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 93 of Chapter 154 of the Acts of 2018, 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 2018, the Office reviewed the adult day health, adult foster care, dental care, optometry, and personal care attendants programs. Following the Office's reviews, it provided MassHealth with recommendations to improve its program integrity in each program reviewed.

Adult Day Health. Adult day health is a community-based service that provides nursing care, supervision, and health-related support services to eligible members in a structured group setting. After reviewing claims for approximately 100 adult day health providers, the Office noted that certain providers billed for multiple days in a single claim without identifying on which specific days the member attended the program; billed too many 15-minute units resulting in payments that exceeded the daily rate; included the same diagnosis for virtually all members attending a program; and submitted claims for complex care for members whose primary diagnoses did not appear to support that level of billing. The Office recommends that MassHealth consider requiring providers to bill for adult day health services one day at a time. It should also evaluate how it is processing 15-minute-unit claims to prevent providers from improperly using this procedure code rather than the daily procedure code. Finally, MassHealth should review claims to determine if providers are accurately presenting member diagnoses and the need for complex care.

Adult Foster Care. Adult foster care allows eligible members to live with a caregiver who provides medically necessary assistance with activities of daily living, instrumental activities of daily living, and other personal care. The Office recommends that MassHealth and its new vendor improve on the current program integrity efforts. MassHealth should 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. MassHealth should also consider setting guidelines for the rate of compensation for the caregivers.

Dental Care. The MassHealth and HSN programs pay for dental care for some MassHealth members and HSN users. The Office reviewed certain aspects of the dental program and determined that MassHealth does not know which claims its vendor audits each quarter and therefore cannot verify the vendor's results; does not have all of the tooth numbers or letters in its data warehouse that would allow it to conduct robust program integrity activities; and has paid providers who billed an incorrect procedure code for oral evaluations of children under the age of three. The Office recommends that MassHealth conduct its own audits of dental claims instead of relying solely on its vendor to self-audit.

At a minimum, it must require the vendor to provide a list of the claims that it includes in its self-audit so that MassHealth can verify the results. MassHealth should also work to address the communication issue between its claim adjudication system and its data warehouse so that it can conduct robust analytics on its dental claims. Additionally, MassHealth should seek to recoup from providers who improperly billed a procedure code that paid them more than they should have received. Finally, MassHealth should analyze providers who erroneously billed a particular procedure code and determine if there are any outliers that require further scrutiny.

Optometry. MassHealth pays for its members to receive optometry care, including the diagnosis, prevention, correction, management, and treatment of optical issues. For members who live in long-term care facilities, MassHealth allows optometrists to bill once per member for their travel to facilities when they provide optometry care to members living there. The Office identified one servicing provider who billed the travel code substantially more than his peers, received substantially more reimbursement than his peers, and frequently used the same diagnosis for many of his patients. The Office recommends that MassHealth review patterns of servicing providers as a regular part of its program integrity activities. This includes analyzing the number of travel code claims that servicing providers submit as well as examining questionable patterns in the use of diagnosis codes. The Office also recommends that the MassHealth optometry program consult with other MassHealth programs that serve members outside of the office setting to analyze creating a standard payment methodology for travel across programs. Ultimately, if MassHealth decides to maintain a different payment methodology for each program, the Office recommends that MassHealth consider returning the optometry program to the pre-2007 practice of billing one travel 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.

Personal Care Attendants. The purpose of the personal care attendant ("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, on three occasions. Each time, the Office identified problems with the accuracy of the data from each fiscal intermediary. Specifically, the Office identified social security numbers and dates of birth that did not belong to the PCAs; missing or placeholder dates of birth; PCAs with the same first name, last name, and social security number, but more than one date of birth; and multiple PCAs with the same last name and date of birth but unique social security numbers. The Office directed the PCA program to conduct a risk assessment to determine the source of these errors and to work with the FIs to ensure that the FIs have adequate systems in place to detect and prevent these errors from recurring.

BACKGROUND

I. The Office of the Inspector General

Created in 1981, the Office of the Inspector General ("Office") was 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 2018, the Legislature enacted chapter 154 of the Acts of 2018. Section 93 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 2019, the office of the inspector general may expend 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, 2019.

Pursuant to this legislative mandate, the Office examined several MassHealth and HSN programs, including the adult day health, adult foster care, dental care, optometry, and personal care attendant 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 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. Adult Day Health

A. Overview

MassHealth provides adult day health for some of its members with physical, cognitive, or behavioral health issues.[3] Adult day health is a community-based service that provides nursing care, supervision, and health-related support services in a structured group setting. To be eligible for adult day health, the MassHealth member must:

- be 18 years or older;
- receive an order for adult day health from a primary care physician;
- have one or more chronic medical, cognitive, or behavioral health condition(s) that requires "active monitoring, treatment or intervention and ongoing observation and assessment by a nurse, without which the member's condition will likely deteriorate;" and
- require one skilled service (nursing, physical, occupational, or speech therapy), or daily or regular hands-on assistance or cuing[4] with one or more specific activities of daily living.

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 may 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.[5] For members at a basic payment level, the provider must document that it provided at least one of the following services: assistance with one or more activities of daily living, daily behavior support or evaluation, daily activity participation, or skilled services care. 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 provides; (2) in a hospital, skilled nursing facility, or intermediate care facility; or (3) absent from the adult day health program.

[3] 130 CMR 404.000 et seq.

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

[5] Starting in 2017, the daily reimbursement rate for basic care is $58.83 and for complex care is $74.50.

MassHealth reports that it oversees the adult day health program and enforces provider compliance with the regulations by conducting provider reviews and audits.

B. The Office's Review

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 health program would benefit from additional oversight. 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 seven days. This appears to be permissible, but 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.
- 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.[6]
- 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.

C. Recommendations

The Office recommends that MassHealth 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. In addition, MassHealth should evaluate how it is processing 15-minute-unit claims to prevent providers from improperly using this procedure code. MassHealth should also audit claims to determine if providers are accurately presenting member diagnoses and the need for complex care. Once MassHealth has conducted these types of program integrity reviews, it should provide education to those providers that

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

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.

II. Adult Foster Care

A. Overview

MassHealth has an adult foster care program.[7] This program allows MassHealth members to live with a caregiver[8] who provides medically necessary assistance with activities of daily living,[9] instrumental activities of daily living,[10] 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.

Figure 1. Overview of MassHealth Adult Foster Care Program Structure

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[11] 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.

[7] 130 CMR 480.000 et seq.

[8] 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.

[9] 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).

[10] 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.

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

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.[12]

MassHealth reports that it oversees the adult foster care program, enforces provider compliance with its regulations, and conducts reviews and various audits of its providers. MassHealth also reports that it has hired a new vendor that will oversee the providers and assist with and enhance its program integrity efforts.

B. The Office's Review

The Office reviewed the claim histories for a number of providers from fiscal year 2018. Trends in the claims data indicate that MassHealth is not conducting adequate program integrity activities. For example:

- Providers are submitting claims with the same diagnosis for many, if not most, members. Further, these diagnoses do not appear to describe illnesses that would result in a member meeting MassHealth's criteria for adult foster care services.[13] It may be that these members require adult foster care, but the presence of common and subacute diagnoses on many of a provider's claims is a red flag for fraud, waste, or abuse. For example, 99% of one provider's claims contained the primary diagnosis "other malaise."[14] MassHealth reimbursed another provider that submitted 92% of its claims with a primary diagnosis of type 2 diabetes without complications. A third provider submitted 33% of its claims with hypertension as the primary diagnosis.
- Providers are submitting claims for complex care for members whose primary diagnoses do not appear to warrant that level of care. Again, it is possible that these members require complex care, but the presence of a claim for complex care with a less-than complex diagnosis is a red flag for potential fraud, waste, or abuse. For example, one provider submitted claims for complex care for more than half of its claims; of these complex care claims, more than 90% contained a primary diagnosis of type 2 diabetes without complications. A second provider submitted claims for complex care for two-thirds of its claims; of these complex care claims, half the primary diagnoses were primary hypertension, type 2 diabetes without complications, and low back pain.

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

[13] The Office of Inspector General overseeing the United States Department of Health and Human Services noted that a high percentage of primary diagnoses of diabetes and hypertension in home health programs is one indicator of fraud. https://oig.hhs.gov/oei/reports/oei-05-16-00031.pdf (last visited Feb. 28, 2019).

[14] This pattern was similar in fiscal year 2017.

C. Recommendations

MassHealth and its new vendor must improve the current program integrity efforts. There needs to be improved 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. MassHealth should also 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 are providing to members. Instead of allowing the providers such wide leeway, MassHealth should 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.

III. Dental Care

A. Overview

The MassHealth and Health Safety Net ("HSN") programs pay for dental care for some MassHealth members and HSN users.[15] 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.[16] 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.

B. The Office's Review

1. DentaQuest audits its own work and MassHealth cannot verify the results of these audits because it does not know which claims DentaQuest audits each quarter.

DentaQuest conducts quarterly "self-audits" to evaluate its performance for MassHealth. DentaQuest provided the following examples of a self-audit from the first quarters of 2015, 2016, and 2017:

[15] 130 CMR 450.105; 101 CMR 613.03(3)(a)(6) and (4)(b)(4).

[16] MA Bulletin No. 8-8-2016, 2016 WL 4183998 (Aug. 8, 2016).

Figure 2. DentaQuest Self-Audit (1st Quarter 2015)

Group Name	QC Samples	Claims w/Errors
MassHealth - Adult (DDS) Medicaid	185	0
MassHealth - Adult (Regular) Medicaid	1,740	0
MassHealth - Child Medicaid	4,572	0
MassHealth - Limited (Emergency Coverage Only)	65	0
Totals	6,562	0

Figure 3. DentaQuest Self-Audit (1st Quarter 2016)

Group Name	QC Samples	Claims w/Errors
MassHealth - Adult (DDS) Medicaid	145	0
MassHealth - Adult (Regular) Medicaid	1,783	0
MassHealth - Child Medicaid	2,541	0
MassHealth - Limited (Emergency Coverage Only)	97	0
Totals	4,566	0

Figure 4. DentaQuest Self-Audit (1st Quarter 2017)

Group Name	QC Samples	Claims w/Errors
MassHealth - Adult (DDS) Medicaid	168	0
MassHealth - Adult (Regular) Medicaid	1,439	0
MassHealth - Child Medicaid	2,743	0
MassHealth - Limited (Emergency Coverage Only)	114	0
Totals	4,464	0

First, a vendor should not audit itself. MassHealth needs to audit the vendor to (a) ensure that it is processing claims correction; 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 accurately report its performance 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 identified not one error in over 15,000 claims is reason alone for MassHealth to audit DentaQuest's work.

2. Some paid dental claims in the data warehouse do not contain tooth numbers or letters, which hampers MassHealth's ability to properly oversee DentaQuest.

When a provider performs a dental procedure on a specific tooth, the claim should include a tooth letter (primary teeth) or number (permanent teeth) to identify which tooth received treatment.[17] For payment and program integrity purposes, the tooth letter or number allows analysis of 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 that 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.[18] 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,[19] all of which should have a tooth number or letter to indicate which tooth received filling(s) or was extracted. 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. Not having the tooth number or letters in the data warehouse means that MassHealth cannot have robust reporting for its dental claims. As a result, MassHealth is reliant on DentaQuest reviewing its own work and MassHealth cannot perform thorough oversight of DentaQuest's work.

[17] 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.

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

[19] 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.

3. Certain dental providers for MassHealth members under the age of three are using an incorrect procedure code for oral evaluations, and as a result, are receiving a higher reimbursement rate.

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 for children under the age of three years old between 2015 and 2017. 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.[20] 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 said that it will instruct DentaQuest to create an automatic edit in the claim processing system to prevent improper billing for oral evaluations in this age group.

C. Recommendations

MassHealth cannot rely solely on DentaQuest to perform "self-audits" without undertaking any kind of diligence to ensure the accuracy of DentaQuest's work. At a minimum, MassHealth must receive a list of the claims that DentaQuest includes in the self-audit so that MassHealth can verify the results. MassHealth must also routinely perform its own audits of the claims that DentaQuest has processed to ensure that DentaQuest is properly performing its work.

MassHealth should also 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. 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.

MassHealth should review the policies of other insurers to see how they only pay the amount for the under-three-year-old comprehensive examination 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

[20] The other claims included procedure codes that were appropriate for the care provided to these children.

regardless of what code the dentist bills for a comprehensive evaluation.[21] Having indicated that it has instructed DentaQuest to change how it processes claims for this age group, MassHealth must follow up and make sure that DentaQuest implements this change and informs dentists of the correct billing code. MassHealth should also seek to recoup from providers who improperly billed a procedure code that paid them double what they should have received. Finally, MassHealth should analyze the providers who erroneously billed the DO150 procedure code, determine if there are any outliers, and determine whether it should refer those outliers to the Massachusetts Office of the Attorney General's Medicaid Fraud Control Division.

IV. Optometry

A. Overview

MassHealth pays for its members to receive optometry care, including the diagnosis, prevention, correction, management, and treatment of optical issues.[22] 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."[23] Thus, an optometrist could bill the T2002 code for <u>each</u> member for whom she provided services even if she provided services to <u>multiple</u> 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)[.]

[21] https://deltadentalri.com/Content/Docs/URGuidelines.pdf (last visited 2/28/2018).

[22] 130 CMR 402.000 *et seq*.

[23] 130 CMR 402.418(E)(2).

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

B. The Office's Review

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. The Office advised MassHealth of this provider's billing practices. As of the date of this report, this provider is continuing to bill this procedure code and MassHealth is continuing to pay these claims.

C. Recommendations

Based on the Office's findings, the Office recommends that MassHealth review patterns of service providers as a regular part of its program integrity activities.[24] 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 recommends 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 recommends 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.

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

V. Personal Care Attendants

A. Overview

In addition to examining the MassHealth Medicaid and Health Safety Net programs, the Office also monitors the quality, efficiency, and integrity of programs administered by the Executive Office of Health and Human Services.[25] Consistent with the Office's legislative mandates, the Office requested data from MassHealth's Personal Care Attendant program ("PCA program").

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. 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. In state fiscal year 2018, the PCA program served approximately 33,000 MassHealth members at an annual cost of approximately $690 million.

MassHealth contracts with two kinds of vendors to manage the PCA program: personal care management agencies and fiscal intermediaries ("FIs"). The personal care management agencies evaluate members who are eligible for PCA services to determine whether they can participate in the program independently. They also explain the rules to the members, evaluate the members' needs, submit documentation to MassHealth, and generally help members manage their participation in the PCA program. The three FIs help the member with processing timesheets, preparing the PCA's paychecks and direct deposits, sending the paycheck to the member to give to the PCA, and filing and paying the 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.

B. The Office's Review

The Office requested data from MassHealth three times starting in the summer of 2016. Among other information, the Office requested the names, address, social security numbers ("SSNs"), and dates of birth ("DOBs") for all PCAs during a specified date range. As MassHealth does not maintain this information, MassHealth asked the three FIs to provide the requested information. The three FIs produced demographic information for approximately 41,000 PCAs. Each of the three sets of PCA data that the Office received contained errors. After receiving the first two sets of data, the Office asked MassHealth to have the FIs rerun the data. Because MassHealth received the data from the FIs beforeforwarding it to the Office, it is unclear whether the errors originated from the FIs or from MassHealth. The errors include:[26]

[25] M.G.L. c. 6A, § 16V.

[26] The Office used several verification systems to identify the errors.

- SSNs that did not belong to the PCAs, but rather belonged to MassHealth members
    - Some of these related to members who had more than one PCA; in these cases, all of a member's PCAs had one – the member's – SSN
- SSNs that did not belong to the PCAs, but it was unclear to whom the SSN belonged
- DOBs that did not belong to the PCAs, but rather belonged to MassHealth members
    - Some of these related to members who had more than one PCA; in these cases, all of a member's PCAs had one – the member's – DOB
- Missing DOBs, placeholders DOBs (*e.g.*, 1/1/1900), or facially erroneous DOBs (*e.g.*, 8/13/4947)
- PCAs with the same first name, last name, and SSN but more than one DOB
    - For example, John Smith with the SSN 123-45-6789 and multiple DOBs
- Multiple PCAs with the same last name and same DOB but unique SSNs
    - For example, John Smith, Joan Smith, and Julie Smith all with the DOB 4/5/1967 and three unique SSNs

In addition, the dates of birth in the data listed PCAs as young as two years old and as old as 118 years old. At best, the presence of these dates of birth indicates that neither the FIs nor MassHealth is conducting quality control of the data. At worst, the presence of these dates of birth suggests that the PCA program is reimbursing people who may not serve as PCAs.

Finally, all three FIs produced data showing PCAs with out-of-state addresses.[27] Many of these states were in the New England area, which would allow a PCA to travel to Massachusetts to provide PCA services. However, PCAs had addresses in Arkansas, Arizona, California, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Louisiana, Michigan, Mississippi, Minnesota, Montana, North Carolina, Nebraska, New Jersey, Nevada, Ohio, Oregon, Pennsylvania, Puerto Rico, South Dakota, Texas, Virginia, Washington, West Virginia, and Wyoming.

The FIs' inability to produce accurate data regarding PCAs' names, SSNs, and DOBs makes it impossible for MassHealth to conduct meaningful program integrity oversight. It also creates a number of other risks to the PCA program:

- Inaccurate SSNs for PCAs could result in incorrect income reporting to state and federal taxation agencies

[27] One FI listed both a "home" and a "mailing" address field for each PCA. The "home" state field for approximately 5,500 PCAs was blank; 15 PCAs had Massachusetts as their "home" state. The "mailing" addresses for this FI's PCAs include 25 different states, including Arizona, Arkansas, California, Colorado, Florida, Georgia, Indiana, Kentucky, Maryland, Michigan, Minnesota, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, Virginia, Washington, and Wisconsin.

- Inaccurate SSNs and DOBs make program integrity efforts difficult, if not impossible, as these are two of the unique data points used for data matching and analysis
- The lack of consistent and correct data thwarts interagency cooperation to identify and reduce fraud, waste, and abuse occurring in state- and federally-funded programs

The FI's inability to provide accurate information about PCAs also appears to violate their contractual obligations to MassHealth, including that they:

- Maintain all records in a format that is easily retrievable upon request
- Make available to MassHealth compilations of data that pertain to the provision of PCA services
- Apply quality management principles to all aspects of its service delivery system
- Establish and keep current databases of information, including PCAs' names, SSNs, unique PCA identifiers, and addresses
- Conduct program integrity activities, including internal monitoring and auditing

C. Recommendations

The Office directed the PCA program to conduct a risk assessment to determine the source of these errors and to work with the FIs to ensure that there are adequate systems in place to detect and prevent these errors from recurring.