Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

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Office of the State Auditor—Annual Report
Medicaid Audit Unit

March 15, 2014–March 13, 2015

OFFICE OF THE STATE AUDITOR
MEDICAID AUDIT UNIT

March 15, 2014–March 13, 2015

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 2015 budget (Chapter 165 of the Acts of 2014) requires that the OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 13, 2015 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 the OSA in accordance with the requirements of Chapter 165, provides summaries of two OSA audits involving (1) MassHealth's claims for emergency medical services provided to nonqualified aliens and (2) an examination of state policies and practices regarding Medicaid coverage for inmate inpatient healthcare costs. It also provides summaries of six MassHealth audits that are currently underway. Finally, it details the corrective measures and related outcomes reported by the auditees, including MassHealth, in relation to our findings and recommendations for three audits.

For fiscal year 2015, the appropriation for the Unit was $864,638. This report details findings that identified more than $35 million in unallowable, questionable, duplicative, or potentially fraudulent billings—an amount equal to more than twice the OSA's total agency-wide annual budget—and as much as $11.6 million in missed opportunities for federal cost-sharing reimbursements. The report also describes corrective actions being taken by MassHealth as a

result of these findings. Auditees reported progress on implementing 91% of our audit recommendations, which will improve operational efficiency and effectiveness.

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 1.5 million eligible low- and moderate-income children, families, seniors, and people with disabilities. In fiscal year 2014, MassHealth paid more than $11.9 billion to healthcare providers, of which approximately 47% was Commonwealth funds. Medicaid expenditures represent approximately 34% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the U.S. Government Accountability Office (GAO) placed the U.S. Medicaid program on its list of government programs that are at "high risk" of fraud, waste, abuse, and mismanagement. GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Based on these concerns, the OSA began conducting audits of Medicaid-funded programs and, as part of its fiscal year 2007 budget proposal, submitted a request to establish a Medicaid Audit Unit within its Division of Audit Operations dedicated to detecting fraud, waste, and abuse in the MassHealth program. With the support of the state Legislature and the Governor, this proposal was acted upon favorably and has continued in subsequent budgets. Since that time, the OSA has maintained ongoing, independent oversight of the MassHealth program. Audit reports issued by the OSA have continued to identify significant weaknesses in MassHealth's controls to prevent and detect fraud, waste, abuse, and mismanagement in the Massachusetts Medicaid program as well as improper and potentially fraudulent claims for Medicaid services.

Currently, the OSA uses data-mining software on all audits conducted by the Unit. By so doing, our auditors can review 100% of a service provider's claims, thus significantly improving the efficiency and effectiveness of our audits. It takes substantially less time to analyze a provider's entire database of claims than to conduct traditional audit sampling techniques. Additionally, data mining has improved the overall effectiveness of our audits by allowing the OSA's staff to examine 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 15, 2014–March 13, 2015)

During this reporting period, the Office of the State Auditor (OSA) released two audit reports on MassHealth's administration of the Medicaid program. These reports identified tens of millions of dollars in questionable, unallowable, and potentially fraudulent payments; described significant future cost-saving opportunities; and made a number of recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work.

1. Office of Medicaid (MassHealth)—Review of MassHealth Limited Program Claims for Emergency Medical Services Provided to Nonqualified Aliens (2013-1374-3M)

The OSA conducted an audit of MassHealth's Limited Program for the period July 1, 2011 through December 31, 2012. Our objective was to determine whether the Limited Program provided nonqualified aliens with coverage for emergency medical services, as required by federal and state laws and regulations.

Our audit found that MassHealth paid questionable or unallowable medical claims totaling $35,137,347 during our audit period for non-emergency services provided to members of the Limited Program. Specifically, MassHealth paid for (1) inpatient and outpatient services totaling $27,852,214, (2) outpatient prescription drugs and medical supplies totaling $3,656,068, (3) dental services totaling $1,724,733, and (4) rehabilitation/therapy services totaling $1,904,332. These questionable or unallowable costs represent 45% of the $77,627,854 expended for Limited Program members during the 18-month audit period. Further details of our audit work are presented below.

- MassHealth paid a total of $63,649,340 for inpatient and outpatient services for Limited Program members, of which 270,167 claims (totaling $27,852,214, or 44%) were for non-emergency services. The services included evaluation and management, behavioral-health, inpatient, and outpatient and physician services. They were provided to manage all aspects of members' healthcare, including preventive and therapeutic care. Specific examples of these services include scheduled office visits, diagnostic examinations, medical consultations, hospitalizations, immunizations, laboratory and radiological services, and individual and group behavioral-health therapies. These services were not for emergency medical conditions that could have placed a member's health in serious jeopardy, caused serious impairment to bodily functions, or caused serious dysfunction of any body part or

organ at the time of service. Therefore, they did not meet the definition of emergency services in 130 Code of Massachusetts Regulations (CMR) 450.105(F).

- MassHealth paid $4,144,247 for outpatient prescriptions for Limited Program members, of which 116,973 claims (totaling $3,656,068, or 88%) were for drugs and medical supplies to treat chronic and non-emergency conditions, contrary to 130 CMR 450.105(F). For example, members received prescription drugs to treat chronic conditions such as high blood pressure, asthma, arthritis, and diabetes. They also received prescriptions for medical supplies, such as test strips, lancets, and alcohol swabs. In addition, MassHealth reimbursed pharmacists for 80,460 claims, totaling $2,540,320, for drugs and medical-supply prescriptions that violated the 30-day supply restriction for Limited Program members.

- MassHealth paid 87,333 dental-service claims (totaling $3,111,272) for Limited Program members, of which 47,533 claims (totaling $1,724,733, or 55%) were for the treatment of non-emergency conditions, contrary to 130 CMR 450.105(F). The unallowable dental services included routine dental examinations, cleanings, and X-rays; fluoride treatments; minor dental restorations; and orthodontics.

- MassHealth paid 6,637 rehabilitation/therapy claims (totaling $1,909,919) for Limited Program members, of which 6,617 claims (totaling $1,904,332, or 99.7%) were for non-emergency services. The rehabilitation/therapy services included various types of physical and occupational therapy, speech and language therapy, and other therapeutic treatments. The majority of the unallowable claims ($1,793,271, or 94%) were for physical-therapy services; the remaining claims ($111,061, or 6%) were for other services such as occupational therapy, orthotics, and speech/language therapy.

MassHealth could have prevented this unnecessary spending had it established internal controls to ensure that payments were made solely for emergency medical services. Specifically, MassHealth did not (1) develop operational procedures to implement its existing regulations and policies governing the Limited Program; (2) establish claim-processing system edits to pay only for emergency services; and (3) adequately monitor provider claims to identify trends and anomalies that could indicate waste, fraud, and abuse.

2. An Examination of State Policies and Practices Regarding Medicaid Coverage for Inmate Inpatient Healthcare Costs (No. 2013-5155-3M)

The OSA conducted a performance audit of state policies and procedures regarding Medicaid eligibility of inmates and potential federal reimbursement for inmate inpatient healthcare costs for the period January 1, 2011 through December 31, 2012. Our objective was to determine whether the Commonwealth (1) effectively reduced inmate healthcare costs by requiring hospitals and other medical-service providers to bill MassHealth for eligible inmate inpatient health services and (2) sought federal reimbursement for care provided to inmates of the

Department of Correction and county houses of correction who were treated at Lemuel Shattuck Hospital.

According to Section 1905 of Title XIX of the Social Security Act and guidance from the Centers for Medicare & Medicaid Services, federal financial participation (FFP) is available for medical services provided to 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. However, our audit found that MassHealth did not seek federal reimbursement for inmate inpatient medical costs, and consequently the Commonwealth lost the opportunity to save as much as $11,644,611 for these medical expenses during the audit period. MassHealth needs to create policies and procedures to obtain FFP for eligible inmate inpatient healthcare services provided by public hospitals, non-public hospitals, and other medical-service providers.

CURRENT INITIATIVES

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

The Office of the State Auditor (OSA) is conducting an audit of claims paid by MassHealth for mobility-assistive equipment, e.g., wheelchairs, canes, and crutches, from July 1, 2011 through December 31, 2012. The purpose of our audit is to determine whether MassHealth has established adequate controls over these durable medical appliances. Such controls would include, but are not limited to, (1) maintaining edits within its claim-processing system to detect and deny claims submitted contrary to state regulations; (2) requiring service providers to maintain documentation to support the medical necessity, prior authorization, and delivery of members' equipment; and (3) periodically monitoring system outputs to identify questionable price fluctuations, billing irregularities, and potentially fraudulent claims.

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

2. Review of Personal Care Attendant Services (No. 2013-1374-3M3)

The OSA is conducting an audit of claims for personal care attendant (PCA) services provided for members from July 1, 2010 through June 30, 2013. The objectives of this audit are to determine whether MassHealth (1) determined that PCA services were medically necessary; (2) paid only for authorized PCA services; and (3) determined that the services were prescribed by a physician or a nurse practitioner who was responsible for the oversight of the member's healthcare. In this audit, we plan to evaluate MassHealth's regulations and controls over claims for PCA services and use data analytics to identify claims that represent a high risk of violating state regulations or being fraudulent.

3. Review of Medicaid Claims for Transportation Services (2014-1374-3M1)

The OSA is conducting an audit of transportation services paid for by MassHealth during the period January 1, 2012 through December 31, 2013. In this audit, we plan to evaluate MassHealth's regulations and controls over claims for non-emergency ambulance services and use data analytics to identify claims that represent a high risk of violating state regulations. In addition, we will visit selected providers to (1) review members' medical necessity forms, (2) assess mileage calculations and reimbursements, (3) examine ambulance crews' required paramedic / Emergency Medical Technician licenses, (4) verify third-party insurer information, and (5) determine whether employee Criminal Offender Record Information checks were performed as mandated.

4. Review of Managed Care Organizations (2015-1374-3M1)

The OSA is conducting an audit of services provided by state managed-care organizations (MCOs) during the five-year period ended September 30, 2014. According to our preliminary data analytics, MassHealth may have improperly paid more than 1.4 million fee-for-service (FFS) claims (totaling $268 million) for members enrolled in MCOs. The objectives of our audit are to (1) evaluate the internal controls MassHealth has in place to detect and deny FFS claims for services covered by a member's MCO, (2) determine the extent to which MassHealth has improperly paid FFS claims for MCO members, and (3) identify potential reimbursements from MCOs.

In this audit, we plan to visit each MCO to identify the medical services it covers under contract with MassHealth. In addition, we plan to visit selected service providers that subcontract with the MCOs. 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 MCOs.

5. Review of Documentation for Hospital Claims (2015-1374-3M3)

The OSA is conducting an audit of hospital claims for the period January 1, 2013 through December 31, 2014. According to 130 Code of Massachusetts Regulations 450.205(B), all providers must maintain complete patient records to support all charges for all medical services provided. The objective of our audit is to determine whether the selected hospital provider/s

are maintaining appropriate supporting documentation for selected services in accordance with state regulations.

In this audit, we plan to use data mining to identify categories and overall costs of hospital services. In addition, we plan to visit one or more selected hospitals to examine patient records and determine whether selected hospital claims are supported by adequate documentation.

6. Review of Billable Hours by Service Providers (2015-1374-3M5)

The OSA is conducting an audit of service hours billed by selected physical therapists, counselors, psychiatrists, and psychologists from January 1, 2013 through December 31, 2014. The purpose of our audit is to determine whether selected providers are billing for treatment sessions at realistic levels. For example, some sessions are billed at one-hour increments, making it unrealistic for a provider to consistently bill for more than 12 sessions daily. Providers who bill for services above realistic levels may be engaging in fraudulent billing activity.

In this audit, we plan to use data analytics to identify service providers with a high risk of billing at unreasonable service levels. From this preliminary analysis, we will select a sample of one or more providers to audit to determine whether they bill MassHealth only for services actually rendered.

7. Review of Evaluation and Management Service Codes (2015-1374-3M6)

The OSA is conducting an audit of evaluation and management services from January 1, 2012 through December 31, 2014. MassHealth's payment rates for evaluation and management services vary depending on factors such as the complexity of medical decision-making and 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 purpose of our audit is to determine whether providers bill appropriate procedure codes reflecting actual services performed.

In this audit, we plan to use data analytics to identify service providers with a high risk of overuse of the procedure codes representing the most complex services. From this preliminary

analysis, we will select a sample of one or more providers to audit to determine whether procedure codes billed reflect the level of complexity of services provided.

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, the OSA has implemented a post-audit review survey process that is conducted six months after the release of an audit. This process documents the status of the recommendations made by the OSA, including any corrective measures taken by the auditee as well as any estimates of future cost savings resulting from changes made based on our recommendations.

During the report period, the OSA issued, and agencies completed, five post-audit surveys regarding Medicaid audits. According to the survey results, of 11 recommendations, agencies reported that action is in progress on implementing 10. The other recommendation was reported as having had no action taken; it related to a vendor that had ceased operations, whose contract had expired. The tables and narratives below detail agencies' post-audit efforts during the reporting period.

1. Dr. Shahrzad Haghayegh / Hancock Dental, P.C.

Audit No. 2012-4565-3C **Issued December 11, 2013**
Survey Response Received September 9, 2014

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
7	0	7	Up to $154,019	• MassHealth could recover up to $154,019 from Dr. Haghayegh • MassHealth has implemented several dental edits to its system • The Office of the Attorney General (OAG) Medicaid Fraud Division is reviewing the case

Findings from the audit of dental claims submitted by Dr. Shahrzad Haghayegh-Askarian (Dr. Haghayegh), a Quincy dentist who had been a participating dental provider in the MassHealth Dental Program, disclosed 1,429 billings to MassHealth for unallowable detailed oral screenings intended for patients receiving radiation therapy, chemotherapy, or organ transplants worth $89,249; 259 oral evaluations that exceeded MassHealth limits by $10,876; unnecessary fluoride treatments totaling $2,470; and $3,271 in unallowable dental enhancement fees intended for contracted Community Health Centers (CHCs) and Hospital-Licensed Health Centers (HLHCs).

Additionally, the audit reported that Dr. Haghayegh kept illegible member records in violation of state regulations; submitted unallowable claims for denture repairs totaling $24,336; did not document $45,206 worth of dental procedures in member files; and performed 98 tooth restorations that exceed MassHealth limits by $6,342.

Further, the OSA identified certain matters in Dr. Haghayegh's and Hancock Dental's member records and claim data that indicated potential fraud and abuse. These matters were not detailed in the audit, but were instead referred to the OSA's Bureau of Special Investigations for further investigation and resolution. The audit report itself was referred to the OAG.

Dr. Haghayegh's license to practice dentistry was suspended by the Commonwealth for one year in May 2013 for a matter unrelated to the audit (patient complaints about her dental treatments).

MassHealth stated that all seven recommendations specifically made to the agency were "in progress." MassHealth issued a Final Notice of Nonpayment in August 2011 as part of an audit that overlapped the OSA's audit. Included in the notice was $67,168 for unallowable detailed oral screenings. Dr. Haghayegh appealed to the MassHealth Board of Hearings (BOH). MassHealth was reviewing the pursuit of an additional $22,081 in unallowable detailed oral screenings based on OSA work.

The OAG's Medicaid Fraud Division is reviewing Dr. Haghayegh. Depending on the outcome from the BOH process and OAG review, MassHealth could recover up to $154,019 from Dr. Haghayegh; this figure represents funds identified for repayment through MassHealth's and OSA's audits, as the audit periods overlapped.

Further, MassHealth has implemented several edits to its system that will help to avoid audit findings such as these in the future. Edits have been implemented that only allow for payment up to the established limits for oral evaluations; limit payment for fluoride treatment to once per quarter per member (in accordance with American Academy of Pediatric Dentistry standards); only allow dental enhancement fees to be paid to contracted CHCs and HLHCs; put stringent limits on denture repairs; and allow for only one restoration per tooth surface per year.

2. Henry Lee Willis Community Center, Inc.—Executive Office of Health and Human Services' Reply on Behalf of the Departments of Children and Families, Developmental Services, and Public Health

Audit No. 2013-4569-3C **Issued December 19, 2013**

Survey Response Received July 8, 2014

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
1	0	1	Possible $143,775	• As a result of the Henry Lee Willis Community Center, Inc. (HLWCC) ceasing operations, to recoup questionable and non-reimbursable expenses charged by the HLWCC, Executive Office of Health and Human Services (EOHHS) purchasing agencies recommended that the matter be referred to the OAG for resolution
Henry Lee Willis Community Center, Inc.—Department of Housing and Community Development Inquiry				
				Survey Response Received July 21, 2014
1*	0	0	N/A	• The Department of Housing and Community Development (DHCD) as a purchasing agency did not take action on the recommendation; its contract with the HLWCC was not renewed in January 2013
Henry Lee Willis Community Center, Inc.—Operational Services Division Inquiry				
				Survey Response Received July 24, 2014
1	0	1	N/A	• The Operational Services Division (OSD) concurred with EOHHS agencies' decision to refer the HLWCC matter to the OAG; OSD as the oversight agency will continue to monitor the status of the referral

* No action taken

The audit of the HLWCC, a Worcester-based human- and social-services organization (which, owing to financial mismanagement, was forced to close its doors in February 2013), discovered some deficiencies. Auditors disclosed that the HLWCC owed approximately $1 million to its suppliers and vendors, including $235,569 of unemployment-compensation payments to the Commonwealth. In addition, the HLWCC was found not to have taken necessary measures to improve its cash flow and overall financial situation and to have been operating in a deficit position since 2004. It was further found that the HLWCC charged questionable and non-reimbursable expenses totaling $143,775 to the Commonwealth, including $8,207 of inadequately documented credit-card expenses; $57,080 for a lease of a luxury vehicle for its executive director; at least $39,788 of questionable payments to an affiliated management company for maintenance services; $10,000 to hire a public-relations firm; and $28,700 of interest and late fees.

The OSA, in its audit report, did not provide recommendations of corrective action to the HLWCC because the HLWCC had ceased operating. However, the OSA recommended that the OSD and the HLWCC's state funding agencies (the Department of Children and Families [DCF], Department of Developmental Services [DDS], DHCD, and the Department of Public Health [DPH]) review the amounts that the HLWCC owed to the Commonwealth for unemployment insurance and the non-reimbursable expenses identified in the report and determine whether any funds were available to repay the debt. Accordingly, the OSD, DCF, DDS, DHCD, and DPH were issued a post-audit review survey.

OSD, DCF, DDS, and DPH all reported that the recommendation was currently "in progress." Submitting one joint response as EOHHS purchasing agencies, the EOHHS agencies stated that they agreed with the OSA's conclusion that there is probably no means of recoupment of money owed (determined to be the $143,775 in questionable and non-reimbursable expenses) to the Commonwealth. The EOHHS agencies further suggested that this matter be referred to the OAG Public Charities Division to understand what steps, if any, have been taken on the HLWCC's part to petition for dissolution of the entity and the degree to which amounts owed the Commonwealth may be incorporated into the formal dissolution process. OSD, as the oversight agency, concurred with the EOHHS agencies' decision to refer this matter to the OAG, and it will continue to monitor the process of the referral.

No action was taken by DHCD on the recommendation made in the audit. DHCD stated that it did not renew its contract with the HLWCC after it expired on January 31, 2013; the services and client records were assigned to another provider.

3. The Office of Medicaid (MassHealth)—Review of Controls Over Pharmacy Claims

Audit No. 2012-1374-3C2 **Issued July 25, 2013**
Survey Response Received March 21, 2014

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
1	0	1	N/A	• MassHealth submitted a change order request to add National Provider Identification (NPI) numbers to its Data Warehouse and to transfer the allowed number of prescription refills data to the Medicaid Management Information System (MMIS) and the Data Warehouse

Auditors found that MassHealth's Data Warehouse did not contain the necessary information to effectively review its Pharmacy Program. Its Data Warehouse (its central repository for provider claims) did not always identify the prescribing provider or medication associated with certain prescription drug claims, and it contained inaccurate information about the allowed number of refills of a prescription drug that members may receive. Without complete and accurate claim information, independent reviewers of the Pharmacy Program cannot effectively identify trends and anomalies indicative of billing irregularities and potentially fraudulent activities.

In response to the survey, MassHealth stated that it is in the process of implementing the audit's recommendation. MassHealth has submitted a change-order request to add NPI numbers to its Data Warehouse and to transfer data pertaining to the allowed number of refills from the Pharmacy Online Processing System to both MMIS and the Data Warehouse. As a result of these actions, MassHealth's external reviewers will have improved capability to visualize all components of a paid pharmacy claim.