



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

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Office of the State Auditor—Annual Report Medicaid Audit Unit

March 15, 2016–March 14, 2017



OFFICE OF THE STATE AUDITOR

MEDICAID AUDIT UNIT

March 15, 2016–March 14, 2017

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 133 of the Acts of 2016) requires that OSA submit a report to the House and Senate Committees on Ways and Means by no later than March 15, 2017 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 133, provides summaries of two performance audits involving the following:

- adult foster care (AFC) and group adult foster care services
- providers excluded from participating in the Medicaid program

It also summarizes seven provider audits involving the following:

- claims by five dental providers for radiograph services
- claims by a physician provider for evaluation and management services
- claims by a provider of durable medical equipment (DME) for wheelchairs and wheelchair components

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

It also summarizes 13 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 10 audits.

For fiscal year 2017, the appropriation for the Unit was \$1,152,276. This amount represents a 1.06% decrease over the Unit's fiscal year 2016 appropriation of \$1,164,638. With this funding, the Unit maintained its prior year's staffing level, while increasing audit productivity by using data analytics on each assignment. Specifically, the Unit worked on a total of 24 audits (11 were completed and 13 are still being conducted); in contrast, the Unit worked on 19 audits and completed 10 during the prior reporting period. Thus, even with a slight funding decrease (from \$1,164,638 to \$1,152,276), the Unit was able to increase its overall productivity in terms of audits both initiated and completed.

This report details findings that identified more than \$17.6 million in unallowable, questionable, duplicative, unauthorized, or potentially fraudulent billings—a return of more than \$15 for every dollar of funding in the Unit. The report also describes corrective actions being taken by MassHealth as a result of audits whose findings were issued at least six months ago for which a follow-up survey has been completed and MassHealth has taken actions to begin recouping funds. Auditees reported action or planned action on 84% of our audit recommendations, which will improve operational efficiency and effectiveness. MassHealth stated that it was pursuing up to \$17,622,990 in recoveries as a result of the audit work, which will also provide annual savings of \$8,629,316.

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 2016, MassHealth paid more than \$14.8 billion to healthcare providers, of which approximately 50% was Commonwealth funds. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

Heightened concerns over the integrity of Medicaid expenditures were raised in January 2003, when the US Government Accountability Office (GAO) placed the US Medicaid program on its list of government programs that are at “high risk” of fraud, waste, abuse, and mismanagement. GAO has estimated that between 3% and 10% of total healthcare costs are lost to fraudulent or abusive practices by unscrupulous healthcare providers. Based on these concerns, OSA began conducting audits of Medicaid-funded programs and, as part of its fiscal year 2007 budget proposal, submitted a request to establish a Medicaid Audit Unit within its Division of Audit Operations dedicated to detecting fraud, waste, and abuse in the MassHealth program. With the support of the state Legislature and the Governor, this proposal was acted upon favorably and has continued in subsequent budgets. Since that time, OSA has maintained ongoing independent oversight of the MassHealth program. 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 that are 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, 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, 2016–March 14, 2017)

During this reporting period, the Office of the State Auditor (OSA) released 11 audit reports on MassHealth's administration of the Medicaid program and on Medicaid service providers' compliance with state and federal laws, regulations, and other authoritative guidance. These reports identified millions of dollars in questionable, unallowable, unauthorized, and potentially fraudulent payments and made a number of recommendations to strengthen internal controls and oversight in MassHealth's program administration. The following is a summary of our Medicaid audit work.

1. Office of Medicaid (MassHealth)—Review of Providers Excluded from Participating in the Medicaid Program (2015-1374-3M8)

OSA conducted an audit of MassHealth's activities to ensure that excluded providers do not participate in the state's Medicaid program for the period January 1, 2013 through December 31, 2014. Healthcare providers who are found to have violated federal laws and/or regulations may be excluded by the federal government from further participation in federally funded programs, including Medicaid. The purpose of this audit was to determine whether MassHealth had sufficient controls in place to ensure that such providers did not bill or receive payments from MassHealth, in accordance with federal laws and regulations.

Our audit showed that MassHealth made \$426,105 of unallowable payments to excluded physicians and durable medical equipment (DME) suppliers. In total, 12 excluded providers submitted more than 5,500 claims for more than 1,800 members. In addition, 7 excluded providers wrote prescriptions for MassHealth members for a total of \$50,682. These included prescriptions for Schedule II controlled substances that have high potential for abuse. In total, these 7 excluded providers wrote 3,445 prescriptions for 863 members.

As a result of these findings, OSA recommended that MassHealth (1) establish adequate controls to ensure that the excluded-provider lists generated by its customer-service contractor are current and are used effectively and (2) take appropriate action to recoup the \$476,787 in unallowable payments associated with excluded providers.

2. Office of Medicaid (MassHealth)—Review of Paid Claims within MassHealth’s Adult Foster Care and Group Adult Foster Care Programs (2016-1374-3M2)

OSA conducted an audit of paid claims for adult foster care (AFC) and group adult foster care (GAFC) services for the period January 1, 2010 through June 30, 2015. AFC and GAFC programs provide assistance with activities of daily living to members who are elderly or disabled but do not need the level of assistance provided in a long-term-care (LTC) facility. The purpose of this audit was to determine whether MassHealth paid for AFC and GAFC services in accordance with applicable regulations and other authoritative guidance.

Our audit showed that MassHealth improperly paid AFC and GAFC providers \$15,201,854 for 57,322 claims for services provided to members residing in LTC facilities, i.e., rest homes and nursing homes.¹ Of this amount, \$14,331,826 (94%) was paid to GAFC providers and \$870,029 (6%) to AFC providers. These payments were for services that were specifically identified in state licensing regulations as services already performed by LTC facilities. The GAFC providers we spoke with said they provided personal care and assistance with hygiene, bathing, dressing, haircare, shaving, and medication. These were the same services provided by staff members at the LTC facilities who were responsible for assisting members throughout the day. AFC and GAFC programs are designed to provide members with sufficient daily assistance to avoid placement in LTC facilities, not to supplement services in those facilities.

To help resolve this matter, OSA recommended that MassHealth (1) not pay for AFC and GAFC services for members who received similar services while residing in LTC facilities, (2) establish and implement system edits to detect and deny claims for AFC and GAFC services provided to members residing in LTC facilities, and (3) enact regulations specifically governing the GAFC program.

3. Office of Medicaid (MassHealth)—Review of Selected Outpatient Evaluation and Management Services Claims Submitted by Dr. Kunwar S. Singh (2016-1374-3M4)

OSA conducted an audit of selected outpatient evaluation and management (E/M) claims paid to Dr. Kunwar Singh for the period January 1, 2010 through June 30, 2015. During this period,

1. A MassHealth member can receive limited AFC and GAFC services while temporarily receiving care in a hospital or nursing home on a medical leave of absence or while away from home on a nonmedical leave of absence.

Dr. Singh was paid approximately \$199,000 to provide outpatient E/M services for 296 MassHealth members. The purpose of this audit was to determine whether Dr. Singh billed MassHealth for E/M services using appropriate procedure codes and whether he properly documented E/M services in member medical records in accordance with applicable laws, rules, and regulations.

Our audit showed that Dr. Singh did not use the correct procedure codes when billing for outpatient E/M services. Specifically, Dr. Singh billed routine, less-complex cases using codes that were designated for high-complexity cases. This billing practice is referred to as upcoding. Dr. Singh's upcoding of E/M services resulted in improper payments totaling approximately \$55,390.

We tested a random, statistical sample of 60 out of 1,086 claims paid during the audit period for procedure codes 99205 and 99215 in order to project the potential problem to the population. Of these 60 claims, we identified 50 as billed using an incorrect procedure code. These 50 claims were billed using E/M procedure codes 99205 and 99215, but Dr. Singh's medical records did not contain documentation of the nature, extent, and medical necessity of care provided to the member to justify using those codes.

E/M codes 99205 and 99215 are used for moderately to highly severe and complex cases. However, the 50 improper claims were for minor or low-complexity cases. For example, Dr. Singh billed E/M code 99215 for minor medical conditions such as coughs / sore throats and headaches. In some instances, Dr. Singh improperly billed 99215 for follow-up visits that by nature would not require a high level of decision-making because that would have been performed at the initial visits. Dr. Singh should have billed for these types of services using lower-level E/M procedure codes 99211 through 99213.

We projected our results to the population of claims for procedure codes 99205 and 99215 using a confidence level of 90% and a tolerable error rate of 10.32%, resulting in projected overpayments of approximately \$55,390 for the audit period.

Our audit report recommended that in order to resolve these problems, Dr. Singh (1) collaborate with MassHealth to repay the approximately \$55,390 in improper payments he received from the upcoding of claims and (2) develop internal controls to ensure that his claims

for E/M services are not upcoded. At a minimum, these controls should ensure that his billing staff has sufficiently reviewed required documentation to support each claim.

4. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Hampshire Family Dental and Orchard Family Dental (2016-1374-7M)

OSA conducted an audit of dental periapical² radiograph claims paid to Hampshire Family Dental and Orchard Family Dental for the period July 1, 2010 through June 30, 2015. MassHealth regulations allow periapical radiographs to be taken by a dental-service provider either as part of a full-mouth series of radiographs (allowed once every three years) or to evaluate a specific dental problem independently. During the audit period, Hampshire Family Dental and Orchard Family Dental were paid approximately \$470,000 to provide periapical radiographs for 7,595 MassHealth members. The purpose of this audit was to determine whether Hampshire Family Dental and Orchard Family Dental billed MassHealth for appropriate periapical radiographs and whether they properly documented periapical radiographs in member dental records in accordance with applicable MassHealth regulations.

We tested a random, statistical sample of 60 paid claims at Hampshire Family Dental and 60 at Orchard Family Dental for dental periapical radiographs in order to project the potential error to the population. Of these 120 claims, 72 were unallowable. These 72 claims were for dental periapical radiographs performed as part of routine dental exams when no full-mouth series of radiographs had been taken and the associated files did not indicate dental pain; anticipated extractions; or any suspected infection, change, or anomaly.

We projected our results to the populations of claims for dental periapical radiographs using a confidence level of 90% and a tolerable error rate of 10%, resulting in projected overpayments of approximately \$290,417 for the audit period.

Our audit report recommended that in order to resolve this problem, Hampshire Family Dental and Orchard Family Dental (1) collaborate with MassHealth to repay the approximately \$290,417 in improper payments they received for periapical radiographs and (2) ensure that in the future, they do not bill MassHealth for periapical radiographs as part of routine biannual dental examinations.

2. A periapical radiograph shows the whole tooth from the top to where the tooth is secured in the jaw.

5. Office of Medicaid (MassHealth)—Review of Claims Submitted by Hudson Home Health Care, Inc. (2015-8018-3M10)

OSA conducted an audit of claims for wheelchairs and wheelchair components submitted by Hudson Home Health Care, Inc.³ to MassHealth for the period January 1, 2012 through December 31, 2014. The objective of our audit was to determine whether Hudson submitted claims and received payments for these items in accordance with certain established state regulations.

When Hudson submitted claims for wheelchair components, it did not bill MassHealth the lowest usual and customary price in accordance with state regulations. Specifically, in our sample of 15 wheelchair components, Hudson billed MassHealth at rates higher than those it charged, or accepted from, other payers (e.g., insurance companies) for the same items. Because Hudson did not properly bill MassHealth, it was overpaid by at least⁴ \$474,486 during the audit period.

Hudson officials stated that they were not aware of state regulations requiring claims to be based on the lowest price that Hudson charges or accepts from any payer for the same equipment. MassHealth officials stated that MassHealth does not know DME providers' lowest accepted prices and therefore pays for wheelchair components based on amounts listed on the a rate schedule established by the state's Center for Health Information and Analysis (CHIA), which are typically higher.

Our audit report recommended that in order to resolve this problem, Hudson (1) submit claims for wheelchair components based on its lowest accepted prices; (2) develop, maintain, and make available to MassHealth a list of its lowest accepted prices for all wheelchair components; (3) collaborate with MassHealth to determine any potential amounts due the Commonwealth identified in our report; and (4) periodically review MassHealth and CHIA's billing and payment regulations and update its policies and procedures accordingly. It also recommended that Hudson work with MassHealth to determine whether additional overpayments resulted from similar improper billings for wheelchair components that were not tested.

3. During November 2014, Hudson was purchased by National Seating and Mobility, Inc. As a wholly owned subsidiary of National Seating and Mobility, Inc., Hudson continues to operate as a MassHealth provider of durable medical equipment, doing business as Hudson Seating and Mobility, Inc.

4. Our analysis includes only 15 of the 219 wheelchair components for which Hudson billed MassHealth. The amount in overpayments that we can confirm from this analysis is \$474,486, but there may have been more.

6. Office of Medicaid (MassHealth)-Review of Dental Periapical Radiograph Claims Submitted by Dr. Najmeh Rashidfarokhi (2016-1374-3M11)

OSA conducted an audit of dental periapical radiograph claims paid to Dr. Najmeh Rashidfarokhi for the period July 1, 2010 through June 30, 2015. During this period, MassHealth paid Dr. Rashidfarokhi approximately \$349,576 to provide periapical radiographs for 4,884 MassHealth members. The purpose of this audit was to determine whether Dr. Rashidfarokhi billed MassHealth for appropriate periapical radiographs and whether she documented them in member dental records in accordance with applicable MassHealth regulations.

We tested a statistically random sample of 60 out of 21,226 claims paid to Dr. Rashidfarokhi for dental periapical radiographs. Because the sample was statistical, we were able to project the potential error to the population. Of these 60 claims, 54 were unallowable. These 54 claims were for dental periapical radiographs performed as part of routine dental exams that were not part of a triennial full-mouth series of radiographs. The associated dental records did not indicate dental pain; anticipated extractions; or any suspected infection, periapical change, or anomaly.

We projected our results to the population of claims for dental periapical radiographs using a confidence level of 90% and a tolerable error rate of 10.60%. The result was a projected overpayment of \$267,251⁵ for the audit period.

Our audit report recommended that in order to resolve this problem, Dr. Rashidfarokhi (1) collaborate with MassHealth to repay the approximately \$267,251 in improper payments she received for periapical radiographs and (2) ensure that in the future, she does not bill MassHealth for periapical radiographs that are unallowable under MassHealth regulations (e.g., radiographs performed as part of routine dental examinations).

7. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Webster Square Dental Care (2016-1374-3M11C)

OSA conducted an audit of dental periapical radiograph claims paid to Webster Square Dental Care for the period July 1, 2010 through June 30, 2015. During this period, MassHealth paid

5. Based on our statistical sampling approach, we are 90% confident that the overpayment for the audit period ranges from \$267,251 to \$314,356.

Webster Square Dental Care approximately \$582,911 to provide periapical radiographs for 7,743 MassHealth members. The purpose of this audit was to determine whether Webster Square Dental Care billed MassHealth for appropriate periapical radiographs and whether it documented them in member dental records in accordance with applicable MassHealth regulations.

We tested a statistically random sample of 60 out of 36,465 claims made by Webster Square Dental Care for dental periapical radiographs during the audit period. Because the sample was statistical, we were able to project the potential error to the population. Of these 60 claims, 33 were unallowable. These 33 claims were for dental periapical radiographs that were performed as part of routine dental exams and were not part of a triennial full-mouth series of radiographs. The associated dental records did not indicate dental pain; anticipated extractions; or any suspected infection, periapical change, or anomaly.

We projected our results to the population of claims for dental periapical radiographs using a confidence level of 90% and a tolerable error rate of 10.61%. The result was a projected overpayment of \$246,497⁶ for the audit period.

Our audit report recommended that in order to resolve this problem, Webster Square Dental Care (1) collaborate with MassHealth to repay the approximately \$246,497 in improper payments it received for periapical radiographs and (2) ensure that in the future, it does not bill MassHealth for periapical radiographs that are unallowable under MassHealth regulations (e.g., radiographs performed as part of routine dental examinations).

8. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Sawan & Sawan, DMD (2016-1374-3M11B)

OSA conducted an audit of dental periapical radiograph claims paid to Sawan & Sawan, DMD for the period July 1, 2010 through June 30, 2015. During this period, MassHealth paid Sawan & Sawan, DMD approximately \$516,734 to provide periapical radiographs for 5,748 MassHealth members. The purpose of this audit was to determine whether Sawan & Sawan, DMD billed

6. Based on our statistical sampling approach, we are 90% confident that the overpayment for the audit period ranges from \$246,497 to \$373,070.

MassHealth appropriately for periapical radiographs and whether it documented the need for them in member dental records in accordance with applicable MassHealth regulations.

We tested a statistically random sample of 60 out of 31,745 claims made by Sawan & Sawan, DMD for dental periapical radiographs during the audit period. Because the sample was statistical, we were able to project the potential error to the population. Of these 60 claims, 15 were unallowable because (1) the claims were for dental periapical radiographs performed as part of routine dental exams and were not part of a triennial full-mouth series of radiographs; (2) the claims were supported by incomplete dental records, so we could not determine the reasons periapical radiographs were taken; or (3) the associated dental records did not indicate dental pain; anticipated extractions; or any suspected infection, periapical change, or anomaly.

We projected our results to the population of claims for dental periapical radiographs using a confidence level of 90% and a tolerable error rate of 10.61%. The result was a projected overpayment of \$79,190⁷ for the audit period.

Our audit report recommended that in order to resolve this problem, Sawan & Sawan, DMD (1) collaborate with MassHealth to repay the approximately \$79,190 in improper payments it received for periapical radiographs; (2) ensure that in the future, it does not bill MassHealth for periapical radiographs that are unallowable under MassHealth regulations (e.g., those performed as part of routine dental examinations); and (3) ensure that dental records reflect the need for periapical radiographs for members.

9. Office of Medicaid (MassHealth)—Review of Periapical Radiograph Claims Submitted by Our Dentist (2016-1374-3M11A)

OSA conducted an audit of dental periapical radiograph claims paid to Our Dentist for the period July 1, 2010 through June 30, 2015. During this period, MassHealth paid Our Dentist approximately \$13,480 to provide periapical radiographs for 447 MassHealth members. The purpose of this audit was to determine whether Our Dentist billed MassHealth for appropriate periapical radiographs and whether it documented them in member dental records in accordance with applicable MassHealth regulations.

7. Based on our statistical sampling approach, we are 90% confident that the overpayment for the audit period ranges from \$79,190 to \$176,359.

During the audit period, Our Dentist submitted claims, and was paid \$3,720, for dental periapical radiographs that were not properly documented. We received information from Dr. Mitesh Brahmbhatt on the need for these periapical radiographs and substantiated it by reviewing member dental records. We concluded that although the reasons for taking these radiographs were not documented in member files, they were administered in situations that were appropriate according to MassHealth regulations. However, without proper documentation of the need for these periapical radiographs in members' files, members will not have a complete dental history if they need to see a new dental provider.

We tested a statistically random sample of 60 out of 808 claims made by Our Dentist for dental periapical radiographs during the audit period in order to project the potential error to the population. Of these 60 claims, 24 did not have adequate supporting documentation in the members' dental records. These 24 claims were for dental periapical radiographs performed when the associated dental records did not indicate the reason the periapical radiographs were performed (e.g., as part of a triennial full-mouth series of radiographs or because of dental pain; anticipated extractions; or any suspected infection, periapical change, or anomaly). Dr. Brahmbhatt stated that periapical radiographs were taken for patients with complaints or for children with tooth-eruption concerns. These issues were not always documented in members' dental records, but we found that the radiographs were not routinely performed during dental exams for MassHealth members, were for children experiencing periapical change or for patients with complaints, and were typically limited to one radiograph. Moreover, these radiographs were needed to determine whether extraction was necessary. Therefore, we concluded that although the periapical radiographs were not adequately documented, they were appropriately taken.

We projected our results to the population of claims for dental periapical radiographs using a confidence level of 90% and a tolerable error rate of 10.22%. The result was a projected overpayment of \$3,720⁸ for the audit period for periapical radiographs that were not adequately documented in members' dental records. The problems we identified during our audit of Our Dentist indicate a need for the dental provider to improve its recordkeeping but do not, in our

8. Based on our statistical sampling approach, we are 90% confident that the overpayment for the audit period ranges from \$3,720 to \$6,386.

opinion, warrant the recoupment of any funds, since OSA determined that the radiographs in question were appropriately taken.

Our audit report recommended that in order to resolve this problem, Our Dentist ensure that the reasons periapical radiographs are taken are properly documented in members' dental records.

AUDITS OF HUMAN-SERVICE PROVIDERS

The Commonwealth annually awards contracts totaling more than \$3 billion to human-service providers, and the Office of the State Auditor (OSA) has an ongoing program of conducting audits of these providers. Since March 15, 2016, OSA has issued audit reports on six human-service providers. Two of these reports were about MassHealth providers Centro Las Americas Inc. (Report No. 2016-4591-3C) and Nonotuck Resource Associates Inc. (Report No. 2016-4592-3C). These reports detail how these two human-service providers received unallowable payments from MassHealth totaling as much as \$300,004 and \$164,649, respectively, during the period July 1, 2013 through June 30, 2015. These payments were for adult foster care (AFC) services that were duplicative and not allowable under MassHealth regulations. The services included personal care and assistance with hygiene, bathing, dressing, walking, and medication, as well as skilled nursing care. These are the same services that are to be provided to Centro Las Americas Inc.'s and Nonotuck Resource Associates Inc.'s clients in their homes under the Home Health Services Program funded by MassHealth. Section 408.437 of Title 130 of the Code of Massachusetts Regulations (CMR) states,

The MassHealth agency does not pay an AFC provider when:

(a) the member is receiving any other personal care services, including, but not limited to . . . home care services under the Executive Office of Elder Affairs regulation 651 CMR 3.03(5).

MassHealth enabled this improper practice in a September 15, 2014 email to AFC providers from its then-director of Long-Term Services and Supports. This email informed AFC providers that they could bill for certain home care services for AFC members for which MassHealth's regulations prohibit them from billing. We originally identified this problem of duplicative services in an audit of MassHealth (No. 2016-1374-3M2) and made several recommendations to MassHealth to address it, including a recommendation that it not pay for AFC services for MassHealth members who are receiving these and similar services while residing in rest homes.

CURRENT INITIATIVES

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

The Office of the State Auditor (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. MassHealth should have redirected these claims to Medicare, but it may have paid 100% of them, a practice that may have resulted in 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 by Medicare; (2) determine the extent to which MassHealth has improperly functioned as the 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.

2. Office of Medicaid (MassHealth)—Review of Claims for Urine Drug Screenings (2017-1374-3M2)

OSA is conducting an audit of claims for urine drug screenings for the period July 1, 2012 through June 30, 2016. A prior OSA audit (2012-1374-3C) identified \$16.5 million of improper payments for urine drug screenings. The majority of the amount, \$9.1 million, involved excessive

drug screenings (every day or every other day) or unallowable urine drug screenings for residential monitoring. Based on our prior audit results, OSA recommended, among other things, that MassHealth take the following actions:

- develop new requirements to avoid overuse of laboratory drug testing, bringing MassHealth into line with community and national standards governing appropriate clinical use of drug screenings
- monitor the frequency with which members receive drug tests and investigate providers who submit unusually large numbers of claims per member to ensure that the tests are for medically necessary purposes (not residential monitoring) and that they originate with physicians who have been actively treating the members

Our recent review of applicable MassHealth regulations indicates that MassHealth has not developed new requirements to avoid overuse of laboratory drug testing. Consequently, providers could still be overprescribing urine drug screenings and prescribing them for residential monitoring purposes. We found that spending on drug screenings, which had decreased after our audit, has been trending upward.

The purposes of this audit are to determine (1) whether urine drug screening paid for by MassHealth was requested by an authorized prescriber who treated the member and used the test results for diagnosis, treatment, or an otherwise medically necessary reason and (2) whether the frequency of drug screenings for MassHealth members is in line with community and national standards governing appropriate clinical use of drug screenings.

To achieve our audit objectives, we plan to review applicable state and federal laws, rules, and regulations; consult with officials from MassHealth, the Massachusetts Bureau of Substance Abuse Services, and the Massachusetts Behavioral Health Partnership (MBHP); and meet with substance-abuse-prevention professionals from local hospitals, universities, and drug-treatment programs. In addition, we plan to use data analytics to obtain information on drug-test claims for the four-year period ended June 30, 2016 and analyze the data to identify (1) the type, frequency, and cost of urine drug screenings ordered by providers and performed by clinical laboratories and (2) drug testing trends and billing anomalies that indicate systemic billing problems and potential instances of fraud and abuse. Based on our data analysis, we will visit a sample of ordering providers, clinical laboratories, and residential treatment programs deemed to be of interest.

3. Office of Medicaid (MassHealth) Review of Hospice Claims Paid to a Hyannis Hospice Provider (2017-1374-3M1C2)

OSA is conducting an audit of claims paid to a Hyannis hospice provider for hospice services for the period July 1, 2011 through June 30, 2016. According to applicable state regulations, the life expectancy of those receiving hospice is six months or less. However, our preliminary data analytics indicated that this company (1) provided hospice services for members for more than two years each and (2) billed MassHealth for hospice services that occurred after a member's death. In addition, the Department of Justice has recently issued a report detailing that a Minnesota-based hospice provider was ordered to pay \$18 million to resolve False Claims Act allegations. The provider claimed Medicare reimbursement for hospice care patients who were not terminally ill.

The objectives of our audit are to determine whether this company (1) provided hospice services that were medically necessary because the MassHealth member served had a terminal illness, (2) maintained required documentation in member files to support its claims for hospice services, and (3) submitted claims for hospice services only for dates prior to a member's death.

To accomplish our objective, we plan to (1) review applicable laws, rules, and regulations to gain an understanding of the MassHealth Hospice Program, (2) meet with MassHealth program staff members to validate our understanding of the program's regulations, (3) use data analytics to review all of the provider's claims for hospice services to identify questionable billing patterns and anomalies, (4) review a statistically valid sample of member files, (5) meet with officials at the provider to discuss audit results, and (6) project any potential billing irregularities found in 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.

4. Office of Medicaid (MassHealth) Review of Hospice Claims Paid to a Newton Hospice Provider (2017-1374-3M4)

OSA is conducting an audit of claims paid to a hospice provider operating in Newton for hospice services for the period July 1, 2011 through June 30, 2016. According to applicable state regulations, the life expectancy of those receiving hospice is six months or less. However, our preliminary data analytics indicated that this company provided hospice services for members

for more than two years each. In addition, the Department of Justice has recently issued a report detailing that a Minnesota-based hospice provider was ordered to pay \$18 million to resolve False Claims Act allegations. The provider claimed Medicare reimbursement for hospice care patients who were not terminally ill.

The objectives of our audit are to determine whether this company (1) provided hospice services that were medically necessary because the MassHealth member served had a terminal illness and (2) maintained required documentation in member files to support its claims for hospice services.

To accomplish our objective, we plan to (1) review applicable laws, rules, and regulations to gain an understanding of the MassHealth Hospice Program, (2) meet with MassHealth's Hospice Program staff to validate our understanding of the program, (3) use data analytics to review all of this hospice provider's claims for hospice services to identify questionable billing patterns and anomalies, (4) review a statistically valid sample of member files, (5) meet with provider officials to discuss audit results, and (6) project any potential billing irregularities found in 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.

5. Office of Medicaid (MassHealth) Review of Evaluation and Management Claims Submitted by a Medical Practice in Lawrence (2017-1374-3M6)

OSA is conducting an audit of evaluation and management (E/M) claims submitted by a Lawrence-based medical practice from January 1, 2011 through June 30, 2016. MassHealth regulations require that providers use modifier codes when billing MassHealth for E/M services provided by nurse practitioners (NPs) and physician assistants (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. Our preliminary data analytics indicated that healthcare providers in this medical practice may have submitted claims for E/M services provided by NPs and PAs without using the required modifier codes.

The objective of our audit is to determine whether this medical practice (1) billed MassHealth for E/M services provided by NPs and PAs using appropriate modifier codes and (2) maintained sufficient appropriate documentation to support these billings.

To accomplish our objective, we plan to (1) review applicable laws, rules, and regulations to gain an understanding of MassHealth's billing requirements for E/M services, (2) use data analytics to review all of the medical practice's claims for E/M services to identify questionable billing patterns and anomalies, (3) review a statistically valid sample of member files, (4) meet with officials from this medical practice to discuss audit results, and (5) project any potential billing irregularities found in 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.

6. Office of Medicaid (MassHealth)—Review of Vision-Care Claims Submitted by a Westborough Optometrist (2017-1374-3M3)

OSA is conducting an audit of vision-care claims submitted to MassHealth by an optometrist practicing in Westborough from July 1, 2011 through June 30, 2016. MassHealth regulations require that all providers include the place of service on their claims. Our initial data analytics indicated that this optometrist's claims for vision care did not accurately reflect the place of service and that this resulted in hundreds of thousands of dollars of potential overpayments.

The objectives of our audit are to determine whether this optometrist (1) submitted vision-care claims that accurately reflected the place of service; (2) provided vision care to members that was medically necessary, delivered, and properly supported by required documentation; and (3) submitted claims that were complete, accurate, and compliant with applicable laws, rules, and regulations.

To accomplish our objectives, we plan to (1) review applicable laws, rules, and regulations to gain an understanding of the MassHealth Vision Care Program, (2) meet with MassHealth's program staff to validate our understanding of the program, (3) use data analytics to review all vision-care claims paid to this optometrist to identify questionable billing patterns and anomalies, (4) review a statistically valid sample of member files, and (5) project any potential billing irregularities found in 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 Vision-Care Claims Submitted by an Optometrist Practicing in Lawrence (2017-1374-3M4)

OSA is conducting an audit of vision-care claims submitted by an optometrist practicing in Lawrence from July 1, 2011 through June 30, 2016. The purpose of our audit is to determine whether the optometrist's daily claims for vision care were at realistic levels. Our initial data analytics indicated that this optometrist submitted 176 claims for just one day of services. Similar levels of unrealistic claims by this optometrist were found throughout the audit period and potentially reflect fraudulent billing activity.

The objectives of our audit are to determine whether this optometrist (1) provided vision care to members that was medically necessary, delivered, and properly supported by required documentation and (2) submitted claims that were complete, accurate, and compliant with applicable laws, rules, and regulations.

To accomplish our objectives, we plan to (1) review applicable laws, rules, and regulations to gain an understanding of the MassHealth Vision Care Program, (2) meet with MassHealth's program staff to validate our understanding of the program, (3) use data analytics to review all vision-care claims paid to this optometrist to identify questionable billing patterns and anomalies, (4) review a statistically valid sample of member files, and (5) project any potential billing irregularities found in 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.

8. Office of Medicaid (MassHealth) Review of Evaluation and Management Claims Submitted by a Newton Doctor (2016-1374-3M3)

OSA is conducting an audit of E/M claims submitted by a Newton doctor 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) provide

frequent, recurring treatment to the same resident (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 of the medical necessity of professional services. According to our preliminary data analytics, this doctor 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 this doctor 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 this doctor'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 to the Commonwealth from this doctor.

9. Office of Medicaid (MassHealth)–Review of Behavioral Therapy for Members Receiving Suboxone (2016-1374-3M13)

OSA is conducting a performance audit of behavioral therapy provided to members receiving suboxone from July 1, 2013 through December 30, 2015. Our preliminary data analytics indicated that some members are being treated with suboxone for substance-use disorders but may not be receiving behavioral therapy as part of their treatment plan. The Center for Medicaid and CHIP⁹ Services (CMCS) has issued a series of informational bulletins on effective practices to identify and treat mental-health and substance-use disorders covered under Medicaid. CMCS's information bulletin dated July 11, 2014 states,

Research shows that when treating [substance use disorders], a combination of medication and behavioral therapies is the most effective. Behavioral therapies help patients engage in the treatment process, modify their attitudes and behaviors related to drug and alcohol abuse, and increase healthy life skills. These treatments can also enhance the effectiveness of medications and help people stay in treatment longer.

9. CHIP is the Children's Health Insurance Program.

Treatment programs that combine pharmacological and behavioral therapy services increase the likelihood of cessation relative to programs without these services.

The purpose of our audit is to determine whether (1) members who are prescribed suboxone to treat substance-use disorders receive appropriate behavioral therapy as part of their treatment plan and (2) behavioral therapy is readily available to these members (and if not, what barriers exist that may limit the services' availability).

To accomplish our objectives, we plan to (1) review guidance published by federal and state agencies for treating individuals with substance-use disorders; (2) meet with private- and public-sector experts to discuss best practices for treating such disorders, including the necessity and current availability of behavioral therapy; (3) use data analytics to determine the extent to which members receive both suboxone and behavioral therapy to treat their substance-use disorders; (4) review a sample of members' treatment files; and (5) meet with a sample of prescribing physicians and behavioral-health specialists.

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

OSA is conducting an audit of 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 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 MassHealth has developed 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.

11. 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 the Medicaid Management Information System (MMIS) to process and pay claims submitted by nursing facilities for member services. MassHealth regulations specify the amount it will pay nursing facilities for member services given various conditions (e.g., level of member care, member insurance coverage). According to our preliminary data analytics, MassHealth might have paid nursing facilities more than its published regulations allow; this could have resulted in millions of dollars in improper payments.

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 in these system edits, and (3) identify potential reimbursements to the Commonwealth.

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

12. Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Paid to a Medical Practice in Brockton and Boston (2016-1374-3M14)

OSA is conducting an audit of E/M claims submitted by a medical practice with offices in Brockton and Boston from January 1, 2011 through December 31, 2015. During this period, the medical practice was paid approximately \$512,000 to provide E/M services for 866 MassHealth members. The purpose of this audit is to determine whether the practice billed MassHealth for E/M services provided to members that were medically necessary, supported by appropriate documentation, and in accordance with applicable state regulations.

Our preliminary data analytics showed that this medical practice may not have used the required modifier codes for non-independent nurse practitioners or the service-provider identification numbers for independent NPs when billing MassHealth for E/M services. MassHealth pays for E/M services provided by both types of nurse practitioners at lower rates than it pays when the same services are provided by physicians.

To accomplish our objectives, we plan to (1) use data analytics to review all of this medical practice'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 to the Commonwealth.

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

OSA is conducting an audit of claims paid for durable medical equipment (DME) for the period July 1, 2010 through December 31, 2015. During this period, MassHealth paid approximately \$279 million for DME provided to 171,446 MassHealth members. The purpose of this audit is to analyze MassHealth's payment information for DME claims and determine whether MassHealth paid claims for DME in accordance with applicable laws, rules, and regulations. The audit focuses on two specific types of potential overpayments: (1) payments made at rates higher than those established by state regulations and the state rate schedule and (2) duplicate payments.

To achieve our audit objective, we plan to review applicable state and federal laws, rules, and regulations and interview MassHealth officials to gain an understanding of the payment process for DME claims. We also plan to query from MMIS all MassHealth DME claims for the audit period. We will analyze these claims to identify trends and anomalies that indicate potential payment irregularities, including rate overpayments and duplicate payments.

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

AUDIT IMPACT AND POST-AUDIT EFFORTS

The objectives of the performance audits conducted by the Office of the State Auditor (OSA) at MassHealth and its providers are not only to identify improper payments for Medicaid services, but also to identify and resolve any systemic problems such as deficiencies in internal controls that may exist in the MassHealth system. Consequently, while measures such as referrals to law enforcement for prosecution, 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, 10 post-audit surveys regarding Medicaid audits. This number reflects audits with findings issued at least six months ago for which a follow-up survey has been completed. The self-reported surveys are issued six months after an audit is issued to allow management time to plan and implement its corrective action. Because the voluntary survey is sent to MassHealth six months after an audit ends, not all of the audits issued during the period covered by this report are included in this section of the report, as those surveys have not yet been completed.

According to the survey results, MassHealth reported that it has acted, or will act, on implementing 31 of 37 recommendations: 15 are fully implemented and 16 are in progress. One recommendation was reported as having had no action taken. This recommendation was proven moot when MassHealth terminated the auditee as a MassHealth provider. Five recommendations were disputed by a different provider that questioned OSA's interpretation of the Code of Massachusetts Regulations as it pertained to submitting claims for wheelchair components based on the lowest accepted prices and making any potential repayments to the Commonwealth.

From the survey results, MassHealth will seek recovery of up to \$17,622,990. This includes the recoupment of \$340,000 of overpaid claims discovered as a result of the audit of controls over mobility-assistive equipment, as well as \$17,258,633 in improper claims submitted by Rite Way, LLC. Additionally, MassHealth stated that it expected to save at least \$8,629,316 annually as a result of terminating Rite Way as a provider. The tables and narratives below detail the agencies' post-audit efforts during the reporting period.

1. Office of Medicaid (MassHealth)—Review of Controls over Mobility-Assistive Equipment

Audit No. 2013-1374-3M2

Issued September 16, 2015

Survey Response Received April 26, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
5	2	3	\$340,000	<ul style="list-style-type: none"> • Post-audit review process has been put into place to prevent overpayments for improperly billed claims • Providers have been told that every repair needs a prior authorization if the total amount of repair and/or needed components or accessories combined is more than \$1,000 • MassHealth will be seeking recoupment of \$340,000 of overpaid claims

Findings from the audit of MassHealth controls over mobility-assistive equipment indicated that the agency’s process for determining how much to pay for wheelchairs and wheelchair components is not cost effective. In most cases, MassHealth pays providers for wheelchairs and wheelchair components based on the amounts listed on its rate schedule, without considering whether those amounts are higher than the lowest usual and customary amounts the providers charge to their other customers as required by state regulations. Additionally, MassHealth paid a total of \$540,801 for wheelchair components that did not have proper prior authorization, were improperly provided, exceeded stated limits, or were duplicative. Further, MassHealth did not properly authorize wheelchair repairs exceeding \$1,000; this resulted in approximately \$2.86 million of unauthorized costs.

MassHealth responded that it has fully implemented two recommendations. Concerning flexibility to pay less than 100% of the Medicare rates for durable medical equipment (DME), MassHealth said that its DME rates are equal to or lower than Medicare rates to ensure MassHealth meets federal standards. With regard to the improperly authorized claims for repairs totaling more than \$1,000, MassHealth said it had revised its DME and oxygen payment tool as it refers to all repairs of mobility systems, including all components/accessories, to

ensure that prior authorizations are secured when needed. Providers have also been told that every repair needs a prior authorization if its total amount is more than \$1,000.

Three recommendations were listed as in progress. To ensure that it pays the lowest price for wheelchairs and their components, the agency responded that pursuant to Section 22 of Title 114.3 of the Code of Massachusetts Regulations (CMR), DME providers must invoice MassHealth for the usual and customary charge for a given item (i.e., the lowest price charged to, or payment accepted from, any payer by the invoicing provider) if it is lower than the MassHealth list price for that item. Also, MassHealth stated that it was preparing a communication to providers to reiterate their obligation to bill the lower amount and said it would conduct audits of DME claims to ensure compliance with MassHealth regulations.

To prevent overpayments for improperly billed claims, the agency said it had instituted a post-audit review process to detect claims that were missing a required prior authorization code. MassHealth said that overpayments would now be recouped as they are identified.

Finally, MassHealth said it would seek recoupment of \$340,000 worth of overpaid claims.

2. Office of Medicaid (MassHealth)—Claims for Wheelchair-Van Services Submitted by Rite Way LLC

Audit No. 2015-1374-3M9

Issued October 5, 2015

Survey Response Received May 16, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
4*	2	1	\$25,887,949— up to \$17,258,633 in a one-time recovery and approximately \$8,629,316 in annual savings	<ul style="list-style-type: none"> • MassHealth terminated Rite Way as a provider • The agency is seeking recoupment of up to \$17,258,633 in overpayments

* No action was taken on one recommendation.

The audit of MassHealth wheelchair-van service provider Rite Way, LLC found that Rite Way submitted, and was paid for, more than \$17 million in improper claims for wheelchair-van transportation. Specifically, Rite Way was missing Prescription for Transportation Forms or

Medical Necessity Forms (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. The funds used to make these improper payments could have been used to provide medically necessary services for eligible MassHealth members.

Two recommendations from the audit were reported as fully implemented. Effective December 2015, MassHealth terminated Rite Way as an agency provider because Rite Way had not provided written 30-day notice to MassHealth that it would be suspending services as required by agency regulations. As a result of the termination, in this specific area, MassHealth said it will see an annual savings of \$8,208,352, a savings equal to the amount paid to Rite Way per year for wheelchair-van transportation for ambulatory members. To prevent future improper claims, MassHealth said it was preparing a communication to fee-for-service (FFS) transportation providers, emphasizing which services are eligible for MassHealth payment and which are not.

In the same context, MassHealth said it was preparing a communication to FFS transportation providers to explain that they must complete and maintain MNFs, including directions and information required for completing the forms. MassHealth estimated cost savings of \$420,964 per year; this amount is equal to the amount that Rite Way was paid for inadequately documented claims for wheelchair-van transportation.

MassHealth reported that one recommendation was in progress: it was seeking recoupment of the funds overpaid to Rite Way in the amount of \$17,258,633.

One recommendation had no action taken. That recommendation—that Rite Way develop internal controls to ensure that claims are not submitted for hospitalized members or members who have not received medical services—was rendered moot because MassHealth had terminated Rite Way's contract. In addition, this case was referred to the Medicaid Fraud Division in 2013.

3. Office of Medicaid (MassHealth)—Review of MassHealth’s Progress to Implement Alternative Payment Methodologies

Audit No. 2015-8018-14M

Issued February 18, 2016

Survey Response Received September 13, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
3	0	3	N/A	<ul style="list-style-type: none"> MassHealth said it was scheduled to reprocur its contracts with managed-care organizations (MCOs) and planned for this process to include strengthened contract requirements for adoption and use of alternative payment methodologies (APMs)

Audit findings from the review of MassHealth’s progress in implementing APMs showed that although MassHealth has made progress, it has not fully reached the required adoption rate. MassHealth’s reported APM adoption rate as of July 1, 2013 was 30%, which exceeded the 25% benchmark established by Chapter 224. However, this rate had dropped to 29% as of July 1, 2014. Chapter 224 of the Acts of 2012 required MassHealth to achieve a 50% adoption rate by this date. Because it missed the mandated July 1, 2014 APM benchmark, MassHealth did not fulfill its requirement from the Legislature to improve the quality of healthcare services and effectively rein in its costs.

Three recommendations were listed as in progress. With regard to reaching APM benchmarks, MassHealth said it is in contract negotiations with six accountable-care organizations (ACOs), covering approximately 145,000 members, for participation in MassHealth’s ACO pilot. For ACOs that participate, subject to all required approvals from the Centers for Medicare and Medicaid Services, MassHealth’s ACO pilot will transition payment for MassHealth Primary Care Clinician Plan members to a “total cost of care”-based payment model. MassHealth said it is also conducting a procurement for a full-scale ACO program, which is scheduled to begin in fiscal year 2018. MassHealth said its preliminary analysis indicates that once the ACO program is fully implemented, approximately 1.4 million MassHealth members will be enrolled, or eligible to enroll, in an ACO. Further, MassHealth said it was reprocurring its MCO contracts and that this procurement would include strengthened contract requirements for APM adoption and use.

Concerning accurate calculation of year-to-year APM adoption rates, the primary area in which MassHealth said it had challenges is in its managed-care programs, where the challenge was due to a lack of a single, transparent standard for MCOs to categorize, and report on, various payment arrangements as APMs. MassHealth said it was reprocurring its MCO contracts for the plan year starting in fiscal year 2018 and was developing a set of MCO program reforms, including increased requirements for MCO data transparency and quality, as well as increased requirements for MCOs to meet and report on MassHealth-defined requirements for APM implementation and ACO contracting. MassHealth said it will strengthen its tracking of MCO APM numbers through this approach.

4. Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Submitted by Asaker Medical Associates

Audit No. 2015-1374-3M5

Issued February 25, 2016

Survey Response Received September 2, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
5	5	0	\$24,357	<ul style="list-style-type: none"> The practice is now taking the measures necessary to ensure that it submits claims that correctly identify the provider of evaluation and management (E/M) services

In response to the post-audit review survey, Asaker Medical Associates stated that it had implemented all five recommendations. The practice is now taking the measures necessary to ensure that it submits claims that correctly identify the provider of E/M services; to repay MassHealth \$24,357 of overpayments for services performed by an independent nurse practitioner (NP); to use required modifier codes when billing for services provided by a non-independent NP; and to properly document services performed by a non-independent NP.

5. Office of Medicaid (MassHealth)—Claims for Wheelchair-Van Services Submitted by Cataldo Ambulance Service, Inc.

Audit No. 2016-1374-3M1

Issued February 12, 2016

Survey Response Received August 25, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
5	3	2	N/A	<ul style="list-style-type: none"> Cataldo has added a field in its systems that allows it to report each month on necessary Criminal Offender Record Information (CORI) checks

Cataldo Ambulance Service, Inc. responded that it had implemented three recommendations. The MassHealth vendor of wheelchair-van services has added a field in its systems that allows the company to generate a report each month for all necessary CORI checks and also said that CORI checks are completed during each employee's annual review. Cataldo also said it had created a formal written policy requiring annual CORI checks for wheelchair-van drivers. Lastly, Cataldo said it will conduct periodic reviews of the relevant criteria regarding CORI checks and update its policies and procedures to reflect any changes.

Two recommendations were reported as in progress. Cataldo said it will better adhere to policies and regulations for completion of MassHealth's MNF and will also periodically review relevant criteria concerning the form, updating policies and procedures as needed.

6. Office of Medicaid (MassHealth)—Hudson Home Health Care, Inc. Inquiry

Audit No. 2015-1374-3M10

Issued April 19, 2016

Survey Response Received December 2, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
6*	1	0	N/A	<ul style="list-style-type: none"> Hudson disputed five findings from the audit

* Five findings were disputed by Hudson.

Hudson Home Health Care, Inc. responded that it had implemented one recommendation. The MassHealth vendor of DME stated that it has always periodically reviewed both MassHealth and

Center for Health Information and Analysis billing and payment regulations and that it updates its policies and procedures where appropriate.

Hudson disputed five findings from the audit concerning \$474,486 of improper billings for wheelchair components that were not billed at the lowest accepted price and \$82,520 for wheelchair components that were individually priced. Hudson questioned the audit’s interpretation of 114 CMR 22.03, the regulation detailing general rate provisions for DME.

7. Office of Medicaid (MassHealth)—Dr. Kunwar Singh Inquiry

Audit No. 2016-1374-3M4

Issued April 27, 2016

Survey Response Received November 18, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
2	0	2	N/A	<ul style="list-style-type: none"> • Dr. Singh’s practice has developed and implemented policies and procedures to ensure that claims are billed properly

In replying to the survey of the audit of his practice’s outpatient E/M service claims submitted to MassHealth, Dr. Kunwar Singh, through his attorney, stated that he had submitted materials for review to MassHealth and was awaiting a response. Dr. Singh also said that his practice had developed and implemented policies and procedures to ensure that claims are billed properly. Auditors found that Dr. Singh’s practice improperly billed for E/M services totaling approximately \$55,390.

8. Office of Medicaid (MassHealth)—Review of Providers Excluded from Participating in the Medicaid Program

Audit No. 2015-1374-3M8

Issued April 20, 2016

Survey Response Received November 21, 2016

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
2	0	2	N/A	<ul style="list-style-type: none"> The claims identified in the audit have been voided in the Medicaid Management Information System (MMIS), and recoupment accounts have been established for the non-pharmacy FFS claims

An audit reviewing MassHealth’s practices regarding excluded providers showed that MassHealth made \$476,787 of unallowable payments for medical services and prescriptions (including opiates) to excluded providers. If excluded providers are allowed to abuse the Medicaid system, MassHealth members could receive substandard services.

MassHealth reported both recommendations to be in progress. Concerning the establishment of adequate controls to ensure that the excluded-provider lists generated by its contractor are current and are used effectively, MassHealth established a workgroup to review the audit findings and implement the recommendations. The workgroup conducted a review of the process for excluding providers and developed additional policies and procedures to ensure that excluded-provider lists are current and used effectively and consistently across all vendors. With regard to taking action to recoup the \$476,787 in unallowable payments, MassHealth said the claims identified in the audit have been voided in MMIS and that recoupment accounts have been established for the non-pharmacy FFS claims.

9. Office of Medicaid (MassHealth)—Review of Dental Periapical Radiograph Claims Submitted by Hampshire Family Dental and Orchard Family Dental

Audit No. 2016-1374-7M

Issued May 17, 2016

Survey Response Received January 20, 2017

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
2	2	0	N/A	<ul style="list-style-type: none"> Both practices have been taking all steps to ensure that radiographs are only taken in the event of medical necessity

Responding to the survey, Hampshire Family Dental and Orchard Family Dental stated that both practices have been taking all steps to ensure that radiographs are only taken in the event of medical necessity. The audit found that Hampshire Family Dental and Orchard Family Dental submitted claims, and were paid approximately \$290,417, for unallowable dental periapical radiographs, which are dental X-rays of a whole tooth that by regulation are to be used under specific circumstances. The practices billed for dental periapical radiographs as part of routine dental examinations.

10. Office of Medicaid (MassHealth)—Review of Paid Claims within MassHealth’s Adult Foster Care and Group Adult Foster Care Programs

Audit No. 2016-1374-3M2

Issued July 14, 2016

Survey Response Received February 15, 2017

Number of Recommendations	Fully Implemented	In Progress	Fiscal Benefit	Selected Actions and Results
3	0	3	TBD	<ul style="list-style-type: none"> MassHealth is in the process of implementing system edits that will deny payments for “medical leave of absence” and “short term alternative placement” days that exceed the permitted amount MassHealth is developing regulations for group adult foster care (GAFC) to clarify settings in which GAFC may be provided

Findings from the audit of paid claims within MassHealth’s Adult Foster Care Program and Group Adult Foster Care Program showed that MassHealth improperly paid adult foster care

(AFC) and GAFC providers \$15,201,854 for 57,322 claims for services provided to members residing in long-term-care (LTC) facilities, i.e., rest homes and nursing homes. Of this amount, \$14,331,826 (94%) was paid to GAFC providers and \$870,028 (6%) to AFC providers. These payments were for services that were specifically identified in state licensing regulations as services already performed by LTC facilities. The AFC and GAFC programs are designed to provide members with sufficient daily assistance to avoid placement in LTC facilities, not to supplement services in those facilities.

MassHealth reported all three recommendations to be in progress. The agency said it is in the process of implementing system edits that will deny payments for “medical leave of absence” and “short term alternative placement” days that exceed the permitted amount. MassHealth said it was drafting GAFC regulations that will clarify settings in which GAFC services may be provided.