OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

Official Audit Report – Issued December 31, 2024

Office of Medicaid (MassHealth)— Review of Capitation Payments with Multiple Identification Numbers

For the period January 1, 2019 through December 31, 2022

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OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

December 31, 2024

Kate Walsh, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Walsh:

I am pleased to provide to you the results of the enclosed performance audit of MassHealth. As is typically the case, this report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2019 through December 31, 2022. As you know, my audit team discussed the contents of this report with agency managers. This report reflects those comments.

I appreciate you and all your efforts at MassHealth. The cooperation and assistance provided to my staff during the audit went a long way toward a smooth process. Thank you for encouraging and making available your team. I am available to discuss this audit if you or your team has any questions.

Best regards,

Diana DiZoglio
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
HHS OIG	US Department of Health and Human Services Office of Inspector General
ID	identification number
MCO	managed care organization
MDM	master data management
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
SSN	Social Security number
T-MSIS	Transformed Medicaid Statistical Information System

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services, within the US Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

In collaboration with the US Department of Health and Human Services Office of Inspector General's Boston office, OSA has conducted an audit of capitation payments made by MassHealth to members with multiple identification numbers (IDs) for the period January 1, 2019 through December 31, 2022. During this period, MassHealth made approximately $3.2 billion total in capitation payments to its two contracted managed care organizations (MCOs), which were Tufts Health Together and WellSense Essential MCO. These MCOs were responsible for providing healthcare services to members and were paid a fee per person (the capitation payment) for coordinating their care.

The purpose of this audit was to determine whether MassHealth ensured that it did not make capitation payments to MCOs on behalf of members who were assigned more than one member ID. OSA conducted the audit as part of our ongoing independent statutory oversight of the state's Medicaid program.

Below is a summary of our finding, the effect of our finding, and our recommendations, with links to each page listed.

Finding 1 **Page 11**	MassHealth made capitation payments on behalf of members with multiple IDs.
Effect	Not ensuring that all MassHealth members are assigned only one member ID creates a higher-than-acceptable risk that payments may be improper. MassHealth could have used this money to provide additional services to other MassHealth members or reduce the cost of its services to the Commonwealth.

Recommendations Page 12	1. MassHealth should require that all members flagged by data matches submit documentation to confirm their identity. If the member does not provide documentation, then MassHealth should either pause the member's coverage or move the member to its fee-for-service model until it can determine whether the member's coverage should be terminated. 2. MassHealth should investigate and resolve all instances where its data matches indicate that a member has been assigned more than one member ID. 3. MassHealth should implement a match criterion that focuses solely on Social Security Numbers (SSNs). Because an SSN should be unique to each individual, a targeted match criterion that only includes an SSN would reduce the prevalence of multiple IDs by 19%, based on our sample testing.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth annually provides access to healthcare services for approximately 2.5 million eligible children, families, seniors, and people with disabilities, all of whom have low or moderate incomes. In fiscal year 2023, MassHealth paid healthcare providers more than $18.1 billion in total, of which approximately 35% was funded by the Commonwealth. Medicaid expenditures represent approximately 35% of the Commonwealth's total fiscal year 2023 budget. Below is a chart of MassHealth's 2023 income standards and federal poverty guidelines.

Family Size	MassHealth Income Limit (Annually)	100% Federal Poverty Level	133% Federal Poverty Level	150% Federal Poverty Level
1	$6,264	$14,580	$19,392	$21,876
2	$7,800	$19,728	$26,232	$29,580
3	$9,300	$24,864	$33,072	$37,296
4	$10,692	$30,000	$39,900	$45,000
5	$12,192	$35,148	$46,740	$52,716
6	$13,692	$40,284	$53,580	$60,420
7	$15,192	$45,420	$60,420	$68,136
8	$16,596	$50,568	$67,248	$75,840

Managed Care Program

MassHealth's Managed Care Program consists of two managed care organizations (MCOs), Tufts Health Together and WellSense Essential MCO, which provide healthcare services to members through managed care plans. Each managed care plan assigns members a group of doctors and other healthcare providers who work together to provide members with coordinated healthcare services. The doctors and other healthcare providers contractually agree to follow certain federal and state requirements about how they provide services. MCO enrollees select a primary care physician to provide basic healthcare and make any necessary specialist referrals. MassHealth pays the MCO a capitation payment, which is a set amount of money for each enrolled person assigned to them, per period of time, whether or not that person seeks care. The amount paid is based on each patient's average expected healthcare utilization, with payments for patients generally varying by age and health status. Rating categories are based on risk factors for each

member, such as whether the member needs facility-based care (e.g., a skilled nursing facility) or behavioral health treatment.

Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) is a database maintained by the federal Centers for Medicare and Medicaid Services. T-MSIS contains Medicaid data from all 50 states, the District of Columbia, and US territories to maintain an accurate, up-to-date, and complete dataset, containing eligibility, enrollment, and healthcare service claims data about Medicaid members. The Centers for Medicare and Medicaid Services use this data to manage Medicaid programs and aid in the detection of fraud, waste, and abuse.

Medicaid Management Information System and Identity Matches

The Medicaid Management Information System (MMIS) is the claim processing and data warehouse system used by MassHealth. MMIS contains various types of information, such as healthcare information about services provided to MassHealth members and billing submission data, and is used for processing data, verifying eligibility, and running reports that identify medical treatment.

Section 502.007(A)(1) of Title 130 of the Code of Massachusetts Regulations (CMR) states that MassHealth reviews eligibility of members "by information matching with other agencies, health insurance carriers, and information sources."

In addition, according to 130 CMR 502.004, "the MassHealth agency may initiate information matches with other agencies and information sources when an application is received, at annual renewal, and periodically, in order to update or verify eligibility."

According to 130 CMR 516.004, these other agencies include the following:

> *Federal Data Services Hub, the Department of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Social Security Administration, Systematic Alien Verification for Entitlements, Department of Transitional Assistance, and health insurance carriers.*

Members who are eligible for MassHealth coverage are provided a unique 12-digit alphanumeric member identification number (ID) that is generated by MMIS after receiving a transaction (application) from an

eligibility system, such as MA-21 or the Health Insurance Exchange.[1] When MMIS receives a transaction from an eligibility system, MMIS tries to find a member's existing ID through match criteria. MMIS automatically performs eight different matches in succession to identify whether a MassHealth member already has a member ID. According to MassHealth's Current Match Criteria document, the eight matches are as follows:

Match 1

Mass Health Member IDs match . . .

Match 2

First and Last Names Match
Other Agency IDs and Agency Source Match . . .

Match 3

First and Last Names Match
[Social Security Numbers (SSNs)] Match (Primary SSN matches Primary SSN)
[Date of Birth (DOB)] Match . . .

Match 4

First and Last Names Match
SSN's Match (Primary SSN matches Primary or Other SSNs),
2 out of the 3 DOB components (YYYY MM DD) match . . .

Match 5

First Initial of First Names Match
Last Names Match
SSN's Match (Primary SSN matches Primary or Other SSNs)
DOB Match
Gender Match . . .

Match 6

First 4 Letters of the First Name Match
Last Names Match, Gender Match
2 out of the 3 DOB components (YYYY MM DD) match
SSN's Match (Primary SSN matches Primary or Other SSNs) . . .

1. Commonwealth residents can apply for health insurance through the Health Insurance Exchange—if applicants are 65 or younger—or the MA-21 system—if applicants are older than 65 and/or require long-term care.

Match 7

SSN's Match (Primary SSN matches Primary or Other SSNs)
Gender Match
AND
[(2 or 3 of the 3 DOB components (YYYY MM DD) match AND
First 4 Letters of the First Name Match)
OR
(DOB and First Initial of First Name Match)] . . .

Match 8

Final match if no match was found on Matches 1-7.
Matches on First Name, Last Name, DOB, Gender and Zip. [SSN] is not considered.

If a member is not identified in MMIS through the previous eight matches, MMIS uses master data management (MDM) probabilistic-based matching approach, which is another method used to find similarities between two or more member IDs. MDM is a modular system used to perform sophisticated matching that is separate from MMIS, the claims processing system, and the eligibility systems. If the member is not found with an existing ID, MMIS will generate a new member ID.

Recovery Process

According to 130 CMR 515.010,

> *The MassHealth agency has the right to recover payment of medical benefits to which the member was not entitled at the time the benefit was received, regardless of who was responsible and whether or not there was fraudulent intent.*

MCOs are paid a fee per person, or per capita, for the coordination of care. If a person has two member IDs, the MCO would receive two capitation payments (based on their two member IDs) but would be coordinating care for only one individual. In these instances, the Commonwealth should recoup the cost of the unnecessary capitation payment that was caused by the multiple member IDs. When multiple IDs are identified through MMIS or MDM, and subsequently linked, there are three components to the recovery cleanup process. The first component involves an automated reconciliation that runs from the middle to end of each month in MMIS, that is constantly paying and recouping capitation payments for members with multiple IDs that are identified and linked. The system automatically looks back three months from the date of linkage to recoup payments made on behalf of inactive and duplicate IDs. The second component involves annual reconciliation reports, which are completed only when requested. The

third component relates to the recovery process running on an as-needed basis for member-specific reconciliation for specific time frames.

Manual Ticket Process

In scenarios where the MMIS match approach or the MDM approach do not uncover multiple IDs for the same member, MassHealth can institute a manual ticket process. There are different ways MassHealth can learn of the prevalence of multiple IDs for the same person that the MMIS and/or MDM processes did not catch. For example, MassHealth staff members can detect multiple IDs when processing eligibility transactions originating from other state agencies. Managed care entities will detect multiple IDs and subsequently send MassHealth reports as well. In these cases, MassHealth creates a ticket to have to the IDs linked and start the recoupment process, if necessary.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of certain activities of MassHealth for the period January 1, 2019 through December 31, 2022.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed further in the audit report.

Objective	Conclusion
1. Did MassHealth ensure that capitation payments were not made on behalf of Medicaid beneficiaries who were assigned multiple identification numbers (IDs) in accordance with Sections 450.235(A), 450.237, 450.259(A), and 450.307(B) of Title 130 of the Code of Massachusetts Regulations, and Sections 433.312 and 438.2 of Title 42 of the Code of Federal Regulations?	**No; see Finding 1**

To accomplish our audit objective, we gained an understanding of the internal control environment relevant to the objective by reviewing applicable policies and procedures and MassHealth's internal control plan, and by conducting inquiries with MassHealth officials. In addition, we performed the procedures described below to obtain sufficient, appropriate evidence to address the audit objective.

Sample Strategy

To determine whether MassHealth ensured that it did not make capitation payments to managed care organizations (MCOs) on behalf of enrollees assigned more than one member ID, we obtained the capitation payment data file from the Transformed Medicaid Statistical Information System (T-MSIS) provided by the US Department of Health and Human Services Office of Inspector General (HHS OIG). The T-MSIS data file included capitation payments made during the audit period, January 1, 2019 through December 31, 2022.

OSA collaborated with HHS OIG to design a statistically[2] valid sampling methodology. HHS OIG and OSA chose a sample with a 90% confidence level[3] and a 50% expected error rate.[4] The data was then separated to show instances where MassHealth made at least $100 in MCO capitation payments for 3,678 enrollee matches for the same service month,[5] totaling $20,474,899, during the audit period. An enrollee match consisted of when more than one member ID was associated with (1) the same Social Security Number (SSN) or (2) the same first four characters of the first name, first five characters of the last name, date of birth, and gender. The data below details the five strata to which each member was assigned for our data analysis purposes. HHS OIG and OSA then selected a random, statistical sample of 115 members out of the total 3,678 enrollee matches in the audit population.

Stratum	Description	Dollar Range per Person in Stratum	Number of MassHealth Members	Population Dollar Value	Sample Size
1	Match by SSN	$100–$5,199	2,221	$ 3,500,857	21
2	Match by SSN	$5,200–$18,699	577	5,724,792	25
3	Match by SSN	$18,700–$80,000	156	5,115,932	23
4	Match by select information	$100–$80,000	709	4,241,073	31
5	Any match	Greater than $80,000	15	1,892,245	15
Totals			3,678	$ 20,474,899	115

Multiple IDs

For each of the 115 members with multiple IDs in our sample, we entered each unique member ID in the Medicaid Management Information System (MMIS) to determine whether each unique ID belonged to the same person. We then investigated further as to whether the IDs were linked in MMIS, indicating that the IDs were for the same person. If linkage had occurred, the link history would display the member's current member ID, whether the ID was active or inactive, and the date processed for the linked IDs. In

2. Auditors use statistical sampling to select items for audit testing when a population is large and contains similar items. Auditors generally use a statistical software program to choose a random sample when sampling is used. The results of testing using statistical sampling, unlike those from judgmental sampling, can usually be used to make conclusions or projections about entire populations.
3. Confidence level is a mathematically based measure of the auditor's assurance that the sample results (statistic) are representative of the population (parameter), expressed as a percentage.
4. Expected error rate is the number of errors that are expected in the population, expressed as a percentage. It is based on the auditor's knowledge of factors such as prior year results, the understanding of controls gained in planning, or a probe sample.
5. These matches fall into the eight categories of matches described in the "Medicaid Management Information System and Identity Matches" section of this report.

instances where multiple IDs for the same member had not been linked, we searched MyWorkspace, a web-based system that archives documents used to apply for MassHealth coverage through eligibility systems, such as the Health Insurance Exchange or MA-21. We did this to determine whether the documents retained in the system contained any personally identifiable information that would provide evidence that a person had multiple IDs. Lastly, for members with multiple IDs confirmed and determined to be linked, we requested evidence of any duplicate payments being recouped.

Data Reliability Assessment

For the T-MSIS data file provided to us by HHS OIG, we performed validity and integrity tests on the data, including (1) testing for blank fields, (2) testing for duplicates, (3) looking for dates outside the audit period, and (4) checking data fields for validity errors. Based on these procedures, we determined that the data obtained was sufficiently reliable for the purposes of this audit.

To determine the reliability of the data pulled from MMIS, we relied on the work performed by OSA in a separate project, completed in 2022, that tested certain information system controls in MMIS. As part of that work, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable MassHealth officials about the data. As part of our current audit, we selected a random sample of 30 capitation payments in MMIS and traced the payment amounts, payment dates, and beneficiary names to data obtained by HHS OIG from T-MSIS. Based on these procedures, we determined that the data obtained was sufficiently reliable for the purposes of this audit.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth made capitation payments on behalf of members with multiple identification numbers.

During the audit period, out of our sample of 115 members, MassHealth incorrectly made capitation payments on behalf of 107 members. Specifically, we determined that 67 members out of these 107 members had linked identification numbers (IDs) within MassHealth's Medicaid Management Information System (MMIS), indicating that MassHealth was aware they were the same person. In addition, 14 members out of the 107 members had multiple IDs that were not linked in the system. Upon inquiry by the audit team, MassHealth agreed that they were the same person. Finally, 26 members out of the 107 members were not linked in MMIS, and MassHealth did not have supporting documentation to determine whether they were the same person.

Summary of Issues

	Number of Members from Our Sample of 115	Total Dollar Amount Overpaid
Member IDs linked in MMIS	67	$ 622,885
Member IDs not linked in MMIS but determined to be the same person	14	31,918
MassHealth unable to determine whether member IDs were for the same person	26	18,143
Total	107*	$ 672,946

* For the remaining 8 cases in our sample population, which we knew had multiple member IDs, MassHealth made the capitation payments correctly.

Because we collaborated with the US Department of Health and Human Services Office of Inspector General (HHS OIG) to pull a statistical sample, HHS OIG's statistician was able to project the results of our testing to the full population and, based on this sample, projected that MassHealth made an estimated $3,813,827 in capitation payments to managed care organizations on behalf of members who were assigned more than one member ID.

Not ensuring that all MassHealth members are assigned only one member ID creates a higher-than-acceptable risk that payments may be improper. MassHealth could have used this money to provide additional services to other MassHealth members or reduce the cost of its services to the Commonwealth.

Authoritative Guidance

Section 450.235(A) of Title 130 of the Code of Massachusetts Regulations (CMR) states,

> *Overpayments include . . . payments to a provider . . .*
>
> *(7) for services billed that result in a duplicate payment; or*
>
> *(8) in an amount that a federal or state agency (other than the MassHealth agency) has determined to be an overpayment.*

According to 130 CMR 450.237, "The existence and amount of overpayment may be determined in an action to recover the overpayment. . . . The MassHealth agency may also determine the existence and amount of overpayments."

Section 433.312(a) of Title 42 of the Code of Federal Regulations states,

> *(1) The State Medicaid agency has 1 year from the date of discovery of an overpayment to a provider to recover or seek to recover the overpayment before the Federal share must be refunded to [the Centers for Medicare and Medicaid Services].*
>
> *(2) The State Medicaid agency must refund the Federal share of overpayments at the end of the 1-year period following discovery in accordance with the requirements of this subpart, whether or not the State has recovered the overpayment from the provider.*

Reasons for the Issue

MassHealth does not have monitoring controls over its match criteria to prevent multiple IDs from being assigned when the Social Security number (SSN) matches. In addition, the MassHealth recovery process did not recoup capitation payments made on behalf of the same person even after MassHealth determined multiple IDs to be for the same person.

Recommendations

1. MassHealth should require that all members flagged by data matches submit documentation to confirm their identity. If the member does not provide documentation, then MassHealth should either pause the member's coverage or move the member to its fee-for-service model until it can determine whether the member's coverage should be terminated.
2. MassHealth should investigate and resolve all instances where its data matches indicate that a member has been assigned more than one member ID.

3. MassHealth should implement a match criterion that focuses solely on SSNs. Because an SSN should be unique to each individual, a targeted match criterion that only includes an SSN would reduce the prevalence of multiple IDs by 19%, based on our sample testing.

Auditee's Response

Specific to the three issues noted in the finding, MassHealth responded with the following:

> ***Member IDs linked in MMIS:*** *The majority of identified overpayments ($622,885 out of $672,946) result from capitation payments made for 67 cases where [member IDs (MIDs)] were linked by MassHealth after the implementation of our enhanced [master data management (MDM)] identification process. MassHealth has reviewed and addressed or is in the process of addressing these resulting overpayments. MassHealth's use of MDM reports to identify and investigate potential cases of multiple MIDs in 2022 resulted in a significant number of cases being linked after the point in time when resulting duplicate capitation payments from 2019, 2020, and 2021 would have been recouped within MMIS. Overpayments made in 2019 and 2020 were not recoverable as MassHealth does not pursue overpayments nor account for underpayments made to managed care entities after the closure of its risk-sharing reconciliation process for that rate year. However, MassHealth was able to recoup [Office of the State Auditor (OSA)]-identified 2021 overpayments associated with linked members made to [accountable care organization] and MCO plans as part of its risk-sharing reconciliation process for rate year 2021. Finally, MassHealth will pursue recoupment for a small amount of 2022 capitation payments associated with three cases that were linked later in 2023 and 2024. Going forward, MassHealth's timely identification and review of any multiple MID cases will result in duplicate capitation payments to be collected within MMIS.*
>
> ***Member IDs not linked in MMIS but determined to be the same person:*** *Based upon MassHealth's review of the OSA's findings, 7 cases that remained unlinked were due to MIDs being associated with an inactive benefit. MassHealth's review of duplicate MIDs is limited to cases where both MIDs are associated with active benefits that result in duplicate capitation payments. For these cases, by the time the MDM enhancements were implemented in 2022, at least one of the MIDs had an inactive benefit. MassHealth notes that these cases account for a smaller overpayment amount of $31,918 over the course of the four-year audit period.*
>
> ***MassHealth unable to determine whether member IDs were for the same person:*** *MassHealth respectfully disagrees with the OSA characterization of the 26 cases under this category. While MassHealth recognizes these cases as instances of multiple MIDs being associated with the same individual, MassHealth is unable to link these cases due to privacy concerns. In certain cases, particularly for children in the care and custody of the Department of Children and Families (DCF), it has been MassHealth's policy to not link certain MIDs. For example, in order to prevent the biological parent from having access to the new family's information, multiple IDs for adopted children are not linked without prior authorization from DCF. MassHealth recognizes that the policy not to link these members may result in duplicate capitation payments made to managed care entities. MassHealth notes that these cases reflected the smallest share of identified overpayments at $18,143. While this policy affects a relatively small number of cases and associated capitation payments, MassHealth will explore new means of preventing and recouping these duplicate payments without risking the privacy of the associated members.*

Specific to our recommendations, MassHealth responded with the following:

> ***Recommendation 1:*** *MassHealth will investigate the feasibility of establishing a process to request further documentation where MassHealth is unable to determine if two [member IDs (MIDs)] are associated with the same individual. MassHealth notes that the majority of cases can be determined via the information submitted through members' applications and external data sources. The cases where [the Office of the State Auditor (OSA)] determined the MIDs cannot be confirmed as the same person instead reflect a policy decision to not link members where there is a privacy concern as described above. MassHealth will explore an alternative course of action for this small subset members to prevent and recoup duplicate capitation payments made in these cases. . . .*
>
> ***Recommendation 2:*** *MassHealth believes that it has established the system infrastructure as well as policies and procedures to comprehensively identify and investigate potential MID duplicates. As stated above, MassHealth's MDM program both prevents the creation of multiple MIDs for the same individual as well as produces routine reports that MassHealth uses to link members with more than one MID. In addition, these routine reports allow MassHealth to investigate cases in a timely manner that ensures any duplicate capitation payments are recouped. . . .*
>
> ***Recommendation 3:*** *MassHealth disagrees with this recommendation. Because MassHealth may receive inaccurate social security numbers due to typographical errors, preventing the creation of an MID due to a matching social security number with no other matches across personal information may result in delayed enrollment for members and impact their access to care. However, in most cases, MassHealth's existing controls prevent the creation of multiple MIDs for an individual where the social security number matches. For those cases where multiple MIDs are created, MDM's regular reporting of potential duplicates allow MassHealth to link MIDs in time to ensure any duplicate capitation payments are ultimately recouped and prevented going forward.*

Auditor's Reply

For the three different issues identified in the finding, MassHealth has provided additional information on how it plans to recoup the duplicative payments, the reasons for the multiple IDs, and enhancements to its procedures for identifying multiple IDs and recouping duplicative payments. MassHealth does disagree with our third issue, where MassHealth was unable to determine whether member IDs were for the same person. MassHealth believes that these individuals should not be linked in MMIS because of high privacy concerns associated with these types of members. We understand the level of privacy needed for these individuals and do not recommend that MassHealth link them. Rather, we recommend that MassHealth investigate these cases further, flag these members internally in the system, perform additional identifying procedures, and recoup duplicative payments. This would not result in providing any personal

information to unauthorized personnel members. We do commend MassHealth as it agrees to explore new ways to prevent and recoup duplicative payments.

For our first recommendation, MassHealth agrees with our recommendation and is exploring new ways to prevent and recoup duplicative payments.

MassHealth believes that it has established policies and procedures that relate to our second recommendation and believes that the majority of our finding is from before the implementation of the master data management program; however, there were still 14 members who were not linked and should have been, resulting in $31,918 in duplicative payments. In addition, of the 67 cases linked, most of those duplicative payments have not been recouped. We encourage MassHealth to actively pursue recoupment for these payments and we will follow up in six months.

Lastly, MassHealth disagrees with our recommendation to implement a match criterion that focuses solely on SSNs because it may result in a delay of enrollment. We do not recommend delaying enrollment for any member; however, if an application comes in with the same SNN as an existing MassHealth member, MassHealth should perform additional procedures to investigate the reason for the two members having the same SSN.