Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued December 10, 2014

Office of Medicaid (MassHealth)—Review of MassHealth Limited Program Claims for Emergency Medical Services Provided to Nonqualified Aliens

For the period July 1, 2011 through December 31, 2012

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December 10, 2014

Mr. John Polanowicz, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Polanowicz:

I am pleased to provide this performance audit of Office of Medicaid (MassHealth) Limited Program claims for emergency medical services provided to nonqualified aliens. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2011 through December 31, 2012. My audit staff discussed the contents of this report with management of the agency, and their 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

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EXECUTIVE SUMMARY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services to approximately 1.4 million eligible low- and moderate-income individuals annually, including children, families, seniors, and people with disabilities. In fiscal year 2013, MassHealth paid more than $10.8 billion to healthcare providers; approximately 50%[1] of this was funded by the Commonwealth. Medicaid expenditures represent approximately 33% of the Commonwealth's total budget. The Office of the State Auditor (OSA) conducted an audit of the MassHealth Limited Program for the period July 1, 2011 through December 31, 2012, during which time MassHealth paid 710,025 claims (totaling $77,627,854) to healthcare providers for emergency services rendered to lawfully present immigrants, protected nonqualified aliens, nonqualified persons residing under color of law, and other nonqualified aliens (including undocumented aliens) residing in Massachusetts. The objective of our audit was to determine whether the Limited Program provided nonqualified aliens with coverage only for emergency medical services, as required by federal and state laws and regulations. This audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. Several previously issued OSA audit reports have disclosed significant weaknesses in MassHealth's claim-processing system that resulted in millions of dollars in questionable or unallowable claims.

Limited Program members who require medical services not covered under the Limited Program (i.e., non-emergency services) have access to community-based free or low-cost clinics that provide urgent and elective healthcare, including primary and preventive care, dental and vision services, behavioral-health treatment, medications, and other health-related services. Also, eligible members may obtain funding assistance for medically necessary services through the state's Health Safety Net payment program. This network of community-based medical clinics and available funding gives members a bridge between Limited Program coverage for emergency services and other non-emergency services.

As with any government program, public confidence is essential to the success and continued support of the Limited Program. Therefore, MassHealth must have effective controls in place,

[1] The federal Medical assistance (federal matching funds) percentage for state Medicaid expenditures is 50%.

including program regulations, operating policies and procedures, monitoring activities, and enforcement action, to ensure that Limited Program members only receive services for emergency medical conditions. In addition, MassHealth must have claim-processing system edits to detect and deny claims for non-emergency services in accordance with applicable state and federal laws and regulations. As described below, MassHealth has not established the controls necessary to ensure that medical services provided to members and paid for by the Commonwealth only represent treatment of emergency medical conditions. Consequently, during the audit period, MassHealth made payments totaling approximately $35 million, representing 45% of total payments, for questionable or unallowable medical services provided to members.

Summary of Findings

The Office of Medicaid (MassHealth) paid questionable or unallowable medical claims totaling $35,137,347 during our audit period for non-emergency services provided to Limited Program members, including (1) inpatient and outpatient services totaling $27,852,214, (2) outpatient prescription drugs and medical supplies totaling $3,656,068, (3) dental services totaling $1,724,733, and (4) rehabilitation/therapy services totaling $1,904,332.

Recommendations

In order to address our concerns over payment for non-emergency inpatient and outpatient services for Limited Program members, including evaluation and management services, behavioral-health services, inpatient services, and outpatient and physician services, we recommend that MassHealth take the following action:

- Establish system edits within its claim-processing system to use the Emergency Indicator and Admittance Type billing indicators to determine whether inpatient and outpatient services provided by physicians and facilities were to treat emergency medical conditions.

In order to address our concerns over payment for non-emergency drug and medical supply prescriptions for Limited Program members, we recommend that MassHealth take the following actions:

- Establish policies and procedures requiring physicians to notify pharmacists when prescribing a drug or medical supply for treating an emergency medical condition. All other prescriptions, except antibiotics, should be self-paid.

- Establish system edits within the Prescription On-Line Processing System to effectively detect and deny claims for prescriptions filled in excess of MassHealth's 30-day supply restriction.

In order to address our concerns over payment for non-emergency dental services for Limited Program members, we recommend that MassHealth take the following actions:

- Develop dental-treatment policies and procedures specific to Limited Program members.
- Establish a system edit within the Dental Program's claim-processing system to allow payment for a case presentation fee only when a Limited Program member receives an allowed emergency service.
- Reexamine the system edits it established during our audit, since some of the unallowable dental procedures are still being paid for.

In order to address our concerns over payment for non-emergency rehabilitation/therapy services for Limited Program members, we recommend that MassHealth take the following actions:

- Complete its review of rehabilitation/therapy services for Limited Program members.
- Develop additional system edits to ensure that it no longer pays for any non-emergency rehabilitation/therapy procedures.

In order to address our concerns over the management oversight of the Limited Program, we recommend that MassHealth take the following actions:

- Update and reissue the MassHealth All Provider Bulletin regarding reimbursable services for Limited Program members to reflect recent changes made to their coverage.
- Create risk-based monitoring activities specific to Limited Program claims to ensure compliance with 130 Code of Massachusetts Regulations 450.105(F).

OVERVIEW OF AUDITED AGENCY

Background

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS), through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. 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 and Medicaid Services within the U.S. Department of Health and Human Services administer the Medicare program and work with state governments to administer their Medicaid programs. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements.

Federal law and regulation permit states to provide medical services through Medicaid for certain classes of nonqualified aliens, but only when those services are necessary to treat an emergency medical condition. These requirements pertain both to nonqualified aliens who are not lawfully admitted to the United States and to nonqualified aliens who have been granted lawful temporary resident status or lawful permanent resident status and meet all other requirements for Medicaid. MassHealth provides these services through the MassHealth Limited Program. According to 130 Code of Massachusetts Regulations (CMR) 450.105(F), the Limited Program only provides these nonqualified aliens with coverage to treat medical conditions that, without immediate medical attention, could reasonably be expected to result in serious risk to the patient's health, impairment to bodily functions, or dysfunction of an organ or body part.

For the 18-month period ended December 31, 2012, MassHealth paid 710,025 claims, which totaled $77,627,854, for 45,370 Limited Program members. The majority of these medical services fell into the categories in the table below.

Medical Service	Amount Paid	Claims	Members Served
Inpatient Services	$ 25,785,351	3,305	2,318
Outpatient and Physician Services	$ 20,904,947	315,081	33,053
Evaluation and Management Services	$ 15,905,115	111,867	26,659
Outpatient Prescription Drugs	$ 4,144,247	148,859	19,110
Dental Services	$ 3,111,272	87,333	14,738
Rehabilitation/Therapy Services	$ 1,909,919	6,637	1,052
Behavioral-Health Services	$ 1,053,927	7,200	1,088

Program Growth

Since its inception in 1997, the Limited Program has grown significantly. Its number of members served, number of claims paid, and costs have greatly increased, as detailed in the table below.

Fiscal Year	Paid Claims	Members Served*	Total Cost of Services	Annual Percentage Increase in Cost
1997	297	111	$ 13,101	N/A
1998	3,720	1,030	166,173	1,168%
1999	4,261	908	200,431	21%
2000	2,468	559	165,151	–18%
2001	3,732	837	274,055	66%
2002	2,667	668	273,992	0%
2003	787	348	153,520	–44%
2004	4,111	1,453	2,532,155	1,549%
2005	120,155	13,381	22,542,711	790%
2006	210,652	19,550	34,512,460	53%
2007	218,095	19,832	37,527,299	9%
2008	242,469	21,651	41,315,967	10%
2009	405,623	32,363	47,822,671	16%
2010	531,593	35,985	57,672,634	21%
2011	519,598	38,089	54,393,844	–6%
2012	454,561	36,011	50,755,317	–7%
2013	375,282	32,787	48,379,568	–5%
Total	3,100,071	112,147	$ 398,701,049	

* This figure represents the number of Limited Program members who received services for emergency medical conditions from 1997 through 2013. In some instances, the same member may be counted in the annual totals for more than one year, but only counted once in the cumulative total. Therefore, the total number of members served is not equal to the sum of the members for each year.

While these numbers remained relatively constant during fiscal years 1997 through 2004 (averaging 739 members served, 2,755 paid claims, and $472,322 in costs per year), the Limited Program began to experience significant increases in these measures in fiscal year 2005. For that year alone, the Limited Program funded medical services for 13,381 members, paid 120,155 claims, and incurred $22,542,711 in costs. This represented a 1,711% increase in members served and a 4,673% increase in costs over an eight-year period. The Limited Program continued to grow through fiscal year 2010, with decreases beginning in 2011.

The growth in Limited Program coverage is due, in part, to state budget cuts in August 2003. EOHHS's Office of Medicaid discusses this in Eligibility Operations Memo 04-09 (dated July 1, 2004), which states,

> *MassHealth benefits became no longer available at state cost to adult immigrants who, because of their immigration status, were not eligible to receive full federally funded benefits. Persons affected by this change are described as "aliens with special status" (AWSS). These are persons permanently residing under color of law . . . or certain qualified aliens subject to the five-year bar. As a result, adult AWSS members either became eligible only for MassHealth Limited coverage or lost MassHealth coverage altogether.*

Federal and State Requirements

As stated above, Medicaid is a federal program that provides healthcare funding for eligible persons through cost-sharing arrangements with states that elect to participate in the program. Under federal law and regulation, certain classes of nonqualified aliens are generally not entitled to full Medicaid coverage, but they may be entitled to medical assistance for the treatment of emergency medical conditions. Section 1903(v) of the Social Security Act (42 U.S. Code 1396b[v][2][A]) states that federal Medicaid funding is available to states for medical services provided to a nonqualified alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only when those services are necessary to treat an emergency medical condition. Mirroring that federal statutory provision, 42 Code of Federal Regulations (CFR) 440.255(c) states that federal Medicaid funding is available to states for medical services provided to the same classes of nonqualified aliens only when those services are necessary to treat an emergency medical condition.

The regulation 42 CFR 440.255(b) goes further and extends the restriction for services necessary to treat emergency medical conditions to nonqualified aliens who have been granted temporary resident status or lawful permanent resident status. Federal law and regulation—Section 1903(v)(3) of the Social Security Act and 42 CFR 440.255[2]—similarly define an emergency medical condition as a condition

> *manifesting itself by acute symptoms of sufficient severity . . . that the absence of immediate medical attention could reasonably be expected to result in—*
>
> *A. placing the patient's health in serious jeopardy,*
>
> *B. serious impairment to bodily functions, or*
>
> *C. serious dysfunction of any body part or organ.*

[2] The regulation 42 CFR 440.255 includes language defining emergency conditions as those involving the "sudden onset" of symptoms of sufficient severity to require immediate medical intervention. The term "sudden onset" is very important in distinguishing the difference between acute and chronic care. Chronic conditions are preexisting conditions requiring long-term medical care, which is outside the constraints of MassHealth Limited.

Pursuant to 42 U.S. Code 1396(a), all state Medicaid plans must conform to these requirements. Massachusetts has chosen to participate in the Medicaid program and has promulgated a regulation that is substantially the same as the applicable federal law and regulations. The specific regulation, 130 CMR 450.105(F), promulgated by EOHHS, details Limited Program coverage and matches federal guidance on emergency services for nonqualified aliens:

> *MassHealth Limited.*
>
> *(1) Covered Services. For MassHealth Limited members . . . the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in*
>
> *(a) placing the member's health in serious jeopardy;*
>
> *(b) serious impairment to bodily functions; or*
>
> *(c) serious dysfunction of any bodily organ or part.*

Additionally, MassHealth's All Provider Bulletin 101, dated June 1997, clarifies the circumstances under which a Limited Program member may receive services and the types of services that are covered. Specifically, the bulletin informs service providers that the Division of Medical Assistance will pay for services provided to these members only when those services are necessary to treat acute medical conditions requiring immediate attention. This bulletin defines the services covered under the Limited Program as follows:

- *Non-elective (urgent, emergent, or newborn) acute hospital inpatient admissions. Such admissions must meet the Medicare/Medicaid Appropriateness Evaluation Protocol (AEP) guidelines.*
- *Services provided by an acute outpatient hospital emergency department.*
- *Both elective inpatient stays that meet the AEP guidelines and ambulatory visits including associated ancillary services for the treatment of acute medical conditions requiring immediate attention.*
- *Transportation by ambulance required in conjunction with any of the above medical services.*
- *Medically necessary drugs, including . . . drugs prescribed by a physician, that are required in conjunction with any of the medical services listed [above]. Such prescriptions and any refills are limited in total to a 30-day supply.*

In addition, the bulletin states that the Division of Medical Assistance will reimburse only the following types of provider for these covered services:

- *acute hospitals (inpatient and outpatient services);*
- *community health centers;*
- *dentists;*
- *dental clinics;*
- *dental school clinics;*
- *hospital-licensed community health centers;*
- *nurse midwives;*
- *pharmacies;*
- *physicians;*
- *public psychiatric inpatient hospitals; and*
- *transportation providers.*

Finally, the bulletin explains that for all services except dental, the Division of Medical Assistance "can determine whether the service is covered by using the information that providers are already required to supply on their claim."

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) Limited Program for the period July 1, 2011 through December 31, 2012. For dental services and rehabilitation/therapy services, we extended our scope through December 31, 2013 to illustrate trends and quantify the total financial impact of our findings.

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.

Our objective was to determine whether the Limited Program provided nonqualified aliens with coverage only for emergency medical services, as required by federal and state laws and regulations. To achieve our objective, we reviewed applicable state and federal requirements; MassHealth Provider Bulletins; MassHealth's 2011 Claims Operations Internal Control Plan; the American Medical Association's 2012 Current Procedural Terminology Codebook; and drug information databases. We also reviewed prior MassHealth audits conducted by OSA, the federal Department of Health and Human Services, and other independent auditors.

We queried all Limited Program claims from the Massachusetts Medicaid Management Information System (MMIS) and MassHealth Data Warehouse for the 18-month period ended December 31, 2012. We performed data analytics on these claims to identify (1) the total number and value of paid claims; (2) the type and frequency of services, procedures, and supplies provided to members; (3) member diagnoses; and (4) service trends and billing anomalies indicative of potential fraud, waste, and abuse. We evaluated MassHealth's system controls designed to ensure that claims for non-emergency services for Limited Program members were detected and denied payment. In addition, we conducted audit field work at three provider locations: Boston Medical Center, Massachusetts General Hospital, and Cambridge Health Alliance. At each location, we reviewed a judgmental sample of 10 member files to determine whether paid claims were for emergency services and supported by appropriate documentation. We did not project the sample results to the entire

population of service claims. Rather, whenever possible, we expanded our audit procedures to quantify the total financial effect of each audit result.

We also consulted with officials from MassHealth, the University of Massachusetts Medical School Provider Compliance Unit,[3] and selected service providers. Additionally, we researched other state Medicaid agencies' emergency-service programs for nonqualified aliens. We used the information we obtained to conduct audit field work and to develop this audit report.

At the conclusion of our audit, we provided a copy of our draft report to the Executive Office of Health and Human Services (EOHHS) and MassHealth officials for their review and comment. In response, EOHHS provided two sets of comments, both of which we considered in drafting this final report. In response to some of these comments, we adjusted some of the totals and dollar amounts in this report. Dollar amounts that have been changed are indicated in brackets in any quotations from EOHHS's responses.

Data Reliability Assessment

MassHealth uses three separate computer systems to process medical, pharmaceutical, and dental claims. Specifically, MassHealth processes medical claims through MMIS, pharmaceutical claims through systems operated by Xerox State Healthcare, and dental claims through systems operated by DentaQuest LLC. To assess the reliability of processed data, we performed validity tests on all claim data that included tests for (1) missing data elements, fields, and/or values; (2) duplicate records; (3) relationships among data elements; and (4) values within designated periods.

In addition, we relied on the work of other auditors who examined the information-system controls for each of the three claim-processing systems. For pharmaceutical and dental claim-processing systems, we reviewed applicable reports known as Service Organization Control 1, or SOC1, reports for the claim-processing systems operated by Xerox State Healthcare and DentaQuest LLC, respectively. For the medical claim-processing system, we reviewed KPMG's[4] 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.

[3] The University of Massachusetts Medical School Provider Compliance Unit is contracted by the EOHHS Office of Compliance to monitor possible fraud, waste, and abuse in the Medicaid program.

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

Additionally, in our examination of the reliability of MMIS data, we relied on the work performed and conclusions reached by OSA in Audit Report 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 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 EHS Security Operations of all terminations.*

Based on our current audit work, KPMG's fiscal year 2013 testing of MMIS's information-technology controls, and the corrective actions 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 RESULTS AND FINDINGS WITH AUDITEE'S RESPONSE

Audit Findings

1. The Office of Medicaid paid $35,137,347 in questionable or unallowable medical claims for members of its Limited Program.

The Office of Medicaid (MassHealth) paid questionable or unallowable medical claims totaling $35,137,347 during our audit period for non-emergency services provided to members of its Limited Program. Specifically, MassHealth paid for (1) inpatient and outpatient services totaling $27,852,214, (2) outpatient prescription drugs and medical supplies totaling $3,656,068, (3) dental services totaling $1,724,733, and (4) rehabilitation/therapy services totaling $1,904,332. These questionable or unallowable costs represent 45% of the $77,627,854 expended for medical services for Limited Program members during the 18-month audit period.

Authoritative Guidance

According to 130 Code of Massachusetts Regulations (CMR) 450.105(F), MassHealth pays only for emergency services for Limited Program members. The regulation defines emergency services as follows:

> *For MassHealth Limited members . . . the MassHealth agency pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in*
>
> *(a) placing the member's health in serious jeopardy;*
>
> *(b) serious impairment to bodily functions; or*
>
> *(c) serious dysfunction of any bodily organ or part.*

Some specific issues discussed in this finding are also governed by MassHealth policies, procedures, and other guidance, which are outlined below in the subsections where they apply.

Reasons for Questionable or Unallowable Payments

MassHealth could have prevented this unnecessary spending had it established internal controls to ensure that payments were made solely for emergency medical services. Specifically, MassHealth did not (1) develop operational procedures to implement its existing regulations and policies governing the Limited Program; (2) establish claim-processing system edits to pay only for emergency services; and (3) adequately monitor provider claims to identify trends and anomalies that could indicate

waste, fraud, and abuse. Other causes of specific issues are discussed below in the subsections where they apply.

a. MassHealth paid questionable claims for inpatient and outpatient services totaling $27,852,214.

During the audit period, MassHealth paid a total of $63,649,340 for inpatient and outpatient services for Limited Program members, of which 270,167 claims (totaling $27,852,214, or 44%) were for non-emergency services. The services included evaluation and management, behavioral-health, inpatient, and outpatient and physician services. They were provided to manage all aspects of Limited Program members' healthcare, including both preventive and therapeutic care. Specific examples of these services include scheduled office visits, diagnostic examinations, medical consultations, hospitalizations, immunizations, laboratory and radiological services, and individual and group behavioral-health therapies. These services were not for emergency medical conditions that could have placed a member's health in serious jeopardy; caused serious impairment to bodily functions; or caused serious dysfunction of any bodily organ or part at the time of service. Therefore, they did not meet the definition of emergency services in 130 CMR 450.105(F).

The table below details the various categories of inpatient and outpatient services reviewed and includes the total amount paid, total allowable costs, and total questionable costs.

Service Category	Total Claims Paid	Total Amount Paid	Total Allowed Amount Paid	Percent Allowed	Total Questionable Amount Paid	Percent Questionable
Evaluation and Management Services	111,867	$15,905,115	$ 5,276,222	33%	$10,628,893	67%
Behavioral-Health Services	7,200	1,053,927	4,013	<1%	1,049,914	99.6%
Inpatient Services	3,305	25,785,351	22,175,876	86%	3,609,475	14%
Outpatient and Physician Services	315,081	20,904,947	8,341,015	40%	12,563,932	60%
Total	437,453	$63,649,340	$35,797.126	56%	$27,852,214	45%

As detailed in the table above, the majority of inpatient services for Limited Program members were paid in accordance with 130 CMR 450.105(F), whereas the services for evaluation and management, behavioral-health, and outpatient and physician services were primarily for non-emergency services.

Authoritative Guidance

MassHealth regulation 130 CMR 450.101 distinguishes emergency medical conditions and emergency services from urgent care, as follows:

> *Emergency Medical Condition—a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part. . . .*
>
> *Emergency Services—medical services that are provided by a provider that is qualified to provide such services, and are needed to evaluate or stabilize an emergency medical condition. . . .*
>
> *Urgent Care—medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.*

In addition, All Provider Bulletin 101, dated June 1997, indicates that the purpose of certain information that providers submit on their claims is to determine whether a service is for emergency purposes:

> *For most services, providers do not need to adjust their method of billing to specifically identify that a covered service was provided to an eligible MassHealth Limited member. For all services except dental, [MassHealth] can determine whether the service is covered by using the information that providers are already required to supply on their claim.*

To this end, MassHealth's claim form CMS-1500 contains an Emergency Indicator data field that providers are instructed to populate when submitting a claim for payment. Within the data field, providers must indicate whether the service provided was for the treatment of an emergency medical condition. MassHealth's Billing Guide for the CMS-1500 instructs providers to indicate services that are the result of an emergency by entering a Y in the data field and to indicate non-emergency services by leaving the field blank.

Similarly, MassHealth's claim form UB04 contains an Admittance Type data field for hospitals and other medical facilities to use when seeking payment for services. MassHealth requires medical facilities to populate this data field with one of six Admittance Type indicators:

Admittance Type Indicators (Form UB04)[5]

Indicator	*Admittance Type*	*Description*
1	*Emergency*	*The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.*
2	*Urgent*	*The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.*
3	*Elective**	*The patient's condition permitted adequate time to schedule the availability of suitable accommodation.*
4	*Newborn*	*Use of this code necessitates the use of a special source of admission codes.*
5	*Trauma Center*	*Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.*
9	*Information Not Available*	*Visits to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or verified by the American College of Surgeons and involving a trauma activation.*

* *Often referred to as a scheduled visit.*

Reasons for Questionable Inpatient and Outpatient Payments

During the audit, MassHealth officials stated that they relied on physicians to determine whether the services provided to Limited Program members were for emergency medical conditions. Moreover, they explained that claims were approved or denied using the Emergency Indicator and Admittance Type data fields. However, the results of our review indicated that MassHealth had not implemented system edits to automatically deny claims that physicians have not designated as treatment for emergency conditions.

Auditee's Response

> *MassHealth appreciates [the Office of the State Auditor's, or OSA's] careful review of its Limited payment policies and procedures but respectfully disagrees with the majority of this finding. OSA's findings are based on a number of assumptions, namely that the services MassHealth has deemed emergencies, and therefore allowable under Limited, are not in fact emergencies. If MassHealth were to rely on the OSA's assumptions . . . MassHealth would deny the treatment of kidney failure, the setting of broken bones, or the treatment of acute pneumonia. This is not in line with federal guidelines, and is not in line with state law and regulation either. MassHealth has reached a different*

[5] The text of this table is taken from CMS Publication 100-04, Medicare Claims Processing, Transmittal 1104, dated November 3, 2006 and updated July 1, 2011 for all institutional claims.

conclusion and believes that the OSA's findings were due to the following three gaps in its review, and will discuss each one in more detail, below:

i. OSA used an erroneous definition of what is allowable by applying incorrect regulations to the Limited program;

ii. OSA did not take into account sub regulatory guidance that provides additional detail and insight into policies governing the Limited program; and

iii. OSA did not take into account the "always emergency" list of diagnosis codes that MassHealth uses in evaluating Limited claims.

For those claims that were unallowable, MassHealth is in the process of implementing enhancements to its system to prevent these from occurring in the future.

i. OSA used an erroneous definition of what is allowable by applying incorrect regulations to the Limited program

Per 130 CMR 450.105(F), the MassHealth Limited program covers all services "for the treatment of a medical condition, including labor and delivery, that manifests itself by acute symptoms of sufficient severity that the absence of immediate medical attention reasonably could be expected to result in placing the member's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part."

The OSA finds that services covered by MassHealth, particularly those marked as urgent admissions, did not meet the definition of emergency services, as defined in 130 CMR 450.101, which states that urgent care is defined as "medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition;" however, allowable services under the MassHealth Limited program are governed by 130 CMR 450.105(F) which neither references 130 CMR 450.101, nor uses the term "emergency" or the term "urgent." OSA also points to the defined term "urgent" as further supporting its interpretation; however, the definition of the term "urgent" is not used substantively in the 450 regulations or in the hospital or physician regulations. MassHealth appreciates that this term has caused some confusion and is committed to doing a thorough review of our regulations to determine if there are other terms included in its regulations that are no longer applicable to the operation of the program.

MassHealth's regulation tracks the federal regulations, which make federal Medicaid funding available for medical services provided to certain eligible noncitizens that are to treat emergency medical conditions. The federal regulations define the covered services available to eligible [nonqualified aliens] as services necessary to treat a medical condition, (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including acute pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body part or organ. See 42 [Code of Federal Regulations, or CFR] 440.255(1).

In addition, in accordance with state law, MassHealth is authorized to provide services to MassHealth Limited enrollees to the greatest extent possible consistent

with federal law, including coverage for chronic medical conditions, which, if left untreated, could reasonably be expected to place the persons' health in serious jeopardy, cause serious impairment to bodily functions or cause serious dysfunction of any bodily organ or part. M.G.L. c.118E, § 16D.

ii. *OSA did not take into account sub-regulatory guidance that provides additional detail and insight into policies governing the Limited program.*

Allowable services for MassHealth Limited members are outlined more specifically in sub-regulatory guidance in the All Provider Bulletin 101 dated June 1997 ("Bulletin 101"). As explained therein, MassHealth pays for those services necessary to treat acute medical conditions requiring immediate attention, as provided by both federal and state regulation. The Bulletin states that the following services are covered for MassHealth Limited members:

- *Non-elective (urgent, emergent, or newborn) acute hospital inpatient admissions. Such admission must meet the Medicare/Medicaid Appropriateness Evaluation Protocol (AEP) guidelines.*
- *Services provided by an acute outpatient hospital emergency department.*
- *Both elective inpatient stays that meet the AEP guidelines and ambulatory visits including associated ancillary services for the treatment of acute medical conditions requiring immediate attention.*
- *Transportation by ambulance required in conjunction with any of the above medical services.*

MassHealth implemented this sub-regulatory guidance through systems that ensure only appropriate claims are paid, by validating the following information:

- *Revenue codes listed on the claim, which indicate where the service is provided, i.e. the site of service, are within the established Emergency Revenue Codes (450 through 459). Revenue codes within this range denote services provided in locations where emergency services would likely be provided, such as an emergency room.*
- *The admit type listed on the UB04 form, which is the claim form that providers submit to MassHealth. The form has a field on it to describe the admission of the member, for example if it is an emergency admission, or an elective admission, or an urgent admission. MassHealth determined that the following admit types of Admission: 1- Emergency, 2-Urgent or 4-Newborn are considered to be allowable under Limited;*
- *The Emergency Indicator on CMS-1500 claim, which is another opportunity for providers to communicate if an encounter is in fact an emergency. MassHealth considers a claim allowable if this indicator is set to "Y" (yes) by the provider; or*
- *The primary diagnosis on the claim is a diagnosis contained on the "always emergency" list of diagnosis codes, and when listed on a claim, MassHealth deems this claim allowable under Limited. This list of diagnosis codes have been compiled based on extensive clinical guidance. . . .*

After reviewing OSA's data, MassHealth was able to identify the source of the discrepancies in allowable payments. As a result of excluding the UB04 Type of Admission= "2-Urgent," an allowable claim under the Limited Program, over [$4 million] in claims were considered [questionable] by the OSA, which, according to federal law, as well as state law, MassHealth regulation, and formal sub-regulatory guidance are in fact allowable.

While OSA focuses its analysis on the difference between emergent claims and urgent claims, it overlooks the governing federal requirements of the Limited program which are to pay for claims to treat acute symptoms of sufficient severity . . . that can reasonably be expected to result in: placing the member's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. . . .

The UB04 form was created by the National Uniform Billing Committee (NUBC), based on CMS policy. As the UB04 form is not one that MassHealth creates itself, MassHealth needed to analyze the potential admit types that may be designated through this form and determine which of these independently established admit types fit within the federal and state definitions of an emergency service. MassHealth determined that the admit types of 1-emergency, 2- urgent and 4-newborn are all within the requirements of services that would be covered by the Limited Program. While admit type 2 is entitled "Urgent," it must not be confused with the term "urgent" found in MassHealth regulations; these two terms have very different definitions. The definition of admit type 2-Urgent is that the patient required immediate attention for the care and treatment of a physical or mental disorder. When compared to the state and federal definitions of an emergency service, requiring "immediate attention" fits within the definition of acute symptoms of sufficient severity that the absence ***of immediate medical attention*** *could reasonably be expected to result in placing the patient's health in serious jeopardy.*

iii. *OSA did not take into account the "always emergency" list of diagnosis codes that MassHealth uses in evaluating Limited claims.*

In addition, because the OSA did not account for the list of "always emergency" diagnosis codes, which were provided to the OSA on December 16, 2013, there is a discrepancy of approximately $13 million in the calculation of allowable claims. This list of diagnosis codes have been compiled based on extensive clinical guidance. Creating a list of "always emergency" codes allows for a system check for those claims that a provider may not mark as a "1," "2" or "4" on the claim form, but is in fact for an emergent service within the meaning of applicable state and federal law. It adds another layer to assure that emergent services are correctly allowed for claims made under the Limited program.

Because the OSA did not account for MassHealth's "always emergency" diagnosis codes, the OSA has determined that approximately $13 million in claims paid to hospitals and community health centers for . . . treatment of acute kidney stones; treatment of kidney failure; treatment of blood infections; chemotherapy for malignant life-threatening cancers, and more were not appropriate. MassHealth disagrees with the OSA's findings on these claims. In all of these examples, the risk of serious harm to the patient is well known.

Auditor's Reply

Section 1903(v) of the Social Security Act, and 42 CFR 440.255, specifically state that federal Medicaid funding to states for medical services is provided to nonqualified aliens who have been granted lawful temporary resident status or lawful permanent resident status, and who meet all other requirements for Medicaid, **only when those services are necessary to treat an emergency medical condition**. In addition, MassHealth's All Provider Manual regulation, 130 CMR 450.103(A), states,

> *All regulations of the MassHealth agency are promulgated in accordance with M.G.L. c.30A. In the event of any conflict between the MassHealth agency's regulations and applicable federal laws and regulations, the MassHealth agency's regulations shall be construed so far as possible to make them consistent with such federal laws and regulations.*

Accordingly, MassHealth promulgated 130 CMR 450.105(F) to reflect the coverage allowed under federal laws and regulations for the Limited Program.

Additionally, the Office of the Inspector General (OIG) within the U.S. Department of Health and Human Services performed similar audits at other state Medicaid programs, examining Medicaid funding for emergency services provided to nonqualified aliens. In each audit report, OIG specified that Section 1903(v) of the Social Security Act and 42 CFR 440.255 were the overarching regulatory criteria upon which it based its decision to allow or deny claims paid for noncitizens. Moreover, these audit reports state that federal financial participation (FFP) is only allowable when the services rendered to noncitizens are emergency, not chronic, urgent, elective, or any other type of non-emergency service. In fact, OIG's audit of the Florida Medicaid program found that claims were improperly paid for chemotherapy, a treatment for a chronic illness.

However, for Limited Program members, MassHealth has chosen to unilaterally expand medical coverage to include chronic, elective, and other non-emergency services, without seeking approval in a form such as a waiver from Centers for Medicare and Medicaid Services (CMS) or authorization from the Massachusetts Legislature. Thus MassHealth has not properly administered state and federal funding it received for the Limited Program totaling approximately $35 million during the audit period.

MassHealth responds that Chapter 118E, Section 16D, of the Massachusetts General Laws authorizes it to provide services to the Limited Program enrollees to the greatest extent possible consistent with federal law, including coverage for chronic medical conditions. Accordingly, MassHealth issued the 1997 All Provider Bulletin 101, stating that urgent care and certain elective inpatient and outpatient (ambulatory) services were covered for Limited Program members.

However, Chapter 118E, Section 16D, does not validate MassHealth's issuance of this Provider Bulletin or its expansion of coverage to include urgent, chronic, elective, and other non-emergency medical services, because federal laws and regulations limit federal coverage for noncitizens to emergency services. Chapter 118E, Section 16D(2)(iv), states that "services or benefits other than emergency services shall not be provided to undocumented aliens unless required by federal law." Therefore, since federal law only allows services to treat emergency medical conditions for nonqualified aliens, MassHealth's decision to pay for services that are elective and/or that treat chronic conditions appears to be contrary to both federal and state law. In performing our audit, we did consider MassHealth's systems for implementing its sub-regulatory guidance, as described below.

Revenue Codes: Revenue codes identify a location where a medical service is provided, a specific accommodation, or an ancillary charge. As MassHealth stated, revenue codes 450-459 identify services in an emergency-room setting. However, providers use emergency rooms not only to treat emergency conditions, but also to treat acute, chronic, and other medical conditions. Therefore, while we did review these codes during our audit, we did not use them to determine whether a claim represented emergency services.

Admittance Type and Emergency Indicator: As noted in our report, providers fill out these data fields when submitting claim forms UB04 and CMS-1500 to MassHealth. On form UB04, medical facilities identify whether a patient is admitted for emergency, urgent, routine, or other reasons; on CMS-1500, physicians use the Emergency Indicator field to indicate whether their services treated an emergency. CMS requires the use of these forms when processing any Medicaid claim. The information comes directly from the service providers who are actively treating the patient and know the severity and nature of the medical condition firsthand. Moreover, hospital officials and billing specialists we interviewed stated that using an indicator

other than the emergency indicators (e.g., Admit Type 1) could result in MassHealth not paying the claim. For these reasons, we found the Admittance Type and Emergency Indicator fields to be the most complete and reliable data source for reviewing claims. Therefore, our claim review primarily relied on these data fields.

Primary Diagnosis Code: MassHealth has developed a list of "always emergency" diagnosis codes. As indicated by the list's name, MassHealth always pays claims containing any of these diagnosis codes, even when the services provided are indicated as elective services. We evaluated this list and found that it appeared to be flawed; therefore, we could not use it for our audit. Specifically, the list included (1) diagnoses for conditions, such as abrasions, bunions, bursitis, and finger dislocations, that do not seem to warrant immediate treatment; (2) diagnoses labeled as "mild," "in remission," or "without crisis"; and (3) diagnoses requiring the care of medical specialists in outpatient settings, e.g., visits to an orthopedist to treat ligament tears or joint pain. Finally, the primary diagnosis code sometimes reflected a patient's overarching chronic medical condition, even when the specific ailment that was treated may not have been related to that condition. For instance, one patient was admitted under the code for schizophrenia even though he was being treated for a hand injury, leading to payment decisions based on the wrong code.

It should be noted that there are more than 13,000 medical diagnosis codes. Since most medical treatment is not for emergencies, we expected that MassHealth would have identified a number of these as categorically non-emergency services and therefore not eligible for payment under the Limited Program. However, MassHealth has only identified 55 diagnosis codes as "Never Pay" codes. This disparity in numbers appears to suggest that MassHealth has not given as much attention to developing a list of non-covered diagnosis codes as it has to its list of 4,517 always-covered codes.

Because of the limitations of two data fields (revenue codes and primary diagnosis codes), we determined the most reasonable and reliable data fields to be the Emergency Indicator and Admittance Type fields. Our analyses of emergency-service claims primarily relied on these two data fields because they were filled out by the providers who specifically treated the patients and were the most familiar with their medical conditions. MassHealth stated during the audit that this guidance had resulted in its paying approximately $1.9 million for non-emergency rehabilitative and therapy services.

In its response, MassHealth states that the laws and regulations cited in our report are not relevant. However, as detailed above, Section 1903(v) of the Social Security Act and 130 CMR 450.105(F) restrict FFP to emergency services for noncitizens. CMS has created claim submission forms (CMS 1500 and UB04) and applicable instructions that clearly differentiate between emergency and non-emergency (including urgent and elective) services. In addition, 130 CMR 450.101, which is applicable to all MassHealth programs, differentiates between emergency and urgent services, defining "emergency medical condition" and "urgent care" as follows:

> *Emergency Medical Condition—a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absences of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the member or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).*
>
> *Urgent Care—medical services that are not primary care, and are needed to treat a medical condition that is not an emergency medical condition.*

As illustrated above, federal and state guidance clearly differentiate between emergency and urgent care. If the federal government had intended to pay for both emergency and urgent care for nonqualified aliens, as MassHealth suggests, then the federal government would not have differentiated between the two types of medical conditions. Yet MassHealth, within its response, minimizes this distinction between emergency and urgent care, stating, "While admit type 2 is entitled 'Urgent,' it must not be confused with the term 'urgent' found in MassHealth regulations; these two terms have very different definitions." However, as previously noted, MassHealth's own definitions are consistent with the federal regulations on this matter in that they also differentiate between emergency and urgent conditions.

In its response, MassHealth states that relying on OSA's assumptions would lead it to deny claims for procedures such as setting broken bones or treating acute pneumonia. This statement is not accurate. We did not make assumptions, as our audit relied on existing federal and state laws and regulations with which states must comply in order to receive FFP. We used the same criteria that OIG used when it performed similar audits at other states. Additionally, when claims are denied because of inaccurate claim submission by providers, MassHealth allows providers to correct and resubmit such claims. For example, a provider may submit a claim for a Limited Program member suffering from acute kidney stones. If the provider submitted a claim

indicating that the service was "urgent" rather than "emergency," the claim would initially be denied. However, if the acute kidney stone actually reflected an emergency, the provider could submit a corrected claim for MassHealth to reprocess for payment. MassHealth's Office of Clinical Affairs is staffed with medical experts to clinically evaluate such resubmissions.

i. Questionable Evaluation and Management Services Totaling $10,628,893

During our audit period, MassHealth paid 111,867 claims (totaling $15,905,115) for evaluation and management services provided to Limited Program members, of which 68,400 claims (totaling $10,628,893, or 67%) were for non-emergency evaluation and management services.[6] Although providers may have reported services for labor and delivery as urgent or elective care, we did not consider these services questionable because federal laws and regulations explicitly require coverage for labor and delivery.

The table below details the questionable claims that MassHealth paid for evaluation and management services for Limited Program members during the audit period.

Total Questionable Claims Paid for Evaluation and Management Services for Limited Program Members

Service Group*	Total Claims	Total Amount	Questionable Claims	Questionable Amount
Office or Other Outpatient Services	55,521	$ 9,216,278	53,019	$ 9,029,996
Office or Other Outpatient Consultations	9	820	9	820
Initial Observation Care	755	97,557	488	50,907
Subsequent Observation Care	161	7,201	132	5,076
Initial Hospital Care	3,298	373,315	2,403	275,073
Subsequent Hospital Care	10,008	544,032	6,650	364,411
Inpatient Consultations	8	825	6	611
Observation or Inpatient Care Services (including admission and discharge)	224	31,497	123	17,218
Emergency Department Services	41,768	5,625,968	5,543	882,787
Other	115	7,622	27	1,994
Total	111,867	$15,905,115	68,400	$10,628,893

* Group descriptions are drawn from the Evaluation and Management tables in the American Medical Association's 2012 Current Procedural Terminology Codebook.

[6] According to the American Medical Association's 2012 Current Procedural Terminology codebook, evaluation and management services "include examinations, evaluations, treatments, conferences with or concerning patients, preventive pediatric and adult health supervision, and similar medical services, such as the determination of the need and/or the location for appropriate care [and treatment of the patient]."

Authoritative Guidance

These claims were submitted using either CMS-1500 or UB04 claim forms. As previously noted, these claim forms include either an Emergency Indicator or an Admittance Type data field for MassHealth to use to determine whether services were for emergencies. The providers populated this field in accordance with MassHealth's billing guidelines, but MassHealth paid these claims even though the Emergency Indicator was not Y or the Admittance Type was not 1 or 5. By not selecting Emergency Indicator Y or Admittance Type 1 or 5, physicians and facilities acknowledged that the services were non-emergency services.

Reasons for Questionable Evaluation and Management Services

These payments were made because MassHealth did not use the information supplied by providers on these claim forms to distinguish whether services provided were for emergency purposes.

Auditee's Response

MassHealth disagrees with this finding as the majority of the claims are allowable under MassHealth policy.

MassHealth reviewed the [68,400] claims that OSA found to be for non-emergency evaluation and management services. These claims represent services such as treatment for chest pain, migraines, lumps or masses in breast, abdominal pain, appendicitis, and abdominal aortic aneurysms. Emergency services such as these would be denied based on the OSA's findings.

Of this group of claims, a total of 44,066, representing $2,366,455 had a diagnosis code associated that is on the list of "always emergency" diagnosis codes. As previously discussed, this list was provided to OSA on December 16, 2013 and has been compiled based on extensive clinical guidance. Of this group of claims, $1 million represents claims for services that were provided in an emergency room or inpatient hospital setting, further supporting that these were allowable claims under the Limited program.

Another portion of these claims, representing $509,294, are claims that had an admit type "2-urgent," which MassHealth established, through the aforementioned Bulletin, are allowable under the Limited Program.

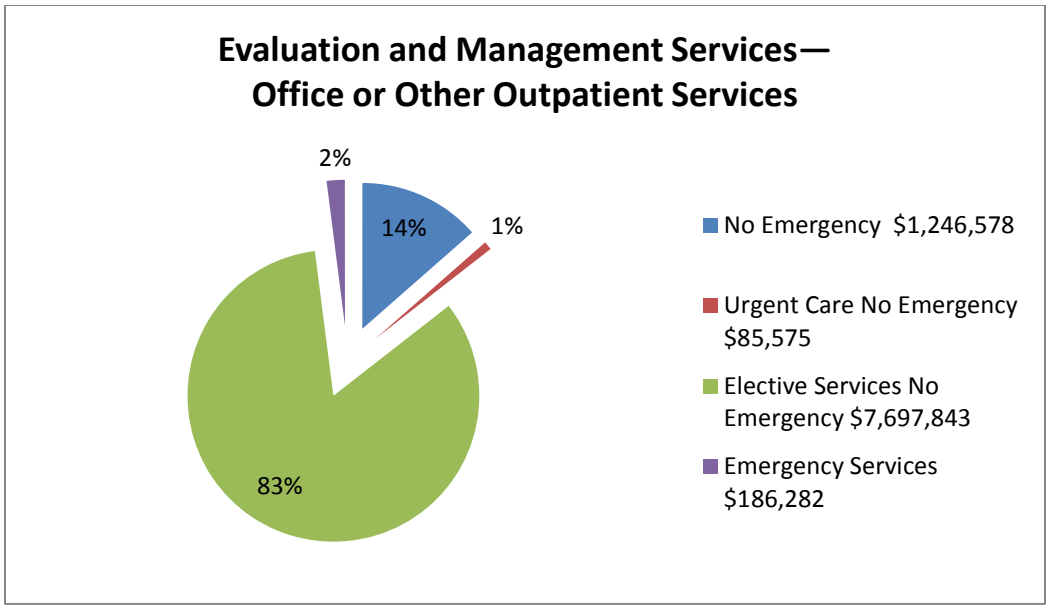
An additional group of these claims, representing $7,809,856, are for claims that specifically had either an "always emergency" diagnosis code OR had a Revenue Code 450 (Emergency Room), which as stated above, MassHealth has explicit policy including these types of claims in the Limited Program.

Auditor's Reply

In its response, MassHealth asserts that the majority of the claims for evaluation and management services that OSA questioned were allowable because the claims represented urgent conditions, services performed within an emergency department, or services in which the diagnoses was listed as "always emergency." However, as previously noted, (1) federal and state regulations do not allow states to receive FFP for urgent care provided to noncitizens; (2) emergency departments sometimes provide treatment for conditions that are not emergency-related, such as services for chronic and elective conditions; and (3) MassHealth's list of "always emergency" services is not limited to emergency services.

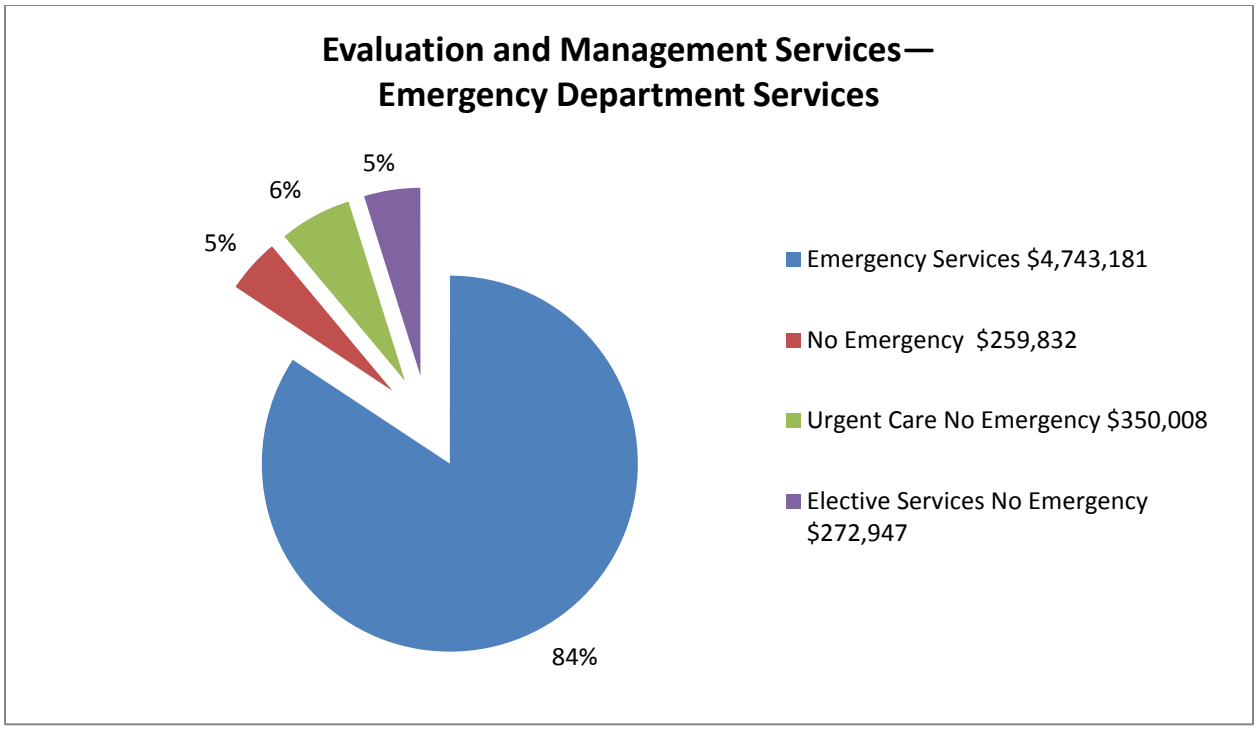
Furthermore, $9,029,996 (85%) of the total $10,628,893 in reported questionable claims for evaluation and management services involved services provided in physicians' offices or other outpatient settings. Of these payments, $7,697,843 represented claims for routine/elective services (Admittance Type 3) with an Emergency Indicator specifically listed as N. Officials at Boston Medical Center and Cambridge Health Alliance stated that they used Admittance Type 3 to indicate that a service was scheduled or planned, not an emergency service. In support of these statements, we found numerous instances in which a provider was paid for recurring (e.g., weekly) visits by the same member. Further, as stated in our report, CMS instructs providers to either populate the Emergency Indicator field with Y or leave it blank. The fact that providers specifically added an N adds further support to our conclusion that these services are non-emergency.

MassHealth states that claims for urgent care are allowed under the Limited Program. However, as illustrated in the chart below, only $85,575 of the $9,029,996 (1%) represents services for urgent care; thus, such services are not a major factor in this finding. Most of the services in this finding—$7,697,843, or 85%—represent elective (routine) services that the physicians specifically indicated as non-emergency services (via the Emergency Indicator field).



Our audit also found that emergency departments submitted claims totaling $5,625,968 for evaluation and management services for Limited Program members. We did not question the majority of these claims (84%), in which the providers indicated that the services involved the treatment of emergency conditions. We considered only $882,787 (16%) as non-emergency, because for those claims, the providers had specifically indicated that the services were not for emergencies.

Nonqualified aliens do require care for non-emergency conditions, but such care is not covered under the Limited Program. Consequently, the non-emergency evaluation and management claims that MassHealth paid for office or other outpatient services, including claims for urgent care, are questionable. In addition, while we are not suggesting that MassHealth's sub-regulatory guidance is not valuable, it should not outweigh the determinations made by healthcare providers. The chart below illustrates that the majority of the evaluation and management paid claims (84%) were for services to treat emergency medical conditions in emergency departments, which qualify for FFP. The chart also shows $882,787 paid to emergency departments for evaluation and management services for non-emergency medical conditions as a result of MassHealth's sub-regulatory guidance.



ii. Questionable Outpatient Behavioral-Health Services Totaling $1,049,914

During our audit period, MassHealth paid 7,200 claims (totaling $1,053,927) for outpatient behavioral-health services provided to Limited Program members, of which 7,171 claims (totaling $1,049,914, or 99.6%) were for non-emergency behavioral-health services. Behavioral-health services include diagnostic services; individual, family, and group therapy; case consultations; medication visits; and development testing.

The table below details the questionable claims paid for behavioral-health services for Limited Program members during the audit period.

Total Questionable Claims Paid for Behavioral-Health Services for Limited Program Members

Outpatient Behavioral-Health Service	Total Claims	Total Amount	Questionable Claims	Questionable Amount
Individual Therapy	4,126	$ 658,496	4,117	$ 657,502
Medication Visit	1,934	249,679	1,933	249,645
Diagnosis Services	674	96,171	655	93,186
Group Therapy*	290	29,363	290	29,363
Couple/Family Therapy*	89	13,436	89	13,436

Outpatient Behavioral-Health Service	Total Claims	Total Amount	Questionable Claims	Questionable Amount
Electroconvulsive Therapy	51	4,313	51	4,313
Other Services	8	1,270	8	1,270
Case Consultation	25	915	25	915
Unlisted Psychiatric Service	2	248	2	248
Family Consultation	1	36	1	36
Total	7,200	$1,053,927	7,171	$1,049,914

* Since MassHealth agreed that these claims should not have been paid, they are unallowable. For ease of presentation, these unallowable claims are included within the total questionable claims.

Authoritative Guidance

These claims were submitted using either CMS-1500 or UB04 claim forms. As previously noted, these claim forms include either an Emergency Indicator or an Admittance Type data field for MassHealth to use to determine whether services were for emergencies. However, as with evaluation and management services, MassHealth paid these behavioral-health service claims even though the Emergency Indicator was not Y or the Admittance Type was not 1 or 5. By not selecting Emergency Indicator Y or Admittance Type 1 or 5, physicians and facilities acknowledged that the services were non-emergency services.

Reasons for Questionable Behavioral-Health Payments

During our audit, MassHealth provided a list of 16 behavioral-health services that it would always pay for Limited Program members. However, MassHealth's decision to pay behavioral-health claims based on this list does not give proper consideration to information supplied by physicians and facilities on the claim forms, i.e., Emergency Indicator and Admittance Type. This information is essential to determine whether behavioral-health services provided to members are for emergency purposes.

Auditee's Response

Although MassHealth disagrees with the majority of this finding, it does agree with the determination that family and group therapy claims should have been unallowable.

Nearly two-thirds of the claims involved a diagnosis with some type of moderate to severe psychosis related to depression or bipolar disorder. Without proper monitoring and/or intervention, these members are at a significant risk of harming themselves or others.

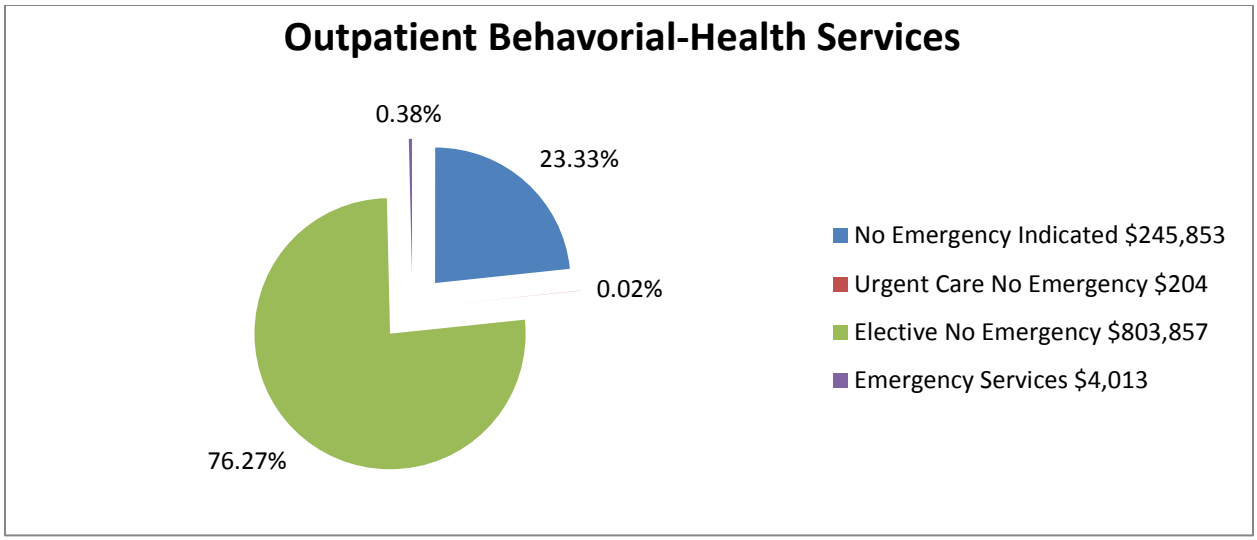
Included in this dataset was the diagnostic group of persons with anxiety disorders, in which clinical judgment reflects that persons with anxiety disorders may be at risk of harming themselves or others, particularly because untreated anxiety can often escalate to a panic state. Therefore, this is included on the list of "always emergency" diagnoses.

MassHealth agrees with the OSA's finding that family and group therapy claims, which make up 4% of the 7,200 claims referenced in this finding, are not allowable claims under MassHealth Limited, as they may not constitute emergency services. Instead, MassHealth will include these procedures in the development of the certification process and require that providers certify that these services were emergency services in order to be reimbursed in the future.

Auditor's Reply

The previously mentioned federal laws and regulations limit coverage for nonqualified aliens to "emergency services required after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity" to represent a serious health risk. Our report identified $1,049,914 in outpatient behavioral-health services (99.6% of the claims MassHealth paid for such services during our audit period) that were provided to Limited Program members for ongoing mental health conditions. In fact, our review of claims found that members received these services on a weekly to monthly basis over our 18-month audit period, indicating that they are chronic care and are not related to specific emergency incidents. Treatment for this type of chronic behavioral-health condition does not meet the definition of emergency care and therefore is not covered under the Limited Program. While these services (including monitoring and/or intervention) may be medically necessary, funding them through the Limited Program is not in accordance with federal laws and regulations.

Our detailed analysis of outpatient behavioral-health claims found that service providers only identified $4,013 as related to emergency services. According to federal and state regulations, these claims were eligible for FFP. For the majority of the remaining claims ($1,045,901), providers indicated that the services were not related to emergency medical conditions and/or were elective services. Therefore, these claims may not have been eligible for FFP. The chart below details both the questionable and the allowable outpatient behavioral-health claims that MassHealth paid.



iii. Questionable Inpatient Services Totaling $3,609,475

During our audit period, MassHealth paid 3,305 claims (totaling $25,785,351) for inpatient services provided to Limited Program members at hospitals;[7] of this amount, 481 claims (totaling $3,609,475, or 14%) were for non-emergency inpatient services. These services were paid for using a Standard Payment Amount at Discharge (SPAD). According to 114.1 CMR 36.02, a SPAD "is a hospital-specific all-inclusive payment for the first 20 cumulative acute days of an inpatient hospitalization; it is the complete fee-for-service payment for an acute episode of care."

Authoritative Guidance

These claims were submitted using UB04 claim forms. As previously noted, these claim forms include an Admittance Type data field for MassHealth to use to determine whether services were for emergencies. However, as with evaluation and management services, MassHealth paid for these inpatient services although the Admittance Type was not 1 (Emergency) or 5 (Trauma Center), both of which types indicate emergencies. By not selecting the Emergency or Trauma Center admittance types, the hospital facilities acknowledged that these services were non-emergency services.

The table below details the total claims paid during the audit period for inpatient services for Limited Program members by Admittance Type.

[7] This amount includes services totaling $8,747 provided at two acute psychiatric inpatient hospitals.

Total Questionable Claims Paid for Inpatient Services for Limited Program Members

Admittance Type Indicator	Description	Allowed Amount	Questionable Amount	Total Claims
1	Emergency	$20,473,710		2,577
2	Urgent	1,560,830*	$3,494,380	688
3	Elective	114,097*	115,095	37
5	Trauma Center	27,239		3
Total		$22,175,876	$3,609,475	3,305

* This represents labor and delivery claims. Throughout the report, we identified all claims with Admittance Type 2 or 3 as questionable. However, in accordance with federal and state regulations, labor and delivery claims are allowed as part of the Limited Program.

Claims for services with Admittance Type 3 (Elective), which total $115,095, do not constitute emergency services and should not be paid for Limited Program members. Services with Admittance Type 2 (Urgent), which total $3,494,380, could be interpreted as emergency services by readers of this report, but as previously noted, federal and state regulations do not define urgent care as emergency medical care. Providers reported services for labor and delivery as urgent ($1,560,830) or elective care ($114,097), which we considered allowable because federal and state laws and regulations explicitly require coverage for labor and delivery.

Reasons for Questionable Inpatient Payments

As with previously discussed services, MassHealth officials stated that they relied on physicians to determine whether the services provided to Limited Program members were for emergency medical conditions, but MassHealth does not have system edits to automatically deny claims that physicians have not indicated as treatment for emergency conditions.

Auditee's Response

MassHealth disagrees with this finding of [$3,609,475] in [questionable] inpatient claims as all of these claims are allowable under MassHealth policy and were for the treatment of emergent conditions.

Of the [481] inpatient claims, all were deemed allowable according to our policies. Of these, 692 claims, representing $5,089,158, referenced one of our criteria for determining an emergent claim, Admit Type 2-Urgent. (In fact, of the 692 claims, a total of 422 claims, representing $3,026,229, had two of the criteria used, both an emergency diagnosis and an Admit Type 2-Urgent reported on the claim.) The

remaining 33 claims, which total $195,244, contained an emergency diagnosis code, which is another criterion for determining emergent claims.

Because OSA did not take the "always emergency" diagnosis codes into account, examples of the types of claims OSA considers [questionable] as part of its review include: acute bacterial and viral infections such as pneumonia, blood infections and septicemia, which represents $33,561 of these claims; treatment and management of diabetes, diabetic comas, and ketoacidosis, a disorder of electrolytes that can lead to coma and death if not treated immediately, representing $56,563 of the claims; and treatment of renal disease, kidney failure, renal dialysis, acute kidney infections and acute kidney stones, an excruciatingly painful condition, representing $125,015 of the claims.

Also included in the services OSA believes MassHealth should not pay for under the Limited Program are treatment of malignant neoplasms, i.e. malignant cancers, representing $480,212, including emergent treatments for diagnosis, treatment (surgical and/or chemotherapy), and complications (including infections, low blood counts), all of which would likely result in death in most cases if left untreated. . . . Not only does the Limited Program guarantee labor and delivery services, but in these cases, life threatening conditions presented. Renal disease ($51,381 of the claims) including treatment of kidney failure, renal dialysis, and treatment of acute kidney infections; treatments for acute fractures (broken bones) and herniated low back discs, also are explicitly emergent conditions, and as such are on the "always emergency" list of diagnosis codes. As noted, MassHealth policy, which reflects extensive clinical research and judgment, allows for these types of emergencies to be covered for its Limited members.

Auditor's Reply

In its response, MassHealth states that all inpatient services were deemed allowable based upon its own sub-regulations. However, as previously noted, MassHealth's sub-regulations do not ensure compliance with federal and state laws and regulations. Section 1903(v) of the Social Security Act, and 42 CFR 440.255, only allow payments for medical services for nonqualified aliens when those services have resulted from what 42 CFR 440.255 refers to as "the sudden onset" of an acute emergency medical condition.

MassHealth provided examples of medical claims it considers allowable, such as diabetes, treatment of renal disease, kidney failure, kidney stones, and chemotherapy for cancer. While these conditions are serious, they represent chronic and urgent conditions, not acute emergency conditions. Therefore, treatment of these conditions is not eligible for FFP under current federal and state law.

If MassHealth had developed strong claim-processing controls to ensure adherence to state and federal laws and regulations, it would have denied the claims that our audit found as questionable, i.e., urgent, elective, and chronic care.

iv. Questionable Outpatient and Physician Services Totaling $12,563,932[8]

During our audit period, MassHealth paid 315,081 claims (totaling $20,904,947) for outpatient and physician services provided to Limited Program members, of which 194, 115 (totaling $12,563,932, or 60%) were for non-emergency services. These outpatient and physician services comprised emergency, non-emergency, urgent, elective, diagnostic, and preventive medical services.

Of the $12,563,932 in questionable claims, $6,777,844, or 54%, was reported as elective services; $4,871,672 or 39%, as non-emergency services; and the remaining $914,416, or 7%, as urgent-care services. While providers may have reported services for labor and delivery as urgent or elective care, we did consider these services allowed because federal and state laws and regulations explicitly require coverage for labor and delivery services for Limited Program members.

The table below details some of these questionable services, which were primarily elective services, paid during the audit period.

Examples of Claims Paid for Questionable Outpatient and Physician Services for Limited Program Members

Service Category	Examples of Services	Claims	Paid Amount
Radiology	X-rays, MRIs, ultrasounds, mammograms	32,223	$3,624,494
Pathology/Laboratory	Tests for STDs, lipids (cholesterol), pregnancy, HIV, hepatitis	100,597	1,300,656
Immunizations, Vaccines, and Injections	Influenza, TDAP (pertussis, or whooping cough), chicken pox / shingles	3,098	462,498
Ophthalmology and Otorhinolaryngology (ear, nose, and throat)	Hearing tests, eye exams, speech recognition tests, ear irrigations, esophageal reflux tests	938	151,096
Cardiovascular	Stress tests, echocardiograms, cardiovascular monitoring	10,456	$ 560,301

[8] Outpatient services and physician claims, totaling $20,904,947, exclude claims for end-stage renal disease. Additionally, outpatient services exclude evaluation and management services and behavioral-health services, which are discussed in separate sections of this report.

Authoritative Guidance

These claims were submitted using CMS-1500 and UB04 claim forms that, as described previously, include Emergency Indicator and Admittance Type data fields for MassHealth to use to determine whether services are for emergencies. However, MassHealth paid these claims even though the Emergency Indicator and Admittance Type data fields did not indicate that a Limited Program member was experiencing an emergency medical condition.

Reasons for Questionable Outpatient and Physician Payments

As with previously discussed services, MassHealth officials stated that they relied on physicians to determine whether the services provided to Limited Program members were for emergency medical conditions, but MassHealth does not have system edits to automatically deny claims that physicians have not indicated as treatment for emergency conditions.

Auditee's Response

MassHealth does not agree with this finding as the claims were for diagnoses and services that are allowable under MassHealth policy.

As previously discussed, OSA did not take into account sub regulatory guidance or the "always emergency" list of diagnosis codes. As a result, when looking at a snapshot of 64,999 of the 242,335 claims, 99% of the professional claims were for diagnoses found on the "always emergency" list. One hundred per cent (100%) of the facility claims that were paid included an emergency diagnosis, and almost 60% of those claims also included an admit type 2-Urgent.

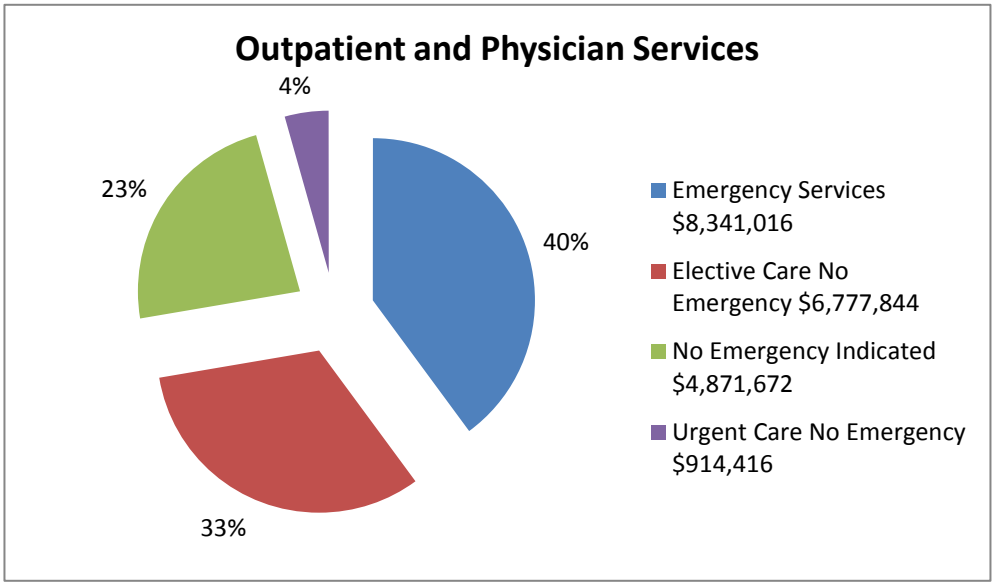
Some examples of the procedures that OSA does not consider allowable under Limited include the splinting of broken bones, the removal of necrotic and infected skin, and critical care services (i.e. ICU). These instances are significant examples of needed immediate care that fit within the governing principles of MassHealth Limited.

Auditor's Reply

In order to respond to this finding, MassHealth reviewed a sample of 64,999 claims for outpatient and physician service claims we identified as questionable. MassHealth states that nearly 100% of its sample was allowable because the outpatient and physician services were provided to treat either urgent conditions or services for which the diagnosis was listed as "always emergency." However, as previously noted, (1) federal and state laws and regulations do not cover urgent care provided to nonqualified aliens and (2) MassHealth's "always emergency" list is not limited to emergency diagnoses, resulting in payment of non-

emergency elective services, such as hearing tests, stress tests, and immunizations. Therefore, OSA disagrees with MassHealth's assertion that these claims should be allowable.

The chart below illustrates that 60% of outpatient and physician claims paid represented urgent, elective, or non-emergency care. These questionable services included influenza vaccinations, tests for speech recognition and esophageal reflux, stress tests, joint-pain treatment, and routine eye exams.



b. MassHealth paid questionable claims for outpatient prescription drugs totaling $3,656,068.

During the audit period, MassHealth paid $4,144,247 for outpatient[9] prescriptions for Limited Program members, of which 116,973 claims (totaling $3,656,068, or 88%) were for drugs and medical supplies to treat chronic and non-emergency conditions, contrary to 130 CMR 450.105(F). For example, Limited Program members received prescription drugs to treat chronic conditions such as high blood pressure, asthma, arthritis, and diabetes. They also received prescriptions for medical supplies, such as test strips, lancets, and alcohol swabs. In addition, MassHealth reimbursed pharmacists for 80,460 claims, totaling $2,540,320, for drugs and

[9] We defined outpatient prescriptions as those filled by pharmacies (e.g., CVS, OSCO). We are not questioning any prescription medications provided to noncitizens while they were hospitalized as inpatients, because inpatient care is generally provided to treat emergency medical conditions.

medical-supply prescriptions that violated the 30-day supply restriction for Limited Program members.[10]

With regard to prescription drugs for chronic conditions, the table below presents the 15 largest drug classifications paid for these members, on an outpatient basis, during the 18-month audit period; 14 of them treat chronic and non-emergency conditions.

Largest 15 Categories of Paid Outpatient Prescribed Drugs and Medical Supplies

Drug Classification Category	Paid Amount	MassHealth Approved Drug Name[11]	Comparable Brand Name*	Medical Condition
Cardiovascular	$ 538,843	Metoprolol, Diovan, Atorvastatin, Simvastatin, Crestor, Revatio	Toprol, Diovan, Lipitor, Simvastatin, Crestor	High blood pressure, elevated cholesterol, pulmonary arterial hypertension
Antibiotics	485,558	Amoxicillin, Clarithromycin, Tetracylines, Bacitracin	Amoxicillin, Clarithromycin, Tetracylines, Bacitracin	Infection
Antineoplastics	464,088	Gleevec, Xalkori, Taceva, Lupron	Gleevec, Xalkori, Taceva, Lupron	Cancer
Antihyperglycemics	408,377	Lantus, Actos, Humalog	Lantus, Actos, Humalog	Diabetes
Anti-infectives/ miscellaneous	324,779	Azole, Stribild, Barclude	Azole, Stribild, Barclude	Fungal infections, HIV, hepatitis B
Antiasthmatics	319,336	Advair, Spirivia, Flovent	Advair, Spirivia, Flovent	Asthma
Ear, nose, and throat preps	176,518	Combigan, Cosopt, Restasis	Combigan, Cosopt, Restasis	Glaucoma, dry eye
Unclassified drug products	163,305.	Alendronate, Evista, Vesicare, Tamsulosin	Alendronate, Evista, Vesicare, Flomax	Osteoporosis, urinary incontinence, enlarged prostate
Blood	133,647	Clopidogrel, Aspirin, Neulasta	Plavix, Aspirin, Neulasta	Antiplatelet, hematopoietic
Cardiac drugs	129,188	Nifedipine, Amlodipine, Diltiazem	Procardia, Norvasc, Cardizem	High blood pressure and chest pain
Diagnostic	127,026	Freestyle Test Strips, Precision Monitors	Freestyle Test Strips, Precision Monitors	Diabetes monitoring
Antiarthritics	124,594	Enbrel, Celebrex, Humira	Enbrel, Celebrex, Humira	Arthritis

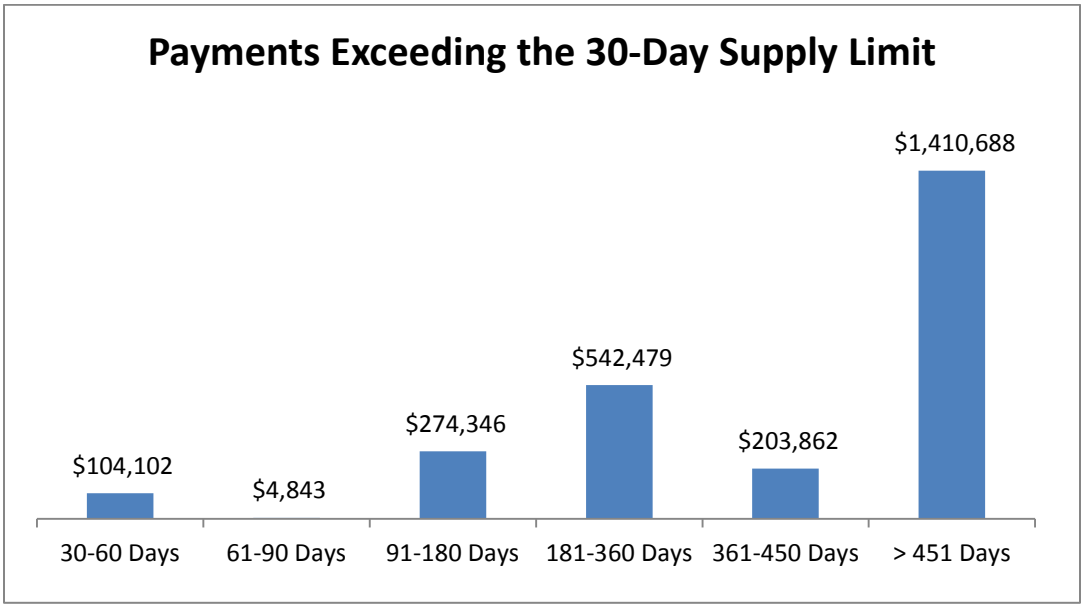
[10] There may be significant overlap between the $2,540,320 questioned here and the $3,656,068 questioned above.

[11] MassHealth follows the generic substitution laws of the Commonwealth. MassHealth only allows prescriptions to be filled with brand-name drugs if a U.S. Food and Drug Administration A-rated generic is not available and proper prior authorization has occurred.

Drug Classification Category	Paid Amount	MassHealth Approved Drug Name[11]	Comparable Brand Name*	Medical Condition
Gastrointestinal	120,591	Omeprazole, Creon, MiraLAX	Prilosec, Creon, MiraLAX	Heartburn, stomach ulcers, acid reflux, digestive disorders, constipation
Psychotherapeutic drugs	108,281	Olanzapin, Quetiapine, Abilify, Cymbalta	Zyprexa, Seroquel, Abilify, Cymbalta	Schizophrenia, bipolar disorder, depression, anxiety
CNS drugs	87,541	Namenda, Banzel, Levetiracetam, Gabapentin	Namenda, Banzel, Keppra, Neurotin	Dementia, Alzheimer's disease, epilepsy
Total	$3,711,673			

* Information regarding certain brand names and medical conditions was obtained from www.drugs.com. According to that website, "the drugs.com Drug Information Database is powered by four independent leading medical-information suppliers: Wolters Kluwer Health, American Society of Health-System Pharmacists, Cerner Multum, and Thomson Reuters Micromedex."

Further, our examination of refills identified 2,843 members who received multiple refills spanning periods of more than 30 days, sometimes exceeding a year. The graph below illustrates the amounts paid for prescriptions exceeding the 30-day supply limit, grouped by the total days' supply.



Below are examples of members who received multiple prescription refills exceeding the 30-day supply limit during our 18-month audit period.

- One member received a 480-day supply of cancer medication (Gleevec), totaling $92,268.

- Two hundred twenty-two members each received more than a 500-day supply for a single prescription, including refills totaling $224,984.

- One member received 234 prescription refills for 26 different drugs, including aspirin, eye drops, calcium and vitamin D supplements, stool softeners, laxatives, alcohol swabs, freestyle test strips, Spiriva and Flovent inhalers, and cholesterol medication (Simvastatin), totaling $9,366.

Agency Requirements

MassHealth has published two provider notifications that describe policies and procedures for pharmacists to follow when filling prescriptions for Limited Program members. First, MassHealth published the guidance document Pharmacy Facts Number 7, dated February 24, 2005 (Pharmacy Facts), which informs pharmacists that Limited Program members are covered for antibiotics and emergency medicines only. Further, Pharmacy Facts states,

> *In the past we have reminded pharmacists that when, in their opinion, an emergency exists they should call UMass [Drug Utilization Review] unit during business hours.*

Also, All Provider Bulletin 101 gave guidance to providers on reimbursable services for Limited Program members. Among other things, it established that prescriptions and any refills are limited in total to a 30-day supply.

Reasons for Payment of Ineligible Prescriptions

MassHealth has not developed policies and procedures to adequately implement Pharmacy Facts and All Provider Bulletin 101 and has not created risk-based monitoring activities specific to Limited Program prescription claims to identify unusual trends and billing anomalies. It also has not implemented system edits in its Prescription On-Line Processing System to identify and deny payment of non-emergency drugs and medical supplies and deny claims that exceed the 30-day supply limit.

Finally, though antibiotics are always covered, payment for other medicines requires a decision from MassHealth. MassHealth officials stated that in making that decision, the Drug Utilization Review unit relies solely on pharmacists to determine whether a medical emergency exists. Consequently, while Pharmacy Facts appears to indicate that MassHealth has created effective controls to restrict coverage of prescription drugs for Limited Program members, in reality MassHealth has given this control to pharmacists.

Auditee's Response

OSA found that MassHealth paid over $3.6 million for [questionable] outpatient prescriptions for members in the Limited benefit plan. However, according to MassHealth data, during the audit period, MassHealth paid a total of $709,077 in Limited pharmacy claims. The [questionable] dollar amount stated by the OSA does not correlate to MassHealth data and is significantly higher than the entire total paid out for the audit period.

Upon further analysis of the data, MassHealth found that the main source of discrepancy was due to inclusion of members outside of the benefit plan of interest. By including members enrolled in benefit plans other than solely Limited in its analysis, the OSA included additional inappropriate pharmacy claims. These additional inappropriate claims were due to the OSA's inclusion of claims paid for members in the aid category "TT." Aid categories are codes used by MassHealth's eligibility system to determine for which benefit plan a member is eligible. The aid category "TT" represents members eligible for both MassHealth Limited and MassHealth Essential, meaning these members are entitled to expanded benefits beyond just those of MassHealth Limited, including full pharmacy benefits. During the audit period, certain individuals were eligible for coverage under both benefit plans, and were coded as such. Per 130 CMR 504.002(F)(2){e}, MassHealth Essential members, including those dually eligible for MassHealth Limited, were entitled to full MassHealth pharmacy benefits. Members in this "TT" aid category constitute the entirety of the discrepancy between OSA and MassHealth data. These claims were all allowable under the MassHealth Essential plan and were, therefore, appropriately paid. . . .

OSA also states that medication in the Limited program is restricted to a 30 day supply in total; however, MassHealth's pharmacy regulations and sub-regulatory guidance do not limit prescription supplies. These regulations and sub-regulatory guidance do provide that emergency supplies must be for at least 72 hours; however, there is no total limit under either state or federal law. See. e.g., 42 USC 1396r-8(d)(5)(B), 130 CMR 406.422(C). MassHealth has a standard limitation for each fill or refill of a prescription of a 30-day supply (with certain exceptions). 130 CMR 406.413. Bulletin 101, MassHealth's sub-regulatory guidance relied upon by the OSA, refers to this general rule, but does not establish an overall cap. The 80,460 claims, totaling $2,540,320, for drugs and medical-supply prescriptions that the OSA finds violates the 30-day supply restriction were also for members in the "TT" aid category, and these refills were all allowable under their richer benefit plan. Therefore, any restrictions to the Limited program do not apply to these claims.

Auditor's Reply

In this finding, OSA highlights MassHealth's questionable payment of prescriptions and medical supplies to treat Limited Program members' chronic medical conditions, contrary to federal and state laws and regulations. We also state that MassHealth paid for prescription refills up to 18 months for these members, which indicates that refills were prescribed for chronic, not acute emergency, medical conditions. However, MassHealth does not address our primary issue; rather, it introduces information not previously shared with OSA regarding the TT aid category.

This new information, however, does not change our finding. Moreover, it draws attention to an additional problem with MassHealth's administration of the Limited Program. First, MassHealth's Essential Program, among other things, provides expanded medical coverage (non-emergency services) to certain noncitizens, including those in the TT aid category. All costs incurred through the Essential Program must be accounted for separately, since these costs are totally funded by the Commonwealth and are not eligible for FFP. While we acknowledge that members with dual eligibility (eligibility for both the Limited Program and MassHealth Essential) have been authorized by MassHealth to receive expanded pharmacy services, MassHealth has improperly commingled the cost of these non-emergency expanded pharmacy services with the costs of emergency pharmacy services in the Limited Program. This accounting caused MassHealth to receive FFP that may not have been appropriate for all these non-emergency pharmacy services, which total $3,656,068.

Finally, MassHealth contends that state regulations do not limit prescription and medical supplies to a 30-day supply for Limited Program members. This is not accurate. MassHealth specifically prohibits emergency prescription refills under 130 CMR 406.411(B). This regulation applies to all MassHealth members, including those in the Limited Program. Also, MassHealth limits the total days' supply of emergency prescriptions to 30 days in All Provider Bulletin 101. This bulletin applies to all Limited Program members. These limitations are detailed below:

From 130 CMR 406.411(B):

> *When the pharmacist determines that an emergency exists, the MassHealth agency will pay the pharmacy for at least a 72-hour,* ***nonrefillable*** *supply of the drug in compliance with state and federal regulations* [emphasis added].

From MassHealth All Provider Bulletin 101:

- *Medically necessary drugs, including . . . drugs prescribed by a physician, that are required in conjunction with any of the medical services listed [in the bulletin]. Such prescriptions and any refills are limited* ***in total*** *to a 30-day supply* [emphasis added].

Thus MassHealth does have regulations and policies that limit prescription drug coverage for Limited Program members.

c. MassHealth paid unallowable dental-service claims totaling $1,724,733.

During the audit period, MassHealth paid 87,333 dental-service claims (totaling $3,111,272) for Limited Program members, of which 47,533 claims (totaling $1,724,733, or 55%) were for the treatment of non-emergency conditions, contrary to 130 CMR 450.105(F). The unallowable dental services included routine dental examinations, cleanings, and X-rays; fluoride treatments; minor dental restorations; and orthodontics.

The table below summarizes the $1,724,733 of unallowable dental payments made during the audit period.

Total Unallowable Claims Paid for Dental Services for Limited Program Members

Dental Service Group	Amount Paid	Number of Paid Claims
Preventive (cleanings, fluoride)	$ 477,347	9,845
Radiographs (X-rays)	384,206	8,766
Case Presentation*	350,629	18,455
Diagnostics (examinations)	249,129	8,967
Exodontic (tooth extractions)	123,207	555
Restorative (fillings)	87,194	681
Endodontic (root canals)	27,646	49
Anesthesia (Novocain)	13,405	124
Periodontic (gum treatment)	6,138	39
Orthodontic (dental braces)	4,738	24
General Services (house call, behavior management)	1,094	28
Total	$1,724,733	47,533

* Dental enhancement (case presentation) fees are available to community health centers and hospital-licensed health centers. These fees are intended to increase access to dental covered services by implementing and reporting on measures to increase the capacity and volume of dental services delivered. Case presentation fees may be billed when other dental procedures are performed on the same day. This fee may be billed once per dental user per day.

Agency Requirements for Dental Services

Dental services are subject to the previously discussed 130 CMR 450.105(F).

Post-Audit Action

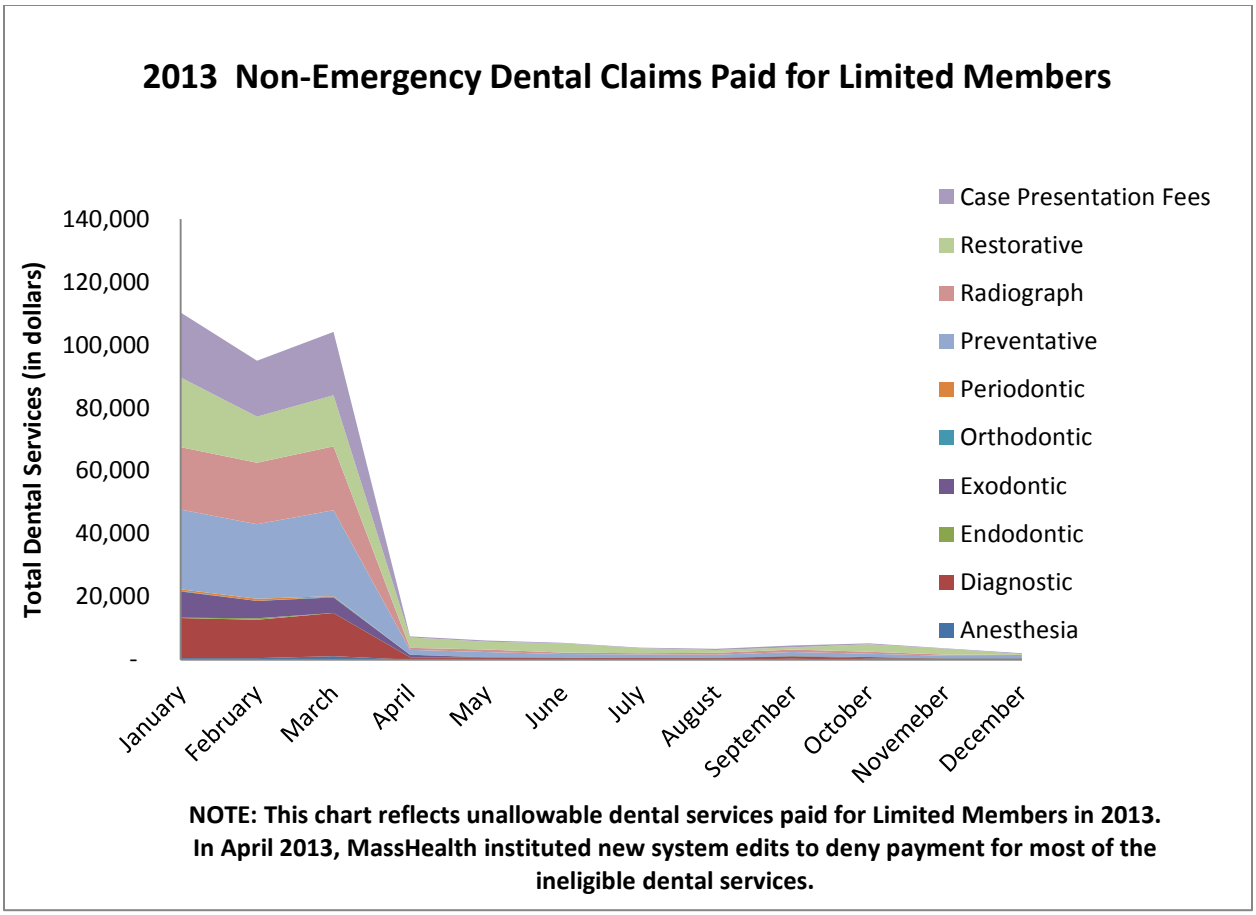
Our audit served as an impetus for MassHealth to align its dental coverage for Limited Program members with 130 CMR 450.105(F). Beginning in April 2013, MassHealth implemented system edits to identify and deny payment for non-emergency dental services for the Limited Program.

MassHealth officials stated that the new system edits limited dental payments to seven specific procedures: problem-focused oral evaluations; periapical X-rays (first film); periapical X-rays (additional films); panoramic X-rays; extractions of erupted teeth or exposed roots; surgical removals of erupted teeth; and palliative (emergency) treatment of dental pain. The MassHealth Dental Program medical director provided an example of the effect of this service-coverage change on members: If a Limited Program member presents with a toothache, and the diagnosis is to either perform a root canal and crown or extract the tooth, MassHealth will now only pay to "extract the offending agent."

In this example, the financial effect would be cost savings of $1,319 to the Commonwealth, calculated as follows:

Dental Procedure	Cost
Root canal and porcelain-fused crown	$ 1,458
Surgical removal of erupted tooth	139
Cost savings	$ 1,319

Since MassHealth implemented these system edits in April 2013, payments for non-emergency dental services have decreased from a monthly average of $103,191 during the first three months of 2013 to an average of $4,621 for the remainder of the year, a 96% decrease in average monthly costs. This reduction is depicted in the graph below.



As mentioned above, MassHealth paid an average of $4,621 per month for non-emergency dental services from April 2013 through December 2013. Its payment for these dental services indicates that MassHealth has not created the edits necessary to eliminate payment entirely for non-emergency dental services for Limited Program members. The table below identifies the 910 claims, totaling $41,586, for dental services since April 2013 that MassHealth paid, contrary to its newly implemented system edits.

Total Unallowable Claims Paid for Dental Services for Limited Program Members April 2013 through December 2013

Procedure Code	Procedure Code and Description	Number of Claims Paid	Paid Amount	Service Group
D0120	Periodic oral examination—established patient	150	$ 3,018	Diagnostic
D0150	Comprehensive oral evaluation—new or established patient	58	2,146	Diagnostic
D0160	Detailed and extensive oral evaluation—problem focused, by report	4	240	Diagnostic
D0210	Intraoral complete series (including bitewings)	39	2,691	Radiograph
D0270	Bitewing—single film	1	13	Radiograph

Procedure Code	Procedure Code and Description	Number of Claims Paid	Paid Amount	Service Group
D0272	Bitewings—two films	16	352	Radiograph
D0274	Bitewings—four films	60	1,986	Radiograph
D1110	Prophylaxis—adult	208	10,255	Preventative
D1208	Topical application of fluoride	8	227	Preventative
D2160	Amalgam—three surfaces—primary or permanent	4	440	Restorative
D2330	Resin-based composite—one surface—anterior	94	6,298	Restorative
D2331	Resin-based composite—two surface—anterior	103	8,930	Restorative
D2391	Resin-based composite—one surface—posterior	9	459	Restorative
D2392	Resin-based composite—two surfaces—posterior	4	310	Restorative
D7220	Removal of impacted tooth—soft tissue	5	980	Exodontic
D7230	Removal of impacted tooth—partially bony	1	232	Exodontic
D9220	Deep sedation / general anesthesia—first 30 minutes	1	114	Anesthesia
D9221	Deep sedation / general anesthesia—each additional 15 minutes	2	178	Anesthesia
D9450	Case presentation, detailed and extensive treatment planning	143	2,717	Case Presentation
	Total	910	$41,586	

Reasons for Unallowable Dental Payments

These unallowable payments occurred because MassHealth's Dental Program did not (1) develop dental-treatment policies and procedures specific to Limited Program members, (2) establish claim-processing system edits to ensure that payment was made only for emergency dental services, and (3) adequately monitor provider claims to identify trends and anomalies that could indicate fraud, waste, and abuse.

Auditee's Response

MassHealth generally agrees with this finding for the audit period and has already taken steps to implement changes to address this issue as, effective April 2013, MassHealth implemented additional system changes to only pay specific dental procedure codes for members with Limited Coverage.

MassHealth found that all but 1,983 claims, representing $73,891, were in fact unallowable. The 1,983 claims were non-emergency services paid for members in the Aid Category "TT" which represents members who have both the Limited Benefit Plan and Essential FFS benefit plan. As described above, MassHealth Members dually eligible for both MassHealth Limited and MassHealth Essential were entitled to all MassHealth Essential benefits. The 1,983 paid dental claims the OSA identified were covered MassHealth Essential benefits that MassHealth properly paid.

MassHealth understands that changes were necessary and has found success with the systems edit made in April 2013. OSA evaluated data from the period after these edits were made to validate our program integrity improvement efforts. MassHealth retrieved all dental claims paid April 1, 2013 through December 31, 2013, and found that of the 24,434 claims, all were paid correctly. While 774 of those claims represented claims for non-emergency services, 552 of these claims were, again, for members in Aid Category "TT," and were therefore appropriate and allowable claims under the Essential benefit plan. MassHealth, however, agrees with OSA that 222 claims, representing $12,873, were paid erroneously post–system edit. The error resided solely in claims paid for members in the Aid Category AR, an aid category that became obsolete on January 1, 2014. As such, MassHealth is confident that the system edits are now fully functional without issue.

Auditor's Reply

In its response, MassHealth indicates the 24,434 dental claims paid between April 1, 2013 and December 31, 2013 were all paid correctly and therefore allowable. However, MassHealth only addresses 774 of these claims and does not offer explanation for the remaining 23,660 claims. Therefore, OSA still asserts that the 23,660 claims were also unallowable.

As previously reported, MassHealth created the Limited Program to provide emergency services for nonqualified aliens. Because this program was designed to be in accordance with federal laws and regulations, all costs related to it are eligible for FFP. MassHealth Essential provides expanded medical coverage (not just emergency coverage) to certain categories of nonqualified aliens. The costs incurred through this program are not eligible for FFP because they are not for emergency services as the federal laws and regulations require. Therefore, all costs incurred through MassHealth Essential must be fully funded by the Commonwealth. While we acknowledge that members with dual eligibility (the Limited Program and MassHealth Essential) are authorized to receive expanded dental services, MassHealth has improperly commingled the emergency and expanded medical coverage for members in the "TT" aid category within the Limited Program. By improperly accounting for the expanded medical services, MassHealth may have improperly received FFP for this $73,891 of payments.

d. MassHealth paid unallowable rehabilitation/therapy claims totaling $1,904,332.

During the audit period, MassHealth paid a total of $1,909,919 for rehabilitation/therapy services for Limited Program members, of which 6,617 claims (totaling $1,904,332, or 99.7%) were for non-emergency services. The rehabilitation/therapy services included 6,637 claims for various types of physical and occupational therapy, speech and language therapy, and other therapeutic treatments. The majority of the unallowable claims ($1,793,271, or 94%) were for

physical-therapy services; the remaining claims ($111,061, or 6%) were for other services such as occupational therapy, orthotics, and speech/language therapy. The table below details the unallowable rehabilitation/therapy claims paid for Limited Program members during the audit period.

Total Unallowable Claims Paid for Rehabilitation/Therapy Services for Limited Program Members

Service Type	Procedure Code	Procedure Code Description*	Paid Claims	Amount Paid	Total by Service Type
Physical Therapy	97001	Physical therapy evaluation	711	$ 201,665	
	97002	Physical therapy re-evaluation	74	22,759	
	97010	Application of a modality to 1 or more areas; hot or cold packs	227	61,541	
	97012	Application of a modality to 1 or more areas; traction, mechanical	28	7,981	
	97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)	160	43,554	
	97018	Application of a modality to 1 or more areas; paraffin bath	1	371	
	97022	Application of a modality to 1 or more areas; whirlpool	49	13,021	
	97032	Application of a modality to 1 or more areas; electrical stimulation (manual) each 15 minutes	7	1,735	
	97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes	24	7,212	
	97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes	195	57,430	
	97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	3,680	1,054,148	
	97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	140	41,403	
	97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	12	3,454	
	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)	80	23,815	
	97139	Unlisted therapeutic procedure (specify)	1	325	

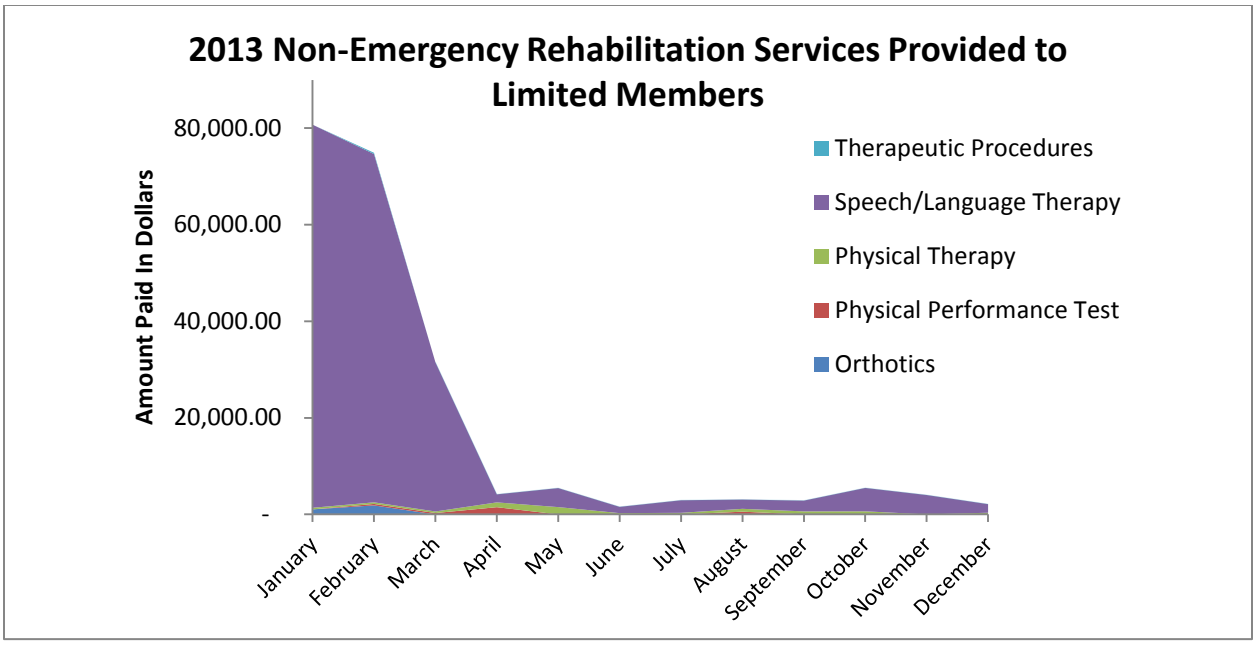
Service Type	Procedure Code	Procedure Code Description*	Paid Claims	Amount Paid	Total by Service Type
Therapeutic Procedures	97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes	849	252,857	$1,793,271
	97150	Therapeutic procedure(s), group (2 or more individuals)	13	3,098	
	97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes	208	61,614	
	97535	Self-care/home management training (e.g., activities of daily living and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices / adaptive equipment) direct one-on-one contact by provider, each 15 minutes	40	11,615	76,327
Occupational Therapy	97003	Occupational therapy evaluation	77	22,948	
	97004	Occupation therapy re-evaluation	2	697	23,645
Tests and Measurements	97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	21	5,983	5,983
Orthotics and Prosthetic Management	97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes	14	4,026	4,026
Development and Cognitive Skills	97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes	3	770	770
Speech and Language Therapy	92506	Evaluation of speech, language, voice, communication, and/or auditory processing	1	310	310
Total			6,617	$1,904,332	$1,904,332

* Procedure code descriptions are drawn from MassHealth pricing regulations.

Post-Audit Action

Our audit served as an impetus for MassHealth to develop the necessary system edits to ensure payment for emergency services only. Specifically, MassHealth identified certain rehabilitation/therapy procedure codes that it would no longer cover for Limited Program members and implemented system edits to deny claims for those procedure codes. Since MassHealth implemented these system edits in April 2013, payments for non-emergency

rehabilitation/therapy services have decreased to an average of $3,617 per month, as shown in the graph below.



As illustrated above, MassHealth has not fully eliminated payments for non-emergency rehabilitation/therapy services for Limited Program members. MassHealth agreed with our results and informed us that its review of emergency services was not complete and that this had caused the payment of certain non-emergency procedures.

Reasons for Unallowable Rehabilitation/Therapy Payments

The unallowable payments occurred because MassHealth did not have specific policies, procedures, and system edits to prohibit payment of claims for non-emergency rehabilitation/therapy services for Limited Program members in accordance with 130 CMR 450.105(F).

Auditee's Response

MassHealth agrees with this finding, with respect to the audit period, however, effective April 2013, MassHealth enhanced the "never pay" list of procedure codes to ensure that these codes are denied if submitted for services provided to a MassHealth Limited enrollee. This list consists of procedure codes, that despite other criteria that may indicate emergency services, these procedures are not allowable under Limited. As a result, since April 2013, these codes no longer pay for MassHealth Limited members.

Recommendations

In order to address our concerns over payment for non-emergency inpatient and outpatient services for Limited Program members, including evaluation and management services, behavioral-health services, inpatient services, and outpatient and physician services, we recommend that MassHealth take the following action:

- Establish system edits within its claim-processing system to use the Emergency Indicator and Admittance Type billing indicators to determine whether inpatient and outpatient services provided by physicians and facilities were to treat emergency medical conditions.

In order to address our concerns over payment for non-emergency drug and medical supply prescriptions for Limited Program members, we recommend that MassHealth take the following actions:

- Establish policies and procedures requiring physicians to notify pharmacists when prescribing a drug or medical supply for treating an emergency medical condition. All other prescriptions, except antibiotics, should be self-paid.
- Establish system edits within the Prescription On-Line Processing System to effectively detect and deny claims for prescriptions filled in excess of MassHealth's 30-day supply restriction.

In order to address our concerns over payment for non-emergency dental services for members, we recommend that MassHealth take the following actions:

- Develop dental-treatment policies and procedures specific to Limited Program members.
- Establish a system edit within the Dental Program's claim-processing system to allow payment for a case presentation fee only when a Limited Program member receives an allowed emergency service.
- Reexamine the system edits it established during our audit, since some of the unallowable dental procedures are still being paid for.

In order to address our concerns over payment for non-emergency rehabilitation/therapy services for members, we recommend that MassHealth take the following actions:

- Complete its review of rehabilitation/therapy services for Limited Program members.
- Develop additional system edits to ensure that it no longer pays for any non-emergency rehabilitation/therapy procedures.

In order to address our concerns over the management oversight of the Limited Program, we recommend that MassHealth take the following actions:

- Update and reissue the MassHealth All Provider Bulletin regarding reimbursable services for Limited Program members to reflect recent changes made to their coverage.
- Create risk-based monitoring activities specific to Limited Program claims to ensure compliance with 130 CMR 450.105(F).

CONCLUSIONS

The purpose of our audit was to determine whether the claims MassHealth paid for Limited Program members were allowable under state and federal laws and regulations. To that end, we examined medical claims paid for Limited Program members for the period July 1, 2011 through December 31, 2012. We reviewed four major categories of services provided to Limited Program members: (1) inpatient and outpatient medical services, (2) prescription drugs and medical supplies, (3) dental services, and (4) rehabilitation/therapy services.

Our audit results indicate that MassHealth had not developed and implemented effective controls to ensure that claims paid for Limited Program members comply with Chapter 118E, Section 16D, of the Massachusetts General Laws; 130 Code of Massachusetts Regulations (CMR) 450.105(F); 42 U.S. Code 1396b[v][2][A]; and 42 Code of Federal Regulations 440.255(b). During our audit period, MassHealth paid for $35,137,347 of questionable or unallowable services provided to Limited Program members to treat non-emergency, urgent, elective, and chronic conditions. MassHealth should improve its operational controls over the MassHealth Limited Program by establishing service policies and procedures specific to Limited Program members, establishing claim-processing system edits to ensure that payment is made only for emergency services, and developing risk-based monitoring activities to ensure that claims are processed and paid in accordance with its regulations.

During our audit, MassHealth examined claims paid for Limited Program members and created new system edits to control these medical claims. MassHealth's implementation of system edits resulted in a reduction in claims paid for dental and rehabilitation/therapy services. We recommend that MassHealth use the information provided in this report to apply additional controls and system edits to prevent and deny claims that do not comply with 130 CMR 450.105(F).

Auditee's Closing Response

> *In order to better understand the standard of review that MassHealth would anticipate be used in an audit such as this one, it should be noted that MassHealth looks to audits performed by the Federal Office of the Inspector General (OIG) for guidance on the operation of its programs. In past audits of Limited benefit plans, the main focus of the OIG has been on whether the state is in fact complying with its own policies and procedures in the implementation of the benefit plan. In the OIG's Review of New Jersey's Medicaid Emergency Payments Program for Nonqualified Aliens, the objective of the audit was defined as "determin[ing] whether the State agency had adequate internal controls to ensure that for, nonqualified aliens, Federal Medicaid reimbursement was claimed only for* ***what it defined as emergencies****," [emphasis added]. In that review, New Jersey also maintained a list of more than 4,000 codes that it defined as emergencies, and for those claims related to diagnoses not on this list, a certification process was*

used. In using the same standard, it would be expected that the focus of the [Office of the State Auditor's, or OSA's] audit would be to determine whether MassHealth is complying with its own policies and procedures. . . .

As mentioned earlier in the response, MassHealth has implemented many improvements to ensure that our program integrity measures are robust, as MassHealth continually works to update and strengthen its programs.

MassHealth created a workgroup in early 2013 to focus on improvements to the Limited program. The workgroup researched other states' policies and audits of those states' programs. The workgroup also implemented joint program and clinical reviews of claims and edits, created and programmed a "never pay" list for the Limited program, identified additional claims scenarios that should "always pay" as they are inherently emergent in nature, as well as identified seven distinct dental codes that should pay as emergency, while establishing restrictions on all other dental codes. We believe that these changes have resulted in minimizing the number of unallowable claims identified by the OSA.

To further protect against variations in coding, MassHealth is in the process of developing a certification process for claims that are denied as not covered under the Limited Benefit Plan. The purpose of this certification process is to make MassHealth less reliant on the judgment and coding habits of individual providers in identifying emergency situations and services, yet allow for individual consideration by enhancing the agency's ability to independently determine the clinical appropriateness of claims submitted for members as emergency. Providers will be required to submit a certification form to MassHealth's Office of Clinical Affairs to seek reconsideration of claims that [are] denied as not covered under the Limited Benefit Plan. The certification form is a signed attestation by the treating clinician that the Limited member needed emergency services as defined in applicable federal and state law.

This enhancement will improve internal controls when adjudicating claims submitted for members with Limited Coverage, while also ensuring that MassHealth meets its obligations under federal law for this member population. MassHealth expects the process to be communicated to the provider community by the first quarter of 2015, and anticipates having it operationalized by July 1, 2015.

Auditor's Reply

We commend MassHealth for forming a work group and making improvements to the Limited Program. MassHealth has made significant improvements in limiting payments for non-emergency dental and rehabilitation/therapy services by limiting them to specific procedure codes. However, for other medical service areas, MassHealth continues to use unreliable data fields, e.g., revenue codes and primary diagnosis codes, to determine the validity of claims for the Limited Program. Our report indicates that MassHealth should instead rely more heavily on the Emergency Indicator and Admittance Type field codes on the claim forms.

MassHealth's pending provider certification process for denied claims, as described in its response, while well intended, may not reduce the payment of unallowable claims, but may instead provide an opportunity for providers to seek payment for the claims MassHealth is presently denying. We

believe that a more effective use of this certification process would be for MassHealth to first adjudicate claims based solely on Emergency Indicator and Admittance Type as we described in this report. This would greatly reduce the payments made for urgent, chronic, and elective services in this program. Then, if a provider's services were for emergency medical conditions, the certification process would give the provider the opportunity to present the case to MassHealth clinical experts for a final ruling and payment. This method could help ensure that state and federal taxpayer dollars are protected and only spent for emergency services for Limited Program members.