



# The Commonwealth of Massachusetts

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**INDEPENDENT STATE AUDITOR'S REPORT ON  
CERTAIN ACTIVITIES OF THE  
OFFICE OF MEDICAID AS ADMINISTERED BY  
MASSHEALTH IN THE PAYMENT OF DURABLE  
MEDICAL EQUIPMENT AND  
MEDICAL/SURGICAL SUPPLY CLAIMS  
JULY 1, 2005 TO JUNE 30, 2006**

**OFFICIAL AUDIT REPORT  
NOVEMBER 25, 2008**

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### INTRODUCTION

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MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services to approximately one million low and moderate-income individuals, couples, and families in Massachusetts. In fiscal year 2006, MassHealth paid in excess of \$6.4 billion on 47.4 million claims to approximately 28,000 providers, of which 50% was federally funded. In fiscal year 2007, MassHealth paid in excess of \$6.2 billion (of which 50% was federally funded) on 49.3 million claims to 30,000 providers within the Commonwealth. In fiscal year 2006, MassHealth paid \$38,330,633 on 644,036 claims to 168 Durable Medical Equipment and Medical/Surgical Supplies (DME) providers. In fiscal year 2007, MassHealth paid \$42,308,030 on 700,375 claims to 153 DME providers. Products categorized as DME include wheelchairs and accessories, incontinence supplies, respiratory equipment, personal emergency response systems (PERS), and other medical and surgical supplies.

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, we conducted an audit of DME provider claims for the fiscal year ended June 30, 2006. Our audit was conducted in accordance with applicable generally accepted government auditing standards. Our objectives were to determine whether DME providers are submitting proper claims and providing the appropriate services to consumers, and whether claims are complete, accurate, and in compliance with applicable laws, rules and regulations, which include a requirement that the provider maintain adequate proof of delivery and medical necessity. In order to accomplish our objectives, we utilized a randomly selected statistical sample of 189 paid claims in fiscal year 2006. We also reviewed provider reimbursement rates set by the Division of Health Care Finance and Policy (DHCFP) within the EOHHS and paid by MassHealth to determine whether the rates are the most cost-effective for the prescribed medical necessity.

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### AUDIT RESULTS

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#### 1. INADEQUATE INTERNAL CONTROLS AT MASSHEALTH MAY HAVE RESULTED IN CLAIM OVERPAYMENTS TOTALING AS MUCH AS \$4.9 MILLION DURING FISCAL YEAR 2006

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Our audit disclosed that MassHealth's internal controls and policies and procedures over DME claims processing and payment were not adequate to ensure that the claims were properly supported with required documentation and in compliance with applicable laws, rules, and regulations because MassHealth's oversight did not include a periodic review of the documentation supporting the claims.

We selected a random sample of 189 paid claims totaling \$7,903 in fiscal year 2006 and questioned 17 claims totaling \$1,129 (questioned claims are defined as claims that are not in compliance with applicable laws, rules, and regulations, are not supported by adequate documentation, or appear to be unreasonable). Specifically, three of these claims lacked required certification of medical necessity, and 16 claims lacked the documentation of proof of delivery of DME. Based on the extrapolated results of the value of the claims in our statistical stratified audit sample to the entire population, as much as \$4.9 million

questioned or potentially fraudulent payments could have been made to DME providers during fiscal year 2006.

In response to the audit report MassHealth stated that they had conducted an internal review of the 17 questioned claims in our report, “and determined that the claims were properly supported, authorized and submitted in accordance with applicable laws, rules and regulations.”

The 130 Code of Massachusetts Regulations (CMR), Recordkeeping Requirements, is very specific as to the form and content of documentation required to be maintained by the provider. None of the 17 questioned claims were supported by sufficient adequate documentation, and were not in compliance with the requirements prescribed by 130 CMR 409.000.

The need for strict enforcement of the documentation requirements of proof of delivery and medical necessity are well chronicled. The Government Accountability Office (GAO) report released in July 2008<sup>1</sup> stated:

*According to the Department of Health and Human Services (HHS), schemes to defraud the Medicare program have grown more elaborate in recent years. In particular, HHS has acknowledged Centers for Medicare and Medicaid Services (CMS) oversight of suppliers of DME, prosthetics, orthotics (DMEPOS) is inadequate to prevent fraud and abuse.*

We therefore restate our position that MassHealth’s internal controls and polices and procedures over DME claims processing and payments were not adequate to ensure that the claims were properly supported with required documentation and in compliance with applicable laws, rules, and regulations.

## **2. SAVINGS OPPORTUNITIES OF \$7 MILLION PER YEAR COULD HAVE BEEN ACHIEVED IN THE PAYMENT RATES TO DME PROVIDERS AND THE RENTAL ARRANGEMENTS OF PERSONAL EMERGENCY RESPONSE SYSTEMS**

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We compared the rates (for claims audited in our sample) established by DHCFP to the published reimbursement rates paid by the State of New York for the same products or services provided in order to determine the reasonableness of the rates being paid by MassHealth. This comparison disclosed that if MassHealth had paid the same rates for these products as those being paid by the State of New York, it would have realized a potential savings in fiscal year 2006 of approximately \$6 million. Moreover, we found a number of the products for sale at retail outlets priced lower than the DHCFP reimbursement rates, evidence suggesting the retail providers are buying at lower rates than those established by DHCFP.

Further, we found that substantial cost savings can be achieved by renting Personal Emergency Response Systems (PERS) on an annual basis rather than the current practice of monthly rental. PERS is an electronic device that attaches to a telephone line and can be activated in an emergency, enabling the patient to communicate with a central monitoring station. To be eligible for PERS coverage, the patient must have conditions that cause multiple functional limitations, such as those that cause difficulties with endurance and ambulation and contribute to a homebound status. Our audit disclosed

<sup>1</sup> GAO-08-955, Medicare – Covert Testing Exposed Weaknesses in the Durable Medical Equipment Supplier Screening Process.

that many PERS providers offered a selection of rental programs with varying terms and rates. DHCFP established the rental rates based on a monthly rental even though quarterly and annual rental terms are available at substantially lower rates. The utilization of an annual rental program would be cost-effective if the majority were long-term PERS users. We calculated that the average PERS system had been in use for 42.3 months at the end of fiscal year 2006, and therefore was long-term. Our analysis disclosed that the use of annual rates, as compared with monthly rental rates, would have produced a potential annual savings of \$1.3 million in fiscal year 2006 without affecting the quality of the services provided. We concluded that an annual rental rate is both cost-effective and prudent. Also, the loss in savings in fiscal year 2006 will carry forward to fiscal year 2007 and beyond until change is implemented.

DHCFP is not required to compare rates with neighboring states or research alternative rental terms for DME products and services. Regulations do require that providers make reasonably certain that DME is furnished in the most cost-effective manner. An effective internal control system would require periodic comparison of established rates with those of neighboring states and alternative rental terms and pricing offered by providers in order to ensure the cost-efficient delivery of services to MassHealth members. MassHealth would have realized a total savings of approximately \$7.3 million on \$38,330,633 in paid claims, or 19.2%, had DHCFP taken advantage of more competitive rates for DME and PERS products.

In response to the audit report, MassHealth stated that the \$6 million potential savings to be gained by substituting New York rates for DHCFP was overstated because the OSA did not take into account claims paid at a lower amount than the DHCFP published rates. Our savings calculations were based on the assumption that New York State also pays providers at less than published rates when the provider bills at lower rates. We found examples within our sample where MassHealth paid the claim at less than DHCFP rates and instances where the payment was in excess of the New York rates. Therefore, we conclude that the influence of these “lower rates” would be immaterial.

In regard to our finding that the adoption of a longer-term rental program for PERS would result in \$1.3 million, or in excess of 30% savings, MassHealth responded that it would continue to evaluate various payment methodologies and purchasing strategies for PERS. We encourage MassHealth to begin the negotiation of a longer-term rental program for PERS to realize the annual savings as reported.

We reassert our position that MassHealth could have overpaid \$4.9 million in inadequately documented claims and would have realized a savings of approximately \$7.3 million on \$38,330,633 in paid claims or 19.2% had DHCFP taken advantage of more competitive rates for DME and PERS products. We strongly recommend that MassHealth adopt our recommendations in order to take advantage of cost saving opportunities, particularly during the current economic climate.

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## INTRODUCTION

### *Background*

MassHealth, within the Executive Office of Health and Human Services (EOHHS), administers the Medicaid program, which provides access to health care services to approximately one million low- and moderate-income individuals, couples, and families in Massachusetts. The Executive Office of Health and Human Services (EOHHS) is the largest secretariat in the Commonwealth, with a budget that equals approximately 40% of the Commonwealth's total operating expenditures. Medicaid expenditures alone represent in excess of 25% of total Commonwealth expenditures. In fiscal year 2006, MassHealth paid in excess of \$6.4 billion on 47.4 million claims to approximately 28,000 providers, of which 50% was federally funded. In fiscal year 2007, MassHealth paid in excess of \$6.2 billion (of which 50% was federally funded) on 49.3 million claims to 30,000 providers within the Commonwealth.

Prior to 2003, the Massachusetts Division of Medical Assistance (DMA) was the single state agency responsible for administering Medicaid as provided for under Title XIX<sup>2</sup> of the Social Security Act. In 2003, the reorganization of EOHHS combined Medicaid and the Children's Health Insurance Program (CHIP), as provided for under Title XXI<sup>3</sup> of the Social Security Act, with MassHealth, which also manages the Insurance Partnership for small businesses.

Chapter 26, Section 15, of the Acts of 2003 requires EOHHS to be organized so that it serves as the principal agency of the executive department for: (a) developing, coordinating, administering, and managing the health, welfare, and human services operations, policies, and programs; (b) supervising and managing the organization and conduct of the business affairs of the departments, commissions, offices, boards, divisions, institutions, and other entities within the executive office to improve administrative efficiency and program effectiveness and to preserve fiscal resources; (c) developing and implementing effective policies, regulations, and programs to ensure the coordination and quality of services provided by the secretary and all of the departments, agencies,

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<sup>2</sup> Social Security Act Title XIX: "For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States that have submitted, and had approved by the Secretary [of EOHHS], State plans for medical assistance."

<sup>3</sup> Social Security Act Title XXI: "The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children."

commissions, offices, boards, and divisions; (d) acting as the single state agency under Section 1902 (a)(5) of the Social Security Act authorized to supervise and administer the state programs under Title XIX, for the programs under Titles IV(A), IV(B), IV(E), XX, and XXI of the Social Security Act, and for the programs under the Rehabilitation Act; and (e) maximizing federal financial participation for all agencies, departments, offices, divisions, and commissions within EOHHS.

MassHealth paid \$38,330,633 on 644,036 claims to 168 Durable Medical Equipment and Medical/Surgical Supplies (DME) providers in fiscal year 2006 and \$42,308,030 on 700,375 claims to 153 DME providers in fiscal year 2007. Products categorized as DME include wheelchairs and accessories, incontinence supplies, respiratory equipment, personal emergency response systems (PERS), and certain medical and surgical supplies, nutritional supplements, and intravenous pumps. Included in paid DME claims in fiscal year 2006 were \$4,363,730 in payments to 15,482 members requiring PERS services.

MassHealth makes payments for all in-state non-institutional providers in accordance with the methodology established by the Division of Health Care Finance and Policy (DHCFP) in EOHHS,<sup>4</sup> subject to federal payment limitations.<sup>5</sup> DHCFP is mandated under Chapter 118G of the Massachusetts General Laws to establish the rates paid to providers of health care services by governmental units. The MassHealth program is the largest state-run program for which the DHCFP sets payment rates. Chapter 118G, Section 7, of the Massachusetts General Laws also sets forth the criteria to be used in establishing rates of payment to providers of services, as follows:

*DHCFP shall control rate increases and shall impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated facilities and providers. Such methods and standards may include, but are not limited to the following: peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or other limitations on the utilization of temporary nursing or other personnel services; use of national or regional indices to measure increases or decreases in reasonable costs; limits on administrative costs associated with the use of management companies; the availability of discounts for large volume purchasers; the revision of existing historical cost bases, where applicable, to reflect norms or models of efficient service delivery; and other means to encourage the cost-efficient delivery of services. Rates produced using these methods and standards shall be in conformance with Title XIX<sup>6</sup>, including the upper limit on provider payments.*

All providers are regulated under the provisions of the Commonwealth of Massachusetts Division of Medical Assistance Provider Manual Series, All Provider Manuals, 130 Code of Massachusetts

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<sup>4</sup> 130 Code of Massachusetts Regulations 450.232: Rates of Payment to In-State Providers

<sup>5</sup> 42 Code of Federal Regulations 447.304

<sup>6</sup> Title XIX: Grants to States for Medical Assistance Programs of the Social Security Act is administered by the Centers for Medicare and Medicaid Services

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Regulations (CMR) 450. The Durable Medical Equipment Manual, 130 CMR 409, establishes the specific requirements for the purchase, rental, and repair of DME and for the purchase of medical/surgical supplies under MassHealth, and the Oxygen and Respiratory Therapy Equipment Manual, 130 CMR 427, establishes the requirements and procedures for the purchase, rental, and repair of oxygen and respiratory therapy equipment and supplies.

For a large percentage of DME procedure codes, the Commonwealth's Medicaid reimbursement rate set by DHCFP is based on the federal Medicare payment schedule as established by Centers for Medicare and Medicaid Services (CMS). At a news conference in Los Angeles on January 9, 2008, Medicare officials stated that the agency pays more than the market rate for DME, and the acting administrator of CMS was quoted as saying, "We know we overpay for medical equipment" in announcing the expansion of a competitive bidding and accreditation program for DME providers. The official acknowledged that there are significant problems with providing DME in the Medicare program and said, "We also know this is an area where there is substantial fraud." A Medicare fraud investigator within the U.S. Department of Health and Human Services Office of the Inspector General (HHS/OIG) said that in fiscal year 2006, administrators estimated that 10% to 20% of Medicare's total cost of \$360 billion represents fraud, waste, and abuse.

In the report "*A Comparison of Medicare Program and Consumer Prices for Power Wheelchairs*," dated October 2007, the HHS/OIG found that federal agency rates for certain products are in excess of those that could be purchased by the consumer directly, as follows:

*Medicare fee schedule amounts for power wheelchairs were 45% higher than median Internet prices available to consumers in the first quarter of 2007.*

*Medicare and its beneficiaries could have achieved savings during the first quarter of 2007 had Medicare reimbursements more closely resembled prices available to consumers over the Internet.*

The HHS/OIG recommended that CMS, the rate-setting body for Medicare, consider performing additional reviews to determine whether the current fee schedule rates for certain procedure codes were appropriate. CMS concurred with the recommendation.

MassHealth will pay up to the Medicaid-allowable rate less any Medicare payment or the co-insurance and deductible amount, whichever is less. In those instances in which MassHealth members are also recipients of Medicare, Medicare will pay 80% of the rate established by CMS, and the remaining 20% balance of the bill may be paid by a third-party insurer (private insurance

company), Medicaid, or a combination thereof. When paid by MassHealth it is referred to as a “Medicare crossover” payment.

The provider has the responsibility for making reasonably certain that the DME or medical/surgical supplies furnished are the most cost-effective, given the medical need for which they are prescribed and the member's physical limitations. Before purchasing equipment or supplies, the provider must make a reasonable effort to purchase the item from the least-costly reliable source by comparing prices charged by different suppliers for comparable items.<sup>7</sup> Moreover, providers are required to maintain documents that confirm delivery, the medical necessity of the product or service, and in some instances prior approval, and an invoice detailing the provider's cost of the product. Prior to July 1, 2004, all providers were restricted to the markup on a product's cost and had to maintain the invoice for its purchase as evidence of the provider's cost.<sup>8</sup> However, as of July 1, 2004, restrictions on the amount of provider markup were no longer regulated for most DME products.

The providers of DME products and services included in our audit sample were all specialty medical equipment suppliers. These providers purchase products either directly from manufacturers or through distributors. All DME products were delivered directly to the MassHealth member's residence.

### ***Audit Scope, Objectives, and Methodology***

In accordance with Chapter 11, Section 12, of the General Laws, we conducted an audit of DME provider claims for the fiscal year ended June 30, 2006. Our audit was conducted in accordance with applicable generally accepted government auditing standards. Our objectives were to determine whether DME providers were submitting proper claims, providing appropriate services to consumers, and whether DME claims were complete, accurate, and in compliance with applicable laws, rules, and regulations, which require the provider to maintain adequate documentation of proof of delivery and medical necessity. We also reviewed provider reimbursement rates set by DHCFP within the EOHHS and paid by MassHealth to determine whether the rates are the most cost-effective for the prescribed medical necessity.

Our audit was conducted as part of the Office of the State Auditor's on-going independent statutory oversight of the Commonwealth's Medicaid program. In January 2003, the U.S. Government

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<sup>7</sup> 130 CMR 409.432: Provider Responsibility, 130 CMR 427.429: Provider Responsibility.

<sup>8</sup> DME Provider Manual, 130 CMR 409.

Accountability Office (GAO) placed the U.S. Medicaid Program on its list of government programs that are at “high risk” of fraud, abuse, or mismanagement.

In order to accomplish our objectives, we utilized a randomly selected statistical sample of 189 paid claims in fiscal year 2006, which allows us to express our results with a 90% confidence level and an error rate of +/- 6%, as follows:

***Stratified Random Sample of DME Claims***

Fiscal Year 2006	Amount	Percentage Amount to Total	Quantity Claims	Percentage Quantity Claims to Total	Average Claim Value	Claim Sample
All Claims	\$38,330,633	100.0%	644,036	100.0%	\$59.52	189
<b>STRATA</b>						
PERS	\$4,348,923	11.3%	145,204	22.5%	\$29.95	43
Wheelchairs & Accessories	\$8,798,474	23.0%	58,322	9.1%	\$150.86	17
Incontinence	\$6,280,402	16.4%	73,065	11.3%	\$85.96	21
Respiratory Equipment	\$6,960,677	18.2%	149,139	23.2%	\$46.67	44
All Other	\$11,942,157	31.2%	218,306	33.9%	\$54.70	64

Our review of selected claims included direct confirmation with providers of the evidence supporting medical necessity, prior authorization, proof of delivery, and provider cost for the DME product or service provided. We compared the rates established by DHCFP for all the procedure codes in our sample with those published for the same codes by the State of New York. Moreover, for selected products, we compared the DHCFP rates with retail prices available to the general public. We researched the pricing/rental terms offered by various PERS providers and visited a provider at its place of business. We also met with various members of management at MassHealth and EOHHS during the audit.

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## AUDIT RESULTS

### 1. INADEQUATE INTERNAL CONTROLS AT MASSHEALTH MAY HAVE RESULTED IN CLAIM OVERPAYMENTS TOTALING AS MUCH AS \$4.9 MILLION DURING FISCAL YEAR 2006

Our audit disclosed that MassHealth's internal controls and policies and procedures over Durable Medical Equipment and Medical/Surgical Supplies (DME) claims processing were not adequate to ensure that the claims were properly supported with the required documentation, and complete, accurate, and in compliance with applicable laws, rules, and regulations. We audited a random sample of 189 paid claims totaling \$7,903 in fiscal year 2006 and questioned 17 claims totaling \$1,129 (questioned claims are defined as claims that are not in compliance with applicable laws, rules, and regulations, are not supported by adequate documentation, or appear unreasonable). Specifically, three of these claims lacked the required certification of medical necessity, and 16 claims lacked documentation of proof of delivery of DME (two of the claims were missing both adequate proof of delivery and medical necessity documentation). Questioned claims are, by definition, not necessarily fraudulent; however, with respect to the 17 questioned claims, there exists a possibility that the DME should not have been delivered, or was not delivered as required. As a result, MassHealth has no assurance that these claims were compliant. Our previous audit reports (Nos. 2004-1374-3S and 2005-1374-3S1A) disclosed significant weaknesses in MassHealth's ability and efforts to detect fraud in the Commonwealth's Medicaid program.

MassHealth's potential overpayment of these DME claims resulted because MassHealth's oversight did not include a periodic review of the supporting claims documentation. Because of an inadequate system of internal controls, policies, and procedures that requires the DME provider to maintain supporting documentation for claims, and the lack of post-payment audits, adequate edits in Medicaid Management Information System (MMIS), or other on-going monitoring activities of DME claims, the risk of questionable or fraudulent claims is high. Our review of claims disclosed missing or inadequate documentation for certain DME, as follows:

	Questioned Claims	Missing or Inadequate Proof of Delivery	Missing or Inadequate Medical Necessity Documentation
Personal Emergency Response System (PERS)	5	5	-
Wheelchairs & Accessories	-	-	-
Incontinence*	4	4	1
Respiratory Equipment*	2	1	1
All Other	<u>6</u>	<u>6</u>	<u>1</u>
Totals	<u>17</u>	<u>16</u>	<u>3</u>

\*One claim in category was missing both adequate proof of delivery and medical necessity documentation.

Based on the extrapolated results of the value of the claims in our statistical stratified audit sample to the entire population, \$4.9 million of questioned and potentially fraudulent claims may have been paid to DME providers during fiscal year 2006, as follows:

Fiscal Year 2006	Paid Claims	Claims in Sample	Value of Claims in Sample	Value of Questioned Claims	Percentage Amount Questioned*	Extrapolated Value of Questioned Claims**
PERS	\$ 4,348,923	43	\$1,303	\$ 158	12.1%	\$ 526,220
Wheelchairs & Accessories	8,798,474	17	806	-	-	-
Incontinence	6,280,402	21	2,587	485	18.7%	1,174,435
Respiratory Equipment	6,960,677	44	1,810	210	11.6%	807,439
All Other	<u>11,942,157</u>	<u>64</u>	<u>1,397</u>	<u>276</u>	19.8%	<u>2,364,547</u>
Totals	<u>\$38,330,633</u>	<u>189</u>	<u>\$7,903</u>	<u>\$1,129</u>		<u>\$4,872,641</u>

\*Percentages have been rounded to nearest single decimal place.

\*\*The total extrapolated value is the sum of the categories.

The 130 Code of Massachusetts Regulations (CMR) 409.434, *Recordkeeping Requirements*, states the following:

*The provider must keep a record of all DME, repair services, and medical/surgical supplies furnished to a member for at least four years following the date of service. This record must include the following:*

- (A) *a physician's prescription for all rentals and purchases;*
- (B) *a copy of the approved prior-authorization request for all equipment, supplies, or services requiring prior authorization;*
- (C) *an acknowledgment of receipt, signed by the member or the member's representative, of prescribed equipment or supplies, that includes:*
  - (1) *the date of receipt of equipment or supplies;*

- (2) *the condition of the equipment or supplies (for example, whether it is in proper working order, damaged, etc.);*
  - (3) *the manufacturer, brand name, model number, and serial number of the equipment or supplies;*
  - (4) *whether the item was purchased or rented by the Division;*
  - (5) *for repair services, a complete description of the service, including the manufacturer, brand name, model number, and serial number of the repaired item; and*
  - (6) *next to the signature, an explanation of the representative's relationship to the member by the individual acknowledging receipt. This individual cannot be associated with either the provider or the delivery service.*
    - (a) *For routine delivery of supplies, the member must acknowledge receipt at least once monthly.*
    - (b) *A signature stamp may be used by or on behalf of a MassHealth member whose disability inhibits the member's ability to write. A signature stamp may be used only by the member or the member's representative, provided that the stamp is used by the member in his or her normal course of conducting business. A signature stamp cannot be used by anyone associated with either the provider or the delivery service;*
- (D) *an invoice showing the cost to the provider of the materials (if the provider is not the manufacturer of the materials);*
- (E) *documentation demonstrating the cost of manufacturing the item provided (if the provider is the manufacturer); and*
- (F) *copies of written warranties.*

The Committee of Sponsoring Organizations (COSO) of the Treadway Commission is a private organization that offers guidance on financial reporting, effective internal controls, and corporate governance. In its publication "Internal Control – Integrated Framework," it states that monitoring and control activities ensure that internal controls continue to operate efficiently, and that a monitoring and control activities process should be in place, as follows:

*Internal control systems need to be monitored – a process that assess the quality of the system's performance over time. This is accomplished through ongoing monitoring activities, separate evaluations or a combination of the two. Ongoing monitoring occurs in the course of operations. It includes regular management and supervisory activities, and other actions personnel take in performing their duties.... (COSO, pp. 5, 69)*

*Control activities are the policies and procedures that help ensure management directives are carried out.... Control activities should include preventive controls, detective controls, manual controls, computer controls and management controls. (COSO, pp. 49)*

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**Recommendation**

We recommend that MassHealth, in conjunction with the Division of Health Care Finance and Policy (DHCFP), implement the following:

1. MassHealth should strengthen its internal controls and oversight over DME providers to ensure that claims are properly supported with the required documentation, and that products and services were delivered with proper prior authorization to members that are qualified for DME and that the claims were in compliance with applicable laws, rules, and regulations.
2. Conduct regular post-payment reviews of paid claims at provider locations in order to ensure compliance with laws, rules, and regulations, since the current internal controls rely on the providers to maintain the documentation in support of DME claims. This internal control activity will not only be valuable in detecting potential abusive or fraudulent billing practices, but also may deter providers from submitting undocumented claims and have a sentinel effect on the provider community.
3. Conduct a cost/benefit analysis of developing, within the new MMIS billing system, a series of edits and procedures capable of providing electronic confirmation of both the documentation and delivery of medical service to the member. This would provide management with an ongoing monitoring and control activity, in the course of operations, as recommended by COSO (COSO, pg. 5, 69).
4. Conduct a follow-up internal audit of the 17 claims lacking documentation of medical necessity or proof of delivery of DME in order to determine whether or not these claims were fraudulent.

**Auditee's Response**

In its response to the audit report, MassHealth offered, in part, the following comments:

*MassHealth conducted an internal review of the... claims in the audit report, and has determined that the claims were properly supported, authorized, and submitted in accordance with applicable laws, rules, and regulations.*

*MassHealth performs targeted post-payment audits of the providers' compliance with relevant laws, rules, and regulations including ensuring that evidence is available to support the delivery of claimed services. Such audits are typically desk audits which make the most efficient use of limited MassHealth administrative resources. MassHealth may conduct post-payment audits at the site location if a desk review does not provide sufficient information to confirm provider compliance. MassHealth will continue to conduct post-payment audits of DME providers.*

*MassHealth processes in excess of 70 million claims per year through its MMIS and, as with all payers of health care services, must find an appropriate balance between the efficiency of its claims operations and claims monitoring and control activity. It is standard industry practice to require that providers certify as part of submitting a claim for payment, that the service was medically necessary, provided to the member, and the claim is otherwise compliance with governing rules and regulations.*

***Auditor's Reply***

MassHealth's annual \$8 billion budget represents almost 30% of the Commonwealth's total budget. This requires that MassHealth have professional due diligence; internal controls with a proficient and well-staffed internal auditing department; and compliance oversight, aggressive and sophisticated rate setting, and management's commitment to providing necessary health care services in the most cost-efficient manner.

We disagree with MassHealth's contention that there are adequate internal controls to support the accurate processing of DME claims. We found that the supporting documentation for the questioned claims that MassHealth provided to us and which they said were properly supported, authorized and submitted in accordance with applicable laws, rules and regulations were inadequate and not in compliance with the requirements of the applicable CMR.

The OSA is pleased that MassHealth has taken our Audit Results into consideration and is committed to ensuring that the DME program is meeting the objectives outlined in our audit report. We are encouraged that MassHealth did agree with some of our recommendations and Audit Results. However, all of our recommendations should be taken into consideration. We have had a continual presence at MassHealth and have issued several audit reports that disclosed areas where improvements to internal controls and policies and procedures to deter, detect, and prevent fraud and abuse are needed. DME is a well-known area of exploitation by fraudsters and that, together with our conclusion, is why MassHealth needs to improve its internal controls and policies and procedures. We encourage MassHealth to exercise extreme due diligence and insist on provider compliance with requirements with a strict interpretation and implementation of all laws, rules, and regulations without exception. We further recommend that any internal review of claims be audited under the guidelines of generally accepted government auditing standards, which requires sufficient competent evidential matter. MassHealth did not provide evidence of provider audits at site locations of DME providers. Also, a limited number of desk audits is not sufficient oversight to confirm provider compliance with the DME program.

MassHealth should seriously consider our recommendations regarding a cost benefit analysis of developing within the new MMIS a series of edits and policies and procedures capable of providing electronic confirmation and documentation of the delivery of medical services to

members. This is a necessary, efficient, and effective medium to ensure that only valid claims are processed and paid.

It is important to reiterate and reemphasize the need for strict enforcement of the documentation requirements of proof of delivery and medical necessity are well chronicled. The Government Accountability Office (GAO) report released in July 2008<sup>9</sup> stated:

*According to the Department of Health and Human Services (HHS), schemes to defraud the Medicare program have grown more elaborate in recent years. In particular, HHS has acknowledged Centers for Medicare and Medicaid Services (CMS) oversight of suppliers of DME, prosthetics, orthotics (DMEPOS) is inadequate to prevent fraud and abuse.*

In conclusion, based on the value of the claims we questioned, and a most recent August 2008 report issued by the HHS/OIG regarding Medicare payment errors made for DME, prosthetics, and orthotics (DMEPOS) by the federal government, which estimated a payment error rate of 28.9%, MassHealth should adopt all of our recommendations.

## **2. SAVINGS OPPORTUNITIES OF \$7 MILLION COULD HAVE BEEN ACHIEVED IN THE PAYMENT RATES TO DME PROVIDERS AND THE RENTAL ARRANGEMENTS OF PERSONAL EMERGENCY RESPONSE SYSTEMS (PERS)**

MassHealth is paying DME providers at the rates established by DHCFFP. The federal government requires that states' payments for services in the Medicaid program be consistent with efficiency, economy, and quality of care.<sup>10</sup> The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to consumers at least to the extent that those services are available to the general population.<sup>11</sup>

DHCFFP is mandated under Chapter 118G of the Massachusetts General Laws to establish the rates to be paid to providers of health care services by governmental units, and requires that the rates established by the DHCFFP are "reasonable and adequate to meet the costs which are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal law, regulations, and quality and safety standards, and which are within the financial capacity of the Commonwealth." The law further specifies compliance with federal regulations: "Every rate, classification and other regulation established

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<sup>9</sup> GAO-08-955, Medicare – Covert Testing Exposed Weaknesses in the Durable Medical Equipment Supplier Screening Process.

<sup>10</sup> 42 CFR 447.200

<sup>11</sup> 42 CFR 447.204

by the division shall be consistent where applicable with the principles of reimbursement for provider costs in effect from time to time under Titles XVIII and XIX of the Social Security Act governing reimbursements or grants available to the Commonwealth, its departments, agencies, boards, divisions or political subdivisions for general health supplies, care, and rehabilitative services and accommodations.”<sup>12</sup> The MassHealth program is the largest state-run program for which DHCFP sets payment rates.

The 130 CMR 409.421 requires that the “payment to a provider for the purchase of DME and medical/surgical supplies is the lowest of the provider’s usual and customary charge to the general public or the fee set forth in the schedule of maximum allowable fees that may be adopted by the Division (DHCFP) as an amendment to these regulations.”<sup>13</sup> In addition, “The monthly rental payment for DME is the lowest of (1) one-sixth of the adjusted acquisition cost of the equipment for the first six months and one-twelfth of the adjusted acquisition cost of the equipment for each month after the first six months; 2) the provider’s usual and customary rental rate and terms to the general public; (3) the fee set forth in the schedule of maximum allowable fees that may be adopted by the Division as an amendment to these regulations; or (4) the fee determined by individual consideration.”<sup>14</sup> The rate of payment for an item or service identified as individual consideration is determined by DHCFP based on the provider’s descriptive report of the services provided and the adjusted acquisition cost of materials.<sup>15</sup> Adjusted acquisition cost is the price paid by the provider to the manufacturer or any other supplier for DME, customized equipment, or medical/surgical supplies, excluding all associated costs such as, but not limited to, shipping, handling, and insurance costs. Where the manufacturer is the provider, it is the actual cost of manufacturing such DME or supplies.

According to DHCFP, it determines rates by consulting with purchasing agencies to determine how the payment policies support program objectives and, where possible, DHCFP determines the rates after analyzing cost data submitted by health care providers. If cost data is unavailable, the Division sets rates using other benchmarks, such as Medicare fee schedules. DHCFP’s Pricing Policy and Financial Analysis Group responsibility is to perform the following functions:

(a) Develop health care pricing policies, methods, and rates which support the procurement of

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<sup>12</sup> MGL Chapter 118G, Section 7, Determination of Rates of Payment

<sup>13</sup> 130 CMR 409.421: Purchase of Durable Medical Equipment and Medical/Surgical Supplies (Excluding Customized Equipment)

<sup>14</sup> 130 CMR 409.423: Rental of Durable Medical Equipment

<sup>15</sup> 130 CMR 409.426: Individual Consideration

high-quality services for public beneficiaries in the most cost-effective manner possible; (b) Provide information, analysis, and recommendations to policy makers to support their health care financing decisions; and, (c) Performs specialized analyses of innovative health care financing and purchasing methods.<sup>16</sup> DHCFP sets rates through a public regulatory process and provides notice and opportunity to comment by holding public hearings in accordance with Chapter 30A, Section 2, of the General Laws.

Our audit further disclosed that if MassHealth had paid the same rates to providers of DME, as did the State of New York for the same products, the potential savings in fiscal year 2006 would have amounted to \$6,027,229. The New York State Medicaid Program's Durable Medical Equipment Fee Schedule is readily available to providers and the general public at [MedNY.org](http://MedNY.org). Moreover, we found several products at retail outlets priced lower than MassHealth reimbursement rates, evidence of retail providers buying at lower rates than those of DHCFP. Additionally, we found the potential for significant savings in the rental of personal emergency response systems (PERS) that, if adopted, would have resulted in a savings of \$1,319,347. Combined, the potential savings is \$7,346,576 on \$38,330,633 in paid claims, or 19.2%.

#### **a. Comparison with New York Rates**

We compared the rates paid for the procedure codes within our sample to the State of New York's reimbursement rates.<sup>17</sup> There were 78 distinct procedure codes paid in our 189-claim sample. Two of the procedure codes were associated with PERS and were not included in this comparison. The remaining 76 procedure codes represented \$16,078,693 in paid claims. We compared New York's reimbursement rates for these specific codes with MassHealth's rates and found that 43 procedure codes had a lower reimbursement rate, 18 procedure codes had a higher rate, and 15 procedure codes were unable to be matched, due to differences in the procedure codes. If MassHealth had reimbursed providers using the same rates as New York for the 61 procedure codes able to be matched, a potential savings of 21.2%, or \$3,408,285, may have been realized in fiscal year 2006, as set forth below:

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<sup>16</sup>[http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&L4=About+Us&sid=Eeohhs2&b=terminalcontent&f=dhcfp\\_government\\_how\\_we\\_are\\_organized&csid=Eeohhs2](http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Division+of+Health+Care+Finance+%26+Policy&L4=About+Us&sid=Eeohhs2&b=terminalcontent&f=dhcfp_government_how_we_are_organized&csid=Eeohhs2)

<sup>17</sup> New York State Medicaid Program, Durable Medical Equipment Fee Schedule, Version 2006-1

***Potential Savings Using New York Rates by Stratum within Our Sample of Audited Claims (Excluding PERS)***

	Total Items Compared	Incontinence Supplies	Other DME Products	Respiratory Equipment	Wheelchairs & Accessories
Quantity	61	11	36	10	4
Amount Paid	\$16,078,693	\$4,986,805	\$4,504,244	\$5,386,592	\$1,201,052
Potential Savings	\$3,408,285	\$845,415	\$994,919	\$1,517,930	\$50,021
Potential Savings Percent	21.2%	17.0%	22.1%	28.2%	4.2%

Extrapolating the potential savings from our sample and applying it to the total claims paid in each of the four strata in fiscal year 2006, we can project a savings of 17.7% on \$33,966,903, or \$6,027,229. Our calculations are as follows:

***Potential Savings Using New York Rates Extrapolated From Sample To Total Claims Paid in FY 2006***

	Population Items Compared	Incontinence Supplies	Other	Respiratory Equipment	Wheelchairs & Accessories
Quantity	498,832	73,065	218,306	149,139	58,322
Amount Paid	\$33,981,710	\$ 6,280,402	\$11,942,157	\$6,960,677	\$8,798,474
Potential Savings	\$ 6,027,229	\$ 1,064,719	\$ 2,634,570	\$ 1,961,503	\$ 366,437
Potential Savings Percent	17.7%	17.0%	22.1%	28.2%	4.2%

The following table sets forth some specific examples of the differences between the New York and MassHealth (MH) reimbursement rates:

Procedure Code	Description	MH Unit Rate	NY Unit Rate	Percentage NY Rate Lower	Total Paid FY 2006
A4526	Adult-Sized Incontinence Product, Brief, Medium	\$0.79	\$0.51	35.4%	\$347,309
A4530	Child-Sized Incontinence Product, Diaper, Large	\$0.83	\$0.36	56.6%	\$633,268
A4535	Disposable Liner/Shield For Incontinence	\$0.40	\$0.28	30.0%	\$487,194
B4150	Enteral Formulae; Category I; Semi-Synthetic	\$1.65	\$1.23	25.5%	\$1,474,280
E0244	Raised Toilet Seat	\$60.76	\$20.99	65.5%	\$39,050
E0245	Tub Stool or Bench (Standard Seat)	\$42.37	\$28.79	32.1%	\$95,746
E0277	Powered Pressure-Reducing Air Mattress	\$6,378.62	\$3,961.75	37.9%	\$855,515
E0439	Stationary Liquid Oxygen System, Rental	\$228.80	\$72.50	68.3%	\$674,360
E1390	Oxygen Concentrator, Delivers 85% Concentration	\$228.80	\$150.00	34.4%	\$3,686,014
K0093	Rear Wheel, Zero Pressure Tire Tube, Power Chair	\$151.88	\$57.76	62.0%	\$47,545

We found that several providers were purchasing products, such as diapers, from national companies and marking up their cost to bill MassHealth. These national companies sell similar products to New York providers; however, New York pays its providers at a lower rate than MassHealth, thereby establishing a de facto limit on the provider markup.

We also compared MassHealth's reimbursement rates to retail prices by visiting a number of retail locations and found examples of products with a lower price at retail as additional support to the existence of lower rates, as follows:

***Examples Of Lower-priced Products Found at Retail Providers***

Procedure Code	Description	MH Unit Rate	Retail Price	Percentage Retail Lower <sup>18</sup>	Total Population FY 2006	Potential Savings
A4253	Blood Glucose Test or Reagent Strips; Per 50	\$30.81	\$21.94	28.8%	\$126,675	\$36,469
A4402	Lubricant, Per Ounce	\$0.72	\$0.27	62.5%	\$14,552	\$9,126
A4450	Adhesive Tape, All Sizes; Each, 18 sq. in.	\$0.07	\$0.05	28.6%	\$20,886	\$6,216
A4526	Adult-Sized Incontinence Product, Brief, Medium	\$0.79	\$0.55	30.4%	\$347,303	\$105,729
A4527	Adult-Sized Incontinence Product, Brief, Large	\$0.79	\$0.72	8.9%	\$384,154	\$34,951
A4530	Child-Sized Incontinence Product, Diaper, Large	\$0.83	\$0.26	68.7%	\$633,268	\$431,527
A4532	Child-Sized Incontinence Product, Brief, Large	\$0.58	\$0.37	36.2%	\$126,425	\$44,775
A4535	Disposable Liner/Shield For Incontinence, Each	\$0.40	\$0.25	37.5%	\$487,194	\$182,932
A4927	Gloves, Non-Sterile, Per 100	\$4.78	\$3.48	27.2%	\$498,261	\$135,510
A6260	Wound Cleansers, Any Type, Any Size	\$11.23	\$9.79	12.8%	\$29,736	\$3,813
B4150	Enteral Formulae; Category I; Semi-Synthetic Intact	\$1.65	\$1.33	19.4%	\$1,474,280	\$282,193
E0163	Commode Chair, Stationary, With Detachable Arms	\$81.80	\$69.99	14.4%	\$86,298	\$12,459
E0244	Raised Toilet Seat	\$60.76	\$25.99	57.2%	\$39,050	\$22,346
E0245	Tub Stool or Bench (Standard Seat)	\$42.37	\$34.99	17.4%	\$95,746	\$16,677

<sup>18</sup> Retail price is rounded to nearest cent. Percentages are calculated using fractional cents.

We provided DHCFP with a complete analysis of our comparison with the New York rates. Prior to our audit, DHCFP was not aware of the differences between Massachusetts and New York rates. As a result, DHCFP representatives informed the Office of the State Auditor (OSA) that they “have initiated discussions with New York Medicaid representatives to discuss their listed prices and to better understand the similarities and differences in environment (e.g., regulatory process, legislative directives, program rules, provider supply) between New York and Massachusetts.” DHCFP determined from their discussions with New York representatives that New York Codes Rules and Regulations (NYCRR), Title 18, Section 505.5, refers to payment for purchase of DME as being based on the lower of the following options: (a) for listed items, “the maximum reimbursable amount” based on “an average cost of products representative of that item;” (b) for unlisted items, invoiced acquisition cost plus 50%; or (c) provider’s usual and customary price. Additionally, New York (Section 230 of the Acts of 1997) authorizes the Commissioner of Social Services to “implement a program of cost saving related to surgical supplies and durable medical equipment purchased through the Medicaid program including but not limited to using multiple award contracts, a defined durable medical equipment reimbursement methodology that incorporates ‘lesser of’ pricing, acquisition price plus 30 percent on nutritional supplements or other such measures as may be applicable.” Further, New York researches the basis for fees utilizing sources such as EPIC Plus (an electronic equipment catalog database that lists manufacturers’ prices for thousands of products), internet searches, invoices accumulated over time for manually priced products, manufacturers, Medicare, and providers.

Prior to July 2004, MassHealth’s payment for DME and Oxygen was based on the lowest of three pricing benchmarks: 1) the rate specified in the regulations, 2) the provider’s usual and customary charge, or 3) the provider’s adjusted acquisition cost plus a graduated mark-up ranging from 30% to 50%. According to MassHealth, “This *cost plus* methodology fostered disincentives for providers to seek lowest cost of inventory, required submission of invoices which was inefficient and burdensome for both MassHealth and the providers, and used mark-ups based on the cost of the item rather than the provider value added. By eliminating the third prong of the calculation, DHCFP and MassHealth increased efficiency for providers and the state.”

The result of the policy change from the *cost plus* methodology was a significant increase in reimbursements to providers. New York has maintained its *cost plus* methodology and the differences in reimbursement rates are substantial. Further, MassHealth does not utilize EPIC Plus, internet searches, or invoices accumulated over time for manually priced products, manufacturers, Medicare, and providers.

The benchmark DHCFP uses for most of MassHealth's Medicaid rates is that which was established by Centers for Medicare and Medicaid Services (CMS) for Medicare reimbursement. However, at a news conference in Los Angeles in January 2008, the Acting Administrator of CMS stated; "we know we overpay for medical equipment." Additionally, a report issued by HHS/OIG in October 2007 disclosed that some rates set by CMS are greater than those that are available to the public at retail. Our audit disclosed that reliance on federally established rates does not guarantee the best price available.

DHCFP is obligated under state law to encourage the cost-efficient delivery of services by using such methods as the use of national or regional indices to measure increases or decreases in reasonable costs and peer group cost analyses.<sup>19</sup> We have ascertained that DHCFP does have frequent dialog with both providers and industry representatives and does hold public hearings on rate setting. Before purchasing equipment or supplies providers must make a reasonable effort to purchase the item from the least-costly reliable source by comparing prices charged by different suppliers for comparable items.<sup>20</sup> Also, providers must charge the lower of the provider's usual and customary charge to the general public or the set rate or fee established by MassHealth.<sup>21</sup> Providers are further governed by the following regulations:

130 CMR 409.432: Provider Responsibility

*(A) The provider is responsible for making reasonably certain that the DME or medical/surgical supplies furnished are the most cost effective, given the medical need for which they are prescribed and the member's physical limitations.*

*(B) Before purchasing equipment or supplies, the provider must make a reasonable effort to purchase the item from the least-costly reliable source by comparing prices charged by different suppliers for comparable items.*

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<sup>19</sup> MGL 118G, Section 7

<sup>20</sup> 130 CMR 409.432: Provider Responsibility

<sup>21</sup> 130 CMR 409.421: Purchase of Durable Medical Equipment and Medical/Surgical Supplies (Excluding Customized Equipment)

**b. PERS Rental Rates**

PERS is an electronic device connected to a telephone line. In an emergency, it can be activated by the consumer either by pushing a small button on a pendant, pressing the help button on the console unit, or by an adaptive switch set-up. When the device is activated, a person from the 24-hour-a-day, seven-day-a-week central monitoring station answers the call, speaks to the patient via the console unit, assesses the need for help, and takes appropriate action. A medical communication system qualifies as a PERS if it includes all four of the following requirements: (1) an in-home medical communications transceiver; (2) a remote or portable activator; (3) a central monitoring station with backup systems by trained attendants 24 hours a day, seven days a week; and (4) current data files at the central monitoring station containing pre-established response protocols and personal, medical, and emergency information for each client.

The requirements for PERS coverage is that the patient has conditions that cause multiple functional limitations, such as those that cause difficulties with endurance and ambulation and that contribute to a homebound status. The consumer must: (a) be physically able to summon help with the PERS unit; (b) be mentally alert and self directing; (c) have a functioning telephone with a direct line; (d) be alone for extended periods or have no regular contacts; (e) be at risk of requiring institutional services at least at the nursing facility level, as determined by the Division; and (f) be at risk for falls or other medical emergencies.<sup>22</sup>

There were 15,482 consumers that received \$4,363,730 in PERS services during fiscal year 2006. We researched PERS rental programs offered by nine service providers. Each provider offered a variety of rental programs. All offered the monthly rental program that MassHealth utilizes in the Commonwealth's Medicaid program. Six offered a quarterly rental program at a pro-rated rate less than the monthly rate, and five offered an annual rental that was even more economical. DHCFP set an allowable rate for monthly rental and monitoring of PERS at \$29.90 per month. Annual rentals are available at a pro-rated monthly rental and monitoring for \$19.95 per month.

The utilization of an annual rental program would be more cost-efficient if the majority of the population were long-term PERS users. Our PERS statistical sample of claims included 43 consumers, who had the system in use for an average of 42.3 months, thereby indicating long-term use. We re-calculated the amount paid by MassHealth over the period that the PERS was

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<sup>22</sup> 130 CMR 409.445

installed at the members' places of living using the DHCFP installation rate of \$38.53 and substituting the monthly rental rate with the pro-rated annual rate. Based on our sample, we determined that by utilizing the annual rental rate instead of the monthly rental rate, a 30.2% savings could be realized without affecting the quality of services provided. As a result, we project that a potential savings of \$1,319,347 could have been realized from the \$4,363,730 paid for the installation and rental of PERS in fiscal year 2006 by utilizing the lower annual rental program. This information is set forth in Appendix I.

Because there is a more cost-efficient delivery method of PERS, DHCFP may not be fulfilling its requirement under state law to control rate increases, as follows:

*Control rate increases and shall impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated facilities and providers. Such methods and standards may include, but are not limited to the following: peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or other limitations on the utilization of temporary nursing or other personnel services; use of national or regional indices to measure increases or decreases in reasonable costs; limits on administrative costs associated with the use of management companies; the availability of discounts for large volume purchasers; the revision of existing historical cost bases, where applicable, to reflect norms or models of efficient service delivery; and other means to encourage the cost-efficient delivery of services.<sup>23</sup>*

### **Recommendation**

We recommend that MassHealth:

1. Work with DHCFP to develop a more aggressive methodology to ensure that reimbursement rates paid under the Commonwealth's Medicaid program are the most cost-efficient available to deliver the products and services in the fulfillment of the mission of the agency. Compare alternative rental terms and pricing offered by providers to ensure the cost-efficient delivery of services to MassHealth members.
2. Form a task force including managers from the Operational Services Division (Purchasing Agent for the Commonwealth) to develop an independent plan to utilize the purchasing leverage of the Commonwealth to bring economies of scale to ensure the most cost-efficient execution of MassHealth's mission.
3. Adopt an effective internal control system requiring periodic comparison of established rates with those of neighboring states, including reviewing the rate-setting methods, and sources used to establish such rates, for New York, Connecticut, Pennsylvania, and New Jersey. Request from CMS, the

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<sup>23</sup> MGL 118G, Section 7

Government Accountability Office (GAO), and HHS/OIG information pertaining to the best practices utilized by other states in the nation for their rate-setting methodology. Incorporate the best practices learned to gain the maximum benefit for the Commonwealth's Medicaid Program.

4. Adopt the annual rental program for PERS as the regulated standard.

#### **Auditee's Response**

In response to the audit report, MassHealth offered, in part, the following comments:

*MassHealth and DHCFP will continue to work collaboratively to evaluate a payment methodology for DME that is fair, consistent, costs-effective and provides members with access to medically necessary services. The rates established by DHCFP for DME include the rental or purchase of the products itself, the set up and delivery of the products, instruction to members in the use of the products, and administration and overhead costs incurred by providers to do business with MassHealth. As part of its rate review process, DHCFP researches other states' payment methodologies as well as considers the input of consumers and consumer advocates, providers of DME services and the general public. DHCFP will continue this practice.*

*While there may be opportunities to extract further efficiencies out of DHCFP's current rate setting methods, the OSA estimated 19.2% potential savings is overstated by at least 7.8%, or approximately \$3 million. The OSA report cites savings of \$7.3M, through use of rates posted on New York's web site and a monthly PERS rate of roughly two thirds of that listed in the DHCFP fee schedule. DHCFP regulations state that the payment amount is the lower of the provider's charge or the fee listed... [R]eview of the savings figures cited in the report [did not] account for claims that were paid less than the DHCFP rate.*

*MassHealth and DHCFP will meet with OSD to discuss opportunities for collaborative purchasing activities.*

*MassHealth and DHCFP will research GAO and other federal oversight agency recommendations regarding best practices utilized by other states. Although the initial phase off the CMS competitive bidding process has now been delayed for 18 months, DHCFP and MassHealth intend to research the impact that competitive bidding has had on those Medicaid states where competitive bidding was initiated.*

*MassHealth will continue to evaluate various payment methodologies and purchasing strategies for PERS.*

#### **Auditor's Reply**

We do not concur with MassHealth that its methodology in establishing reimbursement rates for DME is cost-efficient. The existence of lower rates is an undisputed fact; lower rates were found in New York and some DME products are priced lower at retail than MassHealth's reimbursement rate. Our savings calculations were based on the assumption that New York State also pays providers at less than published rates when the provider bills at low rates. Our

audit disclosed five examples within our sample where MassHealth paid the claim at less than DHCFP rates, but in four instances the payment was in excess of the New York rates. Therefore we conclude that the influence of these “lower rates” would be immaterial and not compromise our audit methodology.

We are pleased that MassHealth and DHCFP will meet with the Operational Services Division (OSD) to discuss opportunities for collaborative purchasing activities and that they will research GAO and other federal oversight agency recommendations regarding best practices utilized by other states.

### ***Additional Auditee's Response***

*MassHealth is committed to ensuring that the Durable Medical Equipment (DME) program is meeting the following objectives outlined in the Office of the State Auditor (OSA) report: that DME providers provide appropriate, medically necessary services to MassHealth members; that claims submitted by DME providers are complete, accurate, and in compliance with applicable laws, rules, and regulations; and that established payment rates are fair, effective and appropriate to ensure sufficient access to services for members.*

*Over the last few years, MassHealth has enhanced controls over the provision and payment of DME services by implementing a variety of improvements including: the establishment of parameters (“rules”) within the Medicaid Management Information System (MMIS) that help to ensure that claims are paid only when specific conditions established for each service code are met; the refinement of prior authorization requirements; the strengthening of provider enrollment requirements; the development of tools to ensure that providers have complete and accurate information about MassHealth payment and pricing policies; and, working with the Division of Health Care Finance and Policy (DHCFP), the establishment of an equitable and efficient payment methodology for the broad range of DME products and related services purchased by MassHealth. Additionally, MassHealth recently proposed revised program regulations to support the administration of the DME program. In brief, the proposed regulations focus on: strengthening qualifications for applicants seeking to be enrolled as MassHealth DME providers; clarifying covered and non-covered services; removing outdated and unnecessary language regarding pricing, since all pricing matters are covered in the DHCFP regulations; clarifying and strengthening language related to prior authorization and DME; and clarifying language related to DME provided to members in facilities.*

*MassHealth expenditures within the DME program have been contained over the past four years. There has not been a significant increase in expenditures despite a steady increase in the number of members who receive DME services. The growth in DME spending during 2004-2007 was, on average, less than the overall growth of MassHealth expenditures as a whole. We attribute this to the efficiencies implemented by MassHealth and DHCFP outlined above.*

***Additional Auditor's Reply***

We reassert our position that MassHealth could have overpaid \$4.9 million in inadequately documented claims and would have realized a savings of approximately \$7.3 million on \$38,330,633 in paid claims, or 19.2%, had DHCFP taken advantage of more competitive rates for DME and PERS products. We strongly recommend that MassHealth adopt our recommendations in order to take advantage of cost saving opportunities, particularly during the current economic climate.

## APPENDIX I

### Summary of PERS Claims Audited

Claim	Number of Months PERS in Service	Total Paid Since Installation	Total Cost Using Annual Rental Program	Percentage Potential Savings
1	16.9	\$505	\$376	25.5%
2	34.1	1,018	718	29.5%
3	12.0	360	279	22.5%
4	7.5	223	187	16.1%
5	86.1	2,574	1,756	31.8%
6	11.0	328	258	21.3%
7	80.1	2,396	1,637	31.7%
8	105.8	3,162	2,149	32%
9	19.2	575	422	26.6%
10	19.9	595	435	26.9%
11	4.9	145	136	6.2%
12	12.0	359	278	22.6%
13	42.0	1,256	877	30.2%
14	19.1	572	420	26.6%
15	40.0	1,197	837	30.1%
16	26.3	786	563	28.4%
17	62.0	1,855	1,276	31.2%
18	90.0	2,691	1,834	31.8%
19	19.9	594	435	26.8%
20	3.0	90	99	(9.3%)
21	1.6	48	71	(46.7%)
22	41.7	1,247	871	30.2%
23	29.3	877	624	28.8%
24	22.3	666	483	27.5%
25	22.0	659	478	27.5%
26	121.1	3,621	2,455	32.2%
27	25.1	749	538	28.2%
28	94.0	2,811	1,914	31.9%
29	119.0	3,559	2,414	32.2%
30	10.8	324	255	21.3%
31	20.9	626	456	27.2%
32	36.0	1,077	757	29.7%
33	17.7	528	391	26.0%
34	70.0	2,093	1,435	31.4%
35	89.7	2,682	1,828	31.8%
36	26.0	778	557	28.4%
37	8.5	255	208	18.4%
38	9.1	272	220	19.1%
39	31.0	926	656	29.2%
40	112.1	3,351	2,274	32.1%
41	93.0	2,782	1,895	31.9%
42	82.0	2,453	1,675	31.7%
43	<u>25.9</u>	<u>775</u>	<u>555</u>	<u>28.4%</u>
Totals	(AVG.) 42.3	\$ 54,440	\$ 37,982	30.2%
Total Paid All PERS in FY 2006		\$4,363,730	\$1,319,347	30.2%

## APPENDIX II

### Procedure Codes within Audit Sample by Stratum

PERS	S5160 - EMERGENCY RESPONSE SYSTEM, INSTALL & TEST S5161 - EMERG RESPONSE SYSTEM; MONTHLY RENTAL
Wheelchairs & Accessories	E0955 - WHEELCHAIR ACCESSORY, HEADREST, CUSHIONED, PREFABR E0971 - ANTI-TIPPING DEVICE WHEELCHAIRS (PAIR) E1020 - RESIDUAL LIMB SUPPORT SYSTEM FOR WHEELCHAIR E1028 - WHEELCHAIR ACCESSORY, MANUAL SWINGAWAY, RETRACTABL E2367 - POWER WHEELCHAIR ACCESSORY, BATTERY CHARGER, DUAL K0001 - STANDARD WHEELCHAIR K0003 - LIGHT WEIGHT WHEELCHAIR K0004 - HIGH STRENGTH, LIGHTWEIGHT WHEELCHAIR K0093 - REAR WHEEL, ZERO PRESSURE TIRE TUBE, POWER CHAIR
Incontinence	A4521 - ADULT-SIZED INCONTINENCE PRODUCT, DIAPER, SMALL SI A4522 - ADULT-SIZED INCONTINENCE PRODUCT, DIAPER, MEDIUM S A4523 - ADULT-SIZED INCONTINENCE PRODUCT, DIAPER, LARGE SI A4524 - ADULT-SIZED INCONTINENCE PRODUCT, DIAPER, EXTRA LA A4526 - ADULT-SIZED INCONTINENCE PRODUCT, BRIEF, MEDIUM SI A4527 - ADULT-SIZED INCONTINENCE PRODUCT, BRIEF, LARGE SIZ A4530 - CHILD-SIZED INCONTINENCE PRODUCT, DIAPER, LARGE SI A4532 - CHILD-SIZED INCONTINENCE PRODUCT, BRIEF, LARGE SIZ A4533 - YOUTH-SIZED INCONTINENCE PRODUCT, DIAPER, EACH A4535 - DISPOSABLE LINER/SHIELD FOR INCONTINENCE, EACH A4537 - UNDER PAD, REUSABLE/WASHABLE, ANY SIZE, EACH
Respiratory Equipment	A4623 - TRACHEOSTOMY, INNER CANNULA (REPLACEMENT ONLY) A7003 - ADMIN SET W/SML VOL NONFILTRD PNEUMATIC NEBULIZER A7015 - AEROSOL MASK USED WITH DME NEBULIZER A7030 - FULL FACE MASK USED WITH POSITIVE AIRWAY PRESSURE A7032 - REPLACEMENT CUSHION FOR NASAL APPLICATION DEVICE, A7038 - FILTER, DISPOSABLE, USED WITH POSITIVE AIRWAY PRES E0431 - PORTABLE GASEOUS OXYGEN SYSTEM;INCL REGULAT, FLOWME E0434 - PORTABLE LIQUID OXYGEN SYSTEM, RENTAL;INCL PORT CON E0439 - STATIONARY LIQUID OXYGEN SYSTEM, RENTAL;INCL USE OF E0445 - OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS E0471 - RESPIRATORY ASSIST DEVICE, BI-LEVEL PRESSURE CAPAB E0562 - HUMIDIFIER, HEATED, USED WITH POSITIVE AIRWAY PRES E0570 - NEBULIZER; WITH COMPRESSOR, E.G., DEVILBISS PULMO-AID E1390 - OXYGEN CONCENTRATOR, DELIVER 85 % CONCENTRATION

## APPENDIX II

### Procedure Codes Within Audit Sample by Stratum Continued

**All Other**

A4216 - STERILE WATER/SALINE, 10 ML  
 A4217 - STERILE WATER/SALINE, 500 ML  
 A4245 - ALCOHOL WIPES, PER BOX  
 A4253 - BLOOD GLUCOSE TEST OR REAGENT STRIPS; PER 50  
 A4314 - INSERTION TRAY W/DRAINAGE BAG W/INDWELLING CATHETER  
 A4322 - IRRIGATION SYRINGE, BULB OR PISTON; EACH  
 A4331 - EXT DRAINAGE TUBING ANY TYPE ANY LENGTH W/ CONNECT  
 A4357 - BEDSIDE DRAINAGE BAG, DAY OR NIGHT  
 A4385 - OSTOMY SKIN BARRIER 4X4 OR =, EXTENDED WEAR  
 A4393 - OSTOMY POUCH URINARY EXTND WEAR W/CONVEXITY  
 A4397 - IRRIGATION SUPPLY; SLEEVE  
 A4402 - LUBRICANT, PER OUNCE  
 A4414 - OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE  
 A4419 - OSTOMY POUCH, CLOSED; FOR USE ON BARRIER WITH NON-  
 A4450 - ADHESIVE TAPE, ALL SIZES; EACH  
 A4452 - TAPE, WATERPROOF, PER 18 SQUARE INCHES  
 A4595 - TENS SUPPLIES 2 LEAD PER MONTH  
 A4927 - GLOVES, NON-STERILE, PER 100(BEFORE 7/1/04 PER PAIR)  
 A5063 - POUCH, DRAIN; FOR USE ON BARRIER W/ FLANGE (2 PC)  
 A5114 - LEG STRAP; FOAM OR FABRIC, PER SET  
 A5131 - APPLIANCE CLEANER, OSTOMY; PER 16 OZ.  
 A6197 - ALGINATE DRESSING, WOUND COVER, PAD SZ MORE THAN 16S  
 A6219 - GAUZE, NON-IMPREGNATED, PAD SZ 16SQ IN/LESS, W ADHESI  
 A6248 - HYDROGEL DRESS, WOUND FILLER, GEL, PER FLUID OUNCE  
 A6260 - WOUND CLEANSERS, ANY TYPE, ANY SIZE  
 A6402 - GAUZE, NON-IMPREGNATED, STERILE, 16SQ IN/LESS, W/O ADH  
 A7001 - CANISTER NON-DISPOSABLE USE W/SUCTION PUMP  
 B4035 - ENTERAL FEEDING SUPPLY KIT; - PUMP FED (MONTHLY)  
 B4086 - GASTROSTOMY/JEJUNOSTOMY TUBE  
 B4100 - FOOD THICKENER, ADMINISTERED ORALLY, PER OUNCE  
 B4150 - ENTERAL FORMULAE; CATEGORY I; SEMI-SYNTHETIC INTAC  
 E0114 - CRUTCHES UNDERARM, ALUMINUM, ADJUSTABLE OR FIXED,  
 E0163 - COMMODE CHAIR STATIONARY WITH FIXED ARMS  
 E0165 - COMMODE CHAIR, STATIONARY, WITH DETACHABLE ARMS  
 E0244 - RAISED TOILET SEAT  
 E0245 - TUB STOOL OR BENCH (STANDARD SEAT)  
 E0255 - HOSP BED & SIDE RAILS & MATTRESS HI-LO, VAR HEIGHT  
 E0277 - POWERED PRESSURE REDUCING AIR MATTRESS  
 E0630 - PATIENT LIFT, HYDRAULIC, WITH SEAT OR SLING  
 E1340 - REPAR/NON-ROUT SVC DME REQR SKILL, LABOR (15 MIN)  
 J7613 - ALBUTEROL, INHALATION SOLUTION, ADMINISTERED THROU  
 J7644 - IPRATROPIUM BROMIDE INHLTN SOLTN UNIT DOSE FORM