies approximately $1,716,217,958 for 43,579,259 claims for non-compounded drugs prescribed and provided to 1,015,227 MassHealth members. Given the amount of money involved and the decentralized way these prescriptions are prescribed and provided, OSA assessed this area at a high risk of improper payments.

Summary of Finding and Recommendation

OSA reported one three-part finding:

1. MassHealth improperly paid 25,144 of pharmacy drug claims, totaling $982,535, as detailed below.

    a. MassHealth paid pharmacies a total of $300,863 for 4,332 prescription drug refills that exceeded the number of refills authorized by prescribers.

    b. MassHealth paid pharmacies $526,229 for 5,649 refills of emergency (i.e., non-refillable) prescriptions.

    c. MassHealth improperly paid pharmacies $155,443 for 15,163 over-the-counter (OTC) drug fills supplied to members living in institutional settings.

Our recommendation to MassHealth to address these problems was as follows:

1. MassHealth should ensure that system controls are developed and implemented in POPS to prevent payments to pharmacies for unauthorized prescription drug refills, refills of emergency (non-refillable) drug fills, and OTC drugs supplied to members living in institutional settings.

MassHealth's Comments: Implementation of Recommendation

MassHealth did not agree with this finding; it stated that it believed that many of the claims questioned in this finding were appropriately paid. However, it said that it implemented system changes to eliminate potential future concerns similar to those we raised.

3. Office of Medicaid (MassHealth)—Review of Accounts Receivable

Audit Number	2018-1374-3M3
Audit Period	January 1, 2015 through December 31, 2017
Issue Date	October 18, 2019
Number of Findings	1
Number of Recommendations	1
Total Questioned Costs	N/A—operational issues identified
MassHealth Recouping Payments	N/A

Background/Reason for Audit

We undertook an audit to determine whether MassHealth effectively managed its accounts receivable with regard to write-offs of uncollectible accounts. During our audit period, MassHealth's new accounts receivable totaled approximately $625 million; it collected more than $616 million of this amount, but

did not remove and write off accounts receivable as uncollectible. Using data analytics, we determined that as of December 31, 2017, MassHealth had 30,948 accounts receivable, totaling approximately $12.76 million, that were more than two years old. Based on this, we determined that there was a high risk that many of these accounts receivable might not be collectible and therefore should not be included in MassHealth's accounts receivable balance.

Summary of Finding and Recommendation

OSA reported one finding in this audit:

1. MassHealth does not effectively administer its uncollectible accounts receivable balances: it does not write off uncollectible amounts from its accounts receivable balances even though there are thousands of accounts receivable that are at least 2, and sometimes more than 10, years old and are therefore unlikely to be collected.

Our recommendation to MassHealth to address this problem was as follows:

1. MassHealth should develop policies and procedures regarding how it will determine when to write off accounts receivable that it has deemed uncollectible, as well as monitoring controls to ensure that these policies and procedures are adhered to.

MassHealth's Comments: Implementation of Recommendation

MassHealth disagreed that it had not ensured that its accounts receivable balances were accurate and asserted that the balances were accurate except for its uncollectible accounts. However, it agreed with our recommendation that it formalize its policies and procedures for determining when accounts receivable were to be deemed uncollectible and written off. It also said it would implement monitoring controls to ensure adherence to these policies.

4. Office of Medicaid (MassHealth)—Review of Claims Submitted by Dr. Frederick Wagner Jr.

Audit Number	2018-1374-3M11
Audit Period	January 1, 2014 through December 31, 2017
Issue Date	September 24, 2019
Number of Findings	2
Number of Recommendations	7
Total Improper Billings	$310,112
MassHealth Recouping Payments	Yes

Reason for Audit

Dr. Wagner is an optometrist, sole business proprietor, and certified MassHealth provider who travels to nursing facilities across the state. Using data analytics, we determined that he was in the top tier of vision care providers in terms of the amount he received from MassHealth in reimbursements: he received a total of $1,045,556 for vision care provided to 3,741 MassHealth members during the audit period. Given the amount he received in reimbursements and his pattern of service delivery (a higher-than-normal frequency of billings and members seen), we determined that there was a high risk of improper billings.

Summary of Findings and Recommendations

OSA reported two findings in this audit:

1. Dr. Wagner had inadequate documentation to support at least $301,936 in vision care claims.
2. Dr. Wagner submitted improper claims for eyeglass dispensing and fitting services totaling $8,176.

Our recommendations to Dr. Wagner to address these problems were as follows:

1. Dr. Wagner should collaborate with MassHealth to repay the $301,936 discussed in the first finding.
2. Dr. Wagner should document the chief complaint or reasons for the services provided in members' medical records.
3. Dr. Wagner should properly document the required patient medical history, as well as details about the exam and medical decision-making, when billing for vision care using evaluation and management codes; otherwise, he should bill using eye exam codes.
4. Dr. Wagner should submit claims to MassHealth using the actual dates on which vision care is provided to members.
5. Dr. Wagner should collaborate with MassHealth to repay the $8,176 discussed in the second finding.
6. Dr. Wagner should only submit claims for dispensing services after he fits new eyeglasses to a MassHealth member.
7. Dr. Wagner should maintain proper documentation for dispensing services, including documenting a consultation with the nursing facility, measurements, and evidence that he fitted the eyeglasses to the individual.

MassHealth's Comments: Implementation of Recommendations

MassHealth stated that it had previously identified a number of potential issues with this provider through its own audit and that it generally agreed with our findings and would recoup any overpayments.

5. Office of Medicaid (MassHealth)—Review of Claims Paid for Services Provided by Norwood Adult Day Health Center

Audit Number	2018-1374-3M10C
Audit Period	January 1, 2016 through December 31, 2017
Issue Date	June 6, 2019
Number of Findings	2
Number of Recommendations	3
Total Questioned Costs	$92,644
MassHealth Recouping Payments	Yes

Reason for Audit

MassHealth pays for adult day health (ADH) services provided to eligible MassHealth members who receive required authorizations. Using data analytics, we determined that during the audit period, MassHealth paid Norwood Adult Day Health Center (NADHC) approximately $1,854,494 to provide ADH services for 150 MassHealth members. This placed NADHC in the tier of ADH providers that received the highest amount in reimbursements during this period. We believed this was a high risk factor. The purpose of this audit was to determine whether NADHC obtained the required physician orders and clinical authorizations for ADH services for each MassHealth member.

OSA reported two findings in this audit:

1. NADHC did not obtain physician orders to support as much as $92,644 of ADH services provided to three MassHealth members.
2. NADHC did not always properly document claims submitted to MassHealth by its billing agents to ensure that the correct ADH location was indicated. During our audit period, NADHC's billing agent HealthCare Options, Inc. used the wrong location for services provided for 53 out of 150 MassHealth members.

Our recommendations to NADHC to address these problems were as follows:

1. NADHC should collaborate with MassHealth to determine how much of the $92,644 discussed in the first finding should be repaid.

2. NADHC should develop policies and procedures to ensure that completed and authorized physician orders are in place before it provides ADH services to MassHealth members.

3. NADHC should enhance its policies and procedures to make sure that it properly monitors claims submitted to MassHealth by its billing agents to ensure that all the claims they submit indicate the locations where services were provided.

MassHealth's Comments: Implementation of Recommendations

MassHealth agreed with our findings and recommendations and said our audit identified the need for it to conduct its own audit of this provider.

6. Office of Medicaid (MassHealth)—Review of Claims Paid for Services by ActiveLife Adult Day Care, Inc.

Audit Number	2018-1374-3M10A
Audit Period	January 1, 2016 through December 31, 2017
Issue Date	November 14, 2019
Number of Findings	1
Number of Recommendations	2
Total Questioned Costs	$34,137
MassHealth Recouping Payments	Yes

Reason for Audit

MassHealth pays for ADH services provided to eligible MassHealth members who receive the required authorizations. During the audit period, MassHealth paid ActiveLife Adult Day Care, Inc. approximately $2,365,604 to provide ADH services for 108 MassHealth members. This placed ActiveLife in the tier of providers that received the highest amount in reimbursements during this period. We believed this was a high risk factor. The purpose of this audit was to determine whether ActiveLife properly billed for ADH services provided to MassHealth members (i.e., whether it billed for services that were properly authorized and documented).

Summary of Finding and Recommendations

OSA reported one finding in this audit:

1. ActiveLife did not obtain a physician order for $34,137 of services for one MassHealth member.

Our recommendations to ActiveLife to address these problems were as follows:

1. ActiveLife should collaborate with MassHealth to determine how much of the $34,137 discussed in this finding should be repaid.
2. ActiveLife should develop policies and procedures to ensure that completed and authorized physician orders are in place before it provides ADH services to MassHealth members.

MassHealth's Comments: Implementation of Recommendations

MassHealth agreed with our recommendations and stated that it would follow through with its own audit of ActiveLife.

7. Office of Medicaid (MassHealth)—Review of Claims Paid for Day Habilitation Services Provided by United Cerebral Palsy

Audit Number	2019-1374-3M1
Audit Period	April 1, 2015 through July 31, 2018
Issue Date	September 19, 2019
Number of Findings	1
Number of Recommendations	1
Total Questioned Costs	$122,357
MassHealth Recouping Payments	Yes

Reason for Audit

MassHealth covers day habilitation (DH) services for eligible MassHealth members based on properly authorized member service plans that set forth measurable goals and objectives and prescribe integrated programs of activities and therapies necessary to reach them. A service-needs assessment must be completed in order for a member to receive DH services. This is a compilation of evaluations by qualified professionals who determine the member's functioning level, needs, and strengths and make specific recommendations for DH services to address identified needs. During the audit period, MassHealth paid United Cerebral Palsy (UCP) $4,505,326 to provide DH services for 111 MassHealth members. This placed UCP in the tier of providers that received the highest amount in reimbursements

during this period. We believed this was a high risk factor. The purpose of this audit was to determine whether UCP obtained the required authorization from a physician or primary care clinician for DH services for each MassHealth member.

Summary of Finding and Recommendations

OSA reported one finding in this audit:

1. UCP did not obtain physician or primary care clinician authorizations to support payment for DH services provided to six MassHealth members.

Our recommendations to UCP to address this problem were as follows:

1. UCP should collaborate with MassHealth to determine how much of the $122,357 discussed in this finding should be repaid.
2. UCP should update its policies and procedures to require its staff to ensure the completion of physician or primary care clinician authorizations before it provides DH services for MassHealth members.

MassHealth's Comments: Implementation of Recommendations

MassHealth stated that it agreed with our recommendations and would conduct its own audit of UCP.

8. Office of Medicaid (MassHealth)—Review of Claims Submitted by Dr. Joseph O'Connor

Audit Number	2019-1374-3M3
Audit Period	January 1, 2015 through December 31, 2018
Issue Date	January 13, 2020
Number of Findings	1
Number of Recommendations	3
Total Improper Billings	$359,266
MassHealth Recouping Payments	Yes

Reason for Audit

MassHealth pays for physical therapy services provided to eligible MassHealth members. Dr. Joseph O'Connor is a therapist and the owner of Advance Physical Therapy & Sports Rehabilitation. During the audit period, Dr. O'Connor received a total of $568,988 for physical therapy provided to 1,129 MassHealth members. The audit was initiated as the result of a referral from OSA's Bureau of Special

Investigations (BSI). BSI is charged with investigating potential fraudulent claims or wrongful receipt of payment or services from public assistance programs. BSI conducted data analytics of Dr. O'Connor that identified potential improper payments. The purpose of this audit was to determine whether physical therapy provided to MassHealth members was properly supported by documentation and allowable in accordance with MassHealth regulations.

Summary of Finding and Recommendations

OSA reported one finding in this audit:

1. Dr. O'Connor improperly billed MassHealth for $359,266 in physical therapy provided by physical therapy assistants. Specifically, in many instances he submitted claims to MassHealth using his own billing provider identification number for physical therapy that was provided by physical therapy assistants. This is not allowed by MassHealth regulations, even if the services are provided under the supervision of a licensed therapist.

Our recommendations to Dr. O'Connor to address this problem were as follows:

1. Dr. O'Connor should collaborate with MassHealth to establish a plan to repay the $359,266 in overpayments he received from improper physical therapy billings.
2. Dr. O'Connor should bill MassHealth using his billing provider identification number only for services he personally provides.
3. Dr. O'Connor should periodically review all the billing requirements in MassHealth's regulations, as well as updates to these regulations that are described in MassHealth's transmittal letters and provider bulletins, and ensure that he knows and adheres to these requirements when he bills for services provided to MassHealth members.

MassHealth's Comments: Implementation of Recommendations

MassHealth stated that it agreed with our recommendations and would conduct its own audit of Dr. O'Connor to determine the amount to be repaid.

CURRENT INITIATIVES

During this reporting period, the Office of the State Auditor began or continued work on 12 audits of MassHealth's administration of the Medicaid program and of Medicaid service providers' compliance with state and federal laws, regulations, and other authoritative guidance. These audits were selected based on our research and applied data analysis to identify areas of risk in the state's Medicaid program. We anticipate that they will have a significant amount of improper payments related to identified deficiencies in MassHealth's provision of program services and will include recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work in process.

- A review, conducted with the Office of Inspector General within the United States Department of Health and Human Services (Boston office), of claims paid for members with both Medicaid and Medicare eligibility (referred to as dual eligible members) during the period January 1, 2017 through December 31, 2018. We will determine whether MassHealth inappropriately paid for member healthcare expenses through Medicaid that should have been covered by Medicare.

- A review of six MassHealth service providers for the period January 1, 2017 through December 31, 2018 to see whether they submit bills for duplicative services (for example, adult foster care and home health aide services for the same members on the same days).

- A review of MassHealth's real estate recovery efforts during the period July 1, 2016 through December 31, 2018. This audit will determine whether MassHealth properly seeks reimbursement for expenditures it makes on behalf of long-term-care recipients who have assets, typically real estate. We will determine whether MassHealth places liens on these assets and seeks reimbursement through probate upon members' deaths in accordance with state regulations.

- Four separate audits of MassHealth's enrollment centers (in Tewksbury, Chelsea, Springfield, and Taunton) for the period July 1, 2017 through December 31, 2018. We will determine whether the offices have effectively evaluated new applicants in accordance with certain MassHealth eligibility requirements.

AUDIT IMPACT AND POST-AUDIT EFFORTS

The objectives of the performance audits conducted by the Office of the State Auditor (OSA) at MassHealth and its providers are not only to identify improper payments for Medicaid services, but also to identify and resolve any systemic problems such as deficiencies in internal controls that may exist within the MassHealth system. Consequently, while measures such as referring cases to law enforcement for prosecution, recommending restitution, and taking other remedial actions against individual Medicaid vendors are typical results of OSA audits and serve as a deterrent, the systemic changes made by MassHealth as a result of OSA audits, in many instances, have a more significant effect on the overall efficiency of the operation of Medicaid-funded programs.

To assess the impact of our audits and the post-audit efforts made by auditees to address issues raised in our reports, OSA has implemented a post-audit review survey process that is conducted six months after the release of an audit. This process documents the status of the recommendations made by OSA, including any corrective measures taken by the auditee, as well as any estimates of future cost savings resulting from changes made based on our recommendations.

During the report period, OSA issued, and agencies completed, six post-audit surveys regarding Medicaid audits. This number reflects audits with findings issued at least six months ago for which follow-up surveys have been completed. The self-reported surveys are issued six months after an audit is issued to allow management time to plan and implement its corrective action. Because the voluntary surveys are sent to MassHealth six months after the audit ends, some surveys have not yet been completed; therefore, not all of the audits conducted during the period covered by this report are included in this section.

According to the survey results, MassHealth reported that it has acted, or will act, on implementing 15 of 29 recommendations. Summaries of the audit surveys follow.

1. Office of Medicaid (MassHealth)—Review of Drug Testing Frequency

Audit No. 2017-1374-3M2 **Issued July 27, 2018**
Survey Response Received March 8, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
7*	2	4	$408,073

* No action was taken on one recommendation.

Findings from this audit include that MassHealth may have paid as much as $6.2 million for drug tests of its members that were not ordered for diagnosis, treatment, or other medically necessary purposes. In many instances, the agency paid for drug tests for members who were tested very frequently but did not receive medical treatment in a reasonable timeframe according to professional guidelines. Additionally, MassHealth may have improperly paid at least $741,621 for drug tests for 1,753 members living in either certified or noncertified privately owned sober or recovery homes licensed by the Bureau of Substance Abuse Services (BSAS) within the Department of Public Health (DPH). Further, MassHealth paid for $21,073 for 2,722 drug tests that were not supported by proper documentation.

In OSA's six-month survey, MassHealth indicated that it had fully implemented the following two recommendations from this report:

1. MassHealth should perform periodic reviews of laboratory drug test order forms and laboratory result reports to monitor whether laboratories bill for medically necessary drug tests.
2. MassHealth should work with drug test laboratories to ensure that they obtain and retain proper documentation of drug test orders and results for each drug test provided to a MassHealth member.

Further, MassHealth indicated that four recommendations were in the process of being implemented:

1. MassHealth should establish controls to ensure that it only pays for drug tests that are used for diagnosis, treatment, and otherwise medically necessary purposes.

   MassHealth stated,

   > *MassHealth started reviewing providers in January, 2018 who consistently bill the two high level definitive testing codes (G0482 and G0483). For these providers, MassHealth has been suspending the relevant claims and requiring submission of additional documentation to ensure the claims meet applicable regulations and are medically necessary. MassHealth also has been reviewing utilization to identify those members that receive a high volume of drug testing, and has been developing strategies to ensure that those members' claims are medically necessary by coordinating a workgroup to educate providers.*

2. MassHealth should ensure that all claim submissions include the referring provider's identification number. MassHealth should use this information to create a system edit and/or monitor claims to limit payments for drug tests to those ordered by authorized prescribers who are currently treating the members.

   MassHealth stated,

   > *MassHealth published All Provider Transmittal Letter 229 in October 2017 establishing a new enrollment process for ordering and referring providers. This*

process requires the national provider identification (NPI) number to be entered on claims establishing the provider's eligibility to an order or referral. The change applies to services provided by independent clinical laboratory providers. At this time, MassHealth is editing claims against this requirement, though claims are not yet being denied. MassHealth is identifying and outreaching to providers who omit the ordering NPI on claim transactions before denials are fully implemented.

3. If MassHealth wants to continue to enforce its current regulations and not allow providers to bill for drug tests for residential monitoring, it should work with officials at BSAS to ensure that it does not pay for such tests. Sober homes may want to explore the possibility, if practical, of using low-cost drug test kits that can be used on site to provide immediate results rather than having laboratories perform these tests.

   MassHealth stated,

   MassHealth does not plan to change its policy regarding drug tests for residential monitoring at this time. MassHealth has met with DPH/BSAS to educate staff regarding payment limitations governing residential monitoring. BSAS staff has used the information provided by MassHealth to outreach to sober home providers certified by the Massachusetts Association of Sober Homes regarding MassHealth payment policies. Additionally, BSAS participates in a workgroup MassHealth has established to evaluate drug testing policies. Additionally in 2017 BSAS started participated in an ongoing workgroup to educate providers on MassHealth policies.

4. MassHealth should collaborate with the laboratory discussed in Finding 2 of the audit report to establish a plan for repayment of the $21,073 in overpayments for improper laboratory drug test billings.

   MassHealth stated,

   MassHealth requested and received the claim examples and supporting documentation identified by OSA as not having required documentation. MassHealth has reviewed the claims in question and if appropriate, MassHealth will proceed with recovery of any payments for claims lacking the necessary documentation.

MassHealth indicated that it had not taken any action on our recommendation to require laboratories to send all drug test results directly to the prescribing providers. MassHealth noted that DPH's clinical laboratory regulations established reporting and recordkeeping standards for all licensed Massachusetts clinical laboratory providers and that Section 180.290 of Title 105 of the Code of Massachusetts Regulations stated that the laboratory report "shall be sent promptly to the licensed physician or other authorized person who requested the test."

2. Office of Medicaid (MassHealth)—Review of Claims by Dr. Ileana Berman

Audit No. 2017-1374-3M7 **Issued November 14, 2018**
Survey Response Received June 17, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
10*	0	1	N/A

* Dr. Berman's office disputes nine recommendations.

In our audit of claims submitted by Dr. Ileana Berman, an Attleboro-based MassHealth mental health and substance use disorder treatment provider, we found that Dr. Berman did not notify MassHealth of significant changes to her business operations. Specifically, Dr. Berman did not transmit information to the agency regarding changes to the types of substance use disorder treatment she offered to MassHealth members. Dr. Berman also billed MassHealth for $76,641 in drug tests that were not used to diagnose and treat patients, and she did not have adequate documentation to support $176,737 of billings for evaluation and management (E/M) services. Further, she did not maintain documentation for $31,287 in E/M and drug test services billed to MassHealth, and she billed 7,129 unbundled drug tests, totaling $75,261. Unbundled drug test billing has been prohibited by MassHealth since 2013. In total, Dr. Berman billed approximately $359,926 for questionable or unallowable claims.

In our six-month survey, Dr. Berman indicated that she disputed our findings and was in the process of implementing one of them:

1. Dr. Berman should cease ordering quantitative drug tests and qualitative drug screens for the same MassHealth member on the same day.

   Dr. Berman's legal counsel stated,

   > *Dr. Berman was previously billing in accordance with the policies as required by Medicare and one of the MassHealth Vendors, BMC HealthNet. . . . Dr. Berman orders these tests as are clinically necessary and records them both on the claim form. Dr. Berman has now taken measures to ensure that no presumptive tests are billed to MassHealth on dates when definitive tests are also ordered and billed.*

3. Office of Medicaid (MassHealth)—Review of Claims Paid for Services Provided by Liberty Adult Day Health

Audit No. 2018-1374-3M10D **Issued March 15, 2019**
Survey Response Received October 7, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
3*	2	1	N/A

* One recommendation is listed as "planned."

In our audit of Liberty Adult Day Health, a Hopkinton-based MassHealth adult day health (ADH) service provider, we found that Liberty did not properly document physician orders in members' files and did not always obtain physician orders detailing the assistance with activities of daily living that members required. In our six-month survey, Liberty indicated that it had fully implemented two of our recommendations:

1. Liberty should develop internal control policies and procedures to ensure that completed and authorized physician orders are in place before it provides ADH services to MassHealth members.
2. Liberty should develop policies and procedures for the review of physician orders to ensure that they contain the necessary information to develop adequate care plans for MassHealth members.

Liberty indicated that it was working with MassHealth on the following recommendation:

1. Liberty should collaborate with MassHealth to repay the $32,407 discussed in Finding 1.

4. Office of Medicaid (MassHealth)—Review of Claims Paid for Services Provided by Cozy Corner Adult Day Health

Audit No. 2018-1374-3M10B **Issued March 15, 2019**
Survey Response Received October 11, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
2*	0	1	N/A

* No action was taken on one recommendation.

Plymouth-based Cozy Corner Adult Day Health, a MassHealth ADH service provider, stated in its survey response that one recommendation was in progress. Although the provider disagreed with the determination that it provided ADH services for MassHealth members before physician orders and

clinical authorizations were in place, Cozy Corner did state that it constantly reviewed its practices and updated them when necessary to ensure accuracy in its practices.

In response to our six-month survey, Cozy Corner indicated that for two of our three recommendations, it was not providing an update. In one case, this was because the recommendation was directed at MassHealth:

1. MassHealth should determine how much of the $955,587 discussed in this finding should be repaid and seek reimbursement.

In another case, Cozy Corner did not agree with the recommendation:

1. If Cozy Corner believes that any of the requirements established by MassHealth regulations are unclear, it should contact MassHealth for guidance and clarification.

However, Cozy Corner indicated that it was in the process of implementing the following recommendation:

1. Cozy Corner should ensure that completed and authorized physician orders and clinical authorizations are in place before it provides ADH services to MassHealth members. The orders should indicate which activities of daily living, and/or skilled nursing services, members require and be used to develop members' individual care plans.

   Cozy Corner stated,

   > *Cozy Corner denies that it ever provided ADH services to MassHealth members before completed and authorized [physician orders] and clinical authorizations were in place for such members. Cozy Corner has always aimed to ensure that its patient intake, record-keeping, and billing practices comply with MassHealth regulations for ADH services. Cozy Corner views this action as "In Progress" because, while it denies that it ever failed to comply with MassHealth regulations, it constantly reviews its practices and updates them when necessary to remain as thorough and accurate as possible.*

5. Office of Medicaid (MassHealth)—Review of Counseling Provided to MassHealth Members Receiving Medication-Assisted Treatment for Opioid Use Disorders

Audit No. 2016-1374-3M13 **Issued March 21, 2019**
Survey Response Received October 22, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
4*	0	2	N/A

* One recommendation was listed as "planned" and one is being disputed.

In this audit, we found that MassHealth and its prescribers did not effectively facilitate participation in, and access to, necessary counseling for MassHealth members receiving medication-assisted treatment (MAT) for opioid use disorders (OUDs). In addition, some MassHealth members did not receive OUD counseling from healthcare professionals who either were certified or specialized in addiction treatment. Further, prescribers did not always maintain documentation for medical visits in which they gave buprenorphine prescriptions to MassHealth members.

In response to our six-month survey, MassHealth indicated that it disputed our finding and recommendation concerning the training, skills, and knowledge of OUD treatment providers and therefore had not given information on how it would address our concerns or recommendation.

MassHealth stated that it was in the process of implementing two recommendations:

1. MassHealth should take additional measures to ensure that prescribers effectively facilitate member participation in OUD counseling.
2. MassHealth should further investigate the reasons that were provided to OSA during this audit for members' not having access to counseling and take whatever measures it can to minimize these barriers to access.

MassHealth indicated that it planned to implement the following recommendation:

1. MassHealth should conduct a review of the medical records of prescribers of MAT for OUDs and recover any payments for services that were not properly documented.

6. Office of Medicaid (MassHealth)—Review of Claims Paid for Services Provided by Norwood Adult Day Health Center

Audit No. 2018-1374-3M10C **Issued June 6, 2019**
Survey Response Received December 23, 2019

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit
3*	2		N/A

* Action taken for Recommendation 1.1 was cited in the audit report.

In our audit of Norwood Adult Day Health Center (NADHC), a MassHealth ADH service provider, we found that NADHC did not obtain physician orders to support as much as $92,644 of ADH services provided to three MassHealth members. Additionally, NADHC did not always properly document claims submitted to MassHealth by its billing agents to ensure that the correct ADH location was indicated.

In its response to our six-month survey, Norwood stated that it disagreed with our finding about its not obtaining physician orders for $92,644 of billings and therefore did not indicate what action it would take on our recommendation that it collaborate with MassHealth to determine how much of the $92,644 should be repaid.

NADHC indicated that it had fully implemented two recommendations:

1. NADHC should develop policies and procedures to ensure that completed and authorized physician orders are in place before it provides ADH services to MassHealth members.
2. NADHC should enhance its policies and procedures to make sure that it properly monitors claims submitted to MassHealth by its billing agents to ensure that all the claims they submit indicate the locations where services were provided.