Office of the Inspector General
Commonwealth of Massachusetts

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MassHealth's and the Health Safety Net's Management of Healthcare and Healthcare Costs for Super-Utilizers

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Executive Summary

At the direction of the Legislature, as set forth in section 215 of chapter 165 of the Acts of 2014 ("section 215"), the Office of the Inspector General ("Office") has reviewed the administration of the Massachusetts Medicaid program ("Medicaid") and the Health Safety Net program ("HSN") by MassHealth, the state entity that runs both programs. Pursuant to section 215, the Office examined how MassHealth and the HSN program are addressing the needs of "super-utilizers" of the healthcare system. Super-utilizers are a small number of individuals who use a large amount of healthcare resources. Across the country, approximately 5% of beneficiaries account for more than 50% of total federal Medicaid spending.[1] In Massachusetts, providing appropriate, cost-effective care to super-utilizers is important to the financial well-being of Medicaid and the HSN program. Indeed, in fiscal year 2013 (July 1, 2012 through June 30, 2013), the 500 MassHealth members with the highest number of paid claims incurred approximately $68.5 million in healthcare costs; the 322 HSN users with the highest number of paid claims incurred approximately $15.7 million in healthcare costs.[2]

This review focused on the 100 MassHealth members and 99 HSN users who had the highest number of paid claims during fiscal year 2013. The 100 MassHealth members collectively had 69,305 paid claims that covered approximately 200,000 services, totaling over $16 million, or an average of $164,000 per person.[3] The 99 HSN users collectively had 19,316 paid claims that covered over 39,000 services, totaling approximately $5.79 million, or an average of $58,000 per person.[4] Some of these individuals had catastrophic injuries or illnesses, but many have chronic conditions that require regular, ongoing care. The review's broad goal was to understand what programs are, or could be, in place to ensure that super-utilizers are receiving clinically appropriate services delivered in a cost-effective manner, as well as to identify whether there are opportunities for MassHealth to improve its program integrity activities and reduce the potential for fraud, waste, or abuse that increases super-utilizers' healthcare costs.

The review found that both MassHealth and the HSN program could work to provide better care coordination for their members and users, which could lead to better health outcomes and eliminate waste. The review also found that MassHealth and the HSN program, combined, paid approximately $6.6 million for claims that did not contain a diagnosis, which is contrary to both the MassHealth regulations and the HSN's program requirements. The payment of claims without diagnoses also limits program integrity activities and care coordination.

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[1] Symposium, *Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs*, Center for Healthcare Strategies Inc., The Robert Wood Johnson Foundation, and The Atlantic Philanthropies, Hamilton, N.J. (Oct. 2013).

[2] To put these numbers in perspective, during fiscal year 2013 MassHealth paid approximately $9.8 billion in claims for approximately 1.4 million MassHealth members. During this same year, the HSN program paid approximately $367 million for healthcare for approximately 400,000 users.

[3] One claim may contain charges for one or more than one healthcare service.

[4] All HSN dollars in this report are based on MassHealth pricing. However, once MassHealth has priced a claim, the HSN may then adjust the dollar amount up or down before authorizing payment to the provider.

The review also found that MassHealth needs to improve its review of community-based services because its current methods are not working well. Specifically, the review showed that MassHealth paid claims for: transportation that did not have a corresponding claim for medical services; multiple home health agencies to provide the same type of service to the same person on the same day; and adult day care providers to transport members on days on which there was no claim for adult day care.

As a result of these findings, the Office recommends that MassHealth consider participating in the CMS Health Home program, which would provide resources to address the needs of super-utilizers and enhance care coordination. The Office also recommends that MassHealth consider seeking out an administrative partnership with Medicare to increase coordination of care to super-utilizers and enhance its claim review process. The Office further recommends that the HSN program consider implementing demonstration projects to reduce acute hospital payments for HSN users.

With regard to its claim processing, MassHealth should improve its claims review process so that it denies all claims that do not contain a primary diagnosis. MassHealth should also increase its scrutiny of certain community-based services. As part of this scrutiny, MassHealth should include claim information from its managed care organizations in its post-payment review and should explore whether it is feasible to obtain Medicare and private insurance claim information. Including this additional claim information would inform and improve MassHealth's claims review.

Finally, although the review focused on super-utilizers, both MassHealth and the HSN program could apply some of the findings and recommendations to the broader MassHealth and HSN populations. For instance, the payment of claims without a diagnosis code is a flaw in MassHealth's claim adjudication system, as is paying transportation claims that do not have a corresponding medical claim. It therefore is likely that MassHealth and the HSN program are paying these same types of claims with respect to the broader MassHealth and HSN populations.

Introduction

In July 2014, the Legislature enacted chapter 165 of the Acts of 2014. Section 215 of that law directed the Office of the Inspector General ("Office") to study and review the Massachusetts Medicaid program ("Medicaid") and Health Safety Net ("HSN") program:

> Notwithstanding any general or special law to the contrary, in hospital fiscal year 2015, the office of the inspector general may expend a total of $1,000,000 from the Health Safety Net Trust Fund, established by 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 all hospitals including, but not limited to, the care of the uninsured and the resulting free charges. The unit shall also study and review the commonwealth's Medicaid program including, but not limited to, reviewing the program's eligibility requirements, utilization, claims administration and compliance with federal mandates. The inspector general shall submit a report to the house and senate committees on ways and means on the results of the audits and any other completed analyses on or before March 1, 2015.

For ease of reference, the Office will refer to individuals who utilize these programs as "MassHealth members" and "HSN users."

Pursuant to this legislative mandate, the Office conducted a review of the MassHealth members and HSN users who generated the highest number of paid claims during fiscal year 2013 (July 1, 2012 through June 30, 2013). The review's broad goal was to understand the needs of "super-utilizers" (individuals who frequently use the healthcare system), to assess how the MassHealth and the HSN programs address the needs of super-utilizers, and to identify whether there are opportunities for MassHealth to improve its program integrity activities and reduce the potential for fraud, waste, or abuse that increases super-utilizers' healthcare costs.

Nationally, approximately 5% of beneficiaries account for more than 50% of all federal Medicaid spending. Traditional reviews of super-utilizers look at patients with the highest number of inpatient admissions and emergency department visits, which are high-cost settings that super-utilizers tend to use frequently. This review focused instead on MassHealth members and HSN users with the highest number of paid claims for all healthcare services, thereby representing the largest number of encounters with the healthcare system. The purpose of this focus was to gain insight into the kinds of services MassHealth members and HSN users access most frequently and to evaluate whether there are ways for MassHealth to better detect fraud, waste, or abuse relating to those encounters with the healthcare system.

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Background

I.   The Office of the Inspector General

Created in 1981, the Office of the Inspector General 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 provides assistance to the public and private sectors to help prevent fraud, waste, and abuse in government spending.

The Office has considerable experience reviewing healthcare programs that have eligibility, documentation, and verification components and has issued a number of analyses, reports, and recommendations regarding Medicaid, the HSN program, healthcare reform, and other healthcare topics. The Office also has expertise in developing fraud-control best practices for state agencies and municipalities.

II.   The Medicaid Program

The federal government created the Medicaid program in 1965 to provide medical assistance to low-income Americans, particularly children, through a shared state-federal commitment. Today, Medicaid 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 & 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.

A.   Overview of types of MassHealth categories and coverage

Medicaid provides healthcare coverage for certain individuals who would not otherwise have access to such coverage. Although it is partially funded by the federal government, the Commonwealth is responsible for administering the program. As the administrator, MassHealth must ensure that the program meets both federal and state mandates. With permission from the federal government, the Commonwealth may create programs that broaden payment for healthcare services to include more residents who do not meet all the federal Medicaid standards. MassHealth currently administers seven different types of Medicaid programs and five additional non-Medicaid benefit programs. The MassHealth Medicaid programs are:

1) MassHealth Standard: for pregnant women, children, parents, caretaker relatives, young adults, disabled individuals, certain individuals who are HIV positive, individuals with breast or cervical cancer, independent foster care adolescents, Department of Mental Health members, and medically frail individuals;

2) CommonHealth: for disabled adults, disabled young adults, and disabled children who are not eligible for MassHealth Standard;

3) CarePlus: for adults 21 through 64 years of age who are not eligible for MassHealth Standard;

4) Family Assistance: for children, young adults, certain noncitizens, and individuals who are HIV positive who are not eligible for MassHealth Standard, CommonHealth, or CarePlus;

5) Small Business Employee Premium Assistance: for adults or young adults who work for small employers; are not eligible for MassHealth Standard, CommonHealth, Family Assistance, or CarePlus; do not have anyone in their family who is otherwise receiving a premium assistance benefit; and have been determined to be ineligible for a qualified health plan;

6) MassHealth Limited: for certain lawfully present immigrants, nonqualified persons residing under color of law, and certain other noncitizens; and

7) Senior Buy-In and Buy-In: for certain Medicare beneficiaries.

130 C.M.R. § 505.001(A).

The five additional non-Medicaid benefit programs are the Health Safety Net Program (discussed in Section III at page 7), the Children's Medical Security Plan (provides certain uninsured children and adolescents with primary and preventive services), the Healthy Start Program (promotes early, comprehensive, and continuous prenatal care to low-income, uninsured pregnant women), the Insurance Partnership (makes health insurance more affordable for qualified small businesses and their employees), and the Special Kids/Special Care Pilot Program (provides coordinated medical care to children in foster care with special healthcare needs).

B.   MassHealth fee-for-service and managed care

Broadly speaking, MassHealth uses two models to provide for its members' healthcare: fee-for-service and managed care organizations. MassHealth describes fee-for-service as "a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice." Managed care involves a group of healthcare providers that work together, which creates administrative control over, and coordination of, the services that they provide. The overarching goal of managed care is to eliminate redundant or unnecessary services and to reduce costs. Most MassHealth members who are under 65 years old must enroll in a managed care option and can choose either the Primary Care Clinician Plan ("PCC") or a MassHealth-contracted Managed Care Organization ("MCO"). These managed care options provide for the management of healthcare services, including primary care, behavioral health,

and other medical services. Members who enroll in a PCC obtain their primary care services from the PCC and behavioral health services through the MassHealth behavioral health contractor, the Massachusetts Behavioral Health Partnership ("MBHP"). Members who enroll in an MCO obtain all of their healthcare services, including behavioral health services, from the MCO.

C.   Dual eligibles

Some adults between the ages of 18 and 65 are eligible for both Medicaid and Medicare ("dual eligible"). These adults may be eligible for both Medicaid and Medicare based on their disability, low economic status, or chronic medical condition. Dual eligibles typically have complex medical and socio-demographic needs. For example, 55% of dual eligibles under the age of 65 have at least one limitation in activities of daily living[5] and 40% do not have a high school diploma. Accordingly, dual eligibles tend to have high per-person healthcare spending.

Some healthcare claims for these individuals are referred to as "crossover claims," which means that Medicare pays a portion of the claim and MassHealth receives a claim for any remaining healthcare costs that Medicare did not cover. MassHealth then evaluates whether to pay the claims. Except for its receipt of crossover claims, MassHealth does not seek out or receive Medicare claims for clinical review or program integrity activities, such as to ensure that care for which it is paying is not duplicative and is medically necessary.

III.   The Health Safety Net

In 1985, the 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[.]" G.L. c. 6A, § 75 (repealed 1988). 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 under-insured patients. In addition, the UCP reimbursed hospitals for emergency services for uninsured patients for 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." Initially, the Division of Healthcare Finance and Policy managed the HSN program, but in 2012 the Legislature transferred that responsibility to the Office of Medicaid ("MassHealth") within the Executive Office of Health and Human Services. MassHealth in turn created the HSN Office to oversee the HSN program.

There are three categories of services for which the HSN program pays: (1) health services to low-income patients; (2) medical hardship for individuals whose medical expenses have so depleted their income that they are no longer able to pay for services; and (3) bad debt

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[5] Activities of daily living, or "ADLs," include the things that individuals do every day to care for themselves, including bathing and showering, dressing, eating, personal hygiene and grooming, and toilet hygiene.

arising from accounts receivable that hospitals and community health centers have tried to collect without success. The HSN program pays only for services that are medically necessary and for which no other public or private payor is responsible. In fiscal year 2013, the HSN program reported that it paid acute care hospitals and community health centers approximately $367 million.

IV.   Overview of Super-Utilizers

State Medicaid agencies across the country have long recognized that a large proportion of the costs they incur result from healthcare provided to a relatively small group of individuals. These individuals who use a large percentage of healthcare services, as compared with other users of the healthcare system, are sometimes referred to as "super-utilizers." Indeed, across the country, approximately 5% of Medicaid beneficiaries account for more than 50% of total federal Medicaid spending.

Although some of these beneficiaries are at the end of their lives or are facing catastrophic illnesses and injuries, others face multiple, chronic issues that can result in expensive care. It is also possible that some individuals are receiving unnecessary care. Studies have found that super-utilizers often face challenges that have an impact on their healthcare use patterns or their ability to comply with their providers' directions.[6] These challenges include:

- Chronic healthcare conditions, such as diabetes, end-stage renal disease, asthma, and heart disease;

- Mental illnesses;

- Substance abuse and addiction;

- Homelessness and unstable living arrangements; and

- Lack of family support.

In addition, the way the healthcare system itself works can affect these individuals and their utilization patterns in dramatic ways. For example, individuals without timely access to quality primary care or a regular source of care are more likely to use the emergency room or inpatient services. Conversely, those being served by providers with integrated clinical information systems and a holistic care management approach may experience less fragmentation and more efficient care. Finally, individuals who are especially vulnerable may experience unnecessary care or have expensive claim patterns that include services they did not actually receive.

Policymakers and program administrators have increasingly turned their attention to super-utilizers, hoping to identify and adopt programs that can improve the quality of care they receive while lowering costs. There are numerous care and cost interventions that can improve

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[6] *See*, *e.g.*, Symposium, *Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs*, Center for Healthcare Strategies Inc., The Robert Wood Johnson Foundation, and The Atlantic Philanthropies, Hamilton, N.J. (Oct. 2013).

the provision of healthcare for super-utilizers. Indeed, the Centers for Medicare & Medicaid Services ("CMS") as well as a number of foundations and state Medicaid agencies have super-utilizer initiatives in place. Such initiatives, including some already under way in Massachusetts, provide valuable information that MassHealth can use to identify program components that fit the needs of their patient populations. Moreover, advances in data analytics have the potential to enhance Medicaid agencies' abilities to identify and monitor this population, as well as more closely analyze the high volume of claims associated with super-utilizers to deter fraud, waste, and abuse.

A.   **MassHealth currently has several initiatives under way to address super-utilizers.**

Several initiatives are currently under way in Massachusetts to improve program and care coordination for MassHealth members. For example, Massachusetts recently partnered with the federal government to launch a program, One Care, which addresses the healthcare needs of adults between the ages of 18 and 65 who are eligible for both Medicare and Medicaid ("dual eligibles"). The stated purpose of One Care is to link the benefit structures for dual eligibles to allow for better coordination of care, more streamlined service delivery and reimbursement processes, and lower costs. Massachusetts had enrolled 17,797 individuals in the program as of March 1, 2015. One Care program utilization is in its early stages, but has resulted in substantial financial losses for the private insurers who are participating in the program. In spite of this initial result, several of the private insurers participating in the program believe that it is the right model of care and are working to find ways to "fix" the program.[7]

Massachusetts is also in its fourth year of implementing the Money Follows the Person ("MFP") demonstration, which targets a subset of MassHealth super-utilizers. The MFP demonstration is a joint federal-state initiative based on the premise that many high-need Medicaid beneficiaries currently residing in institutions could receive more appropriate and cost-effective care in a community setting. Because state Medicaid programs frequently have reimbursement restrictions on the types of home and community-based services ("HCBS") that can help this population to live in the community, the MFP demonstration aims to provide states with more flexibility around payments for nontraditional HCBS services. The most recent federal annual report on the MFP demonstration found that in the year after they transition out of institutionalized care, expenditures for MFP enrollees decrease by approximately 20% across all subpopulations, including older adults and individuals with physical disabilities, intellectual disabilities, and mental illnesses.[8]

Through the Massachusetts Behavioral Health Partnership ("MBHP"), MassHealth provides integrated care management services to "high-risk individuals." MBHP identifies these high-risk individuals through claims data using a predictive modeling tool that flags those with complex medical, mental health, or substance abuse disorders. This integrated care management program is in its third year. The stated purpose of the MBHP integrated care management

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[7] Priyanka Dayal McClusky, *Program To Manage Care Of Poor, Disabled Sustains Losses*, Boston Globe (Aug. 3, 2015).

[8] Carol V. Irvin et al., *Money Follows the Person 2013 Annual Evaluation Report*, Cambridge, MA (Feb. 25, 2015).

program is to use care managers (primarily nurses and social workers) to connect members with services such as child care or transportation. The design of this program also includes supplementing a primary care provider's team with services such as home assessments; care coordination among different providers and agencies; assistance with appointment reminders and transportation arrangements to decrease appointment no-shows; and education to help patients comply with medication regimens.

Over the course of the program's early implementation, MBHP reports that primary care provider teams have welcomed the care management services, even those practices that have strong relationships between their providers and patients. MBHP also reports that the general feedback from providers has been that, although they feel well-equipped to meet the needs of their general patient population, they do not have the capacity to perform the extensive care management that high-utilizing and medically complex patients require. Therefore, MBHP believes that the integrated care management program has allowed for a natural division of labor between providers and MBHP that capitalizes on the strengths of each type of entity without overburdening either. In addition to its integrated care management program, MBHP also reports that it has a community support program that targets a subset of super-utilizers when they are discharged from residential or acute care settings (*e.g.*, detoxification centers or inpatient psychiatric units). These individuals often need particular assistance in accessing the resources required to transition back into community-based settings. MBHP indicates that its community support managers connect these individuals to various services so that they can access the necessary follow-up care to avoid a readmission or another type of high-cost intervention.

Going forward, MBHP believes that it has identified several opportunities to enhance care management for super-utilizers. For example, MBHP reports that it is adding providers that are typically less costly than nurses and social workers, such as community health workers or peer counselors, to its care management team. MBHP also reports that it is developing an alternative payment strategy to create incentives for providers working with super-utilizers.

B. Other program models also address the needs of super-utilizers, including managed care, provider network, and fee-for-service arrangements.

Providers have developed a variety of program models to address the needs of super-utilizers.[9] These models include managed care, provider network, and fee-for-service arrangements.

1. Celticare – Medicaid managed care model

One of the managed care organizations that administers services for the Massachusetts Medicaid population – Celticare – reports that it has developed a new approach to address the

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[9] *See, e.g.*, Symposium, *Super-Utilizer Summit: Common Themes from Innovative Complex Care Management Programs*, Center for Healthcare Strategies Inc., The Robert Wood Johnson Foundation, and The Atlantic Philanthropies, Hamilton, N.J., Oct. 2013; Thomas Bodenheimer, *Strategies to Reduce Costs and Improve Care for High-Utilizing Medicaid Patients: Reflections on Pioneering Programs*, Center for Healthcare Strategies, Inc., Hamilton, NJ., Oct. 2013.

needs of super-utilizers. Celticare states that it runs monthly queries of its database to generate reports that identify individuals with the highest total medical spending, individuals with the most emergency department visits, and individuals at high risk of resource utilization due to physical and behavioral health issues. Celticare indicates that it assesses all of these members for clinical need and then coordinates with providers to conduct face-to-face interventions when necessary. Celticare also reports that it is conducting several small-scale initiatives in selected service areas to identify different approaches to managing super-utilizers.

2. Camden Coalition of Healthcare Providers – provider network model[10]

The Camden Coalition of Healthcare Providers ("CCHP") is a network that considers itself a community organizer of health providers in Camden, New Jersey. After building a consolidated patient database and conducting an analysis of its community's utilization, CCHP developed the "Link2Care" program to meet the needs of its super-utilizer population. The program is a community-based model with care management teams that connect with hospitalized patients, stabilize them for transition to home, and then continue to connect with them for a set time period. The stated goal of the program is to ensure that these patients have continued access to low-cost care settings, such as outpatient behavioral health and primary care.

Since its initial launch in 2007, the Link2Care program has encountered several of the barriers typically presented by a high-utilizing population and reports that it has identified strategies to address those barriers. For example, care management teams were originally led by higher-cost professional staff, such as registered nurses. However, when it became apparent that the majority of super-utilizers were more likely to need assistance with filling out housing forms rather than clinical expertise, the program changed its approach. Care management teams now include lower-cost staff, such as licensed practical nurses, community health workers, and peer health coaches. The Link2Care program reports that this change has lowered the cost of the Link2Care program and enabled it to expand further into the communities served by CCHP.

In addition, the Link2Care program is tracking whether the program is meeting its objectives. It is measuring the number of patients who have an outpatient follow-up visit within seven days of an inpatient discharge. It is also tracking outcome measures such as the proportion of patients who are readmitted to an inpatient facility within 30 days of discharge. The program reports that its staff and care teams use these kinds of data to identify gaps in care and to then target approaches and interventions to fill those gaps.

The healthcare providers participating in the Link2Care program were not initially part of the same network. To address this challenge, CCHP not only coordinates care across providers for individual patients enrolled in the program, it also holds periodic meetings for providers to discuss concerns and barriers to effective super-utilizer care, as well as to brainstorm potential solutions. According to CCHP, through these efforts, providers have built relationships with one another to better address the needs of super-utilizers.

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[10] Letter from Jeffrey Brenner to Valerie Harr and Carol Grant, New Jersey Department of Human Services (Mar. 5, 2015). *See also* www.camdenhealth.org/.

One of the factors that CCHP reports is critical to its program is its effort to engage stakeholders in the Camden community, including religious organizations, social service agencies, private volunteer and aid groups, and providers from multiple care settings. Community engagement is critical because super-utilizers often have needs that go beyond the healthcare system and there may be unique assistance available in – or challenges facing – a particular community about which healthcare providers may be unaware.

The potential savings of the Link2Care program are currently being evaluated. However, program leaders reported anecdotally that they have started to see a positive impact on patient utilization of services and other intermediate outcomes. At the same time, leaders acknowledge that most super-utilizers will likely have persistent healthcare needs that require increased clinical and care management. One potential area that CCHP is exploring is the earlier identification of potential super-utilizers by targeting individuals with diagnoses that are more difficult to treat in later stages. These conditions include diabetes, hypertension, depression, and Hepatitis C, all of which, if poorly managed, place individuals at risk for serious health outcomes and expensive care.

3.   Washington State – fee-for-service Medicaid program model[11]

Washington state's Medicaid program has adopted CMS's "Health Home" program model to address the needs of its super-utilizer population. The Health Home approach allows state Medicaid agencies to designate networks of service providers to meet the primary, mental health, and long-term services and support ("LTSS") needs of super-utilizers. Part of the rationale for building networks of providers rather than designating a single primary care practice as the central source of care is that a single practice may not have the in-house capacity to address all of a super-utilizer's needs. These networks are eligible for shared savings and the Medicaid agency holds them accountable to measures of quality and efficiency in delivering services. States are eligible for enhanced federal funding from CMS for Health Home services.

In Washington, the Aging and Long-Term Services Administration's Chronic Care Management ("CCM") program was one of three pilot programs that the state used between 2007 and 2012 to test Health Home services. The CCM program reports that it had the highest return on investment of the models tested, returning $1.15 for every $1.00 spent on the program. The CCM program used nurse care managers to coordinate care for a subset of disabled Medicaid beneficiaries who had functional limitations, received in-home personal care, and had cost-based risk scores in the top 20% of disabled beneficiaries. The stated objective of the program was to improve the quality and efficiency of care by coordinating care across providers, educating beneficiaries about their health, and helping beneficiaries set and achieve goals for self-management.

In adapting the CCM model for application to a statewide Health Home program, Washington automatically enrolls all Medicaid beneficiaries who have one identified chronic condition and are at risk for developing another chronic condition and assigns them a care

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[11] Washington State Healthcare Authority, *Health Home Interim Report*, Olympia, WA (Dec. 5, 2014).

coordinator. The care coordinators are responsible for connecting enrolled beneficiaries to providers on their Health Home team and other social or community services.

In the program's first year (July 2013 – June 2014), Washington enrolled 33,354 individuals and designated 500 provider practices to deliver Health Home services. Early results from the program have highlighted the needs of enrollees for coordinated care beyond medical services, including treatment for substance abuse, serious mental illness or developmental disabilities, and long-term care.[12] One challenge Washington has encountered in expanding the CCM beyond the elderly and disabled population to a broader population of super-utilizers is engaging Medicaid recipients. In particular, the state found that younger disabled beneficiaries typically had unstable housing situations, making it difficult for Health Home teams and care coordinators to maintain consistent contact with them to manage their care. Going forward, Washington plans to enhance its beneficiary contact information databases by collaborating with other state social service agencies, and provide additional training to care coordinators around connecting Medicaid beneficiaries to housing programs.

4.   Minnesota – dual eligibles program model[13]

Like Massachusetts, Minnesota is implementing a dual-eligibles demonstration program. However, Minnesota chose a different approach by seeking to coordinate the administrative functions between Medicare, Medicare Advantage, and its Medicaid agency to save money in program operation. Minnesota and the federal government will partner to streamline the enrollment processes, the quality measurement and reporting requirements, and reimbursement policies. There are several expected outcomes of this approach, including the reduction of administrative expenses. The administrative coordination also has the potential to enhance the state's capacity to investigate suspected fraud or abuse, as Medicare and the Minnesota Medicaid department are developing systems to share information about cases in which claims are denied, services are appealed, or fraud is suspected. One of the challenges Minnesota has encountered in developing its program for dual eligibles is how to fairly allocate any cost savings between the Medicaid and Medicare programs.[14]

5.   Common themes and key features of existing programs

There are several common themes that connect the programs described above. First, programs that serve as extensions of provider care settings appear to be beneficial. These initiatives focus on adding services to existing provider activities rather than implementing a parallel program that may duplicate or disrupt care already in place. Using a care coordinator

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[12] Washington State Healthcare Authority, *Health Home Interim Report*, Olympia, WA (Dec. 5, 2014).

[13] Memorandum of Understanding Between CMS and the State of Minnesota Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience (Sept. 12, 2013); s*ee also* Memorandum from Marilyn Tavenner, Centers for Medicare & Medicaid Services, and Lucinda Jesson, Minnesota Department of Human Services (Sept. 12, 2013).

[14] New York also has an integrated appeals model. Although it is not included in this review, it is another potential source of useful information as it is a model for federal and state partnership in supporting administrative simplification. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.pdf.

would be an example of an additional service that would work in conjunction with a patient's existing healthcare providers. Because primary care providers typically do not have the capacity to meet all the care management needs of super-utilizers, programs that place this responsibility solely with those providers have faced significant challenges. Instead, programs can use the strengths of different kinds of healthcare providers, balancing clinical care with a broader view of all of the patient's potential needs and available services.

Carefully identifying a super-utilizer population and tailoring an intervention to that population's needs is another important feature of current programs. The term "super-utilizer" can cover a broad group of individuals with very different clinical and socio-demographic characteristics. For example, the services and expertise necessary to manage the care and treatment for a homebound elderly beneficiary with cancer are unlikely to be suitable for a young homeless adult with a substance abuse disorder, diabetes, and hypertension. The wide array of physical, intellectual, mental health, and substance abuse disorders that may be present in a super-utilizer population make it challenging to implement a one-size-fits-all solution to improve quality and efficiency outcomes. Setting clear parameters for a target population and outlining the desired goals of a program are also critical steps in addressing the needs of super-utilizers.

Most of the super-utilizer programs reviewed include a component that facilitates connections between healthcare services and other stabilizing services, such as housing, income, and other long term services and support ("LTSS"). Indeed, going to the doctor often is not a priority for an individual who does not know how he will get access to food, shelter, or transportation. Thus, assisting super-utilizers achieve the goals that are important to them is part of establishing a successful partnership. By building the capacity to meet the needs of the whole person, these programs increase the likelihood that health interventions will be implemented in a stable and receptive environment.

Finally, engaging healthcare providers in designing programs to address the needs of super-utilizers is essential. Providers typically have insight into the issues facing the super-utilizer population that state Medicaid agencies may not. Without information from local providers, the Medicaid agency might not be able to identify important issues for the health of these patients and, as a result, may implement a program that does not address critical needs. Provider involvement can generate information about quality and outcome measurement, care management support, and beneficiary engagement strategies.

V.   The Office's Review of MassHealth and HSN Super-Utilizers

The Office began by identifying the MassHealth members and HSN users with the greatest number of claims that MassHealth and the HSN program paid for healthcare services received during fiscal year 2013 (July 1, 2012 through June 30, 2013) ("paid claims"). Specifically, the review included the 100 MassHealth members and the 99 HSN users with the greatest number of fee-for-service[15] paid claims. There were 69,305 paid claims that covered

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[15] This review included only fee-for-service claims, which MassHealth describes as a method of paying for medical services provided by any MassHealth participating provider with no limit on provider choice. The review did not include claims for services provided by managed care organizations. Managed care involves a group of healthcare providers that work together, which creates administrative control over, and coordination of, the services that they

199,690 services for these MassHealth members, totaling $16,444,321 (an average of $164,443 per MassHealth member).[16] There were 19,316 paid claims that covered 39,183 services for these HSN users, totaling $5,790,154.00 (an average of $58,486.40 per HSN user).[17] Using data analysis and case reviews to understand the services these individuals received, the Office identified potential gaps in care for individuals for whom MassHealth and the HSN program could take steps to reduce the cost of care, reduce unnecessary services, improve quality of care, and reduce inappropriate billing. The Office also examined whether MassHealth and the HSN program could do more to uncover fraud, waste, or abuse.

The review also relied on profile reports for each MassHealth member and HSN user during the year under review to provide a high-level understanding of their care patterns and needs as well as potential program integrity concerns. For each member or user, the profile reports included:

- Individual demographic information, including age, gender, and the city and zip code of the person's residence;

- The most common services and diagnoses found on the claims that providers billed for the person;

- The providers that billed the greatest number of services for each person, the payments made to these providers, and the number of other individuals these providers served;

- Service use information, including the total number of services that providers billed during the year on behalf of the person, and the numbers of inpatient stays, emergency room visits, physician visits, and prescriptions filled;

- Number of transportation services, durable medical equipment services, and adult day healthcare or day habilitation services provided to the person during the year;

- Number of inpatient admissions the individual had during the year;

- Number of readmissions and emergency room visits within 90 days of inpatient discharge;

- Total payments MassHealth or the HSN program made on behalf of the member or user; and

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provide. The overarching goal of managed care is to eliminate redundant or unnecessary services and to reduce costs.

[16] One claim may contain one or more healthcare services. For example, a home health provider may include more than one visit on a single claim.

[17] All of the HSN claim information in this report came from MassHealth because MassHealth processes HSN claims. In that process, MassHealth applies its own prices to the HSN claims. As a result, all HSN dollars in this report are based on MassHealth pricing. However, once MassHealth has priced a claim, the HSN may then adjust the dollar amount up or down before authorizing payment to the provider.

- Number of distinct prescriptions.[18]

The review team included a board-certified internal medicine physician with significant experience treating Medicaid patients. He performed a clinical review of each of the cases using the profile reports and claims history to assess the care provided to each person to the extent possible without access to medical records or interaction with the patients or their practitioners. His goal was to identify a number of issues. First, he looked at individuals for whom actions could be taken to lower costs or provide less fragmented care. He identified these individuals as "potentially actionable." For the potentially actionable individuals, he reviewed their profile reports to identify one or more of the following opportunities:

- Care coordination for individuals with chronic diseases and conditions;

- Improved patient compliance for individuals with chronic diseases and conditions;

- Behavioral healthcare coordination, enhancement, and improved patient compliance; or

- Substance abuse care coordination, care enhancement, and improved patient compliance.

Second, he identified indicators signifying that fraud, waste, or abuse might have occurred. In these cases, he sought to assess whether the profile suggested any of the following:

- Drug-seeking behavior through doctor- or pharmacy-shopping;

- Selling addictive or high street-value medications;

- Billing for unnecessary services or services that were not rendered; or

- Potential medical identity theft.

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[18] There were a number of challenges with the data and as a result not all of these measures were available for every individual. For example, the pharmacy data did not include prescriber information. In addition, the data was all related to fee-for-service claims, and therefore the profile reports did not include any Massachusetts Behavioral Health Partnership ("MBHP") data (the MassHealth managed care plan for behavioral health) or managed care organization ("MCO") information. However, in specific instances the Office sought out additional information regarding both MBHP and MCO encounters.

Findings

I.   Opportunities Exist for MassHealth and the HSN Program to Provide Better Care Coordination that Could Eliminate Waste in the Provision of Healthcare Services.

      A.   The majority of MassHealth members and HSN users could benefit from enhanced care coordination.

The majority (78 out of 100) of the MassHealth members presented potentially actionable utilization patterns. As indicated above, potentially actionable utilization patterns are situations that might present MassHealth or the HSN program with opportunities to have an impact on utilization.   Of these 78 MassHealth members, 53 would benefit from increased care coordination.   Care coordination involves organizing patient care activities and sharing information among all of the people involved in the patient's care to achieve safer and more effective care.[19] Care coordination has the potential to improve the effectiveness, safety, and efficiency of the provision of healthcare and can improve outcomes for patients, providers, and payors (like MassHealth and the HSN program).

The 53 MassHealth members identified above demonstrated certain trends in their claim histories and profile reports that would benefit from increased care coordination. For example, there was high utilization of emergency departments for conditions that can be addressed in a lower-cost setting (*e.g.*, sprains, respiratory infections, cellulitis, diabetes, and behavioral health issues).   Some of these members sought treatment at multiple hospitals and from multiple providers, increasing the risk of disjointed, redundant, or inefficient healthcare. The review also identified a large number of home health claims for MassHealth members whose profile reports did not indicate that the members would benefit from home health services. For example, there were members with many claims for home health services, but no clear indication from their claim history as to why they needed those services, what kinds of home health services would benefit their conditions, or whether there was any physician oversight of their care.

Sufficient care coordination for these MassHealth members could have helped to (1) reduce care in high-cost settings by diverting potential emergency department visits to office visits; (2) encourage members to seek care from a consistent group of providers; and (3) manage community-based services such as home health services to ensure that they are medically necessary and clinically appropriate.

For the HSN program, 19 out of 99 of users presented potentially actionable patterns. As with MassHealth beneficiaries, care coordination opportunities for HSN users with chronic conditions was the most common reason for an actionable pattern, but was typically only one of several reasons. The HSN users presented patterns that included high numbers of inpatient stays, multiple emergency department visits for the same condition, and care received at multiple hospitals by different providers. Proactively seeking out HSN users with a history of receiving large amounts of healthcare treatment for which the HSN program reimburses providers could create opportunities to improve care coordination.

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[19] *See*, *e.g.*, www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html.

It is important to recognize that the HSN program is fundamentally different from MassHealth. MassHealth is an insurance program that has a relatively consistent group of members whereas the HSN program reimburses hospitals and community health centers for healthcare services provided to uninsured and underinsured patients, many of whom only intermittently receive services for which the HSN program reimburses providers. However, it is possible to use data analytics to conduct claim reviews and identify the HSN super-utilizers. The HSN program also could proactively seek out HSN users with high numbers of inpatient stays, multiple emergency department visits, and care at multiple hospitals and different providers to try and centralize their care; this would likely improve their clinical outcomes, manage the acuity of the care settings in which they receive care, and ultimately reduce the number of interactions with the healthcare system.

B. **MassHealth and the HSN program provided what appeared to be well-coordinated care to a small percentage of MassHealth members and HSN users with catastrophic illnesses.**

Using the same analysis described above, the review identified 67 individuals who had catastrophic illnesses or injuries during the year, 11 of whose claims were potentially actionable. These nine MassHealth members and two HSN users, particularly those with more than one chronic condition, could have benefited from improved efficiency. However, the remaining 56 individuals with catastrophic illnesses or injuries also included examples of individuals who were exceptionally ill but who received what appeared to be efficient, high-quality care. These individuals did not have high inpatient or emergency department utilization, suggesting that they were receiving care that prevented exacerbations of chronic conditions, which kept them out of high-cost settings. Specifically, several of these individuals who appeared to have late-stage cancer and other serious conditions had a significant number of physician claims, but a relatively small number of claims for hospital inpatient or emergency room care. This indicates high-quality and well-coordinated care that prevented exacerbation of conditions that could have required care in higher-cost acute care settings. Based on these examples, it appears that MassHealth and the HSN program have the potential to provide quality, cost-effective care coordination that is necessary to achieve good health outcomes and contain related costs.

II. **There Are Opportunities to Reduce Potential Fraud or Abuse in the Payment of Claims for Both MassHealth Members and HSN Users.**

The Office also reviewed whether any of the paid claims resulted from fraud or abuse. The review found that both MassHealth and the HSN program paid claims that did not contain a primary diagnosis, which is contrary to their own policy and rules. The review also identified concerns with MassHealth's oversight of certain community-based services. In short, there are opportunities for both MassHealth and the HSN program to reduce spending by increasing program integrity activities, including through the better use of data analytics.

A. MassHealth and HSN program paid claims that did not contain a primary diagnosis, which violates MassHealth policy and HSN rules.

Since January 1, 2012, MassHealth has required all providers to include a valid diagnosis on their claims.[20] The failure to include a valid diagnosis on a claim should result in the denial of the claim. Despite this rule, many paid claims in this review did not contain a diagnosis.[21]

Specifically, MassHealth paid approximately $2,752,245 for 22,573 claims (covering 41,697 services) that did not contain a diagnosis. MassHealth paid the highest number of claims without a diagnosis to pharmacies,[22] acute outpatient hospitals, transportation providers, and adult foster care providers.

Type of Claim Without a Diagnosis	Number of Claims Without a Diagnosis	Number of Services Provided	Amount Paid
Pharmacy	14,688	14,688	$1,300,000
Acute Outpatient Hospital	3,622	3,622	$929,227
Transportation	2,099	18,825	$323,103
Adult Foster Care	1,108	4,957	$199,915

Although there were multiple transportation providers and acute care hospitals that submitted claims without diagnoses, one adult foster care provider submitted all of the paid claims without a diagnosis. Overall, 33% of the total MassHealth paid claims in this review did not contain a diagnosis.

The HSN program paid approximately $2,936,670 to 33 acute care hospitals and five community health centers ("CHC") for 7,941 claims that did not contain a diagnosis. Five acute care hospitals submitted approximately 72% of the hospital claims without a diagnosis. One CHC received reimbursement for 188 out of the 454 CHC paid claims, or 41% of the CHC paid claims, without a diagnosis. In addition to the claims listed above, the HSN program paid approximately $957,000 for 3,663 pharmacy claims with "N/A" as a diagnosis. All told, the HSN program paid almost $4 million for claims that did not contain a diagnosis.

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[20] MassHealth reported that this rule applied to HSN claims as of July 15, 2012. Even before the HSN claims had to comply with the MassHealth rule, the HSN program reported that it required a valid diagnosis on medical claims. A valid diagnosis is one that appears in either the International Classification of Disease ("ICD") or the Diagnostic and Statistical Manual of Mental Disorders.

[21] MassHealth and HSN claims may include a "primary" diagnosis as well as a "secondary" diagnosis. Typically, the primary diagnosis indicates the reason for the healthcare visit; the secondary diagnosis can either indicate another issue being evaluated or an issue that the patient has had in the past.

[22] The pharmacy claim processing system, "POPS," does not even require or capture diagnoses on claims.

As part of its review, the Office asked MassHealth officials to confirm what its claim processing system was supposed to do when a claim appeared without a required piece of information, such as a diagnosis. MassHealth responded that:

> Generally, claims submitted to MassHealth that do not contain completed required fields are denied. Including a diagnosis code has been a required field since January 1, 2012. Since then, claims that do not contain a diagnosis code are denied.

Similarly, all HSN claims must also include a diagnosis code. Based on the Office's review, it appears that the method MassHealth is using to verify that its claims and HSN claims are complete is not working.

In short, MassHealth and the HSN program improperly paid approximately $6.6 million for claims without diagnoses, or almost 30% of the total amount paid for the claims in this review. This does not only mean that MassHealth and the HSN program failed to have an effective method of applying their own rules for paying claims. Paying claims that lack a diagnosis undermines the very purpose of a healthcare system in which all services must be medically necessary to be reimbursable. With more than 1.5 million MassHealth members and HSN users, these programs cannot review detailed clinical information for each and every person. One way to screen for medical necessity is to compare the healthcare service provided with the diagnosis on the claim, which is impossible to do in the absence of the diagnosis.

The lack of any diagnoses on a claim also undermines MassHealth's and the HSN program's ability to conduct program integrity activities to determine whether providers are engaging in fraudulent activities. Further, a provider's submission of multiple claims without a diagnosis code – such as the adult foster care provider that submitted nearly 1,108 such claims covering nearly 5,000 services – indicates potential fraud or abuse and should have raised red flags at MassHealth. With regard to pharmacy claims in particular, the system that processes pharmacy claims does not even require or capture diagnoses, which is contrary to the MassHealth and HSN requirements. MassHealth's payment of claims without diagnoses indicates shortcomings in the agency's program integrity capabilities. In short, the lack of a diagnosis on claims violates MassHealth and the HSN program's own rules; undermines the purpose of these important programs; and impedes program integrity activities that could detect fraud, waste, or abuse. MassHealth's payment of these claims evidences a weakness in its program integrity activities.

B. MassHealth must increase its oversight of payments to transportation, home health, and adult day health providers.

The profile reports in the review suggest that MassHealth[23] must increase its oversight of payments for certain types of community-based care: transportation, home health, and adult day health providers. There is a difficult balance with regard to these types of community-based services. On the one hand, the services are generally more cost-efficient than services provided

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[23] The HSN program does not pay for care in the three areas that raised the most questions (transportation, adult day health, and home health).

in a healthcare facility. They can also help individuals with acute conditions transition out of a facility and can enable those with chronic conditions to reside in lower-cost, less-restrictive settings. On the other hand, if a Medicaid agency does not have sufficient controls in place to oversee the provision of these services, the agency is at risk of paying improper claims. Indeed, the Office of the Inspector General for the United States Department of Health and Human Services identified transportation, adult day health, and home health claims as top fraud concerns nationally.[24] As set forth below, there are ways for MassHealth to effectively use data analytics to screen claims for community-based services for fraud, waste, and abuse.

1. Transportation services.[25]

In this review, there was a noticeable pattern in the billing of transportation services for MassHealth members. Specifically, the Office noted a lack of diagnoses on transportation claims, the overuse of the diagnosis of "malaise and fatigue" by one transportation provider, and transportation claims occurring on days without claims for medical services. With regard to the numbers of claims and services set forth below, one claim may contain more than one service. A service may be a one-way trip or a mileage charge.

MassHealth pays for emergency and non-emergency transportation only when members are traveling to obtain medical services. The MassHealth regulations define medical services as "medical or related care, including goods and services provided to members, the cost of which is paid or payable by the MassHealth agency."[26] To that end, MassHealth specifically prohibits the use of its transportation services to certain destinations, including taking children to daycare or school, visiting a sick relative, traveling to a pharmacy to obtain medications, or going to a government agency. Each form of transportation has its own requirements, but generally a MassHealth member must obtain prior authorization for transportation services in the form of a verbal authorization from MassHealth; a prescription for transportation completed by a doctor, physician assistant, psychologist, or other approved medical provider; or a completed medical necessity form.

In this review, MassHealth paid $827,863 for 5,799 transportation claims that covered 34,834 services for 86 MassHealth members, including claims for emergency and non-emergency transportation and separate claims for mileage.[27] This Office found that more than half of the transportation services had no primary diagnosis (2,099 claims that covered 18,825 services, or 36% of the total transportation claims). MassHealth paid $323,103 for these claims. As set forth above, MassHealth violated its own rules by paying these claims. Furthermore, one way to review claims for potential fraud, waste, or abuse is to review the diagnosis on the claim. Without the diagnoses, MassHealth has no way of evaluating the validity of the medical need for transportation in its post-payment review of transportation claims.

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[24] United States Department of Health and Human Services Office of Inspector General, *Work Plan: Fiscal Year 2015*, Washington, D.C. (2015).

[25] 130 C.M.R. 407.000.

[26] 130 C.M.R. 450.101.

[27] Certain types of transportation providers can submit claims for mileage in addition to claims for trips.

When the transportation claims did contain a diagnosis, the most frequently occurring primary diagnosis was "malaise and fatigue," which appeared on 2,083 paid transportation claims that covered over 11,000 services.[28] MassHealth paid $186,506 for these claims. This is particularly notable because for the entire group of paid claims in this review, one transportation provider alone submitted 98% of the claims with a diagnosis of "malaise and fatigue."[29] The prevalence of this diagnosis for this one provider, combined with the lack of this diagnosis from almost any other provider in this review, raises questions regarding the validity of this one provider's claims. This is an example of how the strategic use of data analytics – the use of sophisticated computer programs to match one kind of data with another – to analyze claim patterns can quickly identify potential issues that indicate potential fraud, waste, or abuse. For example, data analytics could quickly identify providers who submit claims without diagnoses, or large numbers of claims with only one diagnosis, allowing MassHealth to follow up with those providers to determine the legitimacy of the claims.[30]

The review of these claims also indicated that there were instances in which MassHealth paid transportation claims on behalf of MassHealth members who had no other fee-for-service paid claims that day, or no other fee-for-service paid claims that day that would have required them to travel to receive a medical service (*e.g.*, the patient only received home health services that day). It is possible that some of these individuals received services from one of MassHealth's managed care organizations ("MCOs"). In these situations, MassHealth would have properly paid the transportation claims to MCO appointments as a covered service. The problem, however, is that MassHealth does not review its MCO encounter claims before or after paying a transportation claim. As a result, MassHealth is paying these transportation claims without verifying whether it should be doing so. Rather, MassHealth should be denying these claims.

Moreover, for members who use MassHealth transportation services to travel to medical services that Medicare or a private insurer covers, MassHealth has no way of knowing if it properly paid the MassHealth member's transportation claims. This is because MassHealth's post-payment verification of transportation claims does not check to see whether an individual received medical services covered by Medicare or a private insurer. As a result, MassHealth's algorithm should identify these transportation claims in its post-payment review as not associated with a medical service and should deny the claim.

MassHealth reports that it performs post-payment verifications of transportation claims by confirming that the member is traveling to obtain medical services. MassHealth indicates that it conducts this check by running the transportation claims through a computer algorithm that identifies transportation claims without an associated medical service. Based on the Office's

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[28] The ICD describes the symptoms of "malaise and fatigue" as including feeling tired all of the time, exhaustion, frailty, generally feeling unwell, having a lack of energy, and weakness. The diagnosis of malaise and fatigue can be associated with a wide variety of illnesses, including influenza, bronchitis, hepatitis, congestive heart failure, cancer, kidney disease, severe anemia, or depression. *See*, *e.g.*, www.nlm.nih.gov/medlineplus/ency/article/003089. htm.

[29] There were a total of 2,112 claims that covered 11,293 services that listed "malaise and fatigue" as the diagnosis. The one transportation provider submitted 2,070 of these claims, covering 11,160 services.

[30] The Office has provided MassHealth with the name of the vendor so that it may conduct its own review.

review, MassHealth is not effectively verifying that its members are receiving medical services on the day on which it has paid for a transportation claim.

In summary, MassHealth is not adequately identifying transportation claims that have no associated medical service. As a result, MassHealth may be paying fraudulent claims.

Thus, transportation is the first area of community-based services that presents an opportunity for MassHealth to strengthen its claims review. At a minimum, MassHealth must ensure that the claims comply with MassHealth's rules requiring a diagnosis that supports the provision of transportation services. MassHealth must also improve its review of transportation claims to ensure that they occur in conjunction with a covered medical service. As part of this, MassHealth needs to explore ways to determine whether a patient received medical services that an MCO, Medicare, or a private insurer covered. Without performing this important check, MassHealth cannot know whether it is properly paying for transportation services. Finally, MassHealth should more effectively use data analytics to identify potentially fraudulent claims. For instance, MassHealth could use data analytics to identify transportation providers who are submitting large numbers of claims with the same diagnosis.

2.   Home health services.[31]

The second area of community-based services in this review involved home health services. The Office found there were individuals who did not appear to be under a physician's care as required by MassHealth's home health regulations. The Office also found that some MassHealth members received the same kind of home health service from different home health providers on the same day.

MassHealth pays for home health services provided by nurses; home health aides; and physical, occupational, and speech and language therapists. MassHealth is supposed to pay for these services only if the member is under the care of a physician, who may be the members' private physician or on the staff of a home health agency. The physician must certify the medical necessity for the services ("certification") and establish an individual plan of care ("plan"). The plan must contain details about the person's diagnosis, frequency of visits, prognosis, any teaching activities,[32] and the discharge plan. The physician must recertify, sign, and date the plan every 60 days. When there is a family member or other caregiver available to provide services that meet the member's needs, MassHealth will not pay for the services.

In this review, 88 members had a total of 9,280 paid home health claims that covered 70,711 services for which MassHealth paid approximately $6.5 million. For 29 members, payments to home health agencies constituted over 50% of their MassHealth fee-for-service healthcare. Frequently, home health providers billed for multiple visits each day of the year. The profile reports for many of these members indicated that some had minimal hospital care

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[31] 130 C.M.R. 403.410.000.

[32] As a part of the home health nursing or therapy services, the nurse or therapist must teach a member, family member, or caregiver how to manage the member's treatment.

and little or no apparent physician care, which should raise a red flag to MassHealth about whether a physician was overseeing these members' care as required under the regulations.

Indeed, MassHealth reports that it receives the certification and plan only when the plan includes services that require prior authorization, such as occupational, physical, speech, or language therapy. For other home health services, MassHealth does not receive the certification or plan. Rather, MassHealth reports that the provider must maintain the certification and plan in its records and make them available to MassHealth upon request. MassHealth further reports that it has a contractor that performs select audits of home health provider claims, which includes reviewing the certification and plan. However, MassHealth does not review physician claims to confirm that the member is under the care of a physician, or that the physician who provided the certification had actually examined the member.

Not reviewing physician claims in conjunction with home health claims creates a gap in MassHealth's home health program integrity activities and creates opportunities for fraud and waste to go undetected. MassHealth could, for example, use data analytics to identify members who do not have claims for physician visits during the course of their home health care services. MassHealth could then have its contractor audit those home health providers' files to verify that there is a certification and plan for each of those members and confirm that there are physician claims to confirm that the member is under the care of the physician signing off on the home health care.

Another pattern also emerged. Out of the 88 MassHealth members who received home health services, 15 (or 17%) received the same kind of home health service from different home health providers on the same day (*e.g.*, a visit from two registered nurses from two different home health providers on the same day). As indicated above, MassHealth pays for home health agencies to provide nurses (registered or licensed practical nurses); home health aides; and physical, occupational, and speech and language therapists. It is possible, for example, that some providers have only nurses available but not physical therapists. In that situation, it would make sense for a MassHealth member who needs both a registered nurse and a physical therapist to use two different home health agencies. It is also possible that there would be occasions when a home health provider is short-staffed and as a result, the MassHealth member would need to use two different home health agencies.

However, out of the 88 MassHealth members receiving home health services, at least seven members (8%) regularly received the same type of service on the same day from multiple home health agencies, which raises red flags about fragmented services or potentially improper or fraudulent billing practices. For example, one MassHealth member received registered nursing services from two different home health providers on 28 days. Another member received licensed practical nurse services from three different home health providers on 22 days and registered nursing services from three different home health providers on 45 days. A third MassHealth member received licensed practical nurse services from two different providers on 102 days.

The frequency of these overlapping services raises questions not only about fragmentation of care for these MassHealth members, but also about the validity of these claims. MassHealth must review home health claims to determine whether the same individual is

receiving the same kind of care on the same day from multiple providers. When MassHealth sees this pattern of claims, it should determine whether the services are medically necessary and also whether there is fragmentation of care or fraudulent billing. Because of the high number of home health claims that the MassHealth super-utilizers generate, this is a second area of community-based care that requires MassHealth to increase its claim review to ensure that the services are medically necessary and that the MassHealth member's physician is appropriately coordinating the community-based care.

3.   Adult day health.[33]

Finally, the Office reviewed claims for adult day health programs and found that MassHealth paid adult day health providers for transportation claims on days when there were no paid claims for attending an adult day health program. Overall, however, it appears that MassHealth effectively matched the adult day health program claims in this review with corresponding adult day health transportation claims.

a.   Overview

Adult day health programs provide a place where MassHealth members can go to receive "an organized program of nursing services and supervision, maintenance-therapy services, and socialization." MassHealth members are eligible for adult day health services if they:

1) have a medical or mental dysfunction that involves one or more physiological systems and require nursing care;

2) require services in a structured adult day health setting;

3) have a personal physician; and

4) require a health assessment, oversight, monitoring, or services provided by a licensed nurse.

The Office's review of adult day health services included 4,960 paid claims covering 18,207 services, totaling $570,340, for 33 MassHealth members. Of these claims, MassHealth paid $357,544 for 5,681 days of adult day health service (six hours or more per day); $32,508 for 614 occurrences of less than six hours of adult day health; and $180,287 for 11,912 transportation services to or from the adult day health location. To better understand the medical issues with which the individuals who attend adult day health are dealing, the five most frequent primary diagnoses were: type II diabetes without complication (2,300 services); schizophrenia (2,172 services); hypertension (1,560 services); debility (weakness) (1,524 services); and schizoaffective disorder (1,247 services).

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[33] 404 C.M.R. 400.000.

b. Findings

MassHealth allows adult day health providers to bill separately to transport members to and from the adult day health program location. All but one of the 33 super-utilizers who received adult day health services also had paid claims for transportation to or from the program. Many of these adult day health providers transported the MassHealth members every day on which the member had a claim for adult day health services.

One provider, however, was paid to transport two MassHealth members on days in which the members had no paid claims for adult day health services. For one of these members, the adult day health provider billed for transportation on 14 days on which there was no paid claim for adult day health services. In the second case, the adult day health provider submitted claims for nine days on which the provider did not bill for any adult day health services. Thus, out of the 32 super-utilizers who received adult day health transportation services, there were two individuals (6%) whose providers received reimbursement for transportation on days when the member did not attend the program. Because MassHealth's claim adjudication system did not detect these claims, the failure to detect transportation claims that have no corresponding adult day health services may not be limited to the MassHealth members in this review. Stated differently, there is nothing unique about how MassHealth processed these super-utilizer adult day health claims. As a result, the Office recommends that MassHealth review adult day health providers' transportation claims against the adult day health claims for the broader MassHealth population.

MassHealth reports that its Provider Compliance Unit ("PCU") reviews adult day health providers' transportation claims against the adult day health claims to verify that the transportation occurred on a day when the member is attending the program. Based on the results of the Office's review, the PCU's review may not be sufficiently robust because MassHealth paid adult day health transportation claims on days when there were no paid claims for the adult day health program. At a minimum, MassHealth must work with its PCU to improve its data analytics and ensure that the date on which an adult day health provider bills for transportation is also a date on which the person attended the adult day health program.

Recommendations

Based on the findings above, the Office makes the following recommendations for MassHealth and the HSN program:

I.   MassHealth Should Consider Participating in the CMS Health Home Program.

The Office recommends that MassHealth consider participating in the CMS Health Home program. As of March 2015, 27 states had been approved to participate in the program, but the CMS list does not include Massachusetts. Participation in the Health Home program would enable Massachusetts to access additional resources that would improve the quality and efficiency of service delivery to super-utilizers. Participation in the Health Home program would also provide enhanced federal funding.

The CMS Health Home program provides states the option to deliver enhanced services to beneficiaries who may be at risk for becoming super-utilizers, including those who have two or more chronic conditions, have one chronic condition and are at risk for a second, or have a serious and persistent mental health condition. The CMS Health Home program gives states substantial flexibility in designating provider eligibility criteria and payment models, and provides a 90% Federal Medical Assistance Percentage for the enhanced health home services delivered under the program. Technical assistance and planning funds are available to states, as well as the ability to participate in a design and implementation workgroup with other states to share best practices and lessons learned about delivery and payment system models for Medicaid beneficiaries with complex needs. Participation in the Health Home program would provide Massachusetts with access to these and other resources that could support the development of initiatives to improve the quality and efficiency of care for super-utilizers and do so with enhanced federal funding.

MassHealth reports that it is currently preparing a request that it will send to CMS requesting approval for its participation in the Health Home program. MassHealth anticipates that it will send its request by June 2016. The Office supports MassHealth's efforts to pursue participation in the CMS Health Home program.

II.   MassHealth Should Seek Out an Administrative Partnership with Medicare to Increase Coordination of Care and Enhance its Claim Review.

MassHealth would benefit if it could strengthen its information-sharing and administrative strategies with the Medicare program. By way of example, MassHealth could review Minnesota's partnership with Medicare, given its progress in developing a streamlined fraud-review process as well as improved collaboration around network adequacy determinations and quality measure reporting.[34] This type of partnership would allow MassHealth to better assess its dual eligible members in light of all of the services that they are receiving. Having an

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[34] Although New York's integrated appeals model is not included in this review, it is another potential source of useful information as it is a model for federal and state partnership in supporting administrative simplification.

administrative partnership with Medicare would also increase MassHealth's ability to perform program integrity activities because it would have access to a wider number of claims that it could use to verify exactly what healthcare services its members are receiving.

MassHealth reports that its program for a small number of dual-eligibles, One Care, has helped MassHealth to start working more closely with Medicare. The Office strongly recommends that MassHealth continue to improve its working relationship with Medicare by creating an administrative partnership that will facilitate program integrity and care coordination for all dual-eligibles.

III.   The HSN Program Should Consider Implementing Demonstration Projects to Reduce Payments to Acute Care Hospitals.

The HSN's enabling statute allows the HSN program to expend up to $6 million annually from the HSN Trust Fund for demonstration projects that show promise in reducing acute hospital payments. For example, in fiscal year 2009, the HSN Trust Fund paid for a demonstration project to support HSN providers in identifying and implementing interventions that reduced unnecessary emergency department utilization, such as establishing a 24-hour nurse hotline for a community health center. This type of demonstration project could allow the HSN program to test interventions that could improve the efficiency and quality care for HSN super-utilizers. Similarly, the HSN program could consider implementing a demonstration project that would allow the HSN program to test interventions that would identify HSN users who are receiving healthcare services from multiple providers and design a program to coordinate and streamline their care.

Furthermore, one of the limitations of the HSN program is that it covers a narrow range of providers: acute care hospitals and community health centers. These providers may not have adequate, cost-effective resources to address the needs of HSN beneficiaries with substance abuse disorders. In particular, acute care hospitals are high-cost settings that are not well-suited to providing ongoing management of chronic substance abuse. Furthermore, although access to mental health and substance abuse treatment in community health centers has been increasing, nearly a third of patients report an unmet need. The HSN program could consider expanding the types of services and providers available to HSN users with substance abuse disorders, such as community health workers and home-based services, or embedding those types of providers in community health centers or acute care hospitals under a demonstration project.

The HSN reported that it is in the beginning stages of considering creating a demonstration project. It has not yet, however, narrowed its consideration to a particular focus. The Office suggests that the HSN consider the recommendations contained in this report as it moves forward with a demonstration project.

IV.   MassHealth and the HSN Program Should Not Pay Claims that Do Not Contain a Primary Diagnosis.

MassHealth and the HSN program should not pay claims that do not contain a valid diagnosis. The lack of primary diagnoses undermines the very purpose of a system of care in

which all services must be medically necessary to be reimbursable. There is no way for either MassHealth or the HSN program to assess the medical necessity of the services on a healthcare claim if it does not know the diagnosis – *i.e.*, the medical problem the provider was treating. The lack of primary diagnoses also undermines MassHealth's and the HSN program's ability to conduct program integrity activities to determine whether providers are engaging in fraudulent activities. In short, the lack of a primary diagnosis on claims violates MassHealth's policy and the HSN's rule, undermines the purpose of these important programs, and impedes program integrity activities that could detect fraud, waste, or abuse.

V.   MassHealth and the HSN Program Should Improve the Claim Review Processes.

Both MassHealth and the HSN program should improve their claim review processes. MassHealth and the HSN program have robust data systems that could support increased monitoring of MassHealth and HSN claims. For example, MassHealth and the HSN program could use data analytics to develop, test, and deploy algorithms and models that could identify and address potentially actionable beneficiaries as well as fraud and abuse. Indeed, MassHealth could use an integrated analytical and clinical review to identify providers who are billing for services they did not provide, or who are providing duplicative and unnecessary care. Outliers and anomalies in the claims data – such as one provider submitting 98% of the claims with a single diagnosis – could be a red flag for fraudulent billing.

A.   Transportation

MassHealth needs to improve its review of transportation claims so that it denies claims that do not contain a diagnosis. MassHealth also should focus its claim review on transportation claims that occur on a day on which the MassHealth member does not appear to have received any medical services and either investigate or deny those claims. Specifically, MassHealth should use the MCO encounter information that it has to determine whether a MassHealth member was transported to a medical service covered by an MCO. MassHealth should also explore whether there are ways that it could determine whether a member received a medical service that either Medicare or a private insurer covered. In short, MassHealth needs to have a way to verify that transportation for which it is paying occurred in conjunction with a medical service. In the absence of such verification, MassHealth should further investigate or deny those claims.

MassHealth reports that it has a working group that is focusing on transportation issues and that it will bring the Office's recommendations to that group.

B.   Home health services

MassHealth could better analyze its data to identify those individuals who are receiving home health services but who do not appear to be under the care of a physician as required by the applicable regulations. For example, it could identify individuals who are receiving home health services but do not have any claims for an inpatient hospital stay or a physician office visit for a set amount of time that its clinical staff deems appropriate. Once it identifies those individuals, MassHealth could then have its vendor audit the members' files to determine whether there are

plans of care and whether the individuals are under the care of a physician. Moreover, MassHealth could identify its members who are receiving the same type of home health service on the same day by more than one provider. MassHealth could then conduct a clinical review to determine whether the home health services are medically necessary.

MassHealth indicates that it is aware that there are improvements that it could make to its home health regulations. For example, MassHealth indicated to the Office that it intends to include a prior authorization requirement for home health services that the member's physician would have to sign. MassHealth also indicated that it intends to include a recertification requirement that the physician would have to sign periodically to verify that the member continues to require home health services. The Office supports the inclusion of both of these requirements in the regulations as a way to verify and maintain oversight of the medical necessity of the services.

C.   Adult day health

Finally, MassHealth could work to ensure that adult day health providers are only billing for transportation on days on which MassHealth members attend the adult day health program.

While the Office's review identified three areas that appear vulnerable to fraud and abuse by providers – transportation, home health, and adult day health – MassHealth could use data analytics to identify many other areas at risk for fraud and abuse.

MassHealth and the HSN program could also use their claims data to identify individuals who could benefit from care coordination, additional care, or different services. For example, MassHealth could develop a program that would identify individuals who had received a certain number or certain types of community-based services over an extended period during which the patient had few or no physician claims. MassHealth could then perform a clinical review to determine whether an individual needs to be under a physician's care or requires an additional or different set of services.[35] Another example would have MassHealth using its claims data to compare primary diagnoses and prescriptions (or lack thereof) to determine the appropriateness and quality of care for certain high-cost illnesses and medications.

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[35] This same review could potentially identify unnecessary or fraudulent billing for community-based care.

Conclusion

Implementation of effective interventions for super-utilizers could realize significant benefits for the MassHealth and HSN programs, as well as for individuals who have unique and complex health and social service needs. Massachusetts has already implemented a number of measures, but the Office's review, current literature, and model programs suggest that additional strategies hold promise for further improvements. With the top 500 MassHealth members accounting for $68.5 million of healthcare costs in one fiscal year, there is opportunity for significant savings through the implementation of greater care coordination. This is also true of the HSN program, where 322 users accounted for $15.7 million of healthcare costs during that same fiscal year. Taking proactive, creative steps to address super-utilizer care will assist in curbing overall healthcare spending while at the same time improving the health outcomes for these individuals.

Moreover, although the focus of this review was super-utilizers, the issues the Office identified concerning claims processing and program integrity are systemic and apply to the entire MassHealth system and HSN program. Similarly, MassHealth and the HSN program have the opportunity to utilize their data to detect trends in the use of a variety of healthcare services for all MassHealth members and HSN users, to reduce unnecessary or fraudulent services, and to work with their members and users to improve the coordination and quality of their healthcare.