Commonwealth of Massachusetts
Office of the State Auditor
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Official Audit Report – Issued October 17, 2012

MassHealth's Eligibility Determination Process for Healthcare Services

For the Period July 1, 2009 through December 31, 2011

TABLE OF CONTENTS

INTRODUCTION AND SUMMARY OF FINDINGS AND RECOMMENDATIONS

This audit concerns public healthcare costs being borne by the Commonwealth's Medicaid program that is administered in Massachusetts by an agency within the state's Executive Office of Health and Human Services (EOHHS) called MassHealth. MassHealth provides access to healthcare services to approximately 1.3 million eligible low- and moderate-income individuals, couples, and families annually. Expenditures in this program have been increasing significantly (on average, 8.69% per year since 2007), while enrollment between June 2006 to March 2011 grew by over 26%. In fiscal year 2011, MassHealth paid in excess of $12.2 billion to healthcare providers, of which approximately 35% was funded with Commonwealth funds.

Healthcare is the subject of significant public debate in terms of who should be covered; how to control increasing costs; and, in the case of publicly funded healthcare, how to prevent abuses of taxpayer dollars. The effectiveness of the policy decisions and the internal controls that MassHealth establishes over its eligibility determination process are essential in addressing these concerns and maintaining the public's confidence in the integrity of the administration of MassHealth programs.

The Office of the State Auditor (OSA) initiated an audit of MassHealth's eligibility determination process to (1) assess the adequacy of the policies and internal controls MassHealth has established relative to this process and (2) if possible, identify opportunities for developing more effective policies and internal controls aimed at ensuring that only eligible applicants receive benefits, which could result in savings to the Commonwealth's taxpayers.

Highlight of Audit Findings

1. **The process that MassHealth uses to verify the self-reported income of applicants/members is not consistent with state and federal regulations and needs to be improved in order to ensure that only eligible individuals receive benefits.**

    - MassHealth does not fully verify applicants' self-reported earned income or attestation of no income either at the time of their application or on at least a quarterly basis once they are enrolled as required by MassHealth and federal regulations. In fact, the first attempt MassHealth makes to independently verify an applicant's earned income is not performed until approximately one year after the applicant is enrolled and receiving benefits.

    - Contrary to federal regulations, MassHealth does not request information about an applicant's unearned (non-wage) income (e.g., lottery winnings, dividends, interest, annuity and pension payments, rental income) from the Internal Revenue Service (IRS) or other independent sources. As a result, MassHealth cannot ensure that it is identifying, to the extent possible, each applicant's unearned income. In fact, we found that during our audit period at least 18 MassHealth members had annual lottery winnings ranging from $8,977 to $159,987 and had no interruption in their MassHealth coverage.

- At the time of application, MassHealth does not require applicants who claim zero family income to provide any additional information on the means by which they are paying for their living expenses. During our audit, we reviewed the files of 55 members who received MassHealth benefits during the audit period and found that 16 reported on their applications that no one within their family had any income. However, there was no documentation in these files that indicated that these applicants were questioned on how they were paying for any living expenses. This is in contrast to some other state Medicaid programs that require applicants to provide additional details about their financial situation when declaring zero family income.

2. MassHealth has not established a process to effectively verify the residency of applicants and, as a result, thousands of non-residents may be inappropriately receiving healthcare benefits.

According to MassHealth regulations, as a condition of eligibility, applicants must live in the Commonwealth with the intent to remain permanently or for an indefinite period. However, MassHealth accepts an applicant's self-declaration of residency and, unlike the Medicaid agencies of some other states, does not require applicants to provide any documentation to substantiate that they are actually residing in Massachusetts. Consequently, the Commonwealth may be incurring health care costs for non-Massachusetts residents. In fact, during our audit, we determined that 71,519 individuals who applied for and received MassHealth benefits during fiscal year 2010 were subsequently terminated by MassHealth including 38,970 for reasons that bring into question their residency status. While it is clear that a number of these 38,970 members were terminated for failing to provide requested documentation, for 4,649 of these members who had received benefits totaling $6,456,195 during this fiscal year, MassHealth determined that they were either non-Massachusetts residents, receiving benefits in another state or that their whereabouts was unknown.

3. Inadequacies in MassHealth's policies and procedures to resolve conflicts found in residency and income information in applicant and member records may be unnecessarily costing the Commonwealth millions of dollars annually in health care expenses.

The 42 Code of Federal Regulations 435.913 requires that MassHealth include in the case file of applicants/members evidence to support the decision it makes on their requests for benefits. Further, MassHealth's own regulations state that it will investigate any conflicts in information provided by applicants and members. Despite this, our audit found that MassHealth provides healthcare services to some applicants/members who provide information that directly conflicts with other documentation they provided and/or in the case of foreign visitors, representations they made to the federal government when obtaining their temporary visas, without resolving these conflicts and ensuring that these individuals meet MassHealth's residency and financial eligibility requirements. As a result, MassHealth may be providing millions of dollars in benefits each year to individuals who are not entitled to receive such benefits. For example, during fiscal year 2010 alone, MassHealth provided healthcare benefits totaling over $12 million to foreign visitors without effectively verifying

these visitors' residency and financial status, even though the financial and residency information they provided to MassHealth to obtain these benefits directly conflicted with what they represented to the federal government in obtaining their temporary visas.

Auditor's Recommendations

In order to address our concerns relative to the proper verification of wages and unearned income, the OSA recommends that MassHealth amend its policies and procedures to comply with applicable federal regulations. Specifically, MassHealth should:

- At the time of application, perform data matches with the Massachusetts Department of Revenue (DOR) for all applicants and their family members as a means to verify the accuracy of wage information submitted by these individuals.
- Utilize DOR's 14-Day New Hire reports and Quarterly Wage reports as they are received instead of reviewing these documents only during the annual redetermination process.
- Establish a data match with the IRS and other independent governmental agencies to periodically verify applicant/member income, including unearned income.
- Establish, at least quarterly, a data match with the Office of the State Treasurer to identify any significant lottery winnings by members and, if warranted, adjust the eligibility status and benefit levels of those members affected.
- Amend its application forms so that applicants who report zero household income are required to provide additional information about the means by which they pay for their daily living expenses. Also, MassHealth should provide necessary training material, including a list of pro-forma questions, that MassHealth enrollment specialists and certified MassHealth providers would use to help solicit such information from applicants filing on-line applications.

In order to address our concerns relative to the proper verification of applicant/member residency, the OSA recommends that MassHealth amend its policies and procedures. Specifically, MassHealth should:

- At the time of application, utilize electronic data matches with federal and other state agencies, including the IRS, the Social Security Administration, DOR, and the Division of Employment Security, to verify individuals' self-declared residences.
- If an electronic data match is not possible for certain applicants because the applicant does not have a verified Social Security number, require the applicant to submit documentation to support his/her self-declared residence. In this regard, MassHealth should publish within its application forms examples of acceptable documents for verifying residency.

- At quarterly intervals, utilize the same federal and state agency electronic data matches to verify the residences of members. For each conflict found, MassHealth should require that the affected member provide documentation to resolve the conflict.

- If quarterly electronic data matches are not possible for certain members because the members do not have a verified Social Security number, require the members to submit documentation during their annual review process to re-verify their self-declared residence.

In order to address our concerns relative to resolving conflicts in information provided by applicants/members when applying for benefits, the OSA recommends that MassHealth:

- Establish formal procedures to address conflicts in information provided by applicants/members, including a requirement to document in each case file the measures taken by MassHealth to address the conflicting information. These procedures should also include verification procedures of the self-declarations made by foreign visitors who are present in Massachusetts with unexpired visas, who provide passports as proof of their immigration status.

OVERVIEW OF AUDITED AGENCY

MassHealth, within the Massachusetts Executive Office of Health and Human Services (EOHHS), administers the Massachusetts Medicaid and Children's Health Insurance Program (CHIP), providing access to healthcare services to low- and moderate-income individuals, couples, and families. MassHealth offers several insurance coverage types, with different eligibility rules for each (see Appendix I). In fiscal year 2011, MassHealth paid in excess of $12.2 billion to healthcare providers, of which approximately 35%[1] was funded with Commonwealth funds. Since 2007, MassHealth's enrollment has grown, on average, 4.6% annually, and, as of July 2011, enrollment was approximately 1.3 million members, or nearly one out of every five Massachusetts residents.

CHIP

In 1997, Congress created the State Children's Health Insurance Program (SCHIP) to provide health insurance to children of families with incomes that are less than 200% of the federal poverty level (FPL). SCHIP was designed as a federal/state partnership with the goal of providing health insurance to children whose parents earn too much to qualify for Medicaid, but not enough to purchase private health insurance. On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) into law. This statute preserved coverage for the millions of children who relied on SCHIP and provided funding for states to cover millions of additional uninsured children. The Children's Health Insurance Program is now referred to as CHIP rather than SCHIP.

Medicaid

Medicaid is a joint federal/state program created by Congress in 1965 as Title XIX of the Social Security Act (Act). At the federal level, the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) administers the Medicare program and works in partnership with state governments to administer their Medicaid programs. Each state must administer its Medicaid program in accordance with a CMS-approved state plan. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements. Each state's Medicaid policies for eligibility vary considerably, even

[1] The Federal Medical Assistance Percentage (federal matching funds) for state Medicaid expenditures is 50%. However, as a result of the American Recovery and Reinvestment Act of 2009, the federal reimbursement rate during our audit period, including fiscal year 2011, was 65%.

among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state.

Section 1115 of the Act gives the Secretary of HHS the authority to waive a state's compliance with federal Medicaid regulations and requirements for what are referred to as demonstration purposes. In order to receive a waiver, a state's demonstration projects must promote the objectives of the Act. Since 1997, the Massachusetts Medicaid program has been operating under a federal "research and demonstration" waiver, which allows Massachusetts more latitude to cover other groups of residents in its Medicaid program. The Commonwealth has renewed this waiver four times since 1997. CMS has recently approved the Commonwealth's current Section 1115(a) demonstration project waiver through June 30, 2014.

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). PPACA will require states to make a number of changes to their Medicaid programs, including expanding Medicaid coverage to all individuals under age 65 with incomes up to 133% of the FPL. Because MassHealth already covers much of this population, the financial impact of this and other aspects of this national reform initiative on Massachusetts should be less than that of other states.

MassHealth Eligibility Criteria

Medicaid-eligible citizens can be grouped into seven general categories: people over the age of 65, children, pregnant women, adults with dependent children, people who are disabled, adults who work for a qualified employer, and long-term unemployed individuals. Although Medicaid eligibility varies by state, there are mandatory groups of people who qualify for benefits regardless of where they live. These mandatory groups include very low-income families; pregnant women; infants and children in low-income households; and people with disabilities and older persons who receive SSI cash assistance, except in §209(b) states where individuals must meet somewhat more stringent criteria. Appendix II of this report provides additional details regarding individuals who automatically qualify for Medicaid/MassHealth benefits.

MassHealth classifies its members into two populations: the waiver population and the traditional population. The waiver population refers to members below the age of 65 who are not living in a nursing home or other long-term-care facility. The traditional population includes members over the

age of 65 and persons of any age needing long-term-care services. Both groups must meet both universal and specific eligibility criteria in order to qualify for benefits. The following is a summary of some of the universal eligibility criteria for MassHealth program participation established by MassHealth in its regulations[2]:

- Residency: As a condition of eligibility, an applicant or member must live in the Commonwealth with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address.

- Income: Applicants must meet certain income requirements to qualify for MassHealth coverage. The gross earned and unearned income of all family group members cannot exceed a designated percentage of the FPL. The applicable percentage is based upon the family group size and the MassHealth coverage type. Appendix IV of this report details some of the monthly income limits in effect during our audit period.

- Assets: Unlike waiver population applicants, traditional population applicants are subject to asset limitations, which vary based upon the applicant's coverage type and whether the applicant is (1) a community resident living with or without a spouse or (2) a resident of a medical institution living with or without a spouse in the same medical institution. For example, the total value of countable assets owned by or available to individuals applying for or receiving MassHealth Standard, Essential, or Limited coverage may not exceed $2,000 for an individual and, in most instances, $3,000 for a couple living together in the community. Countable assets include, but are not limited to, cash, bank accounts, individual retirement accounts, Keogh Plans, pension funds, securities, and cash-surrender value of life-insurance policies. Traditional long-term-care (LTC) applicants are also subject to a "transfers of resources (income and assets) look-back period." Specifically, in accordance with MassHealth regulation 130 Code of Massachusetts Regulations (CMR) 520.019(B)(2), LTC applicants must provide verification of their assets for a 60-month period prior to their application date.

- Citizenship: United States citizens must provide proof of their citizenship and identity to MassHealth in order to qualify for benefits. Citizen applicants can satisfy both of these requirements by providing a single document such as a United States Passport (current or expired), a Certificate of Naturalization, or a Certificate of U.S. Citizenship. Citizen applicants can also choose to submit separate documents to provide proof of their citizenship and their identity such as a birth certificate as proof of their citizenship and a driver's license to prove their identity.

  Similarly, aliens must document their immigration status in order to qualify for MassHealth benefits other than emergency care. Acceptable documentation includes Certificates of Naturalization, Certificates of U.S. Citizenship, U.S. Citizen I.D. Cards, Employment

[2] Under 130 Code of Massachusetts Regulations 503, MassHealth has established other universal eligibility requirements for enrollment, such as requiring all applicants who are requesting health coverage other than MassHealth Limited to provide a Social Security number and requiring all applicants to assign to MassHealth their rights to medical-support and third-party payments.

Authorization Cards, and Permanent Resident Cards. The MassHealth benefits that are available to aliens depend upon an alien's current and former immigration status, the date on which the alien entered the United States, the date of obtaining status, as well as factors unrelated to immigration, such as any incidents of domestic violence, service in the military, age, and disability. Aliens who fail to submit verification of their immigration status (undocumented aliens) are still eligible to receive emergency care under MassHealth's Limited Program.

MassHealth Application Process

When applying for MassHealth benefits, most applicants under the age of 65 (waiver population) must complete a standard application form developed by MassHealth called a Medical Benefit Request (MBR) form, whereas people over the age of 65 and people of any age seeking long-term nursing home care or services to live at home instead of in a nursing home (traditional population) need to complete a Senior Medical Benefit Request (SMBR) form. Waiver population applicants send a paper copy of their MBRs to MassHealth's Central Processing Unit (CPU), which is located in Charlestown. Traditional population applicants can either mail or hand-deliver their SMBRs to one of four MassHealth Enrollment Centers (MEC), which are located in Revere, Springfield, Taunton, and Tewksbury (see Appendix III). In addition, except for traditional population applicants who are seeking LTC benefits, MBRs and SMBRs may also be submitted on-line through the Commonwealth's Virtual Gateway[3] (VG). MassHealth enrollment specialists and certified providers assist applicants with the on-line application process at most hospitals, community health centers, and some community organizations. As of June 30, 2010, approximately 60% of the applications for MassHealth benefits were submitted via the VG.

At the CPU, staff members review each MBR application and, if necessary, clarify information with applicants. The CPU staff then input this information into MassHealth's electronic eligibility processing system, which it calls its MA-21 system. For each application, the MA-21 system first performs several administrative tasks, such as performing a data match with the U.S. Social Security Administration to determine whether the applicant is receiving Social Security benefits and sending out required verification request[4] forms to applicants if there is any information missing. Once these tasks are completed, the MA-21 system determines whether the applicant meets all of MassHealth's

[3] The Virtual Gateway, which EOHHS introduced in 2004, is an internet portal through which the state provides its employees, the general public, medical providers, and community-based organizations with on-line access to health and human services information.

[4] Applicants are provided 60 days to verify information. If this information is not received within this timeframe, the MA-21 system will deny the application for "Failure to Cooperate."

eligibility requirements and, if so, determines the most comprehensive health care coverage type for which the applicant is eligible.

Although all SMBRs are processed at the MEC centers, SMBRs for individuals living in the community are processed slightly differently from those of individuals requiring LTC in a medical facility. In both cases, MEC staff screen the SMBRs and clarify information with applicants. However, final processing is only performed by the MA-21 system for individuals living in the community. In contrast, MEC staff process all applications where applicants require LTC in a medical facility.

Eligibility Redetermination

States are required to redetermine member eligibility for Medicaid at least every 12 months, and must have procedures for members to report any changes that may affect their eligibility. Through the redetermination process, waiver population households are mailed an Eligibility Review Verification (ERV) form, and traditional population households are sent a MassHealth Eligibility Review (MER) form. Members are required to complete and return the form within 30 days. If a household does not return this form, MassHealth terminates the household's members from their MassHealth program.

Income and Eligibility Verification System

States are required to obtain and use certain information to verify Medicaid eligibility and the amount of medical assistance payments for each applicant. In this regard, 42 CFR 435.948(b) and 435.952(a) require state Medicaid programs to request various income-related information on applicants from various state and federal agencies and, within 45 days of receipt of the information, to compare this information against each applicant's case file to determine whether it affects his or her eligibility.

Medicaid Eligibility Quality Control/ MassHealth Operations Evaluation Services Unit

Federal regulations[5] require states to have a Medicaid Eligibility Quality Control (MEQC) program designed to reduce erroneous expenditures by monitoring eligibility determinations. The MassHealth Operations Evaluation Services Unit administers the MEQC program for Massachusetts and

[5] Title 42 Public Health Chapter IV Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 431: State Organization and General Administration, 42 CFR 431.800 - 431.865.

conducts evaluations on MassHealth eligibility policies, procedures, and processes that are submitted annually to the CMS for review.

AUDIT SCOPE, OBJECTIVES, AND METHODOLOGY

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor (OSA) conducted an audit of certain aspects of the process that MassHealth uses to determine an applicant's eligibility to receive health care benefits. Our audit, which covered the period July 1, 2009 through December 31, 2011, was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence that provides a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Our objectives were to determine whether MassHealth has established adequate policies and procedures to (a) verify applicants' residency, income, citizenship, and, if applicable, immigration status; (b) ensure that only eligible applicants receive MassHealth benefits; and (c) make eligibility determinations in compliance with applicable laws, rules, and regulations.

To achieve our objectives, we first reviewed state and federal laws, rules, and regulations applicable to Medicaid eligibility. We conducted interviews with officials at the Executive Office of Health and Human Services, MassHealth, the Centers for Medicare & Medicaid Services (CMS), and the U.S. Citizenship and Immigration Services. We also toured MassHealth's Central Processing Unit, Central Filing Unit, and Enrollment Center in Taunton and spoke with officials at each of these facilities. Further, we interviewed Boston Medical Center's Manager of Patient Financial Services, whose staff is responsible for assisting applicants with their on-line Virtual Gateway applications. In addition, we obtained a list of individuals who applied for MassHealth benefits during the audit period and, based upon our analysis of this list, selected files of 55 individuals (25 Medical Benefit Requests and 30 Senior Medical Benefit Requests) to review. Because the 55 files were judgmentally selected, we did not project the sample results to the universe. Rather, we used the sample results to identify potential systemic problems within the policies and procedures that MassHealth uses for determining program eligibility. For the sampled applicants, we reviewed their personal and financial information that MassHealth maintains within its MA-21 system and the applicants' hard-copy files, and assessed whether MassHealth's decisions on the sampled applicants were made in accordance with state and federal regulations. In addition, we obtained from MassHealth lists of applicants who were (a) initially approved for benefits during fiscal year 2010, but were subsequently terminated from the program and (b) non-U.S. citizens who received MassHealth benefits during fiscal year

2010. We obtained and analyzed claims from the Massachusetts Medicaid Management Information System (MMIS) to determine the types and cost of medical services being provided to undocumented aliens by MassHealth. We also obtained information relative to eligibility determination from other states as well as reports on this subject issued by various federal agencies, which are detailed in this report. Finally, we used information collected by the OSA's Bureau of Special Investigations, which is responsible for investigating fraud within the Commonwealth's public assistance programs, regarding MassHealth recipients who also had significant lottery winnings.

As noted, during our audit, we used data we retrieved from the MassHealth's MMIS and MA-21 systems as well as information provided to us by MassHealth officials from these systems. In order to assess the reliability of this information, we interviewed state agency officials knowledgeable about these systems and, during this and prior audits of MassHealth, were able to trace source documents to these systems. We also noted that MMIS was reviewed by CMS and obtained CMS certification. Based on this, we believe that the data essential to our audit was sufficiently reliable for the purposes of our audit.

Our audit was limited in scope and only included a review and assessment of MassHealth's eligibility process in the areas of residency, income, citizenship, and immigration status. Also, we did not assess MassHealth's eligibility redetermination process or review and assess the activities of MassHealth's Medicaid Eligibility Quality Control program, which could be the subject of future audits.

AUDIT FINDINGS

1. THE PROCESS THAT MASSHEALTH USES TO VERIFY THE SELF-REPORTED INCOME OF APPLICANTS/MEMBERS IS NOT CONSISTENT WITH STATE AND FEDERAL REGULATIONS AND NEEDS TO BE IMPROVED IN ORDER TO ENSURE THAT ONLY ELIGIBLE INDIVIDUALS RECEIVE BENEFITS

Our audit found that the process that MassHealth has established to verify the self-reported income of applicants/members is not consistent with requirements of state and federal regulations. Specifically, MassHealth does not fully verify applicants' self-reported earned income either at the time of their application or on at least a quarterly basis once they are enrolled, contrary to MassHealth and federal regulations. In fact, the first attempt MassHealth makes to independently verify the earned income of applicants/members is not until approximately one year after they are enrolled and receiving benefits. Further, contrary to federal regulations, MassHealth does not verify information about applicants' unearned (non-wage) income (e.g., lottery winnings, dividends, interest, annuity and pension payments, rental income) from the Internal Revenue Service (IRS) or from other independent sources such as the Office of the State Treasurer. As a result, MassHealth cannot ensure that it is identifying, to the extent possible, each applicant's/member's unearned income. In fact, we found that at least 18 MassHealth members during our audit period had annual lottery winnings ranging from $8,977 to $159,987 with no interruption in their MassHealth coverage. We also found that, during the time of application, MassHealth does not require applicants claiming that no one in their family has any income to provide any additional information on the means by which they are living. During our audit, we reviewed the files of 55 members who received MassHealth benefits during the audit period and found that 16 members reported on their applications that no one within their family had any income, but there was no documentation in these files that indicated that these applicants were questioned on how they were paying for any living expenses. This is in contrast to some other state Medicaid programs that require applicants to provide additional details about their financial situation when declaring zero family income. As a result of the problems we identified with the process that MassHealth uses to verify income, there is inadequate assurance that all MassHealth members who are deemed eligible for MassHealth benefits actually meet the income eligibility requirements to receive these benefits.

When applying for MassHealth benefits, each applicant must provide details of both the earned and unearned income of every member in their family, regardless of whether all family members

are applying for benefits. The IRS defines earned income generally as all the taxable income, including wages, tips, and other taxable benefits, that an individual receives from working,[6] including self-employment income. Similarly, examples that the IRS gives for unearned income include interest and dividends, retirement income, Social Security income, unemployment benefits, alimony, child support, and lottery winnings.

The 130 Code of Massachusetts Regulations (CMR) 506 promulgated by MassHealth establishes the following criteria for assessing whether an applicant meets MassHealth's income eligibility requirements:

> *In determining eligibility for MassHealth, the gross income [including gross countable earned and unearned income] of all family group members is counted and compared to an income standard based on the family group size. Caretaker relatives and parents of children younger than 19 years of age who are pregnant or who are parents may choose whether or not to be part of the child's family group.*

At the time of application, each applicant is required to declare his or her income under the pains and penalties of perjury and provide some documentation as proof of all of their earned and unearned income. In terms of earned income, for applicants who do not indicate that they are self-employed, this documentation is generally in the form of copies of the applicant's two most recent pay stubs. Applicants are also asked to provide information about their employment (including the name and address of their employer) as well as information about their family members. However, although each applicant is required to provide employer information, MassHealth does not contact employers or conduct a wage match analysis to verify this information.

Once an applicant provides this income information to MassHealth, both federal and MassHealth regulations require this information to be periodically verified using independent sources. For example, 130 CMR 516.006(D) states, in part:

> *The MassHealth agency matches files of MassHealth members who appear on the Department of Revenue (DOR) records as "new hires" or for whom DOR has received quarterly wage reporting information. If the DOR records contain data that is inconsistent with information previously recorded on the MassHealth case file, the MassHealth agency sends a notice with a Job Update form to the MassHealth member whose name appears on the DOR file. MassHealth must receive the completed Job Update form within 30 days*

[6] Earned income also includes long-term disability benefits received prior to minimum retirement age, gross income received as a statutory employee, and union strike benefits.

> *from the date on the notice. If the Job Update form is not received within the 30-day period, MassHealth coverage for the family group is terminated. If the member submits a written update after the end of the 30-day period, the MassHealth agency determines family group eligibility as of the date the written update is received and the start date of MassHealth coverage is established in accordance with 130 CMR 516.005.*

Federal Medicaid regulations (42 Code of Federal Regulations [CFR] 435.940 through 435.965) establish income and eligibility verification requirements for state Medicaid programs. These regulations specify that state Medicaid programs must, in a timely manner, request and use information to verify Medicaid eligibility and the amount of medical assistance payments for each applicant. In this regard, 42 CFR 435.948(b) and 435.952(a) require state Medicaid programs to request various income-related information on applicants from various state and federal agencies and, within 45 days of receipt of the information, to compare this information against each applicant's case file to determine whether it affects his or her eligibility. Under 42 CFR 435.948(a), the U.S. Department of Health and Human Services (HHS) identifies specific federal and state agencies from which state Medicaid programs must request this information during the application process and periodically thereafter, as follows:

> *[T]he agency must request information from the sources specified in this paragraph for verifying Medicaid eligibility and the correct amount of medical assistance payments for each applicant (unless obviously ineligible on the face of his or her application) and recipient. The agency must request—*
>
> > *(1) State wage information maintained by the SWICA[7] during the application period and at least on a quarterly basis;*
> >
> > *(2) Information about net earnings from self-employment, wage and payment of retirement income, maintained by SSA [the Social Security Administration] . . .for applicants during the application period and for recipients for whom the information has not previously been requested;*
> >
> > *(3) Information about benefit and other eligibility related information available from SSA . . .for applicants during the application period and for recipients for whom the information has not previously been requested;*
> >
> > *(4) Unearned income information from the Internal Revenue Service . . . during the application period and at least yearly;*

[7] The State Wage Information Collection Agency (SWICA) is "the state agency administering the state unemployment compensation law; a separate agency administering a quarterly wage reporting system; or a state agency administering an alternative system which has been determined by the Secretary of Labor, in consultation with the Secretary of Agriculture and the Secretary of Health and Human Services, to be as effective and timely in providing employment related income and eligibility data." In Massachusetts, the Department of Revenue administers the state's quarterly wage reporting system.

(5) Unemployment compensation information maintained by the agency administering State unemployment compensation laws . . . .

During our audit, we determined that MassHealth does in fact obtain and utilize information from some federal and state agencies in order to verify an applicant's eligibility. Specifically, as previously noted, MassHealth's MA-21 system conducts daily matches with information maintained by the U.S. Social Security Administration through the State Verification Exchange System (SVES). The SVES match verifies those MassHealth applicants/members having valid Social Security numbers who are currently receiving Social Security benefits and the amount of these benefits. Also, for those applicants who declare having no family income or unemployment benefits, effective July 2011, MassHealth began utilizing an information data match with the Massachusetts Division of Unemployment Assistance to verify that these applicants were in fact not receiving unemployment benefits. In addition, MassHealth obtains information through the Public Assistance Reporting Information System (PARIS), which is a federal-state information exchange system that provides all 50 states, Washington D.C., and Puerto Rico with such information as an interstate match of benefits to determine whether recipients are receiving Medicaid benefits in more than one state. MassHealth performs a PARIS match for all its members quarterly (in August, November, February, and May).

Despite these verification procedures, we found issues with the process that MassHealth uses to verify an applicant's both earned and unearned income that we believe make its income verification process less effective, as follows:

Earned Income

During our audit, we determined that, consistent with federal requirements, MassHealth does obtain a "14-Day New Hire" report that identifies any members that may have become employed during the past 14-day period and a "Quarterly Earnings" report that details the prior quarter's (previous three months) earnings for members. Prior to September 9, 2010, MassHealth used these reports to monitor each applicant's income and, when conflicts were identified, to take measures to address these discrepancies, including requesting additional income information from members on a standard Job Update Form, terminating members, and adjusting member benefits. However, on September 9, 2010, MassHealth instructed its MassHealth Enrollment Centers (MEC) personnel to stop sending Job Update Forms to members and to only use DOR wage match information during the member's annual

redetermination (which is approximately one year after the member has been enrolled), as follows:

> *MassHealth will no longer send Job Update Forms as a result of data matches with the Department of Revenue (DOR) quarterly wage reporting and the 14 day new hire files. This should reduce the current operational workload. Research indicates the information provided through this process can be obtained in a more efficient manner . . . .*

This change in policy is in direct conflict with federal regulations that require MassHealth to follow up within 45 days on the information that it receives from DOR. During our audit, we brought this matter to the attention of MassHealth officials, who stated that the agency discontinued conducting quarterly wage matches with DOR because MassHealth determined it was not cost-effective in that the number of members MassHealth was identifying with conflicts was not sufficient to justify the cost of performing the quarterly wage matches.

MassHealth officials also stated that DOR wage information is historic (for the previous quarter) and is not effective in determining an applicant's eligibility, since an applicant's income for eligibility determination purposes is based on his or her self-reporting of any current income as indicated in the two recent pay stubs that the applicant provides. Nevertheless, although the DOR wage match information is for the previous three months, it is still reasonably current and provides a practical means of assessing a member's financial eligibility within the required 45 days of the receipt of the applicant's information. Also, conducting both initial and quarterly wage matches as required by MassHealth and federal regulations would assist MassHealth in identifying other potential discrepancies, such as applicants who report no family income but who might have a family member who had reported income. By not conducting these wage matches or some other timely alternative verification procedure at the time of application and on at least a quarterly basis, MassHealth is not in compliance with federal regulations as well as its own regulations for ensuring that only eligible recipients receive benefits.

Under federal regulations 42 CFR 435.953, MassHealth could request approval to exclude from the aforementioned follow-up requirements certain categories of information that it determines to be not cost-effective. Specifically, these regulations state in part:

> *(a) With respect to information received on beneficiaries under §§435.940 through 435.960, the agency may either review and compare against the case file all items of information received or it may identify (target) separately for each data source the*

> *information items that are most likely to be most productive in identifying and preventing ineligibility and incorrect payments.*
>
> *(b) An agency that wishes to exclude categories of information items must submit for the Secretary's approval a follow-up plan describing the categories that it proposes to exclude. For each category, the agency must provide a reasonable justification that follow-up is not cost-effective; a formal cost/benefit analysis is not required.*

However, MassHealth did not provide us with any evidence that it has made such a request for approval.

During the audit, we brought this matter to the attention of the federal Centers for Medicare & Medicaid Services (CMS) officials, who provided the following written response indicating their concerns relative to this situation.

> *You have cited MassHealth for discontinuing the data matching process with the State Department of Revenue (DOR). As described under 42 CFR §435.948, States have an obligation to share and use information available from other sources within State or federal agencies. MassHealth claims to have suspended this process because the administrative burden it created outweighed the benefits it provided. At this time, we are unsure of MassHealth's plans to develop an alternative process that would use this data in a more streamlined way. We intend to follow-up with the State to determine what interim processes are in place.*

In our opinion, MassHealth's delaying the verification of an applicant's income until the member's annual redetermination is performed is not consistent with MassHealth and federal regulations and may allow ineligible applicants to receive benefits for up to one year before they are found to be ineligible. For the state fiscal year ended June 30, 2011, the average MassHealth caseload totaled 1,317,000 and the annual spending was $12,124,000,000 (see Appendix V). Based on the magnitude of this program, the financial ramifications of MassHealth's not performing effective income eligibility verifications for applicants could have an adverse effect on the Commonwealth's finances.

Another problem we found is that, during the application process, MassHealth does not require applicants who claim zero family income to provide any additional information on the means by which they are paying for their daily living expenses. As previously stated, during our audit we reviewed the files of 55 members who received MassHealth benefits during the audit period and found that 16 reported on their applications that no one in their family had any income. However, MassHealth did not attempt to verify these attestations through data matches with federal and state agencies except, as previously discussed, with the U.S. Social Security

Administration and the Massachusetts Division of Employment Security. Moreover, MassHealth's application forms do not require such applicants to explain how they pay for their day-to-day living costs. This is in contrast to other state Medicaid programs that require applicants to provide additional details about their financial situation when declaring zero family income. For example, the State of New York's Medicaid application asks, "If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing?" In our opinion, asking such questions is part of the due diligence necessary to make informed decisions about applicants' eligibility and benefit levels. This condition is particularly concerning given that, as of June 30, 2010, MassHealth indicated that it was receiving approximately 60% of its applications through the Virtual Gateway (VG). The VG enables MassHealth enrollment specialists and certified MassHealth providers to submit electronic MassHealth applications on behalf of applicants. However, we found that MassHealth has not established specific questions for VG users to ask of applicants who report zero family income. Since August 2004, the Boston Medical Center (BMC) has submitted the most electronic applications of any other certified MassHealth provider organization. Because of its extensive experience with the VG, we spoke with BMC's Manager of Patient Financial Services about applicants reporting zero income and the types of questions, if any, that BMC personnel ask of such applicants. We were informed by the manager that (a) BMC staff are encouraged to clarify information with applicants, but specific questions to ask these applicants have neither been provided by MassHealth nor developed by BMC and (b) counselors at the BMC are responsible for assisting individuals in applying for MassHealth benefits but are not required to verify any of the information reported to them by applicants.

During our audit, we asked MassHealth officials what is specifically done by agency staff to verify applicant claims of having zero family income. In response, MassHealth officials provided the following written comments:

> *In signing the application/review, individuals certify under the penalty of perjury that the information on the application/review and any supplements is correct and complete to the best of their knowledge.*

Another weakness in MassHealth's income verification process is that, unlike the Medicaid agencies of some other states, MassHealth only relies on earned income information that it obtains from DOR and does not independently access earned income information from the IRS,

which would provide a more complete picture of an applicant's total income. In this regard, a DOR wage match analysis, although useful, is limited in that it would only show earned income received by the member/applicant from Massachusetts employers. Therefore, the earned income of applicants working out-of-state, as well as any self-employment income or unearned income, would not appear on a DOR wage match.

Unearned Income

As previously discussed, federal regulations 42 CFR 435.948(a)(1) through (5) require MassHealth to verify applicant information, including any unearned income, with specific federal and state agencies (e.g., IRS, U.S. Social Security Administration, DOR). However, as previously noted, although MassHealth does verify certain types of an applicant's unearned income with the U.S. Social Security Administration and the Massachusetts Division of Employment Security, it does not conduct any information matches with the IRS or other alternative state or federal sources to verify an applicant's unearned income. As a result, members may have unearned income that is not being reported by members or identified by MassHealth that may have made them ineligible to receive MassHealth benefits, or only eligible for a lower level of benefits.

For example, in accordance with 130 CMR 501.010(B), MassHealth members are required to report any changes to household status, such as income from the Massachusetts State Lottery, within 10 days, as follows:

> *The applicant or member must report to the MassHealth agency, within 10 days or as soon as possible, changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.*

However, MassHealth officials informed us that the agency does not conduct data matches with the Massachusetts State Lottery Commission (MSLC) to match lottery winners with its member information. Rather, MassHealth relies solely on members and applicants to report their lottery winnings. The Office of the State Auditor's Bureau of Special Investigations, which is responsible for investigating fraud within the Commonwealth's public assistance programs, compared MSLC information with MassHealth member information and identified at least 18 MassHealth members who had annual lottery winnings ranging from $8,977 to $159,987 without any interruption in their MassHealth coverage. Had MassHealth implemented a data match process with the MSLC as required by CFR 435.948(a)(6), it would have been made aware of

these members' lottery winnings in a timely manner and would have been able to review the members' changed financial circumstances and, if applicable, terminate the members' enrollment or adjust their benefit level.

As a result of the weaknesses we identified in the process MassHealth uses to verify applicant/member income, MassHealth cannot ensure that all of its applicants/members meet the income requirements for enrollment or continued participation in its program.

Recommendation

In order to ensure proper verification of applicant/member wages and unearned income, we recommend that MassHealth amend its policies and procedures to comply with applicable federal regulations. Specifically, MassHealth should:

- At the time of application, perform data matches with DOR for all applicants and family members as a means to verify the accuracy of wage information submitted by these individuals.
- Begin utilizing DOR's 14-Day New Hire reports and Quarterly Wage reports within 45 days of the date that the reports are received as opposed to the current practice of only reviewing these documents during the annual redetermination process.
- Establish a data match with the IRS to verify unearned income (e.g., dividends, interest, annuity and pension payments, rental income) reported by applicants and members.
- Establish a data match with the Office of the State Treasurer to verify significant lottery winnings of members. MassHealth should perform this data match at least quarterly and, if warranted, adjust the eligibility status and benefit levels of those members affected.
- Amend the Medical Benefit Request (MBR) and Senior Medical Benefit Request (SMBR) forms in such a way that applicants who report zero household income must provide additional information about the means in which they pay for their daily living expenses. In addition, MassHealth should provide necessary training material, including a list of pre-set questions, for MassHealth enrollment specialists and certified MassHealth providers to use in soliciting such information from VG applicants.

Auditee's Response

In response to this issue, MassHealth officials provided the following comments, which are excerpted below:

> *At the time of application, MassHealth verifies income for each applicant. MassHealth requires all applicants to provide their two most recent pay stubs, and their most recent*

federal tax returns (as a measure to detect unearned income and rental income in addition to other information). Applicants who do not provide this information are denied MassHealth. If MassHealth learns that an applicant or Member intentionally falsifies any financial information used to determine eligibility, that individual would be referred for further investigation to the program integrity unit. If appropriate, a further referral for a fraud investigation is made. Eligibility for MassHealth is redetermined annually, and MassHealth requires members to demonstrate they meet financial eligibility requirements each year.

In addition, MassHealth receives quarterly information from the Massachusetts Department of Revenue (DOR) and is in the process of developing and implementing innovative uses of this DOR match information to better insure program integrity. In fall of 2012 MassHealth will implement additional income verification activity utilizing DOR data collected between annual reviews at key transitional income levels that would be most likely to indicate potential ineligibility. Beginning in January of 2014, as part of Affordable Care Act implementation MassHealth will utilize an Integrated Eligibility System IT Platform that will have access to Massachusetts DOR, the IRS and other state and federal databases that will improve the effectiveness and efficiency of our eligibility systems, work processes, and program integrity efforts.

MassHealth agrees with the Auditor Report that it should continue to review and improve the current process for verifying income, particularly in light of the opportunities created by the Integrated Eligibility System made possible by the Affordable Care Act. . . .

MassHealth does obtain information about applicants' unearned (non-wage) income. For example, as stated above, MassHealth requires applicants to produce their federal tax returns to report all rental income and other unearned income. The MassHealth Benefit Request Form (MBR) also explicitly requests information about dividends, annuity interests, and pensions. Once the Integrated Eligibility System made possible by the Affordable Care Act is in place, MassHealth will have access to IRS and other federal data sources through an IT system.

MassHealth does not currently perform a match with the State Lottery Commission but will initiate discussions with the Lottery Commission to determine the feasibility and practicability of such matching. . . .

All applicants must report all "Non-working Income" on page three of the MassHealth Benefits Request form (the "MBR"). "Nonworking Income" includes all rental income, unemployment benefits, and other nonworking incomes such as alimony, annuities, child support, dividends/interest, pensions, retirement, social security, SSI, trusts, veterans' benefits, workers compensation and other income. All income derived from sources other than employment must be reported and the applicant must provide verification of these sources of incomes. The Integrated Eligibility System described above will include a link with DUA that will facilitate further verification of unemployment benefits.

Auditor's Reply

We agree with MassHealth that individuals who report earned income on their application form must provide some documentation of the income they report. In this regard, MassHealth's Medical Benefits Request (MBR) form states, "Send proof of all income, like copies of two

recent pay stubs." However, contrary to MassHealth's assertion, all applicants are not required to submit their most recent federal tax returns as a measure to detect unearned income. In fact, MassHealth's MBR form and its instruction page make no reference to federal tax returns being required of any applicants to support either their earned or unearned income. Moreover, the MBR instruction page advises applicants to read the MassHealth Member Booklet carefully before filling out their application. This booklet indicates that only individuals who are self-employed or have rental income need to submit federal tax returns. In most cases, applicants only have to provide their two most recent pay stubs as proof of their current income, and MassHealth does not perform any independent verification of this information.

Given that MassHealth does not have policies and procedures in place to provide a full, independent verification of self-declared income at the time of application, its decision to not compare quarterly wage reports provided by DOR to the case files until the annual redetermination process reflects a control deficiency within the program. This practice not only limits MassHealth's ability to ensure that applicants are accurately reporting their income, but also is contrary to federal regulation 42 CFR 435.952, which requires MassHealth to request and use information such as quarterly wage match information within 45 days of receiving the information to verify Medicaid eligibility and the amount of medical assistance payments. Further, although MassHealth requests applicants to provide information about their unearned income, contrary to federal regulations MassHealth does not independently verify information about their unearned income from the Internal Revenue Service (IRS) or from other independent sources such as the Office of the State Treasurer. As a result of these issues, we believe that the process currently being used by MassHealth to verify both earned and unearned income of applicants and members is deficient and ineffective in ensuring that only individuals who meet MassHealth's income eligibility requirements receive services.

In its response, MassHealth states that it plans to implement additional income verification activity utilizing DOR data starting in the fall of 2012. However, MassHealth's plan as described only affects members who have been enrolled in MassHealth for over a year. Moreover, the plan does not address MassHealth's requirement under federal regulation 42 CFR 435.948(a) and 435.952 to request information from DOR during the application process and periodically thereafter to verify the financial eligibility of applicants and enrollees, respectively. As the most critical time to verify income is during the application process before benefits are provided,

MassHealth's allowing over a year to pass before performing such data matches unnecessarily increases the possibility of MassHealth providing benefits to individuals who were not eligible to receive these benefits for an extended period of time.

We agree with MassHealth that utilizing an Integrated Eligibility System IT Platform, which provides access to Massachusetts DOR, the IRS, and other state and federal databases, will improve the effectiveness and efficiency of its eligibility systems, work processes, and program integrity efforts. However, we believe that MassHealth should not wait for this system to be available in order to establish controls to effectively verify income reported by applicants and members.

In its response, MassHealth indicates that it plans to initiate discussions about data matching with the Massachusetts State Lottery Commission in order to determine its feasibility and practicality. We believe the actions taken by MassHealth in this area are appropriate and should serve to help MassHealth identify in a more timely manner individuals who may have become ineligible for MassHealth benefits as a result of their lottery winnings.

2. MASSHEALTH HAS NOT ESTABLISHED A PROCESS TO EFFECTIVELY VERIFY THE RESIDENCY OF APPLICANTS AND, AS A RESULT, THOUSANDS OF NON-RESIDENTS MAY BE INAPPROPRIATELY RECEIVING HEALTHCARE BENEFITS

Our audit identified that MassHealth needs to strengthen its policies and procedures for verifying the residency of applicants/members. According to MassHealth regulations, as a condition of eligibility, applicants and members must live in the Commonwealth with the intent to remain permanently or for an indefinite period. However, MassHealth accepts an applicant's self-declaration of residency and, unlike the Medicaid agencies of some other states, does not require applicants to provide any documentation to substantiate that they actually reside in Massachusetts. Consequently, the Commonwealth may be incurring health care costs for non-Massachusetts residents. In fact, during our audit, we determined that 71,519 individuals who applied for and received MassHealth benefits during fiscal year 2010 were subsequently terminated by MassHealth including 38,970 for reasons that bring into question their residency status. While it is clear that a number of these 38,970 members were terminated for failing to provide requested documentation, for 4,649 of these members who had received benefits totaling $6,456,195 during this fiscal year, MassHealth determined that they were either non-Massachusetts residents, receiving benefits in another state or that their whereabouts was

unknown. Had MassHealth implemented effective policies and procedures to independently verify residency at the time of application and periodically thereafter, it could have identified in a more timely manner those applicants and members who were ineligible for benefits due to unmet residency requirements. In so doing, MassHealth may have saved millions it expended on these terminated members during this fiscal year.

MassHealth's residency requirements are detailed in 130 CMR 503.002 and 130 CMR 517.002, respectively, for its waiver and traditional populations. As detailed below, each set of regulations requires that, as a condition of eligibility, an applicant must live in the Commonwealth with the intent to stay for an indefinite period.

> *503.002: Residence Requirements*
>
> *(A) As a condition of eligibility, an applicant or member must live in the Commonwealth with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address.*
>
> *517.002: Residence*
>
> *(A) Requirements. As a condition of eligibility an applicant or member must:*
>
> > *(1) live in the Commonwealth, with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address; or*
> >
> > *(2) live in the Commonwealth at the time of application and have entered the Commonwealth with a job commitment, whether or not he or she is currently employed.*

MassHealth promulgated 130 CMR 517.002(B)[8], which allows applicants and members to self-declare their residency. This regulation only mandates verification of an applicant's declared residency if conflicting or contradictory information regarding the applicant's/member's declared place of residence is identified.

During our audit, we asked MassHealth officials why, if an applicant's eligibility is predicated upon his or her residing in Massachusetts with the intent to stay for an indefinite period, MassHealth does not routinely obtain independent verification of residency through data matches with federal or other state agencies or, if necessary, through supporting documentation from applicants. In response, MassHealth officials provided the following written comments:

[8] MassHealth informed us that this requirement applies to both the traditional and waiver population. However, due to an oversight, the requirement was not detailed under 130 CMR 503.002 as well.

> *Per 130 CMR 517.002(B), verification of MA residence is self-declared unless there is conflicting contradictory information regarding the applicant or member's declared place of residence. In signing the application/review, individuals certify under the penalty of perjury that the information on the application/review and any supplements is correct and complete to the best of their knowledge. If the eligibility worker suspects the individual may not meet residency requirements, verification of residency will be requested.*

In July 2005, the U.S. Department of Health and Human Services, Office of the Inspector General (OIG) published a report entitled Self-Declaration of U.S. Citizenship for Medicaid (Report OEI-02-03-00190). Within this report, the OIG states, "By their nature, self-declaration policies have inherent vulnerabilities in that they can allow applicants to provide false statements of citizenship. As such, it is vital to have protections in place to prevent such practices."

As previously discussed, MassHealth utilizes PARIS to perform interstate matches to determine whether members are receiving benefits from multiple states. MassHealth has reported that PARIS matching has resulted in 3,306 cases being closed in fiscal year 2009 and 3,789 cases being closed in fiscal year 2010 because the MassHealth members were found to be receiving Medicaid benefits in other states. Accordingly, it appears that the PARIS match is effective in identifying abuses in this area. However, the results of these PARIS matches also demonstrate a possible deficiency within MassHealth's process, which allows the self-declaration of residency with no verification, since some of these individuals might not have been deemed eligible at the time of their application if MassHealth had conducted some type of verification of their residency status.

Our analysis of MassHealth's program application and termination data for fiscal year 2010 indicates that MassHealth should consider implementing verification procedures for residency. Specifically, MassHealth records indicate that during fiscal year 2010, 71,519 individuals who applied for and received MassHealth benefits were terminated from MassHealth programs including 38,970 for the following reasons (a) non-Massachusetts resident, (b) whereabouts unknown, (c) receiving benefits in another state, (d) did not provide required information, and (e) failure to complete or return information request. While it is clear that a number of these 38,970 members were terminated for failing to provide requested documentation, for 4,649 of these members who had received benefits totaling $6,456,195 during this fiscal year, MassHealth determined that they were either non-Massachusetts residents, receiving benefits in another state or that their whereabouts was unknown. The time span from the members' application date to

their termination date for all 38,970 members ranged from less than a month to over one year. Certainly, it is reasonable to assume that some of these individuals may have been Massachusetts residents at the time of their application and, as such, were eligible to receive MassHealth benefits for some portion of this fiscal year. However, based upon the sizable number of applicants terminated and the reasons for those terminations, there is a higher than acceptable risk that a number of these individuals may have received benefits during periods in which they did not meet MassHealth's residency requirements.

Description	Members Terminated	Benefits	Blank[9]	Days from Application to Termination							
				< 26	26 to 50	51 to 75	76 to 100	101 to 150	151 to 200	201 to 365	> 365
Not a Massachusetts Resident	1,800	$ 2,148,546	529	3	45	50	103	168	174	419	309
Whereabouts Unknown	1,796	3,132,174	319	17	184	86	68	109	157	381	475
Receiving Benefits in Another State	1,053	1,175,475	240	0	3	0	5	111	162	451	81
Required Documentation Not Provided	9,338	10,304,324	2,704	380	140	87	2,988	1,193	242	512	1,092
Failed to Complete or Return Information Requested	24,983	31,258,599	2,967	10	4	157	637	1,053	916	1,994	17,245
Totals	38,970	$48,019,118	6,759								

[9] MassHealth provided the raw data that was used to prepare this table. The data, which we neither independently verified nor audited, in some instances did not include either the application or the termination date. We summarized those instances under the "Blank" column.

MassHealth's decision to allow applicants to self-declare their residency also appears to be inconsistent with federal documentation requirements. Specifically, under 42 CFR 435.913(a), MassHealth is required to maintain documentation within each applicant's file to support the decisions it makes regarding an applicant's eligibility. During our audit, we brought this matter to the attention of CMS officials, who stated that applicants' self-declaration of their residency under the pains and penalties of perjury may meet this requirement. However, in October 2006, the U.S. Department of Health and Human Services, Office of the Inspector General (OIG) issued a report entitled, "Review of Medicaid Eligibility in New York State" (A-02-05-01028), which cited the State of New York's Medicaid program for insufficient documentation within its applicant files. In reporting on this issue, the Inspector General referenced 42 CFR 435.913 and stated:

> *For some cases, we were unable to verify residency information, and we categorized those cases as "insufficient documentation to support eligibility determinations."*

Additionally, as previously noted, in July 2005, the OIG issued a report entitled "Self-Declaration of U.S. Citizenship for Medicaid." Within the report, the Inspector General stated:

> *In recent years, CMS has encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process. While the policy to allow applicants to self-declare citizenship can result in rapid enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false citizenship statements. As such, there are inherent challenges in trying to provide Medicaid benefits expeditiously while still ensuring the accuracy of eligibility determinations.*

Based on the concerns over self-declaration of residency reflected in the aforementioned OIG report, the process that MassHealth uses, which allows applicants to self-declare their residency without any additional verification being conducted, increases the risk of applicants being able to submit false statements about their residency in order to qualify for MassHealth benefits.

In response to this matter, CMS officials also provided us with written comments that seem to support MassHealth's position that it is acceptable to allow applicant self-declaration of residency and to verify residency only in cases where conflicts are found within applicant information, as follows:

> *You have cited MassHealth for not requesting proof of residency at the time of application. The State Residence regulations under 42 CFR §435.403 set standards by which the State agency applies the Medicaid residency rules, but do not specifically require any particular type of verification of residency. CMS has generally allowed States*

the flexibility to accept self-attestation as a verification of residency. Over half the States use self-attestation. In the Notice of Proposed Rule Making (NPRM) for the Medicaid eligibility changes under the Affordable Care Act (published in the Federal Register (Volume 76, Number 159 (Wednesday, August 17, 2011)), CMS proposes to give States even greater flexibility for verifying residency, income, and citizenship. The NPRM sets out regulations that rely less on paper processes, but promote self-attestation and increased coordination with electronic sources. These rules are not yet final and will not be in effect until January 1, 2014. The NPRM sought comments from the public on the position CMS currently advocates for a streamlined approach to the application and eligibility process.

Although CMS officials stated that it generally allows states to accept an applicant's self-declaration of residency, it is important to note that the HHS's Notice of Proposed Rule Making (NPRM) for the Medicaid eligibility changes under the Affordable Care Act of 2010 that CMS officials reference in their response indicates that state Medicaid programs are going to rely less on paperwork but are going to be required to perform verifications of self-declared information from various electronic sources. An excerpt from these proposed rule changes[10] follows:

Sec. 435.945 General requirements.

(a) Nothing in these regulations in this subpart should be construed as limiting the State's program integrity measures or affecting the State's obligation to ensure that only eligible individuals receive benefits, consistent with part 455 of this subchapter.

(b) Except with respect to citizenship and immigration status information, and subject to the verification requirements set forth in this subpart, the agency may accept attestation without requiring further paper documentation (either self-attestation by the applicant or beneficiary or by a parent, caretaker or other person acting responsibly on behalf of an applicant or beneficiary) of all information needed to determine the eligibility of an applicant or beneficiary for Medicaid.

(c) The agency must request and use information relevant to verifying an individual's eligibility for Medicaid in accordance with Sec. 435.948 through Sec. 435.956 of this subpart.

Otherwise, as detailed below, these proposed rule changes suggest that states should verify self-declarations by electronic means and, in the case of conflicting information, requesting documentation from applicants.

Sec. 435.952 Use of information and requests of additional information from individuals.

(a) The agency must promptly evaluate information received or obtained by it in accordance with regulations under Sec. 435.940 through Sec. 435.960 of this subpart to determine whether such information may affect the eligibility of an individual or the benefits to which he or she is entitled.

[10] Federal Register,Vol. 76, No. 159, Wednesday, August 17, 2011, Proposed Rules

(b) If information provided by or on behalf of an individual (on the application or renewal form or otherwise) is reasonably compatible with information obtained by the agency in accordance with Sec. 435.948, Sec. 435.949 or Sec. 435.956 of this subpart, the agency must determine or redetermine eligibility based on such information.

(c) An individual must not be required to provide additional information or documentation unless information needed by the agency in accordance with Sec. 435.948, Sec. 435.949 or Sec. 435.956 of this subpart cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual.

(1) In such cases, the agency may seek additional information, including a statement which reasonably explains the discrepancy or other additional information (including paper documentation), from the individual.

Lastly, during the audit, we compared the application forms of other state Medicaid programs to the MBR and SMBR application forms used by MassHealth. Relative to residency verification, we found that, unlike MassHealth, a number of other state Medicaid programs require applicants to provide documentation validating their declared place of residence, including rent receipts, utility bills, government photographic identification cards, etc. For example, such documentation is required of individuals applying for Medicaid in New York, New Hampshire, and California, as follows:

- New York requires that the address on the application form match the applicant's home address as indicated on either (a) a lease, letter, or rent receipt from the applicant's landlord or (b) a driver's license (if issued in the past six months), utility bill (gas, electric, phone, cable, fuel, or water), a government ID card with address, property tax records or mortgage statement, or a postmarked envelope or postcard.

- New Hampshire provides applicants with a list of acceptable verifications needed to determine eligibility. For example, acceptable verification for residence/shelter expenses include: "Rent, mortgage payments, taxes, heat, electricity, insurance, telephone, sewage, and garbage fees. A current rent receipt signed by your landlord with your name, address, date, amount of rent and whether heat or utilities are included, current receipts, canceled checks, statement from person you live with regarding charges for room or food, current utility bills, or our Form 775."

- California's Medicaid application instructions state: "Send proof of California residency. You can use your proof of income as proof of residency. If your income is not from California, send other proof of residence. For example: rent receipts, utility bill or a child's school records."

We believe that MassHealth should consider implementing such additional verification procedures of residency.

Recommendation

In order to address our concerns relative to the proper verification of applicant/member residency, we recommend that MassHealth amend its policies and procedures, as follows:

- At the time of application, MassHealth should utilize electronic data matches with federal and other state agencies, including the IRS, the Social Security Administration, DOR, and the Division of Employment Security to verify individuals' self-declared residences.

- If an electronic data match is not possible for certain applicants because the applicant does not have a verified Social Security number, MassHealth should require the applicants to submit documentation to support their self-declared residence. In this regard, MassHealth should publish within the MBR and SMBR forms examples of acceptable documents for verifying residency.

- At quarterly intervals, MassHealth should utilize the same federal and state agency electronic data matches to verify the residency of members. For each conflict found, MassHealth should require that the affected member provide documentation to resolve the conflict.

- If quarterly electronic data matches are not possible for certain members because the members do not have a verified Social Security number, MassHealth should require such members to submit documentation during their annual review process to re-verify their self-declared residency.

Auditee's Response

In response to this audit finding, MassHealth officials provided the following comments, which are excerpted below:

> *MassHealth's process for verifying residency is fully compliant with federal law and, as a policy matter, ensures that eligible Massachusetts residents are able to access needed MassHealth benefits without unnecessary barriers. Under federal Medicaid law, the Commonwealth must provide Medicaid to eligible residents, including residents who are absent from the state. Current federal Medicaid policy allows states to accept self-attestation of all eligibility criteria, except citizenship and immigration status. In fact, the practice of accepting self-declaration is used in more than half of all states.*
>
> *If there is any question of residency, such as conflicting or contradictory information about the applicant's place of residence, MassHealth asks the applicant to provide additional proof of residency. If the applicant fails to provide that verification within 30 days of the request, the application is denied or the member is terminated. Additionally, if there is a suspicion that the applicant is providing fraudulent information, eligibility workers are instructed to process the application and then report the information to the MassHealth Operations Integrity Unit.*

In 1997, the Commonwealth first implemented the MassHealth 1115 Demonstration Project (1115 Waiver) for the express purpose of expanding access to health care to uninsured populations through streamlining of both eligibility rules and processes. A key feature of the 1115 Waiver has always been "administrative simplification", built on the shared federal and state premise that excessive paper requirements do not necessarily enhance program integrity and that unnecessary administrative barriers can contribute to the churning of eligible individuals on and off coverage are ultimately costly to the system. These gaps unnecessarily increase other safety net spending or provider bad debt, increase medium and long-term Medicaid spending due to pent up demand and lack of access to adequate preventive care, and require additional administrative resources for Medicaid agencies. When the 1115 Waiver was first implemented, paperwork requirements that resulted in denial or gaps in coverage for individuals who were likely, ultimately, eligible for benefits, were specifically targeted for elimination.

The recommendation that paper documentation of residency be required for all individuals for whom electronic data are not available to buttress an attestation of residency is inconsistent with these administrative simplification efforts and goals, would create a significant administrative burden for MassHealth, and would result in gaps in coverage for individuals who are eligible. Ultimately, an individual who lacks any of the traditional forms of documentation may still have the intent to remain in the state and therefore meet the residency requirement. Moreover, the recommendation would create a unique barrier to access for all individuals who are homeless (not all of whom use shelters) but who may be eligible for MassHealth Limited under federal law. At the same time, where there is specific information that raises questions about the individual's residency in the application or case file, such as an out of state license or mailing address, MassHealth seeks additional verification of residency. In all cases in which MassHealth requests additional verification, the individual has 30 days to respond. If MassHealth does not receive a response, the application is denied or the Member is terminated. . . .

Of the 38,970 individuals that the Draft Audit identifies as being terminated for reasons that "bring into question their residency status," 34,321 were terminated for not providing documentation of any kind (not necessarily related to residency) or not completing or returning any type of requested information. It is incorrect to suggest that these terminations all are related to residency. Members must recertify their eligibility every year. If they fail to return a document stating that they meet residency and financial eligibility standards, they are terminated. MassHealth asks for verification of any and all facts asserted on the benefits application, if it determines such verification is needed. It is not reasonable to draw any conclusion about residency status solely based on the fact of these terminations, any number of which may have nothing to do with residency. Similarly, it is unreasonable to include either these 34,321 individuals' status or the $41,562,923 in MassHealth expenditures for them as potential costs that could have been avoided by adding more documentation about residency. This number is also inflated since it includes all benefits received in FY2010, including benefits received before the individuals became ineligible.

Of the 38,970 individuals cited, 1,796 were terminated because their "whereabouts were unknown." The fact that MassHealth is unable to find a member could mean that the member has become homeless, moved in with friends or family, or passed away. Again, it is not reasonable to assume the $3,132,174 as costs that could be avoided by requiring additional documentation of residency status. This number also includes all benefits received in FY2010, including benefits received before the individuals became ineligible and is therefore inflated.

- *2,853 individuals of the 38,970 cited received a total of $3,324,021 in benefits were appropriately and successfully identified and terminated because they were receiving benefits in another state (1,053) or were no longer Massachusetts residents (1,800). MassHealth agrees that these individuals were properly terminated for failure to meet residency requirements. Our verification processes appropriately resulted in the termination of these members either because of concerns about the documentation that they submitted, tips from providers or others, members who voluntarily informed us of their move, or links with the PARIS Match that compares our database with those of other states. We use the PARIS Match to verify this type of concern quarterly, significantly more frequently than most other states. This number is also inflated since it includes all benefits received in FY2010, including benefits received before the individuals' MassHealth eligibility was appropriately terminated.*

The chart . . . is misleading and suggests that none of the 38,970 individuals were eligible. . . .

Beginning in October 2011, MassHealth initiated procedures to more thoroughly investigate and verify residency in those applications or files containing conflicting or contradictory information. MassHealth now applies more stringent rules regarding the circumstances in which it will request residency verifications, and has streamlined the process for sending those verification requests to members/applicants. MassHealth has already implemented this for new applicants and during the annual recertification process. MassHealth continues to enhance its training and Quality Control procedures to ensure that this new process is fully utilized throughout the eligibility determination process. These improvements have already begun to ensure more thorough follow-up for cases like the one noted in this section. . . .

We do note that federal rules require the Commonwealth to make Medicaid available to all eligible residents of the state, including those who are absent from the state . . . .

Auditor's Reply

Although MassHealth's policy of accepting an applicant's self-declaration is permissible under federal law, for the reasons stated in our report, we believe that MassHealth should take measures to strengthen its controls over the process its uses to establish an applicant's residency status. Implementing better verification controls in this area at the time of application would facilitate more timely and accurate eligibility determinations, which potentially could result in cost savings to the Commonwealth. MassHealth can perform these verifications through either data matching with other state and federal agencies or, if necessary, by requiring applicants to submit documents that support their self-declarations.

MassHealth's response states that if there is any question of residency, such as conflicting or contradictory information about an applicant's place of residence, MassHealth asks the applicant to provide additional proof of residency. We acknowledge that, if properly implemented, this control procedure would help to ensure that applicants meet MassHealth's residency

requirements in order to qualify for benefits. However, our audit found that no documentation was maintained in the 55 member files we reviewed to substantiate that such conflicts are being consistently resolved.

In its response, MassHealth states, "In 1977, the Commonwealth first implemented the MassHealth 1115 Demonstration Project for the express purpose of expanding access to health care to uninsured populations through streamlining of both eligibility rules and processes. A key feature of the 1115 Waiver has always been 'administrative simplification' . . . ." However, our audit found through its efforts to streamline both its eligibility rules and processes, MassHealth has eliminated what we believe are essential controls over its eligibility determination process, including the proper verification of an individual's residency status. The objective of administrative simplification is not to mitigate essential controls over an activity but rather to identify more effective and efficient ways of accomplishing tasks associated with various required processes and activities. In this regard, HHS's NPRM for the Medicaid eligibility changes under the Affordable Care Act of 2010 indicates that state Medicaid programs are going to rely less on paperwork and are going to be required to perform verifications of self-declared information from various electronic sources. Using various electronic sources to independently verify self-declared information as will be required under these rules--which is exactly the type of control that we are recommending that MassHealth utilize--will serve to simplify MassHealth's administrative process through the reduction of paperwork but still effect proper verification controls over eligibility determinations.

Certainly, a balance must be achieved between administrative simplification and the internal controls implemented to help ensure program integrity. We believe by data matching applicant/member residency information with other state and federal government data bases in a timely manner, MassHealth can achieve this balance between program delivery and program integrity with a minimal increase in its administrative costs.

We acknowledge that, for some individuals, electronic data matching may not be possible, and obtaining alternative proof of residency from them will be necessary. Since MassHealth already requires many applicants to submit documents (e.g., copies of federal tax returns) to resolve conflicts in income information, requiring individuals to submit one or two documents, (e.g. utility bill, rent receipt) to support their self-declarations of residency would not appear to

represent excessive paperwork requirements, create unnecessary administrative barriers to the receipt of MassHealth benefits, or have a significant impact on the timely processing of applications and redeterminations.

Additionally, we do not believe that implementing effective controls relative to the verification of residency would result in the "churning" of eligible individuals as described by MassHealth. For most individuals, MassHealth can verify residency through data matching with other state and federal agencies. In order to address the verification of residency for individuals who do not have Social Security numbers, MassHealth would need to amend its application and redetermination forms to specify the types of acceptable documentation that individuals may submit in lieu of valid Social Security numbers. MassHealth applications and redetermination forms already include similar instructions relative to applicant and member income. As previously noted, many states, including New York, California, and New Hampshire, require applicants to provide documents such as rent receipts, utility bills, etc. during the application process. Although homeless applicants would not have access to such documents, they could potentially obtain verification letters from the homeless shelter or food kitchen that provides them assistance with their daily living needs. For those individuals who would have difficulty requesting even such documentation, exceptions could be made and substantiated within the applicant's file.

We concur with MassHealth that not all terminations of members noted in this report who neither provided documentation of any kind nor completed or returned any type of requested information are related to residency. Certainly, some of these members may have failed to respond to MassHealth's requests for information for other reasons, including their (a) obtaining medical coverage through their current employer, (b) no longer meeting the financial eligibility requirements of the program, (c) relocating within Massachusetts without providing a forwarding address to the United States Postal Service, or (d) becoming deceased. However, it is equally possible that a number of these members may never have resided in Massachusetts or could have departed from the state after enrolling in the MassHealth program. MassHealth could more effectively identify individuals who provide false statements about their residency by independently verifying all self-declarations made by applicants. In addition, for those individuals who meet Massachusetts residency requirements at the time of application but depart the state after being enrolled, MassHealth could identify in a more timely manner when these individuals

may have left the state and were therefore not entitled to any more benefits if it instituted a policy of verifying member residency on a frequent periodic (e.g., quarterly) basis. Presently, with the exception of PARIS matches, MassHealth does not have an effective means of ensuring that applicants and members meet its residency requirements, which may be resulting in millions of dollars in unnecessary expenditures annually by MassHealth.

In its response, MassHealth contends that it is unreasonable to include either the $41,526,923 in expenditures for the 34,321 individuals who did not provide requested documentation or the $3,132,174 in expenditures for the 1,796 individuals who were terminated because their "whereabouts were unknown" as potential costs that MassHealth could have avoided by having better controls over the verification of an applicant's residency. However, the fact that members did not return requested documentation and that their whereabouts are unknown in our opinion, raises concerns about their Massachusetts residency. These figures are included in our report to show the maximum potential cost savings that could have been realized during this fiscal year had MassHealth verified each applicant's self-declarations of residency and deemed ineligible anyone who provided false statements about residency at the time of application. Further, in a number of cases, up to a year had passed from application to termination date for many of these members. The lapses in time could have been potentially shortened had MassHealth verified member residency through electronic data matching on a quarterly basis.

Based on its response, beginning in October 2011, MassHealth initiated procedures to more thoroughly investigate and verify residency in those applications or member files containing conflicting or contradictory information. Although these measures taken by MassHealth in this area are appropriate and necessary, we believe that MassHealth needs to take additional measures, such as those detailed in our recommendation to this Audit Result, to effect proper control over the residency verification of individuals applying for MassHealth benefits.

3. INADEQUACIES IN MASSHEALTH'S POLICIES AND PROCEDURES TO RESOLVE CONFLICTS FOUND IN RESIDENCY AND INCOME INFORMATION IN APPLICANT AND MEMBER RECORDS MAY BE UNNECESSARILY COSTING THE COMMONWEALTH MILLIONS OF DOLLARS ANNUALLY IN HEALTH CARE EXPENSES

Federal regulation 42 CFR 435.913 requires that MassHealth include evidence in each applicant's case file to support the decision it makes on their requests for benefits. Further, MassHealth's own regulations state that it will investigate any conflicts in information provided by applicants

and members. Despite this, our audit found that MassHealth provides healthcare services to some applicants who provide information that directly conflicts with either other documentation they provided and/or in the case of foreign visitors, representations they made to the federal government when obtaining their visas, without resolving these conflicts and ensuring that these applicants meet MassHealth's residency and financial eligibility requirements. As a result, MassHealth may be providing millions of dollars in benefits each year to individuals who are not entitled to receive these benefits.

As previously noted, federal regulation 42 CFR 435.913 requires that MassHealth include evidence in each applicant's case file to support the decision it makes on the applicant's requests for benefits. In keeping with this requirement, MassHealth has promulgated regulations that require its staff to investigate any conflicting information provided by applicants. For example, 130 CMR 517.002 requires MassHealth to investigate conflicts in an applicant's self-declaration of residency by stating, in part;

> *Verification of residence is required only if there is conflicting or contradictory information regarding the applicant's declared place of residence.*

Despite these requirements, our review of 55 applicant files found six instances in which MassHealth either disregarded apparent residency conflicts or failed to document within the applicant file how such residency conflicts were resolved. For example, the self-declared residency of a sampled 83-year-old applicant was in Rockport, Massachusetts. However, the applicant's file contained documents indicating that Florida was her state of residence, including a Durable Power of Attorney, a Florida condominium resident identification card, a Florida car registration, Social Security documents, and Florida bank statements. MassHealth personnel told us that, given this conflicting information, a MEC worker should have attempted to verify the residency for this applicant. However, we found no evidence of any such verification in this applicant's file.

Additionally, under federal law (42 U.S.C. § 1396b[v]) and federal regulations (42 CFR 440.255), aliens who are not admitted for permanent residence in the United States or who are permanently residing in the United States under the color of law[11] must be provided emergency

[11] An alien is considered permanently residing under color of law (PRUCOL) if the alien is residing in the United States with the knowledge and permission of the U.S. Citizenship and Immigration Service (USCIS) and the USCIS does not contemplate enforcing the alien's departure.

services under state Medicaid programs. According to these federal requirements, these emergency services are required to be provided if the alien has, after sudden onset, a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part (42 U.S.C. § 1396[v][3]; 42 CFR 440.255[c]).

However, federal law 42 U.S.C. § 1396b(v)(2) requires that, in order to receive these emergency services, aliens who are residing in the United States on a temporary basis (i.e., foreign visitors) must meet the eligibility requirements of the state Medicaid plan, including the state's Medicaid regulations, as follows:

> *Payment shall be made under this section for care and services that are furnished to an alien . . . only if . . . such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter. . . .*

In most cases, a citizen of a foreign country who wishes to enter the United States must first obtain a visa (either a nonimmigrant visa for temporary stay or an immigrant visa for permanent residence). The visa allows a foreign citizen to travel to a United States port-of-entry and request permission of the U.S. immigration inspector to enter the United States. The "visitor" visa is a nonimmigrant visa for persons desiring to enter the United States temporarily for business (B-1 visa) and for pleasure, tourism, or medical treatment (B-2 visa).

The United States Department of State has established certain requirements that foreign visitors must meet to qualify for visitor visas. Among these is the requirement that applicants must declare that they are only going to remain in the United States for a specific, limited period of time and that they have funds to cover all of their expenses, including medical expenses, while in the United States. Also, applicants for visitor visas must have a residence outside the United States as well as other binding ties that will ensure their return abroad at the end of the visit. In addition, foreign visitors who have indicated that they are traveling to the United States for medical treatment must provide the following information:

- A medical diagnosis from a local physician, explaining the nature of the ailment and the reason the applicant requires treatment in the United States.

- A letter from a physician or medical facility in the United States, expressing a willingness to treat this specific ailment and detailing the projected length and cost of treatment (including doctors' fees, hospitalization fees, and all medical-related expenses).

- A statement of financial responsibility from the individuals or an organization that will pay for the patient's transportation, medical, and living expenses. The individuals guaranteeing payment of these expenses must provide proof of ability to do so, often in the form of bank statements, other statements of income/savings, or certified copies of income tax returns.

As previously discussed, MassHealth has established universal eligibility requirements that MassHealth applicants and members, including all aliens, must meet as a condition of eligibility. Among these requirements, applicants and members must be residents of Massachusetts. This requirement is detailed under 130 CMR 503.002(A) as follows:

> *(A) As a condition of eligibility, an applicant or member must live in the Commonwealth with the intent to remain permanently or for an indefinite period, but is not required to maintain a permanent residence or fixed address.*

In addition, aliens seeking enrollment in MassHealth's Limited Program must also meet certain financial eligibility requirements. These financial requirements are detailed under 130 CMR 505.808(A)(1) and 130 CMR 519.009(A)(1), as follows:

> *505.008(A)(1): MassHealth Limited is available to persons who meet the financial and categorical requirements of MassHealth Standard, except women described at 130 CMR 505.002(H) . . . .*
>
> *519.009(A)(1): MassHealth Limited is available to community residents aged 65 and older meeting the financial and categorical requirements of MassHealth Standard coverage as described at 130 CMR 519.005(A) and (B) . . . .*

During the audit, we spoke with officials from the United States Citizenship and Immigration Services (USCIS) about foreign visitors entering the United States under visitor visas. The USCIS officials stated that aliens with visitor visas (a) are admitted to the United States for a specific period, (**b**) must leave the United States in accordance with their Arrival/Departure Record (Form I-94),[12] (c) cannot form an intent to reside in the United States, and (d) may only become permanent United States residents by returning to their foreign residence and applying for an immigration visa from the U.S. Embassy or Consulate with jurisdiction over their place of primary residence.

[12] The Department of Homeland Security, U.S. Customs and Border Protection (CBP) has the authority to permit or deny admission to the United States. If an alien is allowed to enter the United States, a CBP official will determine the length of the alien's visit on the Arrival Departure Record (Form I-94).

Based solely on the representations foreign visitors make to the federal government in obtaining their visas (e.g., that they are only going to be in the United States for a specific, temporary period of time; will be returning to their home country; and have sufficient funds to cover any expenses they incur in the United States, including medical expenses), if these visitors provided this same information to MassHealth, they would not meet MassHealth's residency and financial eligibility requirements. During our audit, we found that many aliens who self-declared Massachusetts residency on their application form also provided MassHealth with temporary visas and foreign passports to verify their identity and immigration status. Inherently, as previously discussed, temporary visas and foreign passports represent that the holder of these documents is a foreign visitor who does not intend to reside in Massachusetts permanently or for an indefinite period. Consequently, based upon MassHealth's regulations, it should be identifying this as a conflict and obtaining additional information from these foreign visitors about their permanent residence and financial situation, and based upon federal regulations, documenting the results of this further inquiry within the applicant's file. However, MassHealth does not require its staff to perform the necessary due diligence on these cases and instead simply accepts self-declarations made by foreign visitors about Massachusetts residency.

We brought this matter to the attention of MassHealth officials, who stated that MassHealth considers an applicant's immigration status separately from his or her residency status and therefore believes that aliens who are in the United States even on a temporary basis are still eligible to be enrolled in MassHealth and receive emergency health services. In addition, MassHealth provided the following written response regarding policies and procedures it developed to verify residency.

> *Per 130 CMR 517.002(B), verification of MA residence is self-declared unless there is conflicting contradictory information regarding the applicant or member's declared place of residence. In signing the application/review, individuals certify under the penalty of perjury that the information on the application/review and any supplements is correct and complete to the best of their knowledge. If the eligibility worker suspects the individual may not meet residency requirements, verification of residency will be requested.*

Similarly, foreigner visitors who have obtained temporary immigration visas from the federal government have also represented to the federal government that that they have adequate financial resources to cover any expense they incur in the United States including medical expenses. However, these same foreign visitors present themselves as financially needy when

applying for MassHealth benefits, which again creates a conflict within the foreign applicant's file relative to financial eligibility. We believe that such conflicts need to be resolved in order to ensure that only financially eligible individuals are provided MassHealth benefits. However, our audit found that MassHealth has not established policies and procedures for eligibility workers to follow to verify the financial status of foreign visitors and resolve such conflicts.

In order to quantify the potential financial impact of these problems, we requested and received from MassHealth a listing of all aliens who were enrolled and received MassHealth benefits during fiscal year 2010. According to the information we received, MassHealth provided benefits to 10,468 aliens who presented MassHealth with foreign passports[13] (indicating that they were here for a temporary period of time) and 5,531 aliens who presented temporary visas to MassHealth when they applied for MassHealth benefits. MassHealth paid medical claims for these temporary aliens that totaled $7,924,871 and $4,780,746 respectively, during this fiscal year.

By not having controls in place to verify and resolve conflicts between the information provided by foreign visitors when they obtain their temporary visas and what they represent to the Commonwealth when they apply for MassHealth benefits, we believe that there is a higher than acceptable risk of potential abuse of MassHealth's program benefits. In this regard, the Office of the State Auditor's (OSA) Bureau of Special Investigations (BSI) has identified a number of cases of foreigner visitors entering the United States on temporary visas; becoming enrolled in MassHealth; and after obtaining costly medical care, including maternity care, returning to their foreign residences, as the following case illustrates.

On February 2, 2010, a family (husband, wife, and three children) applied for MassHealth benefits by completing a Virtual Gateway application at the Greater Roslindale Medical and Dental Center. The family's application did not indicate employment, health insurance, illness, or any disabling conditions. In addition, the family reported that they were in the United States visiting on a temporary visa. Based upon this information, MassHealth approved the children for MassHealth Limited Plus, and the adults were enrolled in MassHealth Limited. MassHealth paid $59,250 in medical treatment for two of the children during 2010. However, BSI's investigation of this case found that (a) the father's B1/B2 visa application stated that he was traveling to the

[13] By presenting a foreign passport, the applicant had to also obtain a waiver to enter the United States or participate in the Visa Waiver Program (VWP), which enables nationals of 36 participating countries to travel to the United States for tourism or business purposes only for stays of 90 days or less.

United States to seek medical treatment for two of the children; (b) the children's visits and surgeries were pre-arranged with the Massachusetts Eye and Ear Infirmary; (c) the family presented a check for $66,000 to the hospital at the time of the children's surgery, which represented a deposit on the estimated $125,250 in medical expenses that the children incurred (the remainder of which was paid by MassHealth); (d) the children had health insurance coverage provided by the Social Institute of Greece, which was responsible for payment of all medical services required by the children; and (e) at least one family member was gainfully employed in Greece. BSI concluded that the family traveled to the United States specifically to seek medical treatment for the children and should not have qualified for MassHealth since the family did not have and never intended to establish Massachusetts residency.

We believe that such instances of apparent abuse of our state's Medicaid program could be prevented if MassHealth had policies and procedures in place to investigate conflicts in the residency and financial resources of applicants who provide temporary immigration documentation when they applied for benefits. MassHealth's policy to provide healthcare services to these foreign visitors without first performing the due diligence necessary to verify their residency and financial status could be causing MassHealth to unnecessarily incur millions of dollars in expenses annually.

Recommendation

In order to address our concerns in this area, we recommend that MassHealth establish formal procedures on how to address conflicts in information provided by applicants/members, including a requirement to document in each case file the specific measures taken to address such conflicting information. These procedures should also include means of verifying the self-declarations made by aliens who are present in Massachusetts with unexpired visas or who provide passports as proof of their immigration status.

Auditee's Response

In response to this issue, MassHealth officials provided the following comments, which are excerpted below:

> *[T]he audit report raises a number of questions about eligibility for and services provided to individuals enrolled in MassHealth Limited and, in addition, generally raises questions*

about services provided to all MassHealth enrolled individuals who are not U.S. Citizens. Specifically,

- *The audit questions eligibility for MassHealth Limited of [these] categories of individuals:*

  a) individuals with unexpired temporary visas;
  b) individuals who present with foreign passports and no documentation of their immigration status. . . .

Under federal Medicaid rules, MassHealth must provide Medicaid to eligible residents of Massachusetts. Eligibility is determined by state residency requirements and financial eligibility standards. The test for state residency is distinct from an individual's citizenship and immigration status. Under federal rules, state residency is established if the individual is over age 21, living in a state "with the intention to remain there permanently or for an indefinite period," or living in a state "in which the individual entered with a job commitment or seeking employment. . . . Every person, including every person in each of the . . . categories questioned in the Audit Finding, must meet Massachusetts residency and financial eligibility tests to qualify for Medicaid in the state. If an individual meets these standards, citizenship and immigration status will determine the level of Medicaid benefits he is eligible to receive. Under federal rules, eligible U.S. Citizens and qualified aliens who can show proof of citizenship or immigration status are entitled to MassHealth Standard benefits. Individuals who are otherwise eligible for Medicaid but are not U.S. citizens or qualified aliens are entitled to MassHealth Limited, which only provides coverage for emergency services.

***a. Individuals with unexpired temporary visas**:*

To qualify for MassHealth Limited coverage, all individuals must attest under penalty of perjury that they are residents of Massachusetts and intend to remain in the state. Pursuant to federal regulations, non-qualified aliens who meet Medicaid eligibility requirements need not document immigration status to receive MassHealth Limited coverage. Eligibility regulations promulgated to implement the Affordable Care Act emphasize this requirement by explicitly stating "evidence of immigration status may not be used to determine that an individual is not a state resident."

Massachusetts' highest court recognizes the distinction between the test for residency and the test for citizenship and alienage. In Salem Hospital v. Commissioner of Public Welfare, 410 Mass. 625 (1991), the Supreme Judicial Court upheld the decision of the state Medicaid program denying the Medicaid application of an individual who had a valid temporary visa. However, the applicant did not assert that she was a state resident and relied solely on her temporary visitor's visa to support her application. Because she did not meet residency requirements, her application was denied. The SJC made clear in the Salem Hospital case that only residents of the state are entitled to Medicaid and that merely holding a temporary visa cannot establish state residency. The Salem Hospital case stands for the proposition that only residents of the state are entitled to Medicaid, ***not*** *that temporary visa holders cannot establish state residency. Accordingly, to verify residency, MassHealth requires applicants to swear under the pains and penalties of perjury that they reside in Massachusetts with the intention to stay.*

In conclusion, MassHealth is following the applicable federal regulations in reviewing eligibility, which is based upon state residency requirements and asserts that individuals "need not document immigration status" to receive MassHealth Limited. In other words, one's immigration status is not dispositive of whether he or she is a resident of the state. The immigrant's present intent to stay in the Commonwealth permanently, or lack thereof, is dispositive. For these reasons, EOHHS respectfully disagrees that MassHealth provided as much as $4,727,950 in benefits to aliens who did not meet eligibility requirements based on their immigration status as holders of current, temporary visas.

b. Individuals with foreign passports:

A foreign passport is an acceptable form of identification. If a financially eligible state resident presents a foreign passport as a form of identification and nothing else, the resident would be entitled to MassHealth Limited coverage. MassHealth therefore disagrees with the Audit's conclusion that any individual with a foreign passport would not be eligible for MassHealth Limited coverage…

Auditor's Reply

We disagree with MassHealth's assertion that the test for state residency is distinct from an individual's citizenship and immigration status. The regulations proposed by CMS for implementing provisions of the Patient Protection and Affordable Care Act of 2010, Federal Register/Volume 77, No. 57, Page 17212, which take effect on January 1, 2014, state, "Evidence of immigration status may not be used to determine that an individual is not a state resident." However, CMS's proposed regulations do not prohibit states from using evidence of immigration status to investigate whether an individual should provide more than an attestation to prove residency. Moreover, CMS's comments to its proposed regulations, Federal Register/Volume 77, No. 57, Page 17180, state, "States may request additional information in accordance with § 435.952 to verify residency if an immigration document gives a state reason to question an individual's residency." As detailed within this report, approximately 16,000 applicants provided temporary immigration documents to MassHealth as part of their application package for benefits during fiscal year 2010. These temporary immigration documents give MassHealth a reason to question the applicant's declared Massachusetts residency in that these documents represent that the holder of these documents is a foreign visitor who does not intend to reside in Massachusetts permanently or for an indefinite period of time. Based upon CMS's current and proposed federal regulations, MassHealth is tasked with resolving such conflicts within applicant files to ensure that only Massachusetts residents participate in the MassHealth program and preserve the integrity of the Medicaid program.

We agree with MassHealth that a foreign passport is an acceptable form of identification. However, non-qualified aliens who provide foreign passports to MassHealth in support of their applications create conflicts within their case files relative to their residency and financial status. MassHealth is not resolving these conflicts prior to enrolling non-qualified aliens into the Limited Program and, as such, is jeopardizing the integrity of the MassHealth Program. In addition, 42 CFR 435.913(a) requires that MassHealth include in each applicant's case record facts to support the agency's decisions about an individual's eligibility. Without resolving these conflicts, we believe that MassHealth cannot adequately support its decisions in these cases as required by these federal regulations.

We agree with MassHealth that it is required under federal law to provide MassHealth Limited to individuals who meet the state residency and income requirements. However, our concern is that MassHealth has not performed the due diligence necessary to ensure that such aliens meet the residency and income requirements of MassHealth's Limited Program. In this regard, MassHealth's application forms clearly identify applicants who are not United States citizens. For those individuals, we believe that MassHealth should ask questions about their immigration documents, travel plans, foreign residency, and financial resources in order to determine whether the applicant is eligible for the Limited Program or is instead a temporary visitor to our country seeking health care. By gathering such facts, MassHealth can make informed decisions about a foreign applicant's eligibility, improve the integrity of the Limited Program, and ensure full compliance with federal regulations.

APPENDIX I

MassHealth Coverage Types

- MassHealth Standard: Comprehensive health insurance, including long-term-care for low-income Massachusetts residents, including eligible parents with children under 19 years of age, pregnant women, children up to 19 years of age, the elderly, and disabled individuals.

- MassHealth CommonHealth: Complete coverage similar to MassHealth Standard, for eligible disabled adults and disabled children through age 18 who cannot get MassHealth Standard because their incomes are too high.

- MassHealth Family Assistance: Health insurance with most of the services of MassHealth Standard, for children under 19 and people with HIV who are not eligible for MassHealth Standard or CommonHealth. The program also provides health insurance premium assistance for certain employed adults.

- MassHealth Basic: A full range of health care benefits or premium assistance for Emergency Aid to Elders, Disabled and Children recipients and low-income Department of Mental Health clients who are long-term unemployed.

- MassHealth Limited: Emergency medical coverage for noncitizens whose immigration status makes them ineligible for other MassHealth programs.

- Medicare Buy-In: Programs that pay all or part of Medicare health insurance expenses for eligible low-income Medicare recipients.

- MassHealth Prenatal: Short-term outpatient prenatal care (does not include labor and delivery) for low-income pregnant women.

- MassHealth Essential: A wide range of health care benefits for the long-term unemployed who do not meet the eligibility requirements for MassHealth Basic. Coverage is similar to MassHealth Basic, but more limited.

In addition, MassHealth has special programs for people with certain medical conditions or who are in certain target groups. These programs have separate eligibility requirements and may offer benefits in addition to the aforementioned MassHealth insurance coverage programs. These include the following:

- The Breast and Cervical Cancer Treatment Program is a health insurance program for women in need of treatment for breast or cervical cancer.[14] This program offers MassHealth Standard coverage to certain women under 65 who do not otherwise qualify for MassHealth.

- Adult Family Care is a MassHealth program that pays family members or non-family members to care for frail elderly adults or adults with disabilities in a home setting. The goal of the program is to delay or prevent nursing home placements.

- Group Adult Foster Care (GAFC) is a MassHealth program that pays for personal care services for eligible seniors and adults with disabilities who live in GAFC-approved assisted living housing. To qualify, residents must be eligible for MassHealth and need help with at least one daily personal care activity, such as bathing or dressing.

- The Kaileigh Mulligan Program is a home care program for severely disabled children who require skilled nursing care or are dependent on assistive technology. It does not count parental income in determining financial eligibility.

- Senior Care Options (SCO) is a combined MassHealth and Medicare program that includes health care and social services to help low-income seniors stay healthy and be able to live at home. SCO participants receive individualized and coordinated health care from a senior care organization in their community.

- Elder Service Plans are part of Programs of All-Inclusive Care for the Elderly (PACE)[15]. These plans provide comprehensive medical and social services to frail elders so that they can live in their communities instead of in nursing homes. A team of health professionals assesses each elder's needs and develops a plan of total care. Services are usually provided in an adult day health center, but may be given in the elder's home or other facility. If an elder does not qualify for MassHealth, he or she may have to pay a monthly premium. Elder Service Plan members do not have to pay any copayments, deductibles, or other cost-sharing fees.

Finally, the following programs are funded entirely by Massachusetts with no federal assistance.

- The Health Safety Net is a program for Massachusetts residents who are not eligible for health insurance or cannot afford to buy it. The Health Safety Net replaced the Uncompensated Care Pool (also called Free Care) on October 1, 2007. The goal of the Health Safety Net is to ensure that all Massachusetts residents have access to health care when they need it, regardless of income.

[14] The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (Public Law 106-354), effective October 1, 2000, gives states the option to provide medical assistance through Medicaid to eligible women who were screened through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program and found to have breast or cervical cancer, including pre-cancerous conditions.

[15] Under 130 CMR: 519.007 (C); PACE is a fully capitated Medicare and Medicaid managed care program authorized under the federal Balanced Budget Act of 1997 and managed jointly by MassHealth and the CMS. MassHealth members must be age 55 or over, reside in a geographical area served by a PACE provider, and be enrolled in MassHealth Standard to be eligible to apply for enrollment in the PACE program.

- Chapter 58 of the Acts of 2006, the Massachusetts Health Care Reform Law, introduced Commonwealth Care as a companion program to MassHealth. Most adults up to 300 percent of the Federal Poverty Level who do not qualify for MassHealth are eligible for publicly subsidized coverage through Commonwealth Care. Thus, nearly all Massachusetts residents with incomes below three times the poverty level now have access to health insurance programs at a minimal cost.[16] Commonwealth Care is a health insurance program for low- and moderate-income Massachusetts residents who do not have health insurance. Commonwealth Care members receive free or low-cost health services through managed care health plans. There are several health plans, offered by private health insurance companies, to choose from, some costing more than others. Commonwealth Care is run by the Commonwealth Health Insurance Connector Authority and funded by the state. The Connector Authority, which was also established under Chapter 58, assists Massachusetts residents and businesses in finding and paying for health insurance.

- The Children's Medical Security Plan (CMSP) is a program for uninsured children and adolescents under the age of 19 years. The cost of the program is funded in part by premiums and co-payments contributed by enrollees depending on certain categories of household earnings. MassHealth has contracted with UniCare to provide administrative services, such as processing claims, providing customer service, and enrolling members. CMSP provides coverage to approximately 90% of all uninsured children in the state. In 2010, CMSP enrollment was approximately 16,500 members. CMSP enrollees do not have insurance coverage from any other sources, including MassHealth (except for MassHealth Limited), often because of their immigrant status. Some children are eligible for services from the Health Safety Net. CMSP is a very small program that provides insurance coverage for a limited set of benefits and services to the majority of children and adolescents who are uninsured.

[16] The Massachusetts Medicaid Policy Institute, Fact Sheet, September 2008

APPENDIX II

Individuals Automatically Eligible for MassHealth Benefits

- Blind or disabled children and adults, and adults age 65 and over who receive Supplemental Security Income (SSI) are eligible for MassHealth Standard Coverage.

- Families with children eligible for Transitional Assistance for Families with Dependent Children or Emergency Aid to Elders, Disabled and Children (EAEDC) are eligible for MassHealth Standard coverage.

- Certain former recipients of SSI are treated as if they still have SSI in order to remain eligible for MassHealth Standard coverage under special rules.

- Children eligible for foster care payments or adoption assistance subsidies are eligible for MassHealth Standard coverage.

- Childless adults eligible for EAEDC are eligible for MassHealth Basic coverage.

- Refugees eligible for refugee resettlement assistance are eligible for MassHealth Standard coverage for eight months from the date of their entry into the United States.

APPENDIX III

MassHealth Enrollment Centers

MassHealth Enrollment Center
333 Bridge Street
Springfield, MA 01103

MassHealth Enrollment Center
21 Spring Street, Suite 4
Taunton, MA 02780

MassHealth Enrollment Center
367 East Street
Tewksbury, MA 01876

MassHealth Enrollment Center
300 Ocean Avenue, Suite 4000
Revere, MA 02151

APPENDIX IV

MassHealth Monthly Income Eligibility Limits

Effective March 1, 2011 through February 28, 2012

Category and Coverage Type	Family Size								
	1	2	3	4	5	6	7	8	+
100% Federal Poverty Guidelines (FPG) •Seniors 65+ (Standard) •Long-term unemployed (Essential) •Department of Mental Health clients (Basic)	$908	$1,226	$1545	$1,863	$2,181	$2,500	$2,818	$3,136	$319
133% FPG •Parents/Caretakers (Standard) •Disabled adults (Standard)	$1,207	$1,631	$2,054	$2,478	$2,901	$3,324	$3,748	$4,171	$424
150% FPG •Children 1 to 18 (Standard)	$1,362	$1,839	$2,317	$2,794	$3,272	$3,749	$4,227	$4,704	$478
200% FPG •Pregnant women (Standard, Prenatal) •Infants under 1 (Standard) •HIV+ under 65 (Family Assistance)	$1,815	$2,452	$3,089	$3,725	$4,362	$4,999	$5,635	$6,272	$637
250% FPG •Women with breast or cervical cancer (Standard)	$2,269	$3,065	$3,861	$4,657	$5,453	$6,248	$7,044	$7,840	$796
300% FPG •Children under 19 (Family Assistance) •Workers 19-64 with insurance (Family Assistance)	$2,723	$3,678	$4,633	$5,588	$6,543	$7,498	$8,453	$9,408	$955

APPENDIX V

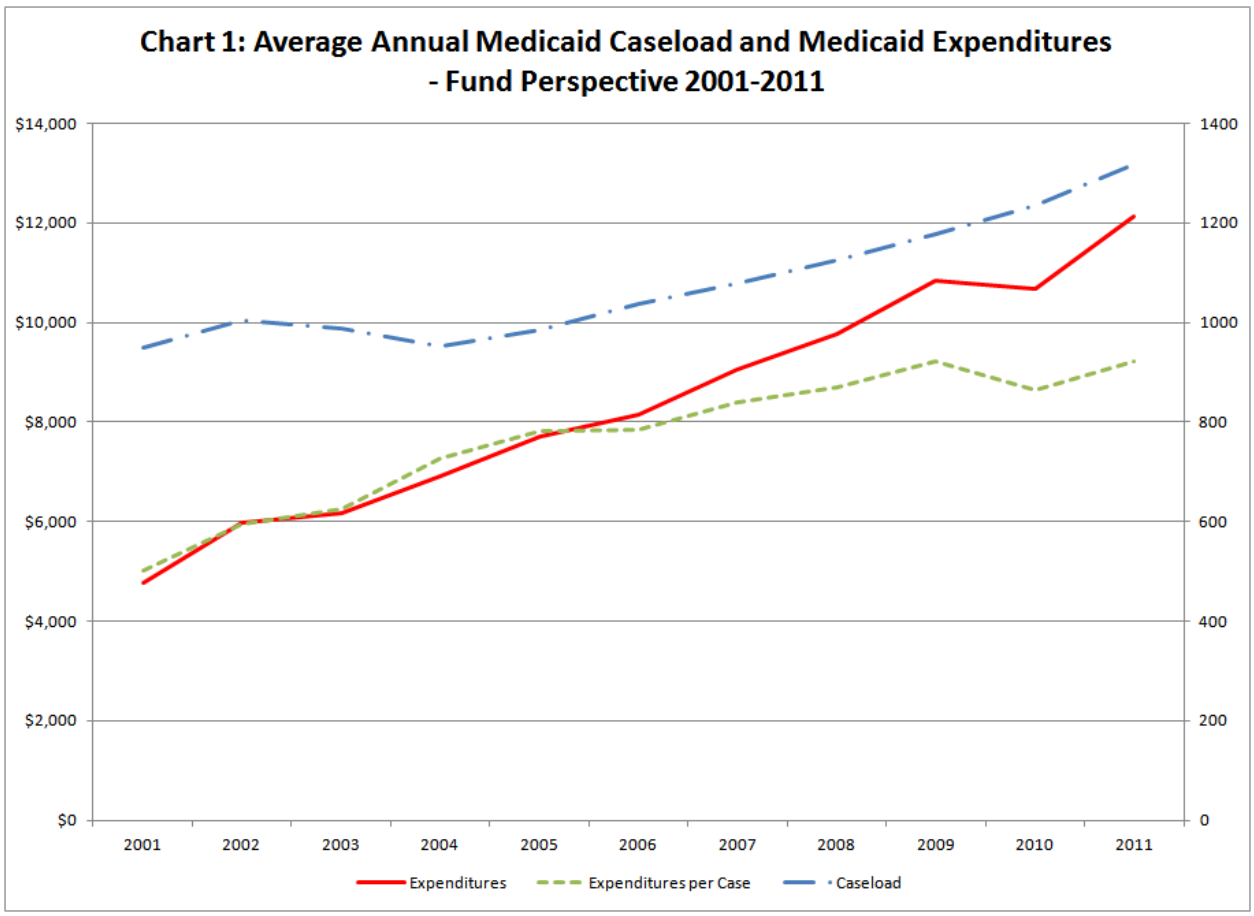
The Impact of Enrollment on Medicaid Expenditures in Massachusetts

The Urban Institute recently concluded that enrollment is the primary cost driver of Medicaid over the 11-year period it studied (2000-2010).[17] The reasons for this have to do with: the increase of the low-income population during the two recessions of this period, the fact that more of the enrollment is from the child and adult population than from the elderly and disabled population (which is a higher per-capita cost demographic), and the cost containment strategies in many states.[18] The Centers for Medicare and Medicaid (CMS) projects continued increasing enrollment nationally as the Patient Protection and Affordable Care Act (PPACA) is implemented, although that impact has likely already occurred in Massachusetts since it has adopted the higher PPACA Medicaid threshold in 2006.[19] CMS has not determined what level of fraud or mistakes might exist in Medicaid enrollments. However, we can assume a baseline of fraud from that which has been detected.

CMS also finds that enrollment is the most important national cost driver in the Medicare program,[20] and economists are concerned that health care costs over time, if not contained, threaten to overwhelm public budgets. This suggests that non-fraudulent enrollment is an area in which state agencies must make a priority to keep costs contained.

Chart 1 below shows several different trends in the enrollment and expenditure growth of the Medicaid program in Massachusetts from fiscal years 2001 through 2011.

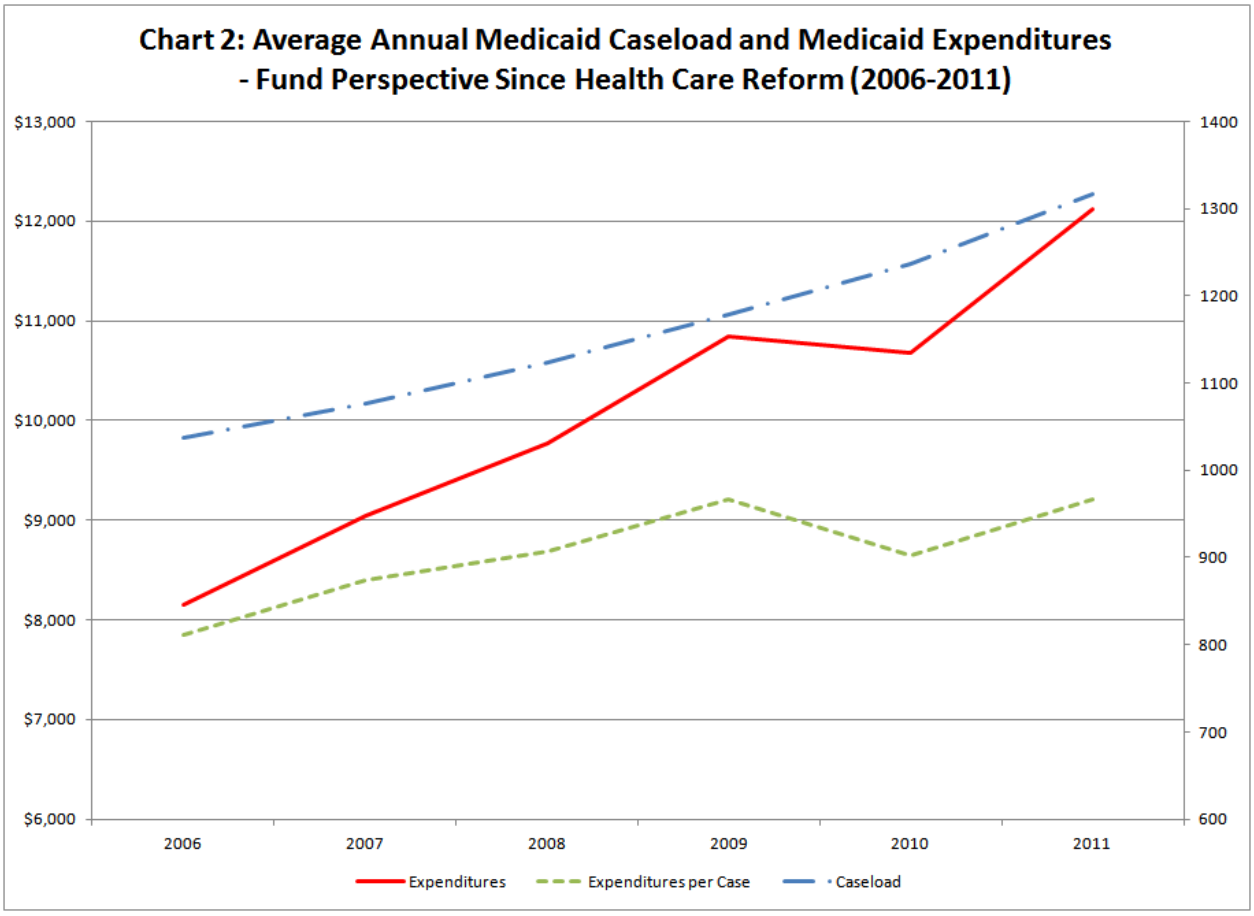
[17] John Holahan and Stacey McMorrow, "Medicare, Medicaid and the Deficit Debate: Timely Analysis of Immediate Health Policy Issues," (Urban Institute: April 2012).
[18] Id.
[19] CMS, "Brief Summaries of Medicaid and Medicare," (as of November 1, 2011), p. 5. The report notes that expansion of Medicaid under PPACA and the health exchanges associated with it will also be important cost drivers, but these are essentially enrollment cost drivers.
[20] Id.



Expenditures figures are in millions; **Expenditure per Case** figures are in actual dollars; **Caseload** figures are in thousands; **Date** is fiscal year
Source: Commonwealth of Massachusetts Comprehensive Annual Financial Report 2011

On the left side of the chart the values are in dollars and relate to the total expenditures and expenditures per case lines. On the right side of the chart the values are in caseload numbers. The chart indicates that although each data series saw an increase during the 11-year period from 2001 through 2011, the most recent cost driver for the program appears to be enrollment (caseload). Expenditures increased alongside enrollment from 2004 through 2011, although the expenditure curve is steeper. (Chart 2 below shows a snapshot of the period since the enactment of health care reform in the Commonwealth.) However, when we look at the expenditure per case we see that since 2008 it has been essentially flat. This chart captures the years of the most recent recession, which began in Massachusetts in 2008 (despite an earlier start nationally). What we can see from this chart is that total expenditures increased sharply during the recession while expenditures per case remained constant. This indicates that there was either little medical inflation for these services during this time or that the program was more strictly managed to contain costs, or perhaps both.

Despite this, overall expenditures continued to increase. The most likely driver of this overall cost is the increased caseload during this period.



Expenditures figures are in millions; **Expenditure per Case** figures are in actual dollars; **Caseload** figures are in thousands; **Date** is fiscal year
Source: Commonwealth of Massachusetts Comprehensive Annual Financial Report 2011

There is evidence that health care costs are slowing, and there is some debate over why.[21] Some economists believe the recession is the reason for the lower costs per case as people decide against pursuing some treatments that they believe are not necessary, whereas others attribute it to the decreasing amount of expensive pharmaceutical drugs that have come on the market in the past few years.[22] Many economists seem to agree that all of these factors are contributors, but the one thing

[21] Wall Street Journal, July 4, 2012, using data from CMS. David Wessel, "Why Health-Spending Trend Matter."
[22] Id., quoting Professor David Cutler, Harvard economist.

that is certain is that Medicaid enrollment has increased and is expected to continue to increase in the future and that alone will drive health care costs up, even if per-case costs drop.[23]

The evidence we have for the Commonwealth is that enrollment is the single most important cost driver for the program and that CMS expects enrollment to further drive costs after 2014, when PPACA is fully implemented.[24] For these reasons, it is especially important for MassHealth to ensure that there is no waste, fraud, or abuse in the enrollment process. A simple trend line analysis shows the potential of increased costs if the current trend of enrollment continues.

Interestingly, private insurance has seen drops in enrollment between 2000 and 2010, yet increases in total expenditures. For the private sector, research shows that costs are driven by increasing per-case expenditures. According to the Massachusetts Budget and Policy Center:

> *Government purchases health care services at a significantly lower rate than the private sector purchases the same services. In fact, by controlling costs so aggressively for the public sector, government payment rates may actually cause problems for other payers. When the public sector pays less than the private sector, there is a risk that the value of health care costs not reimbursed by the public sector gets "shifted" onto the rates charged to the private sector.*[25]

What this means is that not only does enrollment in public health care programs such as Medicaid drive costs in the public sector, it may indirectly drive costs in the private sector. As providers find lower reimbursements through public programs such as Medicaid, costs may be shifted to private insurers that might not be able to hold down costs as effectively as the reimbursement limits do in the public sector.[26] The more people are enrolled in Medicaid, the more services and cases are subject to reimbursement caps. Consequently, a higher expenditure per case might be expected in private insurance. In fact, we do see such a phenomenon in the data.[27] Despite the suggestion of the Massachusetts Budget and Policy Center and others, it is not clear how strong the relationship is between public health care enrollment and private insurance costs. However, the data suggest it might be non-trivial.

[23] CMS
[24] Commonwealth of Massachusetts Comprehensive Annual Financial Report, 2011.
[25] Kristina Richardi, Luc Schuster, and Nancy Wagman, "Quality, Cost, and Purpose: Comparisons of Government and Private Sector Payments for Similar Services," (Massachusetts Budget and Policy Center: January 23, 2011), p. 13.
[26] Id.
[27] Urban Institute.