Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
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Official Audit Report – Issued June 16, 2015

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

For the period October 1, 2009 through September 30, 2014

June 16, 2015

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Ms. Sudders:

I am pleased to provide this performance audit of the Office of Medicaid's (MassHealth's) fee-for-service payments for services covered by managed-care organizations. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, October 1, 2009 through September 30, 2014. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director

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LIST OF ABBREVIATIONS

CFR	Code of Federal Regulations
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare & Medicaid Services
CPE	certified public expenditure
EOHHS	Executive Office of Health and Human Services
FFS	fee for service
MCO	managed-care organization
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
SOCMHC	state-operated community mental health center

EXECUTIVE SUMMARY

MassHealth, the state's Medicaid program, provides access to healthcare services for approximately 1.4 million eligible low- and moderate-income individuals, couples, and families annually. In fiscal year 2013, MassHealth paid healthcare providers more than $10.8 billion, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures typically represent approximately one-third of the Commonwealth's total annual budget.

As of September 2014, MassHealth had 733,644 members enrolled in one of six[1] managed-care-organization (MCO) health plans. An MCO health plan assigns members a group of doctors and other healthcare providers who work together to provide them with healthcare. The doctors and other healthcare providers contractually agree to follow certain federal and state requirements about how they provide services. MCO enrollees select a primary care provider to provide basic care and make any necessary referrals. MassHealth pays the MCO a fixed monthly fee, or capitated premium, for each member enrolled in the MCO. In turn, the MCO pays healthcare providers for medical services it has contractually agreed to cover for its members. Each member is permitted to receive services only from providers in his or her MCO's network, except in a few cases such as emergency care and family planning.

In order to ensure that it properly administers MCO health plans, MassHealth must have effective controls in place, including program regulations, operating policies and procedures, monitoring activities, and enforcement action. In addition, MassHealth must have system edits to detect and deny fee-for-service (FFS) claims for services that are already covered by MCO health plans. Otherwise, MassHealth may pay twice for the same service (by paying a capitated premium to an MCO to provide a type of service and then paying a provider on an FFS basis when the service is actually performed).

1. The six plans are Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, Tufts Health Plan—Network Health, and CeltiCare. CeltiCare was added to the program during the audit period and therefore was not included in some of our audit procedures.

Below is a summary of our findings and recommendations, with links to each page listed.

Finding 1 **Page 9**	Because of inadequate controls over its claim-payment process, MassHealth improperly paid approximately $233 million in FFS claims for members enrolled in MCOs during the audit period.
Recommendations **Page 15**	1. MassHealth should take appropriate action to recoup the approximately $233 million we identified in improper payments associated with the paid FFS claims. 2. MassHealth should develop system edits to detect and deny FFS claims for member services covered by MCOs and should ensure that these edits are applied to all providers, including state agencies and other state-contracted providers. 3. MassHealth should implement a reconciliation process to detect and recoup FFS payments made for members who were retroactively placed in MCOs.
Finding 2 **Page 20**	MassHealth did not develop a master list of medical services and related procedure codes that were to be covered by all MCOs or a list of services actually covered by each MCO. This caused MassHealth to pay at least $288 million in additional FFS claims during our audit period.
Recommendation **Page 22**	In consultation with the MCOs, MassHealth should develop a master list of procedure codes covered by all MCOs and, if applicable, a list of additional services covered by each one. MassHealth should then use this information to create system edits in its claim-processing system to ensure that it only pays for claims that the MCO in question has specifically identified as not covered by its plan.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services administers the state's Medicaid program, known as MassHealth. For the five-year period October 1, 2009 through September 30, 2014, MassHealth paid approximately $12 billion in capitation payments for more than 1.6 million[2] members who were enrolled in managed-care organizations (MCOs), as detailed below.

MCO	Members Served	Amount Paid
Boston Medical Center HealthNet Plan	475,112	$ 4,701,030,388
Neighborhood Health Plan	402,329	3,749,975,168
Tufts Health Plan—Network Health	649,028	3,054,655,271
Fallon Community Health Plan	55,671	339,753,635
Health New England	36,911	209,363,717
CeltiCare	67,070	129,189,162
Total	1,686,121	$12,183,967,341

Medicaid

Medicaid is a joint federal and state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the federal Department of Health and Human Services, administer the Medicare program and work with the state governments to administer their Medicaid programs.

Each state administers its Medicaid program in accordance with its CMS-approved state plan. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements established by Title XIX, Section 1902, of the Social Security Act.

MCOs

Beginning in 1997, Massachusetts began employing a variety of managed-care models to attempt to contain costs and improve the quality of care provided to MassHealth members. Members under age 65 can enroll in one of the six MCOs shown in the table above. MassHealth pays each MCO a fixed monthly

2. This is an unduplicated count of MCO enrollees served during the audit period.

fee, or capitated premium, for each member enrolled in the MCO.[3] MassHealth's contracts with MCOs specify the types of services covered and not covered for MassHealth members, and each MCO develops a list of specific procedure codes that it will pay for based on its contract. The MCOs recruit and oversee networks of third-party direct care providers who 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.

In addition, MassHealth helps providers determine which members are enrolled in MCOs by giving them access to its Eligibility Verification System. According to MassHealth procedures, providers should find out, either online or by phone, whether a member is enrolled in a MCO (and, if so, whether the MCO covers the claimed service) before providing any services.

MassHealth is responsible for ensuring the integrity of all Medicaid paid claims. To this end, MassHealth adjudicates, and pays for, Medicaid claims through its Medicaid Management Information System (MMIS). When processing a claim for a member, MMIS determines whether the member is enrolled in an MCO and, if so, whether the MCO covers the claimed service. MMIS is designed to deny FFS[4] claims for members enrolled in an MCO unless they are for services that meet contractually specified conditions allowing the members to receive the services outside the MCO.

3. The capitation rate for each member is based on factors such as actuarial estimates, the member's health risks, and which plan the member is enrolled in.
4. Some member services are paid for through an FFS delivery system whereby healthcare providers are paid directly by MassHealth for each service (like an office visit, test, or procedure).

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of the Office of Medicaid's (MassHealth's) fee-for-service (FFS) payments for services covered by managed-care organizations (MCOs) for the period October 1, 2009 through September 30, 2014.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide 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.

Below are our audit objective (the question we intended our audit to answer), the conclusion we reached regarding the objective, and links to the audit findings where the objective is discussed.

Objective	Conclusion
Did MassHealth disallow FFS claims for MCO enrollees for services that should have been covered by the MCOs?	**No; see Findings 1 and 2**

To achieve our objective, we reviewed applicable state and federal laws, rules, and regulations; MassHealth Provider Bulletins; and MassHealth's 2012 Claims Operations Internal Control Plan. We also reviewed prior MassHealth audits conducted by OSA, the federal Department of Health and Human Services, and independent auditors.

We requested necessary documentation from MassHealth that included additional internal control plans, organization charts, and policies and procedures for each unit, including a list of internal assessments performed by the Provider Compliance Unit. However, we did not receive any of the requested documents until January 1, 2015, well after our MCO testing was finished. Because we did not receive the requested documentation, we were not able to perform internal control testing. However, this did not prevent us from achieving our audit objective because our testing approach with providers was identical to what it would have been if we had assessed the internal controls as high risk.

From MassHealth's Medicaid Management Information System (MMIS) data warehouse, we obtained Medicaid eligibility data for members enrolled in MCOs during the audit period. The member information included, at a minimum, each member's unique MassHealth identification number, date of birth, dates of MassHealth eligibility, managed-care-plan identifier, services received, and beginning and ending dates of managed-care enrollment.[5] We also obtained all paid FFS claim information for MCO enrollees from MMIS during the audit period. This information included, at a minimum, each enrollee's unique MassHealth identification number and the procedure code, procedure description, provider type, date of service, service category, diagnosis code, place of service, unit of service, amount billed to MassHealth, Medicaid paid amount (if any), and date of payment. We then obtained from MassHealth the contracts between the Executive Office of Health and Human Services (EOHHS) and each of the six MCOs. Appendix C of each contract detailed all the services covered. If an MCO was not required under the contract to cover a service, we considered FFS an appropriate method of payment for that service in our analysis. Examples of services excluded from MCO coverage include certain dental procedures and adult foster care. We then used each member's specific dates of enrollment and unique MassHealth identification number to identify paid FFS claims for services that occurred during his or her MCO enrollment. After our audit testing and analysis was complete in this area, we discussed any discrepancies with MassHealth officials.

We evaluated MassHealth's system controls to determine whether FFS claims that were for services covered for MCO members were detected and denied. In addition, we consulted with MassHealth to gain an understanding of the services covered under the MCO contracts. Further, we met with officials from five of the MCOs (Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Tufts Health Plan—Network Health) to obtain a list of each MCO's covered services and associated procedure codes used for processing provider payments. Also, we visited two medical-service providers (Boston Children's Hospital and Habit OPCO) to verify the validity of payments made by MassHealth and MCOs to these providers.

To assess the reliability of processed data, we performed validity tests on all claim data, including tests for missing data elements, fields, and/or values; duplicate records; relationships between data elements; and values within designated periods. MassHealth stated that the MMIS system is configured

5. MassHealth allows members to enroll in and withdraw from MCOs at any time. Therefore, OSA needed to identify the specific dates when members were enrolled in an MCO.

with system edits that are the basis for approving, denying, or suspending a claim. Additionally, we randomly selected FFS and MCO payments made to the two service providers visited, and we compared the payment data with information in MMIS to determine whether MMIS contained accurate and complete information.

We also relied on the work of other auditors who had examined the information-system controls for MMIS. We reviewed KPMG's[6] fiscal year 2013 and 2014 design and effectiveness testing of MMIS's general information-technology controls, including user access to programs and data, program changes, and computer operations.

In addition, we relied on our work performed and conclusions reached in our Audit No. 2011-1374-4T, reflected in our report "Review of the Internal Controls Established by the Executive Office of Health and Human Services and MassHealth over Selected Information System Applications," issued August 13, 2012. The report, which covered the 18-month period ended June 30, 2011, stated that 488 of the 1,462 MMIS user accounts, or 33%, were associated with individuals who no longer worked at MassHealth. To resolve this problem, OSA recommended that EOHHS's user access security controls be strengthened by "ensuring that access privileges for unauthorized users are deactivated or modified when a change in an employee's status results in the user no longer requiring access to IT resources, or when a change in an employee's position or responsibilities requires a change in access privileges." In response to our report, EOHHS stated, in part,

> *EOHHS will formalize and implement a new Security Request Process . . . and will reissue the Security Request Policy which states that "When requesting access to or a change in access to MIS Resources a Security Request Form, must be completed, authorized by the Users Director or Assistant Director, and submitted to the IT Security Operations Unit. This form is required to be completed by the Director when an employee is hired, transferred, promoted, demoted, terminated or at any other time that an employee's access level or job function changes." . . .*
>
> *In addition the EOHHS Personal Liaisons and EOHHS IT Personnel Department will notify [EOHHS] Security Operations of all terminations.*

Based on our current audit work, KPMG's fiscal year 2013 and 2014 testing of the MMIS information-technology controls, and the corrective action planned by EOHHS to resolve our prior audit issues, we have determined that the claim data obtained were sufficiently reliable for the purposes of this report.

6. KPMG LLP is the auditor for the Commonwealth's Single Audit for the fiscal year ended June 30, 2013. There were no substantive changes between KPMG's 2013 and 2014 reports.

At the conclusion of our audit, OSA provided MassHealth with a copy of our draft report and subsequently met with MassHealth officials to discuss the report. As a result of this meeting, OSA made changes to the original draft report that involved adjusting certain amounts of questioned costs. All of these agreed-upon adjustments are documented in the appendix to this report. OSA then submitted a revised draft copy of this report to MassHealth for its review and written comments, which we incorporated into this final report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth improperly paid approximately $233 million in fee-for-service claims for members enrolled in managed-care organizations.

During the audit period, MassHealth improperly paid providers, including state agencies and public hospitals, $233,208,842 for fee-for-service (FFS) claims[7] for services that should have been paid for by members' managed-care organizations (MCOs). These payments were for services that were specifically identified in the MCOs' contracts as services covered by the MCOs. Therefore, they represent duplicative spending because the Commonwealth paid twice for the same service: first as a portion of the capitated (per member) premium and then through the FFS claim.[8]

For instance, MassHealth might pay an MCO to cover a member's physical-therapy services, but also receive and pay a bill from a provider each time the member goes to a therapy session.

Our analysis of the FFS claims showed that these duplicative payments belonged to 29 service categories (e.g., acute inpatient care, dental services, and laboratory services). We found that 90% of the improper claims were for behavioral-health services, dental treatment, home health services, skilled nursing, or ambulatory surgery / outpatient hospital care. A summary of the improperly paid FFS claims is below.

Improperly Paid FFS Claims

Contract Service Category	Service Category Definition	Identified Claims	Total Payments
Behavioral-Health Services	Services used to evaluate and treat people who have mental-health and/or substance-use disorders	244,623	$ 87,489,328
Dental Services	Emergency-related dental services including oral surgery	850,832	67,578,704
Home Health Services	Nursing care; home health aide care; and occupational, physical, and speech/language therapy	151,451	33,146,962

7. The $233,208,842 represented 1,483,310 of the total 25,494,613 FFS claims paid for MCO enrollees during the audit period.
8. In the case of state agencies, MassHealth does not make an FFS payment directly to the agency, but the payments are still duplicative, as discussed in the Auditor's Reply to this finding.

Contract Service Category	Service Category Definition	Identified Claims	Total Payments
Skilled Nursing Facility, Chronic or Rehabilitation Hospital Services	Services, for all levels of care, provided at a nursing facility, chronic or rehabilitation hospital, or any combination of the two, up to 100 days per year	1,380	16,809,922
Acute Inpatient Care	All inpatient services such as surgery up to 20 days per admission	1,165	8,184,016
Ambulatory Surgery / Outpatient Hospital Care	Outpatient surgical, medical, and dental services	19,024	5,298,163
Physician (Primary and Specialty)	Services including office visits for primary care and specialists, as well as obstetric/gynecological prenatal care	84,527	4,799,663
Emergency Services	Covered inpatient and outpatient emergency services, including behavioral-health services	17,873	4,464,574
Pharmacy	All drugs approved by the Food and Drug Administration	60,008	3,464,177
Laboratory	Services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the member's health	33,266	460,732
Radiology and Diagnostic Tests	X-rays, magnetic resonance imagery, and any kind of medical test performed to aid in the diagnosis or detection of disease	4,746	443,326
Emergency Transportation	Ambulance (air and land) transport for an emergency	610	272,756*
Durable Medical Equipment and Medical/Surgical Supplies	Purchase or rental of medical equipment	2,036	243,210
Therapy	Individual treatment, individual comprehensive evaluation, and group therapy	1,351	155,331
Vision Care	Eye examinations (1) once per 12-month period for members under the age of 21 and (2) once per 24-month period for members 21 and over	940	75,760
Family Planning	Family-planning medical services and family-planning counseling services	1,988	70,590†
Early and Periodic Screening, Diagnosis, and Treatment	A broad range of health services to which children and young adults under age 21 are entitled	6,027	53,903

Contract Service Category	Service Category Definition	Identified Claims	Total Payments
Prosthetic Services and Devices	Evaluation, fabrication, fitting, and provision of a prosthesis	100	51,359
Hospice	Care to terminally ill individuals	26	42,945
Dialysis	Blood-cleansing procedure	590	33,353
Medical Nutritional Therapy	Services provided to individuals with diabetes or kidney disease	78	18,354
Orthotics	Braces (non-dental) and other mechanical or molded devices	41	16,737
Early Intervention	Services for developmental difficulties due to identified disabilities	151	13,076
Chiropractic Services	Chiropractic manipulative treatment, up to 20 office visits, and radiology services	322	9,246
Oxygen and Respiratory Therapy Equipment	Ambulatory liquid oxygen systems and refills	109	8,375
Audiologists	Hearing services	24	3,352
Diabetes Management Self-Training	Education and training provided to people with diabetes or pre-diabetes	14	782
Tobacco-Cessation Services	Face-to-face individual and group tobacco cessation counseling	6	114
Podiatry	Foot care	2	31
Total		1,483,310	$233,208,842‡

* The emergency-transportation number was adjusted so as not to include questionable payments currently being audited by the Office of the State Auditor (OSA).

† In accordance with Section 4.4 of the standard contract between MassHealth and MCOs, MassHealth performs annual reconciliations of all FFS claims paid by MassHealth for family-planning services covered by MCOs. The family-planning totals were adjusted so as to accurately reflect recoupments received by MassHealth as a result of these reconciliations.

‡ Discrepancies in this total occurred because amounts were rounded up or down to whole dollars.

The $233 million in improperly paid FFS claims represents approximately 15% of the total $1.6 billion in FFS claims paid for MCO enrollees during our audit period.

Once OSA identified this problem, we immediately notified and shared relevant claim data with MassHealth in accordance with Section 6.78 of the Government Accountability Office's *Government Auditing Standards*. This notification was provided in November 2014 and was intended to allow MassHealth to take immediate action to cease what appeared to OSA to be ongoing improper payments

of FFS expenses, which at the time averaged more than $9 million a month. However, during our audit, MassHealth did not indicate that it had taken action.

Authoritative Guidance

Under 42 Code of Federal Regulations (CFR) 438.60, state payments for MCO services are restricted as follows:

> *The State agency must ensure that no payment is made to a provider other than the MCO . . . for services available under the contract between the State and the MCO.*

This standard is reflected in 130 Code of Massachusetts Regulations (CMR) 450.105, which contains subsections for each MassHealth program (e.g., MassHealth Standard and MassHealth Basic). For example, for the MassHealth Standard Program, 130 CMR 450.105(3)(a) restricts state payments for MCOs as follows:

> *The MassHealth agency does not pay a provider other than the MCO for any services that are covered by the MassHealth agency's contract with the MCO, except for family planning services that were not provided or arranged for by the MCO.*

In addition, 130 CMR 450.105(3)(b) limits the extent to which MassHealth may pay providers on an FFS basis for members enrolled in an MCO as follows:

> *The MassHealth agency pays providers other than the MCO for those services listed in 130 CMR 450.105(A)(1) that are not covered by the MassHealth agency's contract with the MCO. Such payment is subject to all conditions and restrictions of MassHealth, including all applicable prerequisites for payment.*

Federal laws also indicate, or specifically state, that duplicate payments are not permitted. Section 1902(a)(37)(B) of the Social Security Act (42 US Code 1396a[a][37][B]) requires "proper and efficient payment of claims and management of the program," and Section 1902(a)(30)(A) of the Social Security Act (42 US Code 1396a[a][30][A]) requires that payments be "consistent with efficiency, economy, and quality of care." In addition, 31 US Code 3321(2)(d)(2)(A) and (B) state that duplicate payments are improper and should not be made.

Reasons for Improper Payments

During the audit period, MassHealth did not have effective system edits in place to identify and deny FFS claims for services covered by MCOs. Additionally, MassHealth acknowledged that some of the

payments involved members who were retroactively enrolled in MCOs or who had received services from state agencies. These situations are described below.

Retroactive Member Enrollments

MassHealth tracks[9] member enrollment status in a specific Medicaid Management Information System (MMIS) data file. The data file captures, among other things, each member's name, unique identification number, dates of enrollment, and health plan. MMIS refers to this data file when adjudicating provider claims to determine whether a member's services are covered through an MCO or paid for on an FFS basis. MassHealth must update member enrollment data promptly to ensure that claims are paid properly.

MassHealth acknowledged that in some cases, MMIS's data file is not updated until after the member has been added to, or removed from, an MCO plan. Until a member's enrollment status is updated, MMIS has incorrect enrollment data to use to adjudicate provider claims. This led to more than $20 million in improperly paid FFS claims during the audit period. For example, one member had enrolled in an MCO effective April 1, 2013. MassHealth did not update the member's enrollment status in MMIS until April 23, 2013. During the intervening period, the member received $3,147 of services for which the provider submitted FFS claims. MassHealth paid the claims. Had MassHealth updated the member's enrollment status promptly, MMIS would have properly adjudicated the claims, and the MCO would have made the required payment.

Ultimately, in accordance with 31 US Code 3321(2)(d)(2)(A) and (B), MassHealth should have identified and recovered all the improper FFS payments that resulted from the retroactive enrollment of MCO members. However, MassHealth did not seek to recover any of these payments during the audit period.

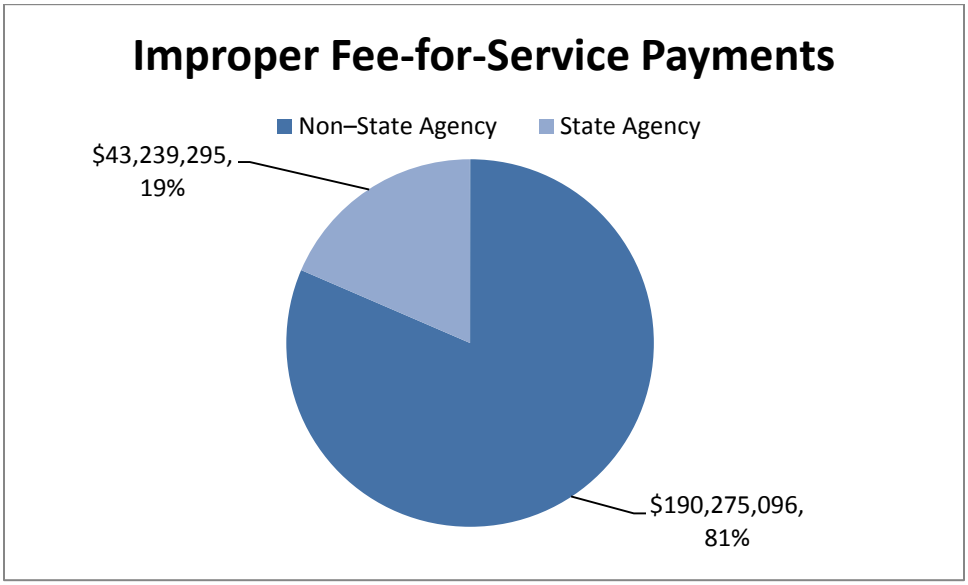
State Agency Payments

In some cases, a member obtains service from a state agency or public hospital under contract with MassHealth to provide that service. In these cases, the agency or contracted entity effectively acts

9. MassHealth initiates member enrollment changes through an 834 system transaction, which represents a computer "benefit enrollment and maintenance document." It is commonly used by employers, unions, sponsors of government plans (Medicare Part D, for example), and insurance marketing organizations to enroll members in a health-benefit plan. This current version developed out of the 1996 Health Insurance Portability and Accountability Act.

as a healthcare provider. However, MassHealth acknowledged that claims for medical services provided by state agencies and public hospitals were not subject to the same system edits as claims from other medical-service providers for MCO enrollees. MassHealth wrote to OSA that "claims from 'state agency providers' are not cost avoided to MCOs (meaning that claims from state agency providers bypass the managed care edits)."

During the audit period, MassHealth improperly approved payments of $43,239,295 for routine medical services provided to MCO members by state agencies. This amount represents 19% of the $233,514,391 in improper FFS payments that we identified, comprising 111,144 FFS claims that included services such as mammograms, behavioral-health counseling, blood tests, electrocardiograms, and immunizations.



Regarding these claims, MassHealth stated that the Commonwealth should be reimbursed by the federal government for state agencies' services provided on behalf of members. MassHealth stated that this billing practice was a source of revenue for the Commonwealth and that these claims should not be paid through the monthly capitated payments to the MCOs.

We also noted that state agencies did not consistently bill MCOs instead of MassHealth for services when required to do so. Specifically, we identified examples of state agencies receiving payments from MCOs for exactly the same types of service for which they received payment from MassHealth. MassHealth officials were unable to explain this billing inconsistency.

Recommendations

1. MassHealth should take appropriate action to recoup the approximately $233 million we identified in unallowable payments associated with the paid FFS claims.

2. MassHealth should develop system edits to detect and deny FFS claims for member services covered by MCOs and should ensure that these edits are applied to all providers, including state agencies and other state-contracted providers.

3. MassHealth should implement a reconciliation process to detect and recoup FFS payments made for members who were retroactively placed in MCOs.

Auditee's Response

In response to our report, MassHealth stated that it would "pursue all actionable recommendations." MassHealth said that approximately $60 million of the more than $233 million in questioned expenses represented duplicate payments, that approximately $127 million of the expenses were appropriately paid for on an FFS basis, and that approximately $46 million in FFS claims submitted by other state agencies lacked clear and consistent guidelines.

In addition to its general comments, MassHealth also provided a more detailed response to our findings. In regard to services provided by state agencies, it stated,

> *According to the draft report, MCOs should have paid for services provided by these agencies. [OSA] asserts that because the MCOs did not pay for these services, MassHealth paid twice for the same service: first as a portion of the capitated (per member) premium and then through the FFS claim.*
>
> *MassHealth agrees that there is a need to further clarify our policies surrounding state agency claiming. The Commonwealth depends upon specialized agencies within the Executive Office of Health and Human Services to provide the services most urgently needed by their clients, each of whom are among the most vulnerable populations in the state. MassHealth uses certified public expenditures (CPEs) to support federal claiming for services provided by the specialized agencies within EOHHS to their clients, in accordance with federal law (42 CFR 433.51). MassHealth's understanding going into this audit was that any claims for services provided by state agencies are not paid by any of the MCOs. [OSA] informed us that in some cases state agencies were billing MCOs. In follow-up discussions and analysis of the data provided by [OSA], MassHealth found that while we do not believe that these claims represent duplicate payments, there is a need to clarify and document the appropriate policies and procedures for state agency billing and claiming. As a companion to the work that MassHealth is doing to create an explicit list of codes to clarify what is and is not covered by MCOs, MassHealth is currently taking steps to update and document its policies and procedures regarding state agency billing and claiming; MassHealth will also ensure that state agency services are captured in its MCO contracts and MMIS edits as appropriate.*

To the extent that billing for certain state agency services shift from MassHealth FFS (CPEs) to the MCOs, there may be an impact on the MCO capitation rates that MassHealth pays. Because many state agency services have not in the past been billed to the MCOs, these services have not been accounted for in the MCO capitation rate development process. This assures that there is no duplicate payment, but if it is determined that additional state agency services should be the responsibility of the MCOs, the capitation rates may increase to reflect these services.

In addition to the state-agency claims, MassHealth identified additional claims it believed were for services that were not covered by the MCO contracts and therefore not included in the actuarial computation of MCO capitation rates. These included, among others, approximately $16.8 million for skilled nursing visits and approximately $67.5 million for emergency dental services including oral surgery. MassHealth specifically stated that dental procedure codes were not covered under MCO contracts.

MassHealth agreed that approximately $60 million in questioned costs represented duplicate payments and stated that it would "take appropriate steps, consistent with [OSA's] recommendations, to address these areas." MassHealth discussed the areas in question as quoted below.

1. FFS claims that should be paid by the MCOs as MCO covered services—$47 million

[OSA] analysis points out FFS claims for services that MassHealth agrees are services that appear to be the responsibility of contracted MCOs. . . . MassHealth agrees with [OSA's] recommendations that MassHealth should provide the MCOs with greater specificity as to the procedure codes for which the MCOs are responsible, based on the MCO covered services set forth in the MCOs' contract with MassHealth. In addition, MMIS edits should be refined to prevent FFS claims for these services for MCO enrollees. Given the five-year audit period, [OSA's] findings with regard to these claims is consistent with MassHealth's internal review and resulting estimates, prompted by the [OSA] audit, that approximately $10M per year in FFS claims for MCO enrollees should not be paid. The Governor's proposed FY2016 budget for MassHealth anticipates savings of $10M based on this finding. For historical claims, MassHealth will pursue reconciliation.

2. Retroactive enrollment of newborns—$12 million

MassHealth found that approximately $12 million in FFS claims was attributable to newborns who were covered immediately upon birth on a FFS basis but were subsequently enrolled in an MCO retroactive to the date of birth. We have confirmed that it takes time for MassHealth to receive the notification of birth (NOB) from the hospital, process the child's eligibility, and then process the child's enrollment in the health plan of the mother. To account for this timing gap, MassHealth retroactively enrolls the child in order to provide continuity of care and family-based enrollment. While this process serves an important policy purpose to ensure that newborns are enrolled in their mother's managed care plan, the multi-step process involved can result in delays, leading to FFS claims being incurred prior to the enrollment of the child into a health plan and associated capitation payment for that child, which goes back to the child's date of birth. In

most cases, these claims are picked up in the regular reconciliation process with the MCOs; however, in some cases, the reconciliation process has failed to account for these claims, as reflected in the audit finding.

MassHealth agrees with [OSA] that this process calls for increased focus on reconciliation with the MCOs to recoup FFS claims made during the retroactive enrollment period. MassHealth will prioritize reconciliation of these types of claims. . . .

As a result of the very important findings of [OSA], MassHealth is taking the following actions to implement [OSA] recommendations:

- *Document covered and non-covered MCO services at the code level to provide the MCOs with greater specificity as to the procedure codes for which the MCOs are responsible for paying based on the MCO covered services set forth in the MCOs' contract with MassHealth.*
- *Implement new MMIS edits to prevent FFS claiming of MCO covered services.*
- *Pursue reconciliation, to the extent practical, on FFS claims that should have been paid by an MCO.*
- *Clarify and document the Commonwealth's policies and procedures for billing, payment and claiming of state agency services.*

Auditor's Reply

Medicaid Services Provided and Arranged by Other State Agencies

We agree that 42 CFR 433.51 entitles states to federal financial participation for CPEs, including state-agency and public-provider expenditures. However, it is not sufficient for the CPE method to be merely authorized; it also must not be duplicative.

The standard MCO contract anticipates that state agencies will participate as MCO network providers. Specifically, Section 1 defines "network provider or provider" as follows:

> *Network Provider or Provider—An appropriately credentialed and licensed individual, facility, **agency**, institution, organization, or other entity that has an agreement with the Contractor, or any subcontractor, for the delivery of services covered under the Contract.* [emphasis added]

Additionally, Section 2.8(C)(2) of the standard MCO contract requires each MCO to enroll certain state agencies as network providers:

State-Operated Community Mental Health Centers (SOCMHCs)

The Contractor shall refer cases to the SOCMHCs in a manner that is consistent with the policies and procedures for Network referrals generally.

In other written comments, MassHealth acknowledged to us that each of the five MCOs that we surveyed had routinely enrolled state agencies and SOCMHCs as network providers.

Had the MassHealth members in question not been enrolled in MCOs, the CPE billing method would have been appropriate in these instances. However, once these members were enrolled in MCOs, the use of the CPE method created duplicative payments. Specifically, the Commonwealth funded these services both through the MCOs' capitated payments and through state appropriations made to state agencies and public hospitals. By not requiring the MCOs to pay the state agencies for these services, the Commonwealth paid twice for them.

Section 2.3(G)(6)(a) of the standard MCO contract requires each MCO to report to MassHealth all services delivered by its network providers:

The Contractor shall . . . collect and maintain 100% Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data.

In our analysis of the data, we found that state agencies had billed MCOs for approximately 300,000 claims, totaling almost $41 million, during the audit period for 129 covered procedure codes. The codes were for routine services such as mammograms, behavioral-health counseling, blood tests, electrocardiograms, and immunizations. As acknowledged by MassHealth, state agency billing practices were inconsistent. On many occasions, state agencies billed a member's services to an MCO on one day and submitted an FFS claim for the same member and service on another day. This occurred with at least 7,900 members during the audit period.

Regarding the capitation rates, the standard MCO contract gives each MCO the opportunity to accept or reject the capitation rates offered by MassHealth. By accepting these rates, MCOs assume the responsibility of paying for the costs of all covered services for each member, whether or not the costs exceed the rates. If MassHealth had properly administered payments for the services provided to members enrolled in MCOs, it would have helped ensure the accuracy of the capitation rates.

MCOs are designed to represent a more cost-efficient means of delivering medical services than paying for them on an FFS basis. Therefore, requiring the MCOs to administer the types of care identified within their contracts should result in cost savings to the Commonwealth; otherwise, they may not be operating as designed.

Emergency Dental Services

We do not agree with MassHealth that the approximately $67.5 million in emergency dental claims that it paid during our audit period on an FFS basis were appropriate. MCOs are contractually required to cover all emergency dental services as well as oral surgery.

In performing our testing in this area, we based our analysis on only the seven specific dental procedure codes that MassHealth itself had identified to us during a previous audit[10] as representing emergency services. We then generated a summary of all FFS payments that MassHealth made for these procedure codes for members who were enrolled in MCOs. We found numerous instances where MCOs paid for these seven procedures when providers submitted bills to them instead of to MassHealth. MCOs paid 805,334 claims, totaling more than $35 million, for these seven emergency dental procedure codes during our audit period.

Skilled Nursing Services

We do not agree with MassHealth that the skilled nursing services we question in our report should have been paid for on an FFS basis. Appendix C of the standard MCO contract describes skilled nursing services as a covered home health service, as follows:

> ***Home Health****—services include:* ***Part-time or intermittent skilled nursing visits****, physical therapy visits, occupational therapy visits, speech language therapy visits and home health aide services. In order to be eligible for Home Health aide services, the Enrollee must have a need for nursing services or therapy services.* [emphasis added]

Appendix C also describes instances in which private duty nursing services are **not** covered, as follows:

10. These seven emergency dental procedures were confirmed by MassHealth officials during OSA's audit of the MassHealth Limited Program (Audit No. 2013-1374-3M1).

> ***Private Duty Nursing / Continuous Skilled Nursing****—a nursing visit of* ***more than two continuous hours*** *of nursing services. This service can be provided by either a home health agency or Independent Nurse.* [emphasis added]

Under these two contract provisions, MCOs must cover skilled nursing services for member claims involving less than two hours of continuous service. Since the procedure codes for these services are billed in 15-minute units, OSA was able to identify and analyze every FFS claim of two hours or less per visit. Our finding does not include FFS claims for private duty nursing visits of more than two hours.

Other Categories

For each of the remaining types of improper expense, we identified instances where MCOs had paid for the services, indicating that they were covered by the MCO contracts.

2. MassHealth's lack of controls over MCO service contracts caused at least $288 million in additional FFS claims.

We found that MassHealth did not maintain adequate records of services covered by MCOs. Specifically, although each contract with an MCO identified the types of service (e.g., acute inpatient care) that were to be covered, MassHealth did not develop a master list of specific medical procedures and related procedure codes that MCOs must cover for all members. This caused the MCOs to develop their own unique lists of covered procedures, which varied from one MCO to the next. Further, MassHealth does not require MCOs to send it a list of the actual procedures and procedure codes they cover so that it can ensure that it does not pay on an FFS basis for services covered by a member's specific MCO. MassHealth was not able to provide a list of services covered by any individual MCO.

These control deficiencies caused MassHealth to make at least $288,952,449 of potentially unnecessary FFS payments during the audit period in addition to the $233,208,842 discussed in the previous finding.

Officials at some MCOs informed us that, as a result of certain court decisions, they contractually agreed to cover certain procedure codes for MassHealth members. This creates disparities in the services covered by each MCO. For example, Neighborhood Health Plan covers habilitation services under procedure codes T2016 and H2014; Fallon Community Health Plan only covers procedure code H2014; and Tufts Network Health Plan, Boston Medical Center HealthNet Plan, and Health New England cover neither of these codes. During our audit, OSA obtained a comprehensive list of covered services and

procedure codes for five of the MCOs (Boston Medical Center HealthNet Plan, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Tufts Health Plan—Network Health; CeltiCare was not included in this analysis). In addition to identifying a universal list of procedure codes that were covered by all five MCOs, which we used in our analysis for Finding 1, we also established unique lists, one for each MCO, of the procedure codes added to the list of covered services because of factors such as court decisions or the quality of care the MCO wished to provide. We then determined the instances in which MassHealth paid for these additional services on an FFS basis. The table below summarizes the FFS claims MassHealth could have declined to pay for these additional services covered by MCOs during the audit period.

Potentially Avoidable FFS Claims

MCO	FFS Claims	Total Payments
Neighborhood Health Plan	2,925,903	$ 212,445,673
Health New England	435,609	29,812,733
Fallon Community Health Plan	559,264	27,354,778
Boston Medical Center HealthNet Plan	356,084	12,246,296
Tufts Health Plan—Network Health	37,779	7,092,969
Total	4,314,639	$ 288,952,449

Authoritative Guidance

As previously stated, Sections 1902(a)(37)(B) and 1902(a)(30)(A) of the Social Security Act (42 US Code 1396[a]) require proper and efficient program management and payments, and 31 US Code 3321 prohibits duplicate payments. Proper program management would entail determining and distributing the list of covered services to ensure that duplicate payments are not made.

Also as previously mentioned, payment to an MCO and a provider for the same service is prohibited by 42 CFR 438.60 and 130 CMR 450.105. In order to prevent paying for services covered by an MCO, MassHealth must know what those services are.

Reasons for Lack of Code List

MassHealth did not have effective internal controls over its contracting process with MCOs to ensure that it gave MCOs a complete list of all agreed-upon procedure codes for medical services covered for members and received from each MCO a list of additional services the MCO covered.

We asked all five MCOs whether MassHealth had given them a basic list of covered services. Although some MCOs recalled discussions with MassHealth on this subject, none were able to provide us with any documentation to support the existence of such a list. We also asked MassHealth for the same information and did not receive any supporting documentation.

Recommendation

In consultation with the MCOs, MassHealth should develop a master list of procedure codes covered by all MCOs and, if applicable, a list of additional services covered by each one. MassHealth should then use this information to create system edits in its claim-processing system to ensure that it only pays for claims that the MCO in question has specifically identified as not covered by its plan.

Auditee's Response

In response to this finding, MassHealth stated,

> *MassHealth agrees that there is a need to be more specific as to the procedure codes for which the MCOs are responsible for paying. . . . MassHealth is actively engaged in developing the master list recommended by [OSA] in order to eliminate any ambiguity as to who is responsible for payment and to provide clear documentation for contracts and systems edits and instructions for state agencies and MCOs. While we are in full agreement with [OSA's] recommendation and recognize that the lack of such a list has resulted in significant exposure for potential duplicate payments to date, it is worth noting that based on our analysis of [OSA's] data and discussions with the MCOs, we believe that the majority of these claims do not represent duplicate payments.*
>
> *Please also note that, to the extent that past and current practices have been in place for state agency claims to be billed FFS and claimed as CPEs, future direction of such claims to MCOs (if that is determined to be appropriate), could result in higher actuarially sound capitation rates and therefore may not translate into overall savings for the Commonwealth.*

Auditor's Reply

In its response, MassHealth agrees that greater control is needed over the MCO contracting process, including the development of specific procedure codes that are to be covered by MCOs. Our analysis in this area did not identify duplicate payments. Rather, our finding emphasized potential savings that MassHealth could have realized if it had communicated with the MCOs to determine what procedure codes they would have covered in the normal course of business—even if not specifically required to do so by their contracts—and used this information to establish system edits in its claim-processing system to ensure that these procedures were not paid for on an FFS basis.

As previously noted, MCOs have reviewed and accepted MassHealth's capitation rates; if they felt that any proposed rates would not cover the costs included in their contracts, they had the opportunity to reject them, which would give MassHealth information that it could use to develop rates that are more in line with MCOs' expected costs.

If MCOs are, as intended, a more cost-efficient means of delivering medical services than FFS payments, then the Commonwealth should save money by adjusting the capitation rates to account for services the MCOs have already agreed to pay.

APPENDIX

Adjustments to Draft Report Totals

Adjustments by Service Category
Identified by the Office of the State Auditor

Contract Service Category	Total Payments (Initial Draft)	Adjustment Made	Total Payments (Revised Draft)
Behavioral-Health Services	$141,705,327	($54,215,999)	$ 87,489,328
Dental Services	75,634,021	(8,055,317)	67,578,704
Home Health Services	35,886,870	(2,739,908)	33,146,962
Skilled Nursing Facility, Chronic or Rehabilitation Hospital Services	19,098,931	(2,289,009)	16,809,922
Ambulatory Surgery / Outpatient Hospital Care	11,253,386	(5,955,223)	5,298,163
Early Intervention	9,069,684	(9,056,609)	13,076
Acute Inpatient Care	8,209,988	(25,972)	8,184,016
Physician (Primary and Specialty)	4,875,751	(76,088)	4,799,663
Emergency Services	4,627,655	(163,081)	4,464,574
Pharmacy	3,478,949	(14,772)	3,464,177
Laboratory	490,073	(29,341)	460,732
Radiology and Diagnostic Tests	487,443	(44,117)	443,326
Emergency Transportation*	274,542	(1,787)	272,756
Durable Medical Equipment and Medical/Surgical Supplies	245,701	(2,491)	243,210
Therapy	164,622	(9,291)	155,331
Prosthetic Services and Devices	103,212	(51,853)	51,359
Vision Care	78,839	(3,079)	75,760
Family Planning[†]	70,773	(183)	70,590
Early and Periodic Screening, Diagnosis, and Treatment	53,903	0	53,903
Hospice	42,945	0	42,945
Dialysis	36,922	(3,569)	33,353
Medical Nutritional Therapy	21,236	(2,882)	18,354
Orthotics	16,737	0	16,737
Chiropractic Services	9,314	(68)	9,246
Oxygen and Respiratory Therapy Equipment	8,375	0	8,375

Contract Service Category	Total Payments (Initial Draft)	Adjustment Made	Total Payments (Revised Draft)
Audiologists	3,352	0	3,352
Diabetes Management Self-Training	782	0	782
Tobacco-Cessation Services	114	0	114
Podiatry	31	0	31
Total	$315,949,481‡	($82,740,639)	$233,208,842‡

* Our previous draft omitted more than $8 million in emergency-transportation costs so as not to include questionable payments currently being addressed in a separate transportation audit by the Office of the State Auditor.

† In accordance with Section 4.4 of the contract between MassHealth and managed-care organizations (MCOs), MassHealth performs annual reconciliations of all fee-for-service claims paid by MassHealth for family-planning services covered by MCOs. Our previous draft omitted more than $7 million in family-planning costs so as to reflect recoupments received by MassHealth as a result of these reconciliations.

‡ Discrepancies in this total occurred because amounts were rounded up or down to whole dollars.

Adjustments by Category Code Identified by the Office of Medicaid

Category Code	Description	Amount Removed	Claim Count
45	Targeted Case Management	$40,140,363	91,378
47	Franciscan Hospital	13,780,995	15,314
50	Early Intervention	9,056,609	48,880
44	Intensive Residential Treatment Program	7,817,367	767
46	Behavioral Health; Long-Term Residential	5,589,512	10,214
48	Elder Affairs	2,741,338	42,370
Various	Commonwealth Care	2,206,703	8,870
49	Rest Home	1,102,204	1,183
51	Adult Foster Care	305,549	49
Total		$82,740,639*	219,025

* Discrepancies in this total occurred because amounts were rounded up or down to whole dollars.