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

March 15, 2017–March 14, 2018

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# OFFICE OF THE STATE AUDITOR
# MEDICAID AUDIT UNIT

## March 15, 2017—March 14, 2018

## 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 2017 budget (Chapter 47 of the Acts of 2017) requires that OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 15, 2018 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."

OSA submits all costs (direct and indirect) associated with running this unit to the Executive Office of Health and Human Services (EOHHS) to be included in its in quarterly filings with the Centers for Medicare and Medicaid Services for federal cost sharing. In calendar year[1] 2017, OSA submitted a total of $1,444,621 to EOHHS for consideration for the state's program integrity, allowing the state to obtain a 50%, or $722,312, reimbursement of these costs.

This report, which is being submitted by OSA in accordance with the requirements of Chapter 47, provides summaries of three performance audits involving the following:

- fee-for-service payments for services covered by the Massachusetts Behavioral Health Partnership
- payments for the durable medical equipment program
- nursing-facility per-diem payments

1. The federal government uses the calendar year as its fiscal year.

It also summarizes six MassHealth medical provider audits involving the following:

- providers that were paid for evaluation and management services (three audits)
- hospice-care providers (two audits)
- a vision-care provider (one audit)

In addition, it summarizes four audits of human-service providers; these included reviews of MassHealth's payments for adult foster care and home health services.

It also summarizes 17 MassHealth audits that are currently underway. Finally, it details the corrective measures and related outcomes reported by the auditees, including MassHealth, in relation to our findings and recommendations for 12 audits.

For fiscal year 2018, the appropriation for the Unit was $1,163,789. This amount represents a less than 1% increase over the Unit's fiscal year 2017 appropriation of $1,152,276. During this reporting period, the Unit completed 9 audits and initiated 17.

This report details findings that identified more than $211 million in unallowable, questionable, duplicative, unauthorized, or potentially fraudulent billings—a potential return of more than $183 for every dollar of funding appropriated to the Unit. The report also describes corrective actions being taken by MassHealth as a result of 12 audits whose findings were issued at least six months ago for which a follow-up survey has been completed and MassHealth has taken actions to begin recouping funds. Auditees reported action or planned action on 87% of our audit recommendations, which will improve operational efficiency and effectiveness. MassHealth stated that it was pursuing up to $2,125,318 in recoveries as a result of the Unit's audit work.

## Background

EOHHS administers the state's Medicaid program, known as MassHealth, which provides access to healthcare services annually to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2017, MassHealth paid more than $15.3 billion to healthcare providers, of which approximately 50% was Commonwealth funds. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the US Government Accountability Office (GAO) placed the US 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, 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, OSA has maintained ongoing independent oversight of the MassHealth program and its contracted service providers. Audit reports issued by 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, OSA uses data-mining software in all phases of audits conducted by the Unit. By so doing, our auditors can identify areas of high risk, isolate outlier providers, and in many cases perform reviews of 100% of the claims under audit, thus significantly improving the efficiency and effectiveness of our audits. The Unit also uses data mining and analytics to identify trends and anomalies that may be indicative of billing irregularities and potentially fraudulent situations. Moreover, data mining has enabled the Unit to fully quantify the financial effects of improper payments, 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 savings, (2) isolate weaknesses in MassHealth's claim-processing system, and (3) make meaningful recommendations regarding MassHealth's system and program regulations to promote future cost savings, improve service delivery, and make government work better.

# COMPLETED AUDITS

## (March 15, 2017–March 14, 2018)

During this reporting period, the Office of the State Auditor (OSA) released nine audit reports on MassHealth's administration of the Medicaid program and on Medicaid service providers' compliance with state and federal laws, regulations, and other authoritative guidance. These reports identified millions of dollars in questionable, unallowable, unauthorized, and potentially fraudulent payments and made a number of recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work.

## Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by the Massachusetts Behavioral Health Partnership (2015-1374-3M11)

OSA conducted an audit of MassHealth's activities to determine whether MassHealth disallowed fee-for-service (FFS) claims for services that should have been covered by the Massachusetts Behavioral Health Partnership (MBHP) in accordance with its contract with the Executive Office of Health and Human Services (EOHHS) as well as applicable regulations and other requirements for the period July 1, 2010 through June 30, 2015. MBHP is responsible for providing behavioral-health and substance-use treatment services for MassHealth members enrolled in its Primary Care Clinician Plan and members enrolled with other MassHealth managed-care organizations that contract with MBHP for these services. This audit focused on reviewing operating policies and procedures and control activities, including system edits, to ensure that MassHealth did not pay twice for a member's behavioral-health services. This could occur if MassHealth paid the monthly fee (capitation payment) to MBHP to provide behavioral-health services and then paid a provider directly via an FFS payment.

Our audit found that MassHealth paid providers $192,600,577 for improper or questionable FFS claims for services that were already covered by the MBHP contract. These improper payments comprised $92,021,777 for services that were not properly identified by MassHealth's Medicaid Management Information System (MMIS) as covered by MBHP, $896,786 for services that were covered by the MBHP contract but paid as FFS, and $99,682,014 for behavioral-health services that should have been covered by the MBHP contract.

As a result of these findings, OSA recommended that MassHealth (1) establish recoupment efforts for the questioned improper payments, (2) develop a more explicit master list of covered behavioral-health services, and (3) design system edits to prevent and deny FFS payments for these covered services.

## Office of Medicaid (MassHealth)—Review of Claims for Durable Medical Equipment (2016-1374-3M12)

OSA conducted an audit of paid claims for durable medical equipment (DME) for the period July 1, 2010 through December 31, 2015. MassHealth covers medically necessary DME for its members, including wheelchairs, traction equipment, canes, crutches, walkers, kidney machines, ventilators, monitors, pressure mattresses, lifts, and nebulizers. The purpose of this audit was to determine whether MassHealth paid for DME based on state regulations and the schedule of published rates established by the Center for Healthcare Information and Analysis (CHIA).

Our audit showed that MassHealth did not pay DME providers in accordance with the CHIA rate schedule; this resulted in overpayments of $57,067. Additionally, our audit identified 2,931 claims, totaling $148,978, in duplicate payments for the same equipment provided to the same member. This type of duplicate payment would occur when a DME provider submitted a claim for equipment to Medicare, which covered the equipment, and was paid by MassHealth for a separate claim for the same item. Our audit report recommended that MassHealth recover all overpayments, ensure that its claim-processing system was promptly updated with DME rate changes sponsored by CHIA, and develop system edits to ensure that providers that submit duplicate Medicare and Medicaid claims received payment for only the portion of the Medicare claim that was not paid by Medicare.

## Office of Medicaid (MassHealth)—Review of Payments for Nursing-Facility Claims (2016-1374-8M)

OSA conducted an audit of MassHealth's payment of claims submitted by nursing facilities for the period January 1, 2010 through June 30, 2015. The purpose of this audit was to determine whether MassHealth properly paid nursing facilities for room and board provided to its

members. MassHealth pays nursing facilities based on their applicable rates[2] for each member's level of care and the number of days the member stayed in the facility. MassHealth's Office of Long-Term Services and Supports is tasked with performing semiannual audits, referred to as Management Minute Questionnaire (MMQ) audits, at each nursing facility to review each resident's level of care through detailed reviews of his/her medical records. Adjustments are made to each member's level of care accordingly, which affects the per diem payment rate.

Our audit found that 34,572 nursing facility payments required adjustment based on MMQ audits during the audit period, but MassHealth did not recoup the overpayments it made. This resulted in $639,445 in unrecouped overpayments. Additionally, we found that MassHealth's contractor did not update members' levels of care based on MMQ audit results in a timely manner; this resulted in overpayments of $326,201.

As part of this audit, we identified two other issues. First, MassHealth did not adjust detailed claim information in its claim-processing system (MMIS) for amounts it had already recouped. This affected over $3 million in payments for nursing-facility per diem services. Second, we identified a weakness in user access controls in MMIS: MassHealth personnel and contracted personnel could update records that affected members' levels of care and nursing facilities' per diem rates even though no properly authorized EOHHS access request forms had been signed and approved by their managers.

Our report recommended that MassHealth recover all identified overpayments from nursing facilities, create system edits to adjust all nursing-facility claim submissions for members whose levels of care were adjusted because of MMQ audits, develop policies and procedures to validate that it promptly updated members' levels of care in MMIS, ensure that all nursing-facility recoupments were properly reflected in the MMIS detailed claim data, and require managers to follow its protocols when requesting access to MMIS functions for staff and contractors.

2. Nursing-facility rates are determined by CHIA and are specific to each nursing facility. Each nursing facility can receive a rate adjustment for factors such as capital improvements and kosher meals for residents.

## Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Paid to Resil Medical Associates, P.C. (2016-1374-3M14)

OSA conducted an audit of evaluation and management (E/M) services paid to Resil Medical Associates, P.C. (RMA) for the period July 1, 2010 through December 31, 2015. During this period, the medical practice was paid approximately $512,000 to provide E/M services for 866 MassHealth members. The purpose of this audit was to determine whether the practice billed MassHealth for E/M services that were medically necessary, supported by appropriate documentation, and in accordance with certain state regulations.

We tested a statistically random sample of 67 out of 4,516 E/M claims paid to RMA. Because the sample was statistical, we were able to project the potential error to the population. Of these 67 claims, we identified 23 as claims for services that were performed by independent nurse practitioners (NPs) and non-independent NPs. Instead of billing for these services using the required modifier codes, RMA billed for them as if they had been performed by a physician. Services provided by independent and non-independent NPs are paid at lower rates than those provided by physicians. We projected these results to the population of all E/M claims using a 90% confidence level and a 10% margin of error. The result was a projected overpayment of $17,346[3] for the audit period.

While testing the statistical sample of 67 E/M claims, we found three other problems and expanded our testing to determine their impact. First, for 2 of the 67 sampled claims, RMA did not use properly licensed staff members to perform complex E/M services. Because MassHealth members' health could be at risk, we expanded our testing of E/M claims and found that staff members who were certified as registered nurses (RNs) had performed high-complexity E/M services, totaling $2,467, even though RNs are only certified to perform low-complexity E/M services.

Additionally, using paid claims, RMA's patient appointment schedules, staff locator sheets and hours worked, and medical records, we found that Dr. Resil did not always provide supervision for his RNs and non-independent NPs as required by MassHealth's regulations. Also, Dr. Resil and his NPs (independent and non-independent) did not document the required collaborative

3. Based on our statistical sampling approach, we are 90% confident that the overpayment for the audit period ranges from $17,346 to $33,158.

arrangements and prescriptive-practice guidelines to ensure that NPs practiced within the scope of their licenses. Both of these problems could jeopardize RMA patients' safety.

To resolve these problems, our audit report recommended that RMA, among other things, (1) collaborate with MassHealth to repay the approximately $19,813 identified in improper payments, (2) cease having RNs perform high-complexity E/M services, (3) work with MassHealth to identify all instances in which RNs performed high-complexity services, (4) adjust its website and billing system to ensure that its patients were aware of the certifications of its employees and that the employees' services were properly billed at the correct rates, (5) establish the required collaborative arrangements that detailed medical services and prescriptive practices each staff member could perform, and (6) ensure that Dr. Resil was present to provide appropriate supervision of all services provided by his non-independent NPs.

## Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Paid to Lawrence Family Doctors (2017-1374-3M6)

OSA conducted an audit of E/M services paid to Lawrence Family Doctors (LFD), owned by Dr. Joel Gorn, for the period January 1, 2010 through June, 30 2016. During this period, the medical practice was paid approximately $1,223,444 to provide E/M services for 1,763 MassHealth members. The purpose of this audit was to determine whether the practice billed MassHealth for E/M services provided to members by its NPs in accordance with certain state regulations.

We tested a statistically random sample of 179 out of 13,391 paid E/M claims from the audit period, using an expected error rate of 50%, a desired precision of 15%, and a confidence level of 95%, to determine whether LFD properly billed MassHealth for these services. Because the sample was statistical, we were able to project the potential error to the population. Of these 179 claims, 125 (70%) were identified as claims for services that were performed by Dr. Gorn's NPs. Instead of billing for these services using the required modifier, LDF billed for them as if they had been performed by Dr. Gorn. Services provided by NPs are paid at lower rates than those provided by physicians. We projected these results to the population of all E/M claims using a 95% confidence level and a 15% margin of error. The result was a projected overpayment of $108,232 for the audit period.

While testing the statistical sample of 179 E/M claims, we found that, for 11 claims, the medical records did not contain documentation of the nature, extent, and medical necessity of services provided to members. Additionally, these medical records were missing components required for E/M claims, including documentation of examinations, medical histories, and/or descriptions of chief complaints, to justify using the codes billed. Also, for another 16 of the 179 tested claims, LFD could not provide the medical records to validate the nature, extent, and medical necessity of care provided to the members

To resolve these problems, our audit report recommended that LFD, among other things, (1) collaborate with MassHealth to repay the approximately $108,232 identified in improper payments, (2) ensure that services performed by NPs were billed properly using the required modifier, and (3) ensure that it maintained necessary documentation to support the nature, extent, and medical necessity of care provided to members, including documentation of examinations, medical histories, and chief complaints.

## Office of Medicaid (MassHealth)—Review of Hospice Care Billing: HopeHealth Massachusetts, Inc. (2017-1374-3M1C)

OSA conducted an audit of hospice claims paid to HopeHealth Massachusetts, Inc. for the period July 1, 2011 through June 30, 2016. During this period, MassHealth paid HopeHealth approximately $17,483,302 to provide hospice care to 611 MassHealth members. The purpose of this audit was to determine whether HopeHealth billed MassHealth for appropriate hospice care, including routine home care, general inpatient care, and long-term room and board, and whether it documented these services in member medical records in accordance with certain applicable MassHealth regulations.

We tested a nonstatistical sample of 30 out of 611 members who received services from HopeHealth during the audit period. Additionally, we selected a judgmental sample of 28 members based on two isolated risk factors: whether they had been in hospice care for more than two years and whether MassHealth paid for hospice care after the dates of death recorded in MMIS.

Our audit found that HopeHealth did not maintain properly completed required documentation for hospice care and that some member files contained inaccurate information. For 27 out of the 58 sampled members, HopeHealth did not maintain properly completed Certification of

Terminal Illness (CTI) Forms or Hospice Election Forms. Additionally, 7 of the 58 tested member medical records contained inappropriate or conflicting documentation: 5 member files included medical forms and other documentation belonging to other HopeHealth patients, 1 member file was missing the Discharge Summary Form, and 1 member file had two Discharge Summary Forms stating conflicting reasons for discharge (one indicated "death" and the other "no longer eligible for hospice services"). We questioned a total of $2,171,683 of hospice claims paid by MassHealth because member records did not have the required CTI Forms or Hospice Election Forms.

To resolve this problem, our audit report recommended that HopeHealth take the necessary measures to ensure that all required forms (CTI Forms, Hospice Election Forms, and Discharge Summary Forms) were complete, accurate, and compliant with MassHealth regulations, as well as taking measures to avoid commingling patients' information in medical files.

## Office of Medicaid (MassHealth)—Review of Hospice Care Billing: Good Shepherd Community Care (2017-1374-3M10)

OSA conducted an audit of hospice claims paid to Good Shepherd Community Care for the period July 1, 2011 through June 30, 2016. During this period, MassHealth paid Good Shepherd approximately $5,992,563 to provide hospice care to 376 MassHealth members. The purpose of this audit was to determine whether Good Shepherd billed MassHealth for appropriate hospice care, including routine home care, general inpatient care, and long-term room and board, and whether it documented these services in member medical records in accordance with certain applicable MassHealth regulations.

We tested a nonstatistical sample of 30 out of 376 members who received services from Good Shepherd during the audit period. Additionally, we selected a judgmental sample of 4 members based on two isolated risk factors: whether they had been in hospice care for more than two years and whether MassHealth paid for hospice care after their dates of death.

Our audit found that Good Shepherd did not maintain properly completed required documentation for hospice care. For 17 out of 34 members' medical records tested, Good Shepherd did not maintain properly completed CTI Forms or Hospice Election Forms. We questioned a total of $866,234 of hospice claims paid by MassHealth because member records did not have the required CTI Forms or Hospice Election Forms.

To resolve this problem, our audit report recommended that Good Shepherd take the measures necessary to ensure that all required forms (CTI Forms and Hospice Election Forms) were complete, accurate, and compliant with MassHealth regulations.

## Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Submitted by Dr. Hooshang Poor (2016-1374-3M3)

OSA conducted an audit of E/M claims paid to Dr. Hooshang Poor for the period January 1, 2012 through September 30, 2015. We expanded our audit period for certain issues back through May 1, 2010 and forward through October 31, 2016. During this period, MassHealth paid Dr. Poor approximately $746,322 to provide E/M services for 977 MassHealth members residing in nursing facilities and rest homes. The purpose of this audit was to determine whether Dr. Poor billed MassHealth for E/M services using appropriate procedure codes and modifier codes, met recordkeeping requirements, and provided supervision of NPs and a PA engaged in prescriptive practices in accordance with certain laws, rules, and regulations.

We performed a mix of probe sample testing, statistical sample testing, testing on samples of services provided, and data analytics for this audit. Our two probe samples covered all claims paid in January 2015 to determine whether Dr. Poor (1) billed and was paid for services not performed (ghost services) and (2) billed for NP and PA services without modifier codes. Based on the results of these tests, we conducted tests using two distinct statistical samples using a 95% confidence level and 5% precision. Since we used statistical samples, we were able to project our findings to the entire population. We also tested a sample of 57 members who each received more than 5 services in a month; we applied what we learned from this sample to 100% of Dr. Poor's E/M services using data analytics.

Our audit found that Dr. Poor did not properly submit claims for E/M services provided to MassHealth members. Our audit questioned the following seven areas:

- Dr. Poor billed for excessive E/M services, totaling $176,730, provided to members in nursing facilities and rest homes. These services exceeded the monthly allowed visits and were not related to emergency services.
- Dr. Poor improperly billed 92 out of a statistical sample of 176 claims without using the required modifier for E/M services provided by his NPs and PA. We extrapolated this error and questioned $35,541.

- Dr. Poor billed for $15,477 of E/M services performed while he was out of the country, based on our review of his travel itinerary from May 2010 through April 2016.

- Dr. Poor and his NPs and PA did not establish written prescriptive guidelines that would have ensured that the NPs and PA received proper guidance from Dr. Poor on matters related to prescribing. The NPs and PA wrote 657 prescriptions for MassHealth members without these written guidelines.

- Dr. Poor did not use the correct procedure codes when billing for $12,608 of services provided to MassHealth members residing in rest homes.

- Dr. Poor did not maintain proper documentation for 34 out of a statistical sample of 240 claims tested. We extrapolated this error and questioned $79,388 in E/M services provided to MassHealth members.

- Dr. Poor did not prepare legible documentation to support 455, totaling $24,501, of 822 claims tested.

To resolve these problems, our audit report recommended that Dr. Poor collaborate with MassHealth to repay all improper payments he received for excessive and/or unnecessary services, services billed while he was out of the country, services performed by his NPs and PA and billed without the required modifier, services billed using the wrong procedure codes, services billed without proper supporting documentation, and services for which the medical records were illegible. It also recommended that he ensure that his NPs and PA only prescribed within a written prescriptive-practice arrangement as required.

## Office of Medicaid (MassHealth)—Review of Vision-Care Claims Paid to Dr. Wenshang Yao (2017-1374-3M4)

OSA conducted an audit of vision-care claims paid to Dr. Wenshang Yao for the period July 1, 2011 through June 30, 2016. During this period, MassHealth paid Dr. Yao approximately $1,210,513 to provide vision care to MassHealth members. The purpose of this audit was to determine whether vision care provided to MassHealth members was medically necessary, properly supported by documentation, and allowable in accordance with MassHealth regulations.

We selected a statistically random sample of 180 out of 35,351 paid vision-care claims from the audit period, using an expected error rate of 50%, a desired precision of 15%, and a confidence level of 95%, to determine whether Dr. Yao properly billed MassHealth for these services. Additionally, we applied data analytical procedures to 100% of Dr. Yao's claims for dispensing

services (fitting of eyeglasses to a member's face). Our audit found that Dr. Yao billed using his provider identification number for an extrapolated amount of $396,962 in vision-care services that were performed by other vision-care providers, not Dr. Yao. For 10 of the 180 claims in our statistical sample, Dr. Yao billed for the wrong date of service. Finally, Dr. Yao improperly billed for a total of $218,784 in dispensing services for which he did not personally fit the new eyeglasses to the members' faces.

To resolve these problems, our audit report recommended that Dr. Yao collaborate with MassHealth to repay the approximately $396,962 of vision care that he did not personally provide and that he repay, at a minimum, $28,744 of dispensing services for eyeglasses that were never ordered from MassHealth's vision-care supplier or were never picked up. Finally, we recommended that Dr. Yao only bill for dispensing services at the time he fits eyeglasses to the members' faces.

# AUDITS OF HUMAN-SERVICE PROVIDERS

The Commonwealth annually awards contracts totaling more than $3 billion to human-service providers, and the Office of the State Auditor (OSA) has an ongoing program of conducting audits of these providers. Since March 15, 2017, OSA's Division of Contract Audits has issued audit reports on four human-service providers certified by MassHealth to provide group adult foster care (GAFC) services to its members. Although these audits were not conducted by the OSA Medicaid Unit, they identified a significant issue that involved Medicaid funds. Specifically, in these four reports, OSA disclosed as an "Other Matter"—an issue outside the scope of these audits, but substantial enough to be disclosed in the reports—that MassHealth had allowed the four providers to bill a cumulative total of more than $12 million for unallowable adult foster care (AFC). OSA determined these payments to be duplicative because these human-service providers provided AFC in-home care on days when the patients also received skilled nursing services. This is contrary to the GAFC guidelines and MassHealth regulations. The table below lists the four providers and the amounts our audits questioned as duplicative for the period July 1, 2011 through June 30, 2016.

| Audit Number | Human-Service Provider | Questioned Amount |
|---|---|---|
| **Report No. 2016-4596-3C** | Medical Community Services, Inc. | $ 1,434,256 |
| **Report No. 2016-4593-3C** | Community Connection Healthcare LLC | 1,814,810 |
| **Report No. 2016-4598-3C** | SafetyNet Solutions Inc. | 1,848,082 |
| **Report No. 2016-4595-3C** | Nizhoni Community Care LLC | 7,821,600 |
| **Total** | | $ 12,918,748 |

OSA recommended that these four human-service providers collaborate with MassHealth to prevent duplicative payments for duplicative member services.

In these four audits, we also found that MassHealth may be able to realize significant savings by changing how it administers medications to GAFC members. Currently, when a GAFC member cannot manage his/her own medications, the GAFC provider notifies the member's physician, who writes a referral for medication management and sends it to the GAFC provider. The GAFC provider typically contracts with a visiting nurse association to provide the needed services and then bills MassHealth directly for the services. GAFC providers use registered nurses (RNs) to manage medication because the home health agencies they use to provide services under the

Group Adult Foster Care Program are not qualified to manage medication according to MassHealth regulations. However, medication could be managed by certified nursing assistants (CNAs) who are certified in medication management.

We believe there appears to be an opportunity for significant savings if MassHealth, rather than paying directly for skilled nursing from RNs, directs GAFC providers to use CNAs who are certified in medication.

# CURRENT INITIATIVES

During this reporting period, the Office of the State Auditor (OSA) began or continued work on 17 audits on MassHealth's administration of the Medicaid program and on Medicaid service providers' compliance with state and federal laws, regulations, and other authoritative guidance. These audits were selected based on our research and applied data analysis to identify areas of risk in the state's Medicaid program. We anticipate that these audits will identify millions of dollars in questionable, unallowable, unauthorized, and potentially fraudulent payments. As part of our current initiatives, we will make recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work in process.

- A review of claims paid for members with both Medicaid and Medicare eligibility (referred to as "dual eligible" members) for the period July 1, 2010 through June 30, 2015. We will determine whether MassHealth inappropriately paid healthcare expenses for members already covered by Medicare.

- A review of MassHealth members' access to counseling services when they were being treated with buprenorphine/naloxone (also known as suboxone) for substance use disorders (SUDs) for the period January 1, 2011 through March 31, 2017. We will determine whether members who had SUDs and were being treated with buprenorphine/naloxone had access to appropriate counseling services to aid in their recovery.

- A review of pharmacy claims paid by MassHealth for refilled prescriptions for the two-and-a-half-year period ended June 30, 2017. We will determine whether MassHealth improperly paid for prescription refills that the pharmacy program had specifically eliminated or disallowed, including whether (1) prescription refills exceeded the maximum number allowed per year, (2) emergency refills exceeded the allowed period (72 hours or 3 days), (3) refills were dispensed one year or more after the prescription dates, (4) refills exceeded the number allowed on a prescription, (5) refills were provided when there was no indication of whether the prescription could be refilled, (6) refills were provided when there was no specific request from the member or his/her caregiver to refill the prescription (e.g., when the prescription was an auto-refill), or (7) "splitting" of prescriptions occurred with refills. (Splitting is a potentially fraudulent billing scheme; prescriptions generally are required to be 30-day supplies or more.)

- A review of a vision-care provider for the five-and-a-half-year period ended December 31, 2016. This audit will determine whether the optometrist properly billed and maintained appropriate documentation for services he provided on a statistical sample of patients, including patients residing in state facilities (such as those operated by the state Department of Youth Services) and in homes run by the Department of Children and Families.

- A review of services provided by an SUD treatment provider for the three-year period ended December 31, 2016. We will determine whether the provider properly documented SUD treatment and drug tests provided to MassHealth members and used the drug tests to treat and diagnose the members.

- A review of an orthodontic-service provider for the five-year period ended June 30, 2017. We will determine whether orthodontic services provided to MassHealth members were properly supported by documentation and allowable in accordance with certain MassHealth regulations.

- A review of MassHealth's recoupment processes for the five-year period ended December 31, 2017. We will determine whether MassHealth's recoupment processes effectively identified, recorded, and collected all overpayments and recoupments.

- Four separate audits of MassHealth's enrollment offices (Tewksbury, Chelsea, Springfield, and Taunton) for the two-year period ended December 31, 2017. We will determine whether the enrollment offices effectively evaluated new applicants in accordance with certain MassHealth eligibility requirements.

- Four separate audits of certain adult day health (ADH) centers for the two-year period ended December 31, 2017. We will determine whether the ADH centers maintained proper documentation and provided services to MassHealth members in accordance with certain MassHealth regulations.

- A review of claims for drug tests and drug screens for the period March 1, 2013 through June 30, 2017. We will determine whether MassHealth properly identified and denied payment for both duplicate and unbundled drug tests. This audit will follow up on our prior audit on this subject (No. 2013-1374-3C), in which OSA identified significant weaknesses in these areas resulting in millions of dollars of improper claim payments.

- A review of drug tests that MassHealth paid for during the audit period to determine whether the nature and frequency of member drug testing complied with MassHealth regulations, which allow authorized prescribers treating MassHealth members to order and use drug tests for diagnosis, treatment, or otherwise medically necessary purposes. The audit period is July 1, 2012 through June 30, 2016. In a previously issued audit report (No. 2012-1374-3C), OSA disclosed significant weaknesses in MassHealth's claim-processing system for drug tests, which resulted in millions of dollars in potentially improper payments.

# 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 in the MassHealth system. Consequently, while measures such as referrals to law enforcement for prosecution, 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 order to assess the impact of all our audits and the post-audit efforts made by auditees to address issues raised in our reports, 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 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, OSA issued, and agencies completed, 12 post-audit surveys regarding Medicaid audits. This number reflects audits with findings issued at least six months ago for which a follow-up survey has been completed. The self-reported surveys are issued six months after an audit is issued to allow management time to plan and implement its corrective action. Because the voluntary survey is sent to MassHealth six months after an audit ends, not all of the audits issued during the period covered by this report are included in this section of the report, as some surveys have not yet been completed.

According to the survey results, MassHealth reported that it has acted, or will act, on implementing 40 of 46 recommendations: 30 are fully implemented, 8 are in progress, and 2 are planned.

Two recommendations were reported as having no action taken. One provider did not take action because it had discontinued its participation in the Group Adult Foster Care Program, and the other did not take action because the action recommended was not in its capacity to perform.

Four recommendations were disputed by three different providers. One dental provider issued a letter to MassHealth (via the University of Massachusetts Medical School) disputing the conclusions of two OSA recommendations; one medical provider disputed the need to collaborate with MassHealth to review instances in which supervising physicians and registered nurses (RNs) worked in the same location; and one human-service provider essentially stated that MassHealth was responsible for responding to a recommendation about group adult foster care (GAFC).

From the survey results, MassHealth has successfully sought, or will seek, recovery of up to $2,125,318. This includes the recovery of $1,132,321 in overpayments to nursing facilities and $666,805 in improper payments for services covered by the Massachusetts Behavioral Health Partnership (MBHP). According to MassHealth, it also includes $227,189 in overpayments concerning durable medical equipment that the agency is in the process of recovering, $79,190 of improper payments for periapical radiographs that it has recovered, and $19,813 that one medical provider plans to reimburse MassHealth for evaluation and management (E/M) services performed by a nurse practitioner (NP) and for an improper payment. The tables and narratives below detail MassHealth's and the auditees' post-audit efforts during the reporting period.

## 1. Centro Las Americas, Inc.

**Audit No. 2016-4591-3C** **Issued September 6, 2016**
**Survey Response Received March 30, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **4** | 3 | 1 | N/A | • Internal reporting has been amended to maintain unallowable costs in separate accounts to better identify and report them on its Uniform Financial Statements and Independent Auditor's Reports (UFRs) |

In its survey response, Centro Las Americas, Inc. stated that it had fully implemented all three of the formal audit recommendations. The organization has resubmitted its UFRs for fiscal years 2014 and 2015, identifying the unallowable costs properly, and has applied available offsetting revenue to cover those costs accordingly. Internal reporting has also been amended to maintain unallowable costs in separate accounts to better identify and report such information on Centro's UFRs. Centro's procurement policy has also been amended to include a competitive bidding process for purchases of goods and services over $25,000.

As an "Other Matter"—an issue that is outside the scope of the audit but is substantial enough to be reported—OSA disclosed that MassHealth allowed Centro to bill $300,004 for unallowable adult foster care (AFC). OSA recommended that Centro collaborate with MassHealth to find out whether MassHealth would cease to pay for these services. On this recommendation, Centro has pursued and will continue to pursue clearer guidance from MassHealth on this matter. MassHealth stated that it was aware of the situation.

## 2. Nonotuck Resource Associates, Inc.

**Audit No. 2016-4592-3C** **Issued December 6, 2016**

**Survey Response Received July 14, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **7** | 7 | 0 | N/A | • Nonotuck has established written policies and procedures for consultant contracts<br>• Nonotuck has strengthened its procedures to ensure that all AFC and Department of Developmental Services care provider files contain the required documents |

Findings from the audit of the Northampton-based Nonotuck Resource Associates, Inc., a not-for-profit human-service agency that offered AFC that was billable to MassHealth, stated that the agency lacked written, signed, and/or current contracts for five consultants; did not maintain required documentation in its personnel files; and charged $4,304 of nonreimbursable costs to its state contracts.

Nonotuck responded that it had fully implemented all six of the formal audit recommendations. Nonotuck has established written policies and procedures for consultant contracts, which ensure that the agency pays a set cost for the contracts' established time periods. It has developed a consultant contract database to carefully track the execution of such documents. Nonotuck has strengthened its procedures to ensure that all AFC and Department of Developmental Services care provider files contain the required documents and has centralized these files in its headquarters. Finally, to address the $4,304 of nonreimbursable costs, Nonotuck refiled its 2014 UFR and has established procedures to ensure that such costs are identifiable and properly classified on the annual UFR.

OSA disclosed as an "Other Matter" that MassHealth allowed Nonotuck to bill $164,649 for unallowable AFC and recommended that Nonotuck collaborate with MassHealth to find out whether MassHealth will cease to pay for these services. On this recommendation, Nonotuck reported that MassHealth had started to share the information that prevents disallowed duplication of AFC. As a result, before it begins any AFC, Nonotuck now consults with MassHealth before performing services in order to prevent disallowed duplication of care.

## 3. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Dr. Najmeh Rashidfarokhi

**Audit No. 2016-1374-3M11** **Issued February 10, 2017**
**Survey Response Received September 19, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **2*** | 0 | 0 | N/A | • Dr. Rashidfarokhi says that she will explicitly document in her patient charts the reasons for taking a periapical radiograph and will only bill allowable radiographs under the MassHealth regulation |

* Both findings/recommendations were disputed by Dr. Rashidfarokhi.

The audit of MassHealth dental-service provider Dr. Najmeh Rashidfarokhi found that Dr. Rashidfarokhi submitted claims, and was paid approximately $267,251, for unallowable dental periapical radiographs. Specifically, she billed for dental periapical radiographs performed as part of routine dental examinations. A periapical radiograph shows the whole tooth from the top to the jaw. When taken independently (not as one of a periodic full set of radiographs), it is used to locate problems with a tooth and the surrounding areas. MassHealth regulations allow periapical radiographs to be taken by a dental-service provider either as part of a full-mouth series of radiographs (allowed once every three years) or to evaluate a specific dental problem independently. They are not to be part of routine examinations.

Dr. Rashidfarokhi disputed both of OSA's recommendations. Dr. Rashidfarokhi has sent a letter to MassHealth (via the University of Massachusetts Medical School, which contracts with MassHealth to perform reviews, audits, and recoveries for the agency) disputing OSA's figures and conclusions. However, she says that she will explicitly document in her patient charts the reasons for taking periapical radiographs and will only bill allowable radiographs under the MassHealth regulation.

## 4. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Sawan & Sawan, DMD

**Audit No. 2016-1374-3M11B** **Issued February 10, 2017**
**Survey Response Received September 12, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **3** | 3 | 0 | $79,190 | • The practice has repaid to MassHealth the $79,190 identified as improper payments received for periapical radiographs |

Audit findings from the review of MassHealth dental-service provider Sawan & Sawan, DMD revealed that Sawan & Sawan submitted claims, and was paid approximately $79,190, for unallowable dental periapical radiographs. Specifically, it billed for dental periapical radiographs as part of routine dental examinations. Also, in some cases the dental records were incomplete, so OSA could not determine the reasons periapical radiographs were taken.

In its survey response, Sawan & Sawan, DMD stated that it had fully implemented all three recommendations. It has repaid to MassHealth the $79,190 identified as improper payments received for periapical radiographs, has ensured that it will follow regulations concerning billing for periapical radiographs, and has improved its recordkeeping process, which will help it make sure that its records reflect the need for periapical radiographs for MassHealth members.

## 5. Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by the Massachusetts Behavioral Health Partnership

**Audit No. 2015-1374-3M11** **Issued April 3, 2017**
**Survey Response Received November 20, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **4** | 1 | 3 | $666,805 | • The provider has implemented new system edits to improve behavioral-health billing<br>• As a result of actions taken, $666,805 will be recovered or saved |

The audit of MassHealth's contract with MBHP found that MassHealth paid providers $192,600,577 for improper or questionable claims for services that should have been paid for by MBHP.

The approximately $100 million of questionable payments were for services that should have been included in MBHP's contract. MassHealth made approximately $93 million of improper payments to providers on a fee-for-service basis after it had paid MBHP a fixed monthly payment to cover the same services.

Additionally, auditors disclosed $10,623,476 in behavioral-health services that were included in payment amount per episode (PAPE) claims. MassHealth had used PAPE payments for individual episodes of care that involved both general medical care and behavioral-health services. MassHealth should have identified the behavioral-health services and directed them to MBHP for payment. However, MassHealth did not have a system edit to identify behavioral-health care within PAPEs.

MassHealth replied that it had fully implemented one recommendation. MassHealth no longer uses PAPE for acute outpatient hospital payments. According to the agency, before the audit, it had recognized that the acute outpatient payment process needed updating and had proceeded to do so. As a result of this action, proper payments of PAPE claims will commence, resulting in a cost savings of $92,070.

Three recommendations were listed as in progress. Concerning recoupment of the $93 million in payments identified as improper, MassHealth stated after several reviews that more than 99% of the claims were paid correctly. However, it also stated that new system edits had been put in to place to improve behavioral-health billing in August 2017. MassHealth noted that it was pursuing $503,028 in recoupment as part of the contract reconciliation process with MBHP.

With regard to the $100 million of questionable claims, after review, MassHealth stated that more than 98% of the claims related to that finding were in fact proper. The agency implemented additional system edits and noted that it planned to recoup $53,396. MassHealth was also developing a list of comprehensive behavioral-health services outlining provider types and procedure codes for claims that MBHP would cover and process. MassHealth further stated that 270 claims for services, totaling $18,311, were improperly paid and cost savings in that amount would be realized as a result of the edits to the behavioral-health procedure and revenue codes.

## 6. Medical Community Services, Inc.

**Audit No. 2016-4596-3C** **Issued April 6, 2017**
**Survey Response Received November 9, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **1** | 1 | 0 | N/A | • Provider is collaborating with MassHealth on finding out whether MassHealth intends to cease paying for duplicative GAFC |

Responding to the post-audit survey, Medical Community Services, Inc. (MCS), a Framingham-based GAFC business, stated that it was collaborating with MassHealth on finding out whether MassHealth intended to cease paying for duplicative GAFC. MCS stated that the company had updated its risk-management policies and procedures to address duplication of services and cost control for GAFC. The audit had found that MassHealth allowed MCS to bill for $1,434,256 in unallowable GAFC, and in the survey, MCS stated that MassHealth wanted to continue paying for these services, if they are crucial for patients' wellbeing.

## 7. Office of Medicaid (MassHealth)—Review of Claims for Durable Medical Equipment

**Audit No. 2016-1374-3M12** **Issued April 13, 2017**
**Survey Response Received November 20, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **5** | 3 | 2 | $227,189 | • MassHealth instituted a system edit that triggers a prepay review of certain claims that may have also been paid as crossover claims<br>• MassHealth entered into a contract with a third-party administrator to recover $227,189.48 of overpayments |

Audit findings from a review of MassHealth's paid claims for durable medical equipment (DME) indicated that MassHealth did not pay DME providers in accordance with the Center for Healthcare Information and Analysis's rate schedule. This resulted in overpayments totaling $57,067. In addition, MassHealth made $148,978 of duplicate payments to DME providers.

MassHealth responded that it had fully implemented three recommendations. MassHealth's DME program staff regularly reviews all DME rate changes to ensure their timely entry in the Medicaid Management Information System (MMIS). The agency also instituted a system edit that triggers a prepay review of certain claims that may have also been paid as crossover claims. Additionally, MassHealth issued DME provider bulletins in September 2016 clarifying and emphasizing providers' responsibilities in submitting crossover claims for DME.

Two recommendations were in progress. MassHealth had entered into a contract with a third-party administrator to recover $227,189.48 of overpayments and duplicate payments.

## 8. Nizhoni Community Care LLC

**Audit No. 2016-4595-3C** **Issued April 18, 2017**
**Survey Response Received November 7, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **1*** | 0 | 0 | N/A | • Nizhoni discontinued participation in the Group Adult Foster Care Program |

* No action was taken on the sole recommendation.

In replying to the survey, Nizhoni Community Care LLC stated that it had not taken any action on OSA's one recommendation (to collaborate with MassHealth to find out whether MassHealth intends to cease paying for GAFC that was duplicative and unallowable when a member was receiving skilled nursing care). The agency stated that it had discontinued its participation in the Group Adult Foster Care Program.

## 9. Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Paid to Resil Medical Associates, P.C.

**Audit No. 2016-1374-3M14** **Issued April 24, 2017**
**Survey Response Received November 23, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **11*** | 8 | 0 | $19,813 | • Provider plans to reimburse MassHealth $19,813 in improper payments |

* Two recommendations were planned, and one was disputed.

Auditors discovered in the review of E/M claims paid by MassHealth to Resil Medical Associates, P.C. (RMA) that RMA did not always use properly licensed staff members to perform high-

complexity E/M services; it used RNs instead of NPs. Additionally, RMA improperly billed MassHealth for $17,346 of E/M services performed by NPs. Further, required physician supervision was not always given to non-independent NPs, and RMA lacked collaborative arrangements and prescriptive-practice guidelines for independent NPs.

RMA stated that it had fully implemented eight recommendations. According to RMA, two NPs now provide services under appropriate supervision by a physician and the practice has updated its website to accurately reflect personnel licensure. RMA also stated that it had modified its eClinical system to record service-provider information and to use such information in billing MassHealth for E/M services. Further, RMA said that it had implemented internal controls to ensure accuracy of claims submitted, begun periodically reviewing MassHealth billing requirements, ensured that the supervising physician was on site when non-independent NPs were attending to patients, developed a collaborative arrangement detailing medical services and prescriptive practices for independent NPs, and established policies ensuring that independent NPs functioned within the scope of their licensure.

Two recommendations had action planned. RMA planned to reimburse MassHealth for a total of $19,813 in improper payments: $2,467 for an unspecified improper payment and $17,346 for E/M services performed by NPs.

RMA disputed one finding and recommendation. Concerning collaborating with MassHealth to determine any additional funds due the Commonwealth in instances where the supervising physician and RNs worked in the same location, RMA stated that all decisions were made by the supervising physician and that the RNs only helped in that process.

## 10. Office of Medicaid (MassHealth)—Review of Payments for Nursing-Facility Claims

**Audit No. 2016-1374-3M8** **Issued April 28, 2017**
**Survey Response Received November 20, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **6** | 4 | 2 | $1,132,321 | • MassHealth recovered $1,132,321 in overpayments to nursing facilities<br>• MassHealth contracted with a third-party administrator to perform Management Minute Questionnaire (MMQ) reviews and update level-of-care changes in MMIS |

An audit of MassHealth's payment of claims submitted by nursing facilities revealed that MassHealth had not recovered $639,445 of overpayments to nursing facilities. Additionally, MassHealth had not ensured that records of members' care levels were promptly updated; this had resulted in a further $326,201 of overpayments. The agency also did not update specific claim information in MMIS for approximately $3 million of recoupments from nursing facilities, and it had granted MMIS access privileges to staff members without proper documentation.

MassHealth stated that it had fully implemented four recommendations. It has implemented a change to MMIS to adjust affected nursing-facility claims after MMQ audits, eliminating the need for nursing facilities to resubmit adjusted claims. It has also contracted with a third-party administrator to perform MMQ reviews and update level-of-care changes in MMIS. Additionally, deficiencies in the Executive Office of Health and Human Services' off-boarding process for user accounts in MMIS have been identified and are in the process of being remediated.

Two recommendations were reported as in progress. MassHealth has recovered $1,132,321 in overpayments to nursing facilities, with $124,521 in overpayments still outstanding as of November 2017.

## 11. Community Connection Healthcare LLC

**Audit No. 2016-4597-3C** **Issued May 23, 2017**
**Survey Response Received December 18, 2017**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **1*** | 0 | 0 | N/A | • No action was undertaken because the action recommended was not within Community Connection Healthcare LLC's (CCHC's) capacity to change |

* CCHC did not take any action on the recommendation.

The audit disclosed an "Other Matter": MassHealth allowed CCHC to bill $1,814,810 for unallowable GAFC. OSA recommended that CCHC collaborate with MassHealth to find out whether it intended to stop paying for these duplicative services.

In response to the survey, CCHC stated that it had not taken any action on OSA's recommendation. CCHC said the recommendation was not within its capacity to change, but rather would need to be executed by MassHealth.

## 12. SafetyNet Solutions Inc.

**Audit No. 2016-4598-3C** **Issued July 11, 2017**
**Survey Response Received February 6, 2018**

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---|---|---|---|---|
| **1*** | 0 | 0 | N/A | • MassHealth intended to put forth GAFC regulations in fall 2017, clarifying when GAFC services do not duplicate other member services |

* This provider disputed the finding.

The audit disclosed an "Other Matter": MassHealth had allowed SafetyNet Solutions Inc. (SNS) to bill as much as $1,848,082 for unallowable GAFC. OSA recommended that SNS collaborate with MassHealth to find out whether it intended to cease paying for these duplicative services.

SNS responded to the post-audit survey by disputing the finding and recommendation; it referred OSA to the response given by MassHealth to characterize its own response. MassHealth stated that its regulations did allow for individuals in GAFC to receive skilled nursing services as well.