



Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by Managed Care Organizations

Situational Analysis:

The Massachusetts Medicaid program, MassHealth, provides access to healthcare services for approximately 1.4 million low- and moderate-income individuals, couples, and families, annually. In an effort to control costs, members under age 65 can enroll in one of six managed care organizations (MCOs) under contract with MassHealth. During our audit period, approximately 50% of members were enrolled in one of these MCOs. MassHealth pays each MCO a fixed monthly fee for each member. MassHealth's contracts with MCOs specify the general types of services covered and not covered for members. The MCOs oversee networks of third-party providers that assume responsibility for providing a range of covered healthcare services; MCOs pay the providers using the monthly capitated premiums received from MassHealth. MCOs' contracts typically require them to cover thousands of services; any services not covered by an MCO's contract are paid for directly by MassHealth on a fee-for-service (FFS) basis. Each member is permitted to receive services only from providers in his or her MCO's network, except in special cases such as emergency care and family planning.

Using Advanced Analytics in Audit Planning:

Our office uses advanced data analytics to identify areas of high risk in state government operations. This audit exemplifies the benefits realized when data analytics is comprehensively integrated into the audit planning, engagement, and post-audit process. To support this effort, we obtained ongoing direct access to the MassHealth data warehouse and using this nearly real-time information, we were able to analyze: all fee-for-service claims paid by Medicaid and data relative to claims paid by the MCOs.

We tested over 25 million Medicaid fee-for-service claims paid on behalf of enrollees in the MCO program to determine whether those claims should have been paid by one of MassHealth's MCO contractors. We initiated our audit when preliminary analysis indicated a significant risk that MassHealth incorrectly paid claims for services it had already paid as part of a payment to an MCO.

Our audit team defined an audit scope and methodology using the preliminary data analytics work as a guide, and provided feedback to the data analytics staff on enhancements and refinements required for the original claim analysis model.

Overview of Audit Objectives:

Based on the results of the data analytics conducted during the planning phase, this audit was undertaken to determine if there were opportunities to reduce healthcare spending by eliminating inefficiencies in MassHealth's payment system. The audit reviewed whether MassHealth was accurately disallowing inappropriate FFS claims for members enrolled in an MCO.

Results:

Through our audit, we identified 1,686,121 members who were enrolled in an MCO for all or part of the audit period, and downloaded 25,494,613 fee-for-service claim records that had been paid on behalf of those members during the audit period. We applied 43 distinct rules, representing different categories of covered and non-covered services under the state's standard MCO contract. These tests flagged each record as either a covered or non-covered MCO service. These records were provided to the auditee for review, feedback and comment and further adjustments to the set of records flagged as improper payments were made by the audit staff based on the feedback received from the auditee. Following this validation process, the audit staff identified – down to the level of the individual claim, and without employing projection – **a total of \$233,208,842 in improper duplicate payments, representing 1,483,310 claim service detail records.**

In the course of this work, the audit team uncovered an additional type of claim that not detected by the preliminary analysis in which the auditee's payment was not improper under the MCO contract(s), but had not been necessary given the contractor's usual and customary business practice. The audit team developed a second finding, and worked with data analytics staff to express that finding as a *second* whole-population analytic test. When that new test was applied to the universe of claims under consideration, **the audit team uncovered a total of \$288,952,449 in potentially unnecessary payments, representing 4,314,639 claim service detail records.**

Through our work, we provided our auditee with a list of claims to be unwound and recouped – which would not have been possible using claim sampling and projection.

Impact of Audit:

MassHealth began recouping the \$233 million in questioned payments and also reduced its annual funding to MassHealth by approximately \$11 million per year; however, we estimate an annual cost savings of approximately \$50 million. MassHealth refined its system edits to better detect and deny FFS claims for members' services covered by the MCOs moving forward. In addition, it increased controls over its MCO contracts to ensure appropriate coverage and payment of contract services and has engaged the MCOs in the creation of a master code list to denote MCO covered versus non-covered services. MassHealth also reported that it has formed a multi-agency work group to review state agency pass-through claiming to further clarify policies and procedures as it relates to state agency claiming.

Over time, these changes will allow MassHealth to have a better understanding of the true costs of providing healthcare to its members which will facilitate better budgeting and a more accurate calculation of MCO capitation rates. These changes will also result in better coordination of care as the MCO's will now be responsible for all covered healthcare services for their enrolled members.

Using our data analysis capabilities, we conducted a post-audit review to gauge the success of our auditee in implementing our recommendations. To do this, we converted the analytic tests we devised for the audit into permanent production assets, allowing us to subject new records to the tests and view the impact on the auditee's implementation of our recommendations while continuing to measure the risk. The auditee has made progress implementing our first recommendation, regarding improper payments, indicating that our audit broke a powerful and worsening trend that represented substantial cost to the Commonwealth and considerable ongoing risk. While work remains to be done to fully implement our recommendation, continuing data appears to demonstrate ongoing savings should be realized.