



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 14, 2015–March 15, 2016



OFFICE OF THE STATE AUDITOR

MEDICAID AUDIT UNIT

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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 2016 budget (Chapter 46 of the Acts of 2015) requires that OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 15, 2016 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.”

This report, which is being submitted by OSA in accordance with the requirements of Chapter 46, provides summaries of three performance audits involving MassHealth’s administration of:

- Personal care attendant services
- Non-emergency ambulance transportation services, and
- Medical-assistive equipment;

Two performance audits involving:

- Fee-for-service payments for services covered by managed-care organizations (MCOs), and
- MassHealth’s progress in implementing alternative payment methodologies;

And five provider audits including reviews of claims submitted by:

- Two transportation providers for wheelchair-van services,
- Two physician providers for evaluation and management services, and
- A community hospital for radiology services.

In addition, it provides summaries of nine MassHealth audits that are currently under way. Finally, it details the corrective measures and related outcomes reported by the auditees, including MassHealth, in relation to our findings and recommendations for four audits.

For fiscal year 2016, the appropriation for the Unit was \$1,164,638. This amount represents a 35% increase over the Unit's fiscal year 2015 appropriation of \$864,638. With the additional funds, the Unit added 5.5 new audit staff positions leading to a significant increase in the Unit's audit productivity. Specifically, the Unit worked on a total of 19 audits (10 completed and 9 in process) during the current reporting period; in contrast, the Unit worked on only 9 audits (2 completed and 7 in process) during the prior reporting period. Thus, with a 35% funding increase (\$864,638 to \$1,164,638), the Unit increased its audit production by more than 100%.

This report details findings that identified more than \$550 million in unallowable, questionable, duplicative, unauthorized, or potentially fraudulent billings—a return of over \$472 for every dollar of funding in our Medicaid Unit. The report also describes corrective actions being taken by MassHealth on those audits with findings issued at least six months ago for which a follow-up survey has been completed as well as actions taken by MassHealth to begin recouping funds. Auditees reported action or planned action on 87% of our audit recommendations, which will improve operational efficiency and effectiveness. These audit recommendations and MassHealth's corrective actions will result in perpetual annual savings of \$20–25 million. Regarding recoupments, as a result of our audit of MassHealth's personal care attendant services, the agency reported that it will seek recovery of \$92,000 in claims that were paid for dates of service that occurred after a member's date of death. As a result of our audit of MassHealth's MCOs, the agency stated that it is in the process of recouping a portion of the \$233,208,842 for FFS claims for services that should have been paid for by members' MCOs. Specifically, MassHealth stated that it was focusing recoupment on the last two years of the audit period and on physician, health center, inpatient, and outpatient hospital claims.

MassHealth stated that it would recoup the maximum amount that due process and proper claim research allows.

Finally, the audit of MassHealth wheelchair-van provider Rite Way, which found more than \$16 million in potentially fraudulent charges for members who did not need or did not use wheelchairs, has been referred to the Massachusetts Attorney General's Office for investigation. Rite Way has not yet been sent its six-month follow-up survey, as the audit was issued in October; thus we do not have an update on the status of this case.

Background

The Massachusetts Executive Office of Health and Human Services administers the state's Medicaid program, known as MassHealth, which provides access to healthcare services annually to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2015, MassHealth paid more than \$13.6 billion to healthcare providers, of which approximately 50% was Commonwealth funds. Medicaid expenditures represent approximately 38% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the U.S. Government Accountability Office (GAO) placed the U.S. Medicaid program on its list of government programs that are at "high risk" of fraud, waste, abuse, and mismanagement. GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Based on these concerns, 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. 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 on all audits conducted by the Unit. By so doing, our auditors can review 100% of a service provider's claims, thus significantly improving the

efficiency and effectiveness of our audits. Additionally, data mining has improved the overall effectiveness of our audits by allowing OSA's staff to examine claim data and identify trends and anomalies typically indicative of billing irregularities and potentially fraudulent situations. Moreover, data mining has enabled the Unit to fully quantify the financial effects of improper payments regardless of whether they involve one claim or 10 million. In summary, the use of data-mining techniques has enabled the Unit to (1) identify greater cost recoveries and (2) recommend changes to MassHealth's claim-processing system and program regulations to promote future cost savings, improve service delivery, and make government work better.

COMPLETED AUDITS

(March 14, 2015–March 15, 2016)

During this reporting period, the Office of the State Auditor (OSA) released 10 audit reports on MassHealth's administration of the Medicaid program and on Medicaid service providers' compliance with state and federal laws, rules, and regulations. These reports identified hundreds of millions of dollars in questionable, unallowable, unauthorized, and potentially fraudulent payments; detailed that MassHealth has not fully reached the required adoption rate for alternative payment methodologies (APMs); 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.

1. Office of Medicaid (MassHealth)—Review of Personal Care Attendant Services (2013-1374-3M3)

OSA conducted an audit of MassHealth's personal care attendant (PCA) services for the period July 1, 2010 through June 30, 2013. The purpose of this audit was to determine whether MassHealth was properly administering PCA services in accordance with applicable federal and state requirements. Our audit identified that MassHealth paid for unallowable PCA services and other medical services totaling \$4,174,275 during the period. The specific audit issues identified within the PCA program and the means by which MassHealth could have prevented these unallowable payments are described below.

- MassHealth paid 6,134 claims, totaling \$604,832, for PCA services and other medical services for 146 members whose recorded dates of death were before the service delivery dates. To prevent these unallowable payments, MassHealth would have needed to maintain members' current dates of death in its member eligibility verification system and implement system edits to prevent and deny claims for PCA services after members' recorded dates of death.
- Members participating in individual or group adult foster care (AFC) received PCA services, contrary to state regulations. MassHealth payments for these PCA services totaled \$3,354,838 for 454 members during the audit period. To prevent these unallowable payments, MassHealth would have needed to deny all applications for PCA services when members are also participating in individual or group AFC funded by MassHealth, and implement system edits to detect and deny claims for PCA services provided to members participating in individual or group AFC funded by MassHealth.

- MassHealth paid a total of \$101,381 for PCA services that exceeded the maximum number of units possible in a day. Additionally, MassHealth paid for unauthorized night hours totaling \$79,357. To prevent these unallowable payments, MassHealth would have needed to maintain system edits to deny payment for PCA services in excess of the maximum number of service units possible per member per day and develop procedures to monitor PCA night hours and investigate repeated instances of PCAs billing for more hours than are authorized.
- Seventy-five members who were enrolled in managed-care-organization (MCO) programs did not receive their PCA services through the MCO program, but through other MassHealth programs. Consequently, by paying for these PCA services outside the MCO programs, MassHealth made duplicative payments totaling \$33,867 for the services. To prevent these duplicate payments, MassHealth would have needed to develop system edits to detect and deny PCA service claims when a member is enrolled in an MCO program.

2. Office of Medicaid (MassHealth)—Review of Non-Emergency Ambulance Transportation (2014-1374-3M1)

OSA conducted an audit of MassHealth’s non-emergency ambulance transportation for the period January 1, 2012 through December 31, 2013. MassHealth members are eligible for this transportation if they have certain medical conditions, such as orthopedic, pediatric, psychiatric, or neurological conditions, that always require transportation by ambulance. The objective of our audit was to determine whether MassHealth was properly administering non-emergency ambulance transportation in accordance with applicable federal and state regulations.

Our audit identified that MassHealth did not have adequate controls over the administration of non-emergency transportation to ensure that it was properly authorized and medically necessary. As a result, certain transportation providers did not maintain the required properly completed Medical Necessity Forms (MNFs) for some members. Specifically, in our sample test of 60 claims, 11 MNFs (18%) were missing; inaccurate; or signed by an individual, such as a licensed practical nurse, who was not authorized to approve transportation. OSA estimates that for the 10 service providers included in our testing, MassHealth processed an estimated \$3,680,796 in questionable payments for non-emergency ambulance transportation during the audit period.

To help resolve this matter, OSA recommended that MassHealth ensure that providers maintain properly completed MNFs to support their non-emergency claims and consider performing periodic site visits at provider locations to verify compliance with MNF requirements.

Our audit also found that certain transportation providers did not consistently complete Criminal Offender Record Information (CORI) checks for ambulance drivers and attendants. Specifically, in our testing of 60 claims, representing 112 ambulance drivers and attendants, we determined that 6 (5%) had never had a CORI check, 96 (86%) had had initial CORI checks but lacked annual re-certifications (some long-term drivers and attendants had not had a CORI check since the regulation requiring them was enacted), and the remaining 10 (9%) had both initial and annual CORI checks. As a result, MassHealth cannot be certain that employees with disqualifying criminal records do not have access to vulnerable MassHealth members, including those who are elderly, underage, and/or disabled.

Only 1 of the 10 providers tested was adequately performing initial and annual CORI checks.

Based on this audit finding, we recommended that MassHealth (1) immediately notify all ambulance providers of the requirements for CORI checks, (2) periodically give subsequent reminders to these providers, and (3) establish an effective monitoring process to ensure that its transportation providers perform required CORI checks for all drivers and attendants.

In addition, our audit found that duplicate payments totaling \$8,594¹ were made for non-emergency transportation for members enrolled in MCOs during the audit period. Specifically, 37 members enrolled in MCOs had their transportation paid for by both the MCO and MassHealth. This occurred because MassHealth did not update member enrollment data (member's name, unique identification number, dates of enrollment, and health plan) promptly within the Medicaid Management Information System (MMIS). Had it done so, MMIS would have properly adjudicated the claims to prevent these duplicate payments.

Based on this finding, we recommended that MassHealth update member enrollment data promptly to ensure that claims are paid properly and develop policies and procedures to detect and deny duplicate payments for non-emergency medical transportation.

1. To develop this finding, we analyzed all claims for non-emergency ambulance transportation services during the audit period. Our analysis was not limited to the top 10 non-emergency ambulance transportation service providers.

3. Office of Medicaid (MassHealth)—Review of Controls over Mobility-Assistive Equipment (2013-1374-3M2)

OSA conducted an audit of claims for mobility-assistive equipment for the period July 1, 2011 through December 31, 2012. Mobility-assistive equipment includes walkers, canes, crutches, and manual and power wheelchairs. For this audit, we concentrated on wheelchairs and wheelchair components. The objective of our audit was to determine whether MassHealth paid for this equipment in accordance with state regulations, maintained effective system edits to control payments, and monitored payments to identify billing irregularities and potentially fraudulent claims.

Our audit identified that (1) MassHealth's process for determining how much to pay for wheelchairs and wheelchair components is not cost-effective and resulted in more than \$1 million in potentially lost cost savings; (2) MassHealth paid for \$540,801 of wheelchair components that were improperly authorized, provided, or billed; and (3) claims for repairs that cost over \$1,000, totaling approximately \$2.9 million, were not properly authorized. These audit findings are further described below.

- **Payment process not cost-effective:** In most cases, MassHealth pays providers for wheelchairs and wheelchair components based on the amount listed in its rate schedule for these components, without considering whether those amounts are higher than the usual and customary amounts that providers charge to their other customers, as required by state regulation. We contacted Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan to obtain information on their pricing practices for wheelchairs and wheelchair components. We learned that these insurance companies did business with MassHealth's wheelchair providers, but at rates lower than those listed on MassHealth's rate schedule. Further, we analyzed 15 wheelchair components² and found that MassHealth could have saved more than \$1 million had it paid the lowest rate that any of these three insurance companies paid for these components, as required by state regulations.
- **Components not properly authorized:** Certain wheelchair components require prior authorization before payment. These components include both high- and low-priced items, such as a power seating system (\$7,736) and a special wheelchair seat with upholstery (\$93). However, MassHealth paid 92 claims, totaling \$13,512, for wheelchair components that did not have the necessary prior authorization.
- **Improper payments for manual wheelchair repairs and accessories for members residing in nursing facilities:** MassHealth places restrictions on repairs and accessories

2. We selected these 15 components because they represented some of the largest unit quantities and amounts paid by MassHealth for components during the audit period.

based on a member's location. Specifically, nursing facilities have financial responsibility for providing repairs and accessories for members who use facility-owned manual wheelchairs. However, MassHealth paid 817 claims, totaling \$158,594, for wheelchair components and repairs for facility-owned manual wheelchairs.³

- **Mobility-assistive equipment beyond MassHealth's service limits:** MassHealth paid for equipment for members that exceeded stated limits in the DME and Oxygen Payment and Coverage Guideline Tool.⁴ For example, members are allowed to receive two general-use seat cushions per year, but MassHealth sometimes paid for more than this number. MassHealth paid 168 claims, totaling \$54,435, for wheelchair components that exceeded stated limits.
- **Duplicate payments for wheelchair components:** MassHealth made \$40,206 of duplicate payments for wheelchair components, contrary to state regulations. Specifically, we identified 153 duplicate payments, totaling \$9,728, related to claims billed for the same member, the same date of service, the same provider, and the same procedure code. Also, we found 237 duplicate payments, totaling \$30,206, related to claims billed for the same member, the same provider, and the same procedure code for service dates within seven days of each other. Finally, we identified one instance in which two different providers billed a total of \$187 for the same component for the same member on the same date of service.
- **"Unbundled" wheelchair and wheelchair-component costs:** MassHealth has designated certain wheelchair and wheelchair-component procedure codes as comprehensive. Providers are prohibited from billing for individual wheelchair components when they are part of an assembly covered by a single comprehensive code. For example, MassHealth does not allow providers to bill for lower leg extension tubes (K0043 and K0044) while also billing for a complete footrest assembly (K0045). However, we identified 1,440 instances, totaling \$274,054, where providers "unbundled" claims.
- **Repair claims not properly authorized:** During the audit period, MassHealth paid 3,337 repair claims, totaling \$3,491,275, for wheelchair repairs costing more than \$1,000, including parts and labor. Of this amount, 2,334 repairs, totaling \$2,856,104 (82% of the total), did not have the prior approval required by MassHealth regulations. MassHealth's approval process was inconsistent in that some repairs were properly approved while others were either partially approved or unapproved.

Our audit report recommended that in order to resolve these problems, MassHealth (1) develop policies and procedures that would ensure that it is paying the lowest price for wheelchairs and wheelchair components in accordance with MassHealth regulations and establish system edits to ensure that these policies and procedures are adhered to, (2) implement system edits in

3. MassHealth officials stated that they do pay for repairs and components to reissued power wheelchairs for members residing in nursing facilities, since a facility would be unable to bear the cost of purchasing complex power wheelchairs.

4. To help providers comply with state regulations when submitting claims for reimbursement, MassHealth created the "DME and Oxygen Payment and Coverage Guideline Tool," as defined in 130 CMR 409.402. MassHealth officials stated that the Tool is a means to educate providers on payment limits and restrictions.

accordance with MassHealth regulations and the sub-regulatory guidance provided in the Tool, and (3) ensure that prior authorization has been obtained for repairs when the billed amount exceeds \$1,000.

4. Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by Managed-Care Organizations (2015-1374-3M1)

OSA conducted an audit of MassHealth’s fee-for-service (FFS) payments for services covered by MCOs for the period October 1, 2009 through September 30, 2014. Our objective was to determine whether MassHealth disallowed FFS claims for MCO enrollees for services that should have been covered by the MCOs.

Our audit found that MassHealth improperly paid providers, including state agencies and public hospitals, \$233,208,842 for FFS claims for services that should have been paid for by members’ MCOs. These payments were for services that were specifically identified in the MCOs’ contracts as services covered by the MCOs. Therefore, they represented duplicate spending because the Commonwealth paid twice for the same service—first as a portion of the MCOs’ capitated (per member) premium and then through the FFS claim.

Our analysis of the FFS claims showed that these duplicative payments belonged to 29 service categories (e.g., acute inpatient care, dental services, and laboratory services). We found that 90% of the improper claims were for behavioral-health services, dental treatment, home health services, skilled nursing, or ambulatory surgery / outpatient hospital care. MassHealth could have prevented this unnecessary spending had it established system edits to detect and deny FFS claims for member services covered by MCOs and applied these edits to all providers, including state agencies and other state-contracted providers.

In addition, we found that MassHealth did not maintain adequate records of services covered by MCOs. Specifically, although each contract with an MCO identified the types of service (e.g., acute inpatient care) that were to be covered, MassHealth did not develop a master list of specific medical procedures and related procedure codes that MCOs must cover for all members. This caused the MCOs to develop their own unique lists of covered procedures, which varied from one MCO to the next. Further, MassHealth does not require MCOs to send it a list of the actual procedures and procedure codes they cover so that MassHealth can ensure that it

does not pay on an FFS basis for services covered by a member's specific MCO. MassHealth was not able to provide a list of services covered by any individual MCO.

These control deficiencies caused MassHealth to make at least \$288,952,449 of potentially unnecessary FFS payments during the audit period in addition to the \$233,208,842 of improper payments discussed above. MassHealth could have prevented this potentially unnecessary spending if it had established effective internal controls over its contracting process with MCOs. Such controls would include (1) providing MCOs with a complete list of all agreed-upon procedure codes for medical services covered for members; (2) receiving from each MCO a list of additional services the MCO covered; (3) developing, in consultation with the MCOs, a master list of procedure codes covered by all MCOs and, if applicable, a list of additional services covered by each one; and (4) using this information to create system edits in its claim-processing system to ensure that it pays only for claims that the MCO in question has specifically identified as not covered by its plan.

5. Review of MassHealth's Progress to Implement Alternative Payment Methodologies (2015-8018-14M)

OSA conducted a review of MassHealth's progress to implement APMs during the period August 6, 2012 through June 30, 2015. The objective of the review was to determine whether MassHealth met the benchmarks established by Section 261 of Chapter 224 the Acts of 2012 for transitioning its members into APMs.⁵ Section 261 of Chapter 224 includes the following benchmarks, which MassHealth must meet to the maximum extent feasible:

- No later than July 1, 2013, MassHealth shall pay for healthcare using APMs for no fewer than 25% of eligible members.
- No later than July 1, 2014, MassHealth shall pay for healthcare using APMs for no fewer than 50% of eligible members.
- No later than July 1, 2015, MassHealth shall pay for healthcare using APMs for no fewer than 80% of eligible members.

Our review found that MassHealth's APM adoption rate as of July 1, 2013 was 30%, which exceeded the 25% benchmark established by Chapter 224. However, its APM adoption rate had

5. The law requires MassHealth to transition from paying for healthcare services for its eligible members using the traditional FFS model to using other payment methods, referred to in Chapter 224 and in this report as alternative payment methodologies.

dropped to 29% as of July 1, 2014. As noted above, Chapter 224 of the Acts of 2012 required MassHealth to achieve a 50% adoption rate by this date. By missing the mandated July 1, 2014 APM benchmark, MassHealth is delaying the opportunity to improve the quality of healthcare services and effectively rein in the Commonwealth's healthcare costs.

6. Office of Medicaid (MassHealth)—Review of Claims for Wheelchair-Van Services Submitted by Rite Way LLC (2015-1374-3M9)

OSA conducted an audit of claims for wheelchair-van services provided to members by Rite Way LLC (Rite Way) for the period January 1, 2013 through December 31, 2014. MassHealth provides wheelchair-van transportation when it is medically necessary for MassHealth members. This transportation is provided for members who have certain medical conditions, such as those who use wheelchairs; must be carried up or down stairs; or have severe mobility handicaps that prevent them from using public, dial-a-ride (e.g., the Worcester Regional Transit Authority's paratransit service for the elderly and disabled), or taxi transportation.

The objectives of this audit were to determine whether Rite Way (1) billed MassHealth only for wheelchair-van services that were medically necessary, properly authorized, and paid in accordance with state regulations and MassHealth policies and (2) established policies and procedures to ensure that CORI checks were consistently performed and documented for all wheelchair-van drivers. During our audit, Rite Way was unable to substantiate the medical necessity of any of the wheelchair-van transportation it provided to members. Specifically, Rite Way:

- was missing Prescription for Transportation (PT-1) forms or MNFs for all claims;
- submitted claims for wheelchair-van transportation for ambulatory members;
- billed for wheelchair-van transportation from members' homes for dates when they were hospitalized; and
- billed for transportation on dates when members did not obtain medical services.

As a result, we questioned all \$17,258,633 of the payments made to Rite Way for wheelchair-van transportation during our audit period. Of this amount, we recommended that Rite Way repay MassHealth the \$16,416,705 it received in improper payments for wheelchair-van transportation for ambulatory members and, with regard to the remaining \$841,928, for which the only issue was a missing PT-1 form or MNF, work with MassHealth to determine whether it

should be repaid. Additionally, we recommended that Rite Way not bill for any wheelchair transportation for ambulatory members; that it maintain required PT-1 forms or MNFs for all members who need wheelchair-van transportation; and that it develop internal controls to ensure that claims are not submitted for hospitalized members or for those who have not received medical services.

7. Office of Medicaid (MassHealth)—Review of Claims for Wheelchair-Van Services Submitted by Cataldo Ambulance Services, Inc. (2016-1374-3M1)

OSA conducted an audit of claims for wheelchair-van services provided to members by Cataldo Ambulance Service, Inc. (Cataldo) for the period January 1, 2013 through December 31, 2014. This audit was selected as a follow-on audit to the Rite Way audit to ensure that problems identified at Rite Way were isolated and not pervasive among other wheelchair-van service providers. The objectives of this audit were to determine whether Cataldo (1) billed MassHealth only for wheelchair-van services that were medically necessary, properly authorized, and paid in accordance with state regulations and MassHealth policies and (2) established policies and procedures to ensure that CORI checks were consistently performed and documented for all wheelchair-van drivers.

Our audit found that Cataldo did not maintain properly completed MNFs for members receiving wheelchair-van services. Our sample testing of 60 wheelchair-van claims identified 49 (82%) that lacked properly completed MNFs. The specific problems identified were (1) MNFs signed by unauthorized individuals, (2) illegible signatures, and (3) missing titles of signatories (such as physicians, physician assistants [PAs], or nurse practitioners [NPs]). OSA estimates that during our audit period, Cataldo received up to \$942,326 in payments from MassHealth for wheelchair-van services that lacked properly completed MNFs.

Although Cataldo did not maintain properly completed MNFs for some of its MassHealth members, through our audit testing we were able to determine that for each transportation claim we reviewed, there was a corresponding medical claim for the member on the same date of service. This confirmed to OSA that this transportation, although not properly authorized, was actually provided.

In addition, although Cataldo was able to document that it performed CORI checks on employees at the time of hire, our audit found that Cataldo did not consistently complete CORI checks for its wheelchair-van drivers annually, as required by state regulations. Our sample of 60 claims involved 36 wheelchair-van drivers. We determined that 32 drivers, associated with 48 claims, did not have a valid CORI check within one year prior to the wheelchair transport. The 4 drivers associated with the remaining 12 claims did have a valid CORI check within one year prior to the wheelchair transport. As a result, Cataldo cannot be certain that employees with disqualifying criminal records do not have access to vulnerable MassHealth members, including those who are elderly, underage, and/or disabled.

As a result of these findings, OSA recommended that Cataldo (1) ensure that it maintains properly completed MNFs to support its wheelchair-van transportation claims; (2) periodically review the relevant criteria regarding MNFs and then update its policies and procedures to reflect any changes; (3) continue to perform initial as well as annual CORI checks for all of its wheelchair-van drivers; (4) establish a formal written policy that requires annual CORI checks for all wheelchair-van-drivers, education of its staff about this policy, and implementation of controls to ensure that it is adhered to; and (5) periodically review the relevant criteria regarding CORI checks and then update its policies and procedures to reflect any changes.

8. Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Submitted by Asaker Medical Associates (2015-1374-3M5)

OSA conducted an audit of evaluation and management (E/M) claims submitted to MassHealth by Asaker Medical Associates for the period January 1, 2013 through December 31, 2014. During this two-year period, Asaker Medical Associates submitted 15,413 claims, totaling \$501,816, for inpatient and outpatient E/M services provided to MassHealth members. Of this amount, \$193,496 represents outpatient E/M services, which were the focus of our audit work.

The objectives of our audit were to determine whether (1) Asaker Medical Associates properly billed MassHealth for E/M services provided by NPs and (2) Dr. Asaker, who is the sole proprietor of Asaker Medical Associates, properly billed MassHealth for E/M services that he provided at a chronic care facility and three nursing facilities while also serving as medical director at these locations.

Our audit found that Asaker Medical Associates improperly billed MassHealth for E/M services using the wrong provider identification number. Specifically, Asaker Medical Associates submitted claims to MassHealth using Dr. Asaker’s provider identification number instead of that of the **independent** NP who actually performed the services. As a result, MassHealth paid Asaker Medical Associates at the higher rates paid for physicians. Based on our statistical sample of 88 E/M outpatient claims, we estimate that MassHealth made \$24,357 of such overpayments during the audit period.

Asaker Medical Associates also employs a **non-independent** NP to work with Dr. Asaker to perform medical services at his outpatient office and several nursing facilities. Our review of the statistical sample of 88 claims showed that in 3 cases, Asaker Medical Associates did not use the required SA modifier code when it billed for E/M services performed by the non-independent NP in collaboration with Dr. Asaker. Consequently, MassHealth paid these claims at the full physician rate, rather than at 85% of that rate as required by MassHealth regulations.

As a result of these findings, OSA recommended that Asaker Medical Associates (1) repay MassHealth for overpayments from all services performed by an independent NP but billed at the physician rate, (2) take the measures necessary to ensure that it submits claims that correctly identify the provider of E/M services, (3) use the required modifier codes when billing for services provided by a non-independent NP in collaboration with Dr. Asaker, and (4) within members’ medical files, properly document services performed by a non-independent NP in collaboration with Dr. Asaker.

9. Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Submitted by Northgate Medical PC (2015-1374-3M6)

OSA conducted an audit of E/M claims submitted by Northgate Medical PC (Northgate) for the three-year period ended December 31, 2014. During the three-year period, Northgate received \$1,325,100 for outpatient E/M services provided to MassHealth members.

MassHealth’s payment rates for E/M services vary depending on factors such as the complexity of medical decision-making and the severity of the presenting problem. There is potential for improper billing by providers in this area. For example, if a patient presents with a low-severity problem, the provider could bill using the highest severity level’s procedure code, resulting in a

greater payment to the provider. Such billing practices are known as “upcoding” and reflect potentially fraudulent activity.

The objectives of our audit were to determine whether Northgate (1) billed for E/M services using procedure codes reflecting the level of service provided, (2) used the required modifier codes to bill for services performed by PAs or non-independent NPs, and (3) maintained documentation in member files that properly supported E/M services provided.

Our audit found that Northgate did not use the correct procedure codes when billing for E/M services. Specifically, Northgate billed routine, less-complex cases using codes that were designated for high-complexity cases. Northgate’s upcoding resulted in its receiving approximately \$54,000 in improper payments during the audit period.

In addition, Northgate did not use required modifier codes when billing MassHealth for E/M services provided by NPs and PAs. MassHealth pays for E/M services provided by NPs and PAs at lower rates than it pays when the same services are provided by physicians. Because Northgate did not submit claims using the required modifier codes, it was paid at the standard physician rate, resulting in approximately \$137,148 of overpayments during the audit period.

As a result of these findings, OSA recommended that Northgate (1) collaborate with MassHealth to repay the overpayment of approximately \$54,000 resulting from the upcoding of claims and approximately \$137,148 resulting from E/M services provided by NPs and PAs but billed at the physician rates; (2) perform independent reviews of claims submitted by its billing agent to ensure that claims submitted for all E/M procedure codes are accurate, reflect the level of services provided, and include required modifiers; and (3) ensure that its medical staff is properly trained on the use of electronic health record software, including modifying suggested E/M procedure codes to reflect the level of services provided.

10. Office of Medicaid (MassHealth)—Review of Radiology Claims Submitted by Baystate Mary Lane Hospital (2015-1374-3M3)

OSA conducted an audit of Baystate Mary Lane Hospital’s claims for radiological services provided to MassHealth members for the period January 1, 2013 through December 31, 2014. During the two-year audit period, MassHealth paid \$583,848 to Baystate Mary Lane Hospital for radiological services including X-rays, mammograms, ultrasounds, and other services. The

objective of our audit was to determine whether Baystate Mary Lane Hospital maintained adequate documentation to support its claims for radiological services provided to MassHealth members.

Based on our audit, we concluded that Baystate Mary Lane Hospital properly documented radiological services it provided to MassHealth members. We did not identify any significant deficiencies in this area.

CURRENT INITIATIVES

1. Office of Medicaid (MassHealth) Massachusetts Behavioral Health Partnership (2015-1374-3M11)

The Office of the State Auditor (OSA) is conducting an audit of Massachusetts Behavioral Health Partnership (MBHP) for the five-year period ended June 30, 2015. MassHealth contracts with MBHP for certain members' behavioral health services. According to our preliminary data analytics, MassHealth may have improperly paid hundreds of millions of dollars in fee-for-service (FFS) claims for members enrolled in MBHP. The objectives of our audit are to (1) evaluate the internal controls MassHealth has in place to detect and deny FFS claims for members' behavioral health services covered by MBHP, (2) determine the extent to which MassHealth has improperly paid FFS claims for MBHP members, and (3) identify potential reimbursements from MBHP.

In this audit, we plan to visit MBHP to identify the behavioral health services it covers under contract with MassHealth. Also, we plan to visit selected service providers that subcontract with MBHP. At these service providers, we will gain an understanding of billing processes and internal controls designed to prevent them from submitting FFS claims for members enrolled in MBHP. In addition, we plan to document and test system edits developed by MassHealth for processing FFS claims submitted by providers for MBHP members. Our planned audit work will enable us to make appropriate recommendations to correct any noted deficiencies.

2. Office of Medicaid (MassHealth) Review of Claims for Members with Medicaid and Medicare Eligibility (2016-1374-3M10)

OSA is conducting a review of claims paid for members with Medicaid and Medicare eligibility for the five-year period ended June 30, 2015. MassHealth members enrolled in both Medicaid and Medicare are described as "dual-eligible." Medicare is the primary payer on claims for a dual-eligible member. Therefore, claims for these members should first be submitted to Medicare for payment. After Medicare has adjudicated and paid its portion of the claim, MassHealth, as secondary payer, covers any remaining liability including deductibles and coinsurance payments. According to our preliminary data analytics, some claims for dual-eligible members are being submitted directly to MassHealth for payment. While MassHealth should

have redirected these claims to Medicare, MassHealth may have paid 100% of the claims, potentially resulting in hundreds of millions of dollars in unnecessary state spending.

The objectives of our audit are to (1) evaluate the internal controls MassHealth has in place to ensure that claims for dual-eligible members are processed properly including initial adjudication and primary payment of these claims by Medicare, (2) determine the extent to which MassHealth has improperly functioned as primary payer of claims for dual-eligible members, and (3) identify potential reimbursements from Medicare.

In this audit, we plan to meet with MassHealth to gain an understanding of the policies and procedures that providers must follow when submitting claims for dual-eligible members. As part of this audit step, we plan to conduct site visits to assess selected providers' knowledge of, and compliance with, these policies and procedures. In addition, we plan to document and test system edits developed by MassHealth for processing claims submitted by providers for dual-eligible members. Our planned audit work will enable us to make appropriate recommendations to correct any noted deficiencies.

3. Review of Providers Excluded from Participating in Medicaid Program (2015-1374-3M8)

OSA is conducting an audit of providers excluded from participating in the Medicaid program for the period January 1, 2013 through December 31, 2014. Providers who have been convicted of patient abuse or committed healthcare fraud (e.g., submitting claims for unnecessary medical services) may be excluded by the federal government from further participation in Medicaid. The objective of this audit is to determine whether MassHealth has sufficient controls in place to ensure that providers who are excluded from participating in the Medicaid program are neither participating in the Medicaid program nor receiving payments from MassHealth, in accordance with state and federal regulations.

In this audit, we plan to obtain databases of excluded providers currently maintained by three federal government entities (the Department of Health and Human Services, the General Services Administration, and the Centers for Medicare and Medicaid Services). We will match these federal databases with MassHealth's list of current eligible providers and to claim data maintained within the Medicaid Management Information System (MMIS) to determine

whether any federally identified excluded providers treated or provided prescriptions to members that resulted in payments from MassHealth.

4. Office of Medicaid (MassHealth) Review of Nursing Facility Claims Paid by MassHealth (2016-1374-8M)

OSA is conducting an audit of MassHealth payments to nursing facilities during the five-year period ended June 30, 2015. MassHealth uses MMIS to process and pay claims submitted by nursing facilities for member services. In addition, MassHealth regulations specify the amount it will pay nursing facilities under various circumstances (e.g., level of member care, member insurance coverage) for member services. According to our preliminary data analytics, MassHealth might have paid nursing facilities amounts greater than those allowed under its own published regulations, potentially resulting in improper payments totaling millions of dollars.

The objectives of our audit are to (1) determine whether MMIS edits ensure that payments to nursing facilities reflect all applicable state regulations, (2) determine the financial impact of any deficiencies found within these system edits, and (3) identify potential reimbursements due to the Commonwealth.

In this audit, we plan to document the MMIS edits developed by MassHealth for processing nursing home claims. We will then examine a sample of nursing facility claims to determine whether MassHealth's edits are working as intended and reflect current state regulations. In addition, we will meet with the Center for Health Information and Analysis (CHIA) to discuss its development and application of payment rates for nursing facilities. Also, we will visit selected nursing facilities to sample and test member files and review the procedures followed by the facilities when submitting claims for member services. Our planned audit work will enable us to make appropriate recommendations to correct any noted deficiencies.

5. Office of Medicaid (MassHealth) Review of Group Adult Foster Care Claims Paid by MassHealth (2016-1374-3M2)

OSA is conducting an audit of claims paid by MassHealth for group adult foster care (GAFC) services for the period January 1, 2010 through June 30, 2015. According to our preliminary data analytics, MassHealth may have improperly paid over \$15 million to GAFC providers. In each instance, the provider billed for GAFC services for members who were residing in long-term care (LTC) facilities. Since GAFC services are included within the scope of services provided by LTC

facilities, the Commonwealth is potentially paying twice for the same services and incurring unnecessary and duplicative costs.

The objectives of our audit are to (1) determine whether MMIS edits ensure that payments to GAFC providers reflect all applicable state regulations, policies, and procedures; (2) determine the financial impact of any deficiencies found within these system edits; and (3) identify potential reimbursements due to the Commonwealth.

In this audit, we plan to document the MMIS edits developed by MassHealth for processing GAFC service claims. We will examine all GAFC service claims to determine whether MassHealth's edits are working as intended and reflect current state regulations. In addition, we will meet with CHIA to discuss its development of payment rates for GAFC providers and LTC facilities. Also, we will visit selected GAFC and LTC providers to sample member files and discuss member services. Our planned audit work will enable us to make appropriate recommendations to correct any noted deficiencies.

6. Office of Medicaid (MassHealth) Review of Evaluation and Management Claims Submitted by Dr. Kunwar Singh (2016-1374-3M4)

OSA is conducting an audit of evaluation and management (E/M) claims submitted by Dr. Kunwar Singh from January 1, 2010 through June 30, 2015. MassHealth's payment rates for E/M services vary depending on factors such as the complexity of medical decision-making and the severity of the presenting problem. There is potential for improper billing by providers in this area. For example, if a patient presents with a low-severity problem, the provider may bill using the highest severity level's procedure code, resulting in a greater payment to the provider. Such billing practices are known as "upcoding" and reflect potentially fraudulent activity.

The objective of our audit is to determine whether Dr. Kunwar Singh billed MassHealth appropriate procedure codes reflecting actual services performed and maintained sufficient appropriate documentation to support these billings. To accomplish our objective, we plan to (1) use data analytics to review all of Dr. Kunwar Singh's claims to identify questionable billing patterns and anomalies, (2) review a statistically valid sample of member files, and (3) project any potential billing irregularities found within the sample to the total population of claims.

Based on this planned audit work, we will make appropriate recommendations to correct any noted deficiencies and identify potential reimbursements to the Commonwealth.

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

OSA is conducting an audit of E/M claims submitted by Dr. Hooshang D. Poor from January 1, 2012 through June 30, 2015. Based on federal audits conducted by the Office of the Inspector General, a potential for billing fraud exists when medical practitioners who provide services at nursing facilities (1) see a large number of residents in a single day (gang visits), (2) treat the same resident on a frequent and recurring basis (routine visits), (3) maintain an unusually active presence in the nursing facility and are given unlimited access to resident medical records, and (4) maintain questionable documentation for the medical necessity of professional services. According to our preliminary data analytics, Dr. Hooshang D. Poor provided only E/M services to members residing in nursing facilities during the audit period. Moreover, the E/M services he provided for these members were frequent and recurring, which indicates a high risk of billing impropriety.

The objective of our audit is to determine whether Dr. Hooshang D. Poor billed MassHealth for E/M services provided to members residing in nursing facilities that were medically necessary, supported by appropriate documentation, and in accordance with applicable state regulations. To accomplish our objectives, we plan to (1) use data analytics to review all of Dr. Hooshang D. Poor's claims to identify questionable billing patterns and anomalies, (2) review a statistically valid sample of member files, and (3) project any potential billing irregularities found within the sample to the total population of claims. Based on our planned audit work, we will make appropriate recommendations to correct any noted deficiencies and identify potential reimbursements due to the Commonwealth from Dr. Hooshang D. Poor.

8. Office of Medicaid (MassHealth) Review of Dental X-Ray Claims Submitted by Hampshire Family Dental and Orchard Family Dental (2016-1374-7M)

OSA is conducting an audit of dental X-ray claims submitted by Hampshire Family Dental and Orchard Family Dental⁶ from July 1, 2010 through June 30, 2015. MassHealth's dental regulations specify the circumstances under which dentists are paid for member X-rays. In addition, these regulations establish limits on the number and frequency of X-rays covered for members. According to our preliminary data analytics, Hampshire Family Dental and Orchard Family Dental potentially billed MassHealth for periapical X-rays that were not medically necessary, resulting in the Commonwealth incurring unnecessary program costs.

The objectives of our audit are to determine whether (1) claims submitted by Hampshire Family Dental and Orchard Family Dental were properly supported by required documentation; (2) services were delivered; and (3) claims were complete, accurate, and in compliance with applicable laws, rules, and regulations. To accomplish our objectives, we plan to (1) use data analytics to review all dental X-ray claims paid to these providers to identify questionable billing patterns and anomalies, (2) review a statistically valid sample of member files, and (3) project any potential billing irregularities found within the sample to the total population of claims. Based on this planned audit work, we will make appropriate recommendations to correct any noted deficiencies and identify potential reimbursements to the Commonwealth.

9. Office of Medicaid (MassHealth) Review of Claims Submitted by Hudson Home Healthcare, Inc. (2015-1374-3M10)

OSA is conducting an audit of claims for wheelchair components submitted by Hudson Home Healthcare, Inc. (Hudson) from January 1, 2012 through December 31, 2014. MassHealth pays providers of wheelchair components based on state regulations and a rate schedule established by CHIA. Generally, these regulations require MassHealth to pay providers the lower of a provider's usual and customary rate or the rate listed on the CHIA rate schedule. However, some wheelchair components are individually priced by MassHealth because a predetermined price is unavailable from CHIA. For these components, state regulations require providers to submit to

6. Both Hampshire Family Dental and Orchard Family Dental are owned by Dr. Samer Tahoun. Dr. Tahoun and other MassHealth-contracted dentists serve members at these two locations.

MassHealth a current receipted invoice,⁷ which MassHealth uses to determine the provider's payment.

The objective of our audit is to determine whether Hudson billed MassHealth the appropriate amounts (i.e., the lowest usual and customary prices) for wheelchair components in accordance with state regulations and submitted the required current receipted invoice to MassHealth for wheelchair components that were not listed in the CHIA rate schedule. To achieve our audit objectives, we plan to (1) review applicable state rules and regulations governing payment rates for durable medical equipment, (2) obtain Hudson's lowest usual and customary rate for selected wheelchair components, (3) use data analytics to review all wheelchair component claims paid to Hudson to identify questionable billing patterns and anomalies, (4) review a statistically valid sample of wheelchair component claims, and (5) project any potential billing irregularities found within the sample to the total population of claims. Based on this planned audit work, we will make appropriate recommendations to correct any noted deficiencies and identify potential reimbursements to the Commonwealth.

7. A current receipted invoice differs from a current invoice in that the receipted invoice shows proof of payment from the manufacturer and discloses all applicable discounts and warrantied items.

AUDIT IMPACT AND POST-AUDIT EFFORTS

The objectives of the performance audits conducted by the Office of the State Auditor (OSA) at MassHealth and its providers are not only to identify improper payments for Medicaid services, but also to identify and resolve any systemic problems such as deficiencies in internal controls that may exist within the MassHealth system. Consequently, while measures such as referrals to law enforcement for prosecution, recommending restitution, and other remedial actions against individual Medicaid vendors are typical results of OSA audits and serve as a deterrent, the systemic changes made by MassHealth as a result of OSA audits, in many instances, have a more significant effect on the overall efficiency of the operation of Medicaid-funded programs.

In order to assess the impact of 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, four post-audit surveys regarding Medicaid audits. This number reflects those 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 surveys are sent to MassHealth six months after the completion of the audit, not all of the audits conducted during this timeframe are included in this section of the report, as those surveys have not yet been completed.

According to the survey results completed, of 23 recommendations, MassHealth reported that it has acted, or will act, on implementing 20: 4 are fully implemented, 10 are in progress, and 6 are planned. Three recommendations were reported as having had no action taken; they were all related to one issue in the non-emergency ambulance audit where MassHealth stated that the responsibility for proper claim management fell on managed-care organizations (MCOs) pursuant to their contracts with providers. MassHealth stated that it communicated with the MCOs to prevent future issues.

In addition, MassHealth will seek recovery of \$92,000 in claims uncovered by the audit of MassHealth's personal care attendant program that were paid for dates of service that occurred after a member's date of death. MassHealth is also in the process of developing an approach to recoup unallowable fee-for-service (FFS) payments made for members enrolled with MCOs, focusing recoupment on the last two years of the audit period. The tables and narratives below detail the agencies' post-audit efforts during the reporting period.

1. Office of Medicaid (MassHealth)—An Examination of State Policies and Practices Regarding Medicaid Coverage for Inmate Inpatient Healthcare Costs

Audit No. 2013-5155-3M

Issued February 25, 2015

Survey Response Received September 21, 2015

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---------------------------|-------------------|-------------|---------------------------|---|
| 4 | 1 | 3 | Approx. \$10–15M annually | <ul style="list-style-type: none"> Working with sheriffs and the Department of Correction, MassHealth has developed a process to obtain Medicaid coverage for eligible inmates who become hospital inpatients as well as to ensure the reactivation of benefits upon an eligible inmate’s release. These actions will provide the state with \$10–\$15 million in federal reimbursements per fiscal year and also will serve as a tool to reduce recidivism. |

Findings from the audit of state policies and practices regarding Medicaid coverage for inmate inpatient healthcare costs identified that the Commonwealth missed the opportunity to receive as much as \$11,644,611 in federal reimbursements for inmate inpatient medical costs. According to Section 1905 of Title XIX of the Social Security Act and guidance from the Centers for Medicare and Medicaid Services, federal financial participation (FFP) is available for medical services provided to eligible inmates who become inpatients in a medical facility. FFP is paid by the federal government to reimburse states for a portion of eligible healthcare expenditures, including inmate inpatient healthcare costs. Massachusetts is currently eligible to receive a 50% federal reimbursement of these medical expenditures.

MassHealth responded that it has fully implemented the audit’s major recommendation: to establish a process to obtain FFP for eligible inmates who become hospital inpatients and to reactivate eligible inmates’ benefits upon release. MassHealth worked collaboratively with sheriffs and the Department of Correction to develop a streamlined application process specifically for use by correctional facilities to expedite access to MassHealth benefits both for inpatient services and upon release. Additionally, MassHealth will develop system functionality that will allow this process to become automated. As a result of these changes, MassHealth will

receive an estimated \$10–15 million in FFP for fiscal year 2016. Additionally, research and literature have stated that access to healthcare is a significant factor in curbing recidivism.

MassHealth replied that the following actions were in progress:

- MassHealth had drafted and submitted a provider bulletin for finalization before the end of September 2015 to instruct providers to bill MassHealth for inpatient services provided to eligible incarcerated individuals.
- MassHealth continues to meet with Executive Office of Health and Human Services revenue staff and Lemuel Shattuck Hospital to discuss how best to maintain and maximize FFP for inmates treated at the hospital.
- MassHealth will submit its next report to the Legislature detailing efforts to develop and implement a process to obtain FFP for eligible inmate inpatient healthcare and report the financial impact on the Commonwealth by March 1, 2016, in accordance with the statutory requirement.

2. Office of Medicaid (MassHealth)—Review of Personal Care Attendant Services

Audit No. 2013-1374-3M3

Issued April 23, 2015

Survey Response Received November 20, 2015

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---------------------------|-------------------|-------------|--|--|
| 9* | 3 | 2 | \$185,679—up to \$92,000 in a one-time recovery and approximately \$93,679 in annual savings | <ul style="list-style-type: none"> • MassHealth has developed policies and system edits to prevent and detect: <ul style="list-style-type: none"> • claims paid after the date of death • claims paid while a member receives adult foster care (AFC) services • claims that exceed the per-day maximum • claims for members enrolled in managed care • MassHealth is seeking recovery of improper payments and reviewing potential options for identifying and assessing member underutilization of authorized personal care attendant (PCA) hours |

*Action planned on the remaining four recommendations

The audit of MassHealth's PCA services found several deficiencies. MassHealth paid 6,134 claims, totaling \$604,832, for PCA services and other medical services for 146 members who, according to MassHealth's records, had died before the services were delivered. The agency also paid \$3,354,838 for unallowable PCA services for members participating in AFC. Further, MassHealth paid \$101,381 for PCA services that exceeded the maximum level possible per day and for unauthorized night hours totaling \$79,357 and improperly paid \$33,867 for PCA services for members enrolled in managed-care programs. The report also noted that PCA service utilization monitoring could be improved.

Three recommendations from the audit were reported as fully implemented. MassHealth has revised its prior authorization process for PCA services to flag when a member is receiving AFC services or group adult foster care (GAFC) services. As a result of this change, at the time that an application for personal care services is being reviewed for prior authorization, MassHealth is able to determine whether the member is receiving AFC/GAFC services. Additionally, MassHealth has implemented system edits that prevent payment of duplicative services, which include AFC/GAFC services when a member is receiving PCA services. As a result of implementing these system edits, MassHealth will realize an anticipated \$93,679 in cost savings over a 12-month period.

Also, MassHealth implemented system edits to ensure that fee-for-service (FFS) PCA claims for members enrolled in a managed-care plan that provides coverage of personal care services are denied.

MassHealth reported that two recommendations were "in progress." MassHealth stated that it was improving its data integrity and developing system edits to prevent and deny claims after a member's death. MassHealth will seek recovery of \$92,000 in claims that were paid for dates of service that occurred after a member's date of death. MassHealth is also in the process of updating any inaccurate eligibility information accordingly and, by March 2016, will complete closing of all eligibility segments that remain open in the Medicaid Management Information System (MMIS) and should be closed due to death.

Four recommendations were listed as "planned." The MassHealth Provider Compliance Unit is in the process of reviewing the claims identified in the audit to determine whether it has already recovered the identified overpayments based on detections by predictive modeling systems.

Concerning the payment of excessive daily and unauthorized nighttime PCA services, MassHealth is reviewing the specific claims identified in the audit to determine whether the members associated with these claims were approved for more than 96 units of PCA services per day. Additionally, MassHealth is in the process of developing requirements for a system edit to ensure that PCA claims exceeding the limit in a given day are only processed for members who have been authorized to receive more than 96 units of PCA services per day.

MassHealth will also review the claims identified in the audit to determine whether they correlate with a decrease in utilization of daytime hours for members who used more nighttime hours than were calculated in their prior authorization for PCA services. Based on the outcome of this review, MassHealth will explore possible methods for improving the accuracy of its prior authorization process, such as considering a single authorization calculation of hours per day without a distinction between day/evening hours. In addition, MassHealth is reviewing potential options for identifying and assessing member underutilization of authorized PCA hours.

3. Office of Medicaid (MassHealth)—Review of Fee-for-Service Payments for Services Covered by Managed-Care Organizations

Audit No. 2015-1374-3M1

Issued June 16, 2015

Survey Response Received January 29, 2016

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---------------------------|-------------------|-------------|---|---|
| 4* | 0 | 2 | Approximately \$10 million annually and an undetermined amount of recovery that should be at least in the tens of millions of dollars | <ul style="list-style-type: none"> MassHealth is working to develop a master list of service codes to denote the services that managed-care organizations (MCOs) are contractually required to deliver, as well as the non-MCO-covered and MassHealth-excluded services. MassHealth is in the process of developing a proposed approach for recouping the identified unallowable FFS payments made for members enrolled with Executive Office of Health and Human Services (EOHHS)—contracted MCOs. |

*Action planned on two recommendations

Audit findings of MassHealth’s FFS payments for services covered by MCOs showed that MassHealth improperly paid providers, including state agencies and public hospitals,

\$233,208,842 for FFS claims for services that should have been paid for by members' MCOs. These payments were for services that were specifically identified in the MCOs' contracts as services covered by the MCOs. Therefore, they represent duplicative spending because the Commonwealth paid twice for the same service—first as a portion of the capitated (per member) premium and then through the FFS claim. Additionally, MassHealth did not develop a master list of medical services and related procedure codes that were to be covered by all MCOs or a list of services actually covered by each MCO. This caused MassHealth to pay at least \$288,952,449 in additional FFS claims.

Concerning the recommendations listed as “in progress,” MassHealth is working to develop a master list of service codes to denote the services that the MCOs are contractually required to deliver, as well as the non-MCO-covered and MassHealth-excluded services (as specified in the MCO and CarePlus contracts). MassHealth has engaged the MCOs in the creation of the master code list and has, beginning this past fall (2015), shared preliminary code sets with the MCOs for their review and input; once the draft of a comprehensive master list has been completed (anticipated in March/April 2016), MassHealth will work with the systems team to ensure that the proper codes and edits have been updated in MMIS. MassHealth reported that these increased controls will result in \$10 million of savings annually.

Two recommendations were listed as “planned.” MassHealth is in the process of developing a proposed approach for recouping the identified unallowable FFS payments made for members enrolled with EOHHS-contracted MCOs, focusing recoupment on the last two years of the audit period and claims for physician, health center, inpatient, and outpatient hospital claims. MassHealth stated that it would recoup the maximum amount that due process and proper claim research allows. The agency will also enhance its review to assess retroactivity on an individual member level and will reconcile with the MCOs accordingly.

4. Office of Medicaid (MassHealth)—Review of Non-Emergency Ambulance Transportation

Audit No. 2014-1374-3M1

Issued June 5, 2015

Survey Response Received January 29, 2016

| Number of Recommendations | Fully Implemented | In Progress | Fiscal Benefit | Selected Actions and Results |
|---------------------------|-------------------|-------------|----------------|--|
| 6* | 0 | 3 | N/A | <ul style="list-style-type: none"> • A Transmittal Letter is currently being drafted to clearly explain the need for providers to complete and maintain medical necessity forms (MNFs), including directions and information required for completing the forms. • MassHealth will also issue a Transmittal Letter to all non-emergency medical transportation providers citing the transportation regulations' provisions requiring providers to perform Criminal Offender Record Information (CORI) checks on all new employees and annual CORI checks on existing employees. |

*No action taken on three recommendations

Findings from the audit of MassHealth's non-emergency ambulance transportation revealed that MassHealth did not have adequate controls over the administration of non-emergency transportation to ensure that it was properly authorized and medically necessary. The report stated that certain transportation providers did not maintain the required properly completed MNFs for some members. OSA estimates that for the service providers included in its testing, MassHealth processed an estimated \$3,680,796 in questionable payments for non-emergency ambulance transportation. Also, certain transportation providers did not consistently complete CORI checks for ambulance drivers and attendants. As a result, MassHealth cannot be certain that employees with disqualifying criminal records do not have access to vulnerable MassHealth members, including those who are elderly, underage, and/or disabled. Further, duplicate payments totaling \$8,594 were made for non-emergency medical transportation for members enrolled in MCOs.

Three recommendations were reported as “in progress.” A Transmittal Letter is currently being drafted to clearly explain the need for providers to complete and maintain MNFs including directions and information required for completing the form. MassHealth will also issue a Transmittal Letter to all non-emergency medical transportation providers citing the transportation regulations’ provisions requiring providers to perform CORI checks on all new employees and annual CORI checks on existing employees. Additionally, the non-emergency medical transportation providers are currently undergoing revalidation. The process is being conducted by a MassHealth vendor and includes a site visit to each provider and a review of files and records. Revalidation of non-emergency medical transportation providers includes verifying that providers have up-to-date and properly retained CORI information. Once validation is complete, MassHealth intends to conduct periodic site visits and communications to ensure compliance.

No action was taken on three recommendations. Concerning duplicate payments, MassHealth stated that MCO payments to non-emergency medical transportation service providers are made pursuant to contracts between MCOs and providers. MassHealth makes payments to non-emergency medical transportation providers for in-state non-emergency medical transportation services that are not covered by MassHealth’s contracts with MCOs. MassHealth has reached out to the MCOs that made these payments to help prevent future issues.