OFFICE OF THE INSPECTOR GENERAL
COMMONWEALTH OF MASSACHUSETTS

JEFFREY S. SHAPIRO
INSPECTOR GENERAL

MassHealth and Health Safety Net: 2023 Annual Report

MARCH 31, 2023

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Office of the Inspector General

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March 31, 2023

Via Electronic Mail

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The Hon. Michael J. Rodrigues, Chair
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The Hon. Aaron M. Michlewitz, Chair
House Committee on Ways and Means
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Re: Office of the Inspector General, MassHealth and Health Safety Net: 2023 Annual Report

Dear Secretary Walsh, Assistant Secretary Levine, Chair Rodrigues and Chair Michlewitz:

Pursuant to Chapter 12A of the Massachusetts General Laws, enclosed please find the Inspector General's 2023 Annual Report on MassHealth and the Health Safety Net, which issued today.

This report, entitled *MassHealth and Health Safety Net: 2023 Annual Report*, is the latest in a series of studies of MassHealth Medicaid and the Health Safety Net that the Office has conducted, which have resulted in the issuance of formal reports since 2005.

With its broad statutory authority, the Inspector General's Office focuses its work on important and impactful reviews and analyses that are designed to provide a level of oversight and focused, continual improvement recommendations for the Secretary of Health and Human Services, the Assistant Secretary for MassHealth, legislative leaders, other interested stakeholders and the public at large.

This year the report examines potential efficiencies between MassHealth and the Department of Developmental Services, MassHealth's new contract with a single fiscal intermediary to help its members manage personal care attendants, and MassHealth's administration of claims relating to COVID-19 vaccines and personal emergency response systems.

I am proud of this report and the Office of the Inspector General's healthcare team, which conducted these studies and developed the report. This team is led by Joshua Giles, Director of the Policy and Government Division, and includes Julie Flaherty, Director of the Bureau of Program Integrity; Alyssa Tasha, Director of the Data Analytics Division; and Judi Goldberg, Karina Ferzoco, Matthew Bruening and Stephen Gerry.

Please contact me if you have any questions about this report, the healthcare team or this Office. I hope that you, too, find this report to provide meaningful and important insight.

Sincerely,

Jeffrey S. Shapiro
Inspector General

Enclosure

cc (with enclosure, via email):

The Hon. Marc R. Pacheco, Chair, Senate Post Audit and Oversight
The Hon. John J. Mahoney, Chair, House Post Audit and Oversight
The Hon. Bruce E. Tarr, Senate Minority Leader
The Hon. Bradley H. Jones, Jr., House Minority Leader
Jane Ryder, Commissioner, Department of Developmental Services
Laura L. Schaub, Cataloger, State Library of Massachusetts
Michael D. Hurley, Senate Clerk
Steven T. James, House Clerk

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James Morris (Attorney General's appointee; term expires September 30, 2024)

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Joshua Giles, Director, Policy and Government Division

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TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Office of the Inspector General for the Commonwealth of Massachusetts (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Since 2004, the Office has maintained a healthcare team to conduct focused reviews of the Massachusetts Medicaid (Medicaid) and Health Safety Net (HSN) programs and provide specific recommendations for improvements to the Office of Medicaid (MassHealth), which oversees both programs. For ease of reference, this report refers to individuals who utilize the Medicaid program as "MassHealth members."

In the last year, the Office made recommendations based on its healthcare team's review of four aspects of MassHealth's management of the Medicaid program: (1) the lack of coordination between MassHealth and the Massachusetts Department of Developmental Services (DDS) concerning eligibility redeterminations and the correct funding source for certain congregate care claims; (2) the administration of COVID-19 vaccine claims; (3) the management of claims related to personal emergency response systems; and (4) MassHealth's oversight of its new contract with a single fiscal intermediary to help its members manage personal care attendants.

Redeterminations and Collaboration with DDS. The Office reviewed eligibility processes and claims data for the subset of MassHealth members who are also DDS service recipients. MassHealth is required by law to annually ensure that all of its members remain eligible for Medicaid coverage.[1] The Office identified potential shortcomings in MassHealth's procedures for determining whether DDS service recipients continue to qualify for Medicaid. Specifically, the Office found that MassHealth does not tailor its processes to facilitate continuous Medicaid coverage for eligible DDS service recipients. Tailoring the Medicaid redetermination process to better fit the needs of DDS service recipients is especially important because DDS has approximately 11,400 service recipients in congregate settings who are also MassHealth clients, making the agencies major partners. A more efficient process could result in better client outcomes and significant savings for the Commonwealth. The Office accordingly recommended that MassHealth strengthen its collaboration with DDS, with a focus on improving communication and information-sharing. The Office further recommended MassHealth and DDS develop automated connections between their systems to exchange validated data to support MassHealth eligibility processes and promote consistent coverage for eligible DDS service recipients.

The Office also examined the procedures in place to ascertain whether MassHealth or DDS has responsibility for covering certain services provided to individuals living in DDS home- and community-based settings. The Office concluded that the agencies do not effectively coordinate to determine the correct funding source for those congregate care claims, even though regulations prohibit MassHealth from paying for some services in those settings. Consequently, the Office recommended that MassHealth and DDS conduct regular joint reviews to ensure that the correct agency pays for those services.

[1] 42 C.F.R. § 435.916.

Moreover, MassHealth and DDS should work to develop automated processes to ascertain the appropriate payor.

Administration of COVID-19 Vaccine Claims. The Office reviewed MassHealth's administration of 590,815 COVID-19 vaccine claims from healthcare providers and pharmacies. Overall, the claims data demonstrated that MassHealth implemented vaccine payments efficiently, with very few indicators of fraud in billed charges or errors in payments made to providers.

The Office did identify several areas of concern in 3,419 vaccine claims, representing less than 0.6% of those examined. Specifically, the Office found duplicative claims for the same member on the same date of service, as well as claims with dose types not correlated to the member's age. As a result of the Office's evaluation, MassHealth updated its claims system to prevent duplicate payments and to ensure that providers bill the agency for the correct age-based vaccine dose.

Moreover, the Office found that MassHealth paid claims when providers gave the first dose of the vaccine but submitted claims for the more expensive second dose, and vice versa. The Office recommended that MassHealth review the claims that the Office identified and seek reimbursements from providers who gave the first dose of the vaccine but submitted a claim for the more expensive second dose. Conversely, MassHealth should determine whether it underpaid providers who gave MassHealth members the second dose of the vaccine but instead billed MassHealth for the first dose.

Personal Emergency Response Systems. A personal emergency response system is an electronic device connected to a subscriber's landline telephone that can be used to summon assistance during an emergency. An employee at the system's central monitoring station answers the call, speaks directly to the subscriber, assesses the need for help and takes appropriate action. The monitoring system is operated 24 hours a day, 7 days a week.

The Office's review of Medicaid claims for the monthly rental costs associated with emergency response systems revealed instances in which the service provider continued to bill MassHealth after the MassHealth member died, resulting in overpayments. The Office also found that providers billed more than 12 claims a year for some MassHealth members, notwithstanding the monthly billing cycle.

The Office recommended that MassHealth audit claims for emergency response systems. Additionally, MassHealth should provide greater oversight to managed care organizations to ensure that they do not pay more than 12 claims in one year. The Office also recognizes that this type of personal emergency response system may fall out of favor as landline telephone use continues to decline. MassHealth should assess the landscape to identify future tools that offer this service without the need for a landline connection.

Personal Care Attendants. MassHealth's personal care attendant (PCA) program provides funds to help its members with permanent or chronic disabilities maintain their independence, reside in the community and manage their own personal care. In the last year, the Office evaluated the agency's implementation of a new contract with its fiscal intermediary, which helps MassHealth members manage

their relationships with their PCAs in areas such as timekeeping, payments, tax withholdings and workers' compensation insurance. The Office also assessed MassHealth's use of unique personal identifiers to manage PCA claims.

MassHealth has traditionally contracted with three fiscal intermediaries to provide member services. In 2022, however, the agency elected to contract with one fiscal intermediary, Tempus Unlimited, Inc. (Tempus). Unfortunately, the transition did not go smoothly, with Tempus unable to effectively process payroll or deliver timely customer service. MassHealth therefore temporarily contracted with a second vendor, Accenture, LLP, to support Tempus in meeting the contract's requirements. MassHealth paid $3 million to Accenture for its services.[2]

With the additional resources, Tempus' performance eventually stabilized. As a result of Tempus' initial performance, MassHealth imposed a corrective action plan and assessed a $509,000 penalty against Tempus. The Office recommended that MassHealth evaluate whether Tempus is dedicating an appropriate level of staffing to manage the contract and further advised the agency to determine whether to hold Tempus responsible for the cost of the additional vendor.

Finally, the Office continued to recommend that MassHealth effectively utilize the unique identification numbers of PCAs to expand its program integrity efforts in areas such as PCA travel claims and allowable work hours.

[2] Accenture is an international management consulting firm with over 200 locations across the globe.

BACKGROUND

I. The Office of the Inspector General

The Office of the Inspector General for the Commonwealth of Massachusetts (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. The Legislature created the Office in 1980 at the recommendation of the Special Commission on State and County Buildings, a legislative commission that spent two years probing corruption in the construction of public buildings in Massachusetts. It was the first state-level inspector general's office established in the country.

Among other responsibilities, the Office reviews programs and practices in state and local agencies to identify system-wide vulnerabilities and opportunities for improvement, and assists the public and private sectors in preventing the misuse of government spending. Additionally, the Office provides guidance to public employees on issues that arise under the Uniform Procurement Act, M.G.L. c. 30B, which governs the purchase and disposition of supplies, services, equipment and real property by municipalities and other public entities. The Office also educates public and private employees through its Massachusetts Certified Public Purchasing Official (MCPPO) training program.

In line with its statutory mission, the Office annually evaluates healthcare programs, including areas relating to costs, eligibility, documentation and verification. Over the past 20 years, the Office has issued analyses, reports and recommendations regarding the Massachusetts Medicaid (Medicaid) program, the Health Safety Net (HSN) program, healthcare reform and other healthcare topics.

In 2022, the Legislature enacted Chapter 126 of the Acts of 2022. Section 161 of that law directed the Office to study and review the Medicaid and HSN programs:

> Notwithstanding any general or special law to the contrary, in hospital fiscal year 2023, the office of inspector general may expend not more than $1,000,000 from the Health Safety Net Trust Fund established in section 66 of chapter 118E of the General Laws for costs associated with maintaining a health safety net audit unit within the office. The unit shall continue to oversee and examine the practices in hospitals including, but not limited to, the care of the uninsured and the resulting free charges. The unit shall also study and review the Medicaid program under said chapter 118E including, but not limited to, a review of the program's eligibility requirements, utilization, claims administration and compliance with federal mandates. The inspector general shall submit a report to the senate and house committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2023.[3]

[3] The Office notified legislative leadership that due to the transition of leadership in this Office, the report would be filed on March 31, 2023.

Pursuant to this legislative mandate, the Office in the past year examined potential efficiencies between MassHealth and the Department of Developmental Services, MassHealth's new contract with a single fiscal intermediary to help its members manage personal care assistants, and MassHealth's administration of claims related to COVID-19 vaccines and personal emergency response systems.[4]

II. The Medicaid Program

The federal government created the national Medicaid program in 1965 to provide medical assistance to low-income individuals, particularly children, through a shared state-federal commitment. Today, the national Medicaid program pays for medical care, as well as long-term nursing and other care, for tens of millions of individuals. At the federal level, the Centers for Medicare & Medicaid Services (CMS) manages the program. Each state administers its own version of Medicaid in accordance with a CMS-approved plan. Although the states have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable federal guidelines. In Massachusetts, the Executive Office of Health and Human Services (EOHHS) oversees the program through its Office of Medicaid (MassHealth). For ease of reference, this report refers to individuals who utilize the Medicaid program as "MassHealth members."

III. The Health Safety Net Program

In 1985, the Massachusetts Legislature created the uncompensated care pool (UCP) with the goal of "more equitably distributing the burden of financing uncompensated acute hospital services across all acute hospitals . . . ."[5] The purpose of the UCP was to pay for medically necessary services that acute care hospitals and community health centers provided to eligible low-income, uninsured and underinsured patients. In addition, the UCP made reimbursements for bad debts that hospitals were unable to recover from patients.

In 2006, the Legislature replaced the UCP with the Health Safety Net (HSN) program, funded by the Health Safety Net Trust Fund. The purpose of the HSN program is to "maintain a healthcare safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth."[6] The Division of Healthcare Finance and Policy initially managed the HSN program, but the Legislature transferred that responsibility to MassHealth in 2012.

[4] When referring to the year of a report, the Office uses the fiscal year of its publication date. The fiscal year begins on July 1 and ends on June 30. For instance, Fiscal Year 2023 runs from July 1, 2022, to June 30, 2023.

[5] M.G.L. c. 6A, § 75 (repealed 1988).

[6] M.G.L. c. 118E, § 66.

I. Opportunities for Collaboration with the Department of Developmental Services

A. Overview

1. DDS

The Massachusetts Department of Developmental Services (DDS) provides support for individuals with intellectual and developmental disabilities and promotes their "meaningful participation and inclusion in all aspects of community life." DDS refers to the persons it serves as "service recipients."

DDS serves over 40,000 individuals, including many who reside in community-based settings like family homes and group homes. DDS operates approximately 250 group homes in the Commonwealth, while its nonprofit human services vendors (DDS vendors) operate approximately 2,000.

2. Eligibility Determinations and Redeterminations

Whenever an individual applies for Medicaid, MassHealth must determine whether the individual meets Medicaid's membership eligibility requirements. Annually thereafter, MassHealth must make a redetermination to ensure that the individual remains eligible for Medicaid coverage.[7]

The Office reviewed eligibility processes and claims data for MassHealth members who also receive DDS residential services, first finding that MassHealth does not tailor its eligibility procedures to meet the needs of DDS service recipients. The Office therefore recommended better communication and information-sharing with DDS to avoid an interruption in critical services. Second, the Office concluded that MassHealth and DDS do not coordinate to determine the agency responsible for covering particular services. The Office accordingly suggested that MassHealth and DDS conduct regular joint reviews of services and claims to ensure that they apply the appropriate funding source. In the long term, MassHealth and DDS must implement an automatic system-level data match to address this concern.

B. MassHealth Eligibility Redeterminations

1. Background

MassHealth determines if applicants are eligible for membership by evaluating the information provided in the application for services. Some MassHealth members designate an authorized

[7] At the onset of the pandemic in March 2020, Congress passed legislation requiring states to provide continuous coverage for most Medicaid recipients without the need for redeterminations. That legislation is expiring, and states must resume the redetermination process on April 1, 2023.

representative – such as a friend, family member or someone appointed by law – to act on their behalf in communicating with MassHealth regarding eligibility and annual redeterminations.[8]

During the redetermination process, if MassHealth confirms a member's continuing eligibility through electronic data matching with state and federal agencies, it automatically renews the member's Medicaid coverage.[9] In the absence of electronic verification, MassHealth mails forms to its members or their authorized representatives to complete and return within 45 days. MassHealth terminates coverage if it does not receive a member's completed form.[10]

Beginning on March 8, 2020, MassHealth stopped conducting annual eligibility redeterminations under federal legislation enacted in response to the COVID-19 pandemic. The agency therefore maintained consistent Medicaid coverage for all enrolled members in compliance with that law, which allowed states to receive enhanced funding if they maintained their enrollment. Under a subsequent federal law, redeterminations will re-commence on April 1, 2023.

2. The Office's Joint Review with DDS

It is critical that DDS service recipients maintain consistent access to healthcare and health insurance, as individuals without private health insurance rely on MassHealth-funded services to address their needs. With that consideration in mind, in 2021 the Office worked with DDS to review the MassHealth eligibility status for all DDS service recipients residing in its vendor-operated group homes. The Office reviewed MassHealth data and identified 184 DDS service recipients whose Medicaid coverage had been terminated, apparently based on a determination that the individual was no longer eligible. Upon further review, DDS confirmed that 43 had indeed experienced a lapse in Medicaid insurance coverage, and the agency worked with its vendors to re-establish those individuals' Medicaid coverage. The Office determined that the remaining 141 service recipients lost Medicaid coverage because they were deceased.

In December 2022, the Office worked with DDS to conduct a broader review of the MassHealth eligibility status of DDS service recipients. DDS identified 11,419 DDS individuals who either resided in group homes or received other DDS residential services. The Office confirmed that 10,967 of those individuals were eligible for Medicaid and had a claim in the last year. Of those remaining, the Office ultimately identified 11 who did not have Medicaid or alternate health insurance coverage. DDS worked with authorized representatives, families and DDS vendors to restore their MassHealth coverage. DDS found several reasons for the disruptions, including inadvertent cancellations, changes in DDS service recipients' residential addresses, changes in assets and coding errors.

[8] 130 CMR 515.001.

[9] Through electronic data matching, MassHealth reviews information from external databases to determine if a member is still eligible for coverage. Agencies such as the Internal Revenue Service, the Social Security Administration and the Massachusetts Department of Revenue may run these databases.

[10] 130 CMR 516.007.

The Office concluded that poor communication was often a root cause for the loss of Medicaid coverage. At times, for example, the DDS service recipients did not receive the redetermination letter or the subsequent notice that their Medicaid coverage had been canceled. Further, the Office learned that MassHealth does not clearly identify DDS service recipients in its eligibility database. Moreover, it does not have a separate eligibility process tailored to this population. Additionally, the Office discovered that DDS and MassHealth did not regularly share lists of DDS service recipients and do not have procedures in place to communicate information about their addresses or authorized representatives. MassHealth and DDS agreed that, while there are occasions when DDS provides MassHealth with data to support its eligibility determinations, it is not a formalized process.

Gaps in MassHealth coverage present compelling risks for DDS service recipients. Such gaps may cause those individuals to experience an interruption in healthcare and critical support services or encounter health setbacks and out-of-pocket medical costs. In addition, there is a significant fiscal risk that DDS might not be able to utilize federal funding for those services and therefore DDS might have to pay for services more appropriately covered by Medicaid.

C. Payment for Services

1. Background

The Office evaluated claims that MassHealth paid for certain healthcare services to determine if MassHealth was paying for services that DDS or its vendors were responsible for providing. Specifically, the Office reviewed long-term programs in place for DDS service recipients who are also MassHealth members, including those related to adult day health, adult foster care, day habilitation, group adult foster care, personal care attendants and home health agencies. In 2021, MassHealth paid 176,621 claims for these long-term support service programs, totaling $15,358,917, for 1,389 DDS service recipients.

MassHealth regulations prohibit MassHealth from paying for services in certain settings, such as a hospital, nursing facility or other institutional facility providing medical, nursing, rehabilitative or related care.[11] This includes some DDS residential settings. This prohibition exists because, in such settings, the agency or organization (such as the hospital or DDS vendor) receive other funding to pay for those services. For example, a contract may obligate a DDS vendor to provide a service that MassHealth would typically cover.

2. The Office's Review

Given the regulatory prohibition discussed above, in the last year, the Office examined how MassHealth ensures that it is not paying for services that DDS or its vendors are responsible for providing. The Office focused its review on a single code that MassHealth used for the administration of medication

[11] 130 CMR 403.409.

in the home health agency program.[12] A code is a five-character designation that healthcare professionals use on health insurance claims in order to get paid for procedures and services.[13] During 2021 MassHealth paid $1,519,756 under this code for DDS service recipients residing in congregate settings.[14] As a result of its review, the Office concluded that MassHealth and DDS need to collaborate and institute structured procedures to ensure that MassHealth is not paying for services that DDS or its vendors should be providing. MassHealth also needs to improve the quality and content of its claims data.

For example, the Office determined that MassHealth cannot use its claims data to identify services that DDS is supposed to cover because MassHealth does not maintain complete records of which of its members are also DDS service recipients. Nor does it have "claims edits" in place to identify services that may overlap with those that DDS or its vendors are required to provide. Claims editing is a step in MassHealth's automated payment system that helps determine whether MassHealth should pay a claim.

In addition, the Office learned that it was not possible to analyze DDS and MassHealth services by assessing MassHealth and DDS data alone. DDS supports individuals with a wide range of healthcare needs and has numerous group home models. Medicaid does pay for services in some, but not all, of these models. For example, in order to determine whether MassHealth should be funding the administration of medication in congregate settings, the agencies would need to review the specific needs of the DDS service recipients in each individual congregate setting. As a result, any solution would require a close review of the needs of the group home residents and the service model for the group home.

The Office also found that while DDS could perform manual reviews of claims data, only a limited number of DDS employees who perform fiscal functions have access to the MassHealth database to view the status and claims of the DDS service recipients they support.

D. Recommendations

The Office recommended that DDS and MassHealth create a workgroup to build a strong and sustainable collaborative relationship and implement short- and long-term improvements for DDS service recipients, working toward the shared goal of clear, accessible and consistent MassHealth coverage and care for those who are eligible.

In the short term, MassHealth should share information about the eligibility status of DDS service recipients and immediately address interruptions in coverage. As an initial step, MassHealth reported plans to work with EOHHS's information technology division to conduct data matching between the agencies and generate regular reports of DDS service recipients to maintain their MassHealth coverage. In addition, MassHealth and DDS should develop an expedited process for problem-solving and

[12] The specific code is T1502 – Administration of oral, intramuscular and/or subcutaneous medication by healthcare agency or professional.

[13] *What Is CPT?*, AAPC, https://www.aapc.com/resources/medical-coding/cpt.aspx (Last visited 3/30/2023).

[14] These recipients lived in acquired brain injury-residential habilitation group homes and state-operated group homes.

reinstatement of MassHealth benefits for those eligible. This is especially critical since MassHealth redeterminations will begin again on April 1, 2023.

Moreover, MassHealth and DDS should use the workgroup to develop systemic communication about DDS service recipients. For instance, MassHealth should share its member eligibility notices with DDS on a regular schedule. In return, DDS should share with MassHealth the current addresses for DDS service recipients, as well as the contact information for any authorized representatives. Through this data sharing, MassHealth and DDS should ensure that those served by DDS receive important notices and updates from MassHealth.

For the long term, MassHealth and DDS should use the workgroup to continue to identify issues with communication and opportunities to improve eligibility and redetermination processes for DDS service recipients. For example, MassHealth and DDS should develop automated connections between their systems to exchange validated data that supports MassHealth eligibility processes and promotes consistent coverage for eligible DDS service recipients. After developing and implementing this model for DDS, MassHealth should extend it to other EOHHS agencies to ensure that MassHealth-eligible clients of those agencies are enrolled and maintain their enrollment in MassHealth.

DDS and MassHealth should also use the workgroup to create processes that ensure the appropriate agency is paying for services provided to individuals in DDS group homes. As a first step, MassHealth and DDS should evaluate the claims for the single code the Office reviewed to determine whether MassHealth should have paid those claims. Further, MassHealth and DDS should use lessons learned from their evaluation to develop a long-term solution. That solution should include data-sharing and automated processes.

II. Administration of COVID-19 Vaccine Claims

A. Overview

Healthcare providers in the United States began using vaccines to combat COVID-19 in December 2020.[15] Compared to previous vaccine implementation plans, the administration of COVID-19 vaccines involved more medical providers and was more costly than other rollouts. COVID-19 vaccine protocols also were implemented quickly, with different vaccines at different price points. Such factors can lead to program integrity lapses, mismanagement and fraud. The Office therefore reviewed claims that healthcare providers and pharmacies submitted to MassHealth for administering COVID-19 vaccines to its members.

Several COVID-19 vaccines are eligible for reimbursement, including those produced by biopharmaceutical companies Pfizer and Moderna. MassHealth providers can bill for the first and second doses, as well as booster doses. The recommended interval between doses for adults ranges from at least

[15] *See 2020 COVID-19 and Related Vaccine Development and Research,* MAYO CLINIC, https://www.mayoclinic.org/coronavirus-covid-19/history-disease-outbreaks-vaccine-timeline/covid-19 (Last visited 3/30/2023).

three weeks to eight weeks.[16] The Centers for Disease Control and Prevention's (CDC) immunization schedule for children recommends a minimum of three weeks between doses of the vaccine, even for the severely immunocompromised.

For MassHealth to pay for vaccine administration, the provider's claim must meet certain criteria. These include the time between doses, the number of doses allowed for different age groups, and the rate paid to providers and pharmacies to administer each dose. Since eligibility rules change and new versions of the vaccines are introduced over time, improper billing and claim disputes may arise. That could lead MassHealth to overpay or underpay providers, as well as cover doses not administered in accordance with Food and Drug Administration (FDA) guidelines.[17]

The Office therefore analyzed data on providers' billed charges and examined MassHealth's processing of the ensuing payments for accuracy. The review covered the period from December 2020 to July 2022 and encompassed 164,232 pharmacy claims and 426,583 medical claims related to 326,778 MassHealth members, 819 pharmacies and 675 medical providers. MassHealth paid a total of $21,979,892 for these COVID-19 vaccinations.

Overall, the Office found that MassHealth efficiently managed COVID-19 vaccine claims, with few indicators of fraud or errors.[18] However, 3,419 claims, or less than 0.6% of the claims examined, had one of three problems. First, the Office uncovered duplicate claims for members on the same date of service. Second, incorrect coding led to incorrect payments in approximately 1,000 instances. Third, the Office identified claims with dose types inconsistent with the MassHealth member's age.

B. Duplicate Claims

The Office found that MassHealth paid $19,869 for 625 duplicate vaccination claims, meaning that the claims indicate that providers billed MassHealth for giving two doses of the COVID-19 vaccine to a MassHealth member on the same day. MassHealth should have investigated these claims since, as noted above, the CDC requires specific intervals between doses.

As a result of the Office's review, MassHealth reports that it implemented a claims edit in January 2023 to ensure that the agency pays COVID-19 vaccination charges only once.

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[16] *See Interim COVID-19 Immunization Schedule for Persons 6 Months of Age and Older*, CDC, https://www.cdc.gov/vaccines/covid-19/downloads/COVID-19-immunization-schedule-ages-6months-older.pdf (Last visited 3/30/2023).

[17] While CDC guidelines set the timing of vaccine administrations, the FDA oversees the safety and effectiveness of vaccines and authorizes specific dose levels for varying age groups.

[18] The Office analyzed MassHealth's administration of claims, not the practices of providers.

C. Incorrect Codes

The Office reviewed COVID-19 vaccine claims from December 16, 2020, when COVID-19 vaccine administration began, to April 1, 2021. During that time span, MassHealth reimbursed providers $33.88 for administering the first dose of the Pfizer or Moderna vaccine, and it reimbursed providers $56.78 for the second dose. When submitting a claim to MassHealth for administering a COVID-19 vaccine, providers had to use a specific code that indicated whether they had administered the first or second dose of the vaccine.

The Office found 518 instances in which providers administered the first dose but billed MassHealth for the second dose, resulting in overpaying providers a total of $10,970.24. The Office also found 487 instances in which providers gave MassHealth members the second dose of the vaccine but billed MassHealth for the first dose. This led the agency to underpay providers by $9,097.06.

D. Member's Age

During its review, the Office also found 1,781 instances in which MassHealth paid claims to providers who charged MassHealth for a dose of the COVID-19 vaccine that was not approved for individuals of the patient's age. The 1,781 claims affected 1,389 MassHealth members. This is significant because MassHealth must only pay for delivery of appropriate services. Additionally, there could be health risks if a member receives the wrong dose of a vaccine.

In accordance with FDA guidelines, the doses for children are not the same as those for adults. Specifically, for the dates of review, December 2020 to July 2022, Pfizer issued three separate vaccines for children: one for children aged 12 through 17 years, one for children aged 5 to 12, and one for children aged 6 months through 4 years.[19] Pfizer also had a separate dose for adults.

Of the 1,781 identified claims, 1,316 pertained to children younger than 12; in these cases, the providers billed MassHealth for a Pfizer dose intended for children in other age groups. (See Figure 1) In 305 other claims, providers billed MassHealth for giving vaccinations to children before the CDC had authorized vaccines for their age group. In this subset, providers administered unauthorized doses to 230 members, at a cost to MassHealth of $13,062.

Claims for the wrong vaccine dose raise concerns not only for health risks, but also for program integrity. The claims indicate billing errors – either intentional or inadvertent – by providers. For example, one pharmacy accounted for 80 (or 26%) of the 305 claims for children before the CDC had authorized vaccines for their age group. Those 80 claims constituted 5% of that pharmacy's total COVID-19 vaccine claims, which is a risk indicator of possible wrongdoing.

[19] Moderna did not have vaccines available for children during the period of review.

As a result of the Office's findings, MassHealth reports that it implemented a coding edit to update age ranges in the system it uses to review and pay claims. That change will assist MassHealth in performing more effective program integrity reviews. Figure 1 details the Office's findings by age group.

Issue	Age Group	Vaccine Type	Number of Claims	Amount MassHealth Paid	Number of Providers	Affected Members	Reason for Concern
Provider Billed for the Wrong Pfizer Dose	Under 12	Pfizer	1,316	$59,975	51	1,001	The dose type for people 12 and older is stronger than that indicated for people 11 and younger
	12 to 17	Pfizer	160	$7,229	44	149	The dose type for people 11 and younger is lower strength than the type indicated for those 12 to 17
Provider Billed for Dose Before it was Authorized for Age Group	1 to 17	Moderna	244	$10,278	40	186	The provider billed for administering a vaccine in a way that was not authorized by MassHealth or the FDA
	1 to 17	J&J	15	$699	12	15	
	1 to 11	Pfizer	22	$2,085	19	39	
	12 to 16	Pfizer	24				

Figure 1. Incorrect Doses by Age Group

E. Recommendations

Overall, MassHealth managed COVID-19 vaccine claims well, with few indicators of fraud or errors. Further, MassHealth has updated its claims system to prevent duplicate payments and to ensure that providers bill MassHealth for administering the correct dose of the vaccine based on the patient's age.

MassHealth should implement a claims edit to identify instances in which providers administer the first dose but bill MassHealth for the second dose, and vice versa. MassHealth also should review the claims that the Office identified and seek reimbursements from providers who gave the first dose of the vaccine but submitted a claim for the more expensive second dose. Conversely, MassHealth should determine whether it underpaid providers that gave MassHealth members the second dose of the vaccine but instead billed MassHealth for the first dose.

Finally, the Office will provide information about the pharmacy it identified in Section D to MassHealth for further review. MassHealth should follow its practice and send a notice of overpayment or conduct provider education, as appropriate.

III. Personal Emergency Response Systems

A. Overview

A personal emergency response system is an electronic device connected to a landline telephone. In the event of an emergency, a subscriber can request assistance by pressing a small button on a pendant or bracelet, by pushing the help button on a console unit or through an adaptive communication switch. When the device is activated, a person from a central monitoring station answers the call, speaks to the subscriber via the console unit, assesses the need for help and takes appropriate action. The central monitoring station operates around the clock.

MassHealth will pay for a member to have an emergency response system if the member has "medical conditions that cause significant functional limitations or incapacitation and prevents the member from using other methods of summoning assistance in an emergency."[20] In addition to satisfying medical eligibility, the regulation states that a member must:

1. Have a functioning landline phone that can accommodate an emergency response system;
2. Live alone or be routinely alone for extended periods of time, such that the member's safety would be compromised without the availability of an emergency response system unit in the home;
3. Be able to independently use the emergency response system to summon help;
4. Understand when and how to appropriately use the emergency response system; and
5. Be at risk of moving to a more structured residential setting or be at significant risk for falls or other medical complications that may result in an emergency situation.[21]

MassHealth will not pay for an emergency response system when other equipment is available to assist the member in an emergency (such as call buttons or other electronic devices), or if the member has a caretaker on a 24-hour-a-day, 7-day-a-week basis.[22]

When a member qualifies for an emergency response system, MassHealth pays the provider $20 a month for the service; managed care organizations pay different monthly rates to different providers. The Office analyzed claims for the monthly costs of emergency response system rentals. During the period

[20] 130 CMR 409.429(A). The agency's regulations do not provide examples of qualifying medical conditions.

[21] *Id.*

[22] 130 CMR 409.429(F).

studied, MassHealth paid $2,126,675 for 95,045 fee-for-service claims and managed care organizations paid $6,402,930 for 246,312 encounter claims, for a total of $8,529,605.[23]

In general, the Office found that MassHealth administers this program effectively. However, the review revealed actual and potential overpayments, such as claims paid after a member's death and more than 12 claims paid in one year.

B. Claims After Death

The Office found that between 2017 and 2021, MassHealth paid $17,448.32 for 785 claims made more than 30 days after the death of 197 members.

Providers bill MassHealth for emergency response system monthly, at the end of the subscribing member's rental month. The end date of the rental month depends on the first date of service and varies per member. For example, if a member's first day of service for an emergency response system was November 16, 2022, the end of the rental month would be December 16, 2022. Further, the emergency response service ends upon the member's death, but monthly payments are not pro-rated. Thus, MassHealth should not have paid for emergency services for deceased members more than 30 days after death.

The Office provided MassHealth with details of the 785 claims discussed above. MassHealth should work to recoup those funds and should update its claims system to identify claims for emergency response systems that providers submit more than 30 days after a member's death.

C. More than 12 Claims a Year

Since providers bill MassHealth for emergency response systems monthly, the Office reviewed instances in which providers submitted more than 12 claims for a member in a single year. In 2021, 258 members fell into that category, resulting in costs to managed care organizations of $91,725 spread over 3,610 encounter claims. There were also eight fee-for-service claims that MassHealth paid which were for a member who also had encounter claims. The highest number of claims paid for a single member in 2021 was 25.

The Office found that managed care organizations do not have the same safeguards in place as MassHealth with respect to identifying providers that bill for more than 12 claims for a member in a single year. MassHealth should provide greater oversight to these organizations to ensure they only pay for 12 claims a year for each member. In addition, MassHealth should work with the managed care organizations to recoup the overpayments the Office identified.

[23] "Fee-for-service" describes claims in which MassHealth pays providers directly for each covered service received by an eligible MassHealth member. "Encounter claims" include information that managed care organizations (MCOs) and accountable care organizations (ACOs) report to MassHealth about each service – such as an office visit or an emergency response system – that they provide to members. MassHealth uses that information to set future capitation rates paid to MCOs and ACOs.

D. Recommendations

The Office recommended that MassHealth regularly audit emergency response system claims. MassHealth should also exercise greater oversight to ensure that managed care organizations do not pay more than 12 claims in one year. The Office also recognizes that this type of personal emergency response system may fall out of favor as landline telephone use continues to decline. MassHealth should assess the landscape to identify future tools that offer this service without the need for a landline connection.

IV. Personal Care Attendant Program

A. Overview

MassHealth manages a personal care attendant (PCA) program, which is designed to help individuals with permanent or chronic disabilities maintain their independence, reside in the community and manage their own personal care. MassHealth pays approximately $780 million annually for the PCA program. On average, the program covers approximately 30,000 members supported by 24,000 PCAs monthly. While the MassHealth member is the employer of the PCA, the agency provides the funds for eligible members to hire PCAs. The agency also contracts with two kinds of vendors to administer the program: personal care management agencies and a fiscal intermediary.

Personal care management agencies evaluate members' eligibility for PCA services. They also explain the program rules to MassHealth members, evaluate their needs, submit required documentation on their behalf, and generally guide members' participation in the program.

The fiscal intermediary assists members in managing their PCA relationships. For example, the fiscal intermediary is responsible for processing PCA timesheets, preparing their paychecks and direct deposits, and filing and paying the member's share of state and federal taxes. The fiscal intermediary also provides workers' compensation insurance for PCAs and produces their W-2 forms.

B. Transition to Single Fiscal Intermediary

MassHealth has historically contracted with three fiscal intermediaries, but on January 1, 2022, MassHealth entered into a new contract with a single intermediary, Tempus Unlimited, Inc. (Tempus). Under the terms of the contract, which runs through December 31, 2025, MassHealth pays Tempus $1.65 per member per day to provide fiscal intermediary services. In 2022, MassHealth paid Tempus $14.5 million under the contract.

Using one fiscal intermediary to administer the program should improve program integrity reviews and provide a streamlined experience for members and PCAs. In last year's report, the Office recommended that MassHealth devote the necessary staff resources to oversee and manage the new contract, stating that the agency must ensure that Tempus fulfills its contractual obligations and addresses any barriers to full implementation of the contract in a timely manner. The Office also stated that

MassHealth must use the contract's performance measures to evaluate Tempus' compliance with the contract and assess financial penalties, if warranted.

1. Contract Violations

Before entering into the new contract, Tempus had been one of MassHealth's fiscal intermediaries for several years. Nevertheless, its initial transition to MassHealth's single fiscal intermediary did not go well. In early 2022, Tempus could not timely or effectively process payroll for all of the PCAs that MassHealth members employed. It also experienced extremely high call volumes, which it could not manage. MassHealth became aware of the problems through its own monitoring and stakeholder feedback. MassHealth determined that Tempus was noncompliant with several contractual requirements, such as maintaining sufficient staffing levels, training employees, providing adequate customer service, and making timely payments to PCAs.

In response, MassHealth spent $3 million to contract with another vendor, Accenture, LLP (Accenture), to assist with the transition.[24] Accenture provided support from January 24, 2022, through June 24, 2022. That support included supplementing call center services, processing timesheets and developing communications plans to inform PCAs and MassHealth members of the problems and anticipated solutions. Accenture also recommended actions Tempus could take to improve its operational capabilities, including with respect to customer service and payroll processing.

After several months of support from Accenture, Tempus' performance stabilized. However, the violations demonstrated that Tempus was not prepared to manage the transition or the scale of work required for a single fiscal intermediary. It also demonstrated that Tempus and MassHealth did not commit adequate time and resources to transition planning and implementation.

2. Corrective Action Plan

During the summer and fall of 2022, MassHealth worked with Tempus to develop a corrective action plan (CAP) to improve Tempus' performance. Tempus submitted several proposals, which MassHealth rejected because they did not sufficiently address the cited problems. Tempus requested and received three extensions from the initial deadline of August 2022 to produce an acceptable CAP. MassHealth ultimately modified a Tempus proposal to contain acceptable terms, citing the importance of reaching a final agreement within a reasonable timeline. In early 2023, Tempus agreed to MassHealth's version of the CAP.

The CAP details the structural deficiencies identified over the last year, including inadequate staffing levels, late payroll processing, poor reporting systems and inadequate transition planning. To address these shortcomings, the CAP requires specific changes to Tempus' operations. For example, MassHealth mandated that Tempus update its communication protocols, submit them to MassHealth for review and implement them swiftly. The CAP also created additional methods of accountability that

[24] Accenture is an international management consulting firm with over 200 locations across the globe.

MassHealth can use to measure Tempus' adherence to the contract's terms. For example, as a follow-up to inadequate staffing and ineffective training curriculums, Tempus must submit monthly reports on staffing levels and training initiatives, as well as a bi-monthly hiring source report. The CAP also includes Accenture's feedback and recommendations.

Furthermore, MassHealth has required Tempus to hire a compliance monitor to ensure the company complies with the CAP**.** Given Tempus' failure to meet its contractual obligations, MassHealth also imposed financial penalties totaling $509,000. In accordance with the contract, that figure includes $159,000 for failing to process timesheets by specified deadlines, at a penalty of $100 per timesheet. It also includes $350,000 to address the impact of the company's poor performance on MassHealth members and PCAs. This represents 3.5% of the total amount that MassHealth paid Tempus during 2022, even though it did not perform adequately during the first half of the year. The CAP also states that if Tempus fails to implement the CAP or improve its poor performance, it will be subject to additional sanctions, including termination of the contract.

The PCA program provides essential services to roughly 30,000 individuals. The Office commends MassHealth for proactively identifying Tempus' difficulties and for hiring Accenture to help ensure that the PCA program operated effectively for MassHealth members and PCAs. MassHealth also demonstrated strong oversight by instituting a corrective action plan and assessing penalties. The penalty, however, appears inadequate in light of the extent of Tempus' failings, the millions of dollars paid to Tempus when it was underperforming, and the fact that MassHealth also paid Accenture $3 million to assist Tempus with the transition.

3. Unique Identifiers

In its 2020 report, the Office presented its finding that MassHealth did not have identifying information about the PCAs who provide services to members. Most significantly, the claims that the fiscal intermediaries submitted to MassHealth did not identify the PCAs who provided the services. As a result, MassHealth could not conduct adequate program integrity reviews or evaluate whether the PCA program was working within its regulatory framework.

For example, MassHealth could not determine whether each PCA was following regulations that, among other things, prohibit a PCA from caring for a family member and working more than 50 hours in a week. The lack of information also made it more difficult for MassHealth to identify potential fraud, such as instances in which a fiscal intermediary may have submitted claims for services that members did not receive. The lack of information also limited MassHealth's ability to conduct program integrity reviews related to PCA claims requesting reimbursement for travel between MassHealth members' homes. Specifically, MassHealth reimburses PCAs for travel from one member's home to another member's home. Because travel claims did not identify the PCA, it was difficult for MassHealth to verify the accuracy of travel claims. Without the unique identifier on claims, for example, MassHealth could not verify that a travel claim correlated to services that a PCA provided to two members at two different addresses. In

sum, MassHealth's incomplete data made it impossible for the agency or its fiscal intermediaries to conduct adequate program integrity reviews.

4. Unique Identifiers on Claims

Consistent with the recommendations in the Office's 2020 report, the new contract requires Tempus to assign each PCA a unique identification number and include that number on all claims. The unique identification number can be included in one of two text fields on a claim for services: the "PCA ID details field" and the "PCA ID header field."

MassHealth paid 4,613,912 PCA claims from April 1, 2022, to September 30, 2022, amounting to $417,459,177 during the period. The Office examined both relevant fields for those claims and identified 163,148 instances, or 3.5% of all claims, in which both fields were blank, meaning that the unique identification number was not on the claim. This should not occur. At least one of the fields should contain the unique identification number before the claim is paid. After the Office brought this to the attention of MassHealth, the agency investigated and determined that the unique identification numbers appeared in its claims adjudication system. However, MassHealth did not transmit that information to the data warehouse that MassHealth uses for program integrity purposes. After the Office brought this to MassHealth's attention, it corrected this problem.

5. Program Integrity Uses

Adding PCA unique identification numbers to claims is an important improvement and will allow MassHealth to conduct more sophisticated data analysis and more readily identify PCA claims that need further review.

For example, the Office identified a PCA who was paid $45,021 for working 181 days in a row. The PCA reported working an average of 12 hours a day, providing services to four MassHealth members. On one day, the PCA purportedly worked a combined 24 hours for the four individuals. It is unlikely that the PCA worked 24 hours, and the quality of care should be questioned if so. This example highlights how MassHealth can use unique identification numbers for program integrity purposes.[25]

Importantly, MassHealth has begun using the identifiers to conduct program integrity reviews of in-person stays and overlapping services. For instance, MassHealth will not reimburse PCA services rendered while a member is in the hospital. The data analysis made possible with unique identification numbers should help MassHealth uncover inappropriate or excessive billing for individual PCAs in other areas.

C. Recommendations

The Office recommended that MassHealth continue to devote staff and resources to monitor and enforce the Tempus contract. Specifically, it should evaluate whether the company is allocating sufficient

[25] The Office will provide the PCA's unique identification number to MassHealth for further review.

resources to fulfill its obligations. MassHealth should also consider whether Tempus should reimburse MassHealth for the costs of hiring Accenture.

Consistently using PCA unique identification numbers should greatly improve MassHealth's ability to evaluate the program's integrity and ensure that MassHealth members receive proper levels of care. If MassHealth uncovers improper PCA billings, it should move to recover payments as appropriate. The Office will supply MassHealth with identifying information for the PCA mentioned above, along with any other PCAs it has identified as needing further investigation. Further, MassHealth should conduct an audit to identify other PCAs with consistently high reported hours. MassHealth could also identify PCAs impermissibly working for family members or confirm whether a PCA is on the excluded provider list.

Finally, consistent with this Office's recommendations, MassHealth has indicated that it plans to conduct an audit of travel claims. The Office continues to recommend that MassHealth ensure it conducts a complete audit of all PCA travel claims, looking for any indicators of fraud, waste or abuse. A full audit should, for instance, evaluate occurrences in which a PCA appeared to finish one shift and start a second shift simultaneously, even though the claims were for members living at different addresses.

ACKNOWLEDGMENT

The collaborative efforts of MassHealth and the Department of Developmental Services during the past year have been instrumental in assisting the Office's review of the Commonwealth's Medicaid programs. The staffs at both agencies were accessible and responsive to the healthcare team's requests for documents and other information. Over the past two decades, moreover the Office and MassHealth have developed a productive relationship as they worked toward the mutual goal of responsibly spending healthcare dollars. The Office is confident that this cooperative approach will continue to positively impact the Medicaid and Health Safety Net programs, as well as the public they serve.