



Commonwealth of Massachusetts
Office of the State Auditor
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Making government work better

Issued March 15, 2014

Office of the State Auditor – Annual Report Medicaid Audit Unit

March 15, 2013 – March 14, 2014



OFFICE OF THE STATE AUDITOR

MEDICAID AUDIT UNIT

March 15, 2013 – March 14, 2014

Introduction

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit (the Unit) for the purposes of preventing and identifying fraud, waste, and abuse in the MassHealth system and making recommendations for improved operations. The state's fiscal year 2014 budget (Chapter 38 of the Acts of 2013) requires that the OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 14, 2014 that includes (1) "all findings on activities and payments made through the MassHealth system"; (2) "to the extent available, a review of all post-audit efforts undertaken by MassHealth to recoup payments owed to the commonwealth due to identified fraud and abuse"; (3) "the responses of MassHealth to the most recent post-audit review survey, including the status of recoupment efforts"; and (4) "the unit's recommendations to enhance recoupment efforts."¹

This report, which is being submitted by the OSA in accordance with the requirements of Chapter 38, provides summaries of two OSA audits involving MassHealth's controls over (1) claims for drug screenings and (2) claims for prescription and selected over-the-counter medications; an audit encompassing two MassHealth-contracted dental providers; an audit of the fiscal and programmatic operations of a MassHealth-funded nursing home; audit work conducted by the

¹ Chapter 38, Section 2, of the Acts of 2013.

OSA at three human-service providers that received Medicaid funding; four MassHealth audits that are currently underway; and all corrective measures and related outcomes reported by the auditees, including MassHealth, in relation to our findings and recommendations.

For fiscal year 2014, the appropriation for the Medicaid Audit Unit was \$864,638. This report details findings which identified over \$21 million in unallowable, excessive, unnecessary, duplicative, or potentially fraudulent billings. The report also describes corrective actions being taken by MassHealth as a result of these findings, which have a fiscal impact (either savings or recoupment of monies) totaling more than \$7,748,048 million. This represents an 800% return on investment. In addition, MassHealth's corrective actions will result in perpetual annual savings of approximately \$3 million, significantly increasing the Commonwealth's overall return on investment.

Background

The Massachusetts Executive Office of Health and Human Services administers the state's Medicaid program, known as MassHealth, which provides access to healthcare services annually to approximately 1.4 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2013, MassHealth paid more than \$10.8 billion to healthcare providers, of which approximately 50% was funded with Commonwealth funds. Medicaid expenditures represent approximately 33% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the U.S. Government Accountability Office (GAO) placed the U.S. Medicaid program on its list of government programs that are at "high risk" of fraud, waste, abuse, and mismanagement. GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Based on these concerns, the OSA began conducting audits of Medicaid-funded programs and, as part of its fiscal year

2007 budget proposal, submitted a request to establish a Medicaid Audit Unit within its Division of Audit Operations dedicated to detecting fraud, waste, and abuse in the MassHealth program. With the support of the state Legislature and the Governor, this proposal was acted upon favorably and has continued in subsequent budgets. Since that time, the OSA has maintained ongoing, independent oversight of the MassHealth program. Audit reports issued by the OSA have continued to identify significant weaknesses in MassHealth's controls to prevent and detect fraud, waste, abuse, and mismanagement in the Massachusetts Medicaid program as well as improper and potentially fraudulent claims for Medicaid services.

Currently, the OSA uses data-mining software on all audits conducted by the Unit. By so doing, our auditors can review 100% of a service provider's claims, thus significantly improving the efficiency and effectiveness of our audits. It takes substantially less time to analyze a provider's entire database of claims than to conduct traditional audit sampling techniques. Additionally, data mining has improved the overall effectiveness of our audits by allowing the OSA's staff to examine claims data and identify trends and anomalies typically indicative of billing irregularities and potentially fraudulent situations. Moreover, data mining has enabled the Unit to fully quantify the financial effects of improper payments regardless of whether they involve one claim or 10 million. In summary, the use of data-mining techniques has enabled the Unit to (1) identify greater cost recoveries and (2) recommend changes to MassHealth's claims-processing system and program regulations to promote future cost savings, improve service delivery, and make government work better.

COMPLETED AUDITS

(March 15, 2013 – March 14, 2014)

During this reporting period, the Office of the State Auditor (OSA) released two audit reports on MassHealth's administration of the Medicaid program and two reports on MassHealth service providers. These reports identified tens of millions of dollars in questionable, unnecessary, unallowable, and potentially fraudulent payments; described significant future cost-saving opportunities; and made a number of recommendations to strengthen internal controls and oversight in MassHealth's program administration. Additionally, the OSA conducted audits of three human-service providers that provided services funded by MassHealth.

The following is a summary of our Medicaid audit work.

1. Office of Medicaid (MassHealth)—Medicaid Claims for Drug Screenings (2012-1374-3C)

The OSA conducted an audit of drug testing claims for the period July 1, 2008 through June 30, 2011. Our objectives were to determine whether (1) drug testing claims paid by MassHealth were for medically necessary services; (2) claims were accurate and properly supported by required documentation; (3) services were delivered; and (4) billings and payments complied with applicable laws, rules, and regulations.

Our audit found that MassHealth had not established effective policies and procedures to ensure that member drug tests are medically necessary and paid for in accordance with applicable laws, rules, and regulations. Consequently, the Commonwealth incurred approximately \$16 million in unallowable, excessive, and unnecessary drug testing and approximately \$5 million in potentially fraudulent and duplicative payments during the audit period. The specific weaknesses identified in the MassHealth drug testing program are provided below.

- The University of Massachusetts Memorial Medical Center (UMMMC) laboratory conducted drug tests for residential monitoring purposes. The orders for these tests originated from sober houses, which provide housing for people recovering from substance-abuse disorders. However, 130 Code of Massachusetts Regulations (CMR) 401.411(B)(5) precludes testing for residential monitoring. Therefore, the OSA determined that UMMC incorrectly billed the Commonwealth \$1,339,352 for 23,882 drug tests.
- MassHealth allows members to be drug tested every day. Consequently, members are being tested at a high frequency—every day or every other day—for periods sometimes exceeding a year, contrary to testing guidelines recommended by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and substance-abuse treatment professionals. During our audit period, MassHealth could have saved approximately \$7.8 million had it more actively monitored the frequency with which members received drug tests, investigated providers who submitted unusually large numbers of claims for drug tests per member, and ensured that the tests were for medically necessary purposes and originated from physicians who were actively treating the members being tested.
- MassHealth could save millions of dollars by limiting or eliminating coverage of certain laboratory tests that are not considered medically necessary for treating substance-abuse disorders. During our three-year audit period, MassHealth spent more than \$7 million on alcohol tests (performed to measure the amount of alcohol in a specimen), specimen integrity tests (performed to ensure that a specimen has not been diluted, adulterated, or substituted to obtain a negative result), and confirmatory tests (performed to verify or refute initial drug test results). Federal guidance from SAMHSA, as well as statements from Massachusetts Department of Public Health officials and substance-abuse treatment specialists, indicates that these tests are usually not medically necessary for individuals receiving treatment for substance abuse. Additionally, these experts identified alternative low-cost or no-cost methods that could be used to determine whether members are abusing alcohol, tampering with urine specimens, or abusing drugs.
- Three laboratories (Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute) used a billing method known as “unbundling” when billing for drug testing services. Both federal and state regulations prohibit unbundling, which occurs when multiple procedure codes are billed separately for a group of procedures that are supposed to be billed using a single comprehensive procedure code. These three laboratories appear to have used this unallowable billing practice to circumvent drug testing limitations that MassHealth established on October 1, 2010. Unbundling by these laboratories resulted in unallowable costs to the Commonwealth totaling approximately \$4.5 million for the four fiscal years ended June 30, 2012.
- MassHealth’s claims-processing system does not adequately detect and deny claims for duplicate drug testing services. Members are currently allowed to receive one drug test per day. However, our audit found 15,606 instances, totaling approximately \$286,000, of MassHealth paying for multiple drug tests (including alcohol tests and creatinine tests) for the same member on the same day.
- Physicians at the Cambridge Health Alliance (CHA) and Codman Square Health Center (CSHC) often ordered two drug tests for the same member on the same day.

The second test was used to verify the accuracy of the member's first test. MassHealth regulation 130 CMR 450.307(B)(1) specifically prohibits providers from billing for this type of duplicate service. The total unnecessary costs that OSA identified for these duplicate services are \$6,196 for CHA and \$21,391 for CSHC.

- MassHealth did not promptly implement pricing changes (price and unit limitations) for drug tests; this caused overpayments of \$107,309 on 2,348 claims during our audit period. Specifically, on February 1, 2009, MassHealth reduced the price it would pay for standard multiclass drug tests, but it did not implement these price adjustments until February 9, 2009. Additionally, MassHealth reduced the number of billable units for certain tests on October 1, 2010, but it continued to pay for the former, higher number of units in some instances.
- Effective December 1, 2011, MassHealth adopted two new procedure codes. However, in adopting these new codes, MassHealth misclassified them within its claims-processing system, causing underpayments totaling \$190,010. Effective April 12, 2012, MassHealth corrected its claims-processing system for this error, notifying all providers of the problem and reprocessing and paying all underpaid claims.
- Some laboratories were not following MassHealth documentation requirements when submitting claims for drug tests. Laboratory order forms and test results were not available for our review at two laboratories where we conducted audit testing of services for which these labs were paid a total of \$41,258. In addition, order forms did not always include physician authorizations and diagnosis codes as required by MassHealth. Lastly, UMMMC used standing order forms (forms requesting that an independent clinical laboratory repeat one or more tests over a specified period of time) in a manner contrary to MassHealth regulations. Specifically, these standing order forms were missing or incomplete in some cases and, in other cases, were being used for member testing for periods that exceeded MassHealth's 30-day limit.

2. Office of Medicaid (MassHealth)—Review of Controls over Pharmacy Claims (No. 2012-1374-3C2)

The OSA conducted an audit of pharmacy claims paid during the period July 1, 2009 through June 30, 2011. Our objectives were to (1) evaluate MassHealth's internal controls over the MassHealth Pharmacy Program; (2) determine whether pharmacies billed for and dispensed prescription drugs in accordance with MassHealth regulations; and (3) identify any unusual utilization trends and/or anomalies in claims data to identify pharmacies, physicians, and members who might warrant further investigation.

Our audit found that the Data Warehouse, MassHealth's central repository for provider claims, did not contain all the information necessary for our audit team to effectively review the Pharmacy Program. Specifically, the Data Warehouse did not always identify the

prescribing provider or the prescribed medication associated with certain prescription drug claims. In addition, the Data Warehouse contained inaccurate information about the number of refills of a prescription drug that members are allowed to receive. Without complete and accurate claims information, our independent review of the Pharmacy Program could not effectively identify trends and anomalies indicative of billing irregularities and potentially fraudulent activities.

3. Dr. Shahrzad Haghayegh-Askarian / Hancock Dental PC (No. 2012-4565-3C)

The OSA conducted an audit of dental claims from Dr. Shahrzad Haghayegh-Askarian (Dr. Haghayegh) and Hancock Dental PC (Hancock Dental) for the period January 1, 2008 through December 31, 2011. Dr. Haghayegh's dental practice and Hancock Dental, both wholly owned by Dr. Haghayegh, were originally selected for audit as part of the OSA audit Review of Controls over Dentist Billings for Detailed Oral Screenings and Other Dental Procedures (No. 2011-1374-3C). However, during that audit, Dr. Haghayegh refused to produce her billing records and those of Hancock Dental. Consequently, the OSA filed legal action against Dr. Haghayegh and Hancock Dental to enforce provisions of state law regarding audits of vendors who receive state funds. The Superior Court Department of the Trial Court found in favor of the OSA in this matter and ordered Dr. Haghayegh and Hancock Dental to provide the OSA with all accounts, books, records, and activities, including patient medical records, regarding their MassHealth billings for dental services.

The objectives of this second audit were to determine whether dental claims filed by Dr. Haghayegh and Hancock Dental were accurate and supported by required documentation; services were delivered; and billings and payments complied with applicable laws, rules, and regulations. Our audit showed that MassHealth paid Dr. Haghayegh and Hancock Dental for unallowable, unnecessary, and undocumented dental procedures totaling \$181,750 during our audit period. The specific audit issues we reported are described below.

- MassHealth regulations specify that detailed oral screenings are only for members undergoing radiation treatment, chemotherapy, or organ transplants. During our audit period, Dr. Haghayegh submitted 1,429 claims and received reimbursements totaling \$89,249 for detailed oral screenings for members who we determined were not receiving radiation treatment, chemotherapy, or organ transplants. Therefore, this \$89,249 represents questionable payments for these services.
- Dr. Haghayegh performed oral evaluations on 259 occasions during our audit period that exceeded the limits established by MassHealth for these procedures, resulting in \$10,876 of unallowable costs to the Commonwealth.
- The American Academy of Pediatric Dentistry recommends that members, depending on their risk of cavities or dental decay, receive between two and four fluoride applications annually. However, Dr. Haghayegh submitted claims for fluoride treatments that greatly exceeded these annual numbers, resulting in unnecessary payments totaling \$2,340. Additionally, in some instances, Dr. Haghayegh submitted claims for two types of fluoride applications for the same member on the same day; this practice resulted in \$130 of unnecessary costs to the Commonwealth.
- Dr. Haghayegh was paid \$3,271 for dental enhancement fees during the audit period. However, according to state regulations, MassHealth only pays dental enhancement fees to contracted Community Health Centers (CHCs) and Hospital-Licensed Health Centers (HLHCs). Since Dr. Haghayegh's dental practices are neither CHCs nor HLHCs, these payments represent unallowable costs to the Commonwealth.
- MassHealth requires dental providers to maintain legible medical records that offer clear evidence of service delivery and of the nature, extent, and necessity of member dental care. However, the files of Dr. Haghayegh that OSA reviewed did not meet this regulatory requirement and were illegible because of poor penmanship, alterations, white-outs, and cross-outs. Additionally, Dr. Haghayegh did not maintain service entries in chronological order, contrary to standards established by the American Dental Association, and some members' files contained notes on other members.
- MassHealth does not pay for the replacement of dentures if the existing dentures are less than seven years old. Dr. Haghayegh allegedly tried to circumvent this prohibition by submitting claims for the replacement of every tooth in members' dentures. In OSA's opinion, Dr. Haghayegh's alternative approach to denture replacement represents a deceptive billing practice, and therefore the \$24,336 she was paid for these procedures represents unallowable costs to the Commonwealth.
- Dr. Haghayegh's files lacked documentation to support claims for member visits and/or services totaling \$45,206. This deficiency was identified in 15 of the 40 sampled member files. (Of that total amount, \$27,731 was questioned in other findings in the report, and the remaining \$17,475 represented further problems with Dr. Haghayegh's claims.)
- MassHealth's regulations specify that it will not pay dental providers to restore the same tooth surface more than once per year. However, Dr. Haghayegh was paid for

\$6,342 of claims for tooth restorations that exceeded this defined limit. These claims represent unallowable costs to the Commonwealth.

In addition, we identified certain matters in Dr. Haghayegh's and Hancock Dental's member records and claims that indicated potential fraud and abuse. These matters were referred to the OSA's Bureau of Special Investigations (BSI) for further investigation and resolution. BSI is charged with investigating complaints of fraudulent claims or wrongful receipt of payment or services from public-assistance programs. Based upon the audit and the results of BSI's investigation, the OSA referred this case to the Office of the Attorney General for further review.

4. Geriatric Authority of Holyoke (No. 2013-4566-3M)

The OSA conducted an audit of the Geriatric Authority of Holyoke (GAH) for the period January 1, 2010 through June 30, 2012. The Holyoke City Council, in conjunction with GAH's board of directors, requested that the OSA perform an audit of GAH in order to provide its new board members with a report on GAH's operations and current fiscal condition. The objective of our audit was to review GAH's fiscal and program operations and to assess the adequacy of its internal controls. For calendar year 2010, GAH received revenue totaling approximately \$6,835,000, of which MassHealth provided 51.3%. For calendar year 2011, GAH's revenue totaled \$6,851,000, of which MassHealth provided 62.9%.

The OSA found that GAH's management and board of directors did not effectively manage its financial operations. Specifically, GAH's management and board did not identify and develop potential available revenue sources that were needed to help ensure its financial viability. GAH also has not established appropriate internal controls, including policies and procedures, over various aspects of its operations; this has resulted in inefficient and unauthorized transactions and inadequate security over cash and other assets. Finally, GAH

may have requested and received over \$150,000 in state funding during 2012 to which it was not entitled.

As a consequence of these management deficiencies, GAH has had to rely on the City of Holyoke (the City) to provide substantial financial support and, as of June 30, 2012, owed the City approximately \$2.2 million. The OSA determined that GAH will need to increase its revenues and/or eliminate unnecessary operating costs in order to prevent the accumulation of further debt, repay the City, and become financially self-sufficient. Otherwise, GAH's financial viability will depend on the City's willingness to continue its financial support. The specific problems we identified during this audit are as follows:

- Approximately 10 years ago, GAH regularly provided outpatient physical therapy services. However, GAH allowed its license for these services to expire and has not attempted to renew it. GAH could have benefited financially by maintaining its license and continuing to provide these services.
- GAH has a four-floor building three floors of which have become vacant and remained unoccupied. Because GAH has left this space vacant (for more than 13 years in some cases), it has lost an opportunity to generate significant rental income. GAH officials told us that the agency had recently negotiated a contract with a local human-services agency to rent two of the three floors, which will enable GAH to realize \$88,515 in rental income for this space annually.
- GAH owns two vans, which it uses to transport its nursing-home residents to and from off-site appointments and its adult-daycare attendees to and from their homes. Through observations and discussions with GAH staff, OSA found that these vans were frequently idle and GAH could have used them more effectively to generate transportation revenue—for instance, by offering transportation services to local facilities that serve the elderly.
- During the audit period, GAH had not established adequate internal controls over the administration of capital projects. As a result, GAH incurred a loss of \$404,143 during fiscal year 2010. The loss resulted from GAH abandoning a planned capital-expansion project, which was intended to replace its aging nursing-home facility. In order to help finance the project, GAH secured approximately \$19 million from the Massachusetts Development Finance Agency and sold 9.5 acres of land to the City for \$1.2 million. However, GAH's management did not adequately research the availability of funding before undertaking this project and was not able to obtain all of the funding necessary to complete the project. In the meantime, it spent much of the land-sale proceeds on costs unrelated to the project. Consequently, the \$404,143 that GAH spent up front during this project had to be written off as an extraordinary expense, which decreased GAH's net worth.

- During the audit period, GAH had not established policies and procedures for the procurement of capital assets (i.e., those costing over \$25,000). During this period, GAH purchased a Ford F250 pickup truck and an industrial-capacity dishwasher for \$27,924 and \$47,275, respectively, without soliciting bids from potential suppliers or, in one case, receiving the required board approval. As a result, GAH cannot be certain that it obtained the best value from these procurements.
- During fiscal year 2011, GAH's former director of Human Resources requested and received a retirement payout package that included a 3% retroactive wage adjustment he had forgone in 2009. The total payout (i.e., sick time, vacation time, and wage adjustment) he ultimately received totaled \$10,905.63. The \$8,035.23 in vacation and sick time payouts included in this amount were appropriate and consistent with GAH's established policies, but the retroactive wage adjustment, which totaled \$2,870.40, was contrary to guidance provided by the board that said that all pay increases and pay adjustments must be approved by the board. The former director of Human Resources worked an additional 960 hours for GAH at the higher adjusted wage rate after he announced his retirement but before actually retiring, resulting in \$4,195.20 in further unauthorized payments.
- During fiscal year 2011, the board appointed an individual to serve as its seventh member. However, after the appointment, the former executive director told us she received allegations of board impropriety, including threats to members and possible vote tampering related to this appointment. Because of the allegations, the former executive director hired outside legal counsel for an opinion on the appointment. GAH paid the legal counsel \$12,605 to resolve this matter, which ended without change to the appointment or additional legal action. The former executive director's actions in this matter appear to have been prudent; however, the board's inability to effectively collaborate on the appointment led to an avoidable expenditure for legal counsel.
- GAH needed to retain legal counsel to resolve a board matter involving stipends for "holdovers," who are board members who resign from a board but remain active on the board because a replacement cannot be found. GAH's bylaws do not address payment of stipends during holdover periods, and when a holdover sought a stipend for \$1,333, that claim was contested. Consequently, GAH spent \$2,565 on legal fees to resolve this matter, as well as ultimately paying the \$1,333.
- The former executive director's employment contract provided for an automobile allowance of \$500 per month plus a per-mile reimbursement for the actual miles she traveled for business purposes. However, for the mileage reimbursement, the former executive director submitted gasoline credit card statements for reimbursement rather than submitting her actual mileage, contrary to the conditions of her employment contract. In total, the former executive director received questionable gasoline reimbursements totaling \$3,789 during the period January 1, 2010 through June 30, 2012.
- GAH maintains an account for each resident that records all revenues received on the resident's behalf, including MassHealth reimbursements, third-party insurance payments, and private funds from residents and their family members. However, GAH has not established written policies and procedures to ensure that these resident accounts are accurate. We tested a random sample of all the billings for 20 of the 181

resident accounts that GAH maintained during our audit period. The testing identified two MassHealth reimbursements, totaling \$59,189, for services provided to these 20 residents that were recorded in GAH's operating account but not in the appropriate residents' subsidiary accounts. As a result of this issue, these resident accounts reflected inaccurate balances that went undetected by GAH staff.

- GAH has not established written policies and procedures to ensure that its cash operating accounts are reconciled monthly. In fact, as of the end of our audit period, GAH had not reconciled its cash operating accounts for any of fiscal year 2012. Consequently, GAH cannot ensure that its account balances are current and accurate.
- GAH did not establish policies and procedures to ensure that only authorized employees signed disbursement checks from its bank accounts. Consequently, GAH's former director of Human Resources—who was an authorized signer on some, but not all, GAH's accounts—signed for disbursements from an account for which he was not an authorized signer. Additionally, we found that when authorized check signers resigned from GAH, it did not remove them from the list of authorized signatories for its bank accounts; we found two former employees who had retired but were still authorized signers. By not establishing effective policies and procedures in this area, GAH unnecessarily placed its monetary assets at risk of fraud or misuse.
- GAH has not established adequate internal controls over the procurement of non-capital items (e.g., over-the-counter medicines, maintenance supplies, office supplies) on which it spends tens of thousands of dollars annually. Specifically, it did not require purchase orders for all purchases, a requirement that would have helped ensure that purchases of these items were properly requested, authorized, and received. As a result, there is inadequate assurance that purchases of these goods are properly safeguarded against waste or abuse.
- GAH has established, but not always followed, policies and procedures for the security of agency credit cards. The policies and procedures require, among other things, that each credit card be locked within an office safe when not needed for purchases. However, during our audit, we noted that GAH's three credit cards were not located in the office safe as required. Moreover, when we asked where the cards were, GAH's accounting staff was not immediately able to identify which employee(s) had the credit cards. Though the staff did ultimately locate all three cards, it appears that GAH was not enforcing its security measures and subjected itself to potential misuse of its credit cards.
- GAH does not have written policies and procedures for the administration of service contracts. As a result, out of the 23 service providers GAH used during our audit period, 8 provided services without a contract; 3 provided services even though their contracts were not properly signed; and 5, whose contracts automatically renewed, had contracts that had not been reviewed and updated for extended periods.
- GAH purchased 23 fixed assets during fiscal year 2010 and correctly (since it did not own the assets for the entire fiscal year) reported a partial year's depreciation for these assets in its accounting records. However, rather than calculating the correct full year's depreciation expense for these assets during fiscal year 2011, GAH incorrectly used its 2010 partial-year depreciation calculation for these assets during

fiscal year 2011, contrary to generally accepted accounting principles. Consequently, GAH understated its depreciation expenses, overstated its income, and overstated its fixed assets by \$5,836 in its fiscal year 2011 financial statements.

- GAH does not have written policies and procedures related to the inventory of its fixed assets. During the audit period, GAH did not take a physical inventory, maintain a complete list, or document disposal of any fixed assets. As a result, GAH did not adequately safeguard its fixed assets, which totaled \$928,000 as of December 31, 2011, against waste, fraud, and abuse.
- In 2012, GAH received \$150,056 in payments from the Massachusetts Executive Office of Health and Human Services (EOHHS) based on documentation that GAH submitted to EOHHS indicating that GAH had received \$367,663 in total appropriations from the City for fiscal years 2009 and 2010. However, the City Treasurer told us that this \$367,663 was not appropriations, but money that GAH owed the City for GAH's portion of its active retirees' health, dental, and life insurance. The City Treasurer further explained that to prevent cancellation of health and life insurance coverage, which includes both City employees and active retirees, the City must pay all applicable premiums and obtain reimbursement from GAH for participating in the plan. Therefore, based on the City Treasurer's comments, the information that GAH provided to EOHHS may be inaccurate and the payments it received from EOHHS based on this information inappropriate.

AUDITS OF HUMAN-SERVICE PROVIDERS

The Commonwealth annually awards contracts totaling approximately \$3 billion to human-service providers, and the Office of the State Auditor (OSA) has an ongoing program of conducting audits of these human-service providers. Since March 15, 2013, the OSA has conducted audits of three providers operating Medicaid-funded programs and, at these providers, identified unallowable and questionable expenses, as well as bad debts totaling over \$800,000. The audits included the Henry Lee Willis Community Center, Inc. (the Center); the May Institute, Inc. and Affiliates (the May Institute); and the South Shore Educational Collaborative (SSEC). The results of these audits are as follows:

1. Henry Lee Willis Community Center, Inc. (No. 2013-4569-3C)

The Center provided various human and social services throughout central Massachusetts, including shelter, substance-abuse recovery programs, child and adolescent services, developmental services, neighborhood services, and community initiative programs. During fiscal year 2011, the Center received Medicaid payments totaling \$89,959. Our audit scope was to review the financial condition and related circumstances of the Center during the period July 1, 2010 through February 15, 2013 that led to the loss of state contract funding and the closure of the agency. We initiated this audit as a result of concerns the Department of Housing and Community Development had over the Center's fiscal and programmatic administration of its shelter-services contract.

We found that management did not effectively respond to financial losses at the Center over the years; ultimately, this resulted in the closure of the Center in February 2013. The Center owed approximately \$1 million to suppliers and vendors when it closed, including \$235,569 to the Commonwealth for unemployment insurance. The Center did not take the measures

necessary to improve its cash flow and overall financial situation and has been in a deficit position since 2004.

Additionally, our audit identified \$143,775 of questionable and non-reimbursable expenses charged to the Commonwealth, including \$8,207 of inadequately documented credit-card expenses, \$57,080 paid to lease a luxury car for the executive director, at least \$39,788 of questionable payments to an affiliated management company for maintenance services, \$10,000 to hire a public-relations firm, and \$28,700 of interest and late fees.

2. The May Institute, Inc. and Affiliates (No. 2012-4416-3C)

The May Institute provides educational, rehabilitative, and behavioral care to individuals with autism spectrum disorders, developmental disabilities, neurological and behavioral disorders, and other mental illnesses. The May Institute receives approximately 6% of its program funding through direct Medicaid payments. Our audit scope was to examine various administrative expenses of the May Institute, including executive salaries, fringe benefits, travel and automobile expenses, and credit-card use, during the period July 1, 2009 through June 30, 2011. We determined that the May Institute charged \$348,769 against its state contracts for non-reimbursable compensation it provided to its president / chief executive officer and certain managers.

3. South Shore Educational Collaborative (No. 2012-4563-3C)

SSEC, located in Hingham, is an association of 10 local school districts and is 1 of 30 educational collaboratives operating within the Commonwealth whose purpose is to provide education and related services to school districts and their students. Historically, education collaboratives have primarily provided services for special-education students, but they may also provide other services, such as professional development, technology and consultation services, student transportation, and collective purchasing of goods and services for use by

participating districts. SSEC receives approximately 5% of its program funding through direct Medicaid payments. The scope of this audit included a review and examination of certain aspects of SSEC's fiscal and program operations during fiscal years 2010 and 2011.

Described below are the details of SSEC's financial and operational deficiencies.

- According to Chapter 41, Section 35, of the Massachusetts General Laws, only the Treasurer of each city and town is authorized to pay bills incurred by his or her municipality. We found, however, that SSEC maintained accounts for nine of its member districts and processed transactions totaling \$525,651 through these accounts.
- Contrary to state regulations, SSEC was not maintaining all of its accounting records in accordance with generally accepted accounting principles (GAAP). Specifically, we found that SSEC was not using an acceptable methodology to allocate its indirect costs to its programs; that it misclassified approximately \$2 million in revenues and expenses; and that it allowed one employee who retired and was subsequently rehired by SSEC to defer \$7,088 in compensation he earned during fiscal year 2010 to fiscal year 2011 in order to circumvent the earnings limitations on rehired public employees established by Chapter 32, Section 91, of the General Laws. As a result of these issues, SSEC's financial information during our audit period was not accurately recorded in SSEC's financial records or accurately reported to the Commonwealth.
- SSEC overbilled the Massachusetts Commission for the Blind \$1,053 for Limited Unit Rate Service Agreement services that were not provided.
- Contrary to GAAP, SSEC had not established adequate internal controls over several aspects of its operations. Specifically, during our audit period SSEC lacked a policy requiring documentation of the business and personal use of agency-assigned vehicles, had not established effective inventory control procedures, unnecessarily lost \$79,309 by not ensuring that retirees were accurately billed for their health-insurance premiums, did not adequately segregate the duties of its business manager / treasurer, and lacked controls over the use of agency computers.

CURRENT INITIATIVES

1. MassHealth Limited Program (2013-1374-3M1)

The Office of the State Auditor (OSA) is currently conducting an audit of the MassHealth Limited Program, which pays for emergency services provided to undocumented noncitizens and certain documented noncitizens because of their immigration status. Our audit objectives include determining whether MassHealth (1) pays for claims for emergency services in accordance with state regulations, (2) maintains edits within its claims-processing system to detect and deny claims that represent non-emergency care, (3) obtains necessary service information from medical service providers in order to properly evaluate and process claims, and (4) monitors system outputs to identify billing irregularities and potentially fraudulent claims. Our audit period is July 1, 2011 through December 31, 2012.

In this audit, we are evaluating MassHealth's regulations, policies, procedures, and controls over the Limited Program by (1) using data mining to identify providers' claims that represent a high risk of violating state regulations; (2) conducting site visits at sampled providers to review member records and document providers' billing policies, control procedures, and compliance with applicable regulations; and (3) consulting with other state Medicaid programs about their emergency-service programs.

2. Review of Medicaid Claims for Mobility-Assistive Equipment (2013-1374-3M2)

The OSA is conducting an audit of claims paid by MassHealth for mobility-assistive equipment, e.g., wheelchairs, canes, and crutches, from July 1, 2011 through December 31, 2012. The purpose of our audit is to ensure that MassHealth has established adequate controls over these durable medical appliances. Such controls would include, but are not limited to, (1) maintaining edits within its claims-processing system to detect and deny claims submitted

contrary to state regulations; (2) requiring service providers to maintain documentation to support the medical necessity, prior authorization, and delivery of members' equipment; and (3) periodically monitoring system outputs to identify questionable price fluctuations, billing irregularities, and potentially fraudulent claims.

In this audit, we plan to conduct the following procedures: (1) using data mining to identify claims that represent a high risk of violating state regulations; (2) evaluating MassHealth's regulations, policies, procedures, and controls over claims involving mobility-assistive equipment; (3) visiting sampled providers to review member files and document each provider's billing policies and control procedures; and (4) consulting with other state Medicaid programs about their pricing practices.

3. Review of Personal Care Attendant Services (2013-1374-3M3)

The OSA is conducting an audit of Personal Care Attendant (PCA) services paid for by MassHealth during the period July 1, 2010 through June 30, 2013. Our audit objectives include determining whether (1) MassHealth has established an adequate system of internal controls over the PCA program; (2) MassHealth reviews all prior authorization requests for PCA services and only authorizes those that are medically necessary; (3) PCA services prescribed for any member are prescribed by a physician or a nurse practitioner who is responsible for the oversight of the member's healthcare; and (4) the member's disability is permanent or chronic in nature and impairs the member's functional ability to perform two or more activities of daily living without physical assistance. We will use data analytics to review 100% of the PCA claims paid during the audit period. Also, we will review a sample of member files and visit MassHealth contractors responsible for certain fiscal and programmatic aspects of the PCA program to ensure their compliance with applicable regulations.

4. **An Examination of State Policies and Practices Regarding Inmate Inpatient Healthcare Costs (2013-5155-3M)**

The OSA has started an audit to determine whether the Commonwealth has effectively reduced inmate healthcare costs by requiring hospitals and other medical service providers to bill MassHealth for eligible inmate inpatient hospital and professional services. Generally, the federal government does not reimburse states for inmate healthcare costs under the Medicaid program. However, an exception is allowed if inmates are otherwise eligible for MassHealth and (1) they are treated in an inpatient hospital setting that is not under the control of a state's correction system or (2) they are living outside the penal institution; are on parole, probation, or home release; and are not returning to the institution for overnight stays. Massachusetts also requires the Department of Public Health (DPH) to seek federal financial participation for care provided to inmates of Department of Correction (DOC) facilities and of county correctional facilities who are treated at public health hospitals. The federal government reimburses the Commonwealth approximately \$0.50 for every \$1.00 spent on Medicaid. Thus, by ensuring that hospitals and other service providers bill MassHealth for eligible inmate healthcare services, the Commonwealth can effectively reduce its costs by transferring costs to the federal government. The audit will include, but not be limited to, (1) reviewing applicable state and federal laws, rules, and regulations; (2) interviewing officials at MassHealth, the DOC, sheriff's departments (county correctional facilities), DPH hospitals, and local hospitals; and (3) conducting field work at each DOC and county correctional facility and selected public health hospitals. Our field work will include documenting each facility's policies and procedures for determining inmate Medicaid eligibility and billing inmate inpatient hospital services, as well as testing these policies and procedures. Also, we will quantify all costs related to inmate inpatient hospital services during the audit period and, if applicable, develop recommendations to ensure that eligible inmate inpatient hospital

services are billed to MassHealth in order to reduce costs to the Commonwealth. The audit period is from January 1, 2011 through December 31, 2012.

AUDIT IMPACT AND POST-AUDIT EFFORTS

The objectives of the performance audits conducted by the Office of the State Auditor (OSA) at MassHealth and its providers are not only to identify improper payments for Medicaid services, but also to identify and resolve any systemic problems such as deficiencies in internal controls that may exist within the MassHealth system. Consequently, while measures such as referrals to law enforcement for prosecution, recommending restitution, and other remedial actions against individual Medicaid vendors are typical results of OSA audits and serve as a deterrent, the systemic changes made by MassHealth as a result of OSA audits, in many instances, have a more significant effect on the overall efficiency of the operation of Medicaid-funded programs. For example, as a result of the OSA's audit work, MassHealth has informed us that it has instituted a number of operational changes that will result in the prevention of an estimated \$3 million in unnecessary payments for Medicaid services annually.

In order to assess the impact of our audits and the post-audit efforts made by auditees to address issues raised in our reports, the OSA has implemented a post-audit review survey process that is conducted six months after the release of an audit. This process documents the status of the recommendations made by the OSA, including any corrective measures taken by the auditee as well as any estimates of future cost savings resulting from changes made based on our recommendations.

During the report period, the OSA issued, and agencies completed, five post-audit surveys regarding Medicaid audits. According to the survey results, agencies have fully implemented 12 of 35 audit recommendations and 22 are either in progress or planned. MassHealth disputed one finding. MassHealth is actively pursuing the recoupment of \$6.7 million due from service providers. The tables and narratives below detail agencies' post-audit efforts during the reporting period.

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
18	3	1	Up to \$7,748,048	<ul style="list-style-type: none"> Pursuing up to \$6,288,048 in potential recoupment for overpayments Has saved approximately \$1,460,000 and will save \$3 million annually because of the implementation of program changes and system claims edits targeting overutilization of certain laboratory tests Continuing to implement a predictive modeling system that will enhance its ability to identify and avoid fraudulent or inappropriate claims
	Planned			
	13			

* MassHealth disputes one of the recommendations for this report.

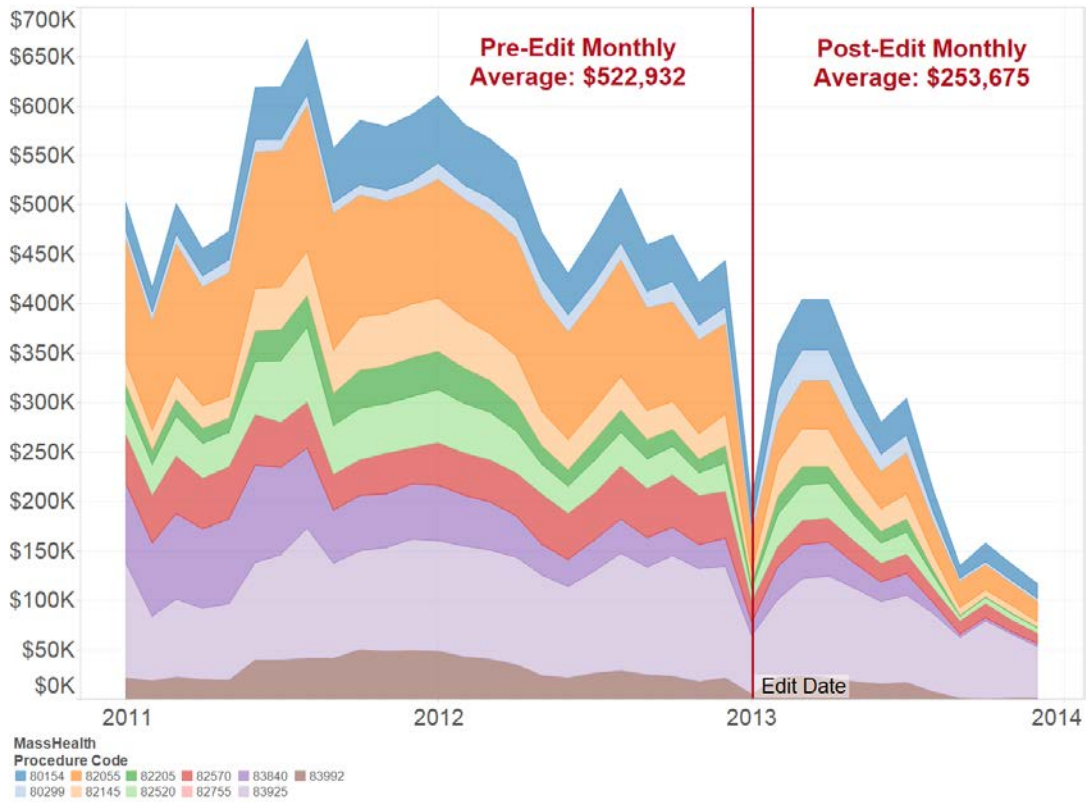
In response to the findings described in the Completed Audits section of this report, MassHealth stated that it has fully implemented two recommendations.

With regard to the recommendation of reviewing system edits within its claims-processing system, MassHealth reiterated its response from the audit report: that it currently has a mechanism that denies duplicate claims for the same service code billed by the same provider for the same member on the same date of service. To address the recommendation further, MassHealth is also continuing the introduction of a predictive modeling system that will increase its ability to systematically identify and avoid inappropriate or fraudulent claims. Also, MassHealth has fully paid the hospitals affected by the improperly classified procedure codes and has requested information from the OSA concerning 63 additional claims identified in which MassHealth made incorrect payments for those particular codes.

As stated in the audit report, MassHealth has implemented program changes that have successfully targeted overutilization of alcohol and specimen integrity tests, including a series of claims edits that deny certain substance-abuse-related quantitative tests if billed on the same date of service as drug-screen services. In the six-month period after making the changes, MassHealth noted a \$1.38 million reduction in costs compared to the prior six months. MassHealth also issued

a provider bulletin regarding confirmation tests, stating that they should be billed only after a positive drug screen and when they are medically necessary. As a result, confirmation test expenditures were \$89,000 lower in the first six months of 2013 than in the first six months of 2012. The measures MassHealth has taken in response to our audit will result in significant savings year over year.

Substance Abuse Test Paid Claims Trend, January 2011 to Present



Since the introduction of system edits in January 2013 to detect duplicate claims and overutilization, MassHealth payments for substance-abuse test claims have dropped, on average, by 51% per month.

However, MassHealth does not agree with the OSA’s recommendation of outright denying claims for confirmation tests performed on the same day as a drug screen.

Regarding the recommendation that was reported as “in progress,” the OSA recommended that MassHealth assist the University of Massachusetts Memorial Medical Center (UMMMC) in reversing 23,882 improper drug-test claims, totaling \$1,339,352, for residential monitoring

purposes. This matter has been referred to the Office of the Attorney General's (OAG's) Medicaid Fraud Division in accordance with a memorandum of understanding between that office and MassHealth for self-reported disclosures exceeding \$150,000.

MassHealth also indicated that it plans to take action on the following 13 recommendations:

- Work with the OAG's Medicaid Fraud Division to pursue recovery of \$4,500,177 in "unbundled billing" overpayments;
- Implement a requirement that the National Provider Identifier number for the ordering and referring provider be included on claims for laboratory and other services;
- Review utilization management strategies and its own experience to avoid overutilization of testing;
- Review clinical laboratory utilization to help monitor frequency of drug testing and identify providers that submit unusually large numbers of claims per member;
- Pursue repayment of \$313,623 in duplicate payments for drug testing services;
- Pursue repayment of \$107,309 in overpayments due to rate and unit adjustments;
- Pursue repayment of \$27,587 for disallowed drug tests used to verify initial drug tests taken on the same day, should its Provider Compliance Unit determine that it is appropriate;
- Issue a directive that would instruct providers that confirmation testing using the same specimen or bodily fluid is duplicative and not payable;
- Issue a directive reminding providers that they must follow existing regulations governing requests for laboratory services, recordkeeping requirements, and all applicable MassHealth administrative and billing regulations;
- Conduct a program review of UMMMC's compliance with MassHealth requirements governing requests for laboratory services;
- Contact the Cambridge Health Alliance and UMMMC to perform a review of their compliance with its documentation requirements regarding provider requests for laboratory services; and
- Implement procedure-code updates and a full comprehensive rate review in 2014 to address concerns about pricing adjustments for drug tests, which addressed two recommendations.

MassHealth is disputing the finding regarding the development of edits in its claims-processing system that would help to detect and deny claims for drug tests ordered for residential monitoring.

MassHealth, referring to its response in the audit report, stated that it did not agree that claims for drug screening or any other claims should be systematically denied based on a member’s place of residence (including sober houses). However, MassHealth also noted that in February 2013, it issued a provider bulletin reminding laboratories and prescribers that it does not provide payments for services performed for residential monitoring purposes, irrespective of provider authorization, and that sober houses are not authorized prescribers.

2. The Office of Medicaid (MassHealth)—Review of Controls over Dentist Billings for Detailed Oral Screenings and Other Dental Procedures				
Audit No. 2011-1374-3C			Issued March 11, 2013	
Survey Response Received November 12, 2013				
Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
5	0	5	Up to \$409,978	<ul style="list-style-type: none"> Pursing \$409,978 in recoupment for unallowable billing Implemented system edit changes to prevent the unnecessary use of X-rays, oral evaluations, and fluoride treatments reported in the audit

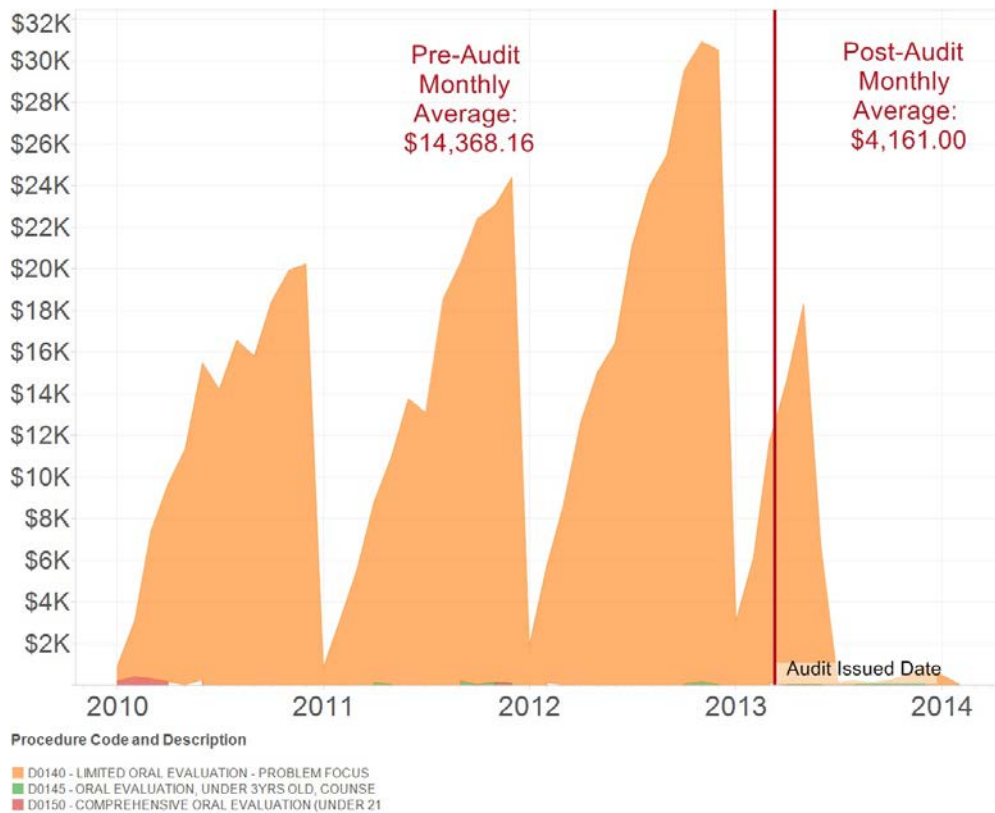
MassHealth has a category of dental services, called detailed oral screenings, intended for patients undergoing radiation treatment, chemotherapy, or organ transplant. Our audit of dental billings for detailed oral screenings revealed several serious problems. We found that MassHealth had paid the 10 dental providers sampled a total of \$1,241,235 for 19,274 claims for detailed oral screenings performed on members who were not undergoing radiation treatment, chemotherapy, or organ transplant. Additionally, 2 of the 10 providers billed and were paid a total of \$37,687 for 972 oral/facial photographic images that MassHealth did not request; the 10 providers were paid a total of \$15,803 for unallowable and medically excessive oral evaluations; 1 provider was paid for services performed by his spouse, who was not a MassHealth dental provider; and \$14,280 was paid to 2 providers for unallowable fluoride treatments.

MassHealth responded that all five recommendations from this report were “in progress.” It is seeking recoupment of \$409,978.68 for unallowable charges, some of which the providers are

disputing. In addition, MassHealth indicated that it had referred a matter concerning 4 of the 10 dental providers (all of which are run by the same proprietor) to the OAG’s Medicaid Fraud Division. It is also evaluating options for seeking recoupment of overpayments for 1 of the 10 providers that is no longer in business.

Further, MassHealth has implemented system edit changes that will allow it to address concerns about unallowable oral/facial photographic images; identify and deny claims submitted for unnecessary fluoride treatments; limit payments for fluoride claims to once a quarter, in accordance with American Academy of Pediatric Dentistry standards; and ensure (as a result of action by DentaQuest, its dental subcontractor) that claims for oral evaluations are not paid for more than the limit established by regulations.

MassHealth Oral Evaluation Spending Exceeding Regulatory Guidelines, by Month



Edits MassHealth has introduced to prevent unnecessary and overutilized oral evaluations have resulted in a 71% decrease in amount of claims paid per month.

MassHealth will also reeducate one provider in the hope of preventing future billings for services conducted by non-MassHealth dental providers.

3. South Shore Educational Collaborative				
Audit No. 2012-4563-3C		Survey Response Received November 19, 2013		Issued April 9, 2013
Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
4	2	2	N/A	<ul style="list-style-type: none"> Terminated fiscal conduit expenditures and worked to return member account funds to member school districts Has been implementing procedures for uniform purchasing using software for purchase orders and accounting

The South Shore Educational Collaborative (SSEC), located in Hingham, is an association of 10 local school districts and is 1 of 30 educational collaboratives operating within the Commonwealth whose purpose is to provide education and related services to school districts and their students. During the audit period, SSEC provided school-age students with educational programs, operated a children’s residential group home, and operated an adult day habilitation program. These programs specialized in providing emotional, behavioral, and developmental services. In addition, SSEC conducted workshops and training through its professional development program and offered Internet support services for member and nonmember districts. Responding to the survey, SSEC stated that it had implemented two recommendations. SSEC has terminated fiscal conduit expenditures, a process in violation of state finance law in which SSEC was paying bills on behalf of municipalities, and worked to return member account funds to its member districts. Additionally, SSEC has reimbursed the Commonwealth for \$1,053 in payment under a Limited Unit Rate Service Agreement (LUSA) for services that were not provided.

Regarding the recommendations that were reported as “in progress,” SSEC disclosed that it planned to consult with the Commonwealth’s Operational Services Division for approval of its administrative allocation procedures; approval of these procedures will allow for enhanced

control of SSEC’s budget, purchasing, and cash flow. Also, to address the issue of inadequate internal controls, SSEC has been implementing procedures for uniform purchasing using software for purchase orders and accounting, which will help SSEC better control its finances.

4. The May Institute, Inc. and Affiliates				
Audit No. 2012-4416-3C		Survey Response Received December 10, 2013		Issued May 20, 2013
Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
2	2	0	N/A	<ul style="list-style-type: none"> • Re-filed fiscal year 2010 and 2011 Uniform Financial Statement and Independent Auditor’s Reports to correctly report \$138,213 in compensation provided to president / chief executive officer (president/CEO) and \$210,556 in salaries provided to management staff as non-reimbursable • Submitted Internal Revenue Service Form W-2Cs to correct non-reporting of \$151,717 of president/CEO’s income to appropriate tax authorities • Implemented policies and procedures to ensure that unallowable compensation expenses are not charged to the state, that taxable compensation is properly reported, and that employee time spent on clinical functions is documented

The May Institute, Inc. and Affiliates (the May Institute), a Randolph-based national organization providing educational, rehabilitative, and behavioral care to individuals with autism spectrum disorders, developmental disabilities, neurological and behavioral disorders, and other mental illnesses, stated that both our audit recommendations had been fully implemented.

The May Institute reported that its fiscal year 2010 and 2011 Uniform Financial Statements and Independent Auditor's Reports (UFRs) had been re-filed to correctly report the \$138,213 in non-reimbursable compensation provided to its president/CEO that was charged against its state contracts and to cover the wages with eligible offsetting revenue. In addition, the institute has filed Internal Revenue Service Form W-2Cs to address the non-reporting of \$151,717 of the president/CEO’s income to the appropriate tax authorities. It has also implemented new policies

and procedures to ensure that in the future, unallowable compensation expenses are not charged against state contracts, and that all taxable compensation is properly reported.

Further, in its re-filing of the fiscal year 2010 and 2011 UFRs, the May Institute took action to correctly report \$210,556 in compensation provided to members of its management staff as non-reimbursable, and it has implemented measures to ensure that all unallowable salary amounts over the state limit will be reported as non-reimbursable in the future. The May Institute also now requires specific documentation of employee time that is spent on clinical functions.

5. Crystal Springs, Inc. (Formerly the Institute for Developmental Disabilities, Inc.) Audit No. 2011-4335-3C Issued November 19, 2012 Survey Response Received June 19, 2013				
Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
6	5	1	N/A	<ul style="list-style-type: none"> • Implemented a procurement policy that requires a competitive bidding process • Amended UFRs to report rental income and unallowable vehicle, compensation, and fundraising expenses • Is working with the Department of Developmental Services to resolve the issue related to the unallowable use of LUSA funding

Crystal Springs, Inc. (formerly the Institute for Developmental Disabilities, Inc.) is a provider of special education, therapeutic, and residential services to children and adults. Crystal Springs receives approximately 6% of its program funding through direct Medicaid payments. The audit found that the Freetown-based agency did not use a competitive bidding process or enter into formal written agreements, as required by regulations, to procure \$359,573 in heating, ventilation, and air-conditioning equipment that it purchased from a related-party organization. Against Department of Developmental Services (DDS) policies, Crystal Springs also used \$90,922 in LUSA funds provided under contracts with DDS to purchase agency vans, a central air-

conditioning unit, and flooring supplies. Funds provided under LUSAs are intended for funding unanticipated, intermittent, and as-needed services for developmentally disabled individuals.

Additionally, Crystal Springs provided unallowable fringe benefits for employee loans and vehicle expenses totaling \$23,839; did not identify in its financial records \$13,200 in rental income that it received from its former executive director as revenue for its Adult Residential Program or use the income to offset the Commonwealth's operating costs for the program; and charged \$38,792 in unnecessary employee compensation and \$9,335 in unallowable fundraising costs against its state contracts.

Crystal Springs reported that it had implemented five of the OSA's recommendations. The organization has put in place a new procurement policy that requires a competitive bidding process, and it has stopped providing employee loans. In addition, Crystal Springs amended its UFRs to report as non-reimbursable expenses \$11,739 in unallowable vehicle costs and the employee compensation and fundraising costs charged to state contracts, along with identifying offsetting revenue for the vehicle and fundraising expenses. The agency also revised its UFRs to report the indicated rental income in its Adult Residential Program.

Crystal Springs stated that it was working with DDS to resolve the issue related to the unallowable use of LUSA funding, and in the future, it will coordinate with DDS to determine the source and proper use of funding that it receives.

Crystal Springs also disclosed that it had completed and submitted to DDS (as instructed) a corrective action plan to address the matters cited in the audit.