Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Massachusetts Comprehensive Program Integrity Review

Final Report

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Massachusetts Medicaid Program (MassHealth). 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 the University of Massachusetts Medical School (UMMS) Center for Health Care Financing, an other government unit. The review team also visited the provider enrollment contractor and conducted phone interviews with four managed care entities (MCEs) and the Medicaid Fraud Control Unit (MFCU).

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

The CMS is concerned that the review identified two partial or complete repeat findings and two partial repeat vulnerabilities from its 2009 review of Massachusetts. The CMS will work closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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. As of January 1, 2012, the program served 1.3 million beneficiaries. About 37.5 percent of these were enrolled in 5 full service managed care organizations (MCOs). Another 383,000 beneficiaries in the Medicaid fee-for-service (FFS) system received behavioral health services through a capitated statewide behavioral health organization (BHO). In addition, nearly 21,000 elderly beneficiaries were enrolled in 4 capitated managed care plans administered by the State Medicaid agency, known as Senior Care Option (SCO) plans.

The State had 37,572 participating FFS providers, while the various health plans each had between 2,000 and 24,000 affiliated providers. According to CMS financial data, total computable Medicaid expenditures in Massachusetts for the State fiscal year (SFY) ending June 30, 2011 were nearly $14.1 billion. This figure includes $4.8 billion in payments to MCOs, or roughly 34 percent of all Medicaid outlays.

Medicaid Program Integrity Division

In Massachusetts, the EOHHS Office of Compliance (OC) is the organizational component dedicated to fraud and abuse activities. At the time of the review, EOHHS had 167 full-time equivalent positions, including 131 at UMMS, allocated to Medicaid program integrity functions. The Provider Compliance Unit (PCU) at UMMS was the focal point for provider surveillance and utilization review (SUR), fraud complaints and referrals to the MFCU. MassHealth was in a transition period and had recently hired a new program integrity director who is also acting as the director of the OC. The table below presents the number of preliminary and full investigations and overpayment amounts identified and collected for the PCU in the last four SFYs as a result of program integrity activities. The investigations and collections data do not include global settlements or dollars collected by other components within the Medicaid agency, such as the Financial Compliance Unit.

Table 1

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Overpayments Identified Through Program Integrity Activities	Overpayments Collected Through Program Integrity Activities
2008	82	16	$2,800,000	$2,300,000
2009	65	17	$2,900,000	$2,700,000
2010	68	14	$5,300,000***	$4,300,000***
2011	74	15	$5,100,000	$4,700,000

* 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.
*** The increase in overpayments identified and collected is due to an increase in program integrity staff and resulting case work.

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, and managed care. A five-person team reviewed the responses and materials that the State provided in advance of the onsite visit. Phone interviews were also conducted with three MCOs (including one SCO), the BHO and the MFCU prior to the team going onsite.

During the week of March 20, 2012, the MIG review team visited the MassHealth and UMMS offices. The team conducted interviews with numerous EOHHS officials as well as with provider enrollment contractor staff. To determine whether MCOs were complying with the contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State's managed care contracts. The team met separately with EOHHS staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Massachusetts' program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the PCU, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment, contract management, and provider training. Massachusetts operates both a stand-alone Children's Health Insurance Program (CHIP) and a Title XIX expansion program. The expansion program operates under the same billing and provider enrollment policies as Massachusetts' Title XIX program. The same effective practices, findings and vulnerabilities discussed in relation to the Medicaid program also apply to the expansion of CHIP. The stand-alone program operates under the authority of Title XXI and is beyond the scope of this review.

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 provided.

Results of the Review

Effective Practices

As part of its comprehensive review process, the CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Massachusetts reported strong inter-agency communications, an enhanced PCU organizational structure, and supportive relationships with the MFCU as effective program integrity tools.

Effective inter-agency communication

The 2009 CMS review team identified a series of regular meetings and information exchanges on program integrity issues as an effective practice in Massachusetts. The 2012 team found that this practice has continued. The State holds quarterly managed care meetings that are attended by MassHealth managed care contract oversight and OC legal staff, MCO and BHO compliance officers, PCU staff from UMMS, and MFCU representatives. The meetings provide a forum to discuss cases, provide training, and to present and exchange strategies to combat fraud and abuse in the MCO and BHO provider networks. The MCOs and the BHO under MassHealth hired dedicated program integrity officers responsible for ensuring that State and Federal program integrity issues are addressed by their organizations and that the State agency and MFCU are aware of plan program integrity activities. The only managed care representatives not participating in these meetings are the State and plan compliance staff associated with the SCO program that oversee and administer a special type of MCO in Massachusetts that serves primarily dual eligibles.

MassHealth has also developed an effective communication strategy of contacting all of the MCOs and the BHO when any plan terminates a provider for cause and also notifying FFS Medicaid of the termination. MassHealth is likewise continuing, on an as-needed basis, the meetings on transportation issues attended by the Human Services

Transportation Unit, which the PCU and MFCU identified as an effective practice in 2009. These meetings focus on Medicaid fraud and abuse issues and how to combat them.

Notwithstanding the continuing meeting activity and information exchanges, the review team found some weaknesses in the State's oversight of the MCOs. These are discussed in general for all the MCOs interviewed and in particular for SCO plans in the Vulnerabilities section of this report.

Organizational structure enhancements in the PCU

MassHealth has an interdepartmental service agreement with UMMS to perform most of the SUR functions and other program integrity functions, such as audits. The organizational structure of UMMS' PCU mirrors that of the MassHealth program. The PCU staff members are assigned to and aligned with specific provider types, an arrangement which greatly facilitates communication with MassHealth analysts on policy issues related to program integrity. This structure has been noted by CMS as an effective practice in the past. The value of the model has been further enhanced by the addition of clinical and auditing components. A nurse clinician has been hired to support all staff, along with three auditors who team up with the case specialists and perform onsite reviews. This model has further strengthened the unit and provides staff with additional input in building algorithms and case management.

Notwithstanding the advantages of the PCU organizational structure, the review team found issues with the overall way in which program integrity functions were dispersed without central oversight throughout the State agency and contractors. These are discussed in the Vulnerabilities section below.

Effective cooperation with the MFCU

The PCU acts as the liaison between MassHealth and the MFCU. However, the State agency is responsible for finalizing and submitting referrals to the MFCU. MassHealth has a high rate of referrals accepted by the MFCU; it also requests information from providers and plans, schedules and participates in basic training sessions with program managers on behalf of the MFCU. The purpose of these trainings is to strengthen the capacity of managers to furnish the MFCU with the kinds of provider and program information needed to help it successfully prosecute provider fraud. The PCU also developed timely policies and procedures for provider cases referred to the MFCU that involved credible allegations of fraud. During case sampling, the team observed that Massachusetts' MFCU referrals met the requirements of the new program integrity regulation that became effective on March 25, 2011. These regulations require State agencies to suspend payments to providers against whom credible allegations of fraud are brought, except in cases where good cause exceptions are documented in writing.

Regulatory Compliance Issues

The State does not comply with Federal regulations relating to the collection and reporting of ownership and control and criminal conviction disclosures. In addition, the State failed to conduct complete exclusion searches, provide adequate exclusion notices, and comply with the

State Plan regarding False Claims education monitoring.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The 2009 CMS review found that MCOs and the dental third party administrator (which performs some fiscal agent functions) were not submitting the ownership, control, and relationship disclosures required by 42 CFR § 455.104. The State had taken steps to correct these compliance issues prior to the 2012 review. A Federally Required Disclosures (FRD) form was created in May of 2011 and made mandatory for use in November. The form solicits the disclosure information required by the regulation in its amended form, which went into effect on March 25, 2011. However, while the FRD form is used for every provider enrolling in the Medicaid Management Information System (MMIS), it has not yet been fully implemented for contracting entities such as MCOs, the BHO, personal care assistant (PCA) fiscal intermediaries serving the self-directed PCA program, and non-emergency medical transportation (NEMT) brokers organized as regional transportation authorities. In addition, the State introduced separate modifications into its contract with the dental third party administrator, but these are still not fully compliant with the regulation.

While required use of the FRD form has been added to most of the MCO and NEMT contracts, the contract renewal dates for some of these entities had not occurred at the time of the review, which meant that the required disclosures had not yet been collected in all cases. At the time of the review, only one of the MCOs interviewed had submitted the FRD form as part of its new contract requirements. Until the FRD form is operational for all contracted health plans, added to the PCA fiscal intermediary contracts, and used as the basis for the dental third party administrator disclosures, the State will not be capturing the following required information:

- name, address, DOB, and SSN/ Employer Identification Number for persons with an ownership or control interest in the disclosing entity or in subcontractors [subsection (b)(1) of the regulation];

- relationship of persons with an ownership or control interest in the entity and any subcontractor in which the disclosing entity has a 5 percent or more ownership or control interest [subsection (b)(2); however, this is in the dental contract]; and
- SSN and DOB of managing employees [subsection (b)(4)].

During interviews, the review team was also told that the FRD form will become effective for NEMT brokers in July 2012 when new contracts are signed.

Recommendations: Fully implement the FRD form that solicits disclosure information required by the amended § 455.104 regulation. Collect required disclosures from NEMT brokers, the BHO and all MCOs. The MIG made the same recommendation regarding the solicitation of § 455.104-related disclosures from MCOs in the 2009 review report.

The State does not capture criminal conviction disclosures from providers or contractors.
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 the U.S. Department of Health & Human Services-Office of Inspector General (HHS-OIG) whenever such disclosures are made. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The FRD form developed since the 2009 CMS review captures appropriate health care-related criminal conviction information. The NEMT broker contracts have been amended to include use of the FRD form but will not go into effect until July 2012. In addition, while use of the FRD has been added as a contract requirement for the BHO and most MCOs (except the SCO plans), at the time of the review the requirement was only effective for one of the four health plans interviewed by the review team. Until the new contract is effective and the FRD form is collected for all plans, the Medicaid agency is not soliciting health care-related criminal conviction disclosures from persons with ownership or control interests, agents or managing employees in its contracted BHO and MCOs. Because the State is not collecting the information, such disclosures cannot be reported to the HHS-OIG, as required by the regulation.

Recommendations: Fully implement policies and procedures for the appropriate collection of disclosures from NEMT brokers and contracted health plans regarding persons with an ownership or control interest, or persons who are agents or managing employees of the NEMT brokers and health plans who have been convicted of a criminal offense related to Medicare, Medicaid or Title XX since the inception of the programs.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)
The Federal regulation at 42 CFR § 455.436 requires that the State Medicaid agency must check

the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS[1]) no less frequently than monthly.

The 2009 CMS review determined that the MassHealth program was not maintaining complete information on persons with an ownership or control interest in the disclosing entity, or managing employees in its MMIS. This has been partially addressed. The State now collects complete information on persons with an ownership or control interest in the provider, and agents and managing employees of the provider and stores that information in a searchable database for those providers enrolled by the enrollment contractor. Dentists are enrolled by the third party administrator, and their identifying information is entered directly into the MMIS. However, the dentist enrollment packages still do not capture managing employees. Upon enrollment, the Medicaid agency checks providers against the State's sanction database, which includes the State's internal sanctions list. It searches both the LEIE and EPLS upon initial provider enrollment but does not search the EPLS on a monthly basis. The provider operations director indicated that MassHealth had not been able to configure a downloadable process that would allow automatic checks against the State's provider files. The review team provided information on how to download EPLS debarment files, and the State is in the process of manually checking for debarments until an automated process can be developed.

One limitation on the use of the FRD form is that individual and group providers are not required to complete Section B, titled Ownership and Control. This section would capture the name, address, DOB and SSN of persons with an ownership or control interest in the provider and in any subcontractor in which the provider has an ownership or control interest. The name, address, DOB and SSN of managing employees would also be captured. However, since individual providers and provider groups are not required to fill out this section, that information cannot be stored and searched for debarments and exclusions. In addition, since all MCOs, the BHO, and NEMT brokers were not using the form at the time of the review, the State is not in position to do similar exclusion and debarment searches.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database (MED)) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Fully implement policies and procedures requiring the collection of the FRD form from the contracted health plans and NEMT brokers and develop new policies and procedures for the State to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the contracted health plans and NEMT

[1] On July 31, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

brokers or who is an agent, or managing employee of the health plans or NEMT brokers.

The State does not provide notice of exclusion consistent with the regulation.
Under the regulation at 42 CFR § 1002.212, if a State agency initiates exclusion pursuant to the regulation at 42 CFR § 1002.210, it must provide notice to the individual or entity subject to the exclusion, as well as other State agencies; the State medical licensing board, as applicable; the public; beneficiaries; and others as provided in §§ 1001.2005 and 1001.2006.

The State agency has a policy on permissive exclusions, but the policy does not provide for the full range of required notifications when the State terminates providers. The Program Integrity Operations manual does not provide for notifications to the public when termination actions for cause are taken against providers. The MassHealth Customer Relations manager confirmed in an interview that public notifications are not undertaken.

Recommendation: Develop and implement policies and procedures to ensure that all parties identified by the regulation are notified of a State-initiated exclusion.

The State does not comply with its State plan regarding False Claims education monitoring.
Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least $5 million annually under a State's Medicaid program have: (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protections, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

The State identifies appropriate entities above the $5 million threshold and requires them to submit a signed annual Attestation of Compliance with the False Claims Act Education Requirements form. In accordance with its State plan, a sample of covered entity certifications along with written policies and compliance documentation are to be reviewed each year. However, the review team was told by the current program integrity manager that the State failed to request attestations and other documentation during Federal fiscal year (FFY) 2010 due to a vacancy in the program integrity director position. The State was therefore unable to confirm compliance for the most recent completed fiscal year in which spot checking was required. At the time of the review, MassHealth indicated that it had just sent out attestation and documentation requests for FFY 2011.

Recommendation: Implement policies and procedures to monitor compliance of all providers and contractors in accordance with the State Plan.

Vulnerabilities

The review team identified eight areas of vulnerability in the State's practices. These included

not maintaining a centralized program integrity function, limited oversight over contracted health plans, not requiring MCOs to verify that enrollees received services as billed, and not capturing appropriate disclosures from health plan network providers. Additional issues include failure to perform complete exclusion searches and not reporting adverse actions to HHS-OIG.

State program integrity oversight is decentralized.
There is no centralized control over program integrity operations in Massachusetts. The majority of MassHealth program integrity operations are conducted through an interdepartmental service agreement with UMMS. However, even at UMMS program integrity operations are not centralized. For example, the PCU is the main unit responsible for provider SUR and overpayment recovery. The Utilization Management (UM) Unit helps ensure acute and chronic hospital and non-institutional provider services are cost effective, medically necessary and of proper quality. The Pharmacy Unit analyzes patterns of medication use, while the Nursing Facility Review Unit helps ensure payments are made for the proper level of care. While the units do interact, the PCU director told the review team that each unit has its own policies and procedures for its portion of MassHealth program integrity. The different units also sometimes take investigative and auditing actions that are not reported to the PCU. This can lead to duplication of effort and inefficiencies in the coordination of resources.

In one instance that came to the team's attention, sampling revealed a provider case from the PCU that was closed by a nurse in the UM Unit. The nurse had written a report negating the SUR findings and showing no findings. This occurred despite the fact that obvious indicators of improprieties and potential fraud existed. The review team was told by UM Unit staff that all of that nurse's closed cases were currently under review for similar problems. This situation showed that a UM nurse can close a case without any additional oversight by PCU staff who may have identified program integrity issues unrelated to medical necessity, which is the main concern of staff in the UM Unit.

In addition, there is no centralized tracking system for all program integrity-related cases. The review team was provided a list of program integrity cases worked by MassHealth. The list reflected only cases worked by the PCU and no cases worked by other units with program integrity responsibilities. The decentralization and fragmentation within MassHealth makes it difficult for key decision makers to have an overview of combined program integrity efforts in the Medicaid agency. The current program integrity director acknowledged that establishing consistent policies and procedures as well as tracking mechanisms that cut across components would be a major benefit to State operations.

Recommendations: Organize all program integrity activities in such a manner as to ensure coordination and communication across the Medicaid program. Protocols addressing provider enrollment, fraud and abuse detection, investigations and law enforcement referrals should include mechanisms for tracking and reporting program integrity activities.

Limited program integrity oversight over contracted health plans.
Although MassHealth has developed effective communication mechanisms with its BHO and MCOs on program integrity issues, in many respects State oversight of the contracted health plans was less than optimal. While the Medicaid agency requires plans to submit an annual

attestation affirming that they are in compliance with contract requirements, the team noted that relatively little look behind activity is undertaken to establish the validity of the attestations, particularly for program integrity.

For example, the State does not review plan operations to determine if compliance plans or guidance furnished in MassHealth Bulletins are being followed. Nor does it validate plan certifications that contractors and subcontractors have not been debarred or suspended by the Federal government. The team also observed that the State does not audit overpayment collections reported monthly by managed care contractors. In addition, the monthly reports furnished by the plans do not identify providers with whom contractors are having issues, information that would be of use to the PCU and other contractors. Finally, the State did not question why only one of the three MCOs interviewed referred any potential fraud and abuse cases to the State in the past four years.

The lack of oversight was particularly noticeable in the case of the SCO program. This is housed in the Executive Office of Elder Affairs (EOEA), which has responsibility for long term care activities. During the team's interview with a SCO plan, it was noted that neither EOEA staff not SCO plan staff attends quarterly program integrity meetings with the PCU, MFCU and other contracted health plans. The SCO plan representatives told the review team that they felt their reporting responsibility was to the SCO program and that it was not essential to report to MassHealth. While SCO plan reports may eventually move from the SCO department hierarchy to the Medicaid agency, this can be a protracted process which leaves program integrity staff uninformed for long periods of time about potentially significant program integrity issues. In addition, there is no indication that the SCO program adopted the FRD form used by MassHealth to obtain disclosures of ownership and control interests and persons with health care-related criminal convictions within the SCO plan organizations.

Recommendations: Develop and implement policies and procedures to provide for enhanced program integrity oversight of the State's Medicaid managed care programs. Such oversight should include proactive verification of program integrity-related attestations by managed care contractors, more detailed monthly reporting requirements, and auditing of plan reports on program integrity overpayments. It should also include State expectations regarding managed care fraud and abuse referrals. Modify the MassHealth MCO, BHO and SCO plan contracts as needed to support the objective of enhanced program integrity oversight in the managed care delivery system.

Not verifying with managed care enrollees whether services billed were received. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 455.20 requires the State Medicaid agency to have a method for verifying with beneficiaries whether services billed by providers were received. An HHS-OIG report on managed care safeguards, *Medicaid Managed Care: Fraud and Abuse Concerns Remain Despite Safeguards*, OEI-01-09-00550, recommended that State Medicaid agency contracts with MCEs require verification with enrollees that services were provided either through the use of explanations of medical benefits or beneficiary questionnaires. To the extent that the State Medicaid agency has delegated the responsibility to its MCE to verify with

enrollees whether services were received, the failure of the MCE to have a method for verifying with enrollees whether services were received and to implement that method, leaves the State Medicaid agency vulnerable to fraud.

MassHealth modified its MCO contracts as a result of the 2009 CMS review to require verification of services with managed care beneficiaries for two of the three MCOs interviewed. However, the State managers who oversee the SCO plan from EOEA, and the SCO plan's management team stated during interviews that there is no process in place for verifying services received by the beneficiaries. The EOEA is a sister State agency alongside the Medicaid agency in Massachusetts' EOHHS. While Medicaid dollars fund the SCO program to a large extent, the Medicaid agency has no direct means of ensuring that the SCO leadership or plans implement this practice.

Recommendation: Develop and implement procedures to verify with MCO enrollees whether services billed by providers were received. The MIG made the same recommendation regarding beneficiary verification of services in managed care plans in the 2009 review report.

Not capturing ownership and control disclosures from network providers.
Under 42 CFR § 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, DOB, and SSN of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under § 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under § 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under § 455.104(b)(4), the disclosing entity must provide the name, address, DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under § 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

Two of the State's MCO network provider entity applications reviewed, as well as the BHO application, do not require the name, address, DOB, and SSN, or employer identification number of persons with an ownership or control interest in the provider or subcontractor that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. The network providers are also not required to disclose the relationship of the disclosed owners or persons with control interests in another disclosing entity. In addition, the name, address, DOB, and SSN for managing employees are not captured. At the time of the review, only one MCO had adopted the State's new FRD form, which solicits the information requested at § 455.104 for use with its network providers.

Recommendations: Modify the managed care contracts to require, or ensure that managed care

provider enrollment forms require the disclosure of complete ownership, control, and relationship information from all BHO and MCO network providers. Include contract language requiring the BHO and MCOs to notify the State of such disclosures on a timely basis.

Not adequately addressing business transaction disclosures in network provider contracts.
The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health & Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

The credentialing forms and provider agreements used for network providers by the State's contracted MCOs and BHO do not require the disclosure of certain business transactions with wholly owned suppliers or any subcontractors upon request. Although the State's managed care contracts require plans to submit information on business transactions to the State within 35 days of request, that provision is missing in the health plan agreements with participating providers.

Recommendation: Modify the managed care contracts to require disclosure upon request of the information identified in 42 CFR § 455.105(b).

Not capturing criminal conviction disclosures from network providers.
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. In addition, pursuant to 42 CFR § 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

Two of the three MCOs interviewed and the BHO do not require the disclosure of health care-related criminal convictions from their network providers that Federal regulations at 42 CFR § 455.106 would otherwise require from FFS providers. For example, the BHO's enrollment forms exclude misdemeanors from disclosure as well as criminal convictions from agents and managing employees. While one of the two full service MCOs uses the State's FRD form to capture these disclosures, the second MCO limits the reportable time frame for criminal convictions to 10 years. The SCO program does not collect any criminal conviction information on managing employees, agents or persons with an ownership or control interest in the provider.

Recommendations: Modify the managed care contracts to require, or ensure that managed care provider enrollment forms require, the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring all contracted health plans to notify the State of such disclosures on a timely basis.

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. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the LEIE or the MED.

The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008, providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL (#09-001) dated January 16, 2009, provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including persons with an ownership or control interest in the provider, and agents and managing employees of the provider. A new regulation at 42 CFR § 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS[2] on a monthly basis.

Two of the three MCOs interviewed and the BHO check the LEIE database for exclusions at the time of enrollment and on a monthly basis thereafter. However, only the BHO conducts monthly checks of the EPLS for debarments, which are performed by a contractor. The State has not issued instructions to the BHO and MCOs on checking the EPLS since the Affordable Care Act's implementing regulations on EPLS searches went into effect on March 25, 2011. The State's most recent guidance in this area was an "All Provider Bulletin" issued in October 2009, which instructs all the contracted plans to:

- Develop policies and procedures for regular review of the LEIE at time of hire and contracting and on a monthly basis;
- Develop reliable, auditable documentation of when these procedures are performed; and
- Periodically conduct self-audits of internal documentation for compliance with this requirement.

Recommendations: Amend contracts to require the appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Require the contractor to search the LEIE and the EPLS upon enrollment, re-enrollment, credentialing or re-credentialing of network providers, and at least monthly thereafter, by the

[2] On July 31, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf for assistance in accessing the database at its new location.

names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all adverse actions taken on provider participation to the HHS-OIG. (Uncorrected Partial Repeat Vulnerability)

The regulation at 42 CFR § 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The 2009 CMS review found that MCOs were not reporting adverse actions taken on provider applications for participation in the MCO networks. The State has taken steps to correct the vulnerability and now has clear policies and procedures and contract requirements directing contracted health plans to report to it all program integrity-related adverse actions taken to limit provider participation in their networks. Two of the three MCOs interviewed by the review team and the BHO indicated that they report to the State when they take any program integrity-related adverse actions on provider applications for participation in the program. However, representatives of the SCO plan told the review team they do not notify the State when they terminate a provider's contract or deny enrollment to a provider even for fraud-related reasons. Since the State is not notified, it is not in a position to notify HHS-OIG of the adverse action as would be standard procedure in the FFS program.

Recommendations: Require all contracted health plans to notify the State when they take adverse actions against or deny enrollment to a network provider for program integrity-related reasons. Develop and implement procedures for reporting these actions to HHS-OIG. The MIG made the same recommendation in its 2009 review report.

Conclusion

The State of Massachusetts applies some effective practices that demonstrate program strengths and the State's commitment to program integrity. 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, eight areas of vulnerability were identified. The CMS is particularly concerned over the four uncorrected repeat findings and vulnerabilities. The CMS expects the State to correct them as soon as possible.

To that end, we will require Massachusetts 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 MIG looks forward to working with the State of Massachusetts on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

Official Response from Massachusetts
September 2012

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September 19, 2012

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Re: Medicaid Integrity Program:
Massachusetts Comprehensive Program Integrity Review
Final Report - August 2012

Dear Mr. Rogers:

Thank you for the opportunity to respond to the above-referenced Final Report that describes the CMS Medicaid Integrity Group's review and assessment of MassHealth's Program Integrity procedures. The Executive Office of Health and Human Services (EOHHS) is committed to ensuring the integrity of the MassHealth program. Accordingly, we appreciate the extensive and comprehensive review that your team conducted.

We also appreciate that you have highlighted some of our many practices that demonstrate our commitment to program integrity. Specifically, for example, the Final Report notes the effective inter-agency communication of the MassHealth program that is targeted towards combating fraud and abuse, organizational enhancements in the MassHealth program's Provider Compliance Unit (PCU), and MassHealth's effective cooperation with the Medicaid Fraud Control Unit (MFCU).

In the attached response to the Final Report we have reproduced your team's findings, vulnerabilities and recommendations and describe our corrective action plan, which we anticipate will be implemented by November 2012, with the exception of the public facing web page as noted in response to Finding 4, below, which is anticipated to be completed in early 2013.

If you have any questions or would like to discuss, please let us know.

Sincerely,

Dr. Julian Harris, M.D., M.B.A., M.Sc.
Medicaid Director

Attachment