



OFFICE OF THE INSPECTOR GENERAL
COMMONWEALTH OF MASSACHUSETTS

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**MassHealth and Health Safety Net:
2022 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 2021, the Office reviewed crossover claims involving substitute physicians as well as data integrity in several Medicaid programs. The Office identified measures MassHealth should take to improve its data integrity in each area reviewed. The Office also followed up with MassHealth regarding findings and recommendations from prior reports. The Office found that MassHealth has implemented changes to enhance its program integrity in each of these areas.

Substitute Physicians. The Office reviewed certain claims – known as crossover claims – in which both the Medicare and Medicaid programs cover members, with Medicare acting as the primary payor and MassHealth as the secondary payor. Under the Medicare program, providers may hire substitute physicians to treat the provider's patients when the provider cannot. MassHealth does not allow a similar arrangement.

However, the Office found instances in which a provider billed Medicare for using the services of a substitute physician on the same day they billed MassHealth for providing direct services. This is an indicator of potential fraud or abuse: it could indicate that (1) the substitute physician billed MassHealth using the provider's identification number, which MassHealth does not allow; or (2) the provider and the substitute physician treated patients at the same time, which neither Medicare nor MassHealth permit.

The Office recommends that MassHealth review crossover claims involving substitute physicians to identify providers that also billed MassHealth as the primary payor on the same day. MassHealth should review any such claims to determine whether they are appropriate and recover any money improperly paid to providers.

Data Integrity. The Office examined MassHealth's progress implementing the Office's recommendations to improve the integrity of its data relating to personal care attendants (PCAs), claims paid after a member's date of death, date-span billing, social security numbers and dental claims. The Office found that MassHealth has made improvements in these areas, and that it needs to continue to enhance its data integrity.

Personal Care Attendants. The PCA program helps MassHealth members who have permanent or chronic disabilities to maintain their independence, reside in their communities and manage their own personal care. In 2020, 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 take steps to ensure 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 prohibit a PCA from caring for a family member or from working more than 50 hours a week.

In response to this finding, MassHealth now requires the company that helps administer the PCA program – known as the fiscal intermediary (FI) – to provide MassHealth with identifying information for all PCAs, including each PCA's name. Moreover, under a new contract that began in 2022, MassHealth will require that every claim for PCA services include a unique PCA identification number. MassHealth anticipates that it will begin receiving PCAs' unique identifiers on claims in the spring of 2022.

In 2019, the Office also reviewed PCA travel claims, which are claims for PCAs when they travel from one member's home to another member's home. The Office found that MassHealth had inconsistent and incomplete data, making it impossible for MassHealth to conduct rigorous program integrity reviews. In addition, the Office observed that MassHealth reimbursed PCAs for traveling significant distances to care for members, raising concerns about good business practices.

In response to these 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.¹ However, MassHealth cannot implement this algorithm until PCA claims include the PCAs' unique identification numbers. Additionally, under the new contract, the FI will be responsible for implementing a new electronic verification system that will record and process the PCAs' time, including travel to and from appointments.

The Office continues to recommend that MassHealth conduct a full audit of all PCA travel claims to identify red flags for fraud, waste or abuse. For example, MassHealth should determine 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 that consistently submit large travel claims or claims for longer-than-average work hours. The Office further recommends that MassHealth devote the necessary staff resources to oversee and manage the new FI contract.

Claims Paid After Date of Death. MassHealth's automated claims system contains dates of death for active MassHealth members. As discussed in this report, that data sometimes is inaccurate and can include dates of death for individuals who are alive.

In 2021, the Office reviewed claims that MassHealth paid for services a member received after MassHealth's claims system recorded a date of death for the member. Specifically, the Office identified members who (1) had a date of death in MassHealth's system; and (2) had at least one MassHealth claim

¹ An algorithm is a set of procedures a computer follows to reach a particular goal, such as identifying atypical travel claims (for instance, travel claims for at least 100 miles). MassHealth runs algorithms through its claims system to identify claims that require additional scrutiny.

between January 1, 2017 and December 31, 2020. The Office found 2,698 members with at least one claim paid after their listed date of death, with a total of \$6.4 million paid for 32,702 claims over the four-year span that the Office reviewed.

The Office found that the majority of claims were for members whose dates of death in the claims system were before January 1, 2017, including members with dates of death as far back as 1953. The Office also observed that the number of claims MassHealth paid past the date of death decreased each year from 2017 to 2019. However, the number and cost of claims increased significantly in 2020.

The Office understands that MassHealth receives eligibility data – including dates of death – from external agencies and that it has no direct control over the data it receives from those agencies. Nevertheless, MassHealth needs to identify a solution to (1) remove erroneous dates of death from its claims system; and (2) ensure it is not paying claims for members who are deceased.

Finally, the Office has provided MassHealth with the list of members it identified in its review. MassHealth should review this information, correct any eligibility errors and recover all payments that it should not have made. MassHealth should also refer providers that appear to be engaging in fraudulent billing to the Massachusetts Office of the Attorney General’s Medicaid Fraud Division.

Date-Span Billing. In previous reports on both the Adult Day Health (ADH) and Adult Foster Care (AFC) programs, the Office found that some providers bill MassHealth for multiple days of service on a single claim, a practice known as date-span billing. For example, providers submitted one claim for seven days of services, listing the dates of service as the first day of the month through the last day of the month, without identifying the seven days on which they provided services. While permissible, date-span billing makes oversight difficult because it is impossible to determine the specific dates the provider allegedly provided ADH or AFC services.

For both programs, the Office recommended that MassHealth require providers to bill for services one day at a time and MassHealth has taken steps towards addressing the Office’s concerns. MassHealth informed ADH providers that they could no longer submit claims using date-span billing. MassHealth subsequently updated its billing system to prohibit ADH providers from using date-span billing and it will implement this change in the first quarter of 2022.

MassHealth also informed the Office that it implemented an edit in its billing system in August 2021 to prevent AFC providers from using date-span billing. However, the Office reviewed claims submitted in October 2021 and identified 15,207 claims, or 4.81% of all AFC claims for the month, in which providers billed for multiple days on a single claim.

The Office recommends that MassHealth ensure that the edit intended to prevent date-span billing is working properly. If not, MassHealth needs to fix it. Further, if MassHealth finds that certain

providers persist in date-span billing, it should furnish those providers with additional guidance or training on appropriate billing practices.

Social Security Numbers. In 2016, the Office made several recommendations to MassHealth to improve its program integrity relating to social security numbers (SSN) after finding that the agency's data contained facially suspect SSNs (e.g., 111-11-1111) and multiple members with the same SSN.

In 2021, the Office again reviewed MassHealth's data integrity for SSNs. After reviewing the SSNs of all 2,270,914 active members, the Office found only one SSN that could be considered invalid. MassHealth's system changes to prohibit staff from entering invalid SSNs appear to be working. However, the Office also found 2,179 SSNs linked to more than one MassHealth member's identification number (ID). One individual may have two MassHealth IDs, making it appear that two people have the same SSN. However, MassHealth needs to evaluate and correct the duplicate SSNs, including removing any duplicate IDs.

Dental Claims. Most dentists in the United States use a universal numbering system for teeth, which assigns a specific number or letter to each tooth in the mouth. This is important because dentists can perform some procedures on a tooth a limited number of times. For example, a tooth can only be extracted once. In 2019, the Office reviewed certain aspects of MassHealth's dental program and found that while MassHealth's claims system contained tooth numbers, its data warehouse did not.² To conduct robust program integrity activity, MassHealth needs to ensure that the claims information in its data warehouse includes the tooth numbers associated with all dental claims.

In 2021, the Office found that a field in the data warehouse that is supposed to contain the tooth number sometimes was blank instead. The blanks follow a pattern. When tooth numbers 1 through 9 were entered as "01" through "09" in MassHealth's claims system, the data transferred properly to the data warehouse. However, when tooth numbers were entered as a single digit, i.e., without the "0" before the tooth number, the numbers did not transfer to the data warehouse.

The Office brought this to the attention of MassHealth's data warehouse team, which is currently working on a solution. The Office commends MassHealth for taking steps to fix the communication error between its claims system and the data warehouse. The Office recommends that MassHealth continue its efforts to resolve this issue for single-digit tooth numbers.

Program Integrity.

PCA Program. MassHealth members who receive PCA services are responsible, not MassHealth, for deciding whether to conduct a criminal offender record information (CORI) check or sex offender

² The data warehouse contains MassHealth claims data; MassHealth uses the data warehouse for program integrity data analysis and reporting.

registry information (SORI) check on a prospective PCA. CORI includes information about a person's criminal history; SORI lists the names and addresses of people who have committed certain sex offenses.

Since 2019, the Office has worked with MassHealth to address barriers to using background checks in the hiring of PCAs. The Office continued these efforts in 2021, working with the relevant agencies to make it possible for MassHealth's fiscal intermediary (FI) – which assists members who receive PCA services – to conduct CORI checks at the member's request. Going forward, MassHealth should devote the necessary staff resources to educate stakeholders about the importance of background checks and to support members who want to conduct CORI and SORI checks. MassHealth should continue to ensure that its FI has the necessary access to run CORI checks on behalf of its members. MassHealth should also monitor the FI to make sure that it performs timely background checks when requested by MassHealth members.

Additional Program Updates. The Office followed up on a several other programs this past year as well. In the ADH program, MassHealth updated its regulations to require prior authorization for those services, created a mandatory training for providers, and conducted provider audits. The Office recommends that MassHealth continue to identify, educate and audit providers with high claim denial rates. In the AFC program, MassHealth also now requires prior authorization for these services, conducts provider audits and has implemented algorithms to identify overlapping claims for AFC and home health aide services, which cannot be billed at the same time. The Office recommends MassHealth continue to conduct field audits, run the algorithms and recover overpayments.

The Office also requested an update on positive airway pressure (PAP) devices, which the Office reviewed for its 2021 report. MassHealth instituted a new edit to identify duplicate claims and is working to review claims for durable medical equipment that can only be reordered on a periodic basis. The Office recommends that MassHealth recoup any overpayments it identifies. In its dental program, MassHealth has implemented measures to improve its oversight of its program vendor and is conducting provider audits when MassHealth identifies vendors that bill certain codes inappropriately. The Office recommends that MassHealth continue identifying outlier providers for audit and recover any overpayments discovered during audits.

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 2021, the Legislature enacted Chapter 24 of the Acts of 2021. Section 109 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 2022, 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 house of representatives and the senate and the house and senate committees on ways and means on the results of the audits and any other completed analyses not later than March 1, 2022.

Pursuant to this legislative mandate, this year the Office examined crossover claims involving substitute physicians as well as data integrity in several Medicaid programs. The Office also followed up with the Office of Medicaid (MassHealth) regarding findings and recommendations the Office made in

previous reports concerning personal care attendants, adult day health, adult foster care, positive airway pressure devices and the dental program.³

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”⁴ 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.”⁵ Initially, the Division of Healthcare Finance and Policy managed the HSN program, but, in 2012, the Legislature transferred that responsibility to MassHealth.

³ When referring to the year of a report, the Office uses the fiscal year in which it published the report. The fiscal year begins on July 1 and ends on June 30. For instance, fiscal year 2022 runs from July 1, 2021, to June 30, 2022.

⁴ M.G.L. c. 6A, § 75 (repealed 1988).

⁵ M.G.L. c. 118E, § 66.

I. Substitute Physicians

The Office reviewed Medicare crossover claims and found multiple instances in which a provider billed Medicare for using the services of a substitute physician on the same day they billed MassHealth for providing direct services.⁶ As explained below, this is a red flag for fraud or abuse.

When a MassHealth member is eligible for services under both the Medicare program and the Medicaid program, they are deemed “dual eligible.” The Medicare program acts as the primary payor for such members, and MassHealth functions as the secondary payor. This means that MassHealth pays the portion of the member’s medical services that the Medicare program does not cover. These claims are commonly called “crossover claims.” Because MassHealth is the secondary payor for crossover claims, it follows the Medicare program’s rules for payment.

Under the Medicare program, a provider may retain the services of a substitute physician to treat the provider’s patients when the provider is unavailable, for reasons including illness, vacation or continuing medical education.⁷ The provider may bill and receive payment for work the substitute physician performed as if the provider had performed the services.⁸ When billing Medicare, a provider must use a special code – the “Q6 modifier” – to indicate that a substitute physician provided the services.⁹ The provider is responsible for paying the substitute physician.

Medicare does not allow a provider to use a substitute physician when the regular provider is available. In other words, the provider may not use a substitute physician to treat patients at the same time that the provider is treating patients. A provider may only retain the services of a substitute physician when the provider is unavailable to work.

Because MassHealth follows the Medicare rules when it is the secondary payor, MassHealth will pay for services rendered by a substitute physician on crossover claims. However, MassHealth does not

⁶ Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with end-stage renal disease. U.S. Ctrs. for Medicare & Medicaid Servs., *What’s Medicare?*, available at <https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare> (last visited Feb. 17, 2022).

A claim is a request for payment that a patient or health care provider submits to Medicare or MassHealth. U.S. Ctrs. for Medicare & Medicaid Servs., *Claim*, available at <https://www.healthcare.gov/glossary/claim/> (last visited Feb. 17, 2022).

⁷ U.S. Ctrs. for Medicare & Medicaid Servs., Pub. No. 100-04, Chapter One: General Billing Requirements in Medicare Claims Processing Manual, at § 30.2.11 (2021).

⁸ The substitute physician is not an employee of the provider’s practice but has the status of an independent contractor. A substitute physician cannot provide services to a patient for more than 60 continuous days at a time.

⁹ A medical coding modifier is two characters appended to a code. The modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code. Am. Acad. of Pro. Coders, *What Are Medical Coding Modifiers?*, available at <https://www.aapc.com/modifiers/> (last visited Feb. 17, 2022).

allow providers to use substitute physicians when it is the primary payor. Rather, MassHealth approves each provider individually and a provider must bill MassHealth using their own provider identification number.¹⁰ For this reason, providers do not use the Q6 modifier when they bill MassHealth as the primary payor. Similarly, MassHealth claims do not include any other fields to inform MassHealth that the provider used a substitute physician.

The Office examined crossover claims for calendar years 2017 through 2020 that included the Q6 modifier and compared them to claims that physicians made to MassHealth as the primary payor. The Office found instances in which a provider billed MassHealth as the primary payor on the same day that the provider billed Medicare using the Q6 modifier, indicating that the provider had used a substitute physician.

It could be appropriate for a provider to bill MassHealth directly on the same day that the provider submits claims to Medicare using a substitute physician. For instance, the provider could have treated MassHealth members in the morning while the substitute physician saw Medicare members in the afternoon. However, billing on the same day is also a red flag for two prohibited activities: (1) the substitute physician could have billed MassHealth under the provider's identification number; or (2) the provider and the substitute physician could have been treating patients at the same time.

The Office recommends that MassHealth use information on crossover claims to enhance its program integrity. For instance, if a crossover claim contains a Q6 modifier, MassHealth should check its claims to determine whether the same provider also billed MassHealth as the primary payor that day. MassHealth should review any such claims to ensure they are appropriate and, if MassHealth is the primary payor, it should recover any improper payments. Where MassHealth is the secondary payor, it should work with Medicare to recover any money improperly paid to providers for the work the substitute physicians performed.

II. Data Integrity

As part of its work over the past six years, the Office has identified weaknesses in MassHealth's data integrity in several MassHealth and HSN programs. This year, the Office examined MassHealth's progress implementing the Office's recommendations to improve the integrity of its data in the following areas: personal care attendants (PCAs), claims paid after MassHealth receives a "date of death" for a member, date ranges on claims, social security numbers and dental claims. The Office found that, overall, MassHealth is making improvements in these areas but that it needs to continue to enhance its data integrity.

¹⁰ 130 CMR 450.231(A); 130 CMR 450.301.

A. Personal Care Attendants

1. Overview

MassHealth manages a personal care attendant (PCA) program, which is designed to help MassHealth members who have permanent or chronic disabilities maintain their independence, reside in their communities and manage their own personal care. MassHealth contracts with two kinds of vendors to manage the PCA program: personal care management agencies and a fiscal intermediary (FI). 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 help members manage their participation in the PCA program.

The FI helps members with processing timesheets, preparing PCAs' paychecks and direct deposits, sending paychecks to members to give to PCAs, and filing and paying the members' share of state and federal taxes. The FI also provides workers' compensation insurance for PCAs and issues PCAs' W-2 forms. In 2022, MassHealth began a new contract with one FI instead of the three it had previously contracted with.

2. Unique Identifiers

In its [2020 report](#), the Office found MassHealth did not have accurate information about the identities of the PCAs who provide services to members. Most significantly, the claims that the FIs submitted to MassHealth did not identify PCAs who provided services to MassHealth members. As a result, MassHealth could not conduct adequate program integrity reviews 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. The lack of accurate information also made it more difficult for MassHealth to identify potential fraud, such as instances in which an FI may have submitted claims for services that members did not receive.

In response to this finding, MassHealth began requiring the FIs to provide MassHealth with identifying information for all PCAs – including each PCA's name, unique identification number, address, and the relationship between the PCA and the member. This was a significant step towards improving data integrity. Because of limitations in its claims system, MassHealth could not require the FIs to include the PCA's identity on claims for PCA services.

3. Travel Claims

Also in 2020, the Office reviewed PCA travel claims, which are claims for a PCA's travel from one member's home to another member's home. The Office found that MassHealth had inconsistent and incomplete data, making it impossible for MassHealth or its vendors to conduct rigorous program integrity

reviews. For instance, MassHealth's data warehouse had incorrect zip codes and outdated addresses for some members.¹¹ Because MassHealth calculates travel claims using the distance between members' residences, the members' addresses need to be accurate and up to date. The Office also found that MassHealth reimbursed PCAs for traveling significant distances to care for members, which raised concerns about good business practices and program integrity.

4. 2022 Update

Rather than contracting with multiple FIs, as it previously had, MassHealth recently entered into a new contract with one FI. The contract runs from January 1, 2022, through December 31, 2025, and is significant for several reasons. First, using one FI to administer the program should help improve program integrity activities and provide a streamlined experience for members and PCAs.

Second, in addition to the FI services described above, the FI will be responsible for implementing a new electronic verification system. The new system will allow PCAs and MassHealth members to electronically record and process the PCAs' time, including travel to and from appointments. PCAs will use a smartphone (or other electronic device) to log in the start and end time for each shift. That time, along with the PCA's location coordinates, will be electronically transmitted to the FI, which will use the information to process both the PCA's time and travel claims.

Under the contract, the FI is responsible for implementing and maintaining the system, including training PCAs to use the system and monitoring compliance with it. Because the electronic verification system is new, this is an additional duty for the FI that did not previously exist.

Third, the contract also requires the FI to include each PCA's unique identification number on all PCA claims. The inclusion of the PCAs' unique identification numbers is an important improvement, which will allow MassHealth to conduct more sophisticated data analysis. This data analysis should help identify inappropriate billing for individual PCAs, including travel time. Additionally, MassHealth will be able to identify PCAs impermissibly working for family members, check if PCAs are on the excluded provider list and identify PCAs who work more hours than regulations allow. MassHealth anticipates that it will be able to include PCAs' unique identification numbers on claims by the spring of 2022.

Fourth, the contract includes five performance standards, with three-to-six measures under each standard. Each measure includes specific language that explains how it will be evaluated. The contract also includes financial penalties if the FI fails to meet the performance standards or other contract requirements.

¹¹ The data warehouse contains MassHealth claims data used for data analysis and reporting.

In addition to entering into a new FI contract, MassHealth reported that it created an algorithm to flag travel claims that need further review.¹² The algorithm will identify travel time that exceeds the program-wide averages for such claims. It will also check to make sure that a member was eligible for services on the dates of service. Results from the algorithm may lead MassHealth to conduct a manual review of travel claims history. However, MassHealth has not yet implemented the algorithm because, until PCA claims include the PCAs' unique identification numbers, MassHealth cannot properly validate the results of the algorithm.

5. Recommendations

The Office recommends that MassHealth devote the necessary staff resources to oversee and manage the new FI contract. For example, MassHealth must ensure that the vendor fulfills all its contractual obligations and that it addresses any barriers to full implementation of the contract in a timely manner. It must use the performance measures in the contract to evaluate the vendor's performance and assess financial penalties, if necessary.

In addition, the Office continues to recommend that MassHealth conduct a full audit of all travel claims, looking for any indicators of fraud, waste or abuse. A full audit should, for instance, evaluate instances in which a PCA appeared to finish one shift and start a second shift simultaneously, even though they cared for members who lived at different addresses. The audit should also include a review of consistently high work and travel claims to identify program integrity concerns, such as inflated claims for travel.

B. Claims Paid After Date of Death

1. Overview

When a MassHealth member or HSN user dies, MassHealth is supposed to change their status to "inactive" and MassHealth is not supposed to pay any further claims for that individual. To identify individuals who have passed away, MassHealth regularly conducts a data match with the Social Security Administration (SSA), which maintains a database of all individuals who have a social security number and who have died. The SSA's data is sometimes inaccurate; the data sometimes contains dates of death for individuals who are alive. MassHealth also receives dates of death from other state and federal agencies. As discussed more below, the data from these agencies also contains dates of death for people who are alive.

In 2016, the Office asked MassHealth to provide demographic information about people who were active MassHealth members from July 1, 2015, through October 31, 2015. The data that MassHealth

¹² An algorithm is a set of procedures a computer follows to reach a particular goal, such as identifying atypical travel claims (for instance, travel claims for distances of at least 100 miles). MassHealth runs algorithms through its claims database to identify claims that do not match a set of rules MassHealth has programmed.

provided included dates of death for over 2,600 MassHealth members. According to MassHealth's records, these individuals had died between October 15, 1985, and October 30, 2015.

The Office reviewed the paid claim history for a sample of the people with dates of death before October 31, 2015. The Office found that for the 30 people with the most distant dates of death – between October 15, 1985, and May 30, 2008 – there were over \$5 million in paid claims with dates of service after the date of death contained in MassHealth's records.¹³ Of these 30 people, 23 appeared to have had claims paid after their dates of death. Many of these paid claims had recent dates of service; the two people with dates of death in the 1980s had dates of service as recent as May and December 2015. MassHealth did not pay claims after the dates of death for the other seven members that the Office reviewed.

In a [2016 letter](#) to MassHealth, the Office made five recommendations: (1) MassHealth should review all services provided after a member's date of death and recoup all amounts improperly paid to providers; (2) MassHealth should ensure that its claims adjudication system does not pay claims for services provided after a member's date of death; (3) MassHealth should identify all active members with a date of death in its eligibility system and verify whether those members are alive.¹⁴ If a member is alive, MassHealth should remove the member's date of death. If not, MassHealth should change the member's status from "active" to "inactive"; (4) when MassHealth has verified that a member has died, MassHealth should change the member's status from "active" to "inactive" at the same time it records the member's date of death; and (5) to ensure that its records are accurate, MassHealth should examine alternative or additional sources from which to obtain an individual's date of death.

In its response, MassHealth acknowledged that some members were listed as "active" even though its automated claims adjudication system, the Medicaid Management Information System (MMIS), included their dates of death. MassHealth further recognized that it paid claims for certain members after their MMIS-posted date of death. This is because MassHealth determines whether claims should be paid based on the member's eligibility status, and a member's eligibility status does not automatically become "inactive" when MassHealth receives a date of death.

MassHealth also acknowledged that the date of death in MMIS was erroneous for some of the members the Office identified and that they were not deceased. MassHealth explained that many people who are eligible for other benefits from state or federal agencies are automatically eligible for Medicaid, and that MassHealth receives eligibility data directly from those agencies. MassHealth also receives updated information from these agencies, including dates of death. According to MassHealth, this data –

¹³ For each of these members, the Office reviewed the MassHealth All Services Report by Member. This report contains a complete detailed account of a member's claim history.

¹⁴ A claims adjudication system determines whether a provider's claim falls within the MassHealth program, and if the service is covered, how much to pay the provider.

including erroneous dates of death – automatically uploads into MassHealth’s eligibility system, overriding existing data in the system. When MassHealth identifies an erroneous date of death, it notifies the referring agency. The referring agency must then update this data in its own system and resubmit it to MassHealth. Only then will the MassHealth system include the member’s updated information.

Finally, MassHealth reported that its pre-payment system identifies claims for members who have a date of death listed in SSA’s database. When a match occurs, MassHealth staff investigate the claim to determine if the member is deceased, verifying the death by finding and reviewing the member’s obituary. MassHealth then initiates a recovery for claims paid after the member’s date of death.

2. 2022 Update

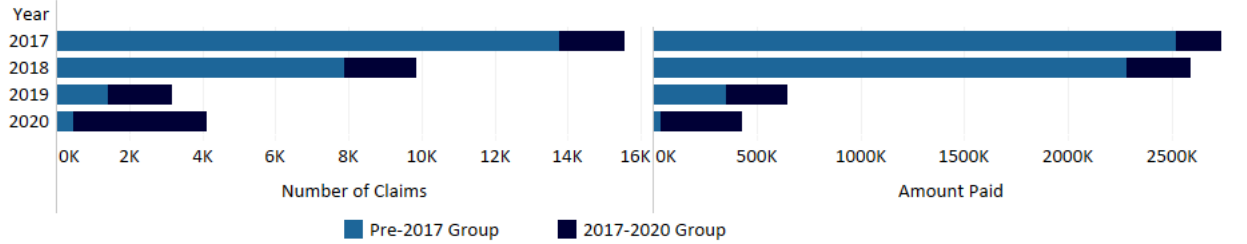
In 2021, the Office used data from MassHealth’s data warehouse to locate records for MassHealth members with a date of death on record and at least one paid claim between January 1, 2017, and December 31, 2020. The Office restricted its analysis to claims paid after a member’s MMIS-posted date of death. The Office found 2,698 members with at least one claim paid after the date of death, with a total of \$6.4 million paid for 32,702 claims over the four-year span. The dates of service ranged from one day to 38 years after the date of death, with 2.9% of claims occurring on the first day after the date of death and 29% occurring during the first year after the date of death.

Figure 1. Summary of Claims

Year	Amount Paid	Number of Members	Number of Claims	Average Claims per Member
2017	2,735,943	740	15,542	21
2018	2,589,890	562	9,859	18
2019	649,514	599	3,162	5
2020	428,946	888	4,139	5
Grand Total	6,404,293	2,698	32,702	12

The Office then divided the 2,698 members into two groups: (1) members whose dates of death were before 2017; and (2) members whose dates of death were listed between 2017 and 2020. There were 104 members in the first group and 2,594 members in the second group. The Office found that the majority of claims came from members in the pre-2017 group. In other words, even though there are only 104 members in the pre-2017 group, these members account for both the highest number and highest dollar amount of claims. In 2018, for example, MassHealth paid 7,873 claims, totaling \$2,280,705, for the 104 members with the oldest dates of death. This is likely due to inaccurate date of death information. For members with a more recent date of death listed, MassHealth is doing an effective job of not paying claims past the date of death.

Figure 2. Claims and Amount Paid for Members by Group



The pre-2017 group includes members with dates of death as far back as 1953. Many of these are likely administrative errors; these members are likely still alive. For the 2017-to-2020 group, MassHealth was improving at limiting the number of claims paid after the date of death until 2020. For example, the number of claims paid past the date of death decreased each year from 2017 to 2019. The Office needs to further examine why the increase in 2020 occurred. It is possible that it may be due to COVID-related factors such as potentially more overall deaths.

3. Recommendations

The Office understands that MassHealth receives eligibility data from external agencies and has no direct control over the data it receives from those agencies. Nevertheless, MassHealth needs to identify a solution to (1) remove erroneous dates of death from MMIS; and (2) change members’ statuses from “active” to “inactive” when they pass away.

Finally, the Office has provided MassHealth with the list of members from both groups above. MassHealth should review the files, correct any eligibility errors and recover any payments that it should not have made. MassHealth should also refer providers that appear to be engaging in fraudulent billing to the Massachusetts Office of the Attorney General’s Medicaid Fraud Division.

C. Date-Span Billing

1. The Adult Day Health Program Allowed Date-Span Billing on Claims

MassHealth provides an Adult Day Health (ADH) program for members with physical, cognitive or behavioral health issues. ADH is a community-based service that provides nursing care, supervision and health-related support services in a structured group setting.

In its [2019 report](#), the Office reviewed MassHealth’s ADH services and made recommendations about ways to improve program integrity. The Office examined claims for approximately 100 providers that served approximately 12,500 MassHealth members during the fourth quarter of 2017. The Office found that some providers billed for multiple days of ADH in a single claim, which MassHealth refers to as “date-span billing.” For example, providers submitted one claim for seven days of adult day health

services, listing dates of service as the first day of the month through the last day of the month, without identifying the seven days on which they provided services.

While permissible, date-span billing makes oversight difficult because it is impossible to determine the specific dates the provider allegedly provided ADH services. Without specific dates of service, it is difficult to conduct program integrity reviews. For example, regulations prohibit MassHealth members from attending an ADH program the same day they receive certain services from a home health agency. Without the actual dates of service on claim, MassHealth cannot determine if a member received overlapping services. Similarly, MassHealth should conduct program integrity reviews to ensure that providers are only billing for services when a member attends the ADH program. When a provider includes a date range, it makes it more difficult for MassHealth to identify if a provider is billing for days a member was not present at the ADH program.

The Office recommended that MassHealth consider requiring providers to bill for ADH services one day at a time.

2. 2022 Update

MassHealth reported that, in early 2020, it informed ADH providers that they could no longer submit claims using date-span billing. MassHealth also updated its billing system to prohibit ADH providers from billing for more than one day of services in a single claim. In the first quarter of 2022, moreover, MassHealth plans to issue a bulletin explaining this system change and communicating the revised billing requirements. MassHealth will provide a copy of the bulletin to the Office. Once this update is implemented, ADH providers will no longer be able to use date-span billing; instead, they will be required to submit an individual claim for each date of service.

3. The Adult Foster Care Program Also Allowed Date-Span Billing on Claims

Adult foster care (AFC) 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.

In [2021](#), 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 use date-span billing. As discussed above, while this practice is permissible, it impedes oversight.

The Office also found (1) 5,168 instances in which a provider submitted two claims for adult foster care for the same member for a single day; and (2) 604 instances in which a provider billed for a month of service – 30 or 31 days – but only listed a single date of service on the claim.

The Office recommended that MassHealth consider requiring providers to bill for adult foster care one day at a time. The Office also advised MassHealth to 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.

4. 2022 Update

MassHealth informed the Office that it implemented an edit in MMIS, effective August 25, 2021, that prevents date-span billing.¹⁵ According to MassHealth, with the implementation of this edit, AFC providers cannot submit one claim for multiple days of service. However, the Office reviewed all 316,414 AFC claims for October 2021 and found that a small number of AFC providers are still using date-span billing. The Office identified 15,207 claims, or 4.81% of all AFC claims for October 2021, in which providers billed for multiple days on a single claim. The edit should not allow this to happen.

In 99.8% of the cases of date-range billing the Office identified, the number of days of service equaled the number of days in the date range. For instance, when a provider billed for seven days of services over a seven-day period, MassHealth paid the claim.

5. Recommendations

Based on the Office's review, AFC providers can still bill for multiple days on a single claim as long as the number of days billed is equal to or less than the number of days in the date range. The Office recommends that MassHealth ensure that the edit implemented in MMIS to prevent date-span billing is working properly. AFC providers should not be able to bill for more than one day on a claim. If MassHealth finds that certain providers are still submitting claims in this manner, it should provide additional guidance or training to those providers.

D. Social Security Numbers

1. Overview

Federal regulations require all persons applying for Medicaid to furnish a social security number (SSN) or proof of application for an SSN, subject to limited exceptions.¹⁶ The regulations further provide that MassHealth must verify each SSN to ensure that the SSN was issued to the applicant and to determine whether any other SSNs were issued to that person. In turn, MassHealth's regulations indicate that it verifies each SSN by an electronic data match with the Social Security Administration (SSA). If the applicant has provided an SSN to MassHealth that the SSA is unable to verify, the applicant has 90 days to provide MassHealth with an approved verification of the SSN.

¹⁵ Claims editing is a step in MassHealth's automated payment system that verifies whether MassHealth should pay a claim.

¹⁶ 42 C.F.R 435.910.

In 2016, MassHealth reported to the Office that it implements these regulations by sending a nightly feed of data to the SSA to validate SSNs. MassHealth stated that it has done this SSN match with the SSA since 1999. After the SSA receives the data from MassHealth, the SSA sends MassHealth a code for each inquiry indicating either that it verified that the SSN belongs to that person, or that it cannot verify the SSN and the reason for non-verification. The SSA will also indicate if, according to the SSA's records, the individual is deceased.

The Office, in 2016, reviewed SSNs in MMIS and in the data that MassHealth provided. The Office found that the SSN verification process may not have been properly verifying SSNs. Specifically, the Office found facially suspect SSNs (*e.g.*, 111-11-1111, 123-45-6789). The Office also found that MassHealth's eligibility system allowed multiple people to have the same SSN. Within a sample of 1.5 million MassHealth members, 2,723 SSNs linked to two or more members (0.18% of the sample).

In 2016, the Office made four recommendations: (1) MassHealth should consult with the SSA to determine whether it is identifying facially suspect SSNs and SSNs that do not belong to applicants for MassHealth; (2) MassHealth should create a list of SSNs that its eligibility system will not accept; (3) MassHealth should create an edit in its eligibility system that prevents anyone from entering an SSN that already exists in the system; and (4) MassHealth should immediately follow up with any applicant who provides a duplicate or facially suspect SSN to determine the cause of the SSN issue, resolve the problem and help to complete the application process.

In response to recommendations (1) and (2), MassHealth corrected the facially suspect SSNs that were in its system. It also reminded staff not to use "dummy" SSNs as placeholders and initiated changes to its eligibility system to prohibit the entry of a facially invalid SSN.

In response to recommendations (3) and (4), MassHealth reviewed the Office's list of 2,723 SSNs that were linked to two or more members. MassHealth linked the correct member with the correct SSN for 772 individuals who had the same SSN as another person. MassHealth also informed the Office that it was possible that some individuals may have more than one profile in the MassHealth system; this would make it appear that two people were using the same SSN when in reality one person had two profiles. As a result, MassHealth reported that it was in the process of reviewing the remaining 1,953 members who appeared to have duplicate SSNs to determine whether they had multiple profiles and, if so, to determine which profiles to keep open.

Furthermore, MassHealth informed the Office that it planned to implement system edits that prevent the entry of duplicate SSNs. Finally, MassHealth planned to run a quarterly report that would identify invalid or unverified SSNs that do not meet the parameters identified by the SSA.

2. 2022 Update

Using data from the data warehouse, the Office located records for MassHealth members who were enrolled between January 1, 2021, and February 9, 2022. This resulted in the identification of 2,270,914 members who were active during this period. The Office then reviewed the SSNs of these members and evaluated their validity, using the following criteria to define an invalid SSN:

- All SSNs that start with 000
- All SSNs that start with 666
- All SSNs that start with 9
- SSN 123456789
- All SSNs comprised of the same number repeating (*e.g.*, 111-11-1111)
- All SSNs that end in 0000
- All SSNs in which the middle two numbers are 00¹⁷

After reviewing the SSNs of all 2,270,914 active members, the Office found only one SSN that could be considered invalid. However, it started with “9,” and SSA resources provide conflicting guidance about the validity of SSNs that begin with a “9.” The Office concluded that the system edits MassHealth implemented appear to be working.

The Office also reviewed duplicate SSNs and found 2,179 SSNs that linked to more than one MassHealth member ID, affecting a total of 4,369 members IDs (0.19% of the sample). The Office will share the specific SSNs and member IDs with MassHealth and recommends that MassHealth review the systems it put in place to eliminate shared SSNs. The Office also recommends that MassHealth conduct a periodic review to identify and fix any duplicate SSNs.

3. Recommendations

Based on the Office’s analysis of 2,270,914 SSNs, MassHealth’s system changes to prohibit entry of invalid SSNs are working. The Office recommends that MassHealth review the systems it put in place to eliminate duplicate SSNs to ensure that the systems are working properly.

¹⁷ The Office used the following three resources to develop this list: Soc. Sec. Admin., *RM 10201.035 Invalid Social Security Number*, available at <https://secure.ssa.gov/poms.nsf/lnx/0110201035> (last visited Feb. 17, 2022); Paulette Staum & Sally Dai, *Identifying Invalid Social Security Numbers*, available at <https://www.lexjansen.com/nesug/nesug07/ap/ap19.pdf> (last visited Feb. 17, 2022); and Soc. Sec. Admin., *Social Security is Changing the Way SSNs are Issued*, available at <https://www.ssa.gov/kc/SSAFactSheet--IssuingSSNs.pdf> (last visited Feb. 17, 2022).

E. Dental Claims

1. Dental Claims Lack Data About Tooth Numbers

The Medicaid and HSN programs pay for dental care for some MassHealth members and HSN users. For its [2019 report](#), the Office reviewed certain aspects of the dental program. Individual dental providers send claims to DentaQuest, MassHealth's dental program vendor. In turn, DentaQuest processes the dental claims and decides whether MassHealth or the HSN should reimburse the provider who performed the dental service. DentaQuest then sends MassHealth files each week containing the claims and its decision regarding which claims MassHealth and the HSN should (and should not) pay. When DentaQuest sends its data file to MassHealth each week, it sends the information to MassHealth's automated claims adjudication system, MMIS. In turn, MMIS sends information each week to MassHealth's data warehouse, where MassHealth can run reports and analyze claim data.

Most dentists in the United States use a universal numbering system, which assigns a specific number or letter to each tooth in the mouth.¹⁸ The Office reviewed paid dental claims that included six procedure codes, all of which should have had a tooth number or letter to indicate which tooth the dentist treated. The majority of these paid claims (20,360 or 75%) included tooth numbers or letters. However, even though MMIS contained tooth numbers or letters for the remaining paid claims (6,449 or 24%), the data warehouse did not. This indicated that there was a problem transferring the data once MassHealth received the adjudicated claims from DentaQuest.

The data warehouse needs the tooth number and letters to conduct robust program integrity reviews. For example, a tooth can only be extracted once; the identification of which tooth the provider billed to extract therefore would allow MassHealth to determine whether a provider billed twice for extracting the same tooth. Similarly, a provider can only bill for one filling per tooth per calendar year. Without having the tooth numbers, MassHealth cannot determine if providers are billing for multiple fillings for the same tooth in a calendar year.

The Office found that MassHealth does require dentists to include the tooth number on claims. Because of a communication error between MMIS and the data warehouse, however, MMIS could not transfer the tooth number to the data warehouse. The Office therefore recommended that MassHealth address the communication issue between MMIS and its data warehouse so that MMIS provides the tooth number when it transmits claims information to the data warehouse.

¹⁸ Baby teeth are assigned letters, while adult teeth are numbered. For instance, tooth number 1 is the adult tooth farthest back on the right side of the mouth in the upper jaw. Numbering continues along the upper teeth toward the front and across to the tooth farthest back on the top left side.

2. 2022 Update

MassHealth reported that it continues to work to ensure that claim information transferred between DentaQuest, MMIS and the data warehouse contains all relevant data, including tooth numbers and letters.

MassHealth has a field in the data warehouse that contains the tooth number or letter that the provider treated. The Office confirmed that this field, referred to as the “Tooth Number Code,” does contain tooth numbers and letters. However, a second field in the data warehouse – referred to as the “Tooth Number Code and Description” – is also supposed to contain the relevant tooth number or letter. The Office found that there were blanks in this field. The Office reviewed this field for paid claims for all four quadrants of the mouth. The upper right quadrant, where teeth numbered 1 to 8 are located, had only 2,474,577 paid claims while the other three quadrants had over six million each.

The blanks seem to follow a pattern. When tooth numbers 1 through 9 were entered as “01” through “09” in MMIS, the data transferred properly to the data warehouse. However, when tooth numbers were entered as a single digit, *i.e.*, without the “0” before the tooth number, the numbers did not transfer to the data warehouse.

The Office has contacted MassHealth’s data warehouse team regarding this communication error. The data warehouse team reported that it would develop a solution for the “Tooth Number Code and Description” field.

3. Recommendations

The Office commends MassHealth for taking steps to fix the communication error between MMIS and the data warehouse. The Office recommends that MassHealth continue its efforts and address the communication gap involving tooth numbers that are entered as single digits. In the meantime, MassHealth should not use the “Tooth Number Code and Description” field for program integrity activities.

III. Updates on Prior Recommendations

A. Personal Care Attendant and Background Checks

1. Overview

As mentioned earlier, 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. Under the PCA program, the member who receives the PCA services is the PCA’s employer. As such, MassHealth has determined that the member, not MassHealth, is responsible for deciding whether to conduct a criminal offender record information (CORI) check or sex offender registry information (SORI) check on a prospective PCA.

CORI includes information about a person's criminal history; SORI indicates the names and addresses of people who have committed certain sex offenses.

As discussed in Section II, MassHealth utilizes personal care management agencies to evaluate members for PCA services and support members participating in the PCA program. As part of their responsibilities, personal care management agencies are required to inform members about resources they can use when they hire a PCA, including the use of CORI and SORI checks. The personal care management agencies also are required to provide members with a form to request a CORI report.

For its 2020 report, the Office reviewed de-identified CORI and SORI for 47,735 people who worked as PCAs during the first quarter of 2018. The Office found that a significant number of PCAs had previous involvement with the criminal justice system. For example, 23,557 PCAs, or almost 50% of those working during the first quarter of 2018, had CORI records. Focusing on CORI records for the period of 2010 through 2019, the Office found 11,809 PCAs with a total of 57,979 criminal charges or convictions (24% of all PCAs). Specifically, 2,556 PCAs had at least one conviction, 1,069 PCAs had at least one term of incarceration and 2,066 PCAs had at least one pending charge. The SORI check revealed 122 PCAs who were sex offenders with an obligation to register with the Sex Offender Registry Board; 13 PCAs were Level 1 offenders, 68 were Level 2 offenders and 41 were Level 3 offenders.¹⁹

The Office recognized that the PCA program is unique among MassHealth programs because it is a self-determination program, allowing members to select and oversee their PCAs. The member is the PCA's employer, with the responsibilities of hiring, training, disciplining and firing. Consistent with this approach, MassHealth gives the member receiving the services the option to conduct a CORI or SORI check.

However, this structure means that members receive no support from MassHealth on how to read or interpret CORI or SORI results even though these results often include terms of art and abbreviations that people without training or a criminal justice background have difficulty deciphering. Members also receive no support on how to use the CORI and SORI results in their decision-making process. Further, MassHealth has no formal follow-up process to determine if a member has conducted any kind of background check, nor does MassHealth track or monitor how many members conduct background checks, or document if a member chooses not to conduct a background check. Finally, not requiring or tracking background checks for PCAs who, by definition, have unsupervised contact with MassHealth members is inconsistent with the policies behind the Executive Office of Health and Human Services' CORI regulations, MassHealth's regulation of other programs and state law.²⁰

¹⁹ The Sex Offender Registry Board classifies offenders to be a Level 1 (low risk), Level 2 (moderate risk) or Level 3 (high risk). The level speaks to the degree of danger and risk to reoffend.

²⁰ For example, MassHealth regulations require certain providers to obtain CORI for people who work with its members. 130 CMR 404.413(D)(3)(b); 130 CMR 407.405(B); 130 CMR 408.434(A)(2); 130 CMR 409.404(C)(10); 130 CMR 419.421(A)(1)(b); 130 CMR

Given both the importance and complexity of conducting CORI and SORI checks, in 2020, the Office recommended that MassHealth create and lead a workgroup to revisit the PCA program's approach to background checks.

In 2021, MassHealth committed to further improving members' use and understanding of background checks, including CORI and SORI reports, while maintaining the self-directed nature of the PCA program. For example, in response to the Office's recommendations, MassHealth began soliciting feedback from members and stakeholders to better understand the barriers to conducting background checks and to explore ways to address those barriers. The Office attended several meetings with PCA program staff and MassHealth members who employ PCAs. Members and stakeholders reported that CORI and SORI reports are helpful during the hiring process, but many also felt that members should retain discretion regarding whether to conduct a CORI or SORI check.

In 2021, 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 survey was conducted from February 1, 2021, through March 15, 2021. MassHealth received 2,033 responses to the six-question survey.²¹ The results indicated that members are aware of the CORI and SORI processes. For example, 76.3% responded that they were familiar with CORI and SORI checks, and 57.5% responded that they knew how to conduct a CORI or SORI check. However, only 14.2% responded that they had conducted at least one check and only 13.9% responded that they had used the results of a background check to make a hiring decision. Additionally, 41.3% responded that they understood how to read or interpret the results of a background check.

MassHealth informed the Office that it planned 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 supported this goal and continued to recommend that MassHealth provide more education to members about how to conduct CORI and SORI checks when hiring PCAs.

2. 2022 Update

In the fall of 2021, the Office convened two meetings. The first meeting included PCA program staff and representatives from the Sex Offender Registry Board and the Department of Criminal Justice Information Services (DCJIS), which is responsible for maintaining CORI. The purpose of this meeting was to share information about the PCA program, CORI and SORI. The second meeting focused on ways to

442.404(B)(12). Similarly, Massachusetts General Laws Chapter 6, Section 172C, requires certain entities to obtain CORI for a person who is working or volunteering with an elderly person or a person with a disability.

²¹ Not every respondent answered every question. The percentages presented are based on the number of respondents who answered the question.

decrease the barriers to obtaining CORI for MassHealth members in the PCA program and to increase the number of members who run CORI checks during the hiring process.

Members had previously identified several barriers to conducting background checks. For instance, DCJIS has an online system some employers can use to obtain CORI, but it is not available to members. Rather, members must mail in a notarized request form for CORI, and DCJIS then mails the results back to the MassHealth member. This process, including getting the form notarized, takes time and slows down the hiring process; members expressed concern that if they requested CORI, they would not be able to obtain the assistance they need in a timely manner.

Further, while the FI can complete many administrative tasks for members, they could not conduct CORI checks on behalf of members.²² This is because only a prospective employer can request a CORI and the FI is not considered the employer for purposes of the PCA program.

As a result of these meetings, MassHealth requested a waiver from the DCJIS Commissioner to allow the new FI to request and receive CORI on behalf of MassHealth members in the PCA program. The DCJIS Commissioner approved this request in January 2022. Once MassHealth and DCJIS execute the waiver agreement, the FI will be able to conduct a CORI check for a potential PCA and provide a member with the results so the member can make an informed hiring decision. The FI will be able to utilize the online system to check CORI.

3. Recommendations

Since 2019, MassHealth has been committed to improving the use of background checks in the PCA program to ensure the safety of its members. Going forward, MassHealth should devote necessary staff resources to support members who want to conduct background checks and continue to remove barriers to running CORI and SORI checks. MassHealth should also work with the FI and personal care management agencies to create training materials about background checks, including how to obtain background checks through the FI and how to interpret results.

MassHealth should also continue working with DCJIS to ensure that the FI is able to run CORI checks on behalf of its members. MassHealth should monitor the FI to make sure that it performs timely background checks when requested by MassHealth members.

²² As discussed in Section II, the FI helps the members with processing timesheets, preparing the PCAs' paychecks and direct deposits, sending paychecks to the members to give to PCAs, and filing and paying members' share of state and federal taxes. The FI also provides workers' compensation insurance for PCAs and issues PCAs' W-2 forms.

B. Adult Day Health

1. Overview

As discussed above, MassHealth's Adult Day Health (ADH) program is a community-based service that provides nursing care, supervision and health-related support services in a structured group setting. MassHealth pays ADH providers either a fixed daily rate or in 15-minute increments for the time that a member attends the program. The rate depends on the degree of the member's needs. MassHealth may pay a provider a basic or complex payment level. For members at a basic payment level, the provider must document that it provided at least one of the following services during each visit: assistance with one or more activities of daily living, daily behavior support or evaluation, daily activity participation or skilled services care. For members at a complex payment level, the provider must document that it provided at least one skilled service to the member or a combination of certain activities of daily living and skilled services.

The adult day health regulations prohibit billing for services when a member is (1) receiving services from a home health agency that would be duplicative of those the adult day health program provides; (2) in a hospital, skilled nursing facility, or intermediate care facility; or (3) absent from the adult day health program.

For its [2019 report](#), the Office examined claims for approximately 100 providers that served approximately 12,500 MassHealth members during the fourth quarter of 2017. Overall, the Office observed that the adult day health program would benefit from additional oversight.²³ For example, the Office identified providers that submitted claims for complex care for members with primary diagnoses (such as type 2 diabetes without complications and essential primary hypertension) that do not appear to support that level of billing. The Office also found providers that included the same diagnosis on claims for all or virtually all members receiving services, or consistently billed the same three diagnoses for 75% or more of their members.²⁴

The Office recommended that MassHealth audit claims to determine if providers are accurately presenting member diagnoses and the need for complex care. Once MassHealth conducted these audits, the Office recommended that MassHealth provide education to those providers that appear to have made errors in billing. The Office also recommended that MassHealth refer providers that appeared to be engaging in fraudulent billing to the Massachusetts Office of the Attorney General's Medicaid Fraud Division.

²³ Other findings related to the ADH program from the 2019 report are included on page 15.

²⁴ For example, type 2 diabetes without complications; major depressive disorder, single episode, unspecified; and primary hypertension.

2. 2022 Update

MassHealth reported that it took several steps to improve program integrity in the ADH program. MassHealth updated its regulations so that as of July 1, 2019, ADH providers must receive prior authorization before providing services to a member. MassHealth must give prior authorization when a member first starts ADH services and then annually, or earlier if there is a significant change to the member's needs. As part of the prior authorization process, a member must undergo a clinical assessment to determine both the member's need for ADH services and the level of services (basic or complex). MassHealth contracts with other entities, not the ADH provider, to conduct the clinical assessment. Moreover, a provider cannot receive payment without prior authorization. In addition, because MassHealth determines the level of care during the prior authorization process, the ADH provider can no longer choose to bill for different levels of care when it submits claims to MassHealth.

In addition, MassHealth created a mandatory training for all ADH providers regarding MassHealth's ADH regulations. MassHealth presented the training to providers in January 2020 and recorded it for new providers.

In response to the Office's recommendation to identify providers that have high levels of billing errors, MassHealth identified ADH providers whose claims were denied at least 40% of the time. It provided additional training to these providers and is conducting selected audits. MassHealth has conducted three on-site audits since resuming audits in December 2021.²⁵ The audit results are still pending. MassHealth expects these field audits to help the agency determine if providers are accurately presenting members' needs for complex care and if they are billing at the appropriate level.

3. Recommendations

MassHealth has made progress in improving program integrity for the ADH program. The Office recommends that MassHealth continue to conduct field audits to ensure providers are billing their services properly. MassHealth should also continue to identify providers with high claim denial rates and educate those providers about proper billing practices. MassHealth should audit any providers whose billing practices do not improve after additional training.

C. Adult Foster Care

1. Overview

As mentioned earlier, MassHealth's Adult Foster Care (AFC) allows members to live with a caregiver who provides medically necessary assistance with ADLs and IADLs.²⁶

²⁵ MassHealth had suspended on-site ADH audits due to the COVID-19 pandemic.

²⁶ See page 16 for a full description of the AFC program and definitions of ADLs and IADLs.

For its [2019 report](#), the Office reviewed the claim histories for a large sample of providers from fiscal year 2018.²⁷ As a result of that review, the Office identified providers that were submitting claims with the same diagnosis for many, if not most, members. The Office also found that providers were submitting claims for complex care for members whose primary diagnoses did not appear to warrant that level of care.

The Office recommended that MassHealth improve its program integrity efforts. The Office also recommended that MassHealth improve its review of adult foster care claims for fraud, waste and abuse to determine if providers were engaging in questionable diagnosis practices, improper billing for complex care or other billing activity that raised questions about the provision of adult foster care services. Finally, the Office recommended that MassHealth consider setting guidelines for the rate of compensation for caregivers.

For its [2021 report](#), 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 MassHealth paid \$664,165 in adult foster care claims on days a member also received home health aide services. MassHealth paid \$514,268 for those home health aide services. MassHealth regulations specifically prohibit payment to an AFC provider on days when home health aide services are provided because the services are considered duplicative.²⁸

The Office recommended that MassHealth implement edits in its claims adjudication system to proactively prevent paying for adult foster care services that members received on the same day they received home health aide services.

2. 2022 Update

In response to recommendations in the Office's 2019 and 2021 reports, MassHealth has taken several steps to strengthen program integrity in the AFC program. In April 2019, MassHealth began requiring a prior authorization before providing AFC services to members. The process is similar to the one MassHealth implemented for ADH services. MassHealth must give prior authorization when a member first starts AFC services and then annually, or earlier if there is a significant change to the member's needs. As part of the prior authorization process, the member must undergo a clinical assessment to determine both the member's need for AFC services and the level of services (basic or complex). MassHealth contracts with other entities, not the AFC provider, to conduct the clinical assessment. A provider cannot receive payment without prior authorization.

²⁷ A fiscal year begins on July 1 and ends on June 30. For example, fiscal year 2018 begins on July 1, 2017 and ends on June 30, 2018.

²⁸ 130 CMR 408.437(B).

With prior authorization in place, the AFC provider can no longer choose which level of care to bill; MassHealth has already determined the level of care during the prior authorization process. MassHealth further reported that because the prior authorization process includes an independent clinical diagnosis, it should also prevent providers from routinely using the same diagnosis for members.

MassHealth also reported that it worked with its third-party administrator, Optum, to develop and implement algorithms to identify overlapping claims for adult foster care and home health aide services. After performing quality control checks to confirm that identified claims are in fact overlapping, MassHealth issues notices of overpayment to AFC providers for those claims. MassHealth and Optum have run this algorithm twice. The first run identified 848 overlapping claims totaling \$64,885.04, and, as a result, MassHealth issued 20 notices of overpayment in September 2019. Preliminary findings from the second run, in 2020, found 2,130 potentially overlapping claims involving 33 AFC providers and totaling \$250,200.76. MassHealth is in the process of drafting and issuing the notices of overpayment associated with this second run.

Finally, MassHealth created an algorithm to identify all adult foster care providers that bill for complex care for 80% or more of their members.²⁹ Since February 2020, MassHealth has conducted 13 audits of AFC providers that the algorithm flagged. Thus far, MassHealth has completed reviews of five of these audits, and it is drafting and issuing notices of overpayment. The initial overpayment estimates for those audits total \$793,808 across the five providers. Five other audits are still under review. The three remaining providers failed to respond to MassHealth's request for records in a timely manner, resulting in an overpayment finding. Those providers still have an opportunity to dispute the results of those audits.

3. Recommendations

MassHealth has taken significant steps to improve the integrity of the AFC program. It should continue to run the algorithms on a regular basis and recover overpayments. It should also conduct field audits on a regular basis to further identify fraud, waste and abuse.

D. Positive Airway Pressure Devices

1. Overview

For its [2021 report](#), the Office reviewed all fee-for-service claims for positive airway pressure (PAP) devices for calendar years 2015 through 2019. Patients use 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

²⁹ A member qualifies for complex care if the member requires hands-on assistance with at least three activities of daily living or hands-on assistance with at least two activities of daily living and behavior management. MassHealth pays for complex care at a higher rate than basic care.

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 measures in place for PAP devices. The Office identified three areas that may benefit from additional oversight. First, the Office found that MassHealth paid a small number of duplicate claims for PAP device rentals. Second, the Office found 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 recommended 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. The Office further recommended that MassHealth continue to monitor its payment system to ensure that it is reimbursing claims appropriately.

2. 2022 Update

In 2021, in response to the Office's recommendation that MassHealth evaluate its claims edits periodically, MassHealth implemented an additional edit to identify duplicate claims. MassHealth reported that, since implementing this edit, it has identified and denied 194 claims.

In its 2021 report, the Office suggested that MassHealth also examine other programs to identify patterns of duplicate billing, such as billing for the same procedure for the same member with different location codes. MassHealth reported that it examined all claims for providers for both PAP devices and accessories. As noted above, MassHealth will not pay rental claims for PAP devices after 13 months. MassHealth examined all rental claims that it paid for longer than the 13-month rental period. It found 145 duplicate claims, totaling \$1,916, and MassHealth is seeking to recover those payments. MassHealth also evaluated three codes, in addition to the codes the Office reviewed, to identify providers that billed for accessories more frequently than allowed.³⁰ MassHealth identified 14 duplicate accessories claims, totaling \$532, and MassHealth currently is working to recover these overpayments.

The Office also recommended that MassHealth review claims for all durable medical equipment that can be reordered periodically to identify providers that are billing more frequently than permitted. The Office identified one provider who accounted for 48% of this type of billing. The Office shared the name of that provider with MassHealth so that it could review the provider's billing and recoup any overpayments. The overpayment to that provider totaled \$137.

The Office further recommended that MassHealth consider implementing edits to restrict how often providers can bill for durable medical equipment. MassHealth stated that it is planning to work with

³⁰ As an example, if a member is allowed to replace an accessory once every three months, it would be inappropriate for a provider to bill MassHealth once every two months for the accessory.

its third-party administrator to review claims for durable medical equipment that can be reordered on a periodic basis to identify providers that are billing more frequently than the period allowed.

3. Recommendations

Since MassHealth recently put in place the edit to address duplicate billing, the Office is still reviewing it. It will follow up with MassHealth to share any feedback. The Office continues to recommend that MassHealth review all claims for durable medical equipment that can be reordered on a periodic basis to identify providers that are billing more frequently than allowed. When identified, MassHealth should recoup any overpayments.

E. Dental

1. Overview

The Medicaid and HSN programs pay for dental care for some MassHealth members and HSN users. The Office reviewed certain aspects of the dental program from 2015 through 2017.

In its [2019 report](#), Office determined that MassHealth did not audit DentaQuest, its dental program vendor, to ensure that it was processing claims accurately and complying with the terms of its contract. Instead, MassHealth allowed the vendor to “self-audit.”

The Office recommended that MassHealth conduct its own audits of dental claims instead of relying on its vendor to self-audit. Additionally, the Office stated MassHealth must require the vendor to provide a list of the claims that it includes in its self-audit so that MassHealth can verify the results.

Finally, the Office found that some providers billed the wrong procedure code for a type of oral evaluation for children younger than three years old. Instead of using the procedure code for children younger than three years old, the providers used the procedure code for children three and older, which paid providers at a higher rate.

The Office recommended that MassHealth analyze providers that billed the wrong procedure code to determine whether the billing was intentional.

2. 2022 Update

MassHealth reported that it has implemented measures to improve its oversight of DentaQuest. Instead of relying solely on DentaQuest’s self-audits, MassHealth now validates that DentaQuest is accurately processing claims by both sampling claims on a biweekly basis and verifying DentaQuest’s self-audits.

DentaQuest performs self-audits every quarter and submits reports to MassHealth. When the Office conducted its first review in 2019, MassHealth did not verify the accuracy of DentaQuest’s self-audits. MassHealth now selects a sample of dental claims from DentaQuest’s quarterly reports to verify

that the vendor is accurately processing claims. To verify DentaQuest's self-audits, MassHealth uses the same factors it considers in the biweekly audit. MassHealth informed the Office that, if errors are found, it meets with DentaQuest to review the claims and ensure that necessary updates are made to policies and systems. MassHealth has sampled seven biweekly audits and one quarterly audit since September 2021. It did not identify any errors.

In response to the Office's finding that providers were using the wrong procedure code MassHealth reported that it has instructed DentaQuest to perform provider audits on its behalf. DentaQuest uses an algorithm to identify providers whose billing patterns for certain codes makes them outliers in comparison to their peers. MassHealth reviews the results of the algorithm to determine whether an audit of the identified provider is necessary. If MassHealth determines that a provider audit is necessary, DentaQuest conducts the audit, after receiving permission from MassHealth and the Medicaid Fraud Division of the Office of the Attorney General.

MassHealth reported that in fiscal year 2021, DentaQuest completed 15 provider audits. Thus far in fiscal year 2022, DentaQuest has completed 9 provider audits, and it has additional audits still in progress. MassHealth has identified instances of overpayments through these audits.

3. Recommendations

The Office recommends that MassHealth continue to run its algorithm and conduct audits of providers. MassHealth should recoup any overpayments it identifies.