Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Massachusetts Focused Program Integrity Review

Final Report

February 2020

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) is committed to performing program integrity reviews with states in order to identify risks and vulnerabilities to the Medicaid program and assist states with strengthen program integrity operations. The significance/value of performing onsite program integrity reviews include: (1) assess the effectiveness of the state's PI efforts, including compliance with certain Federal statutory and regulatory requirements, (2) identify risks and vulnerabilities to the Medicaid program and assist states to strengthen PI operations, (3) help inform CMS in developing future guidance to states and (4) help prepare states with the tools to improve PI operations and performance.

The CMS conducted a focused review of Massachusetts to determine the extent of program integrity oversight of the managed care program at the state level, and to assess the program integrity activities performed by selected managed care entities (MCEs) under contract with the state Medicaid agency. Managed care service delivery is provided through an Accountable Care Organization (ACO) model, a Managed Care organization (MCO) model, a Medicare-Medicaid Plan provided through both a Capitated Financial Alignment Initiative (FAI) Model and a State Demonstration to Integrate Care for Dual Eligible Beneficiaries (One Care), an aligned Fully Integrated Dual Eligible Special Needs Plans provided through Senior Care Options (SCO), and Primary Care Case Management (PCCM)/ Prepaid Inpatient Health Plan (PIHP) model (the MassHealth Primary Care Clinician (PCC) Plan, which utilizes a behavioral health carve-out vendor). Three ACO models form the basis of the ACO program – Accountable Care Partnership Plans, Primary Care ACOs, and MCO-administered ACOs. Managed Care Organization (MCO) administered ACOs, Primary Care ACOs made up of Primary Care Clinicians (PCCs), and Accountable Care Partnership Plans coordinate Medicaid managed care services for Medicaid beneficiaries. The managed care ACO model operates under the Section 1115 Waiver Authority.

During the week of July 8, 2019, the CMS review team visited the Executive Office of Health and Human Services (EOHHS), Massachusetts's single state Medicaid agency. The CMS review team conducted interviews with EOHHS officials, as well as with staff from EOHHS's contracted MCOs, ACOs, and behavioral health carve-out vendor. In addition, the CMS review team conducted sampling of program integrity cases investigated by the MCE special investigations units (SIUs), as well as other primary data in order to validate the state and the selected MCEs' program integrity practices. The onsite review also included a follow up on the state's progress in implementing corrective actions related to CMS' previous comprehensive program integrity review conducted in calendar year 2014.

Summary of Recommendations

The CMS review team identified a total of 10 recommendations based upon the completed focused review modules and supporting documentation, as well as discussions and/or interviews with key stakeholders. The recommendations were in the following areas: State Oversight of Managed Care Program Integrity Activities, MCO Investigations of Fraud, Waste, and Abuse, Encounter Data, Payment Suspensions, and Terminated Providers and Adverse Action Reporting. The recommendations will be detailed further in the next section of the report.

Overview of Massachusetts Medicaid

- The EOHHS is the single state agency charged with administering and overseeing the Medicaid program in Massachusetts.
- MassHealth is the Medicaid and Children's Health Insurance Program in Massachusetts.
- The Office of Compliance is the organizational unit responsible for the overall program integrity operations for the MassHealth Medicaid program.
  In 2018, Massachusetts's Medicaid expenditures exceeded $16.3 billion. The Federal Medical Assistance Percentage matching rate was 50 percent

Overview of Managed Care in Massachusetts

- Massachusetts had approximately 1.8 million unduplicated, enrolled Medicaid beneficiaries as of July 2019. Approximately 65 percent of the Medicaid population were enrolled in MCEs during FFY 2018. The MassHealth managed care program accounts for the majority of the Medicaid expenditures in Massachusetts.
- During the onsite review three MCEs were interviewed; Boston Medical Center Healthnet Plan (BMCHP), Fallon Health Care (Fallon), and Massachusetts Behavioral Health Partnership (MBHP). Table 1 and Table 2 below provide enrollment/SIU and expenditure data for each MCE.

Table 1.

	BMCHP*	**Fallon****	**MBHP*****
Beneficiary enrollment total	230,164	97,844	512,000
Provider enrollment total	14,637	21,200	3,394
Year originally contracted	1997	1979	1996
Size and composition of SIU	5 FTEs	6 FTEs	3 FTEs
National/local plan	Local	Local	Local

*****Figures provided for MCO and ACO enrollments
**Figures provides for ACO enrollments
***Figures provided for PCC Plan and ACO enrollments

Table 2.

MCEs	**FFY 2016**	**FFY 2017**	**FFY 2018**
MCHP	$1.32 Billion	$1.34 Billion	$1.67 Billion
Fallon	$145.7 Million	$196.4 Million	$387.4 Million
MBHP	$439 Million	$445 Million	$494 Million

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. The CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible. These issues and CMS' recommendations for improvement are described in detail in this report.

State Oversight of Managed Care Program Integrity Activities

The MassHealth Payment and Care Delivery Innovation (PCDI) unit is primarily responsible for the programmatic oversight of the MassHealth ACO and MCO Programs, with the goal of ensuring contractual compliance. There are five MCE Contract Managers within PCDI that provide administrative oversight of eighteen MCE plans. The five MCE contract managers serve as the plans' point of contact for all matters, including program integrity. The PCDI coordinates with the following key internal units for comprehensive oversight: Program Integrity, Provider Operations, Operations, Quality Management, Office of Behavioral Health, Purchasing Office, Finance, and Office of Clinical Affairs to ensure MCE compliance with their respective guidelines.

The EOHHS does not have a documented process for coordinating with the various intra-agency units for comprehensive oversight. CMS recognizes that EOHHS utilizes processes that they may consider effective, but those processes are not memorialized in policy or process. However, EOHHS could benefit from a more formal, documented process that helps ensure the appropriate MassHealth teams are notified as needed. Formally adopting procedures for reporting responsibilities, detailing defined oversight roles, and memorializing guidelines for collaboration on program integrity issues will enhance oversight of the Managed Care program.

Recommendation #1: The EOHHS should consider documenting its existing processes in an intra-agency agreement that clearly describes the administrative roles, responsibilities, and notification processes for each division or unit related to MassHealth oversight of program integrity activities.

The EOHHS contractually requires plans to have administrative and management arrangements or procedures, including a mandatory compliance plan, which is designed to guard against fraud, waste, and abuse. The MCEs must also have written internal controls designed to detect and report known or suspected fraud, waste, and abuse activities. Compliance plans are required to be provided to EOHHS by the contract operational start date, and annually thereafter. The contract manager for each plan is responsible for obtaining the compliance plans in accordance with the contract requirement.

When asked how often compliance plans are submitted to EOHHS, each plan provided different responses that were inconsistent with the aforementioned contract requirement. One MCE stated they have never submitted a compliance plan to EOHHS. Another MCE indicated that they submit their compliance plan annually, and the remaining MCE advised CMS that they submit the compliance plan when requested by EOHHS. The EOHHS was unable to provide an internal documented process for annually reviewing the MCE compliance plans.

Recommendation #2: The EOHHS should consider developing an effective monitoring tool to annually obtain, and review MCE compliance plans as required by the MassHealth contracts.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have a documented process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCEs.

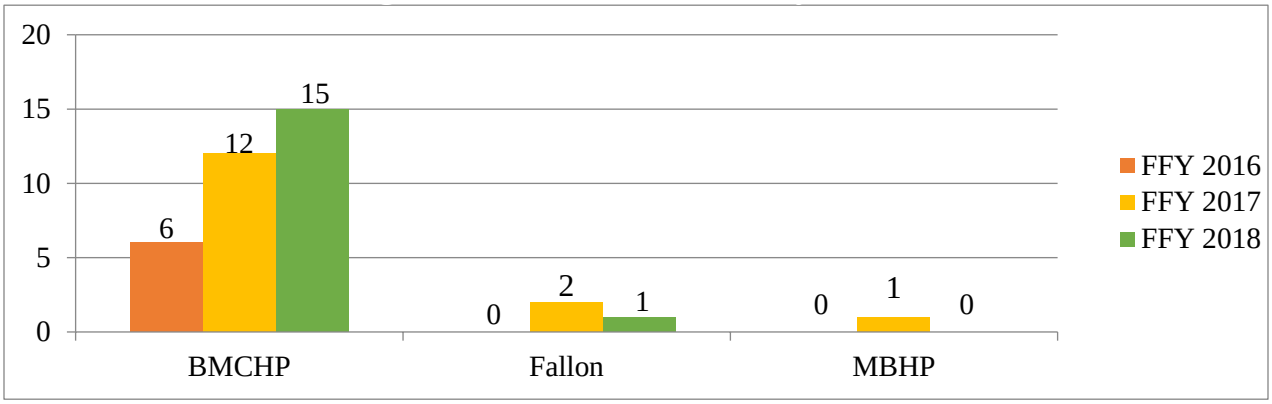
Massachusetts's MCE contracts requires that the program integrity (PI) program include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of fraud, waste, and abuse in the administration and delivery of services. Pursuant to 42

The MCEs do not make referrals directly to the Medicaid Fraud Control Unit (MFCU).[1] MassHealth Program Integrity and EOHHS Legal staff review and forward credible plan fraud referrals to MFCU for investigation. The Program Integrity unit tracks both referrals received from the plans and those referred to the MFCU. The MCEs submit quarterly reports of fraud, waste, and abuse activity to their respective programmatic contract managers, which is a requirement in the MassHealth contract. Some MCE fraud reports also indicated that suspected fraud referrals were provided to EOHHS for review, but EOHHS had not provided any guidance or disposition on the referrals several months after receipt of the suspected fraud referral.

Recommendation #3: In order to ensure prompt and efficient review of suspected fraud referrals submitted by MCEs, EOHHS should consider documenting its policies and procedures for managing case referrals. Consistent timelines for communicating referral dispositions to the plans will help to enhance program integrity efforts.

Table 3 lists the number of referrals that BMCHP's SIU, Fallon's SIU, and MBHP's SIU made to the state in the last three FFYs. Overall, the number of Medicaid provider investigations and referrals by the MCEs is low, compared to the size of the plan. The level of investigative activity by the MCEs has not changed over time.

Table 3.



As illustrated above, the MCEs collectively referred a limited amount of credible allegations of fraud during the review period. The low amount of referrals was of particular concern to the review team. The BMCHP had the most referrals by a wide margin, and MBHP had the lowest amount of referrals to the MFCU. Further analysis of MBHP's audits identified several missteps when suspected fraud had been identified, but not reported to EOHHS. On multiple occasions, employees of a contracted provider were discovered to have falsified medical records to obtain fraudulent Medicaid reimbursements. The employees were later terminated for fraud reasons, but the MCE failed to notify EOHHS of the terminations or refer the suspected fraud to EOHHS. Without proper notification to EOHHS, and potential subsequent referral to the MFCU, the individual employees have no impediments to be hired by other employers without consequence for committing suspected Medicaid fraud.

[1] Additional references to the MFCU in the report refer to the Attorney General's Medicaid Fraud Division (MFD) which acts as the state's MFCU.

Recommendation #4: Program integrity should develop strategies to educate the MCEs on effectively identifying, managing, and communicating suspected fraud to ensure accurate reporting of case referrals.

Encounter Data

Encounters are submitted directly from plans through a secured file transfer protocol server to the MassHealth data warehouse, once per month. The EOHHS has certain rules and the expectations for the plans to submit specific, identified data fields each month. The MassHealth plans are responsible for validating each data field. The EOHHS contracts with Mercer to validate the submitted encounter data, which is utilized by EOHHS actuaries for capitation rate setting. Data validation includes high level analysis, quality checks, identifying outliers, and identifying duplicate encounters. If the specified data fields are not submitted by the plans, the submission is rejected, and the file is returned as an error file. Denied encounters are re-submitted within a week and adjusted accordingly. Reported overpayments are resubmitted through the Massachusetts Medicaid encounter system. These overpayments are accounted for in the rate development process, to the extent that they are reflected in the encounter base data used for rate-setting. In addition, EOHHS' actuary applies price normalization to standardize unit pricing to the Massachusetts Medicaid Fee Schedule; therefore, the impact of such recoupments is minimized. The EOHHS is in the process of procuring a vendor to audit the encounter data submitted by the MassHealth plans to ensure accuracy, and EOHHS does not have a corresponding audit policy to ensure accuracy of encounters. The EOHHS implemented a process for reporting Medical Loss Ratio (MLR) standards in June 2019.

Recommendation #5: The EOHHS should complete its process to arrange for independent audits of the accuracy, truthfulness, and completeness of encounter data submitted by the MCEs in accordance with 42 CFR 438.602(e).

Payment Suspensions

In Massachusetts, Medicaid MCEs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The regulation at 42 CFR 455.23(a) requires that when the State Medicaid agency determines that there is a credible allegation of fraud, it must suspend all Medicaid payments to a provider unless the agency has good cause not to suspend payments or to suspend payment only in part. The MassHealth contract requires the plans to suspend provider payments when directed by EOHHS. The three plans that participated in the onsite review had processes and procedures to suspend payments at the direction of EOHHS. The MassHealth contract also states, "The Contractor may propose that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to a provider against which there is an investigation of a credible allegation of fraud, for a few reasons. Some being, the Contractor determines that payment suspension is not in the best interests of the Medicaid program." And, "The Contractor determines, based upon the submission of written evidence by the provider that is the subject of a whole payment suspension, that such suspension should be imposed only in part." This language in the MassHealth contract appears to delegate some of the state's responsibility and authority to suspend providers when a credible allegation of fraud has been identified. Ultimately, EOHHS is

responsible for determining whether a payment suspension is in the best interest of the MassHealth program.

In addition, a provision in Section 2.8 of the MassHealth contract states, "This Section does not preclude the Contractor from suspending or terminating providers for cause prior to the ultimate suspension and/or termination from participation in MassHealth, Medicare or another state's Medicaid program;" This section of the contract may conflict with 42 CFR 455.23. Specifically, the contract language appears to provide an option to terminate a provider instead of enacting a payment suspension in accordance with 42 CFR 455.23. Such actions could inadvertently allow MCEs to immediately terminate provider contracts when a credible allegation of fraud has been identified. Terminations of this kind may subvert the overall program integrity policy concerns, especially if the provider is contracted with other MCEs or Medicaid programs.

In the last three FFYs, EOHHS had 41 MCE provider suspected fraud referrals accepted by the MFCU for criminal investigation. A payment suspension was imposed at the time of the initial fraud referral on three providers in the last three FFYs. A law enforcement exception was imposed on 32 of the suspected fraud referrals, which is a high amount and atypical when considering the low amount of suspensions that were imposed. Correspondence from suspected fraud referrals to the MFCU indicated EOHHS generally accepts the recommendation of the MFCU when a credible allegation of fraud has been identified. Imposing payment suspensions at the time of the initial referral to MFCU were rarely exercised in the last three FFYs, because EOHHS generally accepts MFCU's recommendation that a law enforcement exception is necessary and appropriate. A consequence of this option is that providers continue to receive taxpayer funded, Medicaid reimbursements, after a credible allegation of fraud had been identified. In some cases, providers continued to receive Medicaid reimbursements several years after a credible allegation of fraud has been identified as the MFCU continues to build a criminal investigation.

Recommendation #6: The EOHHS should consider changes to internal procedures regarding payment suspensions. **1)** The EOHHS should consider developing clear criteria and processes for consideration of all options listed in 42 CFR 455.23, and revisit the rationale for the frequent use of law enforcement exceptions. **2**) The EOHHS should review, and consider clarifying the contract language that may give a perception that EOHHS has delegated some of its authority granted to it by statute and regulation, 42 CFR 455.23, to its MCEs, or provide MCEs an option to terminate providers prior to a payment suspension being imposed by EOHHS.

Terminated Providers and Adverse Action Reporting

The MassHealth contract requires same day notification to EOHHS when MassHealth MCEs terminate a provider from the provider network due to PI issues. The MBHP, the behavioral health MCE, is required to notify EOHHS within three business days of a for-cause provider termination. The MCEs interviewed onsite provided varying responses about the frequency of reporting for-cause terminations. MCEs advised the onsite review team that for-cause provider terminations are reported either monthly, or on an ad hoc basis, except for MBHP. When for-cause terminations are shared with EOHHS, the information is shared with MassHealth plans with the requirement that each plan terminate the provider.

Table 4:

MCEs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated For Cause in Last 3 Completed FFYs
BMCHP	2016 1,848 2017 2,719 2018 2,015	2016 46 2017 36 2018 36
Fallon	2016 2455 2017 2340 2018 13,914	2016 18 2017 10 2018 08
MBHP	2016 192 2017 149 2018 271	2016 39 2017 22 2018 39

*The terminations are high as a result of the contracting period during the transition from MCO to ACO implementation.

Overall, the number of providers terminated for-cause by the plans appear to be low, compared to the number of providers enrolled with the MCEs and compared to the number of providers disenrolled or terminated for any reason.

The Medicaid Provider Enrollment Compendium (MPEC)[2] states for-cause adverse terminations may include, but is not limited to, termination for reasons based upon fraud, integrity, or quality. The MPEC provides guidance on identifying and mandatory reporting of for cause terminations. The EOHHS advised the onsite team that provider terminations based on violations of fraud, integrity, and quality are considered for-cause terminations. CMS acknowledges that this is an expectation of the MCEs pursuant to CMS letters dated 2011 and 2012, which were provided to the plans, but the MassHealth contract does not specify that terminations due to fraud, integrity, or quality are considered for-cause.

The MCEs do not appear to have a clear understanding of what constitutes a for-cause action and how it should be clearly reported. Each MCE interviewed provided varying responses about how they describe for-cause provider terminations, and how those provider terminations are reported to EOHHS. At least one MCE advised CMS that they routinely reported for-cause terminations to EOHHS with the reason for termination being “internal decision.” "Internal decision" does not clearly signal that a provider was terminated due to fraud, integrity, or quality reasons. The MCEs must clearly identify and report for-cause terminations so that EOHHS can take the appropriate actions to safeguard the Medicaid program.

Recommendation #7: The EOHHS should consider the following: **1**) Clarify for-cause provider termination criteria consistent with guidance listed in the MPEC, and amend the MassHealth Contract to include such provisions; **2**) Clarify policies and/or contract language to address clear reporting of for-cause terminations; and **3**) Clarify prompt reporting requirements regarding for-cause terminations that should be adopted by all MassHealth plans. Accordingly, additional education is warranted to ensure provider for-cause terminations are identified, reported, and handled appropriately.

The EOHHS does not credential and enroll MCE only providers. The EOHHS is in the process of developing processes to credential and enroll all providers, including MCE only providers, in

[2] https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf

accordance with 42 CFR 438.602 (b). The EOHHS requires MCEs to credential providers in accordance with 42 CFR 455.436. The EOHHS has robust requirements for provider enrollment and credentialing that include additional databases such as licensing boards in nearby states. Overall, the breadth of databases that are required to be queried are wide ranging.

The EOHHS has identified high risk, and moderate risk providers in accordance with 42 CFR 455.450. High risk and moderate risk providers are subject to enhanced screening that may include onsite visits, FBI background checks, and FBI fingerprinting. The MCEs are required to screen and enroll providers based on the identified, categorical risk levels designated by EOHHS. The MCEs interviewed provided varying responses regarding credentialing practices for providers. Two out of three MCEs advised the onsite team that they do not have separate credentialing requirements for high risk, or even moderate risk provider types. Each provider type is credentialed and enrolled utilizing the same standards, which do not include onsite visits, FBI background checks, or fingerprinting. The EOHHS does not conduct onsite visits, FBI background checks, or fingerprinting on behalf of the MCEs. There are opportunities for improvement to ensure MCE providers that are subject to enhanced screening are screened in accordance with federal guidelines, and the MassHealth contract.

Recommendation #8: The EOHHS should continue to develop, and implement provider credentialing and enrollment processes and procedures in compliance with 42 CFR 438.602 (b).

Recommendation #9: In accordance with 42 CFR 455.432 and 455.434, EOHHS should develop strategies to ensure MCE providers are appropriately screened based on their categorical risk level.

Pursuant to 42 CFR 438.608(c), the MassHealth contract requires the MassHealth plans and subcontractors must comply with all applicable certification, program integrity and prohibited affiliation requirements, including written disclosure of ownership, control, and prohibited affiliations. The EOHHS' customer and provider services vendor, Maximus, is responsible for collecting disclosure of ownership forms on a federally required disclosure form, and verifying the information as required. The EOHHS does not have a documented policy or procedure to ensure the federal disclosures are collected and reviewed in a timely manner. CMS acknowledges that EOHHS has contractual requirements, and an internal process for collecting the required disclosures. However, EOHHS could benefit from a memorialized policy and procedure for the regular collection and review of disclosures.

The EOHHS has not posted the required disclosure of ownership information on their website, in accordance with transparency guidelines listed in 42 CFR 438.602 (g). Further, the MassHealth contracts are not posted on the website. The EOHHS advised CMS that they are also in the process of posting the required disclosures, and MassHealth contracts on their website after making improvements for accessibility. The EOHHS does not have a timeline for completion. The EOHHS also advised the onsite review team that they are developing strategies to become compliant with the additional transparency reporting requirements listed in 42 CFR 438.602 (g).

Recommendation #10: The EOHHS should continue to develop and implement strategies to gain compliance with transparency reporting requirements listed in 42 CFR 438.602 (g).

Status of the Corrective Action Plan from the 2014 Review Report

Massachusetts's last CMS program integrity review was in July 2014, and the report for that review was issued in December 2015. The report contained three risk areas with seven recommendations. CMS completed a desk review of the corrective action plan in August 2017. The desk review indicated that the findings from the 2014 review have all been satisfied by the state, except for one finding. The target date of completion for the outstanding finding is November 2019.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Massachusetts to consider utilizing:

- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Massachusetts are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the Regional Information Sharing Systems (RISS) as a tool to identify effective program integrity practices.
- Access the Toolkits to Address Frequent Findings: Payment Suspension Toolkit website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html.
- Access the Toolkits to Address Frequent Findings: Encounter Data Toolkit: https://www.medicaid.gov/medicaid/managed-care/guidance/index.html
- Access the MPEC to Address Frequent Findings: Provider Terminations: https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-142017.pdf

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Massachusetts to build an effective and strengthened program integrity function.