OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

Official Audit Report – Issued October 30, 2025

Office of Medicaid (MassHealth)—Review of Durable Medical Equipment Providers

For the period January 1, 2021 through December 31, 2023

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OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

October 30, 2025

Dr. Kiame Mahaniah, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Mahaniah:

I am pleased to provide you with 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, 2021 through December 31, 2023. 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 your team available. 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

DME	durable medical equipment
DNP	Do Not Pay
DPH	Department of Public Health
LEIE	List of Excluded Individuals and Entities
MMIS	Medicaid Management Information System
NPI	national provider identifier
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help 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, administers the Medicare program and works with state governments to administer state Medicaid programs.

OSA has conducted a performance audit of MassHealth's durable medical equipment (DME) providers for the period January 1, 2021 through December 31, 2023. During this period, MassHealth paid $165,475,809 for 2,282,131 DME claims. The purpose of this audit was to determine whether MassHealth monitored billing and authorization practices for DME providers and prescribers and monitored various death records to ensure that DME was not ordered for or prescribed to members who had already passed away.

This audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. Several of our previously issued audit reports disclosed weaknesses in MassHealth's claim processing system and improper billing practices by MassHealth providers, which identified millions of dollars in potentially improper payments. As with any government program, public confidence is essential to the success and continued support for public expenditures, such as the state's Medicaid program. Our audit is designed to identify issues that will help improve the Medicaid program, so taxpayers know that their dollars are spent prudently and that there is a system of continuous improvement to support improved efficiency and service over time.

Below is a summary of our findings, the effects of those findings, and our recommendations, with hyperlinks to each page listed.

Finding 1 **Page 9**	MassHealth paid an estimated $521,526 for DME that could not be verified as having been ordered by an eligible provider.
Effect	When providers submit claims for DME to MassHealth without the relevant information required to identify the ordering provider, MassHealth risks paying for DME that was not ordered by an eligible provider. Unsupported DME claims represent unallowable costs to the Commonwealth, and 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 10**	1. MassHealth should not pay claims for DME that do not have a licensed provider's name and national provider identifier on the associated DME order form. 2. MassHealth should investigate the claims identified in this finding and recoup any overpayments that it deems appropriate.
Finding 2 **Page 11**	MassHealth paid $31,724 for DME that was ordered by providers who were excluded from participating in Medicaid.
Effect	MassHealth members may be put at risk when excluded providers are allowed to continue ordering DME on their behalf because they may be prescribed DME that they do not need by providers who are no longer licensed to prescribe it. Additionally, if MassHealth pays claims for DME prescribed by excluded providers, MassHealth is spending money that could have been used to provide additional services to other MassHealth members or reduce the cost of its services to the Commonwealth.
Recommendations **Page 12**	1. MassHealth should develop procedures that deny any claims that are ordered, referred, or prescribed by providers who are excluded from participating in Medicaid or providers whose medical licenses are suspended or terminated. 2. MassHealth should investigate the claims identified in this finding and recoup any overpayments that it deems appropriate.
Finding 3 **Page 13**	MassHealth paid providers $27,400 for DME that was ordered for members who were deceased.
Effect	By not always identifying deceased members quickly enough, MassHealth risks paying fraudulent claims or overpaying its providers for services that were not rendered.
Recommendations **Page 13**	1. MassHealth should investigate the claims identified in this finding and recoup overpayments that it deems appropriate. 2. MassHealth should find a way to address the lag that occurs between a member's death and when that death is entered into the Medicaid Management Information System. MassHealth should also use additional data sources to confirm whether a member is deceased.

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 $17.1 billion in total, of which approximately 35% was funded by the Commonwealth. These Medicaid program expenditures represented approximately 33% of the Commonwealth's total fiscal year 2023 budget.

Durable Medical Equipment

Durable medical equipment (DME) refers to medical devices that can withstand repeated use and are primarily used to serve a medical purpose. Some examples of DME covered by MassHealth include the following:

- ambulatory equipment, such as crutches or canes;
- mobility equipment, such as wheelchairs and scooters;
- nutritional supplements;
- glucose monitors and other diabetic supplies; and
- personal emergency response systems, such as Life Alert.

DME must be ordered by a provider for medically necessary purposes for MassHealth members. When a DME provider bills MassHealth, it must also include the name and national provider identifier (NPI) of the ordering provider on the MassHealth claim.

MassHealth Payments After Member Death

Before paying a claim, MassHealth uses the Department of Public Health's (DPH's) Vital Statistics File to flag any claims where the associated MassHealth member has a date of death occurring before the date of service listed on the claim. After an investigator reviews this file, if the claim is found to be for a member who was deceased before the date of service, MassHealth denies the claim. This procedure relies on DPH's Vital Statistics File being complete and up to date when the MassHealth claim is processed. Once claims are processed and paid, MassHealth's vendors perform additional procedures by running reports every

one to two years on claims data, with the purpose of identifying claims paid for members who are deceased. Previously, MassHealth's process for identifying improper payments made for services occurring after a member's death only used DPH's Vital Statistics File. However, in January 2024, MassHealth updated its procedures for member death verification to include multiple data sources; the agency no longer relies solely on DPH's Vital Statistics File. This update was in response to a previous audit of MassHealth (Audit No. 2023-1374-3M1), in which we used a variety a death data sources and found that MassHealth paid providers $11,797 for 109 claims for services allegedly rendered to 31 members who were proven to be deceased at the time services were rendered.

Medicaid Provider Exclusions

Pursuant to Section 1128 of the Social Security Act, the US Department of Health and Human Services Office of the Inspector General (HHS OIG) has the authority to exclude individuals and entities from federally funded healthcare programs. Providers can be excluded for several reasons, including being found guilty of Medicare or Medicaid fraud; having recorded instances of misconduct with patients, including abuse or neglect; unlawfully prescribing controlled substances; and providing unnecessary or substandard services.

HHS OIG maintains the List of Excluded Individuals and Entities (LEIE), which is available for download on its website. The LEIE is updated monthly with providers who have become ineligible to participate in Medicare or Medicaid. The HHS OIG website also provides guidance to state Medicaid agencies about how they should use the LEIE to prevent improper payments.

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, 2021 through December 31, 2023.

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 a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did MassHealth ensure that durable medical equipment (DME) was not ordered for its members by providers who are excluded from participating in the Medicaid program?	**No; see Findings 1 and 2**
2. Did MassHealth ensure that it did not pay for DME for deceased members?	**No; see Finding 3**

To achieve our audit objectives, we gained an understanding of the internal control environment related to the objectives by reviewing applicable MassHealth policies and procedures related to ensuring that billing providers and ordering providers are not excluded from participating in Medicaid, as well as ensuring that DME is not ordered for MassHealth members who are deceased. In addition, we performed the procedures described below to obtain sufficient, appropriate audit evidence to address the audit objective.

DME Ordering by Excluded Providers

To determine whether MassHealth ensured that DME was not ordered for members by providers excluded from participating in the Medicaid program, we obtained data from the Medicaid Management Information System (MMIS) regarding all 2,282,131 paid claims for DME during the audit period. We filtered the data to identify 152,592 DME claims that did not have an associated ordering provider name and national provider identifier (NPI). We targeted the top five DME providers who did not include the

ordering provider's name and NPI on their associated DME claims. We then stratified the targeted population from these five DME providers into two strata, which consisted of paid claims under $1,000 (Stratum 1) and paid claims of $1,000 or more (Stratum 2). We selected a random, statistical[1] sample of 131 out of 152,592 claims in Stratum 1 and a nonstatistical[2] sample of 60 out of 975 claims in Stratum 2. For our statistical sample in Stratum 1, we used a 90% confidence level,[3] a 50% expected error rate,[4] and a 15% desired precision range.[5] We projected an error for the sampled claims in Stratum 1 to the 152,592 claims in the population for Stratum 1 to estimate a potential overpayment. We did not project an error rate for claims in the sample for Stratum 2 because we used nonstatistical sampling.

For the claims selected from both strata, we inspected order forms for DME to determine whether they were signed by a MassHealth provider and included the provider's NPI. We also inspected the associated MassHealth claim forms to determine whether the ordering provider's NPI was included on the MassHealth claim. We cross-referenced the ordering provider's NPI to the US Department of Health and Human Services Office of Inspector General's (HHS OIG's) List of Excluded Individuals and Entities (LEIE) and MassHealth's Excluded Provider List to determine whether the ordering providers for the sampled claims were eligible to order DME for MassHealth members. See Finding 1 for more information.

For the remaining 2,071,727 DME claims that included the ordering providers' names and NPIs, we matched MMIS data to HHS OIG's LEIE and MassHealth's Excluded Provider List and determined whether the ordering providers were excluded on or before the date of service by examining exclusion letters sent by MassHealth to the ordering provider. See Finding 2 for more information.

1. Auditors use statistical sampling to select items for audit testing when a population is large (usually over 1,000) and contains similar items. Auditors generally use a statistics software program to choose a random sample when statistical 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.
2. Auditors use nonstatistical sampling to select items for audit testing when a population is very small, the population items are not similar enough, or there are specific items in the population that the auditors want to review.
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. Desired precision range is the range of likely values within which the true population value should lie; also called confidence interval. For example, if the interval is 90%, the auditor will set an upper confidence limit and a lower confidence where 90% of transactions fall within those limits.

DME for Deceased Members

To determine whether MassHealth ensured that it did not pay for DME ordered for members who were deceased, we provided the US Department of the Treasury's Do Not Pay (DNP) service with an MMIS data extract of 2,282,131 DME claims paid by MassHealth during the audit period. DNP matched these claims to the following databases to determine whether any of the claims were paid by MassHealth after the member's date of death, according to its website:

Database Name	Description of Data Source
American InfoSource (AIS) Obituary & Probate – Commercial	Contains obituary and probate information on deceased individuals obtained from over 3,000 funeral homes, thousands of newspapers, and county-level probate records
Death Master File Full (DMF-Full)	Contains records of deaths reported to the Social Security Administration (SSA). The deaths reported to SSA come from many sources, including family members, funeral homes, financial institutions, postal authorities, state information, and other federal agencies
Department of Defense Death Data (DOD) – Public	Contains information on active-duty U.S. military and Reserves regarding confirmed or presumed deaths
Department of State Death Data (DOS) – Public	Contains records of American Citizens who are deceased or presumed deceased while abroad, as reported by US embassies or consulates upon its receipt of a foreign death certificate or finding of death by a local competent authority
Electronic Verification of Vital Events Fact of Death (EVVE FOD) Commercial	Contains information about death certificates contained within the vital records databases of participating states and jurisdictions

Source: DNP (https://fiscal.treasury.gov/dnp/search.html)

DNP's death matching identified 11,332 MassHealth members in our population with dates of death. We filtered this result to identify 211 MassHealth members with two or more DME claims paid after their dates of death. We then verified the dates of death provided by DNP for 211 MassHealth members by performing internet searches to cross-reference these dates of death with obituary records from newspapers and funeral homes. We cross-referenced four data points (the names, dates of birth, and places of residence that we obtained from MMIS, as well as the dates of death provided by DNP) with obituary records that we found online. See Finding 3 for more information.

Data Reliability Assessment

To test the reliability of the MMIS data, we relied on the work performed by OSA in a separate project completed in 2023 that tested certain information system controls in MMIS. As part of this work, OSA

reviewed existing information, tested selected system controls, and interviewed agency officials who were knowledgeable about the data. Additionally, we performed validity and integrity tests on all claim data from the audit period, including (1) testing for blank fields, (2) scanning for duplicate records, and (3) looking for dates outside the audit period. We also matched a judgmental sample of 40 paid DME claims to their corresponding hardcopy claim forms.

Based on the results of the data reliability assessment procedures described above, we determined that the information we obtained during the course of our audit was sufficiently reliable for the purposes of our audit.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth paid an estimated $521,526 for durable medical equipment that could not be verified as having been ordered by an eligible provider.

We found that MassHealth paid for 34 durable medical equipment (DME) claims that could not be verified as having been ordered by an eligible provider.

Specifically, in Stratum 1 of our targeted population, we identified 30 DME claims that were missing provider information on the associated DME order forms. Some of these claims were missing the provider's name, some did not include the provider's national provider identifier (NPI), and we did not receive some order forms at all. We extrapolated the test results related to these claims to the entire population of Stratum 1 and estimated, with 90% confidence, that MassHealth made overpayments of at least $493,211 for DME that had missing or incomplete provider information on the associated DME order forms. As a result, we were unable to verify with absolute certainty whether the provider listed on the order form was the provider who actually ordered the DME.

Additionally, we calculated an overpayment of $28,315 related to 4 paid DME claims in Stratum 2. We did not extrapolate an estimated overpayment for the claims in Stratum 2 because it was a nonstatistical sample.

When providers submit claims for DME to MassHealth without the relevant information required to identify the ordering provider, MassHealth risks paying for DME that was not ordered by an eligible provider. Unsupported DME claims represent unallowable costs to the Commonwealth, and 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 1902(kk)(7) of the Social Security Act states the following:

> *The State requires—*
>
> *(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and*

(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

Reasons for Issue

MassHealth officials told us that claim denials for missing ordering provider information were paused in March 2020 because of the COVID-19 public health emergency. MassHealth lifted this pause in September 2023 when it again started denying claims that had missing ordering provider information.

Recommendations

1. MassHealth should not pay claims for DME that do not have a licensed provider's name and NPI on the associated DME order form.
2. MassHealth should investigate the claims identified in this finding and recoup any overpayments that it deems appropriate.

Auditee's Response

As announced in MassHealth's All Provider Bulletin (APB) 286, MassHealth established pre-pay claims edits in September 2019 that denied claims that did not provide an NPI for an ordering, referring or prescribing [(ORP)] provider enrolled with MassHealth. In March 2020, to reduce providers' administrative burden as much as possible during the COVID-19 Public Health Emergency (PHE), MassHealth temporarily suspended this edit. The edit was reinstated as of July 2023 per MassHealth APB 361. The [Office of the State Auditor's (OSA's)] audit period falls within this period of temporary flexibility to reduce provider burden. . . . Going forward, MassHealth's pre-pay edits will prevent claims from being paid that do not provide an NPI of a MassHealth-enrolled ORP provider.

MassHealth agrees with [Recommendation 1]. MassHealth notes that items (such as a licensed provider's name and NPI) missing from a DME order form identified on post pay audits performed by our Third Party Administrator (TPA) would result in recoupment of the claim. MassHealth routinely performs these audits of DME providers to ensure providers maintain appropriate documentation associated with DME claims. . . .

MassHealth agrees with [Recommendation 2]. MassHealth will review the claims identified by the OSA and carry out recovery processes as appropriate.

Auditor's Reply

Based on its response, MassHealth is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

2. MassHealth paid $31,724 for durable medical equipment that was ordered by providers who were excluded from participating in Medicaid.

During the audit period, MassHealth paid 605 claims for DME that were ordered by 15 providers who were excluded from participating in Medicaid. We also found that 8 of these 15 providers had their medical licenses suspended or terminated by the Massachusetts Board of Registration in Medicine before the date of service for the associated DME claims. This resulted in an overpayment of $31,724 by MassHealth to DME providers, which is detailed in the table below.

Exclusion Type	Number of Claims	Overpayment
7 Ordering Providers Excluded from MassHealth	471	$27,224
8 Ordering Providers Excluded from MassHealth and Whose Medical License Was Suspended or Terminated	134	4,500
Total	605	$31,724

MassHealth members may be put at risk when excluded providers are allowed to continue ordering DME on their behalf because they may be prescribed DME that they do not need by providers who are no longer licensed to prescribe it. Additionally, if MassHealth pays claims for DME prescribed by excluded providers, MassHealth is spending money that could have been used to provide additional services to other MassHealth members or reduce the cost of its services to the Commonwealth.

Authoritative Guidance

Section 1902(kk)(7) of the Social Security Act states,

> *The State requires—*
>
> *(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider.*

Section 450.212(A) of Title 130 of the Code of Massachusetts Regulations states,

> *To be eligible to participate in MassHealth as any provider type, a provider must . . . be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type.*

Reasons for Issue

MassHealth relies on a comprehensive process to identify ineligible MassHealth providers and flag them in the Medicaid Management Information System (MMIS). The 15 providers associated with this finding

were flagged as inactive in MMIS, and the associated claims for DME ordered by the 15 inactive providers were flagged by system edits in MMIS. However, MassHealth's system edits operate on a post-payment basis; therefore, the claims were paid anyway and never recouped after a formal review.

Recommendations

1. MassHealth should develop procedures that deny any claims that are ordered, referred, or prescribed by providers who are excluded from participating in Medicaid or providers whose medical licenses are suspended or terminated.

2. MassHealth should investigate the claims identified in this finding and recoup any overpayments that it deems appropriate.

Auditee's Response

As announced in MassHealth's All Provider Bulletin (APB) 286, MassHealth established pre-pay claims edits in September 2019 that denied claims that did not provide an NPI for an ordering, referring or prescribing [(ORP)] provider enrolled with MassHealth. In March 2020, to reduce providers' administrative burden as much as possible during the COVID-19 Public Health Emergency (PHE), MassHealth temporarily suspended this edit. The edit was reinstated as of July 2023 per MassHealth APB 361. The [Office of the State Auditor's (OSA's)] audit period falls within this period of temporary flexibility to reduce provider burden, which explains Finding 2. Going forward, MassHealth's pre-pay edits will prevent claims from being paid that do not provide an NPI of a MassHealth-enrolled ORP provider.

As noted in All Provider Bulletin (APB) 361, MassHealth reestablished pre-pay edits effective July 1, 2023, that will prevent payment for DME claims with an excluded provider listed as the OPR provider.

For services that require an ORP and have dates of service on or after July 1, 2023, claims will be denied if they do not meet the following ORP requirements:

- *The National Provider Identifier (NPI) or the ORP provider must be included on the claim.*
- *The ORP provider must be an authorized ORP provider type (see list on page 2 of APB 286).*

APB 361 further established that, for dates of service on or after September 1, 2023, claims will deny if they do not meet the ORP requirement that the ORP provider must be enrolled with MassHealth (see page 2 of APB 361).

MassHealth believes that these requirements and associated edits capture DME that was ordered by providers who were excluded from participating in Medicaid, including providers whose medical licenses are suspended or terminated, and prevent the overpayments identified in this audit going forward as of July 1, 2023 and September 1, 2023. . . .

MassHealth agrees with [Recommendation 2]. MassHealth will review the claims identified by the OSA and carry out the recovery process as appropriate.

Auditor's Reply

Based on its response, MassHealth is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

3. MassHealth paid providers $27,400 for durable medical equipment that was ordered for members who were deceased.

We identified 865 claims, totaling $27,400 paid by MassHealth, for DME that was allegedly provided to 131 members who we proved to be deceased before the date of service indicated on the claim. We found that MassHealth paid for DME for these 131 deceased members for an average of 516 days after their dates of death and up to 2,779 days after their dates of death.

By not always identifying deceased members quickly enough, MassHealth risks paying fraudulent claims or overpaying its providers for services that were not rendered.

Authoritative Guidance

According to Section 450.235(A) of Title 130 of the Code of Massachusetts Regulations, "Overpayments include, but are not limited to, payments to a provider . . . for services that were not actually provided or that were provided to a person who was not a member on the date of service."

Reasons for Issue

MassHealth officials told us that, although they have program integrity controls in place to prevent some inappropriate payments for deceased members, there may still be a delay between the actual date of death for a MassHealth member and when that date is entered into the Medicaid Management Information System (MMIS). This can result in the payment of claims after a member's date of death.

Recommendations

1. MassHealth should investigate the claims identified in this finding and recoup overpayments that it deems appropriate.
2. MassHealth should find a way to address the lag that occurs between a member's death and when that death is entered into MMIS. MassHealth should also use additional data sources to confirm whether a member is deceased.

Auditee's Response

MassHealth agrees with [Recommendation 1]. MassHealth will review the claims identified by the [Office of the State Auditor (OSA)] and carry out the recovery process as appropriate. MassHealth notes that 381 of the 895 claims in the OSA's finding have already been identified in MassHealth's ongoing post-pay recovery process. Upon review of the OSA's findings, MassHealth was unable to verify the date of death for one member and had verified a more recent date of death for another member, accounting for an additional 47 of the 895 claims identified by the OSA and the claims with the most days between the claim's date of service and the member's date of death. The remaining claims reflect cases where the member's date of death was not present in our available death data sources at the time of our most recent analysis or MassHealth received a different date of death via an existing death data source. MassHealth will ensure that all remaining overpayments identified are validated and recovered as appropriate. . . .

MassHealth has robust program integrity controls to identify members' dates of death and prevent ***or*** *recoup payment for services made after a member's date of death. MassHealth obtains information about deceased members in multiple ways, including but not limited to, the Department of Public Heath Vital Statistics Date of Death File, the Social Security Administration's Death Master File (DMF) and State Verifications and Exchanges System (SVES), as well as referrals from members' head of households, providers, managed care entities and other state and federal agencies.*

Because MassHealth's death data sources may report a member's date of death months or years after the member's death, MassHealth is reliant on routine post-pay recoveries to capture any services that were paid after a member's date of death but prior to notification to MassHealth's. MassHealth has recently increased the frequency of these reviews to occur annually, and because these reviews assess claims up to six years old, the vast majority of claims paid after a member's date of death are ultimately recouped even when a death data source identifies a date of death years after the member's death. In addition, MassHealth will continue to collaborate with state and federal agencies to access new sources of death data to improve the identification members' dates of death.

Auditor's Reply

MassHealth stated that it has increased the frequency of post-payment reviews and continues to collaborate with state and federal agencies to improve the quality of its death data. As part of our post-audit review process, we will follow up on this matter in approximately six months.