MassHealth FY15 Recoveries Report

OVERVIEW

Under 42 CFR Part 433 Subpart D and Parts 455 and 1002, state Medicaid agencies must undertake specific program integrity functions, including: investigating, detecting, and preventing fraud, waste and abuse, avoiding or correcting errors, determining who can receive Medicaid services, properly reimbursing providers, and assuring that Medicaid is the payer of last resort. With the Office of Medicaid (MassHealth) currently providing comprehensive health coverage to approximately 1.8 million low-income individuals throughout the Commonwealth and currently having over 43,827 enrolled providers, MassHealth's integrity program covers a broad spectrum of activities.

Over the last seven years, the Executive Office of Health and Human Services (EOHHS) has significantly improved coordination and control of MassHealth program integrity activities. The EOHHS Compliance Office was established with the mandate to improve program integrity activities within MassHealth, to identify opportunities and risks, and to serve as the central point of information for program integrity activities, reporting, and resources. Additionally, the EOHHS Operation Integrity Unit was established. One of the purposes of this unit is to improve MassHealth member integrity and eligibility quality control activities.

In addition to the ongoing program integrity efforts detailed in this report, MassHealth has launched a systematic review of fee-for-service programs to ensure appropriate controls are in place and services are delivered efficiently.

PREVENTIVE MEASURES

MassHealth has many systems edits and rules in place to ensure that only members who are eligible receive benefits, and to ensure that reimbursable services were rendered to MassHealth members and were provided by qualified enrolled MassHealth providers.

Member and Provider Enrollment: EOHHS engages in a number of activities to ensure that members meet all eligibility requirements and providers meet all conditions for provider enrollment. For example, EOHHS verifies application information provided by applicants and members through data matches with numerous federal and state agencies and with social service agencies of other states and computer files of banks and other financial institutions. EOHHS also verifies the credentials of health care providers applying to become MassHealth

program providers through various data matches with oversight agencies and the Office of the Inspector General to ensure that provider applicants meet enrollment criteria, including, but not limited to, established parameters regarding disciplinary actions, sanctions, and federal provider exclusions.

Fraud, Waste, and Abuse Detection: Claims for payment submitted by providers are processed through the Medicaid Management Information System (MMIS). This federally-certified system includes a sophisticated series of edits, rules and other payment integrity checks and balances to ensure that payments are made only to eligible providers for services rendered to eligible members, and that the services are covered services provided in accordance with MassHealth payment rules and regulations. All paper and electronic claims are subjected to a rigorous review through daily and weekly editing cycles to identify and reject a variety of inappropriate claims, including, for example, claims for services that have been provided without prior authorization, claims in excess of the maximum number of units recognized as appropriate for a procedure, and claims inconsistent with the patient's diagnosis. Claims that require further review because, for example, the amount billed exceeds established thresholds, or the services appear to be duplicative of services already paid by MassHealth, can be suspended prior to a payment or denial determination to allow time for a more thorough review of the claim.

Prior Approval Unit: The MassHealth prior authorization program, managed by UMass Medical School's Center for Health Policy and Research (CHPR) provides a review process for a selection of medical services and procedures. Each case is examined on an individual basis by appropriate clinicians to determine whether the course of treatment is necessary, appropriate, and effective. In a typical month, CHPR conducts more than 15,341 case reviews. On average, 53 percent of these reviews result in approvals, 22 percent in denials, cancelled/voided and 25 percent are approvals with modifications.

DETECTION MEASURES

MassHealth works to recover improperly paid Medicaid funds, enforce rules and regulations, audit providers and claims, review the quality of care given to Medicaid members, and exclude or terminate providers from the Medicaid program where necessary.

Office of Clinical Affairs/Program Review*:* CHPR conducts a retrospective utilization and peer review program for non-institutional MassHealth providers. Individual program review cases are referred to an appropriate expert to conduct record reviews for medical necessity and quality of care for services provided. EOHHS is currently conducting reviews of physician, pharmacies, mental health clinics, transportation, personal care assistants, dentists, home

health agencies, durable medical equipment providers, community health centers, and laboratories. Providers found to be out of compliance with MassHealth regulations (including medical necessity of services) are subject to overpayment determinations and sanctions.

Type	FY 15
Provider Recoveries	$284K

Information from Members Regarding Services Provided: EOHHS also contacts MassHealth members directly to determine whether the MassHealth services billed were provided. Each month, EOHHS sends Explanation of Medical Benefits (EOMB) notices to approximately 900 members with information regarding claims received during the preceding 90 days.

Public Assistance Reporting Information System (PARIS): MassHealth makes highly effective use of the PARIS match IT system to identify and remove individuals found to be receiving MassHealth benefits in other states makes MassHealth a national leader for detecting member fraud and abuse. This is a federal-state partnership which provides all states' detailed information and data to assist them in maintaining program integrity and detecting/determining improper payments. MassHealth performs the match quarterly to ensure members are not receiving benefits in more than one state simultaneously. Most states perform only annual reviews. Our rigorous approach saved the Commonwealth $16 million in FY15.

Type	FY 15
Cost avoided	$16M

Provider Compliance Unit (PCU): The mission of the PCU, within the UMass Medical School's Center for Health Care Financing, is to assist EOHHS to identify improperly paid claims and suspected provider fraud and abuse in the MassHealth Program through data analysis and, where appropriate, referral of suspected provider fraud and abuse to the Attorney General's Medicaid Fraud Division. The PCU is specifically responsible for fulfilling the Surveillance Utilization Review System (SURS) requirement through the evaluation of the efficiency, effectiveness and utilization of the Medicaid program by providers and recovering improper payments. The PCU identifies duplicative, excessive or contraindicated care or services through desk/on-site reviews of individual

providers, who are selected for review based on indicators contained on predefined reports or ad hoc reports, which show them to be aberrant in their billing practices. In addition, PCU assists EOHHS with certain administrative functions in coordinating its overall integrity programs.

Type	FY 15
Provider Recoveries	$6.6M

Financial Compliance Unit (FCU): The FCU, within the UMass Medical School's Center for Health Care Financing, ensures that provider payments conform to state and federal laws and regulations. Activities of the FCU include field and desk audits of the provider's financial statements. The FCU reviews providers' accounts receivable balances to determine if overpayments have been made.

Type	FY 15
Provider Recoveries	$12.9M

LAW ENFORCEMENT AGENCIES

MassHealth is required by federal law to refer all cases of suspected fraud to the appropriate law enforcement agencies. All suspected provider fraud cases are referred to the Medicaid Fraud Division (MFD) of the Office of the Attorney General. All suspected member fraud cases are referred to the Bureau of Special Investigations of the Office of State Auditor. MassHealth works very closely with both agencies and assists and supports them in all investigations and prosecutions.

Attorney General's MassHealth Fraud Division (MFD): As required by law, EOHHS refers to the MFD all matters where EOHHS has reason to suspect fraud or abuse by a MassHealth provider, whether based on information developed through MassHealth's utilization review activities or information received from another source. Through the mutual efforts of both EOHHS and MFD, MassHealth increased its capabilities to ensure that providers receive only payments to which they are entitled and that those providers engaging in fraudulent practices are quickly identified and prosecuted.

Type	FY 15
Provider Fraud	$8.2M

Recoveries	
MassHealth Fraud Referrals	24

Bureau of Special Investigations (BSI): EOHHS refers all cases of suspected applicant and member fraud to BSI, a special investigative unit within the Office of the State Auditor responsible for addressing health and human services recipient fraud.

Type	FY 15
Recoveries/Restitution	$466K
Member Fraud Referrals	142

AFFORDABLE CARE ACT IMPACT ON PROGRAM INTEGRITY

The Affordable Care Act (ACA) introduced various requirements aimed at improving Medicaid program integrity. MassHealth has implemented the following ACA requirements that will improve the prevention and detection of Medicaid fraud and abuse:

- Medicaid payments to providers are now generally required to be suspended where there is a pending investigation of a credible allegation of fraud, thereby enhancing the Commonwealth's ability to minimize payments that may need to be subsequently recovered and protecting taxpayer dollars.

Number of Provider Implemented Payment Suspensions	Monies Withheld as of June 30, 2015
7	$4.4M

- MassHealth has established a Recovery Audit Contractor (RAC) program to identify and recover overpayments and underpayments. RACs are private entities with which states must contract to conduct post-payment review, including provider audits, claim review and improper payment identification and collection. These contractors are paid on a contingency fee basis.

	Number of Provider Audits	FY 15 Identified Overpayments

Pharmacy Audits	39	$742K
Home Health Audits	22	$935K