



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

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## Office of the State Auditor – Annual Report Medicaid Audit Unit

December 1, 2011 – March 15, 2013



# **MEDICAID AUDIT UNIT**

**December 1, 2011 – March 15, 2013**

## **Introduction**

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit (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 2013 budget (Chapter 139 of the Acts of 2012) requires that the OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 15, 2013 that (a) details all findings on activities and payments made through the MassHealth system; (b) includes, 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; (c) includes responses of MassHealth to the most recent post-audit review survey; and (d) includes the OSA's recommendations to enhance recoupment efforts.<sup>1</sup>

This report, which is being submitted by the OSA in accordance with the requirements of Chapter 139, provides summaries of: two OSA audits of MassHealth relative to its eligibility determination process and its controls over billings for certain dental

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<sup>1</sup> Chapter 139, Section 2, of the Acts of 2012.

procedures; audit work conducted by the OSA at three human service providers that received Medicaid funding; seven MassHealth audits that are currently underway; and all corrective measures and related outcomes reported by the auditees relative to our findings and recommendations, including MassHealth.

## **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 1.3 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2012, MassHealth paid in excess of \$11.4 billion to health care providers, of which approximately 50% was funded with Commonwealth funds. Medicaid expenditures represent approximately one-third 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. During this 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 ability and efforts to detect fraud, waste, abuse, and mismanagement in the Massachusetts Medicaid program as well as improper and potentially fraudulent claims for Medicaid services.

Over the past two years, the OSA's Medicaid Audit Unit has begun utilizing data mining techniques on each new assignment, which has significantly improved the efficiency and effectiveness of our Medicaid audits. In the past, the Unit manually sampled and tested member files on a judgmental basis to determine whether claims for provider services complied with state regulations. While this approach proved effective in identifying internal control deficiencies resulting in non-compliance and some unallowable expenses, it was limited in that our conclusions had to be based solely on the sampled transactions. This process was also not effective in identifying any systemic problems that may have existed in the areas under review, which would have allowed the OSA to make more comprehensive recommendations on how to improve program operations.

The Unit no longer fully relies upon this sampling strategy to perform its Medicaid audits. Instead, prior to starting each new audit engagement, the Unit uses data mining software to analyze 100% of the paid claims under audit. Electronic data mining significantly improves the efficiency and effectiveness of these audits because the amount of time needed to analyze a provider's entire database is substantially less than conducting traditional sampling techniques. Additionally, data mining has improved the overall effectiveness of our audits by allowing OSA staff to identify trends and anomalies within claims data typically indicative of billing irregularities and potentially fraudulent

situations. Moreover, data mining has enabled the Unit to fully quantify the financial effects of billing problems regardless of whether they involve one or ten thousand claims. In summary, the use of data mining techniques has enabled the Unit to (a) identify greater cost recoveries and (b) 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

**(December 1, 2011 – March 15, 2013)**

During this reporting period, the OSA released two audit reports on MassHealth that identified millions of dollars in questionable, unnecessary, unallowable, and potentially fraudulent payments and significant cost-saving opportunities, and made recommendations to strengthen internal controls and oversight in MassHealth's program administration. Additionally, the OSA conducted audits of three human service providers who provided services funded by MassHealth.

The following is a summary of our Medicaid audit work:

**1. MassHealth's Eligibility Determination Process for Healthcare Services (No. 2010-1374-3C)**

The OSA conducted an audit of MassHealth's eligibility determination process to (1) assess the adequacy of the policies and internal controls MassHealth has established relative to this process and (2) if possible, identify opportunities for developing more effective policies and internal controls aimed at ensuring that only eligible applicants receive benefits, which could result in savings to the Commonwealth's taxpayers.

Our audit found that MassHealth has not established effective policies and procedures to ensure that only eligible consumers are enrolled and receive Medicaid benefits, which may be unnecessarily costing the Commonwealth millions of dollars annually in health care expenses. We identified the following weaknesses within MassHealth's policies and procedures for determining Medicaid eligibility.

- MassHealth does not fully verify applicants' self-reported earned income or attestations of no income at the time of their application or on at least a quarterly basis once they are enrolled as required by MassHealth and federal regulations.
- Contrary to federal regulations, MassHealth does not request information about an applicant's unearned (non-wage) income (e.g., lottery winnings, dividends, interest, annuity and pension payments, rental income) from the Internal Revenue Service (IRS) or other independent sources. As a result, MassHealth cannot ensure that it is identifying, to the extent possible, each applicant's unearned income.
- At the time of application, MassHealth does not require applicants who claim zero family income to provide any additional information on the means by which they are paying for their living expenses. This practice conflicts with other state Medicaid programs that require applicants to provide additional details about their financial situation when declaring zero family income.
- As a condition of eligibility, applicants must live in the Commonwealth with the intent to remain permanently or for an indefinite period. However, MassHealth accepts an applicant's self-declaration of residency, which is acceptable under federal regulations but, unlike the Medicaid agencies of other states, does not require applicants to provide any documentation to substantiate that they are actually residing in Massachusetts. Consequently, the Commonwealth may be incurring health care costs for non-Massachusetts residents.
- MassHealth's regulations state that it will investigate any conflicts in information provided by applicants and members. Despite this, our audit found that MassHealth provides health care services to applicants/members who provide information that directly conflicts with other documentation they provided and/or in the case of foreign visitors, representations they made to the federal government when obtaining their temporary visas, without resolving these conflicts and ensuring that these individuals meet MassHealth's residency and financial eligibility requirements. As a result, MassHealth may be providing millions of dollars in benefits each year to individuals who are not entitled to receive such benefits. For example, during fiscal year 2010 alone, MassHealth provided healthcare benefits totaling over \$12 million to foreign visitors without effectively verifying these visitors' residency and financial status, even though the financial and residency information they provided to MassHealth to obtain these benefits directly conflicted with what they represented to the federal government in obtaining their temporary visas.

2. **Review of Controls over Dentist Billings for Detailed Oral Screenings and Other Dental Procedures (No. 2011-1374-3C)**

The OSA conducted audits at 10 MassHealth dental providers, which included a specialist in oral surgery and nine providers who practice general dentistry. The objectives of these audits were to determine whether dental claims filed by these providers were accurate and supported by required documentation; services were delivered; and billings and payments complied with applicable laws, rules, and regulations. Our audits identified that MassHealth paid these dental providers for unallowable and unnecessary dental procedures totaling \$1,309,005 during the period January 1, 2008 through June 30, 2011. The specific audit issues identified at these 10 dental providers are described below.

- MassHealth regulations specify that detailed oral screenings are only for members undergoing radiation treatment, chemotherapy, or organ transplant. During our audit period, the 10 sampled dental providers submitted 19,274 claims and received reimbursements totaling \$1,241,235 for detailed oral screenings for members who we determined were not receiving oncological services or organ transplants. Therefore, this \$1,241,235 represents questionable payments for these services.
- MassHealth regulations allow for payment of oral/facial photographic images when MassHealth specifically requests a provider to take these images. However, two sampled dental providers billed and were paid for 972 oral/facial photographic images totaling \$37,687 during our audit period that MassHealth never requested and were therefore unallowable.
- The 10 sampled providers performed oral evaluations during our audit period on at least 540 occasions that exceeded the limits established by MassHealth for this procedure, resulting in unallowable costs totaling \$15,803.
- MassHealth only pays for dental services to dental providers who have contractually agreed to participate in the MassHealth Dental Program. However, one dental provider in our sample submitted claims for services performed by his spouse, who is a dentist but not a participating MassHealth dental provider.



- The American Academy of Pediatric Dentistry recommends that children, depending on their risk of cavities, receive between two and four fluoride applications annually. However, one sampled dental provider submitted claims for fluoride treatments that greatly exceeded these annual amounts, resulting in unnecessary payments totaling \$5,466.
- Additionally, one sampled provider submitted claims for two types of fluoride applications for the same members on the same day, resulting in unnecessary costs to the Commonwealth totaling \$8,814.

## AUDITS OF HUMAN SERVICE PROVIDERS

The Commonwealth annually awards contracts totaling approximately \$2.8 billion to human service providers, and the OSA has an ongoing program of conducting audits of these human service providers. During the report period, the OSA conducted audits of three providers operating Medicaid-funded programs and, at two of the three providers, identified unallowable and questionable expenses totaling over \$2.5 million. The audits included Life Focus Center of Charlestown, Inc., Institute of Developmental Disabilities, Inc., and Center of Hope Foundation, Inc. The results of these audits are as follows:

### **1. Life Focus Center of Charlestown, Inc. (LFC) (No. 2011-4547-3C)**

The LFC provided Boston-area disabled consumers and their family members with social, vocational, educational, and community-based residential and support services. LFC received approximately 15 percent of its program funding through direct Medicaid payments. Our audit scope was to examine various administrative and operational activities of LFC during the period July 1, 2008 through December 31, 2010.

At this provider, our audit identified questionable expenses totaling over \$2 million as follows:

- Inadequately documented billings for program services totaling \$791,307
- Questionable credit card expenses totaling \$28,436 and as much as \$123,173 charged by LFC against its state contracts
- Questionable and inappropriate contract billings totaling \$48,809

- Questionable administration of \$200,644 in consultant and maintenance services
- Inadequate internal controls over time, attendance, and payroll activities resulting in undocumented payroll expenses of \$1,150,801
- Unallowable vehicle costs totaling \$38,072
- Questionable administration of employee bonuses totaling \$35,100
- Inadequate oversight by LFC's Board of Directors

**2. Institute of Developmental Disabilities, Inc. (IDDI) (No. 2011-4335-3C)**

IDDI provides approximately 110 severely to profoundly disabled children and adults with specialized educational, therapeutic, and residential services. IDDI receives approximately six percent of its program funding through direct Medicaid payments. Our audit scope was to examine various administrative and operational activities of IDDI during the period July 1, 2009 through June 30, 2011.

At this provider, our audit identified questionable expenses totaling \$535,661 as follows:

- Questionable related-party transactions totaling \$359,573
- Unallowable contract billings totaling \$90,922
- Unallowable fringe benefits totaling \$23,839
- Unallowable program expenses totaling \$13,200 charged to state-funded contracts
- Unnecessary employee compensation totaling \$38,792 charged to state-funded contracts

- Inappropriate allocation of \$9,335 in fundraising expenses to state-funded contracts

**3. Center of Hope Foundation, Inc. (CHF) (No. 2012-4564-3C)**

CHF's mission is to give consumers with disabilities, and their families, the resources, services, and opportunities necessary to be contributing members of their communities. The CHF receives approximately 34 percent of its program funding through direct Medicaid payments. Our audit scope was to examine various administrative and operational activities of CHF during the period January 1, 2010 through December 31, 2011.

Based on our audit, we concluded that CHF maintained adequate internal controls, received and expended funds in accordance with the terms and conditions of its state contracts, properly recorded all revenue and expenses, and complied with all applicable federal and state laws and regulations and its own internal policies and procedures in the areas examined.

## CURRENT INITIATIVES

### 1. MassHealth Limited Program

The MassHealth Limited Program pays for emergency services provided to undocumented noncitizens and certain documented noncitizens because of their immigration status.

The OSA is currently conducting an audit of 100% of Limited Program expenses for fiscal years 2011 and 2012 to ensure that MassHealth (a) pays for claims for emergency services in accordance with state regulations, (b) maintains edits within its claims processing system to detect and deny claims that represent non-emergency care, (c) obtains necessary service information from medical service providers in order to properly evaluate and process claims, and (d) monitors system outputs to identify billing irregularities and potentially fraudulent claims.

In this audit, we are evaluating MassHealth's regulations, policies, procedures, and controls over the Limited Program by (a) utilizing data mining to identify providers' claims that represent a "High Risk" of violating state regulations; (b) conducting site visits at sampled providers to review member records and document providers' billing policies, control procedures, and compliance with applicable regulations; and (c) consulting with other state Medicaid programs about their emergency services programs.

## **2. Review of Medicaid Claims for Durable Medical Equipment**

The OSA is conducting an audit of claims paid by MassHealth for durable medical equipment (DME) during the period July 1, 2011 through December 31, 2012. The purpose of our audit is to ensure that MassHealth has established adequate controls over DME claims. Such controls would include, but not be limited to, (a) maintaining edits within its claim processing system to detect and deny claims submitted contrary to state regulations, (b) requiring service providers to maintain documentation to support the medical necessity, prior authorization, and delivery of members' DME, and (c) periodically monitoring system outputs to identify questionable price fluctuations, billing irregularities, and potentially fraudulent claims.

On this audit, we will (a) utilize data mining to identify those DME claims that represent a "High Risk" of violating state regulations; (b) evaluate MassHealth's regulations, policies, procedures, and controls over DME claims; (c) conduct site visits at sampled DME providers to review files and document providers' billing policies and control procedures, and compliance with applicable regulations; and (d) consult with other state Medicaid programs about their pricing practices for DME.

## **3. Dr. Shahrzad Haghayegh-Askarian and Hancock Dental, P.C.**

Dr. Shahrzad Haghayegh-Askarian and Hancock Dental, P.C., which is owned by Dr. Haghayegh-Askarian, were originally selected for review as part of the OSA's recently completed audit, Review of Controls over Dentist Billings for Detailed Oral Screenings and Other Dental Procedures (No. 2011-1374-3C).

However, Dr. Haghayegh-Askarian refused to produce for the OSA her billing records and those of Hancock Dental, P.C. Consequently, the OSA filed legal action against Dr. Haghayegh-Askarian and Hancock Dental, P.C. to enforce provisions of the 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-Askarian and Hancock Dental, P.C. to produce for the OSA all accounts, books, records, and activities, including patient medical records, regarding their MassHealth billings for dental services.

The OSA is currently auditing these records to ensure that Dr. Haghayegh-Askarian and Hancock Dental, P.C. submitted claims in accordance with state regulations, including the requirement to maintain adequate documentation to support these claims.

#### **4. Data Mining Initiative – Medical and Dental Services for Children**

The OSA is currently utilizing data mining software to analyze claims paid by MassHealth during fiscal years 2012 and 2013 for medical and dental services provided to children under the age of thirteen years. The purpose of this work is to identify any unusual trends in the claims submitted by physicians and dentists who treated young children. Based upon the results of this work, we will determine whether subsequent detailed audits are required at any provider locations.

## **5. Geriatric Authority of Holyoke**

Based upon two separate requests from the Board of Directors of the Geriatric Authority of Holyoke and the Holyoke City Council, the OSA is conducting an audit of the Geriatric Authority of Holyoke (Authority) for the period January 1, 2010 through June 30, 2012. The purpose of our audit is to determine whether the Authority has (a) established adequate internal controls over its revenues and expenditures and (b) developed policies and procedures to help ensure efficient and effective program operations. During fiscal year 2011, the Authority received Medicaid funding totaling \$5,482,631, which represents 85.6% of its total funding for the period.

## **6. Review of Medicaid Claims for Drug Screenings (No. 2012-1374-3C)**

The OSA is conducting an audit of laboratory claims paid by MassHealth for drug testing services during the period July 1, 2008 through June 30, 2011. On this audit, we are determining whether drug testing claims paid by MassHealth were for medically necessary purposes; whether they were accurate and properly supported by required documentation; whether services were provided; and whether billings and payments complied with applicable laws, rules, and regulations.

## **7. Review of Controls over Pharmaceutical Drugs (No. 2012-1374-3C2)**

The OSA is conducting an audit of MassHealth's Pharmacy Program for the period July 1, 2009 through June 30, 2011. This audit focuses on MassHealth's payment of claims for pharmaceutical drugs with the highest potential for abuse (i.e., narcotics



and stimulants). We are evaluating the effectiveness of MassHealth's internal controls over the processing of claims to ensure that claims were processed in compliance with applicable laws, rules, and regulations; to detect billing trends and/or anomalies that may warrant further investigation of pharmacies, physicians, and/or members; and to evaluate MassHealth's policies and procedures for monitoring and overseeing Pharmacy Program activities.

## **AUDIT IMPACT AND MASSHEALTH'S POST AUDIT EFFORTS**

The objectives of the performance audits conducted by the OSA at MassHealth 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.

In this regard, as a result of the OSA's audit work, MassHealth has instituted a number of operational changes that will result in the prevention of millions in unnecessary payments for Medicaid services annually.

To follow up with audited agencies on recommendation implementation and the resulting outcomes, Auditor Bump initiated post-audit review surveys that are issued six months after the release of an audit with findings.

This process highlights the public interest in using audit recommendations to strengthen government operations by enhancing efficiency, effectiveness, accountability, and transparency.

During the past year, the OSA requested that MassHealth respond to post-audit surveys regarding the seven Medicaid audits completed by the OSA since November 2010. We conducted these survey reviews to determine whether MassHealth had implemented

recommendations we made for improving the Medicaid program and its efforts to recoup monies owed to the Commonwealth -- over \$6 million-- from service providers due to questionable, unallowable, and potentially fraudulent payments. Based upon the survey results, MassHealth has fully implemented 31% of our audit recommendations and the remaining 69% are in various stages of implementation. Additionally, MassHealth is actively pursuing the recovery of the \$6 million due from service providers, but many of the affected providers are contesting the recovery effort. The tables below detail MassHealth's post-audit efforts during the reporting period.

<b>MassHealth – Administration of Dental Claims</b>		
Audit No. 2009-8018-14C Issued November 16, 2010		
<b>Number of Recommendations</b>	<b>Fully Implemented</b>	<b>In Progress</b>
12	7	5

This audit identified over \$5.5 million in overcharges to the Commonwealth by dental and orthodontic providers as well as over \$150,000 lost to inefficient billing practices. In addition, the audit revealed potentially fraudulent billings for services never provided, inadequate system tools to detect unallowable billings, and the overexposure of children to radiation resulting from X-rays in excess of nationally accepted standards.

In response, MassHealth stated that it is seeking \$3.55 million in recoupment from dental providers for unallowable charges. In addition, MassHealth indicated that it has instituted policy, regulatory, and system edit changes that it claims has resulted in \$3.7 million in

savings for fiscal year 2011 and that will, based on a similar continued pattern, lead to approximately \$4.4 million in ongoing annual savings.

MassHealth also indicated that it has updated the dental program’s operational guide and instructions for providers, which now incorporates U.S. Food and Drug Administration, U.S. Department of Health and Human Services, and American Dental Association guidelines and will reduce the amount of radiation to which children are exposed. MassHealth instructed its dental plan administrator (DentaQuest, which conducts periodic data analyses to identify problems) to conduct an initial investigation of excessive X-ray billing (defined as 30 or more X-rays per patient per provider within 12 months) beyond the period and scope of the audit. Subsequent to the post-audit review, MassHealth’s Dental Director informed the OSA that DentaQuest installed an edit that will prevent the payment of more than 19 X-rays per member per rolling 12 months and expressed consideration for reducing the number further to 15.

Regarding the potentially fraudulent billings for services never provided, the OSA referred the matter to the Office of the Attorney General.

<b>Dr. Doreen Chong, DDS</b> <b>Review of Claims Submitted to MassHealth</b> Audit No. 2011-4545-3C Issued May 10, 2011		
<b>Number of Recommendations</b>	<b>Fully Implemented</b>	<b>In Progress</b>
1	0	1

This audit found that Dr. Chong submitted claims and received payments for \$82,316 in X-rays, orthodontic consultations, periodic orthodontic visits, and retention treatment that were noncompliant with MassHealth regulations. These regulations require orthodontic X-rays be requested and authorized by MassHealth. However, the audit reported that over 3,000 X-rays were performed and paid for that MassHealth did not request. System edits were not in place to reject claims for separate X-rays that should have been included in the billing for the overall orthodontic diagnostic treatment.

MassHealth stated that, based on the OSA’s audit, it is pursuing reimbursement of \$82,316.

<b>Dr. Melvin M. Frankel, DMD</b> <b>Review of Claims Submitted to MassHealth</b> Audit No. 2011-4546-3C Issued May 10, 2011		
<b>Number of Recommendations</b>	<b>Fully Implemented</b>	<b>In Progress</b>
3	0	3

This audit found that Dr. Frankel submitted claims and received payments for \$222,866 in X-rays, orthodontic consultations, and retention treatment that were noncompliant with MassHealth regulations. Regulations require orthodontic X-rays be requested and authorized by MassHealth. However, the audit reported that over 4,800 X-rays were performed and paid for that MassHealth did not request. In addition, the audit found that

Dr. Frankel received \$4,982 in duplicate payments and \$1,408 for 10 member visits that were never performed.

MassHealth stated that, based on the OSA's audit, it is pursuing reimbursement of \$229,256.

<b>Community Counseling of Bristol County, Inc.</b>		
<b>MassHealth Inquiry</b>		
Audit No. 2011-4551-3C Issued September 30, 2011		
<b>Number of Recommendations</b>	<b>Fully Implemented</b>	<b>In Progress</b>
1	1	0

This audit found that duplicate payments totaling \$7,918 were made to Community Counseling of Bristol County, Inc. (CCBC). MassHealth reported that it recovered the full \$7,918 in overpayments made to CCBC. MassHealth also said that this problem will not reoccur, as the legacy system that processed these claims has been updated and strengthened.

In addition, MassHealth said that it investigated further into all similar providers for the same issue and identified \$20,718 in potential duplicate payments. The UMMS Provider Compliance Unit was determining final overpayments, sending out provider notices, and initiating recovery of these funds.

SmileCenter – MassHealth Inquiry		
Audit No. 2011-4552-3C Issued December 1, 2011		
Number of Recommendations	Fully Implemented	In Progress
13	0	11

Action on two recommendations was reported as planned.

This audit identified unallowable payments totaling \$253,519 made to a MassHealth Dental provider SmileCenter, a sole proprietor located in Plymouth. Included among them were unallowable orthodontic procedures resulting from the practitioner lacking the required orthodontic training. Other unallowable billings involved: detailed oral screenings, fluoride treatments, dental services, oral/facial photographic images, and conflicts between records and billings.

MassHealth informed the OSA that it has terminated this practitioner’s orthodontic specialty and has initiated a cost recovery action worth \$253,519, reflecting the total of 10 recommendations involving unallowable billings. The practitioner has a pending appeal before MassHealth’s Board of Hearings on both the recovery and orthodontic termination.

MassHealth also said that it has reviewed its codes relative to oral evaluations and the palliative treatment of dental pain in conjunction with its regulations ensuring the implementation of proper system edits. MassHealth reported that it is conducting a

quality assurance review in conjunction with the dental plan administrator, DentaQuest, to implement and enhance system edits.

Finally, MassHealth stated that in accordance with the OSA’s recommendations, it will instruct DentaQuest to conduct a full audit of SmileCenter from 2007 to 2012. It also stated that it is regularly reviewing dental program reimbursement regulations to ensure that they are understandable and consistent with state and federal regulations and policies.

The Carson Center for Human Services, Inc.		
Audit No. 2011-4548-3C Issued December 8, 2011		
Number of Recommendations	Fully Implemented	In Progress
1	1	0

The OSA’s audit of the Carson Center for Human Services (CCHS), a Westfield-based provider of behavioral health and rehabilitative services, identified that CCHS received unallowable Medicaid payments totaling \$1,925.

CCHS reported that it has returned the full \$1,925 in overpayments as requested by MassHealth. The Carson Center also stated that it has a system to resolve any future overpayments made to the agency.

MassHealth Eligibility
Audit No. 2010-1374-3C Issued October 17, 2012



<b>Number of Recommendations</b>	<b>Fully Implemented</b>	<b>In Progress</b>
10	2	7

Our audit of the MassHealth’s eligibility determination process for healthcare services previously discussed in this report found, among other issues, that the process MassHealth uses to verify the self-reported income of applicants/members is not consistent with state and federal regulations and needs to be improved to ensure that only eligible individuals receive benefits.

In response, MassHealth stated that it has fully implemented two recommendations related to using Department of Revenue (DOR) data. MassHealth is now using DOR quarterly wage data as a form of income verification at the time of application. MassHealth also instituted processes utilizing DOR’s 14-day new hire reports and the quarterly wage data to identify members with changed circumstances and re-verify, adjust or terminate benefits. These processes will also focus on members reporting zero income who appear on these reports.

MassHealth reported that actions on the seven recommendations are in progress. Among them are

- Monitoring the development of the Integrated Eligibility System, a component of the Affordable Care Act that will enable real-time access to Internal Revenue Service and other state and federal data in January, 2014,
- Instituting the use of residency verification software used by the Commonwealth Connector and similar to frequently used private-sector systems,
- Developing a new protocol for eligibility workers to identify and resolve discrepancies in residency-related documents, and

- Utilizing newly accessed information from the Massachusetts State Lottery Commission resulting from the successful pursuit of a statutory change, signed into law on Feb. 19, 2013.

The remaining three recommendations in progress and the one recommendation with no specific action noted by MassHealth are being addressed through the corrective measures being taken by MassHealth to address our other recommendation (e.g., the use of the new data access, systems, software and procedures as stated above.)