OFFICE OF THE INSPECTOR GENERAL
COMMONWEALTH OF MASSACHUSETTS

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MassHealth and Health Safety Net: 2021 Annual Report

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EXECUTIVE SUMMARY

The Office of the Inspector General for the Commonwealth of Massachusetts (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Since 2004, the Office has maintained a healthcare unit to conduct focused reviews of the Massachusetts Medicaid (Medicaid) and Health Safety Net (HSN) programs. The Office's healthcare unit also provides specific recommendations for program improvements to the Office of Medicaid (MassHealth), which is responsible for administering the Medicaid and HSN programs.

In 2020, the Office reviewed MassHealth's administration of claims related to the adult foster care program, sleep studies and positive airway pressure devices. The Office found that most claims in these programs were submitted and paid appropriately. The Office also identified measures MassHealth should take to improve its program integrity in each area reviewed.

Adult Foster Care. Adult foster care allows MassHealth members to live with a caregiver who provides medically necessary assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs are physical skills like eating, dressing and bathing. IADLs are life management tasks like paying bills, shopping and preparing meals.

MassHealth members may also receive assistance with ADLs from home health aides. However, regulations prohibit MassHealth from paying for a member to receive adult foster care on the same day they receive home health aide services. Furthermore, adult foster care is billed at a per diem rate. Therefore, providers should not bill – and MassHealth should not pay – multiple adult foster care claims for service provided to the same member on the same day.

The Office reviewed approximately $349 million in adult foster care claims that MassHealth paid between May 1, 2018 and April 30, 2019. The Office found that MassHealth allows providers to bill for multiple days on a single claim. Furthermore, rather than identifying the specific dates that the member received care, providers can list a date range for the services. While this practice appears permissible, it impedes oversight because it can be difficult or impossible to determine the specific dates the services were provided. It also makes it more difficult to identify when a member has received overlapping services.

The Office also found (1) MassHealth paid $664,165 in adult foster care claims on days a member also received home health aide services; (2) 5,168 instances when a provider submitted two adult foster care claims for a single day; and (3) 604 instances when a provider billed for a month of service – 30 or 31 days – but only listed a single date of service on the claim.

To comply with its regulations, MassHealth should implement edits in its claims adjudication system to proactively prevent paying claims for adult foster care services that members received on the same day they received home health aide services. MassHealth should also consider requiring providers to bill for adult foster care one day at a time. Finally, MassHealth should consider whether it is appropriate for providers to bill for a month of service but only list a single date of service on the claim.

Sleep Studies. MassHealth pays for members to undergo medically necessary sleep studies to diagnose sleep disorders, including obstructive sleep apnea. Obstructive sleep apnea occurs when breathing stops temporarily during sleep due to narrowed or constricted airways. A provider may conduct a sleep study at a sleep clinic, at a hospital or in a member's home. Each sleep study requires equipment, supplies and a technician to set up the test, as well as a physician or similar healthcare professional to interpret the sleep study. Providers can either bill MassHealth for the entire process as a single "global" service or submit two separate claims: one for the technical component, covering the test itself, and another for the professional component, covering the interpretation.

The Office reviewed 57,987 claims for sleep studies conducted between January 1, 2015 and December 31, 2019 for a total cost of $25,203,501 for 22,569 members. The Office found 1,286 claims, totaling $557,103, for the technical component of a sleep study without a corresponding professional component for the member. Since the technical component is medically useless without professional interpretation, billing for only half the procedure presents three possibilities: providers are wasting taxpayer money by performing the technical component unnecessarily; providers are defrauding MassHealth by billing for sleep studies they did not perform; or providers are performing full sleep studies but failing to bill MassHealth for the professional component. Two providers accounted for 548, or 50%, of these claims. The Office will forward information about these providers to MassHealth.

The Office recommends that MassHealth evaluate its claims edits and program integrity processes to ensure that the agency only pays for completed sleep studies that include both the technical and the professional components.

Positive Airway Pressure Devices. Patients use positive airway pressure (PAP) devices, a type of durable medical equipment, to treat sleep disorders, including obstructive sleep apnea. MassHealth regulations allow the agency to pay for PAP device rentals for a maximum of 13 months, at which point the member owns the device. MassHealth also will pay for certain parts of each PAP device to be replaced at regular intervals. For instance, MassHealth will pay for a new PAP mask every three months.

The Office reviewed 170,792 PAP device claims for calendar years 2015 through 2019 and found that overall MassHealth has strong program integrity for PAP devices. The Office identified three areas that may require additional oversight. First, the Office found that MassHealth paid a small number of duplicate claims for PAP device rentals. Second, the Office saw a low occurrence of rentals that exceeded 13 consecutive months. Third, the Office found that MassHealth sometimes paid for replacement parts more frequently than the regulations allow.

The Office recommends MassHealth evaluate its claims edits periodically to ensure that it continues to identify and deny duplicate claims as well as too-frequent replacements of durable medical equipment and parts. MassHealth should also continue to monitor its payment system to ensure that it is reimbursing claims appropriately.

Personal Care Attendants. The Office also followed up with MassHealth regarding the personal care attendant (PCA) program, which was the focus of the Office's annual report on the Medicaid and Health Safety Net programs last year. In that report, the Office identified several issues that limited MassHealth's ability to provide meaningful oversight of the PCA program.

The Office found MassHealth did not know the identities of the PCAs who provide services to members. As a result, MassHealth could not conduct adequate program integrity or determine whether the PCA program was working within its regulatory framework. For example, MassHealth could not determine whether each PCA was following regulations that, among other things, prohibit a PCA from caring for a family member and from working more than 50 hours a week.

In response to this finding, MassHealth now requires the fiscal intermediaries (FIs), which help administer the PCA program, to provide MassHealth with identifying information for all PCAs – including each PCA's name. Under a new contract that begins in 2022, moreover, MassHealth will require that every claim for PCA services include a unique PCA identification number. The Office strongly supports this requirement because it will provide a direct link between the PCA, the claim for payment and the MassHealth member(s) for whom the PCA provides services.

Last year, the Office also reviewed de-identified criminal offender record information (CORI) and sex offender registry information (SORI) of PCAs and found substantial numbers of PCAs have had involvement with the criminal justice system. MassHealth allows members to select their own PCAs and decide whether to run CORI and SORI checks. Over the past year, MassHealth has solicited feedback from members and stakeholders about how to increase the number of PCAs who undergo background checks.

Finally, the Office reviewed PCA travel claims, which are claims for PCAs to travel from one member's home to another member's home. The Office found inconsistent and incomplete data, making it impossible for MassHealth or its vendors to conduct rigorous program integrity reviews. The Office also observed that MassHealth was reimbursing PCAs for traveling significant distances to care for members, which raises concerns about good business practices and program integrity.

In response to the Office's findings, MassHealth began taking steps to identify inaccurate travel claims and to recoup improperly paid claims. For example, MassHealth created an algorithm to flag PCA travel claims that require further review. It began using the algorithm in January 2021.

The Office continues to recommend that MassHealth conduct a full audit of all travel claims. This audit should look for red flags of fraud, waste or abuse, including why some PCAs appear to finish one shift and start a second shift simultaneously, even though they are caring for members who live at different addresses. The audit should also examine providers who consistently submit large travel claims and claims for longer-than-average work hours.

BACKGROUND

I. The Office of the Inspector General

Created in 1981, the Office of the Inspector General (Office) is the first state inspector general's office in the country. The Legislature created the Office at the recommendation of the Special Commission on State and County Buildings, a legislative commission that spent two years probing corruption in the construction of public buildings in Massachusetts. The commission's findings helped shape the Office's broad statutory mandate, which is the prevention and detection of fraud, waste and abuse in the expenditure of public funds and the use of public property. In keeping with this mandate, the Office investigates allegations of fraud, waste and abuse at all levels of government; reviews programs and practices in state and local agencies to identify systemic vulnerabilities and opportunities for improvement; and assists the public and private sectors to help prevent fraud, waste and abuse in government spending.

The Office has considerable experience reviewing and analyzing healthcare programs, including issues relating to costs, eligibility, documentation and verification. The Office also has issued a number of analyses, reports and recommendations regarding the Massachusetts Medicaid (Medicaid) program, the Health Safety Net (HSN) program, healthcare reform and other healthcare topics.

In 2020, the Legislature enacted Chapter 227 of the Acts of 2020. Section 86 of that law directed the Office to study and review the Medicaid and HSN programs:

> Notwithstanding any general or special law to the contrary, in hospital fiscal year 2021, the office of inspector general may expend up to a total of $1,000,000 from the Health Safety Net Trust Fund established in section 66 of chapter 118E of the General Laws for costs associated with maintaining a health safety net audit unit within the office. The unit shall continue to oversee and examine the practices in hospitals including, but not limited to, the care of the uninsured and the resulting free charges. The unit shall also study and review the Medicaid program under said chapter 118E including, but not limited to, a review of the program's eligibility requirements, utilization, claims administration and compliance with federal mandates. The inspector general shall submit a report to the clerks of the senate and house of representatives and the senate and house committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2022.[1]

[1] Section 86 states that the report is due in March 2022. The Office is providing this report in 2021, understanding that the report is due annually.

Pursuant to this legislative mandate, the Office examined aspects of sleep medicine and adult foster care. The Office also followed up with the Office of Medicaid (MassHealth) regarding findings and recommendations in its 2020 Annual Report relating to personal care attendants.[2]

II. The Medicaid Program

The federal government created the national Medicaid program in 1965 to provide medical assistance to low-income Americans, particularly children, through a shared state-federal commitment. Today, the national Medicaid program pays for medical care, as well as long-term nursing and other care, for tens of millions of Americans. At the federal level, the Centers for Medicare and Medicaid Services (CMS) administers the program. Each state administers its own version of Medicaid in accordance with a CMS-approved state plan. Although the states have considerable flexibility in designing and operating their Medicaid programs, they must comply with applicable federal and state laws and regulations. In Massachusetts, the Executive Office of Health and Human Services (EOHHS) includes the Office of Medicaid, which oversees the Medicaid program.

III. The Health Safety Net Program

In 1985, the Massachusetts Legislature created the uncompensated care pool (UCP) with the goal of "more equitably distributing the burden of financing uncompensated acute hospital services across all acute hospitals . . . ."[3] The purpose of the UCP was to pay for medically necessary services that acute care hospitals and community health centers provided to eligible low-income uninsured and underinsured patients. In addition, the UCP reimbursed hospitals for bad debt for patients from whom the hospitals were unable to collect payment.

In 2006, the Legislature created the Health Safety Net (HSN) program, funded by the Health Safety Net Trust Fund, to replace the UCP. The stated purpose of the HSN program was to "maintain a healthcare safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents of the commonwealth."[4] Initially, the Division of Healthcare Finance and Policy managed the HSN program, but in 2012, the Legislature transferred that responsibility to MassHealth.

[2] When referring to the year of a report, the Office uses the fiscal year in which it published the report. The fiscal year is July 1 to June 30. For instance, fiscal year 2021 runs from July 1, 2020 to June 30, 2021.

[3] M.G.L. c. 6A, § 75 (repealed 1988).

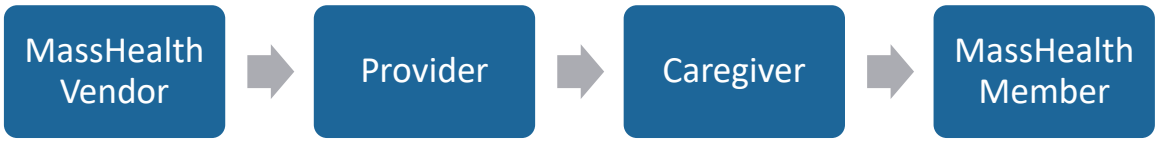
[4] M.G.L. c. 118E, § 66.

I. MassHealth's Adult Foster Care Program

A. Overview

MassHealth has an adult foster care program, which allows a MassHealth member to live with a caregiver who provides medically necessary assistance with activities of daily living, instrumental activities of daily living and other personal care.[5] A MassHealth vendor oversees the providers, reviews member applications for the adult foster care program and maintains all necessary paperwork from the providers. Providers – which typically are for-profit companies or non-profit organizations – oversee caregivers by engaging in nursing oversight and care management. The providers also are responsible for ensuring that MassHealth members meet the eligibility requirements for adult foster care. Unlike a foster parent for a minor child, an adult foster caregiver is not the member's legal guardian.

Figure 1. Overview of the Structure of MassHealth's Adult Foster Care Program



Members qualify to participate in the adult foster care program if (1) the member's primary care physician provides an order for adult foster care; (2) MassHealth (or its designee) approves the adult foster care services; and (3) the member has a medical condition that requires daily hands-on assistance, or cuing, and supervision, to complete the necessary activities of daily living.[6]

MassHealth does not pay for adult foster care on days that the member receives services that overlap with adult foster care. Specifically, MassHealth will not pay for adult foster care on days when the member also (1) receives any other personal care services; (2) receives home health aide services from a home health agency; or (3) is in a hospital, skilled nursing facility or any other residential facility subject to state licensure or certification.

[5] Activities of daily living are tasks that a person needs to perform to survive comfortably, including walking, eating, dressing, grooming, toileting, bathing and moving from one position to another (*e.g.*, sitting to standing). Instrumental activities of daily living are tasks that are part of day-to-day living, including managing finances, transportation, shopping, meal preparation, housing, home maintenance and medications. *See* 130 CMR 408.000 et seq. Lastly, the caregiver must be at least 18 years old. The caregiver may not be the spouse, parent of a minor member (including an adoptive parent) or any other legally responsible relative of the member.

[6] "Cuing" is when a caregiver provides prompts or reminders to the member.

B. The Office's Review of Claims for Adult Foster Care Services

The Office reviewed all claims that MassHealth paid for adult foster care between May 1, 2018 and April 30, 2019. During that one-year period, MassHealth paid $348,632,296 for 2,645,095 claims. The claims involved 16,562 members and 388 providers.

The Office found that MassHealth is improving the processes it uses to pay claims accurately by utilizing an algorithm to identify suspect claims and implementing claims edits.[7] MassHealth is also considering requiring providers to bill claims for a specific day instead of billing using a date range. Nevertheless, the Office identified areas for improvement, including with respect to claims for multiple dates of service and for overlapping services.

1. Providers are able to bill for multiple days on a single claim.

MassHealth allows providers to submit one claim for multiple days of service. For example, a provider can submit one claim for 20 days of adult foster care that a caregiver provided to a member during a 30-day period.

The Office identified 171,211 claims, totaling $175,792,350, in which a provider billed for multiple days on a single claim. In 2,130 claims, it was impossible to identify the specific dates of service. For example, a provider submitted one claim for seven days of adult foster care, with dates of service from the first day of the month to the last day of the month, without identifying on which seven days it provided the services. MassHealth paid $1,347,885 for these 2,130 claims.

The Office reported on its review of adult day health in its 2019 Annual Report. As stated therein, billing for multiple days on a single claim appears to be permissible, but the practice impedes oversight because it can be difficult or impossible to determine the specific dates the services were provided. Without the dates of service, for example, it is more difficult to verify that the member received the services. It is also more difficult to identify when members receive overlapping services.

In response to the Office's recommendation that providers bill only a single day at a time, MassHealth intends to review billing practices across programs with the goal of implementing additional rules.

2. MassHealth paid $664,165 in adult foster care claims that overlapped with claims for home health aide services.

As discussed above, MassHealth prohibits payment for adult foster care on days when the member receives home health aide services provided by a home health agency.[8] Nevertheless, the Office

[7] Claims editing is a step in MassHealth's automated payment system that verifies coding information to determine whether MassHealth should pay a claim.

[8] 130 CMR 408.437(B).

found that between May 1, 2018, and April 30, 2019, MassHealth paid $664,165 in claims for adult foster care on dates when the member also received home health aide services.[9]

The Office shared its findings and examples of these overlapping claims with MassHealth. In response, MassHealth worked with its third-party administrator Optum, to develop algorithms to identify overlapping claims for adult foster care and home health aide services. Specifically, MassHealth and Optum developed and ran an algorithm for calendar years 2018 and 2020. Each algorithm identified adult foster care services that overlapped with home health aide services. MassHealth reported that the 2018 algorithm identified approximately $70,000 in overpayments across adult foster care providers. MassHealth issued notices of overpayment to providers for these claims. MassHealth has recovered $47,906.54 to date; the remainder has not been recovered due to pending hearings.

Further, applying the 2020 algorithm, MassHealth identified approximately $250,000 in overlapping claims across adult foster care providers. MassHealth reported that the increase in overpayments likely is due to two main factors: (1) the expanded timeframe of the review; and (2) expanded parameters for determining overlap, such as identifying both the beginning and end dates of claims for adult foster care that included multiple dates of service. Due to the COVID-19 pandemic, certain notices of overpayment were delayed, including those related to the 2020 algorithm. MassHealth is in the process of developing notices of overpayment and plans to issue notices for the overlapping claims it identified using the 2020 algorithm.

3. MCOs and ACOs also paid for overlapping services.

Some MassHealth members belong to managed care organizations (MCOs) and accountable care organizations (ACOs). MCOs provide care through their own provider networks and ACOs are groups of doctors, hospitals or other providers that coordinate care for members. MassHealth does not pay MCOs or ACOs on a fee-for-service basis, as it does for other providers. Instead, MassHealth pays a flat "capitation fee" to the MCO or ACO for each MassHealth member enrolled in the MCO or ACO.

Nevertheless, it is important that MCOs and ACOs identify and reject claims for overlapping services. For example, MCOs and ACOs report to MassHealth each service – such as an office visit or adult foster care service – that they provide to members. This information, referred to as encounter data, is used to set future capitation rates that MassHealth pays to MCOs and ACOs.

During the review period, the Office identified $169,452 that MCOs and ACOs paid for adult foster services that overlapped with home health aide services. MassHealth reported that the algorithms it developed will not identify overlapping services provided by MCOs and ACOs. MassHealth reported that,

[9] MassHealth paid $514,268 for these home health aide services.

as a result, it will share the overlapping claims the Office identified with the managed care entities so they can conduct their own program integrity reviews.

MassHealth also reported that its contracts with MCOs and ACOs require those organizations to implement program integrity measures. These measures include maintaining policies and procedures for provider recoupment; developing and implementing methods for prevention and detection of fraud, waste and abuse; and sharing data with MassHealth that is necessary for program integrity, program oversight and administration of the program.

4. MCOs and ACOs paid for claims in which the number of units billed exceeded the number of days that the member received services.

MassHealth pays for adult foster care services in units of a single day. That is, a single "unit" on a claim is equal to a single day. Consequently, when a provider bills for adult foster care, the number of units billed should equal the number of days the member received adult foster care services. The Office reviewed all claims MCOs and ACOs paid for adult foster care between May 1, 2018, and April 30, 2019. During its review, the Office observed three anomalies related to the number of units on claims.

First, the Office found 7,191 claims in which the number of units exceeded the number of days that the member received services. As discussed above, because MassHealth pays a per diem rate, it is not possible to provide two units of service in a single day. MCOs and ACOs rejected 234 of the claims and adjusted 5,025 others, paying for the correct number of days. For example, a provider billed $95.48 for two units on a single day of service but the managed care organization paid $47.74, the correct amount for a single day of service. In 1,932 claims, however, MCOs and ACOs paid an amount other than the rate for a single unit.

Of the 7,191 claims, 5,168 (74%) were for a single day of service.[10] That is, the provider billed for two units when it only provided one day of service. The Office found that for 621 (23%) of these claims, MCOs and ACOs incorrectly paid for two units. MCOs and ACOs paid $96,359 over the one-year study period for these claims, or $48,179 in overpayment. The Office found that a single provider billed 364 (59%) of these claims.

A second type of error occurred when a provider submitted a claim for 30 or 31 units, but the claim listed a single day of service. This error occurred in 604 (8%) of the claims. For 99% of these claims, MCOs and ACOs paid for a month of service. This issue may be due to a billing error in which providers intended to bill for an entire month of services but listed a single day on the claim by mistake. Nevertheless, MassHealth should consider whether it is appropriate to pay such claims or whether it should require the provider to resubmit a claim that reflects the correct dates of service. Among other

[10] In the remaining instances, the claim was for multiple days of service.

reasons, requiring a bill with the correct dates of service would prevent a provider from submitting a second bill for the same dates of service.

Finally, the Office identified 2,435 claims in which the number of units was zero. MCOs and ACOs paid only three of those claims, indicating that they correctly identified and denied payment for those claims.

C. Recommendations

The Office recommends that MassHealth consider requiring providers to bill adult foster care a single day at a time. This would enable MassHealth to strengthen its program integrity activities, including by better identifying when members are in adult foster care and not receiving another service. MassHealth should implement this requirement across all similar programs.

The Office also recommends that MassHealth implement changes to its claims adjudication system to prevent paying claims for adult foster care and home health aide services that have the same date of service, as reimbursement for adult foster care on those days is a direct violation of MassHealth's regulations. MassHealth should apply this change to all providers, as well as to MCOs and ACOs. MassHealth should also identify any other services that may overlap with adult foster care and ensure that its claims adjudication system flags any overlap.

To ensure it pays claims appropriately, MassHealth should continue to monitor claims in which the number of units exceeds the number of days. Furthermore, MassHealth should examine disallowing the MCOs' and ACOs' practice of paying for a full month of adult foster services when a provider submits a claim for 30 or 31 units but lists a single day of service.

II. Sleep Studies

A. Overview

MassHealth pays for members to undergo sleep studies to diagnose sleep disorders, including obstructive sleep apnea. Obstructive sleep apnea occurs when breathing stops temporarily during sleep due to narrowed or constricted airways.

There are four types of sleep studies used to diagnose obstructive sleep apnea. The most comprehensive test, Type I, is attended by a technologist who supervises the test and can intervene if needed.[11] A Type I sleep test can be performed in several types of facilities, including a doctor's office,

[11] CTRS. FOR MEDICARE & MEDICAID SERVS., SLEEP TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA), TRANSMITTAL NO. R103NCD (2009), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R103NCD.pdf.

independent clinic or outpatient hospital. Types II, III and IV measure fewer parameters and can be conducted in attended or unattended settings, including at the member's home.

Moreover, sleep studies have two components: a technical component and a professional component. The technical component refers to the equipment, supplies and personnel required to conduct the sleep study. The professional component is the supervision and interpretation of the sleep study by a physician or other healthcare professional.

Finally, providers can bill the two components together, as a global service, or separately. To bill for the technical component only, a provider adds the modifier "TC" to the procedure code on the claim. A provider adds the modifier "26" to the procedure code to bill for only the professional component. If the procedure code does not include a modifier, it is a global service and includes both the professional and technical components.

B. The Office's Review of Claims for Sleep Studies

The Office reviewed the claims for 57,987 sleep studies conducted during calendar years 2015 through 2019.[12] Overall, the Office found that MassHealth manages the program well; the Office found no significant instances of fraud, waste or abuse. The Office did identify one area that would benefit from greater oversight.

The Office identified 1,286 claims for a technical component without a clear corresponding professional component.[13] In other words, a member completed a sleep study, but no provider interpreted it. MassHealth requires a provider to interpret the sleep study in order to diagnose and treat the member. Over the study period, MassHealth paid $557,103 for technical components of sleep studies that did not have corresponding professional components. Two providers accounted for 548, or 50%, of these claims. The Office will forward information about these providers to MassHealth.

Billing for the technical component without the professional component is a red flag for fraud, waste and abuse. Since the technical component is medically useless without professional interpretation, billing for only half the procedure presents three possibilities: providers are wasting taxpayer money by performing the technical component unnecessarily; providers are defrauding MassHealth by billing for sleep studies they did not perform; providers are performing full sleep studies but failing to bill MassHealth for the professional component.

[12] The Office reviewed all paid claims for sleep studies that fell within nine procedure codes. The Office did not review two procedure codes for other types of sleep tests.

[13] The 1,286 claims were for 1,223 members.

C. Recommendations

The Office recommends that MassHealth compare technical components of sleep studies with professional components to ensure that providers are interpreting members' sleep studies, as well as to identify potential fraud or waste.

III. Positive Airway Pressure Devices

A. Overview

Providers use positive airway pressure (PAP) devices to treat sleep disorders, including obstructive sleep apnea. "PAP device" is a general term that health professionals apply to all sleep apnea treatment machines that provide an individual with a stream of compressed air that supports their airway while they sleep. A provider can bill MassHealth for PAP device rentals for a maximum of 13 months. After that, the member owns the device. Before beginning PAP therapy, a member must have a confirmed diagnosis of obstructive sleep apnea or another sleep disorder. A sleep study must confirm the diagnosis.

B. The Office's Review of Claims for Positive Airway Pressure Devices

The Office reviewed all fee-for-service claims for PAP devices for calendar years 2015 through 2019.[14] The Office also reviewed claims from 2014 for office visits and sleep studies that led to the rental of a PAP device. In conducting its review, the Office referred to guidelines from the Academy of Sleep Medicine and the Centers for Medicare and Medicaid Services, the federal agency that administers the federal Medicaid program. The Office also referred to *The Local Coverage Determination: Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea*.[15]

Overall, MassHealth has implemented strong controls in the areas of the program that the Office reviewed. The Office did identify some opportunities for MassHealth to further protect the program from fraud, waste and abuse.

[14] Because the Office reviewed fee-for-service claims, the review did not include claims related to MCOs and ACOs.

[15] *See Coding FAQs*, AM. ACAD. OF SLEEP MED., *available at* https://aasm.org/clinical-resources/coding-reimbursement/coding-faq/ (last visited Feb. 19, 2021); *Sleep Medicine Codes*, AM. ACAD. OF SLEEP MED., *available at* https://aasm.org/clinical-resources/coding-reimbursement/sleep-medicine-codes/ (last visited Feb. 19, 2021); and STEVE PHURROUGH, ET. AL., CTR. FOR MEDICARE & MEDICAID SERVS., CAG-00405N, COVERAGE DECISION MEMORANDUM FOR SLEEP TESTING FOR OBSTRUCTIVE SLEEP APNEA (OSA) (2009), *available at* https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=227&ver=11&NcaName=Sleep+Testing+for+Obstructive+Sleep+Apnea+(OSA)&CoverageSelection=National&KeyWord=sleep+testing&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAEAAA& (last visited Feb. 19, 2021).

1. MassHealth paid a small number of duplicate claims for PAP device rentals.

The Office identified 1,131 claims for PAP device rentals, for which MassHealth paid $17,274, that are duplicates; they are for the same member and date of service. In other words, MassHealth paid twice for the same rental. The Office noted several types of duplicate billing. First, the Office observed that when a provider billed a procedure code more than once on the same day for the same member but used different modifiers, MassHealth paid both claims. Second, when a provider billed a procedure code more than once on the same day for the same member but had a single date on one claim and a date range on another claim, MassHealth paid both claims. Third, the Office identified some cases in which a provider billed the same procedure code and modifier from two different locations and MassHealth paid both claims. In some cases, a combination of these duplicates existed.

Table 1. Types of Duplicate PAP Rental Claims

Duplicate Type	Modifier	Modifier/Date of Service	Provider Location	Modifier/Provider Location
Number of claims	580	487	62	2
Percent of claims	52%	43%	5%	<1%

Of the three types of duplicate billing the Office identified, different modifiers on the same day resulted in the most duplicates, followed by the combination of different modifiers and different dates of service. Although providers billing from two different locations on the same day occurred less frequently, these cases may be the most indicative of fraud, as a provider should know for what location it is billing.

MassHealth informed the Office that it uses edits in its claim adjudication system to deny duplicate claims. Claims editing is a step in the payment processing system that verifies coding information to determine if an entity, in this case MassHealth, should pay a claim. If there is no third-party coverage, MassHealth will manually review claims that appear to be duplicates, but that are not exact duplicates. MassHealth will initially pay these claims, but if MassHealth discovers the claims are duplicate after a manual review, it voids one of the two payments.

2. MassHealth paid a small number of claims for rentals that exceeded 13 consecutive months.

As discussed above, MassHealth allows providers to bill PAP rentals for a maximum of 13 months; after 13 months, the member owns the PAP equipment. The Office looked at codes for three types of PAP equipment (E0601, E0470 and E0471) that providers may only bill for 13 months. During the study period, the Office only identified 76 instances in which MassHealth paid for a PAP rental longer than 13 consecutive months.

MassHealth reports that it uses claims edits to ensure that it is not paying rental claims beyond the number of months allowed. Specifically, MassHealth requires providers to use a special billing code

and modifier on claims for equipment rentals. MassHealth's claims adjudication system is able to link that special billing combination to the number of months that a provider can bill, which helps prevent providers from billing for longer than is permissible.

3. Providers billed claims for some accessories at a greater frequency than allowed.

Some PAP machine parts require periodic replacement. However, MassHealth limits replacement frequency, as outlined in Table 2.[16]

Table 2. Replacement Frequency for PAP Accessories

Procedure Code	Description	Quantity	Replacement Frequency
A7027	Combination oral/nasal mask, used with continuous positive airway pressure device	1	3 Months
A7030	Full face mask used with positive airway pressure device	1	3 Months
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap	1	3 Months
A7035	Headgear used with positive airway pressure device	1	6 Months
A7036	Chinstrap used with positive airway pressure device	1	6 Months
A7037	Tubing used with positive airway pressure device	1	3 Months
A7039	Filter, non-disposable, used with positive airway pressure device	1	6 Months
A7045	Exhalation port with or without swivel used with accessories for positive airway devices, replacement only	1	12 Months

The Office reviewed claims for the PAP device parts listed in the chart. The Office identified 6,795 claims in which the provider billed sooner than the allowed frequency. The cost of these claims was relatively low, totaling $74,689, and they involved 2,036 members. Claims and costs related to early replacement parts appear to be trending upward, however. See Charts 1 and 2 below. Paying providers for replacing accessories sooner than allowed is both contrary to MassHealth regulations and a waste of taxpayer dollars.

The Office also found specific providers that appeared to bill MassHealth for replacement PAP machine parts significantly more often than others. One provider billed both a high number of dollars and a high number of claims. This provider accounted for 48% of these claims during the study period and 40% of the amount paid. In fact, 13% of this provider's records for accessories were for items that it reordered sooner than the time restriction. These are red flags, suggesting that the provider may be engaging in fraudulent activity or that it may not understand the rules.

[16] MassHealth, *MassHealth Payment and Coverage Guideline Tools*, *MassHealth Billing and Claims*, MASS.GOV, *available at* https://www.mass.gov/info-details/masshealth-payment-and-coverage-guideline-tools (last visited Feb. 19, 2021).

Chart 1. Accessory Claims Billed Sooner than Allowed – Number of Claims

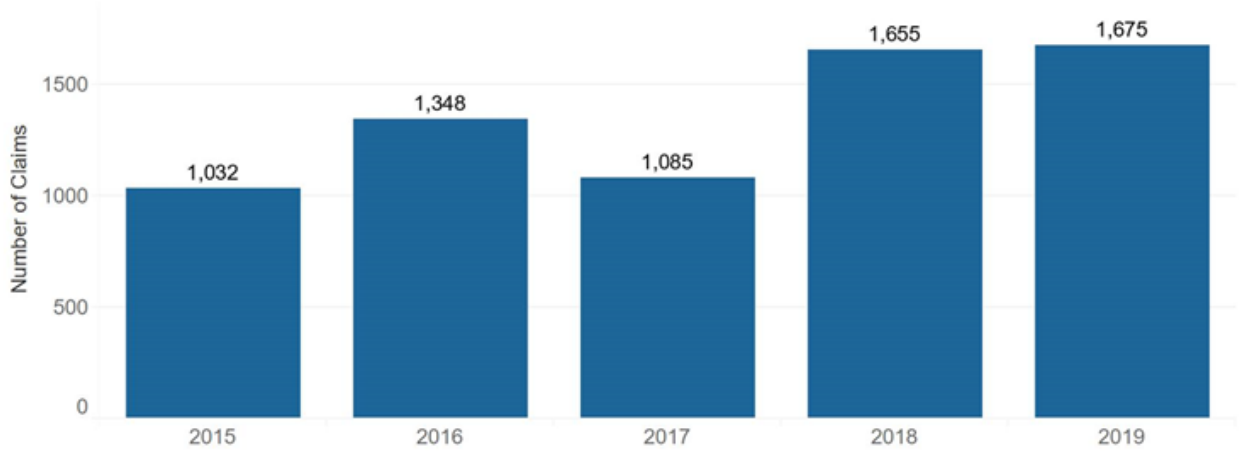
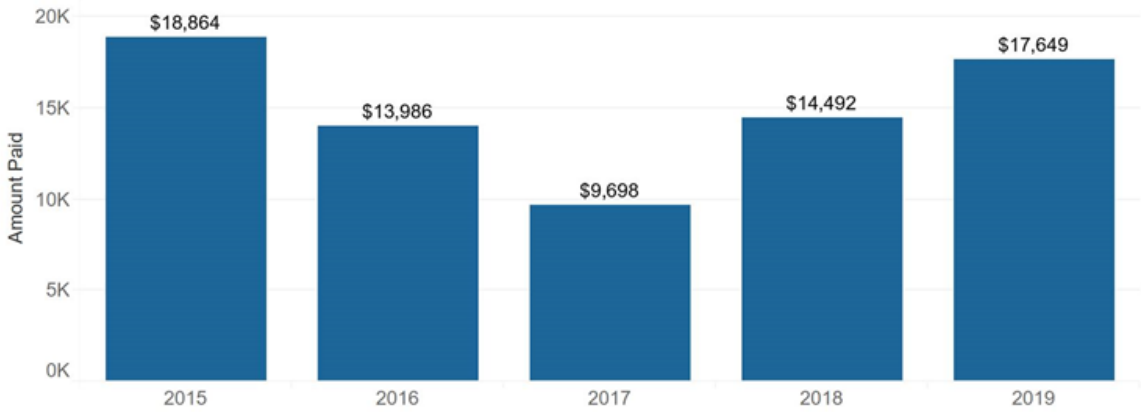


Chart 2. Accessory Claims Billed Sooner than Allowed – Amount Paid



C. Recommendations

Based on the areas that the Office reviewed, MassHealth has strong program integrity processes for its sleep medicine program, including its claims edits and manual reviews of potential duplicate claims. The Office recommends MassHealth evaluate its claims edits periodically to ensure that it continues to identify and deny duplicate claims. While the Office did not find widespread duplicate claims, MassHealth should, at a set interval, audit its PAP claims to identify duplicates and recoup any overpayments. MassHealth could also examine other programs to identify similar patterns of duplicate billing, such as billing for the same procedure for the same member but with a different location code.

The Office also recommends that MassHealth review its claims for all durable medical equipment that can be reordered on a periodic basis to identify providers that are billing more frequently than the period allowed. MassHealth should consider implementing edits to restrict how often providers can bill for durable medical equipment. The Office will share the name of the provider who accounted for 48% of this billing with MassHealth so that it can review the provider's billing and recoup any overpayments.

IV. Update on MassHealth's PCA Program

MassHealth manages a personal care attendant (PCA) program, which is designed to help MassHealth members with permanent or chronic disabilities maintain their independence, reside in the community and manage their own personal care. MassHealth contracts with two kinds of vendors to manage the PCA program: personal care management agencies and fiscal intermediaries (FIs). The personal care management agencies evaluate members who are eligible for PCA services to determine whether they can participate in the program. They also explain the rules to the members, evaluate the members' needs, submit documentation to MassHealth, and generally help members manage their participation in the PCA program.

The FIs help the members with processing timesheets, preparing the PCAs' paychecks and direct deposits, sending the paychecks to the members to give to the PCAs, and filing and paying the members' share of state and federal taxes. The FIs also provide workers' compensation insurance for the PCAs and issue the PCAs' W-2 forms. MassHealth currently has contracts with three FIs.

Last year, the Office reported on its review of MassHealth's PCA program. The Office provides the following update.

A. Overview from the 2020 Annual Report

In the 2020 Annual Report, the Office reported on three aspects of MassHealth's PCA program and provided MassHealth with recommendations to improve its program integrity in each part of the program that the Office examined.

First, the Office found that MassHealth did not know the identities of the PCAs who provide services to its members. The agency did not require the FIs to include the PCAs' names on claims for services or to provide the names in any other fashion. Without information regarding the PCAs' identities, MassHealth could not conduct adequate program integrity for the PCA program. Although MassHealth's contracts require the FIs to conduct program integrity, the Office found that MassHealth was unable to audit the FIs' work or provide meaningful oversight of the FIs' efforts.

For example, MassHealth could not identify providers who may be submitting improper or false bills. Nor could MassHealth verify if a PCA was a family member of the person for whom they were caring, which would violate MassHealth's regulations. Similarly, MassHealth was unable to determine whether a

PCA was working more than 50 hours per week, which also would violate MassHealth's regulations. In short, without the PCA names, MassHealth could not conduct program integrity efforts or verify if the PCA program was working within its regulatory framework. The Office therefore recommended that MassHealth require the FIs to include the identities of the PCAs on the claims for services. This would provide MassHealth with the PCA names and the corresponding names of the MassHealth member(s) for whom they provide PCA services.

Second, the Office reviewed de-identified criminal offender record information (CORI) and sex offender registry information (SORI) for the people working as PCAs during the first quarter of calendar year 2018 and the third quarter of calendar year 2019. Both sets of background checks revealed that a substantial number of PCAs have had involvement in the criminal justice system, including for violent crimes and financial crimes. Currently, MassHealth does not conduct – or require others to conduct – background checks on PCAs. Instead, the personal care management agencies are responsible for informing members about tools available to promote PCA services that are safe, including CORI and SORI checks. MassHealth does not provide any additional support or education to MassHealth members around background checks and does not follow-up to see if members are conducting background checks.

The background check process can be complex and it is important for employers to understand their obligations when using them in hiring decisions. In the case of CORI, for example, if an employer wants to ask an applicant about criminal record information, it must first provide the applicant with a copy of the CORI. And if the employer plans to deny an application based on criminal record information, it must first provide the applicant the opportunity to dispute the accuracy of the record and give the applicant a publication explaining how to correct a criminal record.

Though not applicable to MassHealth providers, the EOHHS CORI regulations demonstrate the complexity of the decision-making EOHHS requires a hiring authority to engage in before deciding whether to hire someone with a criminal history.[17] Specifically, if a hiring authority receives a CORI check that results in a finding of criminal records, it must evaluate any criminal convictions using a series of factors. Those factors include two lengthy tables that list a variety of criminal offenses. One table (referred to as Table A) lists those criminal offenses that EOHHS considers to be more serious offenses (*e.g.*, murder, rape, assault and battery on an elderly person or a person with a disability) and the second table (referred to as Table B) lists those that EOHHS has apparently determined to be less serious offenses (*e.g.*, assault, breaking and entering, drug offenses).

The regulations provide that the hiring authority may not consider a person's criminal background as part of its hiring decision if the CORI reveals one of two results: (1) a conviction of a felony listed on Table B that is more than ten years old; or (2) a misdemeanor listed on Table B that is more than five years old, as long as the individual has no subsequent convictions or pending criminal cases. However, if the

[17] MassHealth requires certain providers to obtain CORI for people who work with its members.

CORI reveals a pending warrant for any type of offense, the hiring authority may not hire the person unless the warrant is removed.

The Office recognizes that the PCA program is unique among MassHealth programs because it is a self-determination program, allowing members to select and oversee their PCAs. However, the lack of a background check is inconsistent with EOHHS regulations that require a CORI check for its employees, or employees of its constituent agencies or vendors, who will have unsupervised contact with EOHHS clients. It is also inconsistent with MassHealth's requirement that other programs conduct CORI checks on employees, contractors and subcontractors before having potentially unsupervised contact with MassHealth members. It is also inconsistent with a state law requiring CORI checks by agencies that supply or refer personal care attendants to people with disabilities and the elderly.

The Office therefore recommended that MassHealth create and lead a workgroup to revisit the PCA program's approach to background checks. Topics for discussion might include:

- Whether to require background checks for prospective or current PCAs;
- Who should conduct background checks;
- How to address liability concerns;
- How to conduct background checks reliably and in a way that MassHealth can track;
- What kind of background checks to conduct;
- Whether to repeat background checks periodically;
- Whether MassHealth members may opt out of background checks for their PCAs;
- How to balance respect for the boundaries of a self-determination program with the need for accountability;
- How to help MassHealth members to make a supported, informed choice when hiring a PCA;
- What role the PCA Council should have in the background check process, if any, and its obligations under Section 172C;
- How to educate MassHealth vendors, the PCA Council, fiscal intermediaries, personal care management agencies, and MassHealth members about CORI and SORI; and
- How to conform the PCA program's practices with the laws and regulations that govern CORI and SORI.

Finally, the Office reviewed travel claims, which are claims for PCAs to travel from one member's home to another member's home. The Office found inconsistencies and errors in data entry that affected the accuracy of the travel claims. For instance, MassHealth's data warehouse had incorrect zip codes and

outdated addresses for some members. Because MassHealth calculates travel claims using the distance between members' residences, the members' addresses need to be accurate and up to date.

The Office further noted that each of the three entities responsible for reviewing and approving travel claims – the FIs; MassHealth; and MassHealth's travel claim vendor, Annkissam – had different sets of information relating to travel claims. No one entity had all of the relevant information necessary to evaluate and conduct program integrity on travel claims.

The Office also observed that MassHealth was reimbursing PCAs for traveling significant distances to care for members, which raised concerns about good business practices and program integrity. First, the Office questioned whether it is fiscally sound to have no limits whatsoever on the distance for which it will reimburse PCAs' travel. Second, traveling long distances is a potential red flag for MassHealth to consider as it conducts its review of PCA claims.

In response to the Office's findings, MassHealth and Annkissam began taking steps to identify inaccurate travel claims and to recoup improperly paid claims. MassHealth also indicated that it would conduct an audit of PCA claims using all of the available data so that it could evaluate travel claim processing. The audit indicated that in certain circumstances PCAs are traveling long distances to provide services. Currently, MassHealth does not have any limitations in its regulations regarding the distance that a PCA may travel to provide services. MassHealth intends to revisit this issue post-pandemic to evaluate whether to implement reasonable limits on PCA travel time.

Finally, MassHealth began planning to comply with the Electronic Visit Verification requirement.[18] As the Office reported in last year's report:

> [As] part of its implementation of the Electronic Visit Verification, the PCA program has delegated to the FIs the responsibility of setting up an electronic verification system. This system will allow PCAs and MassHealth members to electronically process the PCAs' time more quickly and accurately. The system would have a PCA use a smartphone (or other electronic device) to log in a start and end time for each shift. That time, along with the location coordinates, would be electronically transmitted for processing of both the PCA service and travel claims. This type of electronic verification system would address many of the problems stemming from the submission of incorrect information; it also would expedite the transmission of the PCAs' work to the FIs.
>
> One of the FIs has contracted with a vendor to build an electronic verification system. The fiscal intermediary anticipates beginning a pilot of this system during the first half of 2020.

[18] Electronic Visit Verification is a federal requirement for Medicaid-funded personal care and home health service.

B. 2021 Update

1. PCA claims.

MassHealth now requires FIs to provide it with PCA data, including each PCA's full name, unique identification number, address, other identifying information, and the relationship between the PCA and the member. As noted in last year's report, this information will greatly enhance MassHealth's ability to conduct program integrity for the PCA program. As discussed in the next section, a new contract with a single FI for the entire PCA program, instead of three FIs, will begin on January 1, 2022. Under that contract, MassHealth will require that every claim for PCA services include a unique PCA identification number. The Office strongly supports this requirement because it will provide a direct link between the PCA, the claim for payment and the MassHealth member(s) for whom the PCA provides services.

2. New fiscal intermediary contract.

The Office reviewed various procurement documents related to the new FI contract, which will run from January 1, 2022, through December 31, 2025.[19] The procurement was issued on September 22, 2020, and the anticipated award date is April 1, 2021. The two important changes for the new contract are the use of a single FI and the focus on implementing and utilizing the electronic verification system. Using one FI to administer the program should help improve program integrity activities, as well as provide for a streamlined experience for members and PCAs. Under the contract, the FI will be responsible for the implementation and maintenance of the new electronic verification system, as well as user training. Additionally, the FI will be responsible for oversight and monitoring compliance with the electronic verification system.

3. PCA travel claims.

MassHealth reports that it has created an algorithm-based review that allows MassHealth to identify travel claims that may need further review. The algorithm identifies travel time that exceeds the program-wide averages for such claims. It also checks for an active prior authorization for all associated dates of service. Results from the algorithm may lead MassHealth to do a manual review of travel claims history. MassHealth began using the algorithm in January 2021 and has not yet identified any inappropriate claims.

MassHealth further reported that once claims include PCAs' identification numbers, the agency will be able to use the claims data to match PCAs with potentially abnormal travel times. MassHealth can also use this information to target education and training for PCAs and MassHealth members. Additionally, PCAs will have greater accountability for program integrity issues related to travel time.

[19] Bid Solicitation for Fiscal Intermediary Services Contract, COMMBUYS, *available at* https://www.commbuys.com/bso/external/bidDetail.sdo;jsessionid=8F4C8625FD499C8E2CFFF7CE0719A1E9?bidId=BD-21-1039-EHS01-EHS01-54443&parentUrl=activeBids (last visited Feb. 19, 2021).

While MassHealth reported to the Office about the audit results related to PCAs traveling long distances, the Office continues to recommend that MassHealth conduct a full audit of all travel claims. This audit should look for any other red flags of fraud, waste or abuse, including why some PCAs appear to finish one shift and start a second shift simultaneously, even though they are caring for members who live at different addresses. The audit should also examine providers who consistently submit large travel claims and claims for longer-than-average work hours.

Finally, the Office followed up with the FI that had started to build MassHealth's electronic verification system. According to the FI, its electronic verification system schedule shifted in 2020 because it had to focus on its daily operations during the COVID-19 pandemic. The FI did report making progress in developing and testing the system during 2020 and early in 2021. The FI currently is using a pilot group to test the system and provide feedback. The FI expects to increase the number of users in the pilot group over the next few months. It is hoping that during 2021 users will be able to submit live data and receive payment using the system. However, this is dependent on outcomes from the pilot, as well as from listening sessions and discussions with MassHealth.[20]

4. PCA background checks.

MassHealth reported that, while maintaining the self-directed nature of the PCA program, it is committed to further improving members' use and understanding of background checks, including CORI and SORI. Consequently, in response to the Office's recommendations, MassHealth began soliciting feedback from members and stakeholders in 2020. The Office attended two such stakeholder meetings in early 2020. Members and stakeholders reported that CORI and SORI reports are helpful during the hiring process, but many of the members and stakeholders felt that members should retain discretion of whether to conduct a CORI or SORI check.

In response to the Office's report, MassHealth also directed the 18 personal care management agencies that participate in MassHealth's PCA program to survey members, surrogates, parents and legal guardians regarding their use and understanding of CORI and SORI checks. The personal care management agencies began preparing the survey in February 2020, but the COVID-19 pandemic interrupted it. The personal care management agencies reissued the survey in February 2021, with responses anticipated in mid-March. MassHealth informed the Office that it plans to use the results to guide future policy decisions, including finding ways to encourage more members to use CORI and SORI reports when hiring a PCA. The Office supports this goal.

Finally, the Office continues to recommend that any solution MassHealth develops include greater education for members on how to conduct CORI and SORI checks. The background check process is

[20] MassHealth, *Electronic Visit Verification (EVV)*, MASS.GOV, *available at* https://www.mass.gov/info-details/electronic-visit-verification-evv#provider-resources- (last visited Feb. 19, 2021).

complex, and understanding how to request the checks, interpret the results and use the results to make hiring decisions can be complicated.