



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

Making government work better

Official Audit Report – Issued April 23, 2015

Office of Medicaid (MassHealth)—Review of Personal Care Attendant Services

For the period July 1, 2010 through June 30, 2013





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Office of the State Auditor
Suzanne M. Bump

Making government work better

April 23, 2015

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

Dear Secretary Sudders:

I am pleased to provide this performance audit of the Office of Medicaid's (MassHealth's) personal care attendant services. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2010 through June 30, 2013. 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,

A handwritten signature in blue ink, appearing to read "SMB", written in a cursive style.

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director of MassHealth

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LIST OF ABBREVIATIONS

ADLs	activities of daily living
AFC	adult foster care
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare & Medicaid Services
EOHHS	Executive Office of Health and Human Services
EVS	Eligibility Verification System
FCA	False Claims Act
FI	fiscal intermediary
IADLs	instrumental activities of daily living
MCO	managed care organization
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
PAU	Prior Authorization Unit
PCA	personal care attendant
PCM	personal care management

EXECUTIVE SUMMARY

MassHealth, the state’s Medicaid program, provides access to healthcare services to 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%¹ was funded by the Commonwealth. Medicaid expenditures represent approximately 33% of the Commonwealth’s total budget.

The Office of the State Auditor has conducted an audit of MassHealth’s personal care attendant (PCA) services for the period July 1, 2010 through June 30, 2013. The purpose of this audit was to determine whether MassHealth was properly administering PCA services in accordance with applicable federal and state requirements.

In order to ensure that it properly administers PCA services, 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 claims for medically unnecessary or duplicative services, in accordance with applicable state and federal laws and regulations. As described below, MassHealth has not established controls to ensure that PCA services provided to members and paid for by the Commonwealth were allowable. Consequently, during the audit period, MassHealth made payments totaling as much as \$4,174,275 for questionable or unallowable PCA services.

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

Finding 1 Page 10	MassHealth paid 6,134 claims, totaling \$604,832, for PCA services and other medical services for 146 members whose recorded dates of death were before the service delivery dates.
Recommendations Page 13	<ol style="list-style-type: none">1. MassHealth should establish system edits to prevent and deny claims for services after a member’s recorded date of death.2. MassHealth should ensure that the dates of death purchased for its predictive modeling program are used to update members’ dates of death in all of its records.

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 a portion of our audit period, fiscal year 2011, was 60%.

Finding 2 Page <u>14</u>	Members participating in individual or group adult foster care (AFC) received PCA services, contrary to state regulations. MassHealth payments for these PCA services totaled \$3,354,838 for 454 members during the audit period.
Recommendations Page <u>15</u>	<ol style="list-style-type: none">1. MassHealth should deny all applications for PCA services when members are also participating in individual or group AFC funded by MassHealth.2. MassHealth should establish system edits to detect and deny claims for PCA services provided to members participating in individual or group AFC funded by MassHealth.3. MassHealth should recover overpayments made to PCAs.
Finding 3 Page <u>16</u>	MassHealth paid a total of \$101,381 for PCA services that exceeded the maximum number of units possible in a day. Additionally, MassHealth paid for unauthorized night hours totaling \$79,357.
Recommendations Page <u>19</u>	<ol style="list-style-type: none">1. MassHealth should develop system edits to deny payment for units in excess of 96 units per member per day.2. MassHealth should develop procedures to monitor PCA night hours and investigate repeated instances of PCAs billing for more hours than are authorized.
Finding 4 Page <u>20</u>	Seventy-five members who were enrolled in managed care organization (MCO) programs did not receive their PCA services through the MCO program, but through other MassHealth programs. Consequently, by paying for these PCA services outside the MCO programs, MassHealth made duplicative payments totaling \$33,867 for the services.
Recommendation Page <u>21</u>	MassHealth should develop system edits to detect and deny PCA fee-for-service claims when a member is enrolled in an MCO program.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS) is responsible for the administration of the state's Medicaid program, known as MassHealth. For the three-year period ended June 30, 2013, MassHealth paid approximately \$1.4 billion for personal care attendant (PCA) services for 38,174 members, as detailed below.

Fiscal Year	Paid Amount	Members Served	Average per Member
2011	\$ 441,080,930	27,146	\$16,248
2012	472,877,191	28,344	16,684
2013	514,598,334	29,881	17,222
Overall	<u>\$1,428,556,455</u>	<u>85,371*</u>	<u>\$16,734</u>

* Of this total, 38,174 represents the unduplicated member count.

Medicaid

Medicaid is a joint federal-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 in partnership 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. Massachusetts is one of 31² states and federal districts that offer PCA services to Medicaid members. Of these, 22 states, including Massachusetts, provide PCA services to members of all ages. The remaining 9³ offer PCA services only to members aged 18 and older.

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2. These 31 states and districts are Alaska, Arizona, Arkansas, California, Idaho, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, Utah, Washington, West Virginia, Wisconsin, and the District of Columbia.
 3. These 9 states and districts are Arkansas, Louisiana, Maine, Missouri, New Hampshire, North Carolina, Texas, Utah, and the District of Columbia.

PCA Services

According to the state’s PCA Consumer Handbook, MassHealth provides PCA services to the elderly and people with disabilities to enable them to “keep their independence, stay in the community, and manage their own personal care.” MassHealth members are eligible for PCA services if they have (1) approval from their doctor or nurse practitioner, (2) a chronic or permanent disability that prevents them from performing their own personal care, and (3) a need for hands-on assistance in certain daily activities. PCA services assist members with activities of daily living (ADLs) (e.g., taking medications, bathing, dressing, eating, and toileting) and instrumental activities of daily living (IADLs) (e.g., preparing meals, shopping, doing housework, and traveling to medical providers). Members can apply for PCA services by contacting a personal care management (PCM) agency, which will evaluate a member’s need for PCA services and submit a request for prior authorization to MassHealth for these services. The PCA Program (as well as other community programs, including Home Care, School-Based Medicaid, and other special programs) relies on PCAs to provide these services. Our audit focused on the PCA Program.

The table below details PCA services funded through each of these programs for the audit period.

Program	Expenditures
PCA Program	\$1,314,083,546
Home Care	113,222,517
School-Based Medicaid	25,221
Special Programs	1,225,171
Total	<u>\$1,428,556,455</u>

PCM Agencies

PCM agencies contract with EOHHS to provide services in accordance with their contracts and with state regulations. These services include, but are not limited to, the following:

- evaluating and reevaluating members’ medical need for PCA services
- completing and submitting prior-authorization requests for PCA services to MassHealth
- assessing whether members can manage their PCA services independently or whether a surrogate is required
- maintaining members’ personal and medical data; assessments and evaluations; contact information, including surrogate and physician; and service agreements

-
- instructing members in the rules of the PCA Program
 - providing PCAs with functional skills training to effectively care for members
 - providing members with functional skills training on how to manage their PCA services
 - resolving member complaints in a timely manner
 - reporting suspected fraud to MassHealth and cooperating with any investigations that follow
 - notifying MassHealth of member surrogates who are not managing PCA tasks in accordance with MassHealth regulations

Fiscal Intermediaries

Fiscal intermediaries (FIs) contract with EOHHS to perform various employer-related tasks for members, including, but not limited to, the following:

- responding to members' payroll questions related to PCA payments, timesheets, tax forms, etc.
- resolving member and PCA complaints in a timely manner
- distributing and using standard forms to document PCA use and meet the requirements for reimbursement
- issuing payroll checks to PCAs
- reporting suspected fraud to MassHealth and cooperating with any investigations that follow

Personal Care Attendants

PCAs are employed by members to assist them with ADLs and IADLs in order for the members to live independently in the community. Members are fully responsible for recruiting; hiring; scheduling; training; and, if necessary, firing PCAs. According to 130 Code of Massachusetts Regulations (CMR) 422.411, a PCA must be all of the following:

- (a) not a family member as defined in 130 CMR 422.402 [the spouse of the member; the parent of a minor member, including an adoptive parent; or any legally responsible relative];*
- (b) not the member's surrogate;*
- (c) not the member's foster parent;*
- (d) legally authorized to work in the United States;*
- (e) able to understand and carry out directions given by the member or the member's surrogate;*

(f) willing to receive training and supervision in all PCA services from the member or the member's surrogate.

(g) not receiving compensation from any other entity for that activity time [except under certain circumstances]

Activity Forms (Timesheets)

The activity form is essentially a timesheet for a two-week pay period. It details the hours worked, in 15-minute segments (units), by the PCA providing services to the member. According to 130 CMR 422.420, the member must

ensure that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services, and the correct hours and dates that the PCA services were provided.

The member or surrogate signs the activity form, certifying “under pain and penalty of perjury that [s/he has] received MassHealth PCA services during the times described on this activity form.” The PCA also signs, similarly certifying, under pain and penalty of perjury, that s/he has provided the services as described. The member or surrogate submits the activity form to the FI for processing.

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 MassHealth’s personal care attendant (PCA) services for the period July 1, 2010 through June 30, 2013.

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 is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did MassHealth determine that PCA services were medically necessary?	No; see Findings 1 , 2 , and 4
2. Did MassHealth pay only for authorized PCA services?	No; see Finding 3
3. Did MassHealth determine that the services were prescribed by a physician or a nurse practitioner who was responsible for the oversight of the member’s healthcare?	Yes

To achieve our objectives, 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 other independent auditors.

We queried all MassHealth PCA claims from Massachusetts’s Medicaid Management Information System (MMIS) and MassHealth’s Data Warehouse for the three-fiscal-year period ended June 30, 2013. We performed data analytics on these claims to identify (1) the frequency and cost of services performed by PCAs and (2) service trends and billing anomalies indicating potential fraud, waste, and

abuse. Our data analytics identified potential issues with deceased members, members enrolled in managed care organizations and adult foster care programs, and members requiring nighttime services. We performed additional audit procedures to determine the extent of these potential problems.

We evaluated MassHealth system controls designed to control and monitor the payment of PCA services. In addition, we conducted audit fieldwork at two fiscal intermediaries: Cerebral Palsy of Massachusetts and Stavros Center for Independent Living. At these locations, we reviewed judgmental samples of 30 and 25 member files, respectively, to determine whether paid claims were properly authorized and supported by appropriate documentation, including prior authorizations, activity forms, surrogate agreements, member communication logs, and payroll information. We did not project the sample results to the entire population of service claims. Rather, wherever possible, we expanded our audit procedures to quantify the total financial effect for each audit result.

We also consulted with officials from MassHealth. Additionally, we performed research on other state Medicaid agencies' PCA programs. We used the information we obtained to conduct audit fieldwork and to develop this audit report. At the conclusion of our fieldwork, we discussed the results with MassHealth personnel and considered their comments when preparing this report.

Additionally, we provided our Bureau of Special Investigations with a list of 146 members who may have received services after their recorded dates of death. Some of these members were under active investigation for this type of overpayment.

To assess the reliability of processed data, we relied on the work of other auditors who had examined the information-system controls for the MMIS claim-processing system. We reviewed KPMG's⁴ fiscal year 2013 design and effectiveness testing of MMIS's general information-technology controls, including user access to programs and data, program changes, and computer operations.

Additionally, in our examination of the reliability of MMIS data, we relied on the work performed and conclusions reached by OSA in Audit No. 2011-1374-4T, "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 16-month period ended June 30, 2011, stated that 488 (33%) of the 1,462 MMIS user accounts were associated with individuals who no longer worked at MassHealth. To resolve this problem, OSA recommended that the Executive Office of

4. KPMG LLP is the auditor for the Commonwealth's Single Audit for the fiscal year ended June 30, 2013.

Health and Human Services' (EOHHS's) user access security controls be strengthened by ensuring that access privileges for unauthorized users were deactivated or modified when a change in an employee's status resulted in the user no longer requiring access to IT resources, or when a change in an employee's position or responsibilities required 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 [MMIS] 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 user terminations. . . .

We performed validity tests on all claim data, including tests for (1) missing data elements, fields, and/or values; (2) duplicate records; (3) relationships between data elements; and (4) values within designated periods. Based on our current audit work, KPMG's fiscal year 2013 testing of MMIS's 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.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth paid as much as \$604,832 for personal care attendant services and other medical services provided after members' recorded dates of death.

MassHealth paid 6,134 claims, totaling \$604,832, for personal care attendant (PCA) services and other medical services for 146 members who, according to MassHealth's records, had died before the services were delivered. Payment for these claims is contrary to MassHealth's regulations and indicates potentially fraudulent activity. Not only did MassHealth pay for PCA services after members' recorded dates of death, but it also processed and paid claims for other services, such as skilled nursing; transportation services; rental of emergency-response equipment; and medical supplies, such as incontinence products, gloves, and enteral formulas. Based on MassHealth's recorded dates of death, we question \$604,832, as detailed in the table below.

Services Provided	Number of Claims	Amount Paid
PCA	4,036	\$ 329,049
Other	2,098	275,783
Total	<u>6,134</u>	<u>\$ 604,832</u>

Below are examples of these questionable payments based on the recorded dates of death in the state's Medicaid Management Information System (MMIS).

- One member with a recorded date of death of January 8, 2012 received services totaling \$50,104 through January 5, 2013. These services included PCA services, chest X-rays, office visits, skilled nursing, and morphine.
- One member with a recorded date of death of January 24, 2013 received services totaling \$21,349 through June 30, 2013. These services included PCA services, a power wheelchair, wheelchair accessories, and hospital bed accessories.
- One member with a recorded date of death of July 25, 2010 received services totaling \$48,469 through August 9, 2011. These services included PCA services, dental services, and glasses.

Authoritative Guidance

The federal False Claims Act (FCA), 31 U.S. Code 3729–3733, provides examples of fraudulent claims that can lead to the prosecution of an individual or entity who

1. *knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;*
2. *knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government.*

Not having adequate controls over recorded member dates of death increases the risk of PCA fraud.

The FCA applies to claims paid by MassHealth because the federal government reimburses the Commonwealth approximately 50% of all Medicaid claims.

In addition, MassHealth has issued various regulations to ensure that claims paid for medical services reflect actual services provided. First, 130 Code of Massachusetts Regulations (CMR) 450.223(C) states that by entering into a contract with MassHealth, providers agree to the following:

2. *that the submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that . . .*
 - b. *the medical services for which payment is claimed were actually provided to the person identified as the member at the time and in the manner stated . . .*
 - e. *the information submitted in, with, or in support of the claim is true, accurate, and complete.*

MassHealth also requires members (or their surrogates) to complete all PCA activity forms properly in accordance with 130 CMR 422.420(A), certifying the accuracy of timesheets:

3. *Complete and sign activity forms and submit them to the fiscal intermediary in accordance with the instructions provided and time frame specified by the fiscal intermediary;*
4. *ensure that information submitted on the activity forms for each pay period correctly identifies who provided the PCA services, and the correct hours and dates that the PCA services were provided.*

Moreover, the member or surrogate is required to sign each PCA activity form certifying “under pain and penalty of perjury that [s/he has] received MassHealth PCA services during the times described on this activity form.”

Likewise, the PCA must sign the activity form, certifying, under pain and penalty of perjury, that s/he has provided the services as described.

In order for these regulations to be effective, MassHealth must verify that these activities have been appropriately performed before paying claims.

Current Practices

Upon receiving PCA activity forms, fiscal intermediaries (FIs) rely on MassHealth's Eligibility Verification System (EVS) to verify member eligibility, including whether the member is still living, before processing and submitting a claim for payment. However, the FIs stated that MassHealth did not always update the necessary records in a timely manner to ensure that EVS contained correct information, and that this had led to overpayments.

Post-Audit Action

In 2013, the PCA Workforce Council and the 1199 Service Employees International Union signed an agreement requiring all Massachusetts PCAs hired after January 1, 2014 to attend a PCA New Hire Orientation within the first six months of their employment. According to the Personal Care Attendant New Hire Orientation brochure issued by the Executive Office of Health and Human Services (EOHHS),

The goal of the PCA New Hire Orientation is to support PCA workers in their positions, support the integrity of the PCA program in the state, and increase communication between [members] and PCA workers following hire.

Orientation instructors emphasize that by signing their activity forms, PCAs certify to MassHealth, under pain and penalty of perjury, that the information on the forms is true and accurate. In addition, PCAs are informed that knowingly submitting a false timesheet is a deliberate deception to secure unfair or unlawful payment from MassHealth. Finally, PCAs are informed that Medicaid fraud, regardless of severity, is a serious crime, punishable by law.

Beginning September 2013, MassHealth launched a new prepayment predictive modeling program. Using sophisticated algorithms to analyze claims, the program builds profiles of providers with

suspicious billing patterns and assigns risk scores to potentially inappropriate claims. The program provides alerts on a claim-by-claim basis, including those where a member's date of death precedes the date of service. Based on these alerts, the Massachusetts Medicaid Program Integrity Unit performs additional research to determine whether to pay or deny the claim.

Reasons for Payment of Claims after Recorded Dates of Death

Although MassHealth maintains a Date of Death field within MMIS, it had not developed system edits to prevent payment of claims for services provided after members' recorded dates of death. In addition, EVS did not contain members' current dates of death. This information is critical for FIs preparing claims for payment.

Recommendations

1. MassHealth should establish system edits to prevent and deny claims for services after a member's recorded date of death.
2. MassHealth should ensure that the dates of death purchased for its predictive modeling program are used to update members' dates of death in all of its records.

Auditee's Response

With respect to the [Office of the State Auditor's, or OSA's] financial findings, MassHealth reviewed all of the claims in this finding and found that \$490,000 represent claims that were in fact paid appropriately for services received prior to death. The date of death information for these members was incorrectly entered into MMIS, which led to the [OSA's] findings. MassHealth found that \$92,000 represents claims that were in fact for services claimed after the date of death, and MassHealth will seek recovery on these claims. MassHealth could not verify whether the remaining \$21,000 was paid appropriately because we were unable to confirm date of death, neither through the purchased date of death date, nor through an obituary search.

Given the above, MassHealth agrees with the [OSA's] recommendation to improve its data integrity processes for date of death information. Prior to this audit, MassHealth did not have an effective system in place to check date of death information in our systems; however, we are now using the purchased date of death information to validate MassHealth's date of death information on a monthly basis, per the [OSA's] recommendation. . . .

The three members the [OSA] cites as specific examples in its report. . . . were examples of data entry errors whose dates of service are in fact prior to their date of death. To address errors in data entry, MassHealth will implement enhanced quality control measures to ensure entry of member date of death information is completed accurately. Based on the results of MassHealth's review, the three examples included in the [OSA] report are not accurate examples of services being provided to a member after the member's date of death. . . .

In addition to enhanced quality control measures, MassHealth has implemented the [OSA's] recommendation. MassHealth will use the purchased date of death information to validate its eligibility data to further enhance the accuracy of member date of death information.

Auditor's Reply

Based on its response, MassHealth has identified the underlying causes of these questionable payments and is taking corrective action to improve its data-entry process and enhance the accuracy of member dates of death. The approximately \$490,000 caused by data-entry errors highlights the deficiencies in MassHealth's current data-entry process and the lack of related system edits. In addition, MassHealth acknowledged that at least \$92,000 of our finding represents claims for services provided after the members' actual date of death. We believe that MassHealth should take measures to prevent this in the future, including those described in its response.

2. MassHealth paid \$3,354,838 for unallowable PCA services for members participating in adult foster care.

Members participating in individual or group adult foster care (AFC) received PCA services, contrary to state regulations. MassHealth's payments for these PCA services totaled \$3,354,838 for 454 members during the audit period, as illustrated below.

	Amount Paid	Members Served
Individual AFC	\$2,001,797	203
Group AFC	1,353,041	251
Total	<u>\$3,354,838</u>	<u>454</u>

Authoritative Guidance

MassHealth does not pay for PCA services when a member is also participating in certain other programs funded by MassHealth, including individual and group AFC. Specifically, 130 CMR 422.412 states,

MassHealth does not cover any of the following as part of the PCA program . . .

(E) PCA services provided to a member during the time a member is participating in a community program funded by MassHealth including, but not limited to, day habilitation, adult day health, adult foster care, or group adult foster care.

Current Practices

When personal care management (PCM) agencies complete the MassHealth Application to Request Prior Authorization for PCA Services for a member, they are required to obtain information from the member about other MassHealth community programs in which the member participates, such as individual and group AFC. MassHealth requires PCM agencies to update applications for PCA services at least annually and/or when the member's condition changes. MassHealth's Prior Authorization Unit (PAU) relies on this information when approving PCA services.

Reasons for Payment of Unallowable Services

During the audit period, MassHealth did not have system edits in place to identify and deny claims for members who received AFC and PCA services at the same time. Additionally, PAU relied solely on the disclosures made by members to the PCMs about other services they received, rather than performing their own independent verification through MMIS.

Recommendations

1. MassHealth should deny all applications for PCA services when members are also participating in individual or group AFC funded by MassHealth.
2. MassHealth should establish system edits to detect and deny claims for PCA services provided to members participating in individual or group AFC funded by MassHealth.
3. MassHealth should recover overpayments made to PCAs.

Post-Audit Action

According to statements from officials at FIs and EOHHS, in 2013 MassHealth began monitoring PCA claims to identify members who are also receiving other community services, such as individual and group AFC.

Auditee's Response

MassHealth has in place a specific process to prevent duplicative claiming for PCA members who participate in community programs. As of May 2013, MassHealth, through the predictive modeling program, has been able to successfully identify and suspend a member's receipt of duplicative services prior to payment. This includes instances where PCA services are being provided to a member in AFC or [group adult foster care, or GAFC] or where PCA services are being provided during the same time of day that a member is attending a community program funded by MassHealth, such as Adult Day Health. While we believe that the predictive modeling

program is effective, we are also in the process of implementing edits in MMIS that will deny claims for duplicate services as an additional safeguard.

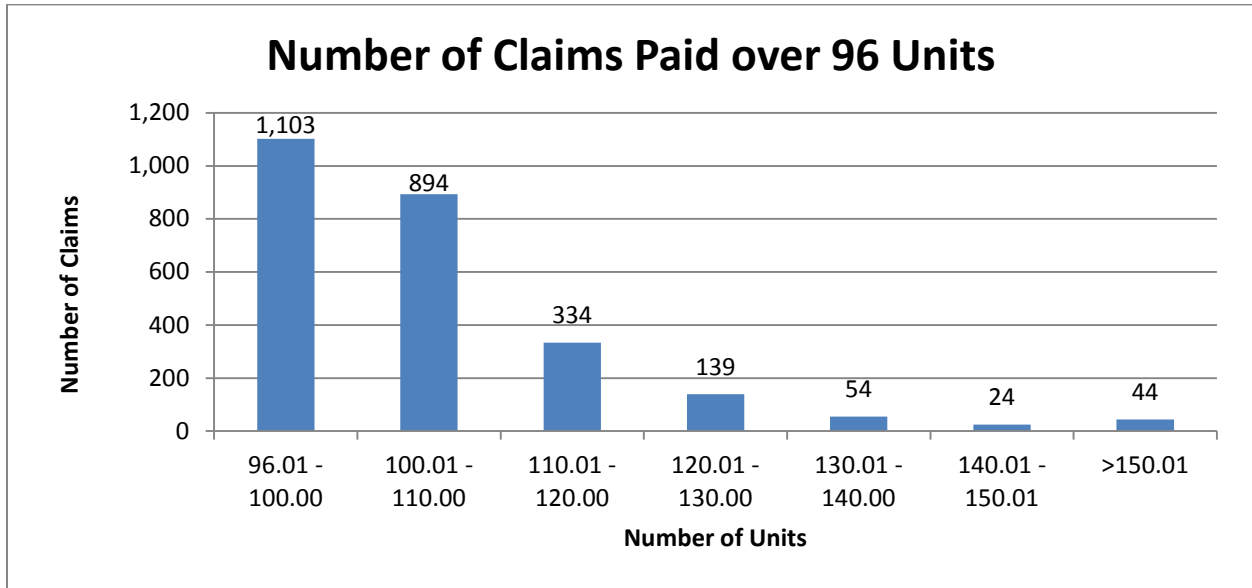
Auditor's Reply

MassHealth states that its new predictive modeling program is capable of identifying and suspending a member's receipt of duplicative services before payment, including PCA services received by a member who is enrolled in individual or group AFC paid for by MassHealth. MassHealth is also taking further precautionary measures to prevent this type of duplicative payment by establishing claim-processing system edits. We believe these measures will reduce duplicative payments.

However, we believe the predictive modeling program could be improved. Although it was outside the scope of our audit, after receiving MassHealth's response to our draft report, OSA performed some limited audit testing to assess the effectiveness of MassHealth's predictive modeling program. Specifically, we reviewed PCA claims processed by MassHealth between July 1, 2013 and June 30, 2014, after the predictive modeling program was implemented. From this testing, we still identified \$501,762 in potential unallowable payments for PCA services for members also enrolled in individual AFC. While our audit testing in this area was limited and does not constitute a complete evaluation of the predictive modeling program, it does raise some concerns over the effectiveness of this program and, in OSA's opinion, further demonstrates a need for MassHealth to continue developing system edits in its claim-processing system to prevent and deny payment for these duplicative services.

3. MassHealth paid \$101,381 for PCA services that exceeded the maximum level possible per day and for unauthorized night hours totaling \$79,357.

MassHealth paid for PCA services that exceeded the maximum number of units possible in a day. The maximum number of units possible per day is 96 units (24 hours x 4 units per hour). However, for 2,592 cases, MassHealth paid a total of \$101,381 for PCA services above this number, which reflects potential fraudulent activity. The excessive amounts ranged from 1 unit to more than 64 units per day. The chart below details the 2,592 instances involved with these unallowable payments.



Additionally, MassHealth officials told us that they typically authorize only two night hours, or 8 units, of PCA services per member. MassHealth distinguishes between day/evening hours and night hours when approving PCA services. MassHealth’s regulations define night hours as 12:00 a.m. to 6:00 a.m.

Our test of 68 members⁵ found that for 26 members, MassHealth paid a total of \$79,357 for unauthorized night hours. In fact, for 3 of these members, MassHealth did not authorize any night hours; the unauthorized payments for these members totaled \$6,497. The table below details the unauthorized payments during the audit period.

Sample Member Number	Authorized Night Units	Average Night Units Paid	Number of Occurrences	Unauthorized Payments
1	0	23	57	\$ 4,768
2	0	16	24	1,384
3	0	24	4	345
4	8	14	620	14,267
5	8	16	384	12,204
6	8	14	409	8,777
7	8	14	247	6,116
8	8	18	100	3,723
9	8	23	58	3,144

5. These 68 members had received 80 to 96 units per day of PCA services in 50 or more instances.

Sample Member Number	Authorized Night Units	Average Night Units Paid	Number of Occurrences	Unauthorized Payments
10	8	17	88	3,020
11	8	13	157	2,865
12	8	20	60	2,751
13	8	16	70	2,209
14	8	17	67	2,199
15	8	14	73	1,795
16	8	17	50	1,677
17	8	12	95	1,461
18	8	18	35	1,279
19	8	14	52	1,116
20	8	19	26	1,055
21	8	17	33	1,055
22	8	15	36	933
23	8	15	35	915
24	8	19	4	156
25	8	20	2	86
26	8	12	4	57
Total				<u>\$79,357</u>

Of our 68 sampled members, 38% received unauthorized night hours, and this happened as often as 620 times for 1 member, indicating a systemic problem.

Authoritative Guidance

To determine the reasonableness of paid nighttime services, we relied on the level of services authorized by MassHealth for each sampled member. In addition, we defined as unallowable any units above the maximum number contained in a 24-hour day (96).

Reasons for Unallowable Payments

MassHealth does not have procedures requiring investigation of PCAs who repeatedly bill for unauthorized night hours, nor has it designed system edits to deny claims for PCA services that exceed a member’s daily authorized units, including night hours, or 96 units per day. In addition, MassHealth did

not collaborate with FIs to ensure that members and PCAs were properly trained and, if necessary, retrained on appropriate billing practices for PCA services.

Recommendations

1. MassHealth should develop system edits to deny payment for units in excess of 96 per member per day.
2. MassHealth should develop procedures to monitor PCA night hours and investigate repeated instances of PCAs billing for more hours than are authorized.

Auditee's Response

We believe that the policies and practices currently in place in the PCA program have prevented overbilling from happening and that the [\$101,381] in claims was appropriately paid. However, MassHealth shares the [OSA's] concerns about the importance of this issue and is therefore reviewing its processes and training activities to ensure that overbilling does not occur in the future.

MassHealth approves PCA services beyond 96 units per member per day through prior authorization, based on clinical need or scheduling needs. The 96 units per day cap is monitored through a review of reports that state staff at the Office of Long Term Services and Supports review from our Fiscal Intermediaries. For example, some members receiving PCA services have extremely complex medical needs that require a second PCA to assist with certain activities of daily living (ADLs) such as transfers and bathing. Accordingly, in situations where a member has been approved for the assistance of a second PCA it is possible for the member to exceed 96 units per day, and as such it would not be appropriate to implement a fixed limit of 96 units of PCA services per member per day. This information is captured in the Notes field in MMIS. By including the notes fields in its analysis, the [OSA] would find the context related to each of these instances.

Regarding monitoring PCA night hours, MassHealth currently works with its Fiscal Intermediaries (FIs) on procedures for monitoring night hours and will continue to do so. If a consumer is over-utilizing PCA services, regardless of whether they are over-utilizing day or night time hours, the FI sends notices to the member, withholds payment, and contacts the PCM agency. The PCM agency then provides Functional Skills Training to the member and/or surrogate. If the member continues to over-utilize PCA hours, the FI contacts MassHealth and requests the member's hours be capped, in which case the FI will deny payment for hours the member submits for payment that are in excess of the number of PCA hours the member has been approved to receive.

Auditor's Reply

In its response, MassHealth asserts that prior authorization was granted for members who received more than 96 units of service per day. Although OSA provided MassHealth with a complete list of all questioned instances of members receiving more than 96 units per day, MassHealth did not provide any

specific examples supporting its assertions, but gave an example of instances in which such care would be medically necessary. In order to confirm MassHealth's assertion, we performed additional audit work on a sample of our questioned claims. Specifically, we reviewed MMIS Notes and External Text fields along with related prior-authorization approval letters. In each instance, these fields did not indicate that more than 96 units per day were medically necessary. Additionally, MassHealth's prior-authorization approval letters allowed for 96 units per day at most. Therefore, we maintain that MassHealth's policies and practices have not prevented this type of overbilling and that the \$101,381 in questioned claims was not appropriately paid.

While MassHealth has established protocols to limit overutilization of PCA services, we believe these protocols are not effective. Overutilization of night hours, as well as day hours, appears to be a prevalent problem that is not prevented by MassHealth's current protocols. For example, one FI stated that it sends approximately 800 consumer notifications weekly. In its response to our draft report, MassHealth explained that consumers who overutilize PCA services are sent notices by the FIs and that the FIs withhold payment, contact the PCM agency, and may ultimately ask MassHealth to cap the members' hours. While we agree that consumers are notified of overutilization, our audit work indicates that they are rarely denied payment and services are rarely capped. One FI told us that the capping of hours does not occur until the consumer overbills MassHealth by at least 10% in three consecutive pay periods. For these reasons, we continue to recommend that MassHealth develop system edits to better control overutilization for PCA services.

4. MassHealth improperly paid \$33,867 for PCA services for members enrolled in managed care programs.

During the audit period, MassHealth improperly paid \$33,867 for PCA services to members enrolled in managed care organizations (MCOs). MCOs are paid a monthly fee to provide their enrollees with a variety of healthcare services, including PCA services. However, 75 members enrolled in MCO programs⁶ received their PCA services through other MassHealth programs instead. Consequently, by paying for these PCA services outside the MCO programs, MassHealth made duplicative payments for the services.

6. Senior Care Options (SCO) and Program of All Inclusive Care for the Elderly (PACE).

Authoritative Guidance

The following rules apply to MassHealth members enrolled in a MCO program, according to 130 CMR 450.105(A)(3)(a):

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. It is the responsibility of the provider to verify the scope of services covered by the MassHealth agency's contract with the MCO.

Additionally, MassHealth's PCA Consumer Handbook communicates these restrictions to members:

If you are enrolled in a Senior Care Option (SCO) or the Program of All-Inclusive Care for the Elderly (PACE), personal care services will be provided through the SCO or PACE.

Reasons for Improper PCA Payments

All members enrolled in MCO programs are given the option to end their enrollment at any time. However, MassHealth does not have adequate internal controls to track member enrollment and does not have system edits to prevent payment of fee-for-service claims for members enrolled in MCO programs.

Recommendation

MassHealth should develop system edits to detect and deny PCA service claims when a member is enrolled in an MCO program.

Auditee's Response

MassHealth agrees that \$33,867 was improperly paid and has implemented changes in accordance with the [OSA's] recommendation. In April of 2014, a system edit to MMIS was implemented that ensures that claims do not bypass the managed care edits for members enrolled in a managed care plan that includes coverage of PCA services (SCO, PACE and One Care). MassHealth continues to monitor this edit to ensure its efficacy.

Auditor's Reply

Based on its response, we believe MassHealth's actions are appropriate and should help to address our concerns on this matter.

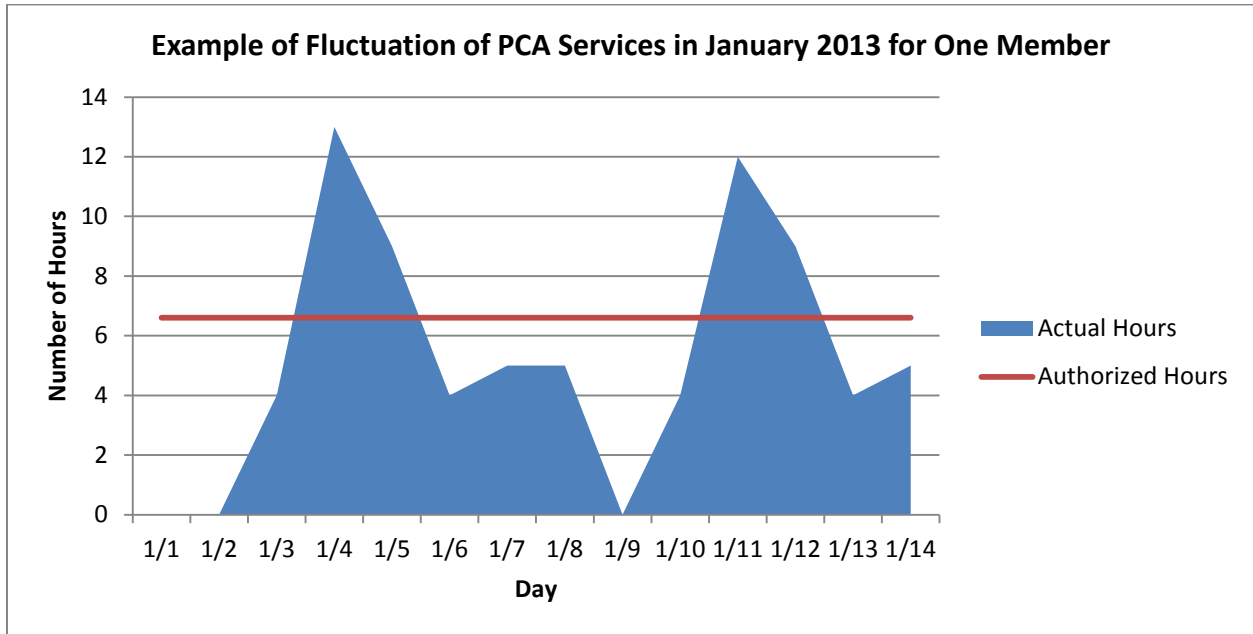
OTHER MATTERS

1. Service utilization monitoring could be improved.

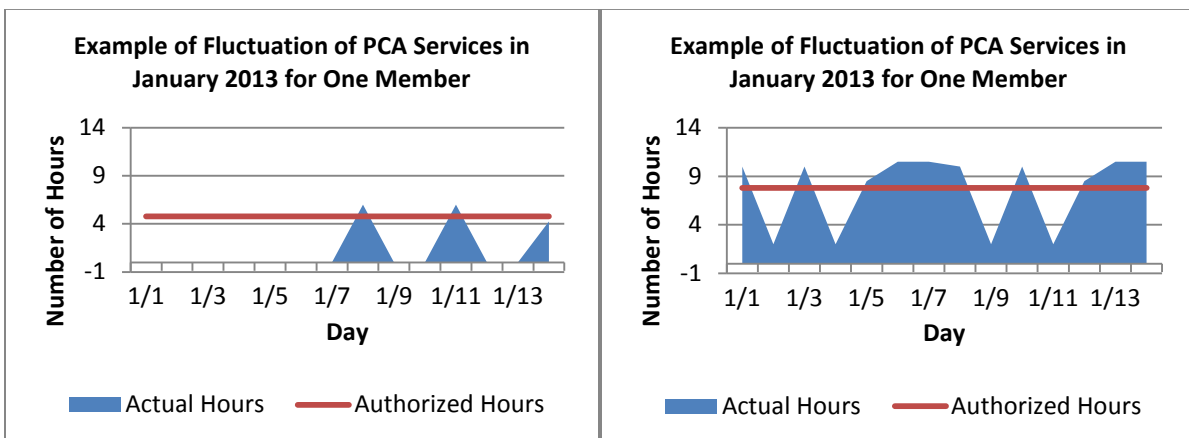
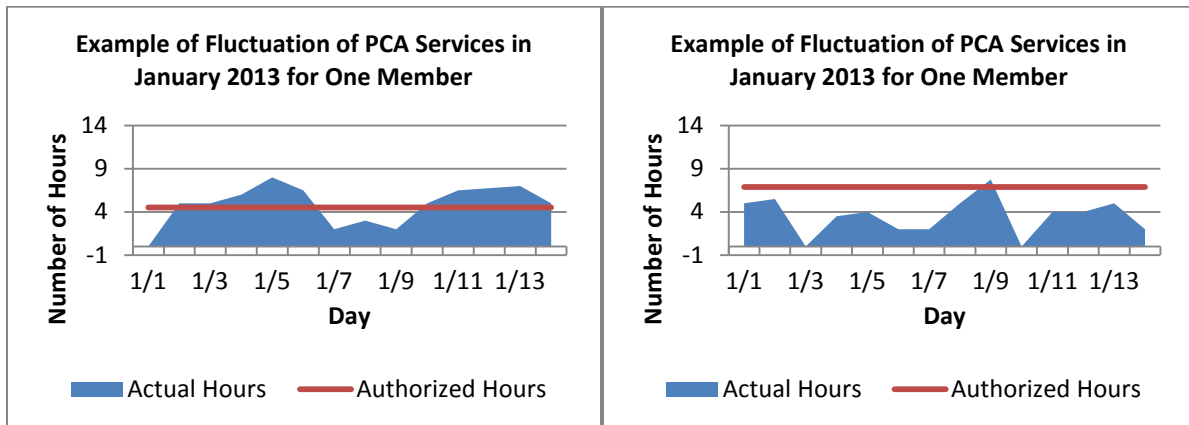
As previously discussed, personal care attendant (PCA) services involve helping members with basic activities of daily living, including taking medications, bathing, dressing, eating, and toileting. These tasks are necessary for a member to live independently within the community. MassHealth requires personal care management (PCM) agencies to perform an evaluation that accurately represents a member's need for physical assistance in order to maintain independence in the community. MassHealth officials said these daily services should be provided in a relatively consistent manner and in accordance with the authorized level of care.

Monitoring members' utilization of services is important because fluctuations in service use can indicate a problem such as a member or surrogate's ineffective management of PCA services, a member's inability to retain a PCA, inaccurate billing information, or potential fraud. Fiscal intermediaries (FIs) are required to notify PCM agencies and members when services are overutilized in three consecutive billing periods. However, there is no current practice to report underutilization.

Our analysis of paid claims during the audit period showed that members were, at times, either underserved or overserved in comparison to levels that MassHealth had authorized and determined medically necessary. For example, we examined PCA services provided to 10 members during a six-month period (January 2013 through June 2013). For each of the 10 members, we found daily fluctuations in the number of hours submitted on PCA timesheets, which MassHealth paid. Some of these fluctuations were substantial; for example, the chart below illustrates one member's service fluctuations (0 to 13 hours per day) during a two-week period, compared to the number of hours authorized (6.25 per day).



The charts below detail four other members with similar fluctuations during the audit period.



The two FIs we visited, Stavros and Cerebral Palsy of Massachusetts, both follow current protocol by notifying MassHealth, PCM agencies, and the member when a member overutilizes services in three consecutive billing periods. Cerebral Palsy of Massachusetts officials further stated that they only notify MassHealth when a member overbills by at least 10% for three consecutive pay periods. However, there is no current requirement to report underutilization. Therefore, MassHealth should consider establishing processes and controls that would allow it to monitor total service utilization more effectively in order to identify and address potential problems in a timely manner.

Auditee's Response

[The Office of the State Auditor, or OSA] recommends in its report that efforts should be made to ensure member utilization of approved PCA hours is consistent from day to day. The PCA program, however, is a self-directed program, under which the member is the employer of his/her PCA, and as the employer, the member is responsible for the scheduling of his/her PCA. MassHealth does not require members to utilize their PCA services in a prescriptive pattern as this would be contrary to the self-directed nature of the program and would impede upon a member's ability to effectively manage his/her personal care needs. MassHealth does believe that we need to find ways to ensure that we are providing both cost-effective and quality-based services and will consider this as part of its overall system transformation efforts.

As additional background, the prior authorization process for PCA services provides for a specific number of medically necessary PCA hours per week for a member to consume in a manner that best meets the member's needs and schedule. Fluctuation in a member's utilization of services often reflects changes in the availability of family members who assist with the member's care (e.g. family members are home on weekends but at work during the week). There may also be times that a member is receiving other non-duplicative services during which time PCA hours are not required (e.g. attending a day program in which ADL assistance is provided, but the member requires a PCA at home in the evening for assistance with ADLs in the home). Finally, medical appointment scheduling and non-daily IADLs (such as laundry or shopping) may also factor into reasons for why a member schedules his or her PCA for different amounts of time from one day to the next.

Auditor's Reply

OSA agrees with MassHealth that the PCA program is directed by the consumer. In addition, OSA acknowledges that slight variations in the delivery of these services, due to appointments and other personal matters, can be expected. At the start of the audit, MassHealth explained that member services should be delivered fairly consistently on a daily basis. Also, MassHealth's PCA Services Evaluation Form assesses consumer need hourly, projected into a weekly total. However, during the audit, we noted a trend of major fluctuations in service delivery. While it is possible that, for instance, a family member is providing care on days with a sudden drop in service, it is also possible that consumers

are not receiving the care they need. The fluctuations may also indicate mismanagement of services. For these reasons, we continue to recommend that MassHealth establish policies and procedures to effectively monitor over- and underutilization of PCA services and intervene when necessary.

2. Prior-authorization information is unreliable.

During the audit, we queried MassHealth’s prior-authorization data to determine whether all PCA services were properly authorized and paid in accordance with MassHealth regulations. However, we found that MassHealth’s prior-authorization data query⁷ did not produce reliable information about approved member services. We identified problems with the query when testing the results for completeness and accuracy through comparisons with source documents and member data stored in the Medicaid Management Information System (MMIS). Specifically, the query (1) did not provide results for all approved prior authorizations; (2) reported inaccurate information on “units authorized,” “units used,” and “units remaining”; and (3) did not reflect modifications to units due to changes in member status, such as enrollment changes or death. Based on results from the prior-authorization query, it appeared that MassHealth paid more than \$141,930,101 for unapproved PCA services during the audit period, as shown in the table below.

Number of Authorized Units	331,275,950
Units Paid	371,143,956
Difference	39,868,006
Average Pay Rate Per Unit	\$3.56
Potential Overpayment	\$141,930,101

MassHealth officials were uncertain why this problem occurred. It should be noted that OSA identified a similar concern in its prior audit of this program (No. 2006-5124-3C, which covered the period July 1, 2005 through June 30, 2007).

Auditee’s Response

From MassHealth’s understanding of how the [OSA] ran this data, the [OSA] was lacking important fields from which to evaluate the prior authorization information. The data pulled included claims outside of the PCA program and did not include necessary Notes and External Text fields that provide needed context. Therefore, MassHealth does not agree that one should conclude from this data that its prior authorization information is unreliable.

7. This query was performed using MassHealth’s Cognos enterprise reporting tool.

In order to obtain full and accurate data to assess the reliability of prior authorization information, the parameters would need to be restricted to MassHealth provider type 58 so that the resulting information is only for providers of MassHealth PCA program services. The query should also include Notes and External Text related to a member's prior authorization, which is necessary to understanding the context of a particular prior authorization approval.

MassHealth staff reviewed MMIS for each prior authorization and claim listed under the [OSA's] Prior Authorization Query in its "Finding 3—Prior Authorization Examples" spreadsheet. Under each claim and prior authorization in question, the claim was either unrelated to the MassHealth PCA program or there was external information that provided context for the PA.

Auditor's Reply

In its response, MassHealth states that OSA included claims outside the PCA program in this analysis. While our original analysis included claims involving home-care corporations (provider type 68), we removed these claims after MassHealth explained that home-care corporations perform their own evaluations for members they serve and that therefore this information is not available in the prior-authorization query.

In addition, OSA is aware of prior-authorization data stored in MMIS, including Notes and External Text fields. OSA used this information to review a sample of prior authorizations on a member-by-member basis. However, when OSA used the prior-authorization query, the results did not accurately reflect the underlying information in MMIS. We believe the query needs to be improved before it can be used as an effective analytical tool to monitor MassHealth's administration of the PCA program, including prior-authorization approvals and member utilization of services.