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 13, 2021 through March 1, 2022

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# OFFICE OF THE STATE AUDITOR

# MEDICAID AUDIT UNIT

## March 13, 2021 through March 1, 2022

## 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 2022 budget (Chapter 227 of the Acts of 2020) requires that OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 12, 2022 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 2022, the appropriation for the Unit was $1,312,862. This amount represents an approximately 3% increase over the Unit's fiscal year 2021 appropriation of $1,274,449. 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] 2021, OSA submitted a total of $46,103,199 to EOHHS for consideration for the state's program integrity, allowing the state to obtain a 50%, or $23,051,600, reimbursement of these costs.

This report, which is being submitted by OSA in accordance with the requirements of Chapter 227, provides a summary of a performance audit of MassHealth's payments for hospice-related services for dual-eligible members. This audit was conducted in conjunction with the US Department of Health and Human Services' Office of Inspector General, involving the following:

- proper verification of MassHealth Hospice Election Forms for dual-eligible members who chose to receive hospice services

1. The 2021 federal fiscal year is October 1, 2020 through September 30, 2021.

- proper payments for professional services coordinated by hospice providers for dual-eligible members who chose to receive hospice services
- proper payments for durable medical equipment (DME) for dual-eligible members who chose to receive hospice services
- proper payments for ambulance and inpatient services for dual-eligible members who chose to receive hospice services

It also provides a summary of a performance audit of MassHealth's estate recovery, involving the following:

- review of undue-hardship waiver cases
- review of estate recovery cases and the total cash receipts collected by MassHealth

This report details findings that identify $45,110,697 of improper payments for professional services not coordinated by hospice providers, $789,367 of unnecessary payments for durable medical equipment that should have been paid for by hospice providers, $203,135 of unnecessary payments to ambulance and inpatient services, and potential missed opportunities for $56,640,242 of cost savings in the administration of the hospice program. The report also describes corrective actions that MassHealth is taking as a result of an audit issued at least six months ago for which MassHealth has taken actions and completed follow-up surveys. MassHealth reported action on 100% of our 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 2021, MassHealth paid more than $18.1 billion to healthcare providers, of which approximately 45% was Commonwealth funds. Expenditures, including administration costs, for the Medicaid program represent approximately 40% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the US 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. At that time, GAO estimated that between 3% and 10% of total healthcare costs were 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 analytics 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 analytics has enabled the Unit to fully quantify the financial effects of improper payments, whether they involve 1 claim or 10 million. The use of data-analytics 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 13, 2021 through March 1, 2022)

During this reporting period, the Office of the State Auditor (OSA) released two audit reports on MassHealth's compliance with state and federal laws, regulations, and other applicable authoritative guidance. These reports identified $46,103,199 in improper payments to both hospice and non-hospice providers, as well as MassHealth's management of its estate recovery process causing some families to incur undue financial hardship. The reports also 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)—Payments for Hospice-Related Services for Dual-Eligible Members

| | |
|---|---|
| **Audit Number** | 2020-1374-3M1 |
| **Audit Period** | January 1, 2015 through July 31, 2019 |
| **Issue Date** | July 20, 2021 |
| **Number of Findings** | 4 |
| **Number of Recommendations** | 9 |
| **Total Improper Billings** | $46,103,199 |
| **MassHealth Recouping Payments** | N/A |

### Background/Reason for Audit

MassHealth members who have both Medicare and MassHealth are known as dual-eligible members. Federal and state requirements stipulate that MassHealth must be the payer of last resort t (i.e., it only pays for covered services if no other payer existed) for MassHealth members with other insurance, including dual-eligible members. Therefore, providers must identify and obtain payment from all other liable parties, including Medicare, before billing MassHealth.

### Summary of Findings

OSA reported four findings in this audit:

1. MassHealth did not ensure that it had accurate information in its Medicaid Management Information System (MMIS) about dual-eligible members who chose to receive hospice services.

2. MassHealth paid for professional services that were not coordinated by hospice providers.

3. MassHealth paid for durable medical equipment (DME) that was included in members' plans of care.

4. MassHealth unnecessarily paid for ambulance and inpatient services for dual-eligible members.

## Summary of Recommendations

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

1. MassHealth should establish an effective monitoring process to ensure that hospice providers send it a MassHealth Hospice Election Form for every dual-eligible member who chooses to receive hospice services.

2. MassHealth should consider collaborating with the Centers for Medicare & Medicaid Services (CMS) to obtain CMS's hospice election information about dual-eligible members and determine whether all MassHealth's hospice providers have submitted the required MassHealth Hospice Election Forms.

3. MassHealth should review MMIS for all members who have elected the hospice benefit to ensure that their MassHealth Hospice Election Forms are accurately reflected in MMIS.

4. MassHealth should ensure that its hospice providers coordinate professional services with non-hospice providers for dual-eligible members to ensure proper service coordination and billing.

5. MassHealth should update its system edits in MMIS to detect and deny claims for dual-eligible members in hospice care that might be duplicative of services that should be paid for by hospice providers.

6. MassHealth should ensure that information in MMIS about hospice election by dual-eligible members is accurate.

7. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and rejecting improper claims.

8. MassHealth should ensure that its hospice providers explain to its members and their families that the members and families are required to inform any non-hospice providers that the members have elected the hospice benefit to ensure service coordination and billing.

9. MassHealth should ensure that the system edits in MMIS for claims for hospice services for dual-eligible members are effective in detecting and denying improper claims.

## Executive Office of Health and Human Services and MassHealth's Comments: Implementation of Recommendations

The Executive Office of Health and Human Services (EOHHS) and MassHealth responded to the report as follows:

> *When MassHealth receives a Member's MassHealth hospice election form it opens a hospice segment in MassHealth's Medicaid Management Information System (MMIS) enabling the MassHealth hospice provider to bill MassHealth for the per diem hospice rate intended to cover hospice services provided to the member. In completing and signing the MassHealth hospice election form the member is affirmatively waiving their right to receive other MassHealth covered services related to or for the treatment of their terminal illness, the submission of the MassHealth hospice election form also triggers additional program integrity measures related to the member's receipt of other MassHealth covered services. Specifically, submission of the MassHealth hospice election form and the establishment of a hospice segment in MMIS activates an MMIS edit ("edit 2018"), that denies claims for other MassHealth covered services that may be related to the member's terminal illness, such as physician services and inpatient hospital services, during the period the MassHealth hospice segment is in place and active. Importantly, and by design, edit 2018 does not deny payments for MassHealth services categorically unrelated to the member's terminal illness, such as 1915(c) home and community-based waiver services that enable members with disabilities to live and remain in the community as an alternative to facility settings.*

EOHHS and MassHealth (hereafter EOHHS) indicated that they had conducted an analysis of the claims in our sample and, based on all available information, determined that there were no inappropriately paid claims. EOHHS separated the claims in our sample into five categories and explained why it believed it would have paid the claims:

> 1. *Medicare Crossover Claims [64 claims; $74,845]*
>
> *The claims in Category 1 are appropriately paid Medicare crossover claims. Here, Medicare determined that the claim was not precluded from payment by the dual eligible member's election of Medicare hospice and therefore Medicare paid the Medicare portion of the claim as primary payor, and the crossover claim was forwarded to MassHealth by Medicare for processing of the remaining patient responsibility (the cost-sharing amount) as secondary payor. . . . The MassHealth program is required to pay any patient responsibility amount for Medicare crossover claims in accordance with Sections 1902(a)(10)(E) and 1902(n)(1) & (2) of the Social Security Act and MassHealth regulations at 130 [Code of Massachusetts Regulations] 450.318.*
>
> 2. *Claims for 1915(c) Home and Community Based (HCBS) Waiver Services [85 claims; $868,810]*
>
> *The claims in Category 2 are appropriately paid claims for 1915(c) HCBS Waiver services. Claims identified by the auditors in this category include claims for residential habilitation waiver services (group home services) provided through MassHealth's [Intellectually Disabled / Developmentally Disabled, or ID/DD] Residential Supports Waiver, claims for home health aide, homemaker, and*

*companion services provided through the Frail Elder Waiver, and a claim for acquired brain injury skills training services provided through one of MassHealth's Acquired Brain Injury waivers. . . .*

*MassHealth members enrolled in a 1915(c) HCBS Waiver are not required to disenroll from their waiver upon the election of hospice and may continue to receive HCBS waiver services while on hospice. . . .*

*For all 1915(c) HCBS waiver services the auditors identified as being inappropriately paid, EOHHS disagrees with the auditors' draft finding that the identified 1915(c) HCBS waiver services may have been duplicative or otherwise unallowable. EOHHS's review of the subject claims indicates that the claims were for waiver services that were either not related to the member's terminal illness, and/or were for waiver services not covered by hospice (e.g., residential habilitation services; companion services; homemaker services and home health aide services for the provision of in-home respite). . . .*

*3. Claims for State Plan Services Categorically Unrelated to Hospice [108 claims; $35,219]*

*Claims in this category are appropriately paid claims for State Plan services that are categorically unrelated to hospice, as well as claims for Medicaid personal care services for which a hospice election does not apply. Claims for State Plan services in this category include claims for services such as non-emergency medical transportation as well as claims for Adult Foster Care ("AFC") services, which provide 24/7 personal care provided by a live-in caregiver. . . .*

*4. Claims Outside the Hospice Election Period [1 claim; $17,215]*

*This category includes one claim for acute inpatient hospital services after the member had disenrolled from Hospice. EOHHS found that this claim was appropriately paid, where it was for services after the member had disenrolled from Medicare hospice, and therefore, the member was entitled to their full Medicare and MassHealth benefits.*

*5. Claims for State Plan Services Appropriately Payable If Unrelated to the Terminal Illness [60 claims; $14,290]*

*Claims in this category are appropriately payable if the provided service was not related to the terminal illness for which the member elected hospice. This category consists of [durable medical equipment] claims and oxygen and respiratory equipment claims. The claims in this category would require further clinical review to validate whether they were related to the terminal illness; however, based on all information reviewed to date (including all information provided by the auditors), EOHHS has not identified any inappropriately paid claims in this category.*

EOHHS provided the following additional comments:

*The audit pertains to dual eligible members receiving Medicare covered hospice services and sub-regulatory guidance from CMS in its Medicare Benefit Policy Manual at Chapter 9, Section 20.3 that Medicare hospice providers must require dual eligible members to waive their right to receive all other Medicare and Medicaid covered services related to their terminal illness for which they would otherwise be eligible to receive via simultaneous election of both the Medicare and Medicaid hospice benefits. The audit identified that some Medicare hospice providers, when providing Medicare*

*covered hospice services to dual eligible members, failed to require such members to simultaneously complete a MassHealth hospice election form with the election of their Medicare hospice benefit. In particular, the auditors found that for 223 out of the 400 MassHealth claims for non-hospice services associated with certain dual eligible members who had elected Medicare hospice and were receiving Medicare covered hospice services, that the Medicare hospice provider had not required the member's completion of a MassHealth hospice election form through which the member waived their right to receive certain MassHealth covered services related to their terminal illness.*[2]

*EOHHS agrees in part with the auditors' findings indicating that the audited Medicare hospice providers failed to require dual eligible members to complete a MassHealth hospice election form along with their Medicare hospice election in some of the 223 cases . . . in violation of the sub-regulatory Medicare guidance in the Medicare Benefit Policy Manual at Chapter 9, Section 20.3.*[3] *However as previously discussed and as provided below, EOHHS has not identified any inappropriately paid claims as a result of this deficiency on the part of the audited Medicare hospice providers.*

*In particular, all of the claims identified in Finding 1 fall into one of the MassHealth Categories of appropriately paid claims as follows:*

- *Category 1 (Medicare Crossover Claims): 45 Claims; $59,622*
- *Category 2 (1915[c] HCBS Waiver Claims): 77 Claims; $813,099*
- *Category 3 (State Plan Services Unrelated to Hospice): 48 Claims; $23,628*
- *Category 4 (Claims Outside Hospice Election Period): 1 Claim; $17,215*
- *Category 5 (Claims Payable if Unrelated to Terminal Illness): 52 Claims; $12,029*

*Accordingly, while EOHHS agrees that the audited Medicare hospice providers failed to require the dual eligible member to complete a MassHealth hospice election form in some cases, EOHHS strongly disagrees with the auditors' finding of any "improper payments" arising out of this issue. Notably, MassHealth's Third Party Liability (TPL) edits deny claims for services covered under Medicare to ensure that MassHealth is the payer of last resort. Via TPL edits, MassHealth is able to ensure that it only pays for services that are not covered under Medicare, which includes all of the claims identified by the auditors (i.e. Medicare cross-over claims, claims for Medicaid 1915(c) HCBS waiver services, claims for AFC services, etc.). Any asserted "risk that the payments for these services may be improper" arising out of this issue (i.e. the absence of a MassHealth hospice*

2. *A member's completion of the MassHealth hospice election form (through which the member waives their right to MassHealth coverage of certain medical services) is required in order for MassHealth to appropriately deny non-hospice provider claims that are for the treatment of or related to the member's terminal illness.*
3. *MassHealth's analysis revealed that MassHealth election forms were absent for 184 out of 223 cases alleged by the auditors where there should have been such a form present. For the remaining 39 cases (approximately 17%), MassHealth disagrees with the finding that MassHealth election forms were missing where they should have been present, based on discrepancies between the auditors' findings and the Medicare and MassHealth hospice election data in MMIS. For example, in some cases there was a MassHealth hospice election form present, and in other cases the claims were outside of the hospice election period and therefore no form was required for the dates of service on the underlying claim.*

*election form in certain situations in which a dual eligible member was receiving Medicare covered hospice services) does not rise to the level of "approximately $56,640,242" as asserted by the auditors, as EOHHS analysis of the claims at issue revealed that many of the services identified by the auditors are categorically unrelated to hospice and were appropriately payable regardless of whether there was a MassHealth hospice election on file. . . .*

*EOHHS agrees with [Recommendation 1] and in October 2020 took action. EOHHS issued MassHealth Hospice Provider Bulletin 15 as a reminder to MassHealth enrolled hospice providers of the federal sub-regulatory guidance that requires dual-eligible members to simultaneously elect their hospice benefit under both Medicare and Medicaid, and that hospice providers need to submit a MassHealth hospice election form for these members regardless of whether MassHealth is paying for the hospice services. MassHealth will continue to follow up and provide education and training for MassHealth hospice providers on their responsibility to comply with this requirement when providing Medicare covered hospice services to dual-eligible members.*

*In addition, EOHHS is developing additional measures to ensure it receives MassHealth hospice election forms from MassHealth enrolled hospice providers providing Medicare covered hospice services to dual-eligible members:*

- *additional program integrity processes to identify when a dual eligible member has elected Medicare covered hospice services via Medicare data and confirming there is an associated MassHealth hospice election on file for the member; and*

- *administrative sanctions on MassHealth enrolled Medicare hospice providers will be imposed when they fail to submit a MassHealth hospice election form for a dual-eligible member simultaneous to the member's completion of a Medicare hospice election form, as required by federal sub-regulatory guidance and as set forth in MassHealth's Hospice Bulletin 15 issued in October of 2020. . . .*

*EOHHS agrees with [Recommendation 2] and is developing program integrity processes to confirm there is a MassHealth hospice election on file in instances where the MassHealth member is receiving Non-MassHealth Medicare covered hospice services, and as described above under Recommendation 1. . . .*

*EOHHS agrees with [Recommendation 3] and is developing program integrity processes to ensure MassHealth enrolled providers of Medicare covered hospice services submit a MassHealth hospice election form for dual eligible members receiving Medicare covered hospice services, as described above in EOHHS's response to Recommendations 1 and 2. In addition, as described in the initial section of this audit response, EOHHS has an effective process for ensuring that there is a MassHealth Hospice election form in place for MassHealth members receiving MassHealth covered hospice services. Specifically, EOHHS requires submission of a MassHealth hospice election form as a prerequisite for a hospice provider to bill MassHealth for MassHealth covered hospice services. Through this process, MassHealth is able to deny the provider's claims for MassHealth covered hospice services until the provider submits the Member's MassHealth hospice election form, which ensures compliance with this requirement in situations in which MassHealth is the payor of the hospice services. . . .*

*EOHHS appreciates this audit of Medicare hospice providers' compliance with the federal sub-regulatory guidance on hospice election for dual eligible members and appreciates the opportunity*

*to utilize these findings as a vehicle towards improving MassHealth's oversight of MassHealth enrolled hospice providers that provide Medicare covered hospice services to dual eligible members.*

*EOHHS disagrees with the conclusion indicated by the auditors' draft findings that if a member with disabilities enrolled in an HCBS waiver elects to receive hospice services, the member should cease to receive HCBS waiver services such as residential habilitation, companion services, or services that provide in-home respite. For purposes of residential habilitation, this would likely mean requiring the member to be placed in a nursing facility. Similarly, as hospice does not cover in-home respite (only inpatient respite services), this would likely result in unnecessary and inappropriate hospital admissions for members whose caregivers had previously utilized in-home respite through the member's HCBS waiver prior to the member's election of hospice. EOHHS disagrees with an outcome in which members with disabilities enrolled in an HCBS waiver must choose between, on the one hand, their continued receipt of HCBS waiver services that help them to remain in the community, and on the other hand, receipt of hospice services for the palliation and management of their terminal illness. . . .*

*Pursuant to CMS guidance on the scope of the Medicare hospice benefit, Medicare hospice services are meant to supplement rather than replace personal care services provided under Medicaid. Specifically, CMS clarified at page 32905 of Federal Register Vol. 73, No. 109 (2008) (announcing changes to Medicare hospice regulations) that:*

> Hospice care is meant to supplement the care provided by the patient's caregiver. If the individual(s) furnishing Medicaid personal care services is functioning as the patient's caregiver, then the hospice would not be expected to replace the Medicaid personal care providers with its own homemaker services on a round the-clock basis. The Medicare hospice benefit is not meant to be a caregiver benefit and should not be expected to function as such.

*As part of the auditors' basis for their finding that these services should have been paid by the Medicare hospice provider, the auditors cite federal Medicare guidance addressing the scope of the rates for Medicare covered hospice services. Specifically, the auditors cite . . . Federal Register Vol. 83, No. 89 (2018) (announcing Medicare rates for hospice services) and CMS's statement that the Medicare rates for hospice are:*

> comprehensive, and we have reiterated since 1983 that "virtually all" care needed by the terminally ill individual would be provided by hospice. We believe that that it would be unusual and exceptional to see services provided outside of hospice for those individuals who are approaching the end of life.

*Notably, however, Medicare and Medicaid are separate health programs and Medicare is a much narrower benefit than Medicaid, covering a substantially smaller scope of services. As a result, while the CMS guidance cited by the auditors is that the Medicare hospice rates are intended to cover "virtually all" Medicare services, EOHHS disagrees with the auditors' overly broad interpretation that this guidance also means the Medicare hospice rates are intended to cover (or could cover) "virtually all" Medicaid services, such as the array of long term services and supports available under MassHealth that are not covered under Medicare, like Adult Foster Care. . . .*

*EOHHS disagrees with Finding 2. The audit team identified 70 MassHealth claims for non-hospice services totaling $628,298 that fall under Audit Finding 2, in which the auditors assert that the services "were not coordinated by the hospice providers" and "may have been duplicative of services that the hospice agencies were already providing and that were therefore unallowable." EOHHS's review of these claims indicates that all 70 claims were appropriately paid claims for either MassHealth Category 2—1915(c) HCBS waiver services (57 claims) or MassHealth Category 3—state plan services unrelated to hospice (13 claims). Accordingly, EOHHS strongly disagrees with the auditors' finding that MassHealth paid an estimated $45,110,697, based on extrapolation as detailed in the draft audit report, for services that may have been unallowable due to a lack of coordination, where these claims were for either payable 1915(c) HCBS waiver claims or payable claims for state plan services unrelated to hospice.*

*With regard to the 57 HCBS waiver claims, as discussed in EOHHS' introduction, HCBS waiver services provide long term services and supports that enable members with disabilities to remain in the community as an alternative to a facility and are services which are neither covered under Medicare nor included in the scope of the Medicare hospice benefit. MassHealth members enrolled in an HCBS Waiver are not required to disenroll from their waiver upon the election of hospice and may continue to receive HCBS waiver services while on hospice. Additionally, to avoid duplication of services, members enrolled in an HCBS Waiver receive case management and care coordination of their HCBS waiver services, which includes coordination of their HCBS waiver services with other non-waiver services the member may be receiving, such as hospice.*

*Contrary to the auditors' assertions that there was an absence of care coordination, EOHHS's review of Frail Elder Waiver care plans for the members associated with the identified claims for home health aide, homemaker, and companion waiver services indicates that the member's waiver case manager was aware of the member's receipt of hospice services and was coordinating these waiver services with the hospice provider's provision of hospice services. In many instances, the HCBS waiver services were for the purpose of in-home respite, which is not covered under the Medicare hospice services the member was receiving.[4] In other instances, these waiver services were for long standing [activity of daily living and instrumental activity of daily living] support in place prior to the member's election of hospice and which were not related to the member's terminal illness and thus also not covered under the Medicare hospice services the member was receiving.*

*HCBS waiver claims in Audit Finding 2 also included claims for residential habilitation services (group home services) provided under MassHealth's ID/DD Residential Supports waiver. Residential Habilitation is paid at a per diem rate and is provided in group homes that are provider owned-and-operated and include 24/7 staffing and supervision provided by employees of the provider. Where members receiving residential habilitation reside in the provider's group home, it is unrealistic to envision a scenario in which the provider of Medicare covered hospice services was not coordinating its delivery of care with the member's residential habilitation services. Additionally, where residential habilitation services are paid at a per diem rate, absent a denial of residential habilitation services in potential violation of the [Americans with Disabilities Act], it is unclear to*

4. *See Medicare Benefit Policy Manual at Chapter 9, Section 40.2.2, which specifies that hospice "[r]espite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home."*

*EOHHS how "MassHealth could have used this money to provide additional services to other MassHealth members" as the auditors assert. . . .*[5]

*Audit Finding 2 also included 13 claims for MassHealth state plan services unrelated to hospice, which were primarily claims for AFC services (10 claims). As noted above, AFC services provide 24/7 personal care that is provided by a live-in caregiver and which, like hospice, are paid at a per diem rate. Pursuant to federal Medicaid guidance, Members may continue to receive personal care services, such as AFC, while on hospice.*[6] *Contrary to the auditors' assertion that the AFC services were not coordinated with hospice, MassHealth AFC bulletin 13 specifies that "if the member elects hospice, the AFC provider must coordinate its delivery of AFC services with the services provided through hospice. . . ." Notably, the auditors have provided no evidence that the AFC's live-in caregiver failed to coordinate their delivery of care with the Medicare hospice provider and due to the live-in nature of this care, it is difficult to envision a scenario in which the AFC's caregiver and the Medicare hospice provider were not coordinating the delivery of their care. Finally, where AFC services are paid at a per diem rate, absent a denial of AFC services in potential violation of the ADA, it is unclear to EOHHS how "MassHealth could have used this money to provide additional services to other MassHealth members" as the auditors assert. . . .*[7]

*[Regarding Recommendation 1,] as mentioned above, EOHHS's review of the professional services identified in Finding 2 indicates that the services were coordinated and the claims were appropriately paid by MassHealth. EOHHS will continue to provide education to MassHealth enrolled hospice providers on their obligation to coordinate the delivery of hospice services with other non-hospice services a member may be receiving.*

*[Regarding Recommendation 2,] as noted above, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. This process may result in additional MMIS system edits.*

*EOHHS disagrees with Finding 3a. The audit team provided 10 claims totaling $2,387 that fall under Audit Finding 3a, in which the auditors' draft findings state that MassHealth paid an estimated $65,727 for DME that was included in members' plans of care and therefore unnecessary. EOHHS's review of these claims revealed that 3 of the 10 were appropriately paid Medicare Crossover Claims (MassHealth Category 1). The remaining 7 claims fall into MassHealth Category 5 (Claims Payable if Unrelated to Terminal Illness), which would require additional information to determine whether the service was not related to the terminal illness; however, based on all information reviewed to date EOHHS has not identified any inappropriately paid claims. . . .*

5. *To the extent Medicare hospice providers inappropriately billed Medicare for services unrelated to the Member's terminal illness and that should have been provided by the Member's residential habilitation provider, arguably that is a finding to be directed to the Medicare program, where MassHealth was not the payer of the hospice services.*
6. *See Federal Register Vol. 73, No. 109 (2008) (clarifying that Medicare hospice is meant to supplement not replace Medicaid personal care services) at page 32905.*
7. *To the extent Medicare hospice providers inappropriately billed Medicare for services unrelated to the Member's terminal illness and that should have been provided by the Member's AFC caregiver, arguably that is a finding to be directed to the Medicare program, where MassHealth was not the payer of the hospice services.*

*EOHHS disagrees with Finding 3b. The audit team identified 86 MassHealth non-hospice claims totaling $21,457 that fall under Audit Finding 3b, in which the auditors assert that MassHealth paid an estimated $723,640 for DME that should have been included in the members' Medicare hospice plan of care. EOHHS's review of these claims revealed that all 86 claims were appropriately paid as further described above and as categorized as follows:*

- *Category 1 (Medicare Crossover Claims): 11 Claims*
- *Category 2 (HCBS Waiver Claims): 2 Claims*
- *Category 3 (State Plan Services Unrelated to Hospice): 22 Claims*
- *Category 5 (Claims Payable if Unrelated to Terminal Illness): 51*

*EOHHS further notes that the auditors cite as the basis for Finding 3b that "some hospice providers told us in interviews that regulations and guidance on what DME should be included in plans of care [are] unclear" and the auditors then refer to the "Other Matters" section of the audit in which they cite Medicare guidance on what is covered in the monthly rate Medicare pays to a hospice provider and what is to be included in the Medicare hospice plan of care. As discussed in further detail below in EOHHS's response to the "Other Matters" section of the audit report, to the extent that providers of Medicare covered hospice services have confusion about what is within the scope of the monthly rate Medicare pays to Medicare providers of hospice services, that is a matter more appropriately addressed by Medicare, not EOHHS where EOHHS does not oversee the Medicare program nor establish the rates for Medicare covered hospice services.*[8]

*As previously stated in the introduction and EOHHS' response to Audit finding 1, Audit Finding 2 and Audit Finding 3A, Medicare crossover claims, HCBS waiver claims, and claims for state plan services unrelated to hospice are appropriately payable claims. EOHHS therefore disagrees with the auditors' finding that MassHealth paid $723,640 inappropriately. . . .*

*EOHHS agrees with [Recommendation 1]. As noted above in the Responses to Audit Recommendations for Finding 1, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. . . .*

*EOHHS agrees with [Recommendation 2]. As noted above in the Responses to Audit Recommendations for Finding 1, EOHHS is implementing processes to proactively identify dual-eligible members receiving Medicare covered hospice services who have not simultaneously executed a MassHealth hospice election form. This process may result in additional MMIS system edits.*

*EOHHS further notes that MassHealth currently utilizes an MMIS edit (edit 2018) that effectively detects and rejects claims for MassHealth services related to hospice for all members receiving MassHealth covered Hospice services. Additionally, MassHealth requires a Member's completion of a MassHealth hospice election form as a prerequisite for payment of MassHealth covered hospice*

8. *Additionally, where MassHealth was not paying for the Medicare covered hospice services, to the extent providers of Medicare covered hospice services failed to maintain appropriate plans of care, this is a finding that may be more appropriately directed to Medicare.*

*services, which effectively ensures that hospice providers providing MassHealth covered hospice services submit the member's MassHealth hospice election form.*

*EOHHS disagrees with Finding 4. The audit team provided 73 claims totaling $26,037 that fall under Audit Finding 4. EOHHS's review of these claims revealed that 12 of the 73 claims were appropriately paid Medicare Crossover Claims for transportation and acute inpatient hospital services (MassHealth Category 1), and the remaining 61 claims were appropriately paid claims for non-emergency medical transportation provided under an HCBS waiver service (MassHealth Category 2) or as a State Plan service unrelated to hospice (MassHealth Category 3). Accordingly, EOHHS disagrees with the auditors' finding that MassHealth made $203,135 in unnecessary payments, as MassHealth's analysis of the 73 claims at issue revealed $0 in improper payments. . . .*

*EOHHS agrees with [Recommendation 1]. EOHHS will continue to provide education to MassHealth enrolled hospice providers on their responsibilities to provide education to members and their families when providing services to dual-eligible members. In particular, EOHHS will continue to provide clarification that even when such providers are providing Medicare covered hospice services, they still have a responsibility to require the dual-eligible member to complete a MassHealth hospice election form waiving their right to receive other MassHealth covered services for the related to their terminal illness. . . .*

*EOHHS agrees with [Recommendation 2]. See also EOHHS response to Recommendation 2 to Audits Findings 3a and 3b, above.*

## 2. Office of Medicaid (MassHealth)—Review of Estate Recovery

| | |
|---|---|
| **Audit Number** | 2019-1374-3M4 |
| **Audit Period** | July 1, 2016 through December 31, 2018 |
| **Issue Date** | June 28, 2021 |
| **Number of Findings** | 1 |
| **Number of Recommendations** | 2 |
| **Total Improper Billings** | N/A—Operational Issues Identified |
| **MassHealth Recouping Payments** | N/A |

## Background/Reason for Audit

According to Section 515.011(A)(2) of Title 130 of the Code of Massachusetts Regulations (CMR), an estate "includes all real and personal property or other assets in the member's probate estate." MassHealth recovers funds by filing claims in probate court against deceased members' estates for Medicaid expenses paid on their behalf. This process, estate recovery, is used to supplement funds available for medical assistance programs and limit the tax burden on citizens of the Commonwealth caused by rising medical costs. Funds recouped through estate recovery are returned to state and federal medical programs to help provide assistance to those in need. There are two types of estate recovery cases: voluntary cases,

which have assets less than or equal to $25,000 and do not include real estate because the decedents did not have any real estate in their names, and non-voluntary cases, which have assets greater than $25,000 or include real estate.

MassHealth contracts with the Center for Health Care Financing (CHCF) to maintain an Estate Recovery Unit. CHCF is a unit within Commonwealth Medicine, a consulting division of the University of Massachusetts Medical School. CHCF's role is to identify deceased MassHealth members, monitor probate filings, assert recovery claims, identify estate assets, and recover the cost of all MassHealth benefits from estates.

We identified what appeared to be undue financial hardships for low- and middle-income families related to MassHealth's estate recovery process.

## Summary of Finding and Recommendations

OSA reported one finding in this audit:

1. MassHealth's estate recovery may cause some families to incur undue financial hardship.

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

1. MassHealth should establish a cost-effectiveness threshold to prevent undue financial hardship for members' survivors.
2. MassHealth should better promote its undue-hardship waiver process for members' survivors.

## MassHealth's Comments: Implementation of Recommendation

MassHealth responded,

> *MassHealth agrees with OSA's recommendations . . . and has implemented policy reforms effective May 14, 2021 that address the issues contained in those recommendations.*
>
> *MassHealth has already promulgated regulations that took effect on May 14, 2021, implementing a cost effectiveness threshold entirely exempting estates with a total value of $25,000 or less from estate recovery. Accordingly, MassHealth no longer files claims in any probate estate with $25,000 or less of assets. . . .*
>
> *MassHealth has already promulgated regulations effective May 14, 2021, significantly expanding its criteria for undue hardship waivers. MassHealth has also greatly streamlined the waiver process and created new hardship waiver request forms that provide clear, detailed instructions on how to qualify for the waivers. These forms and instructions are available online . . . and are also sent out by mail to all estate representatives when MassHealth files a claim in a probate estate.*

The auditee also said, “It is estimated that these expanded hardship waivers will return approximately $17,200,000 to Massachusetts families each year.”

# CURRENT INITIATIVES

During this reporting period, the Office of the State Auditor (OSA) began or continued work on four 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 the audits will identify a significant number of improper payments as well as deficiencies in MassHealth's administration of program services. When applicable, the audits 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.

- OSA is working with the US Department of Health and Human Services and Office of Inspector General (Boston office) on a review of improperly paid capitation payments[9] for MassHealth members with concurrent eligibility in another state for the period July 1, 2019 through June 30, 2021. We will determine whether MassHealth made capitation payments for Massachusetts Medicaid beneficiaries who lived and were enrolled in Medicaid in another state. As applicable, we will identify the reasons this occurred and make recommendations to resolve the problems.

- OSA will conduct a review of MassHealth's telehealth services for the period July 1, 2019 through June 30, 2021. This audit will determine whether MassHealth ensures the program integrity of its telehealth services, in accordance with federal and state requirements, after the rapid implementation necessitated by the 2019 coronavirus.

- OSA will conduct a review of MassHealth's Delivery System Reform Incentive Payment (DSRIP) Program for the period July 1, 2018 through December 31, 2020. This audit will determine whether MassHealth ensured that DSRIP funds allocated to its accountable care organizations were in accordance with applicable protocols.

- OSA will conduct a review of MassHealth's continuity of operations plan (COOP) for the period January 1, 2020 through June 30, 2021. This audit will determine whether MassHealth's COOP ensured that the more than 1.8 million members to whom MassHealth provides coverage receive continual coverage through emergencies.

- OSA will conduct a review of MassHealth claims submitted by Dr. Nicholas Franco for the period July 1, 2015 through December 31, 2020. This audit will determine whether dental services provided to MassHealth members were properly supported by documentation and allowable in accordance with certain MassHealth regulations.

- OSA will conduct a review of MassHealth claims submitted by Dr. Melissa Hamilton for the period July 1, 2015 through December 31, 2020. This audit will determine whether dental services

9. Capitation payments are set payments to a managed care organization (MCO) from MassHealth to provide healthcare for its members. These payments are paid monthly for each MassHealth member enrolled in the MCO.

provided to MassHealth members were properly supported by documentation and allowable in accordance with certain MassHealth regulations.

# 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 (PAR) 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 reporting period, OSA issued, and MassHealth completed, one PAR survey for 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/s. Because the voluntary surveys are sent to MassHealth six months after the audit ends, not all of the audits conducted from March 15, 2020 through March 12, 2021 are included in this section of the report, as those surveys have not been completed yet.

According to the survey results received, MassHealth and its providers reported that it has acted on implementing both recommendations. A summary of the audit survey follows.

## 1. Office of Medicaid (MassHealth)—Review of Estate Recovery

| | |
|---|---|
| **Audit No.** | 2019-1374-3M4 |
| **Issue Date** | June 28, 2021 |
| **PAR Survey Date** | December 14, 2021 |
| **Total Recommendations** | 2 |
| **Fully Implemented Recommendations** | 2 |
| **Recommendations in Progress** | N/A |
| **Fiscal Benefit** | N/A |

The finding from the audit of MassHealth's estate recovery process was that MassHealth's estate recovery might cause some families undue financial hardship. Specifically, although MassHealth allows undue-hardship waivers, only a small number of members' survivors actually petition for them and even fewer are approved. The resulting financial hardship could place a burden on families. Also, MassHealth pursues estate recovery amounts below $25,000, which may not be cost effective.

In its PAR survey, MassHealth stated that it had fully implemented our recommendations.