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**INDEPENDENT STATE AUDITOR'S REPORT
ON CERTAIN ACTIVITIES OF
THE MEDICAID PROGRAM
ADMINISTERED BY MASSHEALTH**

**OFFICIAL AUDIT
REPORT
OCTOBER 13, 2005**

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INTRODUCTION

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The Executive Office of Health and Human Services (EOHHS) is the largest secretariat in the Commonwealth, with a budget that accounts for approximately 40% of the Commonwealth's total operating expenditures. Within EOHHS, the Office of Medicaid administers the Commonwealth's Medicaid program (MassHealth).

In fiscal year 2005, MassHealth covered approximately 988,000 people in Massachusetts, and the program's benefit payments totaled \$6.3 billion, of which the federal share is 50%. MassHealth spending accounts for approximately 25% of total Commonwealth expenditures. The Commonwealth processes approximately 75 million claims annually from more than 26,000 providers that participate in the MassHealth program.

The Commonwealth is primarily responsible for developing methods and implementing procedures for Medicaid fraud and abuse detection. This responsibility includes ensuring the legitimacy of providers' billings, detecting improper payments, recovering overpayments, and referring suspected cases of fraud to law enforcement. Because of growing concerns about the size and growth of this program, we have conducted an audit to determine the effectiveness of the Commonwealth's program administration in fulfilling its oversight responsibilities specifically related to combating fraud and abuse.

The objectives of this review were to determine: (1) the extent of the oversight of the Commonwealth's Medicaid program; (2) the nature and extent of methods and criteria for identifying and investigating improper payments, fraud, and abuse; (3) measures, including legal action, in place to institute recovery of overpayments and funds obtained fraudulently; (4) measures in place to sanction providers; (5) the amount of funds devoted to program monitoring efforts, and whether there has been an increase or decrease in monitoring funding and staffing levels, both in total and as a percentage of total expenditures; and (6) the degree of collaboration with other state and federal agencies to determine the extent and effectiveness in identifying fraud and abuse cases, as well as investigating and prosecuting fraud.

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Although improper payments due to fraud and abuse exist in the Commonwealth's Medicaid program, the extent of these improper payments has not been measured and is, therefore unknown. Moreover, MassHealth has neither the resources nor the internal controls to effectively detect and deter fraud. As a result, there is little assurance that safeguards exist to prevent loss, theft, or misuse.

According to the United States Government Accountability Office (GAO), formerly the General Accounting Office, and health insurance industry sources, between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. If improper payments due to fraud and abuse in the Massachusetts Medicaid program during the period our review focused on, fiscal years 2001-2003, were

within the 3% to 10% range, it would mean a loss of between \$471 million and \$1.57 billion. During that period the Commonwealth recovered \$287.7 million for various reasons, of which only \$17.2 million was recovered as a result of fraud and abuse, or approximately one cent of every hundred dollars expended. However, if these losses were as much as 10%, or ten dollars of every hundred expended, over \$1.5 billion may remain undetected.

In January 2003, the GAO for the first time placed the US Medicaid Program on its list of government programs that are at “High Risk” of fraud, waste, abuse or mismanagement. GAO stated “like other healthcare payers, Medicaid is vulnerable to waste, fraud and abuse by providers who submit inappropriate claims. The hundreds of millions of dollars in improper payments that a few states have identified in recent years suggests that states have a potential for considerable savings through increased efforts to safeguard program payments”. As a result of the GAO’s action, the United States House of Representatives Energy and Commerce Committee in June 2003 initiated an investigation into Medicaid waste, fraud, and abuse stating, “Such a risk demands immediate attention in a program of this vast size and projected growth.”

In Massachusetts the resources dedicated to the detection of fraud in the Medicaid Program do not match the potential scale of the problem. In fiscal years 2001-2003, the Office of Medicaid expended \$15.7 billion and processed 215 million claims from more than 26,000 providers. That is approximately 290,000 claims and \$21,000,000 per workday. The Internal Control and External Audit Department monthly reviews 550 among the largest claims. In addition, from approximately 6,000,000 claims per month, 450 Explanation of Benefit (EOB) forms are sent to recipients requiring confirmation of services. The post-payment oversight of these claims is minor compared with the Medicaid program’s vast size. The federal Centers for Medicare and Medicaid Services (CMS), moreover, project that expenditures on healthcare services will grow by over 7% per year over the next decade, and Medicaid spending nationally will grow a percentage point or two faster than that.

Although the Office of Medicaid currently spends more than \$6 billion annually, or approximately 25% of Commonwealth expenditures, it does not have an independent internal audit function. The MassHealth Operations Group does have an Internal Control and External Audit Department, which reports to the Deputy Director of MassHealth Operations and the Medicaid Director, but there is no independent internal audit department that reports to an executive independent from MassHealth. Conclusive provider desk audits are few, and onsite provider audits are seldom performed. For the three years covered by our review only 51 provider fraud and abuse cases were referred to the Massachusetts Medicaid Fraud Control Unit in the Office of the Attorney General. Also, MassHealth is procuring a new Medicaid Management Information System (MMIS); however, minimal provisions for fraud- and abuse-identification controls currently exist in the proposed system.

In addition to a lack of provider audits, the investigation of the background of providers of service in the re-credentialing process was suspended after fiscal year 2001 due to budget constraints. Re-credentialing refers to any change in licensure, certification, qualifications, ownership, or data that may affect participation in MassHealth. This deficiency increases the risk that unqualified and undesirable providers are participating in the Medicaid program.

Oversight activities are decentralized within MassHealth, and a central control unit for monitoring and oversight of Medicaid payments does not exist. CMS noted in a review of the Massachusetts Medicaid Program that the fraud and abuse control functions were so widely dispersed among internal DMA components that MassHealth may want to consider instituting more formal coordination to ensure the most efficient use of all of these resources and effective communication among them.

Based on the results of our review, we have made several recommendations that, if adopted, would improve MassHealth's oversight of the Commonwealth's Medicaid Program. The recommendations are summarized as follows:

- Acknowledge the existence of undetected fraud and abuse and initiate an aggressive program to detect and deter fraud.
- Accept the responsibility for designing and implementing programs and internal controls to prevent fraudulent activities.
- Expand use of the Transaction Review and Audit Processing System (TRAPS), a web based system used for utilization review and surveillance, in identifying illegal activities by providers.
- Establish an internal audit unit with the resources to perform regularly scheduled and unannounced audits of the various departments within EOHHS. Additionally, the unit should conduct surprise provider audits that include the verification of delivery of services. Not only will this activity be valuable in detecting fraud and abuse; it will also have a sentinel effect on the provider community.
- Reinstate re-credentialing of providers in order to ensure that they have appropriate credentials to participate in MassHealth.
- Implement the CMS recommendation by instituting more formal coordination of data collection to ensure the most efficient use of all resources and effective communication among them.
- Ensure that the new MMIS system includes adequate fraud and abuse identification/controls and that implementation includes an independent quality assurance component.
- Better utilize the resources of external investigative agencies, such as the Attorney General's Medicaid Fraud Control Unit and the Office of the State Auditor's Bureau of Special Investigations, by increasing referrals of suspected fraud and abuse.

In its response to the audit report, MassHealth stated, in part, the following:

- MassHealth agrees that fraud and abuse exist, but it has extensive systems, functions, and operations in place and believes it can improve. EOHHS has recently procured the services of a contractor to perform a gap analysis of all current program integrity activities in the MassHealth program. The analysis will be completed in July 2005 and will include a comprehensive review and thorough analysis of all current provider and member work activities associated with

- program integrity, including fraud and abuse prevention and detection; an industry comparison of program integrity efforts, including recommendations for best practice, and the most efficient and cost-effective approaches to ensure program integrity; and recommendations to improve policies, practices, processes, and procedures.
- MassHealth sought and obtained approval in 2003 to participate in the Payment Accuracy Measurement (PAM) demonstration project funded by CMS. The PAM objectives were to (1) contribute to a common PAM methodology to be used by all state Medicaid programs in the future; (2) determine a claim payment accuracy measure for Massachusetts in accordance with standards and requirements outlined by CMS; and (3) identify opportunities for improvement. Improper payments encompassed by the project ranged from legitimate services with missing documentation to provider fraud and abuse. MassHealth recently completed its participation in PAM and, in accordance with the procedures prescribed by CMS, found that its overall payment accuracy rate was 97.12%. Though MassHealth is not satisfied with any level of inaccurate payment, the project establishes an important benchmark for MassHealth. It is addressing specific inaccurate payments and assessing the reasons for them, with a view toward refining and improving the payment processes.
 - MassHealth's new MMIS system, anticipated to be operational by August 2007, is expected to be an improvement over the existing system and to enhance the agency's ability to detect and deter inappropriate claims. MassHealth will be working with the new vendor to ensure that specific requirements to detect fraud and abuse are incorporated. Also, the TRAPS contract has been extended.
 - MassHealth will be conducting provider audits during the implementation and construction phase of the new MMIS. It is also planning a wide range of risk management and mitigation strategies.
 - As of July 1, 2005, MassHealth will be resuming the formal process of re-credentialing existing providers; it will verify the credentials of all providers applying to participate in the program, and work closely with the Board of Registration in Medicine, the Division of Professional Licensure, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against currently enrolled providers.
 - Finally, MassHealth emphasizes aggressive management of its front-end program processes to ensure that services provided are medically necessary and provided by qualified healthcare providers to eligible residents of the Commonwealth, and that payments are appropriately made. Ongoing efforts to combat fraud, waste, and abuse, including utilization management and regular program and clinical review, are central to all program areas. Sophisticated information systems support MassHealth's efforts to detect inappropriate billings before payment is made and to ensure that eligibility determinations are accurate. With the program's focus on front-end detection of waste, fraud, and abuse, MassHealth avoids making inappropriate expenditures and deters providers inclined toward fraud from attempting it. The success of MassHealth's program integrity efforts

cannot be measured merely by cost-recovery statistics but must also take into consideration considerable efforts to keep fraud, waste, and abuse out of the program.

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INTRODUCTION

Background

The Executive Office of Health and Human Services (EOHHS) is the largest secretariat in the Commonwealth, with a budget that equals approximately 40% of the Commonwealth's total operating expenditures. Within EOHHS, the Office of Medicaid (MassHealth) administers the Medicaid program. In fiscal year 2005, MassHealth covered approximately 988,000 people in Massachusetts, and the program's benefit payments totaled \$6.3 billion, of which the federal share is 50%. MassHealth spending accounts for approximately 25% of total Commonwealth expenditures. The Commonwealth processes approximately 75 million claims annually from more than 26,000 providers that participate in the MassHealth program.

Prior to 2003, the Massachusetts Division of Medical Assistance (DMA) was the single state agency responsible for administering Medicaid as provided for under Title XIX¹ of the Social Security Act. In 2003, the reorganization of EOHHS combined Medicaid and the Children's Health Insurance Program (CHIP), as provided for under Title XXI² of the Social Security Act, in MassHealth, which also manages the Insurance Partnership for small businesses.

Chapter 26, Section 15, of the Acts of 2003 requires EOHHS to be organized so that it serves as the principal agency of the executive department for the following purposes: (a) developing, coordinating, administering, and managing the health, welfare, and human services operations, policies, and programs; (b) supervising and managing the organization and conduct of the business affairs of the departments, commissions, offices, boards, divisions, institutions, and other entities within the executive office to improve administrative efficiency and program effectiveness and to preserve fiscal resources; (c) developing and implementing effective policies, regulations, and programs to ensure the coordination and quality of services provided by the secretary and all of the departments, agencies, commissions, offices, boards, and divisions; (d) acting as the single state

¹ Social Security Act Title XIX: "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States that have submitted, and had approved by the Secretary of EOHHS."

² Social Security Act Title XXI: "The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."

agency under section 1902 (a) (5) of the Social Security Act authorized to supervise and administer the state programs under Title XIX, for the programs under Titles IV (A), IV (B), IV (E), XX, and XXI of the Social Security Act, and for the programs under the Rehabilitation Act; and (e) maximizing federal financial participation for all agencies, departments, offices, divisions, and commissions within the executive office.

The EOHHS includes the following: (1) the Department of Elder Affairs, under the direction of a Secretary of Elder Affairs, who is appointed by the Governor; (2) the Office of Health Services, which includes the Department of Public Health, the Department of Mental Health, MassHealth, and the Betsy Lehman Center for Patient Safety and Medical Error Reduction; (3) the Office of Children, Youth and Family Services, which includes the Department of Social Services, the Department of Transitional Assistance, the Department of Youth Services, the Office of Child Care Services, the Child Abuse Prevention Board, and the Office for Refugees and Immigrants; (4) the Office of Disabilities and Community Services, which includes the Department of Mental Retardation, the Massachusetts Rehabilitation Commission, the Massachusetts Commission for the Blind, the Massachusetts Commission for the Deaf and Hard of Hearing, the Soldiers' Home in Massachusetts (Chelsea), and the Soldiers' Home in Holyoke; and (5) the Department of Veterans' Services, under the direction of the Secretary of Veterans' Services, who is appointed by the Governor.

Audit Scope, Objectives, and Methodology

In accordance with Chapter 11, Section 12, of the General Laws, we conducted a review of MassHealth. Our audit was conducted in compliance with applicable generally accepted government auditing standards and included a review of MassHealth's policies and activities relating to the Medicaid Program. Our objectives were to review (1) the extent of the oversight of Medicaid programs; (2) the nature and extent of methods and criteria for identifying and investigating improper payments, fraud, and abuse; (3) measures in place to institute recoveries of overpayments and funds obtained fraudulently, including legal action; (4) measures in place to sanction providers; (5) the amount of funds devoted to program monitoring efforts and whether there has been an increase or decrease in monitoring funding and staffing levels, both in total and as a percentage of total expenditures; and (6) the extent of collaboration efforts with other state and federal agencies to

determine the degree of effectiveness in identifying fraud and abuse cases, as well as investigating and prosecuting fraud.

We were provided operational and procedural information and explanations from MassHealth managers and directors from the Internal Control and External Audit Department, Office of Member Services and Provider Operations, the Utilization Management/Program Integrity Unit, Coordination of Benefits and Recovery Unit, the Division's Financial Compliance Unit, the Information Technology Division, the Medicaid Fraud Control Unit of the Attorney General's Office, and UMASS Medical School personnel operating under an Interagency Service Agreement with MassHealth. Furthermore, we reviewed an extensive selection of relevant documents and research by government and private organizations.

The focus of our review encompassed fiscal years 2001, 2002 and 2003, for which we were provided financial data on the overall administration of the program.

AUDIT RESULTS

IMPROVEMENTS NEEDED IN MEDICAID FRAUD AND ABUSE DETECTION EFFORTS

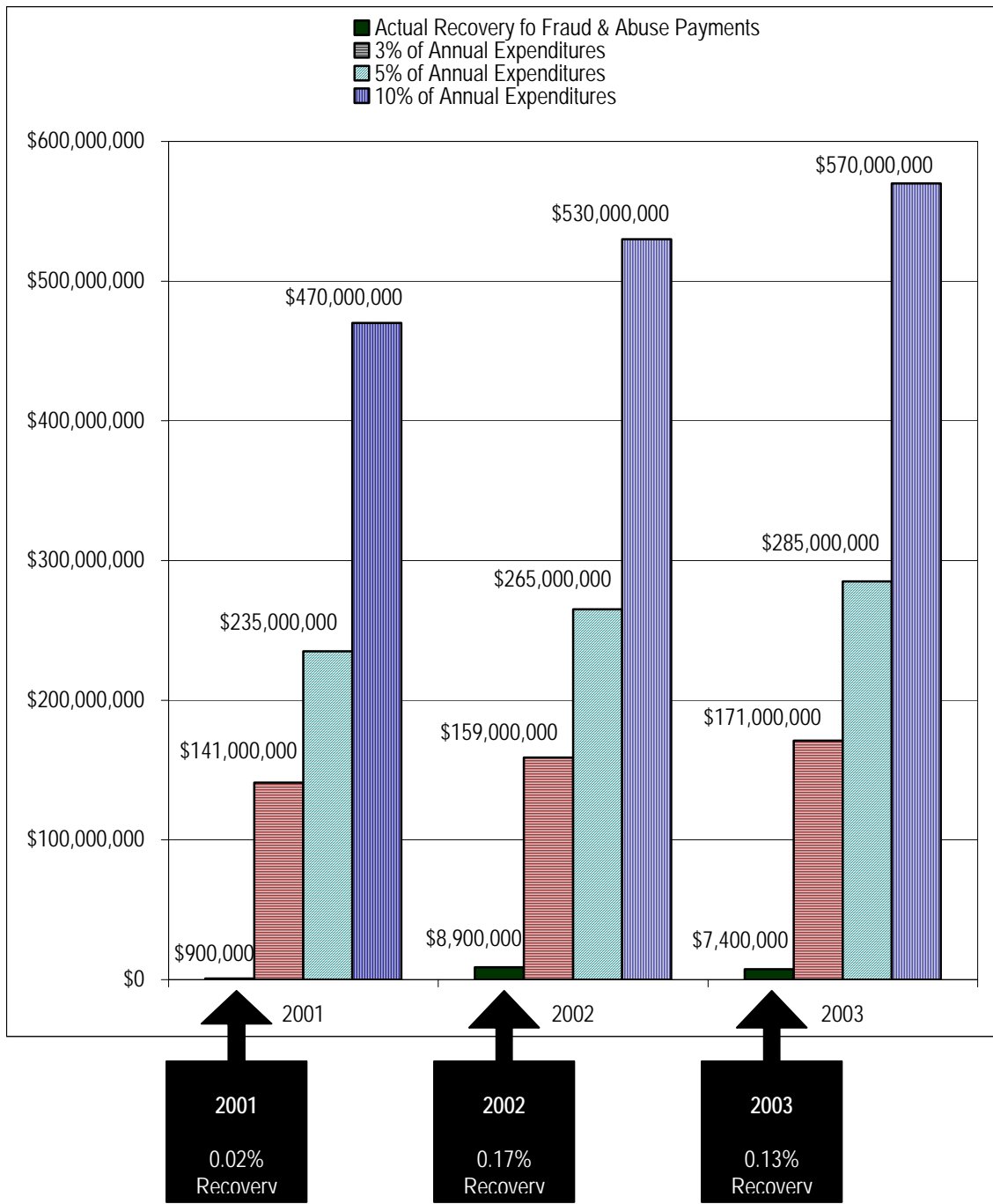
Although improper payments due to fraud and abuse exist in the Commonwealth's Medicaid program, the extent of these improper payments has not been measured and is, therefore, unknown. It has been reported by the United States Government Accountability Office (GAO), formerly the General Accounting Office, and healthcare industry sources, that between 3% and 10% of total healthcare costs are the result of fraudulent or abusive practices by unscrupulous healthcare providers.

According to MassHealth, for fiscal years 2001-2003, the results of its review of fraud and abuse are as follows:

- \$17.2 million of improper payments due to fraud and abuse were recovered.
- 51 provider cases were referred to the Massachusetts Medicaid Fraud Control Unit (MFCU) in the Office of the Attorney General. (The MFCU also received referrals from other sources, including private entities and federal and state agencies.)
- 56 providers were sanctioned.
- Approximately 3,600 member (not provider) cases were referred to the Office of the State Auditor's Bureau of Special Investigations (BSI) from the Department of Transitional Assistance (DTA) and MassHealth.

If improper payments due to fraud and abuse in the Massachusetts Medicaid program during fiscal years 2001-2003 were between 3% and 10%, it would mean a loss of between \$471 million and \$1.57 billion. During that period, the Commonwealth recovered \$287.7 million—or approximately 11% of the expended amounts—for various reasons (errors, medical necessity, ineligible claims, improper claims, etc.), of which only \$17.2 million was recovered as a result of fraud and abuse, which is approximately *one cent* of every hundred dollars expended; however, if these losses were as much as 10%, or *ten dollars* of every hundred expended, in excess of \$1.5 billion may remain undetected. The Commonwealth recovered 1/100th of the potential fraud and abuse that may exist, according to GAO's estimate.

The following chart shows potential levels of fraud and abuse—3%, 5%, and 10%—in Commonwealth Medicaid expenditures and the actual amount recovered for fiscal years 2001-2003:



*Actual recoveries represent referrals made to the MFCU by MassHealth (See Appendix I).

For fiscal year 2003 alone, Medicaid expenditures were \$5.7 billion, and \$7.4 million of fraud and abuse payments were recovered; therefore, if fraud and abuse payments were at a 10% level, approximately \$563 million could have passed through the system undetected.

The Office of Medicaid does not know the extent of improper payments made due to fraud and abuse, because it has neither the resources nor the controls to effectively detect, measure, and deter fraud. Furthermore, MassHealth's oversight activities are decentralized; and although overpayments have been detected, no central control unit exists for monitoring and oversight of Medicaid payments.

The federal Centers for Medicare and Medicaid Services (CMS) noted in a review of the Massachusetts Medicaid program published in July 2002 that the fraud and abuse control functions were widely dispersed among internal MassHealth components. CMS suggested that MassHealth consider instituting more formal coordination to ensure the most efficient use of and effective communication among the control resources used. Also, the request for responses (RFR) by the Executive Office of Health and Human Services (EOHHS) for a new Medicaid Management Information System (MMIS) details the dispersed state of the current system:

MassHealth is currently supported by a variety of disparate systems, desktop applications, and technical workarounds—an assemblage of short-term solutions that are quickly becoming unsustainable in the long term. The number of workarounds and crosswalk tables required supporting the current, homegrown MassHealth MMIS, especially in the new HIPAA-standardized world, as well as the interfaces with other agency systems is large; and the effort to maintain this environment is even larger.

The monitoring and oversight of the decentralized MassHealth units, in addition to the Program Integrity Unit at the University of Massachusetts Medical School (UMMS) and the MFCU at the Office of the Attorney General, include the following:

- The Office of Member Services evaluates member eligibility and maintains records on approximately 987,000 members.
- The Provider Operations Group is responsible for provider credentialing and maintains records on approximately 26,000 providers.
- The Utilization Management/Program Integrity Unit ensures that MassHealth members receive cost-effective, medically necessary, and good-quality care. This unit oversees the Acute Hospital Utilization Management Program, which conducted 7,990 prepayment medical-necessity reviews and 2,459 post-payment medical-necessity reviews. It also

oversees the Chronic Disease/Rehabilitation Hospital Utilization Management Program and Program Review.

- The Coordination of Benefits and Recovery Unit ascertain whether MassHealth is the payer of last resort. This unit recovered approximately \$69,100,000 in overpayments from insurers during fiscal year 2003.
- The Financial Compliance Unit conducted 198 nursing home and hospital audits that resulted in the recovery of \$6,300,000 in overpayments in fiscal year 2003.
- The Management Minutes Questionnaire (MMQ) of the Case Mix Medical Audits of Nursing Facilities produced approximately \$800,000 in recoveries.
- The Prior Authorization Unit reviewed 186,985 cases of certain medical procedures by providers.
- Member Services each month sends explanation of medical benefits (EOMB) to 450-500 members regarding claims received during the preceding 90 days. A 10% reply is usual, and this practice has not led to the identification of fraud and abuse.
- The Internal Control and External Audit Department reviews on a monthly basis the 50 largest claims in each of 11 provider categories. Additionally, the staff reviews an estimated 450 explanation of benefits (EOBs) monthly but has not identified significant issues.

Also, the Massachusetts Medicaid Program was granted federal funding for a Payment Accuracy Measurement (PAM) Program, capped at \$1 million for the period September 30, 2003 through September 29, 2004. The project is designed to estimate payment accuracy in the Medicaid program and State Children's Health Insurance Program; it is not intended to enhance the detection of fraud and abuse in the program.

In January 2003, the GAO placed Medicaid on its list of government programs at high risk of fraud, waste, abuse, or mismanagement. The GAO's High-Risk Series: An Update, stated, in part:

Growing concern about the size, growth, and fiscal oversight of the Medicaid program has led us to include the program on our 2003 high-risk list. Medicaid pays for both acute health care and long-term care services for over 44 million low-income Americans and is the third largest social program in the federal budget (after Social Security and Medicare). Financed jointly by the federal government and the states, Medicaid consists of more than 50 distinct "state" programs that together cost \$228 billion in fiscal year 2001, accounts for more than 20 percent of states' total expenditures, and is projected to double in spending in a decade. The federal government pays from half to more than three-fourths of each state's Medicaid expenditures....

Another area of concern involves federal and state efforts to ensure that payments are accurate and appropriate. Like other health care payers, Medicaid is vulnerable to waste, fraud, and abuse by providers who submit inappropriate claims. The hundreds of millions of dollars in improper payments that a few states have identified in recent years suggest that states have the potential for considerable savings through increased efforts to safeguard program payments.

The exploitation of Medicaid not only penalizes taxpayers, but also jeopardizes the viability of a program that over 44 million low-income Americans depend on for essential health and long-term care services....

As a result of GAO's placement of the Medicaid Program on the high-risk list of government programs, the United States House Energy and Commerce Committee Chairman, along with the Health Subcommittee and the Oversight and Investigations Subcommittee, sent a letter on June 12, 2003 to the governors of all the states, informing them of the committee's investigation of Medicaid abuse, requesting their cooperation, and stating that such a risk demands immediate attention in a program of such vast size and projected growth. The results of this investigation had not yet been published as of the end of our audit fieldwork. The Congressional Budget Office projected Medicaid expenditures to double over the next 9 to 10 years.

A national team from CMS's Medicaid Alliance for Program Safeguards (the Alliance) reviewed the Massachusetts Medicaid program integrity policies and procedures for fiscal year 2002. CMS, formerly the Health Care Financing Administration (HCFA), provides technical assistance, guidance, and oversight to the states, which are primarily responsible for policing fraud in the Medicaid program.

The Alliance's review of the Massachusetts program found that the Commonwealth was complying with all of the required Medicaid program integrity laws and regulations as outlined in the review guide. However, the review also noted several areas that were worthy of attention and improvement. The review team was also interested in learning how other components of MassHealth identify, receive, and use information about potential fraud and abuse involving providers participating in the Medicaid program. The review found that MassHealth needed to do more in the area of the prevention, identification, and referral of fraud and abuse in Medicaid:

DMA needs to do more, however, to guide the efforts that the plans have taken independently, particularly with 66 percent of the Commonwealth's Medicaid eligibles enrolled in mandatory managed care. DMA cannot effectively accomplish its own responsibilities under Federal law and regulations to detect and deter fraud and abuse

unless it clearly defines and articulates DMA's expectations with respect to the prevention, identification and referral of fraud and abuse in Medicaid.

According to public-opinion surveys commissioned by the American Association of Retired Persons (AARP) on the issue of healthcare fraud and abuse, 83% of consumers said they believe fraud is either extremely widespread or somewhat widespread; 76% said their own healthcare would improve if more were done to reduce healthcare fraud; 76% said they were unaware of efforts to reduce healthcare fraud; 53% said they believe healthcare fraud is increasing; and when asked the question, "If you register a complaint about suspected healthcare fraud, do you think that the government or insurance company will do anything on your behalf?" half of respondents said "yes," and half said "no."

The Office of Medicaid needs to improve its internal controls to detect and deter fraud in the Medicaid program. MassHealth has front-end policies and procedures to process its claims. It is likely that some of the claims rejected in this front-end process were for abuse, but not likely fraud. Fraud and abuse detection is not the primary objective of the policies, procedures, and systems currently used to ensure cost containment, payment processing, payment accuracy, medical need, and eligibility of claims for Medicaid payments. The primary objective of the front-end procedures is to facilitate the delivery of and payment for high-quality, affordable healthcare to those in need.

The Office of Medicaid has found that post-payment reviews, including provider audits, have been an effective method to detect and deter fraud. Post-payment claim reviews are done mainly with the Transaction Review and Audit Processing System (TRAPS), a Web-based system surveillance and utilization review subsystem for identifying healthcare fraud, waste, abuse, and improper utilization. TRAPS is contracted through UMMS, primarily to produce algorithms for identifying and collecting overpayments that are not fraud but billing errors. It is anticipated that the TRAPS contract will be terminated because of the development of a new MassHealth-administered system. EOHHS issued an RFR for the design, development, testing, implementation, and operation of a state-of-the-art Medicaid Management Information System (new MMIS) on April 27, 2004. The RFR anticipates that the Web-based software application TRAPS will be eliminated when the new MMIS, which will include a data warehouse, is online. There is minimal mention and focus in the RFR to the detection and deterrence of fraud and abuse.

The Internal Control and External Audit Department (ICEAD) at MassHealth selects and reviews an estimated 450 EOB forms per month (or 0.006% of paid claims). Significant findings have not resulted from these reviews. The reviews are limited in scope and not in compliance with General Law Chapter 118E, Section 38, which requires verification of the accuracy of the bills submitted through the application of statistical sampling methods:

Providers shall submit to the division a bill for goods sold and services rendered not later than ninety days after the goods are sold or the services rendered, and the division shall verify no less than ten percent of said bills with the recipient of said goods or services. The division shall require that the provider maintain proof, subject to audit, of the actual delivery to recipients of services and goods for which bills are submitted. The division shall verify the accuracy of bills submitted under this section through the application of statistical sampling methods.

Every month, ICEAD also reviews the 50 largest claims in each of the 11 provider categories—a total of 550 claims (or 0.008% of paid claims) per month. No significant findings have been made from these reviews. Successful perpetrators of fraud may be shrewd enough to avoid being in the top 50. Post-payment review systems are underutilized, conclusive provider desk audits are few, and onsite provider audits are seldom performed.

The Statement on Auditing Standards (SAS) No. 99 issued by the Auditing Standards Board of the American Institute of Certified Public Accountants increases management's responsibility for fraud prevention, deterrence, and detection. It states that an organization retains the sole responsibility for designing and implementing programs and internal controls to prevent fraudulent activities.

Although often discussed jointly, “fraud” and “abuse” are not synonymous. Each requires separate and distinct procedures for analysis, surveillance, detection, and deterrence. Although systems are in place to detect and deter abuse at the Office of Medicaid, it has neither adequate systems nor resources to detect and deter fraud. Systems and controls used to detect abusive billings are often no protection against fraudulent acts. It is important to establish independent methods for the detection and prevention of both fraud and abuse.

The 42 Code of Federal Regulation (CFR) 455.2 defines abuse and fraud as follows:

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet

professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

The Office of Medicaid heavily relies on front-end procedures for the deterrence of fraud and abuse. However, those procedures are primarily intended to ensure cost containment, payment processing, payment accuracy, medical need, and eligibility of claims for Medicaid payments. Such procedures are largely ineffective in the detection and deterrence of fraud. Rather, post-payment reviews should be used, with onsite provider audits as an integral part of the process.

The extent of improper payments due to fraud in the Medicaid program within MassHealth has not been measured, nor has a risk assessment been performed. As a result, the Office of Medicaid cannot evaluate the adequacy or effectiveness of its internal controls to detect and deter fraud.

The following is an extract from “Medicaid Financial Management—Better Oversight of State Claims for Federal Reimbursement Needed,” which is the testimony and statement of Linda M. Calbom, Director, GAO, Financial Management and Assurance, before the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives:

As discussed in our February 2002 report, we found that CMS has financial oversight weaknesses that leave the Medicaid program vulnerable to improper payments. The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers perform risk assessments, act to mitigate identified risks, and then monitor the effectiveness of those actions. In addition, the standards provide that agencies should ensure that the organizational structure is designed so that authority and responsibility for internal controls are clear. CMS oversight had weaknesses in each of these four areas, which I will discuss in turn.

Our review found that CMS had only recently begun to assess areas at greatest risk for improper payments. As a result, controls were not in place that focused on the highest risk areas and resources had not yet been deployed to areas of greatest risk. The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers perform risk assessments and then act to mitigate identified risks that could impede achievement of agency objectives.

It would be prudent for state agency managers of the Medicaid program to employ the same safeguards as recommended for federal agency (CMS) managers.

The Commonwealth's Office of Medicaid cannot take appropriate actions to help control a nationally recognized crisis if it does not know the size of the problem. Accordingly, it would be prudent for the agency to conduct an independent audit to more accurately determine the actual extent of improper payments due to fraud and abuse in the Medicaid program.

The resources dedicated to the detection of fraud in the Medicaid Program do not match up to the potential scale of the problem. The Office of Medicaid expended \$15.7 billion and processed 215 million claims from over 26,000 providers in fiscal years 2001-2003, or some 290,000 claims and \$21,000,000 per working day. Each month, ICEAD reviews 550 claims, and 450 EOB forms are sent for review (out of 6,000,000 paid claims). The post-payment oversight of these claims is miniscule, whereas Medicaid's current vast size is expected to double in the next 10 years.

Many perpetrators of fraud know the magnitude of the MassHealth program and the limited resources that are currently evident and dedicated to the detection of fraud.

Provider fraud and abuse detection in the Office of Medicaid is principally the responsibility of the UMMS Program Integrity Unit, which makes referrals of fraud to EOHHS that in turn notifies MFCU in the Office of the Attorney General. The Bureau of Special Investigations (BSI), a special investigative unit in the Office of the State Auditor (OSA), is responsible for addressing health and human services applicant or member fraud.

Proactive detection of fraud and abuse in the Office of Medicaid is carried out via an Interdepartmental Service Agreement (ISA) with UMMS. The ISA provides for UMMS to implement and manage a fraud and abuse project for the Office of Medicaid in the interests of making efficient use of limited resources. The UMMS Program Integrity Unit Director is the liaison between the Office of Medicaid and MFCU. In fiscal years 2001-2003, the UMMS Program Integrity Unit referred a total of 51 cases to MFCU.

The UMMS Program Integrity Director has two full-time employees and two trainees who use the Web-based query system TRAPS, which is designed to uncover unusual provider billing practices that may indicate potential fraud or abuse. One of the full-time employees and the two trainees were hired in fiscal year 2005. In fiscal year 2004, when 75 million claims were filed, only two people were dedicated to this function.

In all situations where MassHealth has reason to suspect fraud or abuse by a provider, whether based on information developed through MassHealth's utilization review activities or information received from another source, MassHealth refers the matter to the MFCU, as required by federal law. The agencies communicate almost daily and have regular meetings to discuss ongoing cases. MassHealth, through the Program Integrity Unit, forwarded to the MFCU 23 referrals during fiscal year 2000; 20 during fiscal year 2001; 15 during fiscal year 2002; and 16 during fiscal year 2003. The MFCU also receives referrals from other sources, including private entities and federal and state agencies (See Appendix III for a more detailed discussion of MFCU activities).

In response to the United States House Committee on Energy and Commerce investigation on Medicaid fraud and abuse, the Commonwealth pointed to the MFCU's limited resources:

In the current times of limited resources, coordination of activities between MFCU and the Division [Office of Medicaid] is vital. As a team, the Division and MFCU have been able and will continue to strengthen the Commonwealth's ability to take action against the small minority of providers who may abuse the program.

In all situations where the Division has reason to suspect fraud or abuse by a provider, whether based on information developed through the Division's utilization review activities or information received from another source, the Division refers all such matters to the MFCU. The MFCU has a staff of eight assistant attorneys general and approximately twelve financial auditors and medical investigators. The MFCU has statewide criminal and civil jurisdiction over the investigation of Medicaid health care provider fraud and nursing home patient abuse and neglect.

Due to its finite personnel and material resources, the Massachusetts Medicaid Fraud Control Unit (MFCU) is able to pursue only a portion of the potential investigations and cases it identifies in the course of each year.

MFCU is not responsible for recipient investigations. Whenever MassHealth suspects applicant or member fraud, it refers the matter to BSI. These cases generally originate from DTA or MassHealth's Member Services Operation Unit. MassHealth also receives information from providers and other interested parties. Approximately 1,200 cases are referred each year to BSI. DTA's members are eligible for Medicaid, and it refers most of these cases.

Although the Office of Medicaid currently spends more than \$6 billion annually, or approximately 25% of annual Commonwealth expenditures, it does not have an independent internal audit function. An independent internal audit department fills an essential role by giving

assurance regarding the reliability of financial statements and the effectiveness of internal controls.

However, within MassHealth is ICEAD, which reports to the Director of Provider Operations. It does not function as an internal audit division; rather, it performs the following roles:

- Assists department managers in the development of internal control plans
- Coordinates and facilitates audits of major contractors by external auditors
- Coordinates and facilitates audits by independent external auditors and federal and state auditors
- Reviews monthly the 50 largest claims in each of the 11 provider categories
- Reviews EOB forms
- Coordinates and provides oversight to the federally sponsored PAM

Although the internal control staff does review a minimal number (an estimated 400 per month) of selected EOMB and EOB completed forms, no significant findings have been made from those reviews. Chapter 118E, Section 38, of the General Laws requires that 10% of claims be verified—that is, more than 650,000 reviews per month.

MassHealth's Provider Enrollment and Credentialing Department (PECD) verifies the credentials of all healthcare providers who apply to become Medicaid program providers. Currently there are more than 26,000 Medicaid program providers. The verification of credentials is intended to determine any change in licensure, certification, qualifications, ownership, or other data that may affect participation in MassHealth. CMS recommends providers should be re-credentialed every two years, however, background investigation of providers in the re-credentialing process was suspended after fiscal year 2001 due to budget constraints. As a result, unqualified and undesirable providers could be participating in the MassHealth program.

PECD tracks documents and applications through its software system, the Provider Enrollment Tracking System. PECD has many steps in place to ensure that provider applicants who may not meet the enrollment criteria, including those subjected to disciplinary action and sanctions,

are identified by checking information at oversight agencies and the Massachusetts Office of the Inspector General.

PECD works in collaboration with sister agencies to identify disciplinary actions of currently enrolled MassHealth providers. The Board of Registration in Medicine and the Division of Professional Licensure send to the MassHealth copies of all disciplinary actions, consent orders, and consent agreements as they are issued. This information is compared with the MassHealth provider network, and appropriate action, including suspension, is taken when necessary. When a disciplinary action other than a license suspension is identified, the information is brought before the MassHealth Internal Provider Review Committee for a determination based on MassHealth provider-eligibility regulations.

Recommendations

Based on the results of our review, we offer several recommendations that, if adopted, would improve MassHealth's oversight of the Commonwealth's Medicaid program:

- MassHealth should acknowledge the extent of potential fraud and abuse that federal agencies, consumers, and industry experts have recognized in the Medicaid program, and it should immediately begin an aggressive Medicaid anti-fraud program of detection and deterrence. As part of this effort, an independent review should be conducted to scientifically determine the actual extent of improper payments due to fraud and abuse in the MassHealth Medicaid program.
- MassHealth should adhere to SAS 99 by accepting sole responsibility for designing and implementing programs and internal controls to prevent fraudulent activities. To do so effectively, it must recognize that fraud and abuse are not synonymous—that separate and distinct procedures are required for analyzing, investigating, detecting, and deterring each.
- MassHealth should comply with Chapter 118E, Section 38, of the General Laws pertaining to the review of claims, specifically the verification of the accuracy of bills through statistical sampling. If, for legitimate reasons, this law cannot be complied with, the matter should be addressed by the State Legislature.
- Concurrent with the federally sponsored PAM study, providers' responses to medical record documentation requests should be reviewed, and any atypical changes that occur in their claim-filing profile after they have been notified of the study should be investigated (including surprise visits and audits).
- We suggest the addition of adequate fraud and abuse identification- and prevention-related controls into the new MMIS system. Until these fraud and abuse

- identification/controls are implemented, the termination of TRAPS should be postponed and the use of the system greatly expanded.
- In addition to the MFCU, a proactive Medicaid fraud investigative unit should be established within MassHealth, with the resources necessary to uncover sophisticated criminal schemes, which can then be referred to MFCU.
 - MassHealth should better utilize the resources of external investigative agencies, MFCU, and BSI by identifying and then increasing referrals of suspected cases of fraud and abuse.
 - EOHHS should establish an internal audit unit that has the resources to perform regularly scheduled and unannounced audits of the various departments within EOHHS. In addition, this unit should conduct for the Office of Medicaid provider audits that include the verification of delivery of services. Information gathered from all oversight activities should be consolidated in a centralized repository of intelligence and monitored by the new internal audit unit.
 - Provider audits should be made during the implementation and construction phase of the new MMIS to mitigate the heightened risk of potential losses from fraud and abuse due to the increased demands on management's time and the making public of the RFR. The provider audits would serve as a deterrent to potential fraud and abuse.
 - The re-credentialing of providers should be reinstated to ensure that all providers have appropriate credentials, thereby protecting the integrity of MassHealth and the wellbeing of its members.
 - MassHealth should respond to the recommendation of the CMS report to institute more formal coordination among the entities involved in data collection (specifically, claims investigated or not paid due to suspected or real fraud and abuse) to ensure the most efficient use of all of these resources and effective communication among them.

Auditee's Response

In its response to the audit report, MassHealth offered, in part, the following comments:

MassHealth agrees that it is solely responsible for designing and implementing programs and internal controls to prevent fraudulent activities. MassHealth also agrees that fraud and abuse are not synonymous....

* * *

MassHealth agrees that fraud and abuse exist. The extent is difficult to quantify. We have extensive systems, functions and operations already in place and believe we can improve.... EOHHS has recently procured the services of a contractor to perform a gap analysis of all current program integrity activities in the MassHealth program....

* * *

The gap analysis currently being performed will include:

- *A comprehensive review and thorough analysis of all current provider and member work activities associated with program integrity, including but not limited to fraud and abuse prevention and detection;*
- *An industry comparison, preferably to other state Medicaid programs and private health insurers, of program integrity efforts, including recommendations for best practices;*
- *Recommendations for the best and most efficient and cost-effective approaches to ensure program integrity;*
- *Recommendations to improve policies, practices, processes and procedures, where necessary; and*
- *Recommendations to improve the organization of EOHHS Program Integrity functions.*

We anticipate deliverables from this gap analysis will be an important guide to our efforts to continually improve our program integrity efforts. We expect this analysis to be complete in July 2005....

* * *

We are assessing how program integrity activities are organized. As part of the contract we entered into for a gap analysis of our program integrity activities, we have specifically required recommendations as to the organization of EOHHS program integrity functions.

* * *

While MassHealth verifies a sampling of claims with the recipient of the goods and services, we acknowledge that we do not verify 10%. The Centers for Medicare and Medicaid Services (CMS) has reviewed activities relating to Explanation of Medicaid Benefits (EOMBs) and concurs that there is no measurable fraud and abuse prevention and detection benefit in that activity. We note that we also verify the delivery of services through numerous other means, including provider utilization audits and case mix audits of nursing facilities.

* * *

Although difficult to measure, we are committed to identifying and addressing improper payments. Accordingly, MassHealth sought and obtained approval in 2003 to participate in the Payment Accuracy Measurement (PAM) demonstration project funded by the CMS. The PAM objectives were to (1) contribute to a common PAM methodology to be used by all state Medicaid programs in the future; (2) determine a claim payment accuracy measure for Massachusetts in accordance with standards and requirements outlined by CMS; and (3) identify opportunities for improvement. Improper payments encompassed by the project ranged from legitimate services with missing documentation to potential fraud and abuse committed by providers. MassHealth recently completed our participation in PAM, and, in accordance with the procedures prescribed by CMS, found that our overall payment accuracy rate was 97.12%. While we are not satisfied with any level of inaccurate payment, the project establishes an important benchmark for

MassHealth going forward. We are addressing specific payments found to be inaccurate and we are assessing the reasons for those inappropriate payments with a view toward refining and improving our payment processes....

Our new MMIS system will enhance our ability to detect and deter inappropriate claims. We also will be working with our new vendor to ensure specific requirements to detect fraud and abuse are incorporated. In addition, limitations in our current system as to the number of edits will no longer exist, thereby allowing us to create and expand edits as we identify potential areas for fraud and abuse. We also note that the TRAP contract has been extended....

MassHealth will be continuing to conduct provider audits during the implementation and construction phase of the new MMIS. We also are planning a wide range of risk management and mitigation strategies.

* * *

We believe establishing a new investigative unit within MassHealth would be duplicative and in conflict with the role and responsibility of the Medicaid Fraud Control Unit. Federal regulations state that the Medicaid agency must have methods and criteria for identifying suspected fraud cases. The regulations further state that if the Medicaid agency has reason to believe that an incident of provider fraud or abuse has occurred in the Medicaid program the agency must refer the matter for a full investigation to the State Medicaid Fraud Control Unit....

As of July 1, 2005, MassHealth will be resuming the formal process of re-credentialing our existing providers. We also will be continuing our current practice of verifying the credentials of all providers applying to participate in our program and working closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against currently enrolled providers.

Additional Auditee Comments

MassHealth emphasizes aggressive management of its front-end program processes to ensure that services provided are medically necessary, provided by qualified health care providers, provided to eligible residents of the Commonwealth, and that payments are appropriately made. Ongoing efforts to combat fraud, waste, and abuse, including utilization management and regular program and clinical review, are central to all program areas. Sophisticated information systems support MassHealth's efforts to detect inappropriate billings before payment is made, and to ensure that eligibility determinations are accurate.... With the focus of our program on front-end detection of waste, fraud and abuse, MassHealth avoids making inappropriate expenditures and deters providers inclined toward fraud from attempting it. The success of our program integrity efforts cannot only be measured by cost recovery statistics, but must take into consideration our considerable efforts to keep fraud, waste and abuse out of the program....

Appendix V of the report describes MassHealth information systems that are critical to program integrity. Most notably, our current Medicaid Management Information System (MMIS) processes provider claims and contains a significant number of sophisticated edits, rules and other program integrity checks and balances. As a result, approximately

21% of all claims submitted are denied and a substantial number are suspended for review or verification. EOHHS is currently involved in a multi-year project to design and implement a new MMIS system. We certainly concur with the report's recommendation to incorporate new fraud and abuse support in the new MMIS, and have included related language in that contract. We view the implementation of our new MMIS as an opportunity to enhance our ability to detect and deter inappropriate claims. More generally, information systems support to MassHealth remains a significant priority of EOHHS, in large part because of the potential of leveraging technology to combat fraud, waste and abuse in the Medicaid program. The EOHHS Data Warehouse is a consolidated repository of claims and eligibility data that provides program and financial managers with the ability to develop standard and ad-hoc management reports....

Finally, MassHealth has recently signed a contract for customer services to MassHealth members and providers. MassHealth currently employs two separate vendors for customer services, one responsible for provider relations and another for member relations. The integration of these vendor services brings with it many new opportunities in the program integrity area. We will be resuming the formal process of re-credentialing our existing providers. Our customer services contractor will continue to verify the credentials of all providers applying to participate in our program and will work closely with the Board of Registration in Medicine, the Division of Professional Licensing, the Department of Public Health, the US Department of Health and Human Services, and the Office of the Inspector General to identify disciplinary actions against currently enrolled providers.

Auditor's Reply

MassHealth recognizes that program integrity and that the detection of fraud and abuse are important aspects of its operations. It has made some improvements and enhancements in the area of fraud and abuse detection and prevention. Examples include a new MMIS system anticipated to be functional by August 2007; a GAP analysis study that will assess MassHealth's efforts versus industry standards for program integrity; the resumption of the formal process of re-credentialing existing providers; participation in the Payment Accuracy Measurement project; and the inclusion of our recommendations.

However, as discussed at the exit conference with the Director of Medicaid and the Deputy Director, we reiterate that an internal audit function within Medicaid or EOHHS would not be duplicative of the MFCU. Rather, its purpose would be to conduct provider audits and to refer suspicions of impropriety to the MFCU for investigation and prosecution. In addition, although MassHealth has front-end program processes to ensure that services provided are medically necessary, that they are provided by qualified healthcare providers to eligible residents of the Commonwealth, and that payments are appropriately made, these front-end processes do not take the place of program or provider audits specifically tailored for the detection or prevention of fraud.

Finally, the need for provider audits and increased oversight was clearly acknowledged in the Governor's Fiscal Year 2006 budget, House 1. The budget proposal included a request for \$1,500,000 in new funding for the Executive Office of Health and Human Services to conduct provider and member audit and utilization review activities.

We strongly recommend that this funding request be revisited by the Governor and the State Legislature.

APPENDIX I

MassHealth/Medicaid Statistical Tables and Charts

The following table and charts present selected key data that are pertinent to the efforts of MassHealth in detecting fraud and abuse in the Medicaid program.

	Fiscal Year		
	<u>2003</u>	<u>2002</u>	<u>2001</u>
Employees (Includes Contractors)	1,115	1,095	1,122
Members			
Medicaid Beneficiaries (Members)	928,000	961,000	954,000
Annual Growth in Members	-3.4%	0.7%	NA
Annual Expenditures (Claims Paid)	\$5,700,000,000	\$5,300,000,000	\$4,700,000,000
Annual Growth in Expenditures	7.5%	12.8%	NA
Annual Expenditure per Member	\$6,142	\$5,515	\$4,927
Percent Growth Expenditure per Member	11.4%	11.9%	NA
Claims			
Claims Processed ^(a)	75,400,000	68,300,000	66,700,000
Annual Growth in Claims Processed	10.40%	2.40%	NA
Claims Processed per Member	81	71	70
Annual Growth in Claims Processed per Member	14.1%	1.4%	NA
Claims Filed Electronically ^(b)	63,800,000	55,400,000	54,000,000
Percent Filed Electronically	84.60%	81.10%	81.00%
Providers			
Providers ^(c)	26,500	26,200	25,500
Cases Referred to the Attorney General's Office (AGO)	16	15	20
Percent Providers Referred to AGO	0.06%	0.06%	0.08%
Number of providers sanctioned	13	21	22
Recoveries from Fraud and Abuse			
Trap Systems (VeriClaim)	\$2,800,000	\$5,600,000	NA
MFCU (Office of Attorney General) ^(d)	<u>4,600,000</u>	<u>3,300,000</u>	<u>\$900,000</u>
Total Recovery from Fraud and Abuse	<u>\$7,400,000</u>	<u>\$8,900,000</u>	<u>\$900,000</u>
Percentage of Fraud and Abuse Recovery to Annual Expenditures	0.13%	0.17%	0.02%

MassHealth/Medicaid Statistical Tables and Charts

	<u>2003</u>	Fiscal Year <u>2002</u>	<u>2001</u>
Other Recoveries			
Prepayment and Program Review	\$1,200,000	\$600,000	\$1,600,000
Financial Compliance Unit — Nursing Home and Hospital Audits ^(e)	6,300,000	1,315,000	\$940,000
Case Mix Medical Audits of Nursing Facilities	800,000	NA	NA
Acute Hospital Utilization Management for Medical Necessity	7,665,000	9,059,000	2,474,000
Coordination of Benefits Recovery ^(f)	<u>\$69,100,000</u>	<u>\$98,500,000</u>	<u>\$70,900,000</u>
Total Other Recoveries	<u>\$85,065,000</u>	<u>\$109,474,000</u>	<u>\$75,914,000</u>
Percentage of Other Recoveries to Annual Expenditures	1.5%	2.1%	1.6%
Total Recoveries	<u>\$92,465,000</u>	<u>\$118,374,000</u>	<u>\$76,814,000</u>
Percentage of Total Recoveries to Annual Expenditures	1.6%	2.2%	1.6%

^(a) Based on information developed for calendar year 2003. Approximately 22% of claims are initially rejected, portions of which are resubmitted for payment.

^(b) Based on provider ID number, not locations.

^(c) Paper claims are electronically scanned by and entered into the MMIS System.

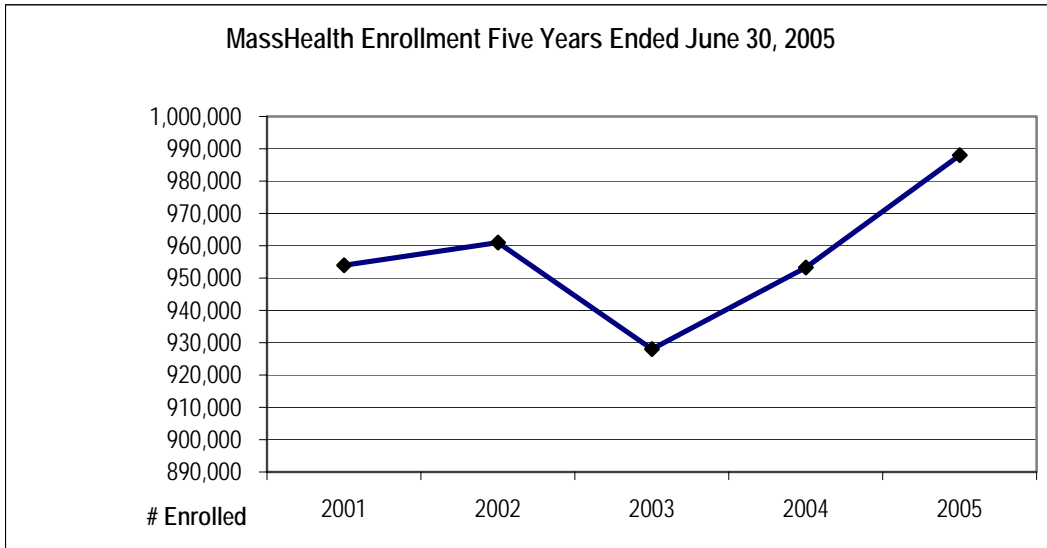
^(d) These figures represent recoveries from MassHealth referrals to the MFCU. According to MFCU, recoveries from various sources of referrals are \$2,615,345 for fiscal year 2001, \$5,163,478 for fiscal year 2002 and \$5,516,768 for fiscal 2003.

^(e) 2001 and 2002 include nursing homes only.

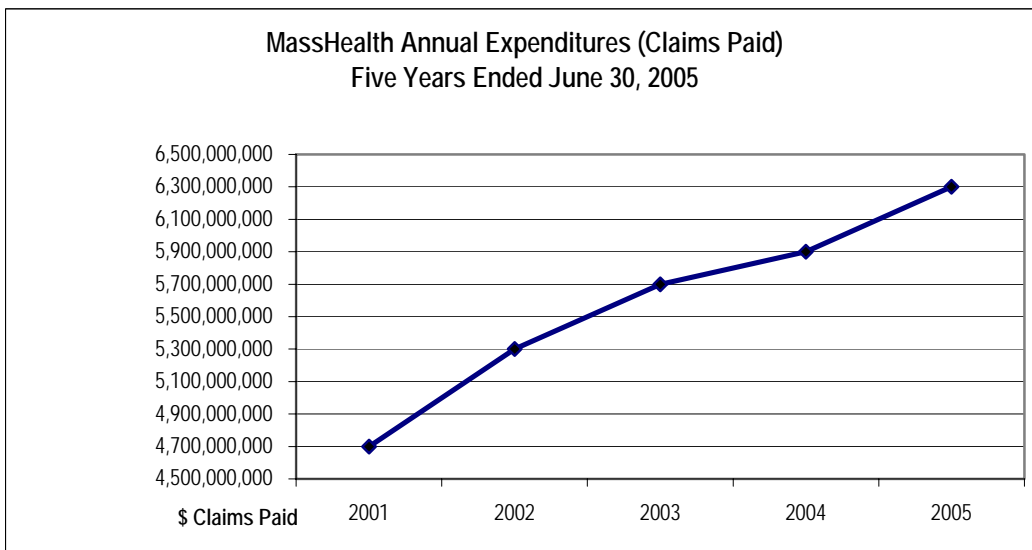
^(f) Recoveries from other insurers after payment.

MEDICAID SPENDING IS OUTPACING ENROLLMENT

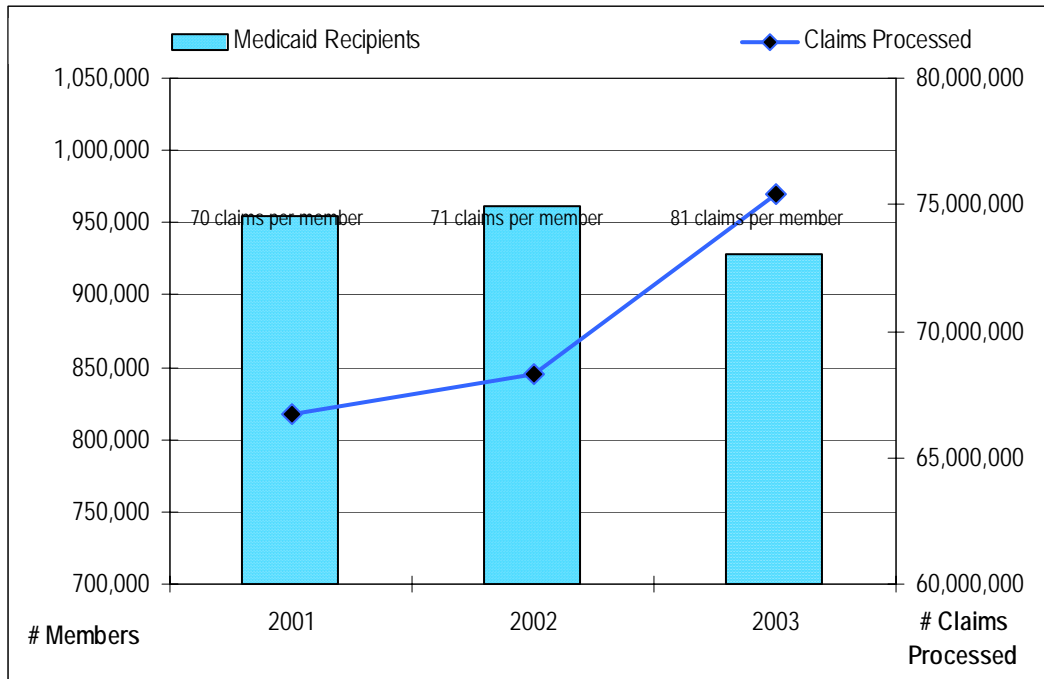
Enrollment Increased 3.5% in Five Fiscal Years Ended June 30, 2005



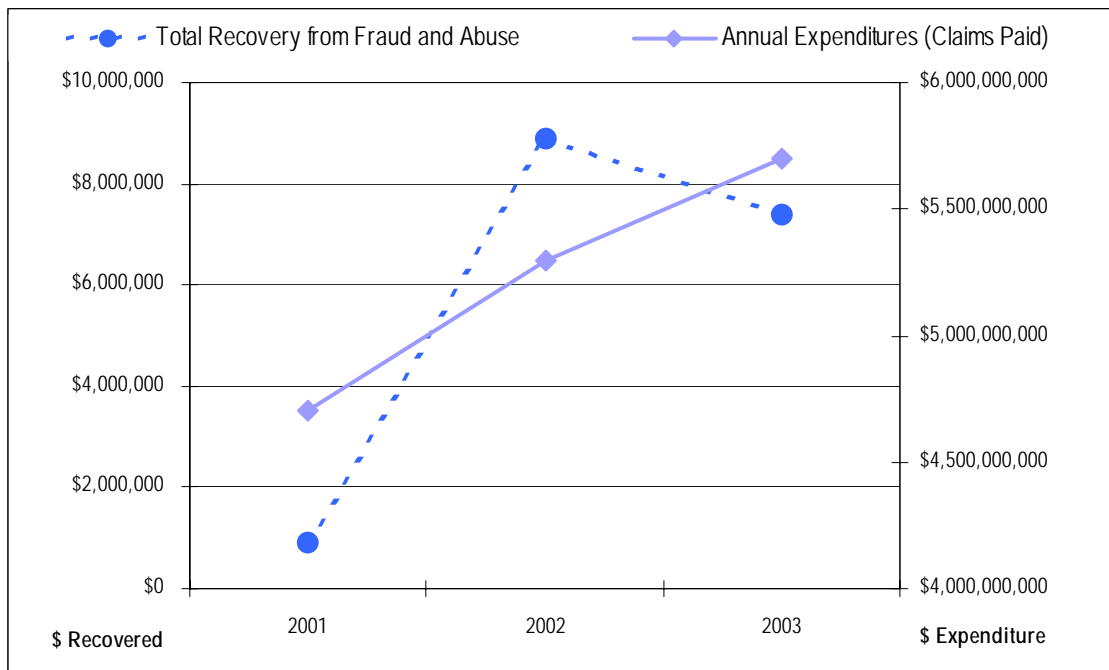
Claims Paid Increased 34.0% In Five Fiscal Years Ended June 30, 2005



CLAIMS PROCESSED PER MEMBER INCREASED 14.3% FROM FISCAL YEARS 2002 TO 2003

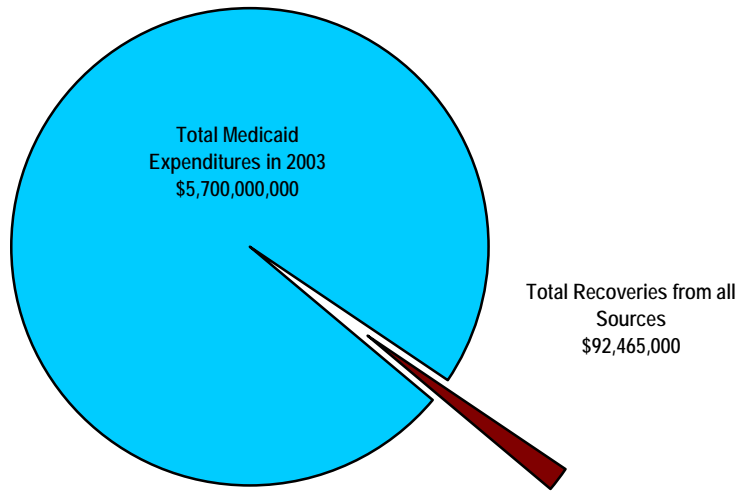


Fraud and Abuse Recovery Decreased 16.9% While Expenditures Increased 7.5% in Fiscal Year 2003

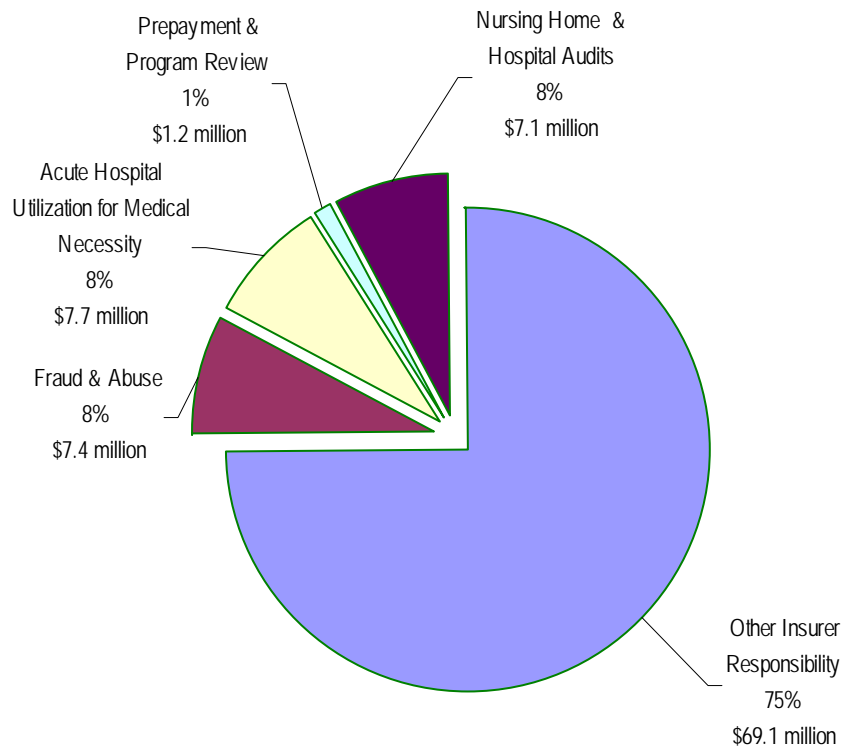


TOTAL MASSHEALTH RECOVERIES IN 2003

Billing Errors, Inaccuracies, Medical Necessity, Incorrect Coding, Fraud and Abuse

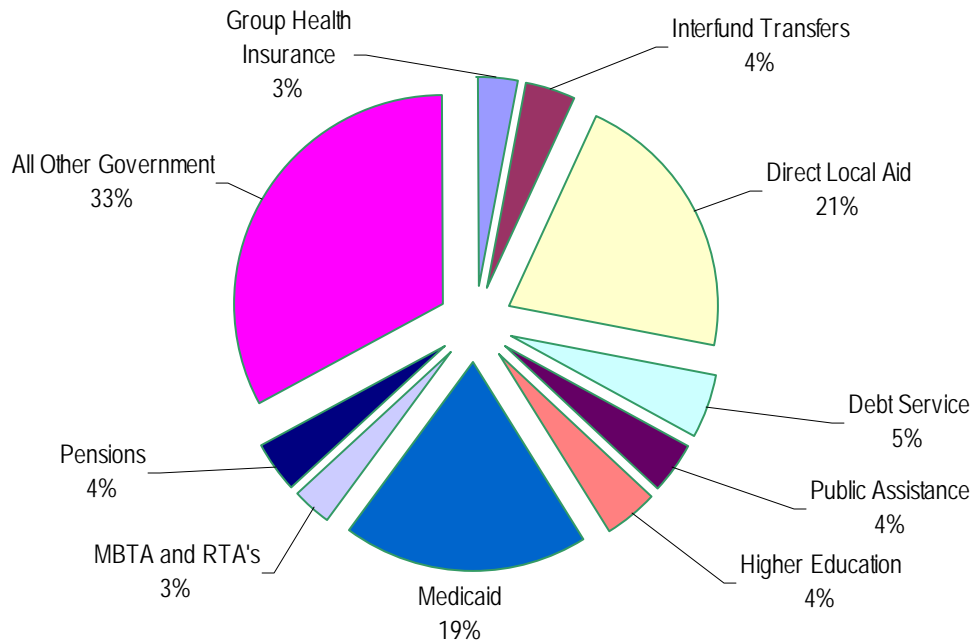


RECOVERY DISTRIBUTION

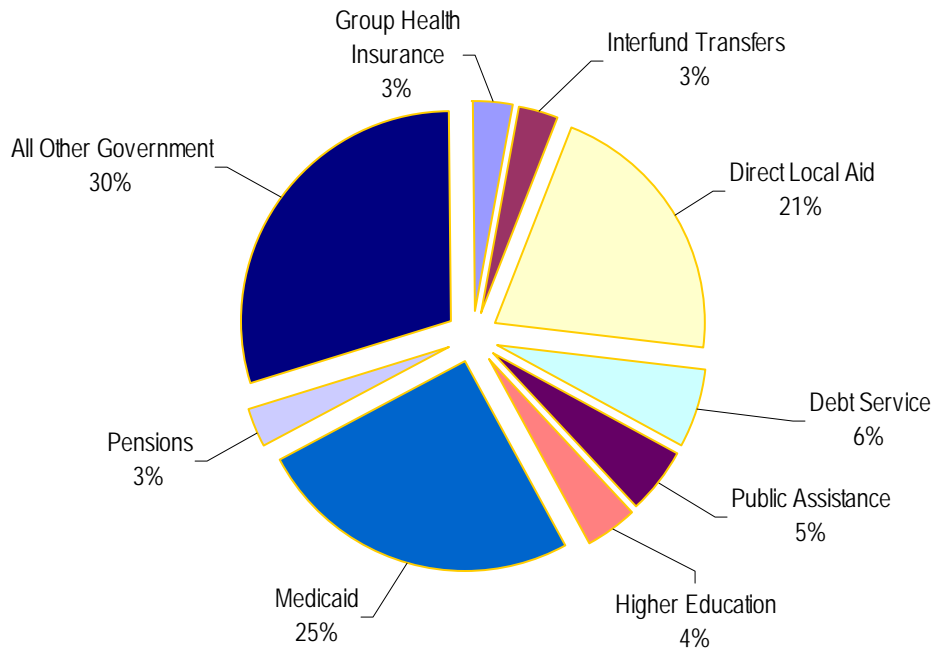


MEDICAID SPENDING HAS INCREASED FROM 19% TO 25% OF TOTAL BUDGETED EXPENSES

Budgeted Expenses and Other Uses Fiscal Year 2000



Budgeted Expenses and Other Uses Fiscal Year 2004



APPENDIX II

MassHealth Functions

Member Enrollment—Office of Member Services: MassHealth is responsible for ensuring that the approximately 988,000 persons enrolled in Medicaid are eligible to receive Medicaid benefits. The agency conducts reviews to verify information provided by applicants and members by matching or obtaining information from numerous federal and state agencies, including the United States Internal Revenue Service, Social Security Administration, and Alien Verification Information System, and the Massachusetts Department of Revenue, Department of Correction, Department of Industrial Accidents, Department of Employment and Training, Department of Veterans' Services, Department of Transitional Assistance, Human Resources Division, and Department of Public Health's Bureau of Vital Statistics. MassHealth also matches information with social service agencies of other states and computer files of banks and other financial institutions. Each Medicaid member's eligibility is reevaluated at least once a year, or more frequently when MassHealth receives information that may affect a member's eligibility.

Provider Enrollment and Credentialing—Activities Conducted by Provider Operations: Credentials of all healthcare providers applying to become Medicaid program providers are verified. MassHealth's Provider Enrollment and Credentialing Department tracks documents and applications through its software system, the Provider Enrollment Tracking System (PETS). Several steps are in place to ensure that provider applicants who may not meet the enrollment criteria, including those who have been subject to disciplinary action and sanctions, are identified by checking information at oversight agencies and the Office of the Inspector General. There are more than 26,000 Medicaid program providers. MassHealth works in collaboration with its sister agencies to identify disciplinary actions against currently enrolled Medicaid Providers. The Board of Registration in Medicine and the Division of Professional Licensure send to MassHealth copies of all disciplinary actions, consent orders, and consent agreements as they are issued. This information is compared with MassHealth's provider network, and appropriate action (including suspension) is taken when necessary. When disciplinary action other than license suspension is identified, the information is brought before the MassHealth Internal Provider Review Committee for a determination based on the MassHealth provider-eligibility regulations. The investigation of the background of providers in the re-credentialing process was suspended after fiscal year 2001 due to budget constraints. This credentialing is regarding any change in licensure, certification,

qualifications, ownership, or data that may affect participation in MassHealth. As a result of the suspension, it is possible that unqualified and undesirable providers are participating in the Medicaid program.

Utilization Management/Program Integrity Unit: This unit ensures that Medicaid members receive cost-effective, medically necessary, and good-quality care. It also ensures that Medicaid providers render care that is consistent with professionally recognized standards and bill in accordance with MassHealth's regulations. The unit oversees the following utilization management control programs:

- a. **Acute Hospital Utilization Management Program**—This program conducted 7,990 pre-payment medical-necessity reviews and 2,459 post-payment medical-necessity reviews of services requested and provided in acute-care hospitals in 2003.
 - Inpatient admission screenings are conducted for elective admissions only and are initiated by the hospital. Inpatient services are subject to pre- or post-payment review to determine the medical or administrative necessity and appropriateness.
 - Pre-payment reviews are conducted to evaluate inpatient admissions for medical necessity, the stability of the member at the time of discharge, the quality of care provided, and compliance with MassHealth's billing procedures and requirements.
 - Post-payment reviews are conducted for the same purposes as pre-payment review, but after services have been provided and the hospital has received payment.
 - Quality improvement projects are undertaken to identify opportunities for improvement in the Acute Hospital Utilization Management Program or in the clinical, administrative, or operational activities of such hospitals.
- b. **Chronic Disease/Rehabilitation Hospital Utilization Management Program**—This program conducts the following reviews to ensure the medical necessity of services requested and provided in chronic disease/rehabilitation hospitals:
 - Admission screenings are conducted for all Medicaid members prior to hospital admission.
 - Conversion screenings are conducted upon the assumption of responsibility for the healthcare coverage of Medicaid members receiving healthcare coverage from a payer other than the MassHealth at the time of hospital admission.
 - Concurrent reviews are conducted for continued hospital stays and for all services provided during a continued stay. This review may be performed at any time subsequent to the member's admission.

- Inpatient and outpatient post-payment reviews are conducted after the services have been provided and after the hospital has received payments to ensure the medical necessity of the continued admission or outpatient services.
- c. **Program Review**—This program conducts a retrospective utilization and peer-review program for non-institutional providers. Individual program review cases are referred to an appropriate expert to conduct record reviews for medical necessity of services provided. Providers found to be out of compliance with regulations (including medical necessity of services) are subject to overpayment determinations and sanctions. Sanctions may include the assessment of administrative fines and/or suspension or termination of Medicaid contracts. Medicaid providers found to be in violation of regulations may be referred to the Board of Registration in their fields; in instances where MassHealth suspects fraud or abuse, it refers the case to the Office of the Attorney General’s Medicaid Fraud Control Unit (MFCU).

Prior Authorization Unit—Certain Medicaid-covered services require prior approval to verify that the services requested are medically necessary and appropriate for the member’s clinical condition. The Prior Authorization Unit reviewed 186,985 cases in 2003.

Management Minutes Questionnaire (MMQ) Case Mix Audits of Nursing Facilities—Case mix medical audits of nursing facilities produced \$822,000 in recoveries in 2003. MMQ case mix audits are designed to ensure that nursing facilities bill, and MassHealth pays for, the appropriate level of reimbursement based on the acuity level of each Medicaid member in nursing facilities. Each nursing facility submits an MMQ quarterly, and each nursing facility is audited at least twice a year for case mix compliance. MassHealth has 14 Registered Nurses who conduct the nursing facility MMQ case mix audits. The nurses audit 100% of the Medicaid members for the submitted quarter. Medicaid member medical records (for approximately 36,500 members) are reviewed and audited by their nurses every six months.

Coordination of Benefits and Recovery Unit—This unit ensures that MassHealth is the payer of last resort as required by federal and state law. MassHealth has a comprehensive program of identifying other sources of payment so that the Medicaid program only pays a claim when no other source of payment is available. MassHealth recovers payments when another source of payment is identified even after Medicaid payment is made. Applicants and Medicaid members are required to supply information regarding other health insurance coverage, including Medicare coverage. MassHealth also requires that all holders of health insurance information, including insurers and employers, provide information to MassHealth on a regular basis to identify members with third-party resources. MassHealth also pursues other sources of indemnification, such as lawsuits seeking

damages for injuries sustained from accidents as a result of which a person has become eligible for Medicaid or Medicaid has paid for treatment. This unit recovered from the appropriate insurers approximately \$69,000,000 in overpayments during 2003.

Information from Members Regarding Services Provided—MassHealth also contacts Medicaid members directly to determine whether the Medicaid services billed were actually provided. Each month, explanation of medical benefits (EOMB) notices are sent to between 450 and 500 members with information regarding claims received during the preceding 90 days. About 10% of these Medicaid members respond, usually with no comments, positive comments or unrelated remarks. Occasionally, MassHealth is informed that the service was not provided. The use of EOMBs has not led to the identification of fraud and abuse.

Financial Compliance—The Financial Compliance Unit (FCU) ensures that all provider payments conform to state and federal laws and regulations. Activities of the FCU include field and desk audits of the provider's financial statements. The FCU conducts these audits to ensure that providers include only allowable costs in reports used to establish rates for reimbursement. In addition, the FCU reviews providers' accounts receivable balances to determine whether overpayments have been made. The FCU conducted 198 nursing home and hospital audits that resulted in the recovery of \$6,305,066 in overpayments during fiscal 2003.

Internal Control and External Audit Department—Within MassHealth, this department reports to the Deputy Director of MassHealth Operations and the Medicaid Director. Its functions are to

- Assist department managers in the development of internal control plans
- Coordinate and facilitate annual compliance audits of major contractors by external auditors
- Review monthly the 50 largest claims in each of the 11 provider categories (Those below the top 50 are not reviewed, and improper payments in this category could remain undetected.)
- Review explanation of benefits (EOB) forms
- Coordinate and facilitate the conduct of audits by independent external auditors and federal and state auditors
- Coordinate and provide oversight to the federally sponsored Payment Accuracy Measurement program (PAM). See Appendix IV.

APPENDIX III

Collaboration with State and Federal Agencies

Federal Government Agencies—Several federal government agencies are involved in decreasing healthcare fraud. The Department of Justice (DOJ) and the Department of Health and Human Services (HHS) provide monitoring and enforcement of healthcare fraud regulations. Within HHS, the Office of the Inspector General (OIG) and Centers for Medicare and Medicaid Services (CMS), aided by the states, initiate and pursue investigations of Medicare and Medicaid fraud.

United States House of Representatives Committee on Energy and Commerce—The Committee has exclusive jurisdiction over the Medicaid program and is conducting an investigation into potential waste, fraud, and abuse in this Federal-State healthcare program for the needy.³ A letter to Governor Romney on June 12, 2003 outlined the extent of the inquiry, stating that it is “approaching each State for assistance with three specific areas of inquiry: (1) state financing mechanisms designed to generate additional Federal Medicaid matching funds; (2) Section 1115 Demonstration Projects; and (3) organization, coordination and funding of waste, fraud and abuse efforts.” A lengthy questionnaire was enclosed.

Another section of the letter addressed the Committee’s overall view of the state’s initiatives in detection and deterrence of fraud and abuse:

The day-to-day surveillance and enforcement of Medicaid waste, fraud and abuse is carried out by a host of actors in the Federal-State partnership administering and overseeing this vast program. An initial look at this complex system suggests two problem areas: (1) organization and coordination and (2) funding. According to one Medicaid Fraud Control Unit (MFCU) official interviewed by the Committee, CMS is equipped to offer little direction of fraud control efforts across the program as a whole. With respect to funding, although the Federal government subsidizes a substantial percentage of any State's efforts to control Medicaid fraud through MFCUs, GAO reports that no State utilizes its full available anti-fraud funding⁴ and, in the case of three States, there are no MFCUs at all. This less than full commitment from both sides of the Federal-State Medicaid partnership exists despite proven returns on anti-fraud dollars in terms of recoveries, fines and deterrence.⁵

³ *Committee News*: The House Committee on Energy and Commerce, W.J. “Billy” Tauzin, Chairman; “Committee Leaders Initiate Investigation Into Medicaid Waste, Fraud and Abuse”: http://energycommerce.house.gov/108/News/06122003_985.htm#_ftn1

⁴ Major Management Challenges and Program Risks: Department of Health and Human Services, GAO-03-101, at 31 (Washington, DC: January 2003); Medicaid Section 1115 Waivers: Flexible Approach to Approving Demonstrations Could Increase Federal Costs, GAO/HEHS-96-44 (November 1995).

⁵ Annual Report, State Medicaid Fraud Control Units, Fiscal Year 2001, Department of Health and Human Services, Office of Inspector General, Appendix B. It must be noted that MFCUs, in light of their enforcement roles, do not report returns on anti-fraud dollars, per se, in order to avoid the suggestion of quotas.

The following are selected excerpts from the Massachusetts reply. The cover letter was dated July 23, 2003 and signed by Ronald L. Preston, Secretary, Executive Office of Health and Human Services (cc: Governor Mitt Romney):

Question posed by the Committee: “Please briefly describe the organization, structure, and duties of your State’s MFCU, or similar type agency.” The Massachusetts reply:

The Massachusetts MFCU also acts in collaboration with and as an advisory resource for the fraud control unit at the Division of Medical Assistance, establishing investigative priorities to identify recurrent schemes, trends in unlawful conduct, cases of waste and abuse, and prevention methods for the protection of health care funds destined for Medicaid recipients.

Question posed by Committee: “For the period beginning January 1, 1999, please provide all records relating to any complaints or criticisms relating to the coordination, structure, organization or effectiveness of your State’s Medicaid anti-fraud efforts.” The Massachusetts reply:

During the period in question, neither the Division of Medical Assistance nor the Massachusetts MFCU has been the target of criticism for its efforts in identifying and combating fraud, waste, and abuse in the Medicaid Program. On the contrary, a July 2002 review of state Medicaid program integrity procedures by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, contained in Attachment 5, cites the Division of Medical Assistance as being in complete compliance with all federal statutory and regulatory requirements.

Question posed by Committee: “For the period beginning January 1, 1999, please describe any proposals or plans to increase or decrease the funding for your State’s Medicaid anti-fraud efforts as well as the status of such proposals or plans.” The Massachusetts reply:

Due to its finite personnel and material resources, the Massachusetts Medicaid Fraud Control Unit (MFCU) is able to pursue only a portion of the potential investigations and cases it identifies in the course of each year. Accordingly, the MFCU regularly advocates for increased funding from the state legislature to support and expand its operations. Earlier this year, the Committee on Ways and Means of the Massachusetts House of Representatives responded to the MFCU's record of accomplishment by reaching out to the state Attorney General to explore the feasibility of appropriating additional funds for the MFCU's ongoing investigative efforts in the area of prescription drug pricing. Responding on behalf of the MFCU, the Attorney General made it clear that additional funding would be welcome and would constitute a wise investment for the Commonwealth.

Question posed by Committee: “Please describe how your State accounts for and tracks Medicaid funds, including Federal Medicaid matching funds, to ensure such funds are used only to pay for legitimate Medicaid services.” The Massachusetts reply:

The Commonwealth's Medicaid agency, the Division of Medical Assistance (the Division), utilizes a number of mechanisms to ensure that funds are used only to pay for legitimate Medicaid services. The Division emphasizes front-end management of its program to ensure that services provided are medically necessary, are provided by a qualified health care provider, and are provided to an eligible resident of the Commonwealth. Efforts undertaken by the Division to combat fraud, waste, and abuse are carried out in all program areas and include information systems features to identify outlier behavior before paying for services, utilization management, and program review. When the Division suspects fraud, it acts aggressively and works closely with the Attorney General's Medicaid Fraud Control Unit (MFCU) to identify and pursue fraudulent behavior. The Division exerts diligent efforts to identify and pursue fraudulent behavior. The Division exerts diligent efforts to identify overpayments made to Medicaid providers and to recover any such overpayments. Descriptions of the Division's extensive efforts to prevent and identify fraud, waste and abuse are contained in Attachment 2.

An attachment in the reply to the House Committee questionnaire was titled Division of Medical Assistance's Efforts to Prevent and Identify Fraud Waste and Abuse. The following are excerpts from that attachment:

In the current times of limited resources, coordination of activities between MFCU and the Division is vital. As a team, the Division and MFCU have been able and will continue to strengthen the Commonwealth's ability to take action against the small minority of providers who may abuse the program....

The Division also contacts many Medicaid members directly to determine whether the Medicaid services billed were provided. Each month the Division sends explanation of medical benefits (EOMBs) notices to between 450 and 500 members with information regarding claims received during the preceding 90 days. About 10% of these Medicaid members respond, usually with no comments, positive comments or unrelated remarks. Occasionally, the Division is informed that a service was not provided. However, this generally occurs when a member does not recognize a laboratory or other health service used by the member's Medicaid provider. The Division's use of EOMBs has not led to the identification of fraud and abuse.

Centers for Medicare and Medicaid Services (CMS)—The CMS, formerly the Health Care Financing Administration, provides technical assistance, guidance, and oversight in the efforts of states, which are primarily responsible for policing fraud in the Medicaid program.

A national team from CMS's Medicaid Alliance for Program Safeguards reviewed the program integrity policies and procedures of selected state Medicaid agencies in 2000, 2001, and 2002. Massachusetts was selected for review in 2002. The team's review of the Massachusetts program found that the Commonwealth is complying with all of the required Medicaid program integrity laws and regulations as outlined in the review guide. However, the review also noted several areas that were worthy of attention and improvement.

The following comment is from the review conducted the week of February 25, 2002 by CMS to determine whether DMA's program integrity policies and procedures comply with federal statutory and regulatory requirements⁶. The review was also interested in learning how other components of the Division identify, receive, and use information about potential fraud and abuse involving providers participating in the Massachusetts Medicaid program.

DMA⁷ needs to do more, however, to guide the efforts that the plans have taken independently, particularly with 66 percent of the Commonwealth's Medicaid eligibles enrolled in mandatory managed care. DMA cannot effectively accomplish its own responsibilities under Federal law and regulations to detect and deter fraud and abuse unless it clearly defines and articulates DMA's expectations with respect to the prevention, identification and referral of fraud and abuse in Medicaid.⁸

United States Government Accountability Office (GAO)—The GAO, in January 2003, placed Medicaid for the first time on its list of government programs at "High Risk" of fraud, waste, abuse or mismanagement.⁹ In 2002, the GAO reviewed the activities of CMS. The following is extracted from the "Testimony and Statement of Linda M. Calbom, Director, Financial Management and Assurance, before the Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations, Committee on Government Reform, House of Representatives":

MEDICAID FINANCIAL MANAGEMENT Better Oversight of State Claims for Federal Reimbursement Needed:

As discussed in our February 2002 report, we found that CMS has financial oversight weaknesses that leave the Medicaid program vulnerable to improper payments. The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers perform risk assessments, act to mitigate identified risks, and then monitor the effectiveness of those actions. In addition, the standards provide that agencies should ensure that the organizational structure is designed so that authority and responsibility for internal controls are clear. CMS oversight had weaknesses in each of these four areas, which I will discuss in turn.

Our review found that CMS had only recently begun to assess areas at greatest risk for improper payments. As a result, controls were not in place that focused on the highest risk areas and resources had not yet been deployed to areas of greatest risk. The Comptroller General's Standards for Internal Control in the Federal Government requires that agency managers perform risk assessments and then act to mitigate identified risks that could impede achievement of agency objectives.¹⁰

⁶ The 42 Code of Federal Regulations 455 and 447.10

⁷ Prior to 2003, the Massachusetts Division of Medical Assistance was the sole state agency responsible for administering Medicaid

⁸ Department of Health and Human Services Centers for Medicare and Medicaid Services, Medicaid Alliance for Program Safeguards, Review of State Medicaid Program Integrity Procedures, Massachusetts, July 2002, Final Report, p. 21

⁹ High Risk Series: An Update, GAO-03-119 (Washington, DC: January 2003)

¹⁰ GAO-02-706T Medicaid Financial Management, pages 2 and 3

Commonwealth of Massachusetts—Fraud and abuse detection in the Massachusetts Office of Medicaid is principally a cooperative effort by the Massachusetts MFCU and the University of Massachusetts Medical School (UMMS) Program Integrity Unit. UMMS and MFCU communicate on an almost daily basis and have regular meetings to discuss ongoing cases. The Bureau of Special Investigations (BSI), a special investigative unit of the Office of the State Auditor, is responsible for addressing health and human services recipient fraud.

University of Massachusetts (UMASS) Medical School—The UMASS Medical School and the Office of Medicaid have an Interdepartmental Service Agreement (ISA). The ISA provides for UMASS to implement and manage a fraud and abuse project for the Office of Medicaid in the interests of making efficient use of limited resources. The UMASS Program Integrity Unit Director is the liaison between MassHealth and the MFCU. In fiscal year 2004, the UMASS Program Integrity Director had one full-time employee who uses the TRAP System, which is designed to uncover irregular provider activity that may indicate potential fraud and abuse. A second individual is being hired for this function.

Medicaid Fraud Control Unit—The MFCU is in the Office of the Attorney General, and the establishment of a unit in the Commonwealth is a federal requirement. In all situations where the Office of Medicaid has reason to suspect fraud or abuse by a provider, whether based on information developed through Office utilization review activities or information received from another source, the Office refers all such matters to the MFCU. The MFCU has a staff of eight assistant attorneys general and approximately 12 financial auditors and medical investigators. The MFCU has statewide criminal and civil jurisdiction over the investigation of Medicaid healthcare provider fraud and nursing home patient abuse and neglect. In fiscal years 2000-2003, MassHealth referred the following number of cases to MFCU: 23, 20, 15, and 16, respectively.

Through our discussions and information we received directly from MFCU, results of their recoveries related to fraud and abuse are not limited to referrals from MassHealth. According to MFCU, its total recoveries for the last five fiscal years are as follows: FY01 - \$2,615,345, FY02 - \$5,163,478, FY03 - \$5,516,768, FY04 - \$13,233,595 and FY05 - \$24,320,426.

In addition to actual recoveries, MFCU stated that its fraud and prevention recommendations have had significant cost avoidance and cost savings impacts on the Medicaid program. Examples cited were the identification of clinical laboratories billing for excessive drug screenings, as well as,

pharmacies billing for certain generic drugs at inflated prices. Correcting these deficiencies are estimated to result in savings of \$10 to \$25 million per year.

Bureau of Special Investigations (BSI)—Applicant and member fraud are referred to the Bureau of Special Investigations, a special investigative unit within the Office of the State Auditor responsible for addressing health and human services recipient fraud.

Department of Transitional Assistance members are eligible for Medicaid, and it refers most of these cases. The Office of Medicaid also receives information from providers and other interested parties. Approximately 1,200 cases are referred each year to BSI.

APPENDIX IV

MassHealth Enhancements to Oversight

Payment Accuracy Measurement (PAM)—Oversight will be enhanced by MassHealth’s participation in a federally sponsored Payment Accuracy Measurement (PAM) study and the development of a new claims processing system, the Medicaid Management Information System (MMIS).

The Centers for Medicare and Medicaid Services (CMS) on June 20, 2003 solicited proposals from states interested in participating in the third year of the PAM project. On August 20, 2003, DMA¹¹ submitted a proposal to participate. The Massachusetts Medicaid Program has been granted federal funding for this project, which is capped at \$1 million for the period September 30, 2003 through September 29, 2004. The project is designed to estimate payment accuracy in the Medicaid program and the state Children’s Health Insurance Program—not to enhance the detection of fraud and abuse in the program.

During the PAM project, providers will be notified of its commencement, and medical record documentation requests will be sent to provider organizations. Surprise or scheduled visits to providers are not planned. The project is not designed to detect potential fraud and abuse. It is possible that during the performance of the project the billing patterns of providers may change. For that reason, monitoring provider billing patterns during this period could lead to the detection of fraud and abuse.

The results of the PAM project were not available as of the end of our audit fieldwork.

New Medicaid Management Information System—On April 24, 2004, the Executive Office of Health and Human Services issued a request for responses (RFR) for the “design, development, testing, implementation and operation of a state-of-the-art Medicaid Management Information System.”¹²

¹¹ Prior to 2003, the Massachusetts Division of Medical Assistance (DMA) was the sole state agency responsible for administering Medicaid

¹² Commonwealth of Massachusetts, Executive Office of Health and Human Services, Request for Responses for the Design, Development, Testing, Implementation and Operation of a State-of-the-Art Medicaid Management Information System (NewMMIS), April 27, 2004

The RFR describes the new MMIS as follows:

The NewMMIS is important to achieving numerous administrative goals, including savings and efficiencies through improved automation, increased Provider and Member satisfaction, program integrity (fraud and error reduction) and quality of care. Specifically, the NewMMIS must be able to:

- 1. Improve coordination with other payers and insurers (e.g., increase Third-Party Liability collections) through automated Coordination of Benefits and increased third party, plan-specific data;*
- 2. Offer Provider and Member self-service opportunities and real-time information (e.g., reduce redundant claims submittals to save Provider and MassHealth administrative costs);*
- 3. Improve business processes (e.g., operational efficiencies and program integrity) for MassHealth's internal processes through automated workflow and generation of "alerts";*
- 4. Reduce risk through updated systems platform/architecture (e.g., open standards, improved documentation/streamlining of workarounds, flexible tables);*
- 5. Coordinate benefits across EOHHS through expanded and automated data interfaces (e.g., by reducing redundant services, which saves program and administrative dollars and together with identifying potential service gaps that would lead to improved quality of services to Members);*
- 6. Reduce the number of claims administration systems in other EOHHS agencies by consolidating these functions within MassHealth, thereby achieving efficiencies and saving administrative costs;*
- 7. Provide better, and more timely, data to facilitate care management and improvements in quality of care; and*
- 8. Improve fraud and abuse detection through automated data review and interagency coordination.*

The implementation and construction of the new MMIS system creates an opportunity to build into the system controls designed to assist the detection of fraud and abuse. Although the RFR suggests that the new system will improve the detection of fraud and abuse, it does not detail the integration or implementation of an integrity function into the system and, in fact, discusses the discontinuation of the Transaction Review and Audit Processing Systems (TRAPS) program.

Transaction Review and Audit Processing Systems (TRAPS)—This is a Web-based software application from TRAP Systems, Inc. The University of Massachusetts Medical School (UMMS) contracts with TRAP Systems to provide the application to the Office of Medicaid to identify healthcare issues, including fraud, waste, abuse, and improper utilization, and perform ad hoc

queries and S/URS reporting activities. The RFR anticipates that this contract will be terminated once the EOHHS data warehouse is online.¹³

Data Warehouse—EOHHS has recently developed and implemented a data warehouse, which will hold five years' worth of MassHealth data related to claims, reference, third-party liability (TPL), prior approval (PA), member, and relationship entity. It will be the primary source of non-claims adjudication reporting, producing all of the CMS-required Surveillance and Utilization Review Subsystem (SURS) and Massachusetts Management Accounting and Reporting System (MMARS) reports and most of the EOHHS administrative reports. Budget analysis and trending, research, and “what-if” analysis will all be performed from the data warehouse, not within the new MMIS. This will allow each system to be optimally configured to support its individual role in the EOHHS-wide architecture.

The beta version of this data warehouse was released in February 2004. A subsequent release was expected in late 2004 to expand the data warehouse not only to hold more MassHealth data but also to include data from the DMH Meditech environment. A third release in mid-2005 will continue to expand the reporting capabilities of the data warehouse, incorporating additional reports and including data from DPH and other sources.¹⁴

¹³ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Request for Responses for the Design, Development, Testing, Implementation and Operation of a State-of-the-Art Medicaid Management Information System (NewMMIS), April 27, 2004, p. 26

¹⁴ Commonwealth of Massachusetts, Executive Office of Health and Human Services, Request for Responses for the Design, Development, Testing, Implementation and Operation of a State-of-the-Art Medicaid Management Information System (NewMMIS), April 27, 2004, Sec. 3.2 K

APPENDIX V

MassHealth Major Systems

Current Systems Environment—MassHealth is supported by disparate systems, desktop applications, and technical workarounds, an assemblage of short-term solutions quickly becoming unsustainable. The number of workarounds and crosswalk tables supporting the current, homegrown Massachusetts Medicaid Management Information System (MMIS), as well as the interfaces with other agency systems, is large; the effort to maintain this environment is even larger.¹⁵

The Massachusetts Medicaid Management Information System is the claims processing system and processes approximately 75 million claims in a 12-month period. There are approximately 26,500 providers, 80 provider types, and 11 invoice formats used for billing claims. The type of service determines the invoice type. The system uses a variety of functions and edits to receive, pay, suspend, or deny claims. The system processes four transaction types: original claims, adjustments, re-submittals, and voids. After the claims enter the MMIS, the claims processing cycle, which involves both daily and weekly editing, begins.

Daily Claims Processing—Daily batch processing utilizes approximately 850 edits. Daily processing involves editing of the claim itself. Validity and syntax checks are performed to ensure dates, etc. are valid; provider, recipient, and reference file edits are also performed daily. (The reference files contain procedure codes, validation tables, relational tables, etc.) A claim will receive a determination as paid, denied, or suspended, based on the editing in the daily process.

As each claim passes through the daily cycle, the claim data is matched against various subsystem files to verify consistency, validity, and relational attributes of claim information. The system uses the Member File to verify member eligibility at the time of service, identify member age and gender, and determine special restrictions. It uses the Provider File to determine provider type, specialty, and rates.

The Procedure, Diagnosis, and Drug Reference files are used to determine whether the service billed is reimbursable and is consistent with the member's age and gender. These files are also used to

¹⁵ Information extracted from Commonwealth of Massachusetts, Executive Office of Health and Human Services, Request for Responses for the Design, Development, Testing, Implementation and Operation of a State-of-the-Art Medicaid Management Information System (NewMMIS), April 27, 2004

determine rate of payment and whether diagnosis and procedure codes are consistent and the claim meets specific federal and state Executive Office of Health and Human Services requirements.

For claims requiring Prior Authorization (PA), the system uses both the Procedure File and the Prior Authorization File to ensure that PA requirements are satisfied. Claims that fail daily claims processing edits are either suspended or denied.

Weekly Claims Processing—During weekly processing, claims are compared with each other. Service Frequency (e.g., maximum units, one visit per day, or tonsils removed twice) and Multiple Surgery (e.g., many procedures on the same date of service) editing occur during this process. Most claims receive a final pricing edit.

Once editing and pricing are complete, the financial component of the weekly processing cycle begins.

Claims may be subject to “Pends,” “Fiscal Pends,” or “Recoupments”:

- Pends—holds that prevent a claim from being paid until a future date
- Recoupments—recoveries of overpayments
- Payment—file transmitted to Comptroller

MA-21: DMA Internal Eligibility System—MA-21 is MassHealth’s internally designed system that determines recipient eligibility based on the financial and category data supplied by applicants on their “MassHealth Benefits Request” application. MA-21 is MassHealth’s eligibility rules engine and contains the appropriate criteria against which the application information is matched. MA-21 contains the eligibility information for those members less than 65 years of age and not institutionalized (approximately 90% of all members). The system runs on the state’s mainframe computer and is operated and maintained by the IT department.

The system is designed to be compliant with laws and regulations. After the application is keyed into the system, it is matched against data contained within various agencies, including the Social Security Administration and Massachusetts Department of Revenue; it also matches information with social service agencies of other states and computer files of banks and insurance companies.

Additional information:

- Recipients are re-qualified annually (This is accomplished by an automatic process that generates 5,000 letters per week that require a response within 35 days—if no response, the member is removed from the file.)
- The system contains an automated process to confirm employment and earnings quarterly.
- On a monthly basis the MA-21 file is sent to the Public Consulting Group, which then electronically matches the file against the files of the top 100 health insurers to search for other insurance coverage.
- The MMIS system is updated on a 24-hour basis via a nightly batch feed from MA-21.

Provider Enrollment Tracking System (PETS)—PETS is maintained by Unisys Corp. and captures all provider information. The information is entered into the system from a Provider Application Form, which includes the following criteria/information fields: Name, Address, Phone Number, Social Security Number, and or Employer ID Number, Professional License Number, Medicare Number, DEA Certificate, etc.

The application also contains copies of the most recent tax returns or, if appropriate, copies of the most recent certified financial statements.

Additional information:

- PETS includes an automated application scanning process.
- The system nightly updates the MMIS system. In the event of a change in status, the provider code is changed in both PETS and MMIS.
- The re-credentialing process, which was the responsibility of Unisys, has been suspended (due to funding restraints). Physician licenses are checked on the Mass Board of Registration in Medicine web site.
- PETS also contains information on out-of-state providers who are used on an emergency basis.
- An average of 300-400 new providers are added per month.

The system is designed to be compliant with regulations.

Drug Utilization Review (DUR)—DUR uses a program to analyze patterns of medication use to identify unusual patterns that may indicate fraud and abuse or suboptimal clinical utilization. The MassHealth pharmacy claims processing software (“prospective DUR”) has the capability that permits claims to be evaluated at the point of sale (POS). If the claim has a condition that demands additional review, the pharmacist must call MassHealth’s clinical pharmacists to evaluate and approve or deny the claim. When DUR identifies outlier behaviors (e.g., high volume narcotic prescribers) through this process, MassHealth implements an intervention to correct the suspected behavior.

Recipient Eligibility Verification System (REVS)—REVS permits providers to verify a MassHealth member’s eligibility prior to providing health services. Providers log into the system through a secure Web site, POS devices, automated voice response (AVR), or a human telephone operator 24 hours a day, 7 days a week. The system is managed and maintained by a contractor, Electronic Data Systems.

Vericclaim System—Vericclaim, the MassHealth Surveillance Utilization Review Subsystem (SURS), is leased from Trap Systems, the developer of the proprietary software. Utilization of this system or a similar surveillance utilization review system satisfies the requirements of 42 Code of Federal Regulations 455 and 456.¹⁶

The system receives the following information on a monthly basis from the MassHealth’s claims processing system (MMIS) via a data cartridge:

- Paid claims data
- Denied claims data
- Provider information
- Recipient information

The system is used by MassHealth as an information retrieval tool to look at paid claims in a format that facilitates analysis. Information can be extracted in formats already designed in the system (algorithms) or in other formats that Trap Systems develops upon request.

¹⁶ Title 42 Public Health—42 CFR 455 Program Integrity: Medicaid, 42 CFR Utilization Control

An example of how the system might be used in order to identify providers whose billing patterns deviate from the norm is as follows:

First, have the system divide providers into groups by specialty and by geographic area. Then choose a series of variables through which one might characterize a provider's behavior (e.g., the number of procedures per patient visit). For each variable the system can calculate the distribution for the particular specialty and geographic area. Those providers at the extreme ends of the distribution can then be selected for further review.

The system has 16 ports; however, only four or five people within MassHealth, including the Program Integrity, Pharmacy, Benefits Coordination and Recovery, Financial Compliance units and the Internal Control Department use it. The Attorney General's Medicaid Fraud Control Unit also uses the system.

The system does not match all paid claims against pre-selected criteria; rather, it is used on an ad hoc basis as an analytical tool to select those claims with the statistically highest probability of fraud and abuse. Therefore, the value and efficacy of the information extracted by the system is dependent on the experience and expertise of the user.

APPENDIX VI

Executive Office Of Health And Human Services Organization Chart

