OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

Official Audit Report – Issued June 28, 2023

Office of Medicaid (MassHealth)—Review of Capitation Payments

For the period January 1, 2018 through September 30, 2021

OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

June 28, 2023

Kate Walsh, Secretary
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Walsh:

I am pleased to provide to you the results of the enclosed performance audit of MassHealth. As is typically the case, this report details the objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2018 through September 30, 2021. As you know, my audit team discussed the contents of this report with agency managers. This report reflects those comments.

I appreciate you and all your efforts at MassHealth. The cooperation and assistance provided to my staff during the audit went a long way toward a smooth process. Thank you for encouraging and making available your team. This audit was conducted under the oversight of former State Auditor Suzanne M. Bump. I am available to discuss this audit if you or your team have any questions.

Sincerely,

Diana DiZoglio
Auditor of the Commonwealth

cc: Mike Levine, Assistant Secretary for MassHealth
Joan Senatore, Director of Compliance of the Executive Office of Health and Human Services
Jeff Clausen, Deputy General Counsel at the Executive Office of Health and Human Services
Nuryelis Herrara, Executive Assistant for Secretary Walsh
Curtis Roy, Regional Inspector General at the Office of Inspector General of the United States Department of Health and Human Services
Richard Miller, Assistant Regional Inspector General at the United States Department of Health and Human Services
Shawn Dill, Senior Auditor at the United States Department of Health and Human Services

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
HHS	United States Department of Health and Human Services
MCO	managed care organization
MMIS	Medicaid Management Information System
NCAO	National Change of Address
OIG	Office of Inspector General
OSA	Office of the State Auditor
PARIS	Public Assistance Reporting Information System
T-MSIS	Transformed Medicaid Statistical Information System

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services, within the United States Department of Health and Human Services (HHS), regulates Medicaid services and works with state governments to administer their Medicaid programs.

In collaboration with the HHS Office of Inspector General's Boston office, OSA has conducted an audit of capitation payments[1] made by MassHealth under its Managed Care Program for the period January 1, 2018 through September 30, 2021. During this period, MassHealth made approximately $2.4 billion in capitation payments to its two contracted managed care organizations (MCOs), which were Tufts Health Together and Boston Medical Center HealthNet Plan.

The purpose of this audit was to determine whether MassHealth ensured that it did not make capitation payments to MCOs on behalf of ineligible members who were residing and receiving benefits in other states or territories. OSA conducted the audit as part of our ongoing independent statutory oversight of the state's Medicaid program.

Below is a summary of our finding and recommendations, with links to each page listed.

1. Medicaid programs make fixed monthly payments to managed care organizations for members enrolled in its Managed Care Program. Each payment is made to MCOs in advance to cover the cost of the anticipated healthcare services of the member, and the amount of each payment is based on the healthcare needs of each member.

Finding 1 **Page 10**	MassHealth made an estimated $84,832,094 in capitation payments on behalf of members who were residing outside of Massachusetts.
Recommendations **Page 13**	1. MassHealth should revise its policies and procedures regarding its data matches for member eligibility. Specifically, MassHealth should require that all members flagged by data matches submit documentation to substantiate that they reside in Massachusetts. If the member does not provide this documentation, MassHealth should either pause this member's coverage or move the member to its fee-for-service model until it can determine whether the member's coverage should be terminated. 2. MassHealth should investigate and resolve all instances where its data matches indicate that a member is enrolled in another state's Medicaid program. 3. MassHealth should provide members with written instructions during the annual enrollment process on how to unenroll from MassHealth if they move outside of Massachusetts. 4. MassHealth should consult with the Centers for Medicare and Medicaid Services to see if it can gain access to Transformed Medicaid Statistical Information System, which MassHealth can use in its eligibility detection and residency verification process.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services for approximately 1.8 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2021, MassHealth paid healthcare providers more than $18.1 billion, of which approximately 45% was funded by the Commonwealth. Medicaid expenditures represent approximately 40% of the Commonwealth's total fiscal year 2021 budget.

MassHealth's Managed Care Program

MassHealth's Managed Care Program consists of two managed care organizations (MCOs), Tufts Health Together and Boston Medical Center HealthNet Plan, which provide healthcare services to members through managed care plans. Each managed care plan assigns members a group of doctors and other healthcare providers who work together to provide members with coordinated healthcare services. The doctors and other healthcare providers contractually agree to follow certain federal and state requirements about how they provide services. MCO enrollees select a primary care physician to provide basic healthcare and make any necessary specialist referrals. MassHealth pays the MCO a capitation payment, the amount of which is based on a rating category assigned by the Executive Office of Health and Human Services, for each member enrolled in the MCO's managed care plan. Rating categories are based on risk factors for each member, such as whether the member needs facility-based care (e.g., a skilled nursing facility) or behavioral health treatment.

Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) is a database maintained by the federal Centers for Medicare and Medicaid Services. T-MSIS contains Medicaid data from all 50 states, the District of Columbia, and the United States territories to maintain an accurate, up-to-date, and complete data set, containing eligibility, enrollment, and healthcare service claims data about Medicaid members. The Centers for Medicare and Medicaid Services use this data to manage Medicaid programs and aid in the detection of fraud, waste, and abuse.

Public Assistance Reporting Information System

MassHealth is part of the Public Assistance Reporting Information System (PARIS), which is the product of a partnership between the United States government and its states, the District of Columbia, and Puerto Rico. PARIS provides a free service quarterly that states, the District of Columbia, and Puerto Rico can use to cross-reference their public assistance program records to identify any data matches (i.e., recipients who also receive benefits from other states, the District of Columbia, or Puerto Rico).

To participate in PARIS and share information about Medicaid members and their healthcare use, states, the District of Columbia, and Puerto Rico must enter into a contract with the United States Department of Health and Human Services (HHS), called an Interstate Data Matching by State Public Assistance Agency Memorandum of Understanding. Every quarter, each state, the District of Columbia, and Puerto Rico may provide data to PARIS from the following assistance programs to identify data matches: Temporary Assistance for Needy Families, Medicaid, Workers' Compensation (a federally funded program that administers disability compensation for workers who are injured on the job), Child Care (which provides childcare financial assistance to states and territories for low-income families), and the Supplemental Nutrition Assistance Program. HHS's Administration for Children and Families oversees PARIS, facilitates the quarterly cross-referencing service, and disseminates information about data matches to the involved states, the District of Columbia, or Puerto Rico.

MassHealth's Residency Requirements and Verification Process

Section 517.002 of Title 130 of the Code of Massachusetts Regulations (CMR) states, "As a condition of eligibility, an applicant or member must be a resident of the Commonwealth of Massachusetts."

According to 130 CMR 517.002, "The individual's residency is considered verified if the individual has attested to Massachusetts residency and the residency has been confirmed by electronic data matching with federal or state agencies or information services."

MassHealth may also require documentation to validate residency with, for example, a utility bill dated within the past 60 days, driver's license, a copy of a lease or rental agreement, or an affidavit written and signed by the member stating that they are a Massachusetts resident.

According to 130 CMR 517.002(F)(10), MassHealth allows applicants and members to self-declare their residency. However, this regulation mandates that MassHealth verify an applicant's declared residency if

it identifies conflicting or contradictory information regarding the applicant's or member's declared place of residence, such as through a PARIS data match.

Under Section 155.335 of Title 45 of the Code of Federal Regulations, MassHealth must annually redetermine members' eligibility. According to 130 CMR 502.007(C)(1), members whose continued eligibility can be redetermined based on electronic data matches will have their eligibility automatically renewed. The programs MassHealth uses for redetermining eligibility include PARIS, the National Change of Address database,[2] and Accurint, a software product from LexisNexis designed to conduct online research of addresses that MassHealth obtained from members. If MassHealth discovers new or conflicting information in these data matches, it sends a request for information letter to the member to verify that they are still eligible. Members who receive a request for information letter have 45 days to respond with verification documents, such as a driver's license, utility bill, or rental agreement, which verifies that the member still resides in Massachusetts. If the member does not respond, they may have their coverage terminated or they may be moved to a fee-for-service model, where MassHealth pays each provider for services received by a member after the member receives those services.

Families First Coronavirus Response Act

Congress enacted the Families First Coronavirus Response Act on March 18, 2020. This Act allowed Massachusetts, and other states that meet certain criteria, to receive a 6.2% increase in its federal Medicaid match rate, which is the portion of the MassHealth program that is funded by the federal government. This Act also requires Medicaid programs to meet a maintenance of eligibility requirement, which means that Medicaid programs must keep current members continuously enrolled until the end of the month in which the public health emergency ends, unless there are changes in circumstances (e.g., a change in residency) that make members ineligible for their current coverage.

2. This database is where the United States Postal Service records all change of address forms it receives to create a permanent record.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of certain activities of MassHealth for the period January 1, 2018 through September 30, 2021.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in this report.

Objective	Conclusion
1. Does MassHealth ensure that it does not make capitation payments to managed care organizations (MCOs) on behalf of ineligible members who reside and receive benefits in another state or territory, in accordance with Section 517.002 of Title 130 of the Code of Massachusetts Regulations and Sections 431.211, 431.213(e), and 435.403(a) and (j) of Title 42 of the Code of Federal Regulations?	**No; see Finding 1**

To achieve our audit objective, we gained an understanding of the internal control environment related to the objective by reviewing applicable policies and procedures and MassHealth's internal control plan and by conducting interviews with MassHealth officials. In addition, we performed the following procedures to obtain sufficient, appropriate audit evidence to test the objective.

Capitation Payment Sampling Strategy and Information Analysis

To determine whether MassHealth ensured that it did not make capitation payments to MCOs on behalf of ineligible members who resided outside of Massachusetts, we obtained a capitation payment data file from the Transformed Medicaid Statistical Information System (T-MSIS) provided by the United States Department of Health and Human Services' Office of Inspector General (HHS OIG). The T-MSIS data file included capitation payments for all 50 states, the District of Columbia, and the United States territories made during the audit period. We sorted the capitation payment data to identify those instances in which MassHealth made at least five consecutive monthly capitation payments to MCOs for members who

concurrently had capitation payments made to MCOs on their behalf by the Medicaid program of another state or United States territory.

To determine our test population, we ranked each state and territory based on the total dollar value of the concurrent payments and then selected the nine states and one territory that had the highest dollar value of concurrent capitation payments made during the audit period. Our final population included the following: California, Florida, Georgia, New Hampshire, New Jersey, North Carolina, Ohio, Pennsylvania, Rhode Island, and Puerto Rico.

OSA collaborated with HHS OIG to design a statistically valid sampling methodology. HHS OIG and OSA chose a sample with a 90% confidence level and a 50% expected error rate. We separated the data into four strata based on the total dollar value of capitation payments made concurrently with another state or territory. Strata one, two, and three included members who had at least 5 months of consecutive concurrent capitation payments made by another state, and stratum four included members who had concurrent capitation payments made by another state or territory for all 45 months of the audit period. HHS OIG and OSA then selected a random, statistical sample of 100 members out of a total of 31,720 members in the audit population. The table below details each of the four strata to which each member was assigned for our data analysis purposes.

Stratum	Dollar Range of Stratum	Sample Size	Number of MassHealth Members	Population Dollar Value
1	$1,000–$5,400	28	21,422	$ 56,105,828
2	$5,401–$14,991	30	7,989	68,145,683
3	$14,992–$114,847	27	2,142	53,024,450
4	$2,090–$162,154	15	167	2,002,643
Total		100	31,720	$179,278,604

For the 100 members in our sample, we contacted Medicaid officials in the nine states and Puerto Rico and sent them a questionnaire in a Microsoft Excel spreadsheet to complete. This questionnaire was designed to validate the accuracy of the T-MSIS information we used in our analysis and help OSA determine each member's actual place of residency during our audit period. We used this questionnaire to collect information such as the date on which the member enrolled in the other state's or territory's Medicaid program, the length of time that the other Medicaid program made capitation payments for each member, the dollar amount of capitation payments made on behalf of each member by their

Medicaid program, and whether the member received any healthcare services in the other state or territory during the time MassHealth made capitation payments on the member's behalf.

Once we completed our analysis, we held follow-up meetings with Medicaid officials in each state or territory, as necessary, to discuss the results of our analysis and to ask follow-up questions about the data. We also reviewed capitation payments and healthcare service data in MassHealth's data warehouse, called the Medicaid Management Information System (MMIS), to confirm the accuracy of the MassHealth data for the 100 members in our sample.

We then requested and analyzed the following information from MassHealth:

- documentation supporting whether a member was referred to MassHealth by another public assistance agency, such as the Social Security Administration or Department of Transitional Assistance;
- copies of any request for information letters that MassHealth sent to the members in our sample regarding their residency status and the members' responses to the requests;
- results from National Change of Address (NCOA) database and Public Assistance Reporting Information System (PARIS) data matches that were performed during our audit period; and
- a list of any members in our sample who were removed from their managed care programs and were either moved to the fee-for-service model or had their MassHealth coverage terminated during the audit period.

Using information from MMIS, we generated a report containing all medical services for each of the 100 members in our sample who were covered by MassHealth during the audit period.

Once we received this information, we assessed MassHealth's residency eligibility verification process as follows:

- We reviewed and analyzed the annual eligibility renewals for each member in the sample.
- We determined whether any members in the sample appeared in MassHealth's NCOA database or PARIS data matches.
- We determined whether MassHealth removed members from the Managed Care Program if the members did not complete annual eligibility renewals, did not respond to request for information letters, or appeared in either NCOA database or PARIS data matches by either moving each ineligible member to the fee-for-service model or terminating their MassHealth coverage.

- We determined whether members received any healthcare services in Massachusetts during the period of time they were concurrently enrolled in MassHealth and the Medicaid program of another state or territory.

Data Reliability

For the T-MSIS data file provided to us by HHS OIG, we performed validity and integrity tests on the data, including (1) testing for blank fields, (2) testing for duplicates, (3) looking for dates outside the audit period, and (4) checking data fields for validity errors. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purpose of this audit.

To determine the reliability of the data from MMIS, we relied on the work performed by OSA in a separate project, completed in 2020, that tested certain information system controls in MMIS. As part of that work, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable MassHealth officials about the data. As part of our current audit, we selected a random sample of 25 capitation payments obtained by HHS OIG from T-MSIS and traced the payment amounts, payment dates, and member names to MMIS. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purpose of this audit.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth made an estimated $84,832,094 in capitation payments on behalf of members who were residing outside of Massachusetts.

During the audit period, MassHealth made an estimated $84,832,094 in capitation payments to managed care organizations (MCOs) on behalf of members who were residing in and had enrolled in Medicaid programs in nine other states and Puerto Rico. Specifically, we found that MassHealth made 1,234 capitation payments, totaling $488,770, on behalf of 63 out of the 100 members in our sample. These 63 members were residing in at least one of nine other states or Puerto Rico and had enrolled in, and received all of their healthcare benefits under, the other state's or Puerto Rico's Medicaid programs.

By not ensuring that all MassHealth members enrolled in MCOs meet its residency eligibility requirement, we estimate that MassHealth overpaid MCOs by $84,832,094. MassHealth could have used this money to provide additional services to other MassHealth members. The overpayments are indicated in the table below.

State	Number of Members	Number of payments	Amount Paid*
California	7	213	$ 94,468
Florida	11	121	53,989
Georgia	5	135	29,785
New Hampshire	4	114	16,217
New Jersey	4	70	17,568
North Carolina	2	31	15,635
Ohio	3	65	10,944
Pennsylvania	5	106	70,212
Rhode Island	7	140	48,901
Puerto Rico	15	239	131,053
Total	63	1,234	$ 488,770

* Discrepancies in dollar amounts are due to rounding.

For 51 (81%) of these 63 members, MassHealth had Public Assistance Reporting Information System (PARIS) data matches that indicated that the members had, in fact, moved to another state or Puerto Rico, but MassHealth continued to make capitation payments on their behalf for periods ranging from 5 to 45 months after the members had moved.

In addition, there were four members for whom we did not have sufficient information to reasonably determine their states of residency because these members did not receive any Medicaid-funded medical services in either Massachusetts or the concurrently paying state during the entire 45-month audit period. Therefore, we did not include these instances in our $84,832,094 projection. The capitation payments made on behalf of these four members are indicated in the table below.

State	Number of Members	Number of Payments	Amount Paid*
California	1	45	$ 162,153
Florida	1	8	2,089
New Jersey	2	23	7,649
Total	4	76	$ 171,892

* Discrepancies in dollar amounts are due to rounding.

We determined that the remaining 883 capitation payments made on behalf of the members in our sample were for members who were enrolled in MassHealth and residing in Massachusetts. However, because other states and Puerto Rico also concurrently made capitation payments on these members' behalf, we met with Medicaid officials from these states and Puerto Rico and brought these matters to their attention. These officials stated that they would investigate and resolve any issues with the members in question.

Authoritative Guidance

According to Section 517.002 of Title 130 of the Code of Massachusetts Regulations, "As a condition of eligibility, an applicant or member must be a resident of the Commonwealth of Massachusetts."

Section 435.403 of Title 42 of the Code of Federal Regulations states the following:

> ***(a) Requirement.*** *The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State. . . .*
>
> ***(j) Specific prohibitions. . . .***
>
> *(3) The agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid.*

Reasons for Issue

MassHealth does not have effective controls to ensure that an individual meets its residency eligibility requirement. Specifically, under its policies, MassHealth does not verify members' residencies either initially upon enrollment or thereafter for members who were referred to the program from another agency (e.g., the Department of Transitional Assistance). MassHealth officials stated in a meeting with us that it is the referring agency's responsibility to determine whether the individual meets MassHealth's residency eligibility requirement. However, in these instances, MassHealth cannot assure that the referring agency has an effective process to verify the member's residency.

Even when MassHealth does participate in a PARIS data match, agency officials told us that they do not follow up with any members who were flagged by the data match as being enrolled in another Medicaid program unless the member has not received any healthcare services from MassHealth for more than 12 months. If the member has received any services covered by MassHealth during the 12 months before being identified in a PARIS data match, the member's enrollment is automatically renewed and the PARIS data-match alert is disregarded. MassHealth informed us that, during the automatic renewal process, it uses Accurint to check members' addresses. However, MassHealth stated that they use this software only to determine whether the address the member provided is an actual address in Massachusetts, not whether the member is actually residing in Massachusetts at that address.

According to MassHealth, Medicaid agencies do not have access to the Transformed Medicaid Statistical Information System (T-MSIS) and must primarily rely on PARIS data matches to detect when an individual may have moved out of the state. However, in our opinion, the PARIS data match process does not appear to be effective in detecting all instances where a member may have moved out of the state; PARIS data matches only detected 51 of the 63 instances that we detected using T-MSIS information.

MassHealth officials stated that, during the period covered by the maintenance of eligibility requirement of the Families First Coronavirus Response Act, when MassHealth found that a member appeared to have left the state (e.g., if it identified that a member had enrolled in another state's Medicaid program using a PARIS data match), it did not conduct a residency check of the member but rather just moved them to the fee-for-service model. However, we found that, of the 51 instances of a member receiving concurrent out-of-state benefits that MassHealth had identified through a PARIS data match, only 27 members were eventually moved to a fee-for-service model or had their coverage terminated from MassHealth during the audit period.

Recommendations

1. MassHealth should revise its policies and procedures regarding its data matches for member eligibility. Specifically, MassHealth should require that all members flagged by data matches submit documentation to substantiate that they reside in Massachusetts. If the member does not provide this documentation, MassHealth should either pause this member's coverage or move the member to its fee-for-service model until it can determine whether the member's coverage should be terminated.

2. MassHealth should investigate and resolve all instances where its data matches indicate that a member is enrolled in another state's Medicaid program.

3. MassHealth should provide members with written instructions during the annual enrollment process on how to unenroll from MassHealth if they move outside of Massachusetts.

4. MassHealth should consult with the Centers for Medicare and Medicaid Services to see if it can gain access to T-MSIS, which MassHealth can use in its eligibility detection and residency verification process.

Auditee's Response

The Executive Office of Health and Humans Services (EOHHS) provided the following response:

> *EOHHS disagrees with the auditor's conclusion on the basis that it is overly broad. The audit reviewed a sample of 100 MassHealth members and found that for 47 of the members, the members appeared to reside in Massachusetts during all months in which MassHealth made a capitation payment on behalf of the member, but that for 63 of the members, the members appeared to reside in the other state or territory for a least one month for which MassHealth made a capitation payment on behalf of the member. . . . Indeed, for one of the 63 members the audit found that out of 45 months of MassHealth capitation payments made on behalf of the member, MassHealth made one incorrect payment. . . . Since January 1, 2018, EOHHS has terminated over 6000 members determined to no longer reside in Massachusetts based on PARIS match data and a subsequent failure to respond to a request for verification of residency, and has additionally transferred over 35,000 members from managed care to [the fee-for-service model, or FFS] who were identified as no longer residing in Massachusetts based on PARIS match data and a failure to subsequently respond to a residency verification request. Contrary to the auditor's conclusion of "no" these actions and outcomes demonstrate that EOHHS takes steps to ensure that it does not make capitation payments to MCOs on behalf of members who reside in another state or territory. . . .*
>
> *EOHHS strongly disagrees with the use of extrapolation in the context of member residency and the unique period covered under this audit. At a high level, the audit did not conclusively determine in which state each member in the 100-member sample resides, but rather made assumptions based on a review of data. Accordingly, because the audit did not include an actual verification of member residency, the reliability of the findings is questionable in the context of extrapolating the audit's individual residency assumptions to the entire MassHealth managed care enrolled population.*

Moreover, the audit findings do not constitute a representative sample of the overall MassHealth managed care enrolled population. Nearly half of the 63 members in the audit finding were under 18 years of age during the audit period. Pursuant to MassHealth regulations, the residency of a child is where the child's parent or caretaker is a resident. . . . See [Section 503.002(B)(2) of Title 130 of the Code of Massachusetts Regulations]. . . . Notably, the residency status of children is subject to more variability than adults, where children of divorced or unmarried parents may frequently shift between parent homes, and where each parent may reside in a different state. Based on the data relied upon by the auditor that formed the basis of its individual residency assumptions, it is not clear that any of the children in the audit findings were not residents of Massachusetts during the period of the audit. As a result, EOHHS disagrees with the inclusion of children without considering the residency of their responsible parent(s) or caretaker(s) in the audit findings and further believes that extrapolation based on audit findings that skew towards children and that therefore are not representative of the residency status of the overall MassHealth managed care enrolled population is not appropriate.

Additionally, the 100-member sample does not appear to be a representative sample of MassHealth capitation payments. As stated in the draft report, capitation payments vary greatly according to the rating and specific needs of each member. . . . Indeed, there is a wide difference in the cost of monthly capitation payments depending on the rating category a member falls within and where they reside in Massachusetts. For example, for [the Boston Medical Center HealthNet Plan] in Rate Year 2021, the monthly capitation amounts range from as low as $231.58 per month for a member in Rating Category I and living in Western Massachusetts to as high as $13,548.24 per month for a member in Rating Category VI and living in Eastern Massachusetts. Currently 54% of MCO enrolled members are in [Rating Category I]. . . . While the draft report acknowledges the existence of varying capitation payment amounts, the report indicates that the audit focused on a 100-member sample that is not drawn from all MassHealth MCO members but rather the highest dollar amounts of capitation payments. By focusing only on the highest dollar amounts (as opposed to apportioning the sample in a manner that reflects the distribution of MassHealth members in each MCO rating category) the outcome of the 100-member sample does not appear representative of the overall MCO population and will greatly inflate the dollar amount of the extrapolated finding. Accordingly, EOHHS strongly disagrees with the use of extrapolation in this instance as it results in a misleading conclusion about the fiscal impact of any error in continuing to provide capitation payments for a certain percentage of members who may no longer reside in Massachusetts.

Finally, EOHHS notes that the audit period overlapped with a global pandemic during which member residency fluctuated more than normal and during a period in which EOHHS' ability to reduce member enrollment was limited by federal law, two factors that strongly limit the appropriateness of using extrapolation for this audit. . . .

EOHHS agrees with [the first] recommendation in part. EOHHS disagrees with this recommendation to the extent that it fails to acknowledge that in the first two years of the audit period (2018 and 2019) EOHHS had policies and procedures in place that required members to submit documentation to substantiate that they reside in Massachusetts and those policies included terminating coverage for members that failed to substantiate that they reside in Massachusetts. During this period, EOHSS terminated the MassHealth eligibility of over 6,000 members identified through the PARIS match process and who subsequently failed to respond to a request for residency verification.

As noted above, in early 2020, EOHHS suspended its practice of terminating member eligibility based on PARIS match data and member's subsequent failure to respond to a residency verification request. This change was made to comply with the [Families First Coronavirus Response Act's maintenance of eligibility, or FFRCA's MOE] requirements and to not jeopardize the approximate $3.3 billion in increased federal match the state has received through the FFCRA.

In the summer of 2021, as an alternative measure that was compliant with the FFCRA's MOE requirements, EOHHS developed and implemented a new policy and procedure to identify members enrolled in a MassHealth managed care plan and shift them to FFS if they were identified through PARIS data as potentially no longer residing in Massachusetts and the member subsequently failed to respond to a request for residency verification.

Since implementation of this process, MassHealth has transitioned over 35,000 members from managed care to FFS who were identified through a PARIS match as possibly no longer living in Massachusetts and who subsequently failed to respond to a request for residency verification. The total cost avoidance from this initiative since implementation is conservatively estimated at $65 million.

In addition to the PARIS match, for members who may no longer reside in Massachusetts, MassHealth's Health Insurance Exchange ("HIX") eligibility system periodically checks a LexisNexis database to confirm that members' addresses are considered Massachusetts residency. This match occurs any time the member's address is updated, including with new applications, as well as any changes for existing members. If the address is not considered a Massachusetts residence, the HIX system will generate a request for information (RFI) for the member to confirm residency. If the member fails to respond to the RFI after all federally required outreach is unsuccessful their eligibility is closed (except during the [2019 coronavirus] Public Health Emergency per federal guidelines, as noted above.) . . .

EOHHS agrees with [the second] recommendation. The MassHealth program has and will continue to investigate all instances where its data matches indicate a member is enrolled in another state's Medicaid program. For all PARIS matches, this includes investigation in the form of a data inquiry to determine if the member is likely to reside in Massachusetts, such as checking whether the member resides in a Massachusetts long-term care facility or has had a recent FFS claim or MCO encounter. . . .

EOHHS agrees with [the third] recommendation. EOHHS further notes that on the initial MassHealth application, the MassHealth renewal form, and the MassHealth website, members or potential members are instructed that they are required to inform MassHealth of any change in information listed on their MassHealth application, which includes any changes in residency and address. If a member moves out of state and informs MassHealth as instructed, they will be disenrolled. . . .

EOHHS agrees with [the fourth] recommendation. EOHHS will consult with [the Centers for Medicare and Medicaid Services, or CMS] to ascertain whether it can obtain access to the Transformed Medicaid Statistical Information System (T-MSIS) data. . . .

EOHHS further notes, however, that CMS did not concur with [the fourth] recommendation in an October 2022 [Office of Inspector General, or OIG] report titled NEARLY ALL STATES MADE

CAPITATION PAYMENTS FOR BENEFICIARIES WHO WERE CONCURRENTLY ENROLLED IN A MEDICAID MANAGED CARE PROGRAM IN TWO STATES. In the report the OIG made the same recommendation to CMS, CMS's response to the recommendation was as follows: "CMS does not concur with this recommendation. CMS appreciates the information provided in the OIG's report and understands the intent behind the recommendation. Because Medicaid is jointly funded by states and the federal government, and is administered by states within federal guidelines, both CMS and states have key roles as stewards of the program and work closely together to carry out these responsibilities, The PARIS Interstate Match already allows states to compare eligibility with other state Medicaid programs to identify beneficiaries that may be concurrently enrolled in more than one state. Most states are already relying on this system and investing resources to use it, and the addition of T-MSIS monitoring could prove redundant, inefficient, and confusing to states, especially considering the existing statutory and regulatory framework underlying state monitoring of concurrent enrollments through PARIS." . . .

As noted above, EOHHS believes this additional data source may be beneficial in assisting it to more quickly identify MassHealth MCO enrolled members that are simultaneously enrolled in another state or territory's Medicaid MCO program and who may no longer be residing in Massachusetts in order to transition them to FFS while working to determine their Massachusetts residency.

As noted above, EOHHS appreciates this audit of capitation payments and appreciates the opportunity to utilize these findings as a vehicle towards improving the MassHealth program's oversight of its member eligibility processes.

Auditor's Reply

EOHHS claimed that the conclusion of the audit is overly broad in its response. Our reply is as follows:

Our Response	Comments
EOHHS misinterpreted the audit objective.	The audit examined concurrent capitation payments made to MCOs for members residing out-of-state that were flagged by United States Department of Health and Human Services' Office of Inspector General (HHS OIG).
EOHHS did not directly explain why MassHealth made ineligible payments.	MassHealth made ineligible payments for 63 individuals out of a sample of 100 tested. EOHHS did not respond to our review of these concurrent capitation payments.
EOHHS overstated the effect of MassHealth's residency eligibility verification steps.	The 12-month healthcare service criteria that MassHealth uses to filter eligibility of individuals is overly broad and risks missing individuals who recently moved out of the state and are therefore ineligible to receive MassHealth benefits. Using the 12-month healthcare service criteria, MassHealth failed to send residency verification letters to 24 out of the 63 individuals flagged by the PARIS data match as having moved out of the state. MassHealth's use of Accurint is ineffective for determining residency as it only confirms whether or not an address is in Massachusetts. The software does not verify that an individual lives at the address they submitted to claim residency eligibility.

EOHHS disagreed with the sample the Office of the State Auditor (OSA) used, claiming that the sample was not representative of the overall MassHealth MCO-enrolled population. Our reply is as follows:

Our Response	Comments
EOHHS misrepresented the rigorous statistical methods OSA and HHS OIG used to create and test the sample.	OSA and HHS OIG used a sound sampling methodology to define and refine the population from 31,720 MassHealth members to a sample of 100. The sample was not drawn from capitation payments based on the highest dollar amount as claimed by EOHHS. MassHealth recipients who were minors were flagged by HHS OIG in PARIS data matches because ineligible payments were made on their behalf. OSA agrees that minors may have greater variability in their residency because they may move between parents' or guardians' homes; however, MassHealth should have taken additional steps to verify residency with the members' parents or guardians. MassHealth should have ensured that its members, regardless of age, resided in Massachusetts, by catching simultaneous enrollment in healthcare (Medicaid) programs in other states or Puerto Rico.

EOHHS disagreed with OSA's use of error extrapolation and claimed that OSA relied on assumptions without verifying observed data. Our reply is as follows:

Our Response	Comments
EOHHS misstated the methods that OSA and HHS OIG used to determine whether MassHealth made ineligible capitation payments for individuals living in another state.	MassHealth made ineligible payments on behalf of 63 individuals out of a sample of 100 tested. OSA verified the following information with the Medicaid agencies of nine other states and one territory: (1) the month and year of the capitation payments made by that state; (2) the total amounts of payments and per-individual payments made by that state; and (3) the dates of enrollment in that state's Medicaid program. OSA further confirmed that the 63 members in the audit finding received healthcare services in that state or territory while MassHealth was making capitation payments to MCOs on behalf of those same individuals.
EOHHS misrepresented the rigor of the statistical methods used to extrapolate to the targeted population.	OSA used a conservative and statistically sound approach for extrapolation by limiting the population to only those members for whom MassHealth made five or more consecutive concurrent capitation payments in at least one of the 10 other states and territories.

EOHHS notes that the audit period overlapped with the coronavirus pandemic and that it was limited by federal law in its ability to reduce MassHealth enrollment. Our reply is as follows:

Our Response	Comments
EOHHS missed opportunities to verify residency given greater fluctuations in residency.	MassHealth did not send address verification letters to 24 of the 63 individuals flagged by PARIS data matches. Given greater fluctuations in residency because of the pandemic, MassHealth should have taken additional steps to verify the residency of members who were flagged in PARIS data matches. MassHealth was not prohibited by the FFCRA MOE to move ineligible individuals to the fee for service model. MassHealth could have taken these measures to prevent concurrent payments on behalf of individuals who moved from Massachusetts and enrolled in another Medicaid program.

EOHHS claimed it had policies and procedures in place that require individuals to submit documentation to substantiate their residency. Our reply is as follows:

Our Response	Comments
EOHHS had insufficient policies and procedures regarding its residency verification process.	MassHealth failed to send address verification letters to 24 of the 63 individuals flagged by PARIS data matches. MassHealth should have taken additional steps to verify the residency of members who were flagged in PARIS data matches.

We strongly urge the swift implementation of our recommendations.