OFFICE OF THE INSPECTOR GENERAL
COMMONWEALTH OF MASSACHUSETTS

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MassHealth and Health Safety Net Annual Report

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EXECUTIVE SUMMARY

The Office of the Inspector General for the Commonwealth of Massachusetts ("Office") is an independent agency charged with preventing and detecting fraud, waste, and abuse, in the use of public funds and public property. Complying with its mandate under Section 78 of Chapter 41 of the Acts of 2019, the Office reviewed several Massachusetts Medicaid ("Medicaid") and Health Safety Net ("HSN") programs to identify possible fraud, waste, or abuse. The Office of Medicaid ("MassHealth"), within the Executive Office of Health and Human Services, is responsible for administering both programs. In 2019, the Office focused on the MassHealth personal care attendant ("PCA") program. Following the Office's reviews of three parts of the PCA program, it provided MassHealth with recommendations to improve its program integrity in each part reviewed.

The purpose of the PCA program is to help MassHealth members with permanent or chronic disabilities maintain their independence, reside in the community, and manage their own personal care. The Office requested data from MassHealth and the three fiscal intermediaries ("FIs") that assist in the administration of the program. The Office first alerted MassHealth as to the importance of obtaining the names of the PCAs and linking those names to the MassHealth member(s) for whom the PCA provides services. MassHealth does not currently know the names of any of the PCAs and, as a result, it cannot conduct any kind of robust program integrity for the PCA program. The Office next notified MassHealth that the Office had conducted background checks (criminal offender record information and sex offender registry information) on the people working as PCAs during the first quarter of calendar year 2018. The current PCA program does not conduct any kind of background checks on PCAs. Finally, the Office reviewed the amount of money that MassHealth is paying PCAs to travel from one member's home to another member's home ("travel claims"). The Office shared a number of observations and recommendations with MassHealth regarding its payment of travel claims.

The Office also continued to work with MassHealth regarding its recommendations from fiscal year 2019. MassHealth reported that it has reviewed the Office's recommendations and made changes regarding its adult day health, adult foster care, dental care, and optometry programs.

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BACKGROUND

I. The Office of the Inspector General

Created in 1981, the Office of the Inspector General ("Office") is the first state inspector general's office in the country. The Legislature created the Office 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. The commission's findings helped shape the Office's broad statutory mandate, which is the prevention and detection of fraud, waste, and abuse in the expenditure of public funds and the use of public property. In keeping with this mandate, the Office investigates allegations of fraud, waste, and abuse, at all levels of government; reviews programs and practices in state and local agencies to identify systemic vulnerabilities and opportunities for improvement; and assists the public and private sectors to help prevent fraud, waste, and abuse, in government spending.

The Office has considerable experience reviewing and analyzing healthcare programs, including issues relating to costs, eligibility, documentation, and verification. The Office also has issued a number of analyses, reports, and recommendations regarding the Massachusetts Medicaid ("Medicaid") program, the Health Safety Net ("HSN") program, healthcare reform, and other healthcare topics.

In July 2019, the Legislature enacted chapter 41 of the Acts of 2019. Section 78 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 2020, the office of inspector general may expend up to a total of $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 chairs of 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, 2020.

Pursuant to this legislative mandate, the Office examined three specific aspects of the MassHealth personal care attendant program. The Office also continued to work with MassHealth on the findings and recommendations from the fiscal year 2019 annual report, including those regarding the adult day health, adult foster care, dental care, and optometry programs.

II. The Medicaid Program

The federal government created the national Medicaid program in 1965 to provide medical assistance to low-income Americans, 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 Americans. At the federal level, the Centers for Medicare and Medicaid Services ("CMS") administers the program. Each state administers its own version of Medicaid in accordance with a CMS-approved state plan. Although the states have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable federal and state laws and regulations. In Massachusetts, the Executive Office of Health and Human Services ("EOHHS") includes the Office of Medicaid ("MassHealth"), which oversees the Medicaid program.

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 . . . ."[1] 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 reimbursed hospitals for bad debt for patients from whom the hospitals were unable to collect payment.

In 2006, the Legislature created the Health Safety Net ("HSN") program, funded by the Health Safety Net Trust Fund, to replace the UCP. The stated purpose of the HSN program was 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."[2] Initially, the Division of Healthcare Finance and Policy managed the HSN program, but in 2012, the Legislature transferred that responsibility to MassHealth.

For ease of reference, this report will refer to individuals who utilize the Medicaid program as "MassHealth members" and those who utilize the HSN program as "HSN users."

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

[2] M.G.L. c. 118E, § 66.

I. Personal Care Attendant Program

A. Overview

The purpose of MassHealth's personal care attendant program ("PCA program") is to help MassHealth members with permanent or chronic disabilities maintain their independence, reside in the community, and manage their own personal care. Personal care attendants ("PCAs") provide physical assistance with activities of daily living, including mobility and transfers, bathing, dressing, eating, and toileting. The MassHealth member is the PCA's employer and is responsible for recruiting, hiring, scheduling, and training the PCA. MassHealth provides the funds to pay the PCAs.

MassHealth contracts with two kinds of vendors to manage the PCA program and to assist the MassHealth members: personal care management agencies ("PCMAs") and fiscal intermediaries ("FIs"). The PCMAs evaluate members who are eligible for PCA services to determine whether they can participate in the program independently. They also explain the rules of the program to the members, evaluate the members' needs, submit documentation to MassHealth, and generally help members manage their participation in the PCA program. The FIs help members with processing timesheets, preparing the PCAs' paychecks and direct deposits, sending the paychecks to the members to give to the PCAs, and filing and paying each member's share of state and federal taxes. The FIs also provide workers' compensation insurance for the PCAs and issue the PCAs' W-2 forms. Finally, the FIs submit claims for reimbursement to MassHealth for PCA services.

B. The Office's Review of the MassHealth PCA Program

The Office reviewed three parts of the MassHealth PCA program: (1) MassHealth's PCA claims; (2) PCA background checks; and (3) PCA travel claims.

1. MassHealth does not know the identities of the PCAs who are providing services to its members for which MassHealth is paying.

The claims for PCA-related services that the fiscal intermediaries submit to MassHealth do not include the names of the PCA performing the services. And MassHealth does not receive the names (or other identifying information) of the PCAs from the fiscal intermediaries unless it requests information specific to individual MassHealth members or PCAs. As a result, MassHealth is unaware of the most basic information regarding an entire group of healthcare providers to whom it is paying hundreds of millions of dollars. This significantly limits MassHealth's ability to conduct program integrity for the PCA program. For instance, without the names of the PCAs providing care to its members, MassHealth cannot:

- Conduct its own program integrity activities using PCAs as a data point;
- Check its vendors' program integrity activities; or

- Collaborate with other EOHHS agencies on program integrity activities based on PCAs' participation in other EOHHS agency programs.

If MassHealth had the names of the PCAs, it could, for example:

- Spot-check PCAs against the excluded provider list to ensure compliance with federal law.
- Audit PCA claims to determine whether:
    - Fiscal intermediaries are properly submitting claims for PCA activity time, overtime, juror service, holiday time, and sick time;
    - Travel claims are processed correctly;
    - PCAs are working more than the permissible number of hours per week; or
    - PCAs are impermissibly providing services to family members.[3]
- Compare PCA names with EOHHS agencies and their vendors that run residential programs to:
    - Help ensure that people are not working both as staff and as PCAs during the same shift;
    - Identify and reconcile all streams of funding for clients participating in more than one EOHHS program; and
    - Work to eliminate overlapping funding to reduce fraud, waste, and abuse.
- Engage in data matching with the Department of Transitional Assistance ("DTA") to:
    - Verify that PCAs who are receiving DTA benefits have properly reported their income;
    - Ensure that DTA recipients correctly report the employers' names in the wage reporting data; the Office understands that DTA recipients are sometimes reporting the member, the fiscal intermediary, and the personal care management agency as their employers;
    - Offer child care and transportation stipends to eligible PCAs; and
    - Connect PCAs with professional training and certification programs.

The Office recommended that MassHealth identify the most effective method to obtain PCA names from the fiscal intermediaries and to connect those names with the MassHealth member(s) for whom they care. For example, MassHealth could require the fiscal intermediaries to include the PCAs' names and unique PCA identifiers on the claims they submit to MassHealth for payment. That is, the fiscal

[3] MassHealth's PCA regulations provide that the following individuals cannot serve as a member's PCA: a spouse; a parent of a minor member; or any legally responsible relative, surrogate, or foster parent. 130 CMR 422.404. In addition, PCAs must be legally authorized to work in the United States, not be on the federal or state list of excluded providers, and have a current and valid PCA number.

intermediaries could identify themselves on PCA claims as the billing providers and the PCAs as the servicing providers. This would provide MassHealth with the PCA names and the corresponding names of the MassHealth member(s) for whom they provide PCA services. In the alternative, MassHealth could request the PCA names from the fiscal intermediaries on a periodic basis. Having the names and demographic information for the PCAs listed alongside the names and demographic information of the members for whom they work would allow MassHealth to conduct any number of program integrity activities. Regardless of how MassHealth obtains the PCA names from the fiscal intermediaries, having the PCA names and the corresponding names of the members for whom they provide services is vital to MassHealth's program integrity efforts for the PCA program.

In response to the Office's letter, MassHealth informed the Office of its intent to request the names and other PCA information from the fiscal intermediaries for the first quarter of 2020. MassHealth will then use that information to conduct program integrity activities on the PCA program. MassHealth also indicated that it is working with its technical team to determine if it is possible to include the names of a member's PCA on PCA claims.

2. Unlike other EOHHS programs, MassHealth does not require background checks for PCAs.

The MassHealth PCA program considers members requiring the assistance of a PCA to be the PCA's employer. As such, MassHealth has determined that the member is responsible for deciding whether to conduct a criminal offender record information ("CORI") check or sex offender registry information ("SORI") check on a prospective PCA. CORI includes information about a person's criminal history; SORI indicates the names and addresses people who have committed certain sex offenses.

To support the member in deciding whether to conduct a CORI or SORI check, one of the responsibilities of the personal care management agencies ("PCMAs") during skills training sessions is to inform members "about the tools available to promote PCA services that are safe, such as the availability of Criminal Offender Record Investigation [sic] (CORI) [and] the sex offender registry[.]"[4] The PCMAs provide members with a form that would enable the member to request CORI information from the Department of Criminal Justice Information Services ("DCJIS").[5] PCMAs also inform the members of the online availability of a SORI check.

MassHealth does not provide any additional support or education to MassHealth members around background checks and no routine, documented follow-up. As the program currently functions, MassHealth has no way to know if a member has conducted any kind of background check on a prospective PCA. There is no way to know if a member is making an informed, supported choice when hiring a PCA. There is no way to know if the member had a meaningful opportunity to consider the options and risks, if any, involved with hiring a particular PCA. And there is no way for MassHealth to know if the

[4] 130 CMR 422.419(A)(14).

[5] https://www.mass.gov/files/documents/2017/09/18/home-health-aide-fillable_0.pdf, last visited March 1, 2020.

member deliberately chose not to conduct a background check on a prospective PCA. Although the Office does not advocate automatically barring someone with criminal history information from working as a PCA, it urges MassHealth to ensure that its members have a meaningful, supported opportunity to evaluate a prospective PCA's background and make an informed hiring decision.

The background check process for the PCA program is unlike other MassHealth and EOHHS programs. For instance, EOHHS has regulations that require a CORI check for any of its employees, or employees of its constituent agencies or vendors, who will have unsupervised contact with EOHHS clients. MassHealth requires that certain programs conduct CORI checks on employees, contractors, and subcontractors before having potentially unsupervised contact with MassHealth members. State law requires CORI checks by agencies that supply or refer PCAs to people with disabilities and the elderly. Presumably, EOHHS and MassHealth do not mandate background checks for PCAs in order to be consistent with the self-determination model that serves as the backbone of the PCA program. The result, however, is that the PCA program functions in a way that is inconsistent with how EOHHS, MassHealth, and state law address background checks for certain populations.

The background check process for the PCA program is also unlike the Participant Directed Program at the Department of Developmental Services ("DDS"). That program provides DDS participants and their families the freedom to choose the services and providers that they want. Similar to the PCA program, the DDS participants are considered to be the employers for certain of these providers. However, unlike the PCA program, the DDS program has a fiscal intermediary that conducts a CORI check before the provider can start providing services to the DDS participants.

To understand the issues relating to PCA background checks, the Office first had to identify the agencies, laws, and regulations involved with background checks.

Department of Criminal Justice Information Services.[6] The Department of Criminal Justice Information Services ("DCJIS") manages and administers the Commonwealth's law enforcement information and criminal records systems, among other duties. DCJIS responds to requests for CORI with court arraignment records. This means that when DCJIS conducts a CORI check, it relies on a person's name and date of birth to match the person with the criminal records system.[7] When someone requests a CORI report for a person who will be providing in-home care, the report includes all Massachusetts adult and youthful offender convictions and pending offenses, but it does not include any sealed, juvenile, civil, and non-incarcerable offenses.[8]

DCJIS offers online training for people who are requesting and receiving CORI so that they understand the process and their obligations regarding CORI. For example, if an employer wants to ask an applicant about criminal record information, it must first provide the applicant with a copy of the CORI.

[6] https://www.mass.gov/orgs/department-of-criminal-justice-information-services, last visited March 1, 2020.

[7] DCJIS can also provide information based on fingerprints.

[8] The information that DCJIS provides varies based on the purpose of the request (*i.e.*, results for a summer camp counselor are different than those for a retail store clerk).

And if the employer plans to deny an application based on criminal record information, it must first provide the applicant the opportunity to dispute the accuracy of the record and give the applicant a DCJIS publication explaining how to correct a criminal record.

Sex Offender Registry Board.[9] The Sex Offender Registry Board ("SORB") registers and classifies convicted sex offenders according to their risk of re-offending and the degree of danger that they pose. SORB classifies offenders with three levels: a Level 1 offender has a low risk of re-offense; a Level 2 offender has a moderate risk of re-offense; and a Level 3 offender has a high risk of re-offense. SORB's website allows a member of the public to search for Level 2 and Level 3 sex offenders by offender name, city, county, or neighborhood. For sex offenses that occur outside of Massachusetts, a sex offender must register with the SORB within two days of moving to the Commonwealth.[10] As a result, the SORB website contains information about people who have committed sex offenses in other states that may not appear on that person's CORI.

EOHHS CORI regulations.[11] EOHHS has a specific set of regulations governing CORI checks. The EOHHS CORI regulations provide that all applicants or employees who would have unsupervised contact with clients of EOHHS, its agencies, or its vendor programs must undergo a background check. Notably, however, the EOHHS regulations specifically exclude MassHealth providers from the application of these regulations.

The EOHHS CORI regulations demonstrate the complexity of the decision-making EOHHS requires a hiring authority to engage in before deciding whether to hire someone with a criminal history. Specifically, if a hiring authority receives a CORI check that results in a finding of criminal records, it must evaluate any criminal convictions using a series of factors. Those factors include two lengthy tables that list a variety of criminal offenses. Table A lists those criminal offenses that EOHHS considers to be more serious offenses (*e.g.*, murder, rape, assault and battery on an elderly person or a person with a disability) and Table B lists those that EOHHS has apparently determined to be less serious offenses (*e.g.*, assault, breaking and entering, drug offenses).

The regulations provide that the hiring authority may not consider a person's criminal background as part of its hiring decision if the CORI reveals one of two results: (1) a conviction of a felony listed on Table B that is more than ten years old; or (2) a misdemeanor listed on Table B that is more than five years old, as long as the individual has no subsequent convictions or pending criminal cases. However, if the CORI reveals a pending warrant for any type of offense, the hiring authority may not hire the person unless the warrant is removed.

The regulations also instruct the hiring authority to give "careful consideration" if the CORI reveals the applicant has a:

[9] https://www.mass.gov/orgs/sex-offender-registry-board, last visited last visited March 1, 2020.

[10] G.L. c. 6, § 178E(g).

[11] 101 CMR 15.00 et seq.

- Conviction of a crime that appears on Table A, regardless of when it occurred;
- Pending Table A or Table B crime;
- Conviction of a Table B felony within ten years; or
- Conviction of a Table B misdemeanor within five years.

The regulations also list specific factors for the hiring authority to consider, including:

- Time since the conviction or pending offense;
- Age of the candidate at the time of the offense;
- Nature and specific circumstances of the offense;
- Sentence imposed and length of any period of incarceration;
- Relationship of the criminal act to the nature of the work to be performed;
- Number of offenses;
- Whether the offenses were committed in association with a dependence on drugs or alcohol, from which the candidate has since recovered;
- Any relevant evidence of rehabilitation or lack thereof; and
- Any other relevant information, including information that the candidate submits or the hiring authority requests.

MassHealth CORI requirements. MassHealth requires certain providers to obtain CORI for people who work with its members. For example:

- Adult day health programs must conduct CORI checks on people who drive MassHealth members to and from the programs.[12]
- To qualify as a durable medical equipment provider, all applicants and providers must conduct CORI checks on employees and subcontractors.[13]
- All day habilitation program providers must conduct a CORI check before hiring or contracting with any staff.[14]

[12] 130 CMR 404.413(D)(3)(b).

[13] 130 CMR 409.404(C)(10).

[14] 130 CMR 419.421(A)(1)(b).

- Transportation providers must "ensure that applicants and employees whose positions entail the potential for unsupervised contact with MassHealth members" undergo a CORI check before having contact with a MassHealth member.[15]
- Adult foster care providers must conduct CORI checks on all prospective caregivers.[16]
- Orthotic providers must conduct a CORI check on employees and subcontractors.[17]

Massachusetts General Laws chapter 6, § 172C. Section 172C of Chapter 6 of the Massachusetts General Laws ("Section 172C") allows certain types of employers to obtain CORI for people who provide:

> [C]are, treatment, education, training, transportation, delivery of meals, instruction, counseling, supervision, recreation or other services in a home or community based setting for any elderly person or disabled person who will have any direct or indirect contact with such elderly or disabled person . . . .

Section 172C lists the entities to which it applies; it specifically includes "any agency or organization that employs or refers personal care attendants." Section 172C then requires these entities to "obtain all available criminal offender record information . . . prior to employing such individual, accepting such individual as a volunteer or referring such individual for employment to an elderly or disabled person."

PCA Quality Home Care Workforce Council.[18] To assist MassHealth members who need PCAs, the PCA Quality Home Care Workforce Council ("Council") "ensure[s] the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants."[19] Section 72 of Chapter 118E of the Massachusetts General Laws requires the Council to establish "a referral directory of personal care attendants; provided that before placing a personal care attendant on the referral directory, the workforce council shall determine that the personal care attendant has met the requirements established by the executive office[.]" Consistent with this mandate, the Council maintains a searchable database of people who would like to work as PCAs; the database is known as the "Mass PCA Directory." The Council's enabling legislation also requires it to provide "routine, emergency and respite referrals of [PCAs] to consumers[.]"

In September 2017, the Council contracted with the University of Massachusetts Medical School to design and build a new PCA referral directory website.20 The directory includes a call-center support feature so that consumers and PCAs can speak with staff for help using the directory. MassHealth

[15] 130 CMR 407.405(B).

[16] 130 CMR 408.434(A)(2).

[17] 130 CMR 442.404(B)(12).

[18] https://www.mass.gov/orgs/personal-care-attendant-workforce-council, last visited March 1, 2020.

[19] G.L. c. 118E, § 71(a).

[20] Massachusetts Personal Care Attendant Quality Home Care Workforce Council, Annual Report (Dec. 21, 2018), available at https://www.mass.gov/files/documents/2019/04/01/council-performance-review-report-2018.pdf, last visited March 1, 2020.

members do not need to use the referral directory to find PCAs, but rather it serves as a resource for members who are looking for PCAs.

The Council is aware of and has discussed background check issues as they relate to the PCA program.

PCAs' CORI. To help evaluate the potential risks involved with the current system for PCA background checks, the Office obtained the names of approximately 50,000 people who worked as PCAs during the first quarter of 2018. Among these PCAs, some had multiple names (*e.g.*, Jane Doe Jones-Smith) and the Office was unable to determine which name to use as the PCA's last name. Therefore, because DCJIS performs CORI checks using names and dates of birth, the Office excluded 3,110 PCAs with multiple names from this review. Thus, the Office requested deidentified CORI information from DCJIS for 47,735 PCAs. That is, the Office received CORI results that included the offenses and dates, among other information, but the results did not identify any individuals.

Because DCJIS matched the list of PCAs by names and dates of birth, it is possible that a small number of the people represented in the results are not the PCAs but rather are another person with the exact same name and date of birth. The Office accepted DCJIS's matching methodology because this is the standard practice that DCJIS follows when it provides CORI to employers. After DCJIS matches names and dates of birth, it provides any resulting CORI to hiring authorities, which must then evaluate the information and make the ultimate hiring determination.

The Office evaluated the data as a whole, and also with a specific focus on January 2010 through August 2019.[21] For this group of 47,735 PCAs, the Office found:

- 209,497 CORI records with arraignment dates ranging from May 1948 through August 2019.
- 23,557 PCAs with CORI records, or almost 50% of the PCAs working during the first quarter of 2018.[22]
    - 7,679 PCAs with at least one criminal conviction for a total of 55,483 offenses (33% of the PCAs with CORI records; 16% of all PCAs).
    - 3,156 PCAs incarcerated for at least one criminal offense for a total of 21,657 offenses (13% of the PCAs with CORI records; 7% of all PCAs).

Focusing on CORI records for the past ten years, the Office found 11,809 PCAs with a total of 57,979 charges (24% of all PCAs). Specifically, 2,556 PCAs had at least one conviction, 1,069 PCAs had at least one term of incarceration, and 2,066 PCAs had at least one pending charge.

[21] The Office selected ten years to mirror EOHHS's CORI regulations.

[22] The Massachusetts court system and DCJIS use a unique identifier ("PCF") for each person. Each person only has one PCF unless they present an alias or incorrect date of birth to law enforcement officials. The Office treated the PCAs as though each had one PCF.

Moreover, DCJIS flagged certain crimes as "serious offenses," including murder, manslaughter, and sex crimes. There were 3,261 charges involving 1,058 PCAs: 63 PCAs had at least one murder charge; 37 PCAs had at least one manslaughter charge; and 991 PCAs had at least one sex crime charge. During the past ten years, there were six PCAs with at least one murder charge, six PCAs with at least one manslaughter charge, and 278 PCAs with at least one sex crime charge.

PCAs' SORI. In addition to obtaining CORI, the Office also received deidentified SORI for 47,735 people working as PCAs during the first quarter of 2018. The SORB used the names, dates of birth, and last four digits of the PCAs' social security numbers to match PCAs with SORI. The SORI check revealed 122 PCAs who are sex offenders with an obligation to register with the SORB, with 13 Level 1 offenders, 68 Level 2 offenders, and 41 Level 3 offenders.

Discussion. The Office's review demonstrated that approximately 24% of the PCAs working during the first quarter of 2018 have a CORI record from the past ten years. The SORI records for PCAs working during the same time revealed 122 PCAs required to register as sex offenders. These findings require MassHealth to weigh the risks and benefits of its current practice of not conducting background checks on PCAs.

MassHealth designed the PCA program to provide the member receiving the services the option to conduct a CORI or SORI check. Presumably, this is because the PCA program is a "self-directed" program; MassHealth considers the member to be the PCA's employer with all of the attendant responsibilities of training, hiring, disciplining, and firing.[23] However, this structure means that MassHealth does not know whether a member has conducted a CORI or SORI check on a prospective PCA or how the member used the results in making a hiring decision. This structure also means that members receive no support from MassHealth on how to read or interpret CORI or SORI results even though these results often include terms of art and abbreviations that people without training or a criminal justice background have difficulty deciphering. There is also no support for the members with how to use the CORI and SORI results in their decision-making process. Finally, MassHealth has no formal follow-up to determine if a member has conducted any kind of background check, nor does MassHealth track or monitor how many members conduct background checks, or document if a member chooses not to conduct a background check. Further, not requiring or tracking background checks for PCAs who, by definition, have unsupervised contact with MassHealth members is inconsistent with the policies behind EOHHS's CORI regulations, MassHealth's regulation of other programs, and state law.[24]

Requiring the member to conduct the CORI or SORI check is also inconsistent with how MassHealth has structured the PCA program itself. With regard to the administrative, employer-related tasks of the PCA program, MassHealth recognized that members requiring the assistance of PCAs may not

[23] For purposes of collective bargaining, the Council "shall be the employer." G.L. c. 118E, § 73(b).

[24] MassHealth regulations require certain providers to obtain CORI for people who work with its members. Massachusetts General Laws Chapter 6, Section 172Cc requires certain entities to obtain CORI for people who are working or volunteering with an elderly person or a person with a disability.

want or be able to conduct these tasks.[25] Accordingly, MassHealth has contracts with three FIs that complete these administrative tasks. Among other tasks, the FIs process PCA claims for reimbursement, develop and distribute to members an employer package containing employment-related forms, issue checks for PCAs with tax and other withholdings, and review PCA activity forms to ensure their accuracy.[26] However, MassHealth did not delegate to the FIs the employer-related task of running a CORI or SORI check. MassHealth's decision to have the PCMAs provide information about CORI and SORI checks to members confirms that this is an important part of the PCA hiring process, but there is a lack of support, follow-up, and accountability.

The Office recommended that EOHHS and MassHealth create and lead a work group to revisit the PCA program's approach to background checks. Topics for discussion might include:

- Whether to require background checks for prospective or current PCAs;
- Who should conduct background checks;
- How to address liability concerns;
- How to conduct background checks reliably and in a way that MassHealth can track;
- What kind of background checks to conduct;
- Whether to repeat background checks periodically;
- Whether MassHealth members may opt out of background checks for their PCAs;
- How to balance respect for the boundaries of a self-determination program with the need for accountability;
- How to help MassHealth members to make a supported, informed choice when hiring a PCA;
- What role the PCA Council should have in the background check process, if any, and its obligations under Section 172C;
- How to educate MassHealth vendors, the PCA Council, fiscal intermediaries, personal care management agencies, and MassHealth members about CORI and SORI; and
- How to conform the PCA program's practices with the laws and regulations that govern CORI and SORI.

Following the Office's review of PCA background checks, the Office met with the Secretary of EOHHS, the MassHealth Director, and the staff responsible for the PCA program to discuss these issues. As part of its ongoing work on improving the PCA program, MassHealth invited the Office to attend its ongoing Program Enhancement Advisory Council ("PEAC") meetings. The PEAC is a group of MassHealth

[25] The PCA program will only pay for services when a member has a disability that "is permanent or chronic in nature and impairs the member's functional ability to perform ADLs and IADLs without physical assistance." 130 CMR 422.403(C)(2).

[26] 130 CMR 422.419(B).

members, healthcare providers, and others who provide input regarding the current design of the PCA program, as well as suggestions about how MassHealth could improve the program. For instance, based on the discussion at one of the recent PEAC meetings, the Office and MassHealth discussed collaborating to create educational opportunities regarding background checks and other related issues for MassHealth members. The Office plans to engage with the PEAC in discussions regarding PCA background checks.

3. MassHealth is paying for PCAs to care for more than one member.

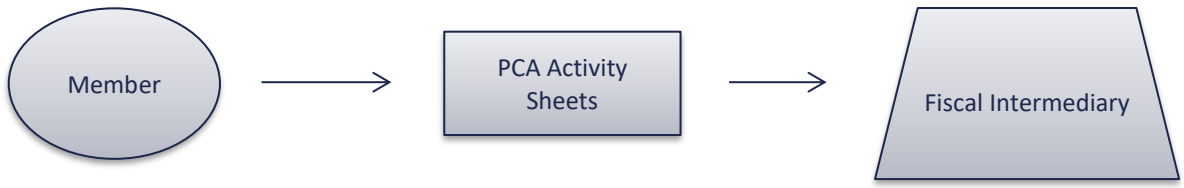
MassHealth pays PCAs for the time that it takes to travel between members for whom they care. The Office examined travel claims from the first quarter of 2018 along with the PCA service claims from that same time.[27] As part of the Office's analysis, the Office worked with the three FIs that submit travel claims to MassHealth, as well as Annkissam, the vendor that processes PCA activity sheets to calculate travel time.

As discussed in more detail below, when the Office combined the information from the FIs and MassHealth, it found inconsistencies in the data caused by incorrect zip codes, mistakes in formatting data, and timekeeping practices. These inconsistencies affect the accuracy of the travel claims. The Office also observed that MassHealth is reimbursing PCAs for traveling significant distances to care for members.

During the Office's review, the Office also determined that each of the three entities involved with travel claims – the FIs, Annkissam, and MassHealth – have different sets of information. No one entity has all of the relevant information necessary to evaluate and conduct program integrity on travel claims.

Processing of travel claims. To understand how travel claims are processed the Office spoke with representatives of the three FIs and Annkissam; the Office also gathered data from Annkissam, the FIs, and the MassHealth claim warehouse. The Office found that the FIs contract with Annkissam to create, maintain, and update the OTravel system, which processes travel claims. Each fiscal intermediary pays Annkissam a hosting fee of $0.075 per day for every member it supports as well as a monthly programming fee.

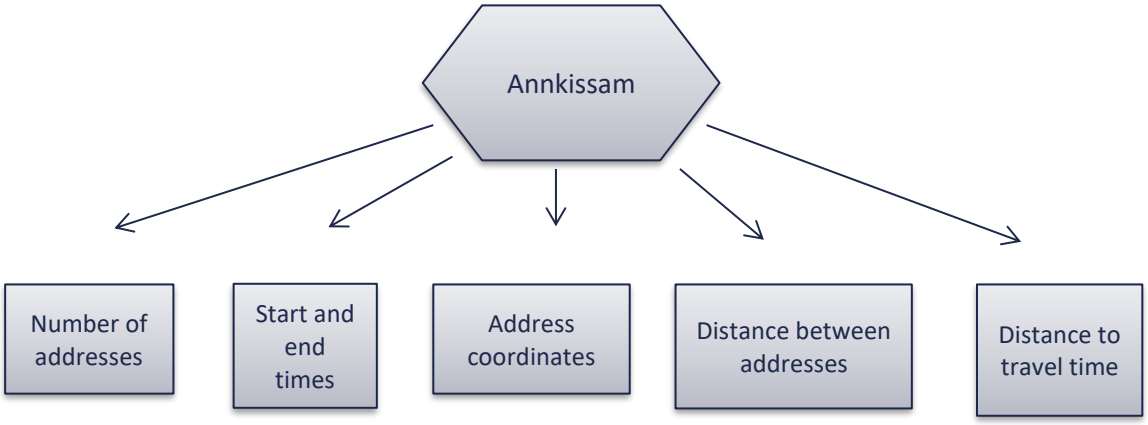
The travel claim process starts with PCA activity sheets (time sheets) that MassHealth members complete and submit to the FIs.



27 The Office describes claims for the time that PCAs spent caring for MassHealth members as "service claims."

The FIs then compile the information from the activity sheets and generate a file to send to Annkissam. The files list each PCA's unique identifier and demographic information, MassHealth member number and demographic information, and the date and hours the PCA worked. Annkissam then uses OTravel to:

- Identify when a PCA has worked at more than one address on a particular day;
- Highlight the start and end time for each shift that the PCA worked;
- Determine the coordinates of each address where the PCA started and ended each shift;
- Calculate the distance between addresses (using the coordinates); and
- Convert the distance into travel time.



Once OTravel has converted the distance between two members' addresses into minutes, it sends the travel calculation back to the fiscal intermediary and the fiscal intermediary submits a travel claim to MassHealth. The PCA's travel time is paid at $0.28 per minute.

Annkissam reports that the OTravel program follows a number of rules as it calculates PCA travel time. For example, the travel time between shifts cannot exceed the actual time between those shifts; if a PCA's first shift ends at 10:00 a.m. and the PCA's second shift starts at 10:30 a.m., for example, OTravel can only calculate up to 30 minutes of travel time regardless of the actual distance between the two members' addresses. Conversely, if a PCA's first shift ends at 10:00 a.m. and the second shift starts at 10:00 a.m., OTravel will not calculate any travel time even if the PCA is providing services at two different addresses.

Another rule that OTravel follows is that it will not use a post office box to calculate travel time. If a fiscal intermediary submits a post office box as a MassHealth member's address, Annkissam sends that information back to the fiscal intermediary and asks for the member's street address and then calculates the PCA's travel time. A third rule that the OTravel program follows is that it will not pay travel time if a PCA cares for more than one member at a single home address. However, if multiple members

live in different apartments in the same complex, the OTravel system will pay a nominal amount for travel from one apartment to another.[28]

MassHealth does not limit the distance for which it will pay a PCA to travel to provide services to a member. As a result, OTravel does not have any limit on the distance for which it will calculate a travel claim. Moreover, there is no alert in OTravel for travel that exceeds a certain distance.

Limitations on review. It is important to note that there were several limitations on the Office's review. First, as the Office noted in its October 23, 2019 letter, MassHealth does not have the names of any of the PCAs providing services to its members. This means that the only way to link the MassHealth members to their PCAs is by comparing information from the FIs with claim data in the MassHealth warehouse. One risk of this approach, as the Office discovered, is that any flaws in the data from the FIs affect the analysis.

By way of example, some of the data from the FIs contained addresses for the MassHealth members as of the date of the data pull rather than the date the member received the PCA services. This issue limited a number of analyses that depended on a comparison of the members' addresses.[29]

Another example involves members with more than one PCA. MassHealth pays travel claims for a specific MassHealth member by using the member's unique identification number. However, if the member has more than one PCA it is impossible to know from the MassHealth claim which PCA received the travel reimbursement. As a result, the Office had to limit parts of its review to those members who had only one PCA who cared only for that member.

A second limitation on the Office's review is the difference in fee-for-service claims and encounter data.[30] Although PCA claims appear in both the fee-for-service and encounter data, some of the procedure codes are different in the two types of claim data.[31] Moreover, many encounter claims appear to be for monthly PCA services, whereas the majority of fee-for-service PCA claims are for daily PCA services. To have an "apples-to-apples" analysis, the Office included only fee-for-service claims in this review. A comprehensive review of travel claims would include both the fee-for-service claims and the encounter data.

[28] Annkissam indicated that the OTravel system will use one minute of travel time in this circumstance.

[29] The same is true for the MassHealth claims; the member's address that is listed with the claims is as of the date of the data pull rather than the date on which the member received the service. For program integrity analyses that involve the member's location, this limits the analysis because the relevant address is that as of the date of service.

[30] Some members have PCA claims only in the fee-for-service data (29,621 members), other members have PCA claims only in the encounter data (17,127 members), and some have PCA claims in both data sets (3,514 members).

[31] Accountable and managed care organizations submit encounter claims to MassHealth to document services they provide to MassHealth members; fee-for-service claims represent payments that MassHealth makes directly to providers. For example, procedure code A0170 represents PCA travel claims in the fee-for-service data. However, this procedure code in the encounter data represents a variety of transportation providers, none of which appear to relate to PCA travel.

A third limitation on the review is that the FIs reported that MassHealth members have up to one year to submit the PCA activity sheets.[32] This means that any review of PCA travel claims is likely incomplete due to members who are not submitting PCA activity sheets in a timely manner. This also means that if a member received PCA services at one address and then moved, the travel claim may be associated with the wrong address.

- If the member has reported the new address to the fiscal intermediary, OTravel will use the new address to calculate the travel claim even if the member received the PCA services at the old address.
- Conversely, if the member has not reported the new address to the fiscal intermediary, OTravel will use the member's old address to calculate a travel claim even though the member receives services at the new address.

In spite of these limitations, the Office was able to review travel claims and identify a number of areas that raised questions regarding the processing of travel claims.

The Office's review of travel claims. For this analysis, the Office reviewed the first quarter of 2018 (January 1 through March 31); during these three months, MassHealth paid $441,927.90 for 107,742 travel claims on behalf of 4,529 members. The smallest travel claim that MassHealth paid was for one minute ($0.28); the largest travel claim that MassHealth paid for a single day was for 396 minutes or 6.6 hours ($110.88). The number of days that one PCA travelled during the quarter ranged from zero to 90, meaning that some PCAs worked every day.

To review the paid claims for PCA travel that occurred during the first quarter of 2018, the Office first obtained from the FIs the names and demographic information for the PCAs and the members for whom they cared. Next, the Office obtained all of the PCA-related fee-for-service claims for those members from the first quarter of 2018. Finally, the Office segregated the travel claims from the other PCA-related claims.

Zip code and formatting issues. The first observation that the Office made relates to zip code and formatting issues that resulted in the payment of travel claims to PCAs who were caring for more than one MassHealth member living in the same home. PCAs who care for members living in the same home should not receive any travel reimbursement because there is no travel required to go from one member to the next.

The Office identified examples from the FIs' data of PCAs who cared for members living in the same house who had MassHealth travel claims during the first quarter of 2018. The Office presented Annkissam and the FIs with these examples and the Office learned the following:

[32] This differs from how MassHealth treats other claims. MassHealth providers typically have 90 days from the date of service or the date of the explanation of benefits from another insurer to submit claims for reimbursement to MassHealth. And with certain exceptions, MassHealth will not pay any claim for services provided more than twelve months before the date of submission or resubmission of the claim. 130 CMR 450.309-314.

- Zip code errors in the addresses that the FIs sent to Annkissam resulted in OTravel processing travel claims for MassHealth members living at the same address.
    - Based on the PCA activity sheets that the MassHealth members and PCAs complete, occasionally the FIs mistakenly provided Annkissam with two different zip codes when two members lived at the same home address. OTravel read the two zip codes as two different addresses, determined the coordinates of each address, calculated the distance between the two addresses, and indicated that the FIs should bill MassHealth for travel.
- Formatting errors in the addresses that the FIs sent to Annkissam also resulted in OTravel processing travel claims for MassHealth members living at the same address.
    - The FIs formatted the members' address by including one member's apartment number in the same field as the street address, but then included the other member's apartment number in a separate field. This slight variation caused the OTravel system to read two different addresses for members living at the same home address.

Annkissam and the FIs have taken two approaches to address this problem. First, Annkissam will implement system edits to catch and fix both of these types of errors before calculating travel claims.

Second, Annkissam and the FIs are working to calculate the correct amount of travel reimbursement to recoup from PCAs who cared for two members at the same home address. Annkissam will audit its systems to identify any other instances in which the zip codes for the same address were incorrect and in which the formatting resulted in incorrect travel claims. Once Annkissam has identified these instances, it will work with the FIs to recoup any incorrectly paid travel claims.

Furthermore, as part of its implementation of the Electronic Visit Verification,[33] the PCA program has delegated to the FIs the responsibility of setting up an electronic verification system. This system will allow PCAs and MassHealth members to electronically process the PCAs' time more quickly and accurately. The system would have a PCA use a smartphone (or other electronic device) to log in a start and end time for each shift. That time, along with the location coordinates, would be electronically transmitted for processing of both the PCA service and travel claims. This type of electronic verification system would address many of the problems stemming from the submission of incorrect information; it also would expedite the transmission of the PCAs' work to the FIs.

One of the FIs has contracted with a vendor to build an electronic verification system. The fiscal intermediary anticipates beginning a pilot of this system during the first half of 2020. It is possible that the other two FIs may make arrangements to use that system or they may build their own system.

PCA shifts for different members that end and start at the same time. The second observation that the Office made from the FIs' data relates to PCAs who appeared to have traveled between two or

[33] Electronic Visit Verification is a federal requirement for Medicaid-funded personal care and home health services.

more MassHealth members' homes, but the PCAs were not paid for the travel. To understand why this is occurring, the Office presented Annkissam and the FIs with examples of PCAs not receiving travel compensation when it appeared that they cared for more than one member at different addresses. The Office learned the following from Annkissam and the FIs:

- Some PCA activity reports (time sheets) show a PCA completing one shift at the same time that the PCA began the next shift.
    - For example, an activity report might list a PCA completing work with one MassHealth member at 10:00 a.m. at one address and beginning work with a second MassHealth member at 10:00 a.m. at a different address. Because there was no gap of time between shifts, the OTravel system did not process any travel time for these PCAs.
- One PCA who completed shifts at the same time as beginning shifts also had two "unique" PCA identifier numbers. As a result, the PCA received no travel time and no overtime from 2017 through December 2018. The Office referred the FIs to MassHealth to discuss how to resolve this issue with that PCA.

OTravel's failure to generate travel time when the PCA activity reports indicate the same end and start times was not a technical glitch; the OTravel system was performing as expected when presented with no gap of time between a PCA's shifts. However, having the same end and start time for two different members who do not live at the same address cannot be correct because a PCA cannot be in two places at the same time. It is also inconsistent with the PCA program paying PCAs one unit of travel time ($0.28) for their "travel" between two members who live in the same apartment complex but in different apartments.

The FIs reported that this issue could be the result of two practices. First, MassHealth members appear to be rounding the PCA's time to the nearest 15-minute increment on the PCA activity sheets. The FIs uniformly reported that they rarely receive an activity sheet with a different unit of time. Second, the FIs properly submit claims to MassHealth in 15-minute increments; as a result, the FIs add up the total number of minutes that a PCA has provided services to a MassHealth member and then round up to the nearest 15-minute increment. Both of these rounding practices can make it appear as though a PCA is both ending and starting a shift at the same time.

In a conference call with the Office in November 2019, MassHealth indicated that it will conduct an audit of PCA claims for the first quarter of calendar year 2020. As part of that audit, MassHealth should evaluate why some PCAs appear to both finish and start a shift at the same time for members who live at different addresses. Once the reasons are identified, MassHealth can determine what steps should be taken to ensure that PCAs are paid accurately for their work and travel time.

PCAs receiving reimbursement for significant amounts of travel and work time. The third observation that the Office made concerns 15 PCAs who earned a combined total of $26,062.40 for travel time during the first three months of 2018. These 15 PCAs earned the most travel reimbursement during this time period. The following examples call into question whether paying for an unlimited amount travel

is fiscally sound, as well as whether there is fraud, waste, or abuse, occurring with travel claims. The following examples illustrate the high number of hours that MassHealth is reimbursing some PCAs for travel time:

- One PCA cared for two members during the first quarter of 2018; she lived with and cared for one MassHealth member (a family member) and took care of another member who lived approximately 121 miles away (approximately 2 hours of driving time).
    - On average, this PCA traveled 4.25 hours per day with a maximum daily travel of 6.6 hours. This PCA traveled 6.6 hours on 17 different days during the quarter. All told, this PCA traveled 64 out of 90 days.
    - MassHealth reimbursed this PCA $4,567.92 for travel during the quarter. If this PCA continued to travel at this rate throughout the year, MassHealth would have paid this PCA $18,271.68 for travel during calendar year 2018.[34]
- A second PCA traveled 90 out of 90 days while caring for two MassHealth members. On average, this PCA traveled 1.55 hours per day with a maximum daily travel time of 1.62 hours. MassHealth reimbursed this PCA $2,348.08 for travel during the quarter.
- Another PCA traveled 89 out of 90 days while caring for two MassHealth members. On average, this PCA traveled 1.49 hours per day with a maximum daily travel time of 1.75 hours. MassHealth reimbursed this PCA $2,234.40 for travel during the quarter.
- A fourth PCA traveled 28 days while caring for two MassHealth members. On average, this PCA traveled 3.53 hours per day with a maximum daily travel time of 4.23 hours. MassHealth reimbursed this PCA $1,658.16 for travel during the quarter.

As previously discussed, the PCA program is a self-directed program with MassHealth considering the member to be the PCA's employer. One of the hallmarks of the PCA program is that the members can choose their own PCAs. With very few exceptions, the PCA program does not place any limitations on the member's choice of PCA.[35]

However, the distance and number of days that these PCAs traveled suggest that MassHealth might consider whether it is fiscally sound to have no limits whatsoever on the distance for which it will reimburse PCAs' travel. Traveling long distances and working every day are also potential red flags for MassHealth to consider as it conducts its review of PCA claims for the first quarter of 2020.

[34] Because the PCA claims for the rest of calendar year 2018 do not include the name of the PCA, the Office is unable to accurately calculate this PCA's total travel reimbursement.

[35] MassHealth's PCA regulations provide that the following individuals cannot serve as a member's PCA: a spouse; a parent of a minor member; or any legally responsible relative, surrogate, or foster parent. 130 CMR 422.404. In addition, PCAs must be legally authorized to work in the United States, not be on the federal or state list of excluded providers, and have a current and valid PCA number.

A related issue involves the total number of hours that PCAs worked, including both travel time and time spent providing PCA services.[36] For example, the Office identified one PCA who worked and traveled an average of 16.33 hours per day, every day, during the first quarter of 2018. The most time that this PCA worked was 17.8 hours in one day. The PCA also spent 1.55 hours traveling between two members, receiving total compensation (PCA services plus travel) of $32,512.05 for the quarter.

A second PCA lived with one member and cared for another who lived approximately 60 driving miles away. This PCA worked 90 out of 90 days; the least amount of time that this PCA worked and traveled in one day during the first quarter of 2018 was 10.8 hours; the most amount of time that this PCA worked was 13.2 hours. This PCA traveled between 2.8 and 4.2 hours each day.

These examples suggest that MassHealth should consider the accuracy of the activity reports. In addition, consistently high travel and work claims over an extended period of time can be red flags for potential fraud, waste, or abuse.

The Office recommends that MassHealth review claims for those members whose PCAs are traveling substantial distances; MassHealth also should consider whether it would be fiscally sound to place limits on the distance for which it will reimburse travel. Similarly, the Office recommends that MassHealth's audit of PCA claims include a review of consistently high work and travel claims to identify program integrity issues.

No one entity has a complete set of information. The final observation that the Office made during its review is that no one entity has a complete set of information about the PCA travel claims.

- MassHealth has the travel claim submission and adjudication information for the member, but no information about the PCAs (*e.g.*, name, address, name of members for whom they care).
- The FIs have the PCA activity sheets, travel claim submissions, and adjudication information for their own members, but no information about members whose PCAs are associated with the other FIs. In other words, one PCA may be associated with more than one fiscal intermediary, but each fiscal intermediary sees only the PCA information that relates to its members. This gap prevents a complete evaluation of any one PCA's travel time.
- Annkissam has the information that it receives from the FIs to calculate travel time, but has no information regarding the MassHealth claim process.

The fact that no one entity has all of the necessary information to conduct a robust travel claim analysis leaves the PCA program open to undetected problems, such as those the Office has identified, as well as to fraud, waste, or abuse, of the program.

[36] This is a conservative analysis because some of these members may have had encounter claims that the Office did not include. In those situations, the encounter claims would document additional time that the PCAs would have worked.

MassHealth is working with its Medicaid Management Information System team to determine whether and how to include each PCA's name on claims for PCA services.[37] If MassHealth is able to implement this change, this will significantly improve MassHealth's ability to conduct program integrity in the PCA program. The Office also recommends that MassHealth and the FIs discuss other ways to increase their ability to conduct program integrity activities.

II. Updates from Fiscal Year 2019 Report

The Office reported on five MassHealth programs in its 2019 report: Adult Day Health, Adult Foster Care, Dental Care, Optometry, and Personal Care Attendants. The Office has followed up with MassHealth to understand how it is implementing the Office's recommendations.

A. Adult Day Health

MassHealth provides adult day health for some of its members with physical, cognitive, or behavioral health issues.[38] Adult day health is a community-based service that provides nursing care, supervision, and health-related support services in a structured group setting. Depending on how long the member is at an adult day health program on a particular day, MassHealth pays the provider either a fixed daily rate or in 15-minute increments. If a member attends a program six or more hours in a day, then the provider must bill the daily rate. If a member attends a program for less than six hours, the provider must bill in 15-minute increments.

The amount that MassHealth pays also depends on the degree of the member's needs. MassHealth may pay a provider a basic or complex payment level.[39] For members at a basic payment level, the provider must document that it provided at least one of the following services during each visit: assistance with one or more activities of daily living, daily behavior support or evaluation, daily activity participation, or skilled services care.[40] For members at a complex payment level, the provider must document that it provided at least one skilled service to the member or a combination of certain activities of daily living and skilled services.

The adult day health regulations prohibit billing for services when a member is (1) receiving services from a home health agency that would be duplicative of those the adult day health program provides; (2) in a hospital, skilled nursing facility, or intermediate care facility; or (3) absent from the adult day health program.

The Office examined claims for approximately 100 providers who served approximately 12,500 MassHealth members during the fourth quarter of 2017. Overall, the Office observed that the adult day

[37] MassHealth's Medicaid Management Information System is MassHealth's claim processing and information retrieval system.

[38] 130 CMR 404.000 et seq.

[39] For the time under review, the daily reimbursement rate for basic care was $58.83 and for complex care was $74.50.

[40] Activities of daily living include eating, dressing, getting in or out of a chair, bathing, and toileting.

health program would benefit from additional oversight and program integrity activities. The Office identified providers that:

- Billed for multiple days in a single claim. For example, providers submitted one claim for seven days of adult day health, with dates of service from the first day of the month through the last day of the month, without identifying which specific days that they provided the services. This appears to be permissible, but it makes oversight difficult because it is impossible to determine the specific dates of service for the provider. Without that information, it is hard to determine whether a member:
    - Received overlapping services on the same day as the member attended a program; or
    - Attended an adult day health program on the same day during which the member had medical appointment(s).
- Billed more than the allowed 15-minute units for a member in a single day, resulting in a payment that exceeds the daily rate. This is not permissible under MassHealth regulations.
- Included the same diagnosis on claims for all or virtually all members receiving services, or consistently billed the same three diagnoses for 75% or more of their members.[41] This is a red flag for fraud, waste, or abuse, because it is highly unusual for the majority of a provider's patients to have the same diagnosis.
- Submitted claims for complex care for members with primary diagnoses (such as type 2 diabetes without complications and essential primary hypertension) that do not appear to support that level of billing. This is a red flag for overbilling because the diagnosis does not indicate a need for complex services.

The Office made several recommendations:

- MassHealth should consider requiring providers to bill for adult day health services one day at a time. This would enable MassHealth to strengthen its program integrity activities by determining if a person received overlapping services on the same day as attending an adult day health program or if the person was actually present at the program on the day billed.
- MassHealth should evaluate how it is processing 15-minute-unit claims to prevent providers from improperly using this procedure code.
- MassHealth should audit claims to determine if providers are accurately presenting member diagnoses and the need for complex care.

[41] For example, type 2 diabetes without complications; major depressive disorder, single episode, unspecified; and primary hypertension.

Once MassHealth has conducted these types of program integrity reviews, it should provide education to those providers that appear to have made errors in billing and refer those providers who appear to be engaging in fraudulent billing to the Massachusetts Office of the Attorney General's Medicaid Fraud Control Unit.

In response to the Office's recommendations, MassHealth:

- Finalized a policy that requires adult day health providers to have documentation to validate the dates when services were provided, even if the adult day health provider bills for multiple dates of service;
- Created a process that prevents providers from being able to submit and receive payment for claims that exceed the six-hour daily maximum; and
- Clarified clinical eligibility requirements for adult day health members and implemented prior authorization requirements for the provision of adult day health services in which providers submit clinical documentation establishing a member's eligibility for adult day health services.

In addition, MassHealth began identifying all adult day health providers who submitted more than 50 claims with a 40% or higher denial rate, and providing training to those providers and conducting audits as needed. MassHealth will also request a temporary moratorium on the enrollment of new adult day health providers from the Centers for Medicare and Medicaid Services.

These changes address the issues that the Office raised and will help MassHealth to better administer the adult day health program and help prevent fraud, waste, and abuse.

B. Adult Foster Care

MassHealth has an adult foster care program.[42] This program allows MassHealth members to live with a caregiver[43] who provides medically necessary assistance with activities of daily living,[44] instrumental activities of daily living,[45] and other personal care. In addition, providers oversee the caregivers by engaging in nursing oversight and care management. The providers are responsible for making sure that the MassHealth members meet the clinical eligibility for adult foster care and that the live-in caregivers provide necessary assistance to the members. Finally, a MassHealth vendor oversees the providers, reviews member applications for the adult foster care program, and maintains all of the necessary paperwork from the providers.

[42] 130 CMR 480.000 et seq.

[43] The caregiver must be at least 18 years old. The caregiver may not be the spouse, parent of a minor member (including an adoptive parent), or any other legally responsible relative of the member.

[44] Activities of daily living are tasks that a person needs to perform to survive comfortably, including walking, eating, dressing and grooming, toileting, bathing, and moving from one position to another (e.g., sitting to standing).

[45] Instrumental activities of daily living are tasks that are part of day-to-day living, including managing finances, transportation, shopping and meal preparation, housing and home maintenance, and medications.

Members qualify to participate in the adult foster care program if (1) the member's primary care physician provides an order for adult foster care; (2) MassHealth (or its designee) approves the adult foster care services; and (3) the member has a medical condition that requires daily hands-on assistance, or cuing[46] and supervision, to complete the necessary activities of daily living.

There are two levels of care in the adult foster care program: basic care and complex care. A member qualifies for basic care if the member requires hands-on assistance with one or two activities of daily living or the member requires cuing and supervision throughout one or more activity. A member qualifies for complex care if the member requires hands-on assistance with at least three activities of daily living or hands-on assistance with at least two activities of daily living and behavior management. MassHealth pays the provider a fixed daily rate based on the level of care; the provider pays the live-in caregivers an individually negotiated amount. MassHealth does not set maximum or minimum rates of payment for caregivers. The provider may include a modifier on the claim to MassHealth to indicate the level of care; each level reimburses the provider a different rate. The MassHealth reimbursement for complex care is almost double the reimbursement for basic care.[47]

When an adult foster care provider is unable to care for the member, the member may receive care from an alternative caregiver. MassHealth will pay both the regular caregiver and the alternative caregiver for up to 14 days each calendar year.

The Office reviewed dates of service on which MassHealth paid two adult foster care claims for one member. Many, but not all, of these were claims for alternative caregiver days. Trends in the claims data indicate that MassHealth is not conducting adequate program integrity activities. Specifically, the Office found several types of improper billing, such as:

- Two paid adult foster care claims for one member with different levels of care on the same date of service

12/1/2017	**TG - COMPLEX/HIGH TECH LEVEL OF CARE (LEVEL II)**	**1**	**$82.06**
12/1/2017	(NO MODIFIER; LEVEL I)	1	$47.74

- Two paid adult foster care claims for one member – one for the regular caregiver and one for an alternative caregiver – with different levels of care on the same date of service

11/18/2017	**U5 - M/CAID CARE LEV 5 STATE DEF (LEVEL II ALTERNATIVE CAREGIVER)**	**1**	**$82.06**
11/18/2017	(NO MODIFIER; LEVEL I)	1	$47.74

- More than two paid claims for adult foster care for one member with different levels of care – one of which is for an alternative caregiver – on the same date of service.

[46] "Cuing" is when a caregiver provides prompts or reminders to the member.

[47] Starting in 2017, the daily reimbursement rate for basic care is $47.74 and $82.06 for complex care.

12/9/2017	**TG - COMPLEX/HIGH TECH LEVEL OF CARE (LEVEL II)**	**1**	**$82.06**
12/9/2017	TG - COMPLEX/HIGH TECH LEVEL OF CARE, U7 - M/CAID CARE LEV 7 STATE DEF (LEVEL II)	1	$82.06
12/9/2017	U5 - M/CAID CARE LEV 5 STATE DEF (LEVEL II ALTERNATIVE CAREGIVER)	1	$82.06
12/9/2017	(NO MODIFIER; LEVEL I)	1	$47.74
12/9/2017	U7 - M/CAID CARE LEV 7 STATE DEF (LEVEL 1 NONMEDICAL LEAVE OF ABSENCE)	1	$47.74

The Office recommended that MassHealth and its new vendor improve their program integrity efforts. MassHealth needed to improve its review of adult foster care claims for fraud, waste, and abuse, to determine if providers are engaging in questionable diagnosis practices, improper billing for complex care, or other billing activity that raises questions about the provision of adult foster care services. The Office also recommended that MassHealth reconsider its practice of allowing providers to determine the rate of compensation for the caregivers. This practice leaves the program vulnerable to providers not adequately compensating caregivers for the care they give to members. Therefore, the Office recommended that MassHealth consider imposing a standard rate that all providers should pay to caregivers with allowances made for regional differences and the type of care (basic versus complex) being provided.

In response to the Office's recommendations, MassHealth has:

- Contracted with a new vendor that will oversee the providers and assist with and enhance MassHealth's program integrity efforts;
- Acknowledged that the adult foster care claims that the Office identified represented "impermissible billing by AFC providers" and put edits in place in its claim adjudication system to deny payment of claims for these billing situations;
- Revised its prior authorization requirements to ensure appropriate clinical eligibility and leveling for all members receiving adult foster care;
- Conducted a review of adult foster care cost reports to determine the rate that caregivers should be paid and reiterated the standard rate adult foster care providers must pay caregivers; and
- Created an algorithm to identify all adult foster care providers that bill for Level II care for 80% or more of their members.

The targeted changes that MassHealth made will enable the agency to better manage the adult foster care program and identify when providers are impermissibly billing for care.

C. Dental Care

The MassHealth and Health Safety Net ("HSN") programs pay for dental care for some MassHealth members and HSN users.[48] The Office examined the MassHealth and HSN dental program and identified three concerns: (1) MassHealth's vendor, DentaQuest, is conducting self-audits; (2) MassHealth is paying certain claims that should, but do not, contain a tooth number or letter; and (3) MassHealth has paid improperly billed claims for evaluation and management of children under the age of three years old.

DentaQuest is conducting self-audits. In 2016, MassHealth engaged a vendor, Dental Service of Massachusetts, Inc., and its subcontractor, DentaQuest, to act as a third-party administrator ("TPA") for MassHealth and the HSN.[49] A TPA processes claims on behalf of an insurer such as MassHealth.

Individual dental providers send claims to DentaQuest. In turn, DentaQuest processes the dental claims and decides whether MassHealth or the HSN should reimburse the provider who performed the dental service. DentaQuest then sends MassHealth files each week containing the claims and its decision regarding which claims MassHealth and the HSN should (and should not) pay. When DentaQuest sends its data file to MassHealth each week, it sends the information to MassHealth's claim adjudication system, NewMMIS. In turn, NewMMIS sends information each week to MassHealth's data warehouse where MassHealth can run reports and analyze claim data.

DentaQuest's contract with MassHealth requires it, among other things, to provide MassHealth with periodic audits evaluating its own work. DentaQuest therefore conducts quarterly "self-audits" to evaluate its performance for MassHealth. DentaQuest provided examples of a self-audit from the first quarters of 2015, 2016, and 2017, showing that DentaQuest did not identify a single error in over 15,000 claims.

In its report to MassHealth, the Office first noted that a vendor should not audit itself. MassHealth needs to audit the vendor to (a) ensure that it is processing claims correctly; and (b) identify fraud. Additionally, MassHealth does not know which claims form the sample for any of DentaQuest's self-audits. As a result, MassHealth is entirely dependent on its vendor to report its performance accurately and is unable to confirm the results of DentaQuest's self-audits. This further leaves open the possibility of fraud, waste, or abuse, occurring with no oversight by MassHealth. Specifically, MassHealth could be paying claims that it should not be paying; denying claims that it should not be denying; and failing to detect providers who are engaging in fraudulent activity. The fact that DentaQuest did not identify a single error in over 15,000 claims is reason alone for MassHealth to audit DentaQuest's work.

The Office recommended that MassHealth not rely solely on DentaQuest to perform "self-audits" without undertaking any kind of diligence to ensure the accuracy of DentaQuest's work. The Office recommended that, at a minimum, MassHealth receive a list of the claims that DentaQuest includes in the self-audit so that MassHealth can verify the results. The Office also recommended that MassHealth

[48] 130 CMR 450.105; 101 CMR 613.03(3)(a)(6) and (4)(b)(4).

[49] MassHealth Bulletin No. 8-8-2016, 2016 WL 4183998 (Aug. 8, 2016).

routinely perform its own audits of the claims that DentaQuest has processed to ensure that DentaQuest is properly performing its work.

In response to the Office's review, MassHealth requested that DentaQuest submit all claims included in its audit reports to MassHealth. MassHealth then uses those claims to validate DentaQuest's claim processing. Having the claims that underlie each audit report partially addresses the Office's concerns. However, the Office continues to recommend that MassHealth perform its own audits of the claims that DentaQuest has processed.

Claims that do not contain tooth letters or numbers. When a provider performs a dental procedure on a specific tooth, the claim must include a tooth letter (primary teeth) or number (permanent teeth) to identify which tooth received treatment.[50] For payment and program integrity purposes, the tooth letter or number allows MassHealth to analyze whether providers are improperly billing for multiple procedures on the same tooth. For example, a tooth can only be extracted once; the identification of which tooth the provider extracted therefore allows MassHealth to determine whether a provider is properly billing an extraction.

As indicated above, when DentaQuest sends its data file to MassHealth each week, it sends the information to MassHealth's claim adjudication system, NewMMIS. In turn, NewMMIS sends information each week to MassHealth's data warehouse where MassHealth can run reports and analyze claim data. MassHealth reports that although NewMMIS can run reports, it does not have a robust reporting function and therefore MassHealth primarily uses the data in the warehouse to perform data analytics.

The Office reviewed 221,331 paid dental claims from MassHealth's data warehouse.[51] Of these claims, 174,864 (79%) did not have tooth numbers or letters in the data warehouse. Many of these claims, such as oral examinations, would not need a tooth number or letter to document the service for payment or program integrity purposes. However, claims for other types of dental services – such as fillings or extractions – require a tooth number or letter for program integrity purposes.

The Office then looked at paid claims from the data warehouse to include only those with six procedure codes that should have a tooth number or letter to indicate which tooth received filling(s) or was extracted.[52] In the data warehouse, the majority of these paid claims (20,360 or 75%) included tooth numbers or letters. However, even though NewMMIS contained tooth numbers or letters for the remaining paid claims (6,449 or 24%), the data warehouse did not. This gap appears to indicate that there is an issue with the data once MassHealth has received the adjudicated claims from DentaQuest (*i.e.*,

[50] By way of example, the American Dental Association Dental Claim Form Instructions directs dental providers to "[e]nter the appropriate tooth number or letter when the procedure directly involves a tooth or range of teeth. Otherwise, leave blank." http://www.ada.org/~/media/ADA/Member%20Center/FIles/ada_dental_claim_form_completion_instructions_2012.

[51] These claims had dates of service from the first two weeks of January 2018.

[52] The codes that the Office reviewed were: D2392 – resin-based composite, two surfaces, posterior; D2391 – resin-based composite, one surface, posterior; D2331 – resin-based composite, two surface, anterior; D2335 – resin – four/more surfaces involving incisal angle; D7140 – extraction, erupted tooth or exposed root; D7210 – surgical removal of erupted tooth required.

information is not being transferred from NewMMIS to the data warehouse). Not having the tooth number or letters in the data warehouse means that MassHealth cannot have robust reporting for its dental claims. For example, the lack of tooth numbers or letters in the data warehouse prevents MassHealth from running comprehensive reports that could reveal fraud, waste, or abuse, in the dental program. As a result, MassHealth is reliant on DentaQuest reviewing its own work and MassHealth cannot perform thorough oversight of DentaQuest's work.

The Office recommended that MassHealth work to address the communication issue between its claim adjudication system (NewMMIS) and its data warehouse so that it can conduct robust analytics on its dental claims. In response to the Office's review, MassHealth increased its sampling of dental claims to validate that DentaQuest is accurately editing and processing claims according to MassHealth regulations. This partially addresses the Office's concerns because it allows MassHealth to provide oversight of DentaQuest's work. However, the Office continues to believe that MassHealth should improve the communication issue between NewMMIS and its data warehouse so that it can conduct analytics on samples of data that it selects, rather than samples that DentaQuest selects.

Improperly billed evaluation and management codes for children under the age of three years old. For MassHealth members under the age of three, MassHealth has a specific procedure code (DO145) indicating that a dentist provided an oral evaluation in conjunction with a discussion with the child's primary caregiver about the child's overall health. After the age of three, dental providers must use a different code on claims for oral evaluations (D0150). MassHealth reimburses providers $27 for the under-three-year-old procedure code and $58 for the over-three-year-old procedure code.

The Office examined approximately 109,000 evaluation and management claims that dental providers billed to MassHealth between 2015 and 2017 for children under the age of three years old. In this group of paid claims, 42% of the claims incorrectly used the DO150 procedure code whereas only 11% properly billed the DO145 procedure code.[53] Based on a reimbursement rate of $58 for each DO150 procedure code and $27 for each DO145 procedure code, MassHealth overpaid by more than $2 million.

The Office provided this information to MassHealth and MassHealth agreed that the proper evaluation code for children under the age of three is D0145. MassHealth indicated that DentaQuest's claim processing system does not currently ensure that all providers treating children under the age of three use this procedure code. However, MassHealth instructed DentaQuest to create an automatic edit in the claim processing system to prevent improper billing for oral evaluations in this age group.

Finally, the Office recommended that MassHealth review the policies of other insurers to see how they pay the correct amount for the DO145 procedure code regardless of what code a provider bills. For example, at least one private insurer will only pay the under-three-year-old rate regardless of what code the dentist bills for a comprehensive evaluation.[54] Having indicated that it has instructed DentaQuest to change how it processes claims for this age group, MassHealth is validating DentaQuest's claim processing

[53] The other claims included procedure codes that were appropriate for the care provided to these children.
[54] https://deltadentalri.com/Content/Docs/URGuidelines.pdf, last visited March 1, 2020.

to ensure that it complies with MassHealth member benefit guidelines. Although these actions are important, the Office continues to recommend that MassHealth analyze the providers who erroneously billed the DO150 procedure code, determine if there are any outliers, and determine whether it should refer those providers to the Massachusetts Office of the Attorney General's Medicaid Fraud Control Division.

D. Optometry

MassHealth pays for its members to receive optometry care, including the diagnosis, prevention, correction, management, and treatment of optical issues.[55] For members who live in long-term care facilities, MassHealth allows optometrists to bill for their travel to such facilities when they provide optometry care to members living there. Optometrists submit a specific procedure code, T2002, to be paid for traveling to provide services to a member. MassHealth indicated that the purpose of the T2002 code is to address the travel costs associated with servicing members outside of the optometrist's office.

MassHealth allows providers to bill a T2002 code "for each member for whom the provider delivered or picked up eyeglasses, or to whom eye exam services were provided, in a nursing-home or home setting."[56] Thus, an optometrist could bill the T2002 code for each member for whom she provided services even if she provided services to multiple members at the same location during the same visit.

MassHealth adopted this code for vision care services in December 2002. Then-Commissioner Warring's transmittal letter from 2002, indicated that optometrists could bill this travel code once per visit to a facility. The letter stated:

> [o]ptometrist/optician home/nursing facility visit for the pickup of a new prescription and fitting of new eyeglasses, or for the delivery and adjustment of new eyeglasses, or for the pickup of broken eyeglasses, or for the delivery of repaired eyeglasses (payable for first recipient seen only; not payable for additional recipients seen during the same visit)[.]

From the date of that letter until June 2007, MassHealth allowed providers to bill this travel code only once per facility per date of service. In June 2007, however, MassHealth responded to providers' request to change its policy and began to allow providers to bill a T2002 claim once per member regardless of how many members the optometrist treats at a single location. MassHealth reimburses providers $9.26 per T2002 claim.

Billing a travel code once per person regardless of how many people are in that location (a) does not accurately reimburse providers based on the cost of travel; and (b) has the potential to lead to overbilling and fraud. Moreover, dental providers who visit MassHealth members in nursing facilities or

[55] 130 CMR 402.000 *et seq*.

[56] 130 CMR 402.418(E)(2).

other locations outside of the office may only bill once per facility per day. And podiatrists also treat MassHealth members outside of the office, but do not appear to receive any additional reimbursement.

The Office examined all of the paid T2002 claims for optometrists between February 2007 and the end of December 2017. The Office reviewed claims from (a) the servicing providers – the optometrist who provided the treatment to the member; and (b) the billing providers – the person or entity that submitted claims to MassHealth. During this period, MassHealth paid 55 servicing providers $1,562,949 for 177,108 T2002 claims. One servicing provider billed this code significantly more than his peers, receiving substantially more reimbursement than his peers, and frequently using the same diagnosis for many of his patients. He also treated 20 or more members on one day more frequently than any of his peers. Together, these findings raised the question of whether this provider had been properly billing this procedure code.

Based on the Office's findings, the Office recommended that MassHealth review patterns of service providers as a regular part of its program integrity activities.[57] This includes analyzing the number of T2002 claims that servicing providers submit (both total claims and claims per day), as well as examining questionable patterns in the use of diagnosis codes. The Office also recommended that the MassHealth optometry program consult with other MassHealth programs that serve members outside of the office setting to evaluate creating a standard payment methodology for travel across programs. Ultimately, if MassHealth decides to maintain a different payment methodology for each program, the Office recommended that MassHealth consider returning the optometry program to the pre-2007 practice of billing one T2002 procedure code per location per day and adopting a reimbursement rate that would adequately compensate providers for the actual cost of traveling to provide these services.

MassHealth accepted this recommendation and consulted with other MassHealth programs that serve members outside of the office setting to evaluate creating a standard payment methodology for travel across programs. However, MassHealth determined that because of the unique qualities of each program and their providers, it would maintain the individual payment methodologies.

MassHealth also analyzed all optometrists' utilization of transportation codes. It found that, except for the one instance identified by the Office, optometrists were correctly billing the transportation code.

[57] MassHealth reported that it only reviews billing providers.