Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Massachusetts Comprehensive Program Integrity Review

Final Report

February 2011

Reviewers:
Lauren Reinertsen, Review Team Leader
Todd Chandler
Robert Fitzpatrick
Mark Rogers

TABLE OF CONTENTS

INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Massachusetts Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of MassHealth, a component of the Executive Office of Health and Human Services (EOHHS), and at its contractor, University of Massachusetts Medical School (UMMS) Center for Health Care Financing (CHCF). The review team also visited the offices of the Medicaid Fraud Control Unit (MFCU).

This review focused on the activities of MassHealth, which is responsible for Medicaid program integrity. This report describes three effective practices, five regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Massachusetts improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Massachusetts' Medicaid Program

The EOHHS administers the Massachusetts Medicaid program through its MassHealth division. In the State fiscal year (SFY) ending June 30, 2008, the program served 1,134,965 beneficiaries and Medicaid expenditures totaled $8.5 billion. The fee-for-service (FFS) program had expenditures of $6.7 billion and served 735,338 beneficiaries through 30,286 FFS providers. In SFY 08, Massachusetts had 399,627 beneficiaries enrolled in 14 managed care organizations (MCOs). During Federal fiscal year 2008, the Federal medical assistance percentage for Massachusetts was 50 percent.

Program Integrity Section

The MassHealth Operations Integrity Unit, within EOHHS, is the organizational component dedicated to fraud and abuse activities. It has responsibility for recipient integrity and directs and provides oversight to the Provider Compliance Unit (PCU), which is contracted to CHCF at UMMS. Massachusetts also has recently established an Office of Compliance at EOHHS which has a focus on Medicaid program integrity but also is responsible for program integrity in other EOHHS programs. At the time of the review, EOHHS had approximately 203 full-time equivalent staff focusing on Medicaid program integrity. The table below presents the total number of investigations, identified overpayments, and amounts recouped in the past four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Preliminary Investigations**	Number of Full Investigations***	Amount of Overpayments Identified*	Amount of Overpayments Collected
2005	67	10	$60,000	$56,000
2006	94	11	$1,400,000	$1,100,000
2007	62	15	$3,200,000	$1,600,000
2008	82	16	$2,800,000	$2,300,000

*Statistics supplied by the PCU at UMMS, a contractor overseen by EOHHS' MassHealth Operations Integrity Unit.
**Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.
***Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

Methodology of the Review

In advance of the onsite visit, the review team requested that Massachusetts complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit. A staff member from the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) participated as an observer of the review process.

During the week of April 27, 2009, the MIG review team visited the MassHealth, UMMS, and MFCU offices. The team conducted interviews with numerous EOHHS and UMMS officials, the State's provider enrollment contractor, and the MFCU director. Finally, to determine whether the MCOs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team interviewed State staff from EOHHS with managed care oversight responsibilities. The team also reviewed the managed care contract provisions and gathered information through interviews with representatives of four MCOs. In addition, the team conducted sampling of provider enrollment applications, FFS and MCO case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

The review focused on the activities of EOHHS, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, managed care and non-emergency medical transportation.

Massachusetts operates both a stand-alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. That portion of Massachusetts' CHIP operating as a Medicaid expansion program was included in this review. Because the expansion CHIP program utilizes the same FFS billing and provider enrollment policies as Massachusetts' Title XIX program, the same findings, vulnerabilities and effective practices discussed in relation to the Medicaid program apply to CHIP.

Unless otherwise noted, Massachusetts provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that EOHHS provided.

RESULTS OF THE REVIEW

Effective Practices

The State of Massachusetts has highlighted two practices that demonstrate its commitment to program integrity. These practices include effective organization of the Surveillance and Utilization Review Subsystem (SURS) Unit and expanded List of Excluded Individuals/Entities (LEIE) exclusion checking.

Effective organization of the SURS Unit

The organizational structure of the SURS unit, which is contracted out, mirrors the organizational structure of the MassHealth Medicaid program. This mirrored structure provides several administrative efficiencies. It allows the SURS staff person assigned to a particular program to develop a close relationship with MassHealth management and staff who can provide immediate program-related assistance to the SURS staff person. This alignment has added value on both sides. For example, the SURS staff has brought to the attention of their respective State agency program managers such issues as inoperable edits, identified weaknesses in the regulations, monitoring of providers, and verification of correct payment methodology (i.e. crossover pricing, hospice pricing in nursing facilities, and inpatient episode pricing including specific payment at discharge, outliers and transfers). On the management side, this mirrored structure has fostered a trusting working relationship as evidenced by program managers' requests for SURS staff to test new regulations to find potential program-related issues.

Expanded LEIE checking for exclusions

In response to State Medicaid Director Letter #08-003 (issued June 12, 2008), the State checked the LEIE for all their providers and identified 22 personal care attendants (PCAs) who had been excluded by the HHS-OIG and therefore not eligible to participate in the State's Medicaid program. Massachusetts anticipated returning approximately $300,000 to CMS for Medicaid expenditures related to these excluded individuals. Additionally, Massachusetts implemented a comprehensive plan to extend regular LEIE exclusion checking to individuals providing services through its waiver programs, including its waivered PCA program. Although Massachusetts noted this positive action in its PCA, personal care services and waivered services areas, other issues related to LEIE checking are discussed in the *Vulnerabilities* section of this report.

Additionally, the MIG review team identified a practice that is particularly noteworthy. The CMS recognizes efforts by Massachusetts to improve effectiveness of program integrity-related communication within the State Medicaid agency, the MFCU, the SURS contractor, and MCOs.

Effective inter-agency communication
MassHealth has initiated regular meetings and communication exchanges focused on prevention of Medicaid fraud. It has established monthly meetings on transportation issues which are attended by the State Medicaid Human Services Transportation Unit manager, the SURS Unit manager and the MFCU. The meetings focus on issues relating to Medicaid fraud, waste and abuse and development of joint strategies to combat those issues. Massachusetts also has quarterly managed care meetings which are attended by managed care contract oversight and legal staff, MCO compliance officers, and the MFCU. The meetings provide a forum to discuss cases, provide training, and to present and exchange strategies to combat fraud and abuse in MCO provider networks.

MassHealth has also developed an effective communication strategy of contacting other MCOs when an MCO terminates a provider for cause and also notifying FFS Medicaid of the termination.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations related to notices of withholding and disclosure and notification activities.

The State's notice of payment withholding does not include all required information.
The regulation at 42 CFR § 455.23(b) stipulates that the Medicaid agency's notice of withholding state that payments are being withheld in accordance with the Federal regulation.

Massachusetts' withholding letter does not contain the required Federal language. The letter references language required under the State Code of Massachusetts Regulations (CMR) 450.249 but that regulation does not include the Federal language in 42 CFR § 455.23(b)(1,3,4).

***Recommendation*:** Modify withholding letters to include language that references § 455.23 as required by the regulation.

The State's MCO and dental third party administrator contracts do not capture all required ownership, control, and relationship information.
Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other

disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

Although Massachusetts indicated that it captured the required disclosure information in its Request for Proposals (RFP) processes, the State could not provide the required disclosure information from its MCOs and dental third party administrator, which acts as a quasi-fiscal agent. The State indicated that its RFPs serve as contracts. However, these documents do not capture ownership, control and relationship information from each person with an ownership and control interest in the disclosing entity as required by 42 CFR § 455.104. Because the RFPs do not request all of the required disclosures, the interrelationships of entities, related organizations, and subcontractors cannot be established.

Recommendation: Ensure that MCO and dental third party administrator contracts request the full range of information required to be disclosed under 42 CFR § 455.104.

MassHealth provider agreements do not require disclosure of business transactions.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

The Massachusetts regulation at 130 CMR 450.223(C)(5) includes the language of the Federal regulation at 42 CFR § 455.105 verbatim, and it is reproduced in the MassHealth provider manual. In addition, the review team noted that Massachusetts has sent educational materials to its Medicaid providers indicating that compliance with 42 CFR §§ 455.104 through 106 is mandatory. However, the MassHealth provider agreement itself does not contain the required business transaction language in whole or a reference to either the specific Federal or state regulation which contains it. As the business transaction disclosure language must be incorporated in the provider agreement, the State was unable to demonstrate full regulatory compliance.

Recommendation: Modify the MassHealth provider agreements to require disclosure, upon request, of the information identified in 42 CFR § 455.105 or to refer providers to the specific section of the CMR which contains this language.

MassHealth dental enrollment applications do not capture required criminal conviction information from managing employees.
The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify HHS-OIG whenever such disclosures are made.

The sole proprietor dental enrollment package only asks for criminal conviction information for the treating dentist. It does not ask for managing employee criminal conviction disclosure as required. Since the information is not gathered and reported to the State, the State cannot notify HHS-OIG as required.

Recommendations: Modify provider applications to require disclosure of criminal convictions to comply with regulatory requirements. Develop and implement procedures to report to HHS-OIG, within 20 working days of receipt or notice, any criminal conviction disclosures.

Massachusetts does not report to HHS-OIG adverse actions taken on provider applications for participation in the program.
The regulation at 42 CFR § 1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

Although Massachusetts notifies HHS-OIG of adverse actions in its FFS program, when actions were taken to terminate PCAs in MassHealth's Office of Long Term Care, the HHS-OIG was not notified.

Recommendation: Develop and implement procedures to report to HHS-OIG all adverse actions taken against and limits placed on all providers' participation in the program.

Vulnerabilities

The review team identified four areas of vulnerability in Massachusetts' Medicaid practices. These include not conducting complete exclusion searches, not collecting disclosures from managing employees of providers, not requiring MCOs to conduct recipient verification of services, and not reporting adverse actions taken on MCO provider applications.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.
The regulations at 42 CFR §§ 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. Even if the State was compliant with the requirements in the regulations, the State is not maintaining complete information on owners, officers and managing employees in the Medicaid Management Information Systems. Therefore the State cannot conduct adequate searches of the LEIE or the Medicare Exclusion Database (MED).

Because Massachusetts only captures the names of practitioners and entities in a searchable database, ongoing exclusion searches cannot be conducted on individuals with an ownership or control interest in the provider or contracted entities. Post-enrollment exclusion searches for individuals with an ownership or control interest is an important step in protecting Massachusetts' Medicaid program from making improper payments as discussed in the June 12, 2008 State Medicaid Director Letter #08-003. In addition, non-emergency medical

transportation driver disclosures are not captured at enrollment, and therefore cannot be searched for exclusions then, or after enrollment.

The MIG team's review of 25 provider enrollment files revealed that only 14 files had evidence of an HHS-OIG LEIE exclusion search for the practitioner or entity enrolling. In addition, evidence of an exclusion search for 6 of those 14 files was obtained and placed in the files after Massachusetts was provided the sample list, as evidenced by print dates on the documents. That action appeared to delay the delivery of a portion of the sample to the review team. In addition, 7 of the 25 files were incomplete because they did not include provider agreements.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information. Conduct LEIE or MED searches for all required persons and entities upon enrollment, reenrollment, and at least monthly thereafter.

Not capturing managing employee information on enrollment and credentialing forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." Neither the State (in its FFS program) nor its MCOs and dental provider solicit managing employee information in all provider enrollment and credentialing forms. Thus, the State would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads. Since this information is not gathered, the State cannot search for exclusions and notify HHS-OIG of disclosures as required.

Recommendations: Modify FFS provider enrollment forms and managed care and dental credentialing packages to require disclosure of managing employee information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not conducting recipient verification of services within Medicaid managed care.
While Massachusetts meets the requirements of 42 CFR § 455.20 by sending explanations of medical benefits to FFS recipients, an equivalent verification of the services furnished by providers is not conducted with Medicaid managed care enrollees. Neither the MCOs nor EOHHS have a mechanism in place to ensure that Medicaid managed care recipients have received the services which MCO providers claim to have provided.

Recommendation: Modify the MCO contracts to require use of a method for verifying with Medicaid managed care recipients whether billed services were actually received or have the State undertake such verification directly with enrollees.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications. Although MCOs are reporting network provider terminations to MassHealth, they are not reporting adverse actions taken on provider applications for participation in the MCO Medicaid network. This omission may make it easier for problem providers to find a way into other MCOs and the FFS program undetected. The failure of MCOs to notify the Medicaid agency of adverse actions taken for program integrity reasons also precludes the Medicaid agency from reporting such actions to the HHS-OIG, as the regulation at 42 CFR § 1002.3(b) would require in the FFS program.

Recommendations: Require contracted MCOs to notify the State agency when they deny providers credentialing for program integrity-related reasons. Develop and implement procedures for reporting these adverse actions to HHS-OIG.

CONCLUSION

The State of Massachusetts applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. These effective practices include:

- organization of the SURS unit using the same structure as the State Medicaid agency,
- expanded LEIE exclusion checking, and
- effective inter-agency communication.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of five areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages EOHHS to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require EOHHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Massachusetts will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Massachusetts has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Massachusetts on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building its effective practices.