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Massachusetts Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare and Medicaid Services (CMS) conducted a focused review to determine whether Massachusetts's program integrity procedures satisfy the requirements of federal regulations that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act. Another purpose of the review was to determine the extent of program integrity oversight of the managed care program at the state level and assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state. The review also included a follow up on the state's progress in implementing its corrective action plan (CAP) that resulted from CMS's last program integrity review in 2012.

The report below discusses the results of the focused review on provider enrollment and screening as well as managed care program integrity activities. The assessment of the Medicaid agency's CAP is included as an addendum to this report.

Background: State Medicaid Program Overview

The Massachusetts Medicaid program is called MassHealth. In federal fiscal year (FFY) 2013, it ranked ninth among states in total computable Medicaid expenditures. Of the approximately $13.3 billion spent in FFY 2013, a little over $3.2 billion (or 24 percent) was spent on beneficiaries in the state's managed care programs. However, of the 1.9 million Medicaid beneficiaries in Massachusetts, approximately 1.3 million, or 68 percent, were enrolled in one of the state's five managed care programs. These programs included a mainstream Medicaid managed care program, the Children's Health Insurance Program (CHIP), and the CarePlus program for Medicaid expansion enrollees, as well as two smaller programs for elderly beneficiaries. On January 1, 2014, the CarePlus program for Medicaid expansion enrollees was implemented as well. The overall MassHealth program is a component of the state's Executive Office of Health and Human Services (EOHHS).

Methodology of the Review

In advance of the onsite visit, CMS requested that Massachusetts and the MCOs selected for the focused review complete a review guide that provided the CMS review team detailed information on the operational activities of the areas that were subject to the focused review. A five-person team reviewed the responses and materials that the state provided in advance of the onsite visit.

During the week of July 14, 2014, the CMS review team visited several MassHealth offices and the state's provider enrollment contractor. It conducted interviews with numerous state staff involved in program integrity, provider enrollment, and managed care. The CMS review team also undertook onsite interviews with three MCOs and the Special Investigation Units (SIUs) at Boston Medical Center Health Net Plan (BMCHP), Celticare, and Neighborhood Health Plan (NHP). In addition, the CMS review team conducted sampling of provider enrollment

applications, program integrity cases, and other primary data to validate Massachusetts' and the selected MCOs' program integrity practices.

Results of the Review

The review of Massachusetts' program integrity activities found the state to be in compliance with many of the current program integrity requirements. However, the CMS review team identified some areas of concern and instances of regulatory non-compliance in its program integrity activities, which represent a risk to the Medicaid program.

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's recommendations for improvement are described in detail in this report.

Section 1: Affordable Care Act Provider Screening and Enrollment

Overview of the State's Provider Enrollment Process

Massachusetts's provider enrollment and screening are overseen by EOHHS. Sister agencies are not involved in the enrollment and screening process. The EOHHS has a primary enrollment contractor which screens and enrolls most MassHealth fee-for-service (FFS) providers, including providers in the state's Primary Care Clinician Plan, which is a primary care case management program. However, EOHHS also contracts with other vendors to enroll certain specialty providers, including dentists and home and community based services waiver providers. Providers enrolling in MassHealth have the option of completing electronic or paper applications.

42 CFR 455.410: Enrollment and screening of providers
The regulation at 42 CFR 455.410 requires that the state Medicaid agency: (a) screen all enrolled providers; and (b) enroll all ordering or referring physicians or other professionals providing services under the state plan or under a waiver of the plan as participating providers; and (c) the state Medicaid agency may rely on the results of the provider screening performed by any of the following: (1) Medicare contractors. (2) Medicaid agencies or Children's Health Insurance Programs of other states.
The state is not fully in compliance with this regulation.
The state does not require all ordering or referring physicians or other professionals providing services under the state plan or under a waiver to be enrolled as participating providers. At the time of the review, the state only required certain providers to enroll in MassHealth as ordering and referring providers as a condition of obtaining and maintaining state licensure. The state noted that it had passed legislation requiring all ordering and referring providers to enroll, but had not yet set a target date for full implementation of this requirement. During interviews, the state indicated that it was currently working on an application template with all the information needed to enroll these providers.

42 CFR 455.410: Enrollment and screening of providers
Recommendations: • Develop policies and procedures to implement the legislation requiring all ordering or referring physicians or other professionals providing services under the state plan or under a waiver to be enrolled as participating providers. This would include finalizing the application template containing all the information needed to enroll these providers.
42 CFR 455.412: Verification of provider licenses
The regulation at 42 CFR 455.412 requires that the state Medicaid agency: (a) have a method for verifying that any provider purporting to be licensed in accordance with the laws of any state is licensed by such state; and (b) confirm that the provider's license has not expired and that there are no current limitations on the provider's license.
The state is in compliance with this regulation.
The state Medicaid agency confirms most provider licenses and ensures that there are no limitations on the license upon initial enrollment and during re-validation by checking with the Massachusetts Board of Registration in Medicine and the Massachusetts Department of Public Licensure. License verifications for dentists and waiver providers are undertaken by the specialty enrollment contractors. Procedures are in place to closely monitor the expiration dates of in-state licenses. The state receives a license expiration report from the Massachusetts Board of Registration in Medicine the first of every month, which lists providers whose licenses have expired or are due to expire in 30, 60 and 90 days. Out-of-state providers are required to provide a copy of their license. The state through its provider enrollment vendor verifies all out of state licenses as part of the enrollment and credentialing process. The contractor verifies the license via the applicable state licensing board website, where license limitations are also displayed. In the instance where a fee or an outreach call would be needed in order to verify a license and identify any limitations prior to enrollment, the contractor works.
Recommendations: • None
42 CFR 455.414: Revalidation of enrollment
The regulation at 42 CFR 455.414 requires that the state Medicaid agency revalidate the enrollment of all providers regardless of provider type at least every 5 years.
The state is at risk of non-compliance with this regulation by March 25, 2016.

42 CFR 455.410: Enrollment and screening of providers
The state Medicaid agency has begun the revalidation of currently enrolled providers but is still in an early stage of the process. Massachusetts documented a formal plan to revalidate all eligible providers by a targeted completion date of March 25, 2016. Subsequently, all providers would be revalidated at least once every five years. The revalidation plan included a detailed flow chart as well as internal policies and procedures. It initially targets limited risk providers for review first, followed by providers at the moderate and then high risk levels. In addition, the state has issued bulletins to providers explaining the process. At the time of the review, the state Medicaid agency had revalidated 594 of approximately 45,000 providers. Despite ample evidence of careful planning and thought behind the process, a large volume of revalidation work remains to be done for the revalidation process to meet the federal deadline.
Recommendations: • Revisit the formal revalidation plan and make revisions to ensure that all eligible providers are revalidated by March 25, 2016. Ensure that adequate staff resources are allocated to meet this requirement.
42 CFR 455.416: Termination or denial of enrollment
The regulation at 42 CFR 455.416 describes several conditions under which a state Medicaid agency must terminate or deny enrollment to any provider. These include situations in which the Medicare program or another state Medicaid or Children's Health Insurance Program has terminated a provider for cause on or after January 1, 2011 unless the state Medicaid agency determines that denial or termination of enrollment is not in the best interests of the Medicaid program and documents that determination in writing.
The state is not in compliance with this regulation.
The state Medicaid agency has promulgated administrative regulations[1] which reflect the requirements of 42 CFR 455.416. Massachusetts has access to the CMS server which lists Medicare revocations and state-initiated for- cause terminations. However, a check of the Medicare revocations on this server at the time of the review showed that the state had not yet terminated 34 of the 57 Medicare providers who had lost their billing privileges for cause. When asked about this, the state attributed the omission to an administrative oversight and said it would be addressed. A targeted correction date was not reported to the CMS review team during the onsite review.
Recommendations: • Develop a plan that would enable the state to check the CMS server on a routine basis and promptly terminate any Massachusetts Medicaid providers that have been revoked from the Medicare program or terminated by any other state's Medicaid or Children's Health Insurance Program.
42 CFR 455.420: Reactivation of provider enrollment
The regulation at 42 CFR 455.420 requires that the state Medicaid agency, after denial or termination of a provider for any reason, require the provider to undergo rescreening and pay the associated application fees pursuant to 42 CFR 455.460.
The state is in compliance with this regulation.

[1] Under 130 CMR 450.212(B) and 450.216.

42 CFR 455.410: Enrollment and screening of providers
The state requires providers who have been terminated from the program to go through a full reapplication and rescreening process, and to pay any associated application fee. Permission to reapply presupposes that providers who were terminated for cause have been reviewed by the agency's Provider Review Committee and approved for reinstatement. A potential risk was identified in that the state does not currently deactivate or terminate a provider enrollment number due to inactivity, though the state indicated it has plans to reach out to providers who have not billed in over 12 months and terminate those who do not respond.
Recommendations: • Implement a process to identify and contact all providers who have not billed in over 12 months to determine their status and terminate or deactivate any such providers who do not respond.
42 CFR 455.422: Appeal rights
The regulation at 42 CFR 455.422 requires that the state Medicaid agency give providers terminated or denied pursuant to 42 CFR 455.416 any appeal rights available under state law or regulations.
The state is in compliance with this regulation.
The state Medicaid agency provider agreement contains specific language which addresses the appeal rights that must be offered when provider terminations or denials of enrollment occur.[2]
Recommendations: • None
42 CFR 455.432: Site visits
The regulation at 42 CFR 455.432 requires that the state Medicaid agency conduct pre-enrollment and post-enrollment site visits of providers who are designated as ''moderate'' or ''high'' categorical risks to the Medicaid program.
The state is not fully in compliance with this regulation.

[2] Massachusetts administrative regulations at section 130 CMR 450.213, 450.214, and 450.240-248

42 CFR 455.410: Enrollment and screening of providers
The state Medicaid agency through its contractor performs site visits as part of the enrollment process. Each enrolled provider is assigned a categorical risk level according to Medicare guidelines for providers. This information can be found on the MassHealth website, which specifies the limited, moderate, and high risk provider types. As part of the enrollment process, a site visit coordinator must schedule a visit within two business days of a notification from program managers that the application may move forward. Site visits must be completed within 10 business days of this notification. However, these standards apply only to in-state providers. Per Mass Health, the state Medicaid agency does not typically conduct site visits for medium or high-risk providers located out-of-state. The state indicated that in lieu of these, it attempts to determine if Medicare conducted a site visit for the providers in question. State officials also said that they hoped to arrange for the states in which billing providers resided to perform site visits on MassHealth's behalf. The CMS review team also found that the current Massachusetts provider agreement did not contain language requiring providers to grant MassHealth and CMS or their agents and designated contractors access to their premises for unannounced on-site inspections. During the review, the state documented that an unannounced site visit provision had been incorporated in a draft administrative regulation.
Recommendations: • Develop and implement policies and procedures for conducting site visits for medium or high-risk providers who are located out of state. In lieu of MassHealth performing these visits, arrange for necessary site visits by other states and/or confirm that Medicare's site visit contractor has performed such visits. • Ensure that the Massachusetts provider agreement contains language requiring providers to grant MassHealth and CMS or their agents and designated contractors' access to their premises for unannounced on-site inspections.
42 CFR 455.436: Federal database checks
The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE), the Excluded Parties List System (EPLS) on the System for Award Management (SAM), the Social Security Administration Death Master File (DMF), and the National Plan and Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.
The state is not fully in compliance with this regulation.

42 CFR 455.410: Enrollment and screening of providers
Upon provider enrollment and re-enrollment (or revalidation), the state Medicaid agency checks the providers as well as persons with ownership or controlling interests in and agents and managing employees of the provider against the mandatory databases listed above. Information on persons with ownership and control interests, agents and managing employees is taken from a Federally Required Disclosure Form developed by the state since its last CMS comprehensive program integrity review. The state also indicated that it checks the LEIE and DMF on a monthly basis. However, in the ongoing LEIE searches, only the provider is scrutinized for exclusions on an ongoing basis. Persons with ownership and control interests, agents, and managing employees are not, although the regulation requires this. Furthermore, the EPLS is not checked monthly as required by the regulation.
Recommendations: • Perform the full range of required LEIE and EPLS database checks on a monthly basis after enrollment, re-enrollment, or the revalidation of providers. These should include checks on all persons with ownership and control interests in the provider as well as agents and managing employees of the provider.
42 CFR 455.440: National Provider Identifier
The regulation at 42 CFR 455.440 requires that the state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier (NPI) of the physician or other professional who ordered or referred such items or services.
The state is not in compliance with this regulation.
The state Medicaid agency requires the use of an NPI on the UB-04 and CMS-1500 claim forms, which provide space for listing the NPI number for all ordering and referring physicians or other professionals. Ordering or referring providers who are not authorized to enroll in MassHealth, such as mid-level practitioners, may submit claims using the NPI of their supervising physician or hospital. A potential risk was identified in that, as this report was being developed, MassHealth had not yet provided CMS with requested documentation to confirm that the Medicaid Management Information System rejects claims lacking an NPI number or containing an incorrect NPI number.
Recommendations: • To mitigate the potential risk of noncompliance with this regulation, provide documentation that the Medicaid Management Information System will reject claims lacking an NPI number or containing an incorrect NPI number.
42 CFR 455.450: Screening levels for Medicaid providers
The regulation at 42 CFR 455.450 requires that the state Medicaid agency screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation of enrollment request based on a categorical risk level of ‘‘limited,’’ ‘‘moderate,’’ or ‘‘high.’’ Under certain circumstances, such as where the provider has an existing overpayment or where there is a credible allegation of fraud against the provider or an HHS-OIG exclusion in the past 10 years, the state must adjust the categorical risk level from “limited” or “moderate” to “high.
The state is not fully in compliance with this regulation.

42 CFR 455.410: Enrollment and screening of providers
The state Medicaid agency has assigned low, moderate, or high risk levels to all enrolled Medicaid provider types. However, MassHealth has not developed a policy for adjusting the categorical risk levels of providers/entities that have an existing Medicaid overpayment or meet the other conditions for an increase in risk level as discussed in the regulation. State staff indicated that they are currently reviewing the state's audit and data mining activities to determine what threshold amount and type of overpayment would be appropriate to trigger a risk level adjustment.
Recommendations: • Develop and implement a policy and procedure for adjusting the categorical risk levels of providers who have an existing Medicaid overpayment or meet the other conditions for an increase in risk classification specified in 42 CFR 455.450.
42 CFR 455.460: Application fee
The regulation at 42 CFR 455.460 requires the state Medicaid agency to collect the applicable application fee prior to executing a provider agreement from certain prospective or re-enrolling Medicaid-only providers as stipulated in the regulation.
The state is in compliance with this regulation.
The state Medicaid agency collects application fees from Medicaid-only provider types. For those providers identified as owing an application fee, the state requires proof of payment prior to enrollment. However, if a provider applicant feels that the application fee would be a significant financial hardship, it may submit a Hardship Exception Request form. The state Medicaid agency reviews the request and approves or denies it at the discretion of the Medicaid Director, which then forwards the decision to CMS for review. At the time of the onsite review the state Medicaid agency had collected application fees from 45 providers.
Recommendations: • None
42 CFR 455.470. Temporary moratoria
The regulation at 42 CFR 455.470 requires the state Medicaid agency to impose temporary moratoria on enrollment of new providers or provider types identified by the Secretary as posing an increased risk to the Medicaid program unless the state Medicaid agency determines that imposition of a temporary moratorium would adversely affect beneficiaries' access to medical assistance.
The state is positioned to comply with this regulation if invoked.
The state Medicaid agency reported that it has not yet used temporary enrollment moratoria. However, Massachusetts already had enabling regulations to do so [under 130 CMR 450.212(A)(2)]. In the event the HHS Secretary were to impose a moratorium on specific provider types, the state Medicaid agency said that it would have to initially determine if this action would adversely affect beneficiary access to care before imposing the moratorium in Massachusetts.
Recommendations: • None

Table 1

Provider Enrollment and Screening in Managed Care

In the Massachusetts Medicaid Managed Care Program, network providers do not have to be enrolled by the state. The MCOs are responsible for performing the enrollment and screening of their network providers. During the interview with state managed care staff, the CMS review team asked whether there are provisions in the Massachusetts Medicaid managed care contract that direct the MCOs to conduct enhanced provider enrollment and screening activities similar to the activities the state is required to conduct by the regulations at 42 CFR 455 Subpart E. The CMS review team was particularly interested in whether managed care contracts require the reporting of for-cause terminations and the checking of federal databases for excluded parties. Likewise, CMS asked if different provider types are assigned different risk levels and subject to greater screening and site visits during the credentialing process when categorized at a higher risk.

While the MassHealth model contract addresses the managed care provider credentialing process, it does not currently include any provisions directing the plans to conduct enhanced provider enrollment and screening activities similar to the activities the state is required to conduct by the regulations at 42 CFR 455 Subpart E. Instead, the contract directs the MCOs to have processes in place that are consistent with managed care industry standards, such as those provided by the National Committee for Quality Assurance and relevant state licensing boards. Additionally, the contract requires that a site visit be conducted for all providers prior to their acceptance in the network.

With regard to terminations, the state's contract directs that MCOs not authorize treatment by or make payment to providers who have been terminated or suspended from participation in MassHealth, Medicare, or another state's Medicaid program. Furthermore, MCOs are expected to terminate, suspend, or deny enrollment to a provider if that provider has been terminated or suspended from MassHealth, Medicare, or another state's Medicaid program. When an MCO takes one of these actions, it is contractually required to notify the state in an ad hoc report as well as annual report which includes a summary of the administrative actions taken over the past year.

In addition, the state's model contract makes clear that plans may also suspend or terminate providers for cause on their own initiative and not solely in response to a prior Medicaid or Medicare action. Plans are contractually required to provide prior notice to EOHHS before imposing a fraud-related provider termination or suspension[3] and must report to the state when any suspension occurs.[4]

At the time of the review, state staff reported that approximately 68 percent of Medicaid beneficiaries were enrolled in one of the risk capitated MCOs contracted with the state. As noted, the state does not require managed care providers to be enrolled in the state FFS Medicaid program in order to enroll with a MCO.

The CMS review team conducted onsite interviews with three of the state's contracted MCOs. The interviews contained some questions about enrollment and screening procedures to determine if actual MCO provider enrollment and screening practices were aligned with the current regulations that apply to the FFS Medicaid program. Below are the CMS review team's observations:

- Federal Database Checks: The MCO model contract (section 2.8.H.1.f.1) requires contracting plans to check both the LEIE and EPLS (on the System for Award Management) at least monthly as well as before contracting, credentialing and recredentialing with a provider. While the MCOs are also required to check certain state exclusion lists, there is no requirement in the contract that MCOs check the DMF or NPPES as part of the credentialing and recredentialing process.

    - All of the surveyed MCOs recredentialed their providers every two years, but the similarities of their enrollment processes stopped there. One of the three plans, NHP required all providers to be enrolled in the FFS Medicaid program so its providers and affiliated parties were screened to the same extent that the state screens all FFS providers. This MCO also verified sanctioned providers on an ongoing basis by checking the EPLS, the LEIE, and certain other databases, such as the National Practitioner Data Bank and registration list at the state licensing agency. A second MCO,BMCHP, checked its providers and affiliated parties against the LEIE, MED and EPLS upon enrollment and reenrollment. However, it did not check persons with ownership and control interests or managing employees on an ongoing monthly basis. It also did not check the DMF and the NPPES at the time of credentialing. The third MCO, Celticare, which is a new contractor, indicated that it monitored the LEIE, the National Practitioner Data Bank, and the licensing board twice a month, but was not aware of the FFS requirements regarding other federal database checks. The provider files sampled by the CMS review team confirmed these gaps in the database searches.

[3] In section 2.3.K.2 of the model contract.
[4] Per section 2.8.H.1.f.3 of the model contract.

- Provider Risk Levels and Site Visits: The MCO model contract did not require that risk levels be assigned to providers as part of the enrollment process. However, it did require contractors to conduct site visits to all providers "prior to them becoming Network Providers and in accordance with relevant state regulations" (section 2.8.H.1.c.). The requirement for site visits is not limited to medium or high risk providers as in the federal regulation at 42 CFR 455.432.

    - None of the MCOs assigned low, medium, or high risk designations to all providers, as federal regulations have required in the FFS Medicaid program. However, one MCO, Celticare, indicated that it did require site visits for any provider type classified as high risk by CMS. A second MCO,BMCHP, required site visits upon initial credentialing for all providers but only to high risk providers upon recredentialing, while the third MCO,NHP, indicated that it only performed site visits in limited instances to organizational providers that were not otherwise accredited. None of the site visit policies were in full compliance with the requirements of the MassHealth model contract.[5]

- Provider Terminations: The MCO model contract requires contracting plans to terminate, suspend or deny enrollment to a provider who has been terminated or suspended from MassHealth, Medicare or another state's Medicaid program or is the subject of a state or federal licensing action.[6] The contract also requires plans to report to EOHHS terminations or denials of enrollment undertaken for program integrity reasons.[7] These provisions are consistent with, though not identical to, existing federal FFS requirements on terminating providers for cause across the Medicare, Medicaid and CHIP programs and reporting adverse actions that relate to fraud or abuse.

    - When asked about their policies on terminations, the two large MCOs, BMCHP and NHP, provided reports showing that they reported providers to the state who were terminated from their network or denied credentialing for program integrity reasons. The third MCO, Celticare indicated that it had not yet had occasion to terminate anyone for cause. All MCOs provided annual summary reports listing their actions. BMCHP and NHP indicated that a large majority of the terminations they undertook for cause were in response to licensure actions or notifications about state exclusionary actions. The state appeared satisfied that for cause actions initiated by the plans were being reported individually in a timely manner after they occurred. However, a sampling which the CMS review team undertook of ten for cause termination cases by two of the plans raised questions. In the first MCO,BMCHP, nine of the ten cases reviewed, including three providers originally terminated by MassHealth, did not appear on the CMS terminations database. Likewise, six of the ten case files reviewed for the second MCO, Celticare, did not elaborate on the causes of the termination and contained

[5] See Section 2.8 (Network Management) of the First Amended and Restated MassHealth MCO Contract, Subsection H.1.c., page 120.
[6] See Section 2.8.H.1.f.2. of the MassHealth model contract.
[7] See Sections 2.8.H.1.f.3. and 2.8.H.1.l. of the MassHealth model contract.

no evidence that the state was notified of the action. The third MCO, NHP, appeared to be reporting fraud-related terminations in a timely manner.

The MassHealth program should ensure that all MCOs comply with existing contracting requirements mandating site visits prior to the acceptance of providers in plan networks. MassHealth should also ensure that providers terminated by the MCOs or denied credentialing for program integrity reasons are reported to the state in a timely manner so that the state can notify other plans, HHS-OIG, the Medicaid Fraud Control Unit (MFCU), and other authorities of these actions as needed.

Section 2: Managed Care Program Integrity

Overview of the State's Managed Care Program

The MassHealth program had approximately 1.9 million Medicaid beneficiaries at the time of this review, with total computable Medicaid expenditures of around $13.3 billion in FFY 2013. A little over $3.2 billion went to various types of managed care programs, including one offering comprehensive Medicaid services to mainstream beneficiaries on a risk capitation basis and two smaller programs offering different mixes of long-term care services to seniors. In response to the Affordable Care Act, Massachusetts also created the CarePlus program which was implemented on January 1, 2014. This expansion program is separate from the state's traditional Medicaid managed care program, although many of its services are similar. The state contracted with six MCOs to serve this new population. Five of these MCOs also operate in the state's traditional Medicaid program. One MCO, Celticare, was new to the state's Medicaid program, although it has been operating as part of the state's health exchange. As the scope of this focused review included the impact of Medicaid expansion across the country, three of the six MCOs involved in both CarePlus and the traditional managed care program were selected for review.

Initially, the state expected that implementation of the Affordable Care Act would result in nearly 325,000 individuals entering the state's Medicaid program, with the majority of these in CarePlus. At the time of the review, 268,519 individuals had enrolled in the CarePlus program. The state Medicaid agency paid the six MCOs in the expansion program over $668 million in the first six months of calendar year 2014.

Summary Information on the Plans Reviewed

During the week of July 14, 2014, the CMS review team met with staff from the SIU of three MCOs and discussed their activities at length. Two MCOs, BMCHP and NHP, have been long-standing contractors (20 years or more) with networks of more than 15,000 providers and over 200,000 Medicaid enrollees. One MCO, Celticare, has only been operational since January 1, 2014, with a network of just over 14,000 providers and under 40,000 Medicaid enrollees.

Celticare serves Massachusetts Medicaid clients only[8]; the other two MCOs, BMCHP and NHP, serve Medicaid beneficiaries in both Massachusetts and neighboring states (New Hampshire and Rhode Island, respectively). All MCOs use a mixture of sub-capitation and FFS payments to their provider networks. The three MCOs also do not have dedicated investigative units for Medicaid cases only. Their investigators work fraud cases in all lines of business, including Medicaid.

State Oversight of Managed Care

The state's MCO unit oversees both traditional and CarePlus MCOs. The MCO unit resides within the MassHealth Office of Providers and Plans. The MCO unit collaborates internally with other departments, including the Program Integrity Unit (PIU), in overseeing MCO program integrity work. In addition, the MCO unit and PIU meet quarterly with the state's MFCU (in Massachusetts called the Medicaid Fraud Division, or MFD) and contracted MCOs. Per state officials, it has also been routine practice of the MCO unit and PIU to meet as issues arise.

As part of the focused review, the CMS review team reviewed the state's model contract with its MCOs for specific program integrity requirements. Besides the selected provider enrollment and screening requirements discussed above, the CMS review team considered the contractual requirements for program integrity compliance programs and staffing for such activities. The CMS review team found that the state requires its MCOs to have a compliance program consistent with the regulation at 42 CFR 438.608. Related to this requirement, each MCO must have an internal fraud and abuse program and designate a fraud and abuse prevention coordinator, who may also serve as the plan's compliance officer. The role of the fraud and abuse prevention coordinator requires at least some involvement in fraud and abuse investigations. However, the contract does not delineate how many staff must be assigned to perform program integrity activities based on the number of providers in the plan's network or the number of members served. The contract also does not require that MCOs have an SIU dedicated specifically to fraud and abuse investigations.

State Managed Care Program Integrity Activities

The state Medicaid agency does not conduct any onsite reviews of the MCOs. Nor does it require its external quality review organization to review the plans for compliance with the fraud and abuse provisions of its contract or confirm that the MCOs have a mandatory compliance plan in place. Instead, the state relies on a series of reports, submitted by the plans, to monitor their compliance. These reports include an annual certification that the plan is in compliance with the state contract's fraud and abuse requirements, along with an annual fraud and abuse report. The annual report is a summary of MCO fraud and abuse activities for the year. However, the state's contract does require MCOs to initially report any suspected fraud or abuse to the MCO unit within ten days of concluding a preliminary investigation. The state does not initiate audits of network providers, but upon receiving a referral from an MCO about a network provider, the

[8] Although a plan owned by Celticare called Ambetter serves non-Medicaid clients in the health care reform marketplace.

state will confirm whether the provider is also enrolled in Medicaid FFS to determine if it could be an additional risk to the state.

In Massachusetts, the state pays the MCOs on a monthly capitation rate basis. It does not require the MCOs to return to the state any overpayments recovered from network providers as a result of fraud and abuse investigations or audits. However, if routine auditing results in an overpayment of $75,000 or more, the MCOs are required to report it. The $75,000 threshold does not apply to cases of fraud and/or abuse. In these cases, any amount must be reported.

Training

The state Medicaid agency has not conducted any formal training with the MCOs, although one MCO did indicate an interest in additional training. At the quarterly meetings attended by the state's MCO unit, PIU, MCOs, and the MFD, the MCOs are informed of program integrity issues and provided guidance on how to improve their program integrity practices. MCO staff also receives some training in program integrity issues and techniques by attending meetings and workshops of organizations such as the National Health Care Anti-fraud Association, although such meetings do not have a Medicaid focus. In addition, the MCOs were able to document the provision of training for all new staff and annual refresher courses on general program integrity concepts and ideas.

CMS recommends that Massachusetts provide formal trainings on Medicaid program integrity issues to the MCOs. These could be conducted at the quarterly meetings with the state's MCO unit, PIU, MCOs, and the MFD or in other settings.

Encounter Data

The state Medicaid agency does receive encounter data from the MCOs, but reported that it does not do any type of data mining with the encounters, as the quality of the data is insufficient for individual provider analysis. This hinders the state in identifying aberrant provider billing patterns in the growing managed care sector of MassHealth.

CMS recommends that Massachusetts work with plans to improve the encounter data reported by MCO contractors and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste and abuse issues with MCO network providers.

Reporting of Investigations and Overpayments

In Massachusetts, the MCOs are contractually required to report any suspected fraud or abuse to the state within ten days of a determination based on the preliminary investigation. However, although the state requires the MCOs to submit an annual report listing actions taken against providers the state acknowledged that it did not require the MCOs to submit their investigation logs as part of the annual report. Without such information, the state may not be in a position to determine if any potential fraud or abuse cases at the plan level are going unreported.

When MCOs report suspected fraud or abuse to the state, the PIU reviews the information and will forward a case to the MFD if it is deemed a credible allegation of fraud. During the plan interviews, one MCO reported that it did not receive any further information from the state on the status of cases after they were referred. It often followed up with the MFD at the quarterly meeting but was generally told only that a case was ongoing. This may be standard law enforcement practice, but some additional feedback to plans on whether they can take administrative actions against the referred providers could help prevent the continued outflow of improper payments.

In the past four FFYs, the state reported that it had received a total of 13 cases of potential fraud and abuse from the five traditional MCOs, and had received no cases from the CarePlus MCOs since their implementation in January 2014. In addition, the CarePlus MCOs had reported no overpayment recoveries during the first six months of the program.

CMS recommends that Massachusetts require the MCOs to submit their investigation logs as part of the annual report. The state should also review the activities of the MCO SIUs to determine if cases are unreported. Where managed care network provider cases are referred to law enforcement for possible prosecution, the state should work with the MFCU to provide information on when plans can undertake administrative actions to curb the flow of fraudulent or abusive payments.

MCO Program Integrity Activities

Two of the three MCOs interviewed maintain a distinct SIU which focuses on the investigation of suspected fraud and abuse. BMCHP's SIU is located in Massachusetts, while Celticare's SIU is housed at its parent company, Centene, and located in St. Louis, Missouri. BMCHP reported that it had 4.6 full-time equivalents employees (FTEs) in the SIU dedicated to anti-fraud and abuse activities. One of its contractors, which performs prepayment review activities, provides another 2.5 FTEs; and an additional 2.5 FTEs were budgeted for addition to the SIU staff during current fiscal year. In contrast, as a new MCO, Celticare's SIU was staffed at a much lower level (0.5 FTE). The plan indicated that managers, investigators, analysts, and clinical reviewers all participated in the SIU at the following FTE levels with responsibility for different parts of an investigation:

- Management - .10 FTE
- Investigator - .20 FTE
- Analyst - .10 FTE
- Clinical Reviewer - .10 FTE

These levels may have sufficed for Celticare's startup year in MassHealth, but they will likely prove inadequate to handle the analytical and investigative responsibilities of a mature program going forward.

Unlike BMCHP and Celticare, NHP does not have a dedicated SIU. It conducted all of its program integrity related activities through its provider audit and compliance department. Per

NHP's organization chart, this department consisted of 18 FTEs. NHP staff said it maintained a core team of clinicians and coders who could undertake program integrity investigations as needed and used third party contractors to supplement the internal team.

Both BMCHP and Celticare staff indicated in interviews that besides the work of their SIUs, separate audit departments engaged in a variety of activities designed to detect improper payments to providers. All three MCOs work in conjunction with a variety of contractors to avoid improper payments to providers. The contractors aid in data mining and analysis through the use of algorithms and the application of pre-payment edits to avoid payment for billing inaccuracies, including errors that may indicate fraud, such as unbundling or medically unlikely procedures. All three MCOs said they evaluated the issues identified by their contractors on a quarterly basis and used them to identify providers for retrospective reviews.

CMS recommends that Massachusetts require contracting MCOs to develop SIUs (or functional equivalents) with sufficient resources commensurate with plan size to conduct the full range of program integrity functions, including the review, investigation and auditing of provider types where Medicaid dollars are most at risk.

Overpayments Identified and Recoveries

As part of the focused review, the CMS review team asked all of the MCOs interviewed how much in overpayments they recovered over the past four FFYs as a result of SIU program integrity activities. BMCHP reported average recoveries of just over $1.93 million in state fiscal years (SFY) 2010 - 2012, with recoveries rising to nearly $3.9 million in SFY 2013. In contrast, NHP reported total recoveries of $1.56 million for the entire 4 year period, while Celticare, as the newest plan in the program, reported $5,601 in recoveries at the time of the review.

The Celticare recovery totals may be related to the fact that the plan was still in start-up mode when the review took place. On the other hand, the NHP recovery totals appear relatively modest considering that NHP received $860 million in capitation payments in SFY 2013 alone. However, when the CMS review team asked about the full range of activities designed to curb improper payments in each MCO, a different picture emerged. NHP, for example, averaged nearly $13.9 million in recoveries over the previous four SFYs through various types of audit activities aimed at controlling waste and abuse in its program. Many of these audits are based on information derived from 30-40 standard fraud detection algorithms which the plan runs every month. Moreover, NHP reported an additional $1.1 million in cost avoidance. Besides the $3.9 million in recoveries BMCHP reported in SFY 2013, the plan also reported $11.4 million in cost savings through various claims editing and cost avoidance activities.

Based on documentation provided by the state, it appears that much of the "non-fraud" recoupments and cost avoidance figures are reported to the state in end-of-the-year summaries. To what extent this data is taken into account in the managed care rate-setting process is not clear. Moreover, by treating this type of information differently from SIU suspected fraud reporting, the plans delayed the sharing of information with MassHealth on potential problem

providers who may have been overbilling in other MassHealth MCOs or in the FFS Medicaid program.

During the review, CMS staff sampled case files on providers suspected of fraud in each of the selected MCOs. By and large, these files showed significant gaps. For example, of the ten BMCHP provider investigation files examined, the CMS review team noted the following:

- Four of the ten cases did not make reference to how the provider was selected for audit/investigation;
- Six of the ten case files did not indicate audit/investigation dates; and
- Eight of the ten case files did not contain evidence of a preliminary investigation.

The CMS review team also noted that case files sampled from BMCHP's vision care contractor were generally incomplete and that one file from the plan's behavioral health contractor, which otherwise provided well documented investigations, lacked information about the outcome of a significant case. Similarly, of the ten provider files reviewed from NHP's behavioral health contractor, the CMS review team observed that one case file showed no evidence of a suspected fraud referral to MassHealth, although the case involved an overpayment of nearly $185,000.

The CMS review team also observed that the tracking system used by NHP to follow the progress of complaint investigations was different from and did not communicate with a SharePoint system used by NHP's provider audit and compliance staff to track the results of audits triggered by data mining activities. For the most part, the results of provider audits are not input into the database that is supposed to house information on cases from intake to the point of closure. Theoretically, if fraud were suspected, a case identified through the running of an algorithm could be entered in the general tracking system. However, in practice, NHP was unable to provide a complete list of Medicaid cases, including audits and preliminary and full investigations over the three most recent fiscal years because of the separate tracking tools.

The responsibility for moving cases along expeditiously cannot be placed on the plans alone. The MCOs studied in this review were able to document compliance with the requirement that they promptly report all recoupments of over $75,000 to the state. Noting that staffing is limited in numbers, the MassHealth Program Integrity Director acknowledged that the state does not always provide timely feedback on the status of cases reported to it by the plans. This was confirmed in some of the provider case files examined. For example, two of the ten Celticare provider case files reviewed by the CMS team involved requests to MassHealth for permission to investigate, to which the state never responded.

Generally speaking, the timely reporting of a greater range of MCO audit and investigation activity would be helpful in Massachusetts, but improved reciprocal communications from the state could facilitate the development of potential cases. This is a concern because both the number of suspected fraud cases that the MCOs are sending to the state and the number of MCO fraud cases resulting in MFCU referrals are limited in Massachusetts. Only eleven cases reviewed by the BMCHP SIU, for example, and three cases handled by NHP resulted in referrals

to the MFD during the three-year period from SFY 2011-2013. In contrast, the FFS Medicaid program made 36 FFS case referrals to the MFD from calendar year 2011 through 2013.

CMS recommends that Massachusetts review its reporting requirements on MCO audit and investigation activity and ensure that the broadest possible reporting is shared with the PIU and MCO unit as well as with other components in the state assigned to the performance of rate-setting functions. In addition, the state agency should provide for enhanced reciprocal communications on the status of fraud and abuse cases reported by managed care contractors.

Terminated Providers

Between SFY 2011 and 2013, both of the established plans that the CMS review team interviewed showed general provider turnover rates ranging from 4.6 to 9.3 percent. While they disenrolled or terminated 700 to 2,300 providers per year for a variety of non-program integrity related reasons, the number of for cause terminations was much smaller. As the chart below notes, BMCHP averaged 37 such terminations over the 3 year period, while NHP averaged 46.

MCO	Number of network providers in FFY 2013	Providers enrolled in last 3 completed FFYs	Providers disenrolled or terminated in last 3 completed FFYs	Providers terminated for cause in last 3 completed FFYs
BMCHP	15,573	**FY13:** 14,124 **FY12:** 13,469 **FY11:** 12,899	**FY13:** 1,019 **FY12:** 809 **FY11:** 712	**FY13:** 42 **FY12:** 35 **FY11:** 34
Celticare	14,404 (CommCare & Exchange MA)	**FY13:** 11,409 **FY12:** 3,207 **FY11:** 5,666	**FY13:** 26 **FY12:** 0 **FY11:** 0	**FY13:** 0 **FY12:** 0 **FY11:** 0
NHP	24,904	**FY13:** 2,254 **FY12:** 2,154 **FY11:** 2,095	**FY13:** 1,475 **FY12:** 2,310 **FY11:** 1,139	**FY13:** 85 **FY12:** 37 **FY11:** 15

Table 2

While most of these actions involved legally required terminations on the part of the MCOs, for example, in removing providers who lost their license from the networks, there is evidence that the plans carried out terminations requested by the state as a result of fraud investigations. During the review, in fact, the CMS review team uncovered two such cases in which the providers managed to delay or reverse FFS Medicaid terminations through the appeals process or litigation, while the later MCO terminations remained in force. On the other hand, the CMS review team's sampling results called into question whether the MCOs were always reporting program integrity-related terminations. As noted in the above section on Provider Enrollment and Screening in Managed Care, in at least one MCO, the files reviewed involving for-cause terminations did not make clear the causes of the termination actions and did not document that these actions were reported to the state at the time they were taken. The files of another MCO also did not show clear evidence of timely termination reporting to the state, although it is possible in both cases that the termination actions were reported in later MCO provider network updates.

CMS recommends that Massachusetts develop policies and procedures to ensure that MCOs report all fraud-related provider terminations directly to the MFD in a timely manner. MassHealth should further ensure that the information on such terminations is shared with other MCOs, the FFS program, HHS-OIG, and CMS.

Payment Suspension

Massachusetts Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. Although one plan, BMCHP, indicated it would impose a payment suspension if the state told it to in accordance with the contract, a review of the contract showed no clear requirement along these lines. According to the PI Director, when the FFS program suspended payments to a provider, the MCOs were instructed to follow their own contractual obligations in deciding whether to impose a payment suspension. However, as noted earlier, if the state actually terminated or suspended a provider from participation in the program, the MCOs were contractually required to follow suit. The CMS review team sampled files which indicated that BMCHP, in two cases, proactively suspended payments to providers in calendar years 2011 and 2013. However, based on the submitted case files, the CMS review team could not determine whether referrals were made to MassHealth or the MFD.

Celticare reported that its SIU would not suspend payments unless instructed to by a state or federal agency and had no suspensions to report. NHP likewise indicated that it had imposed no payment suspensions in the four preceding fiscal years.

CMS recommends that Massachusetts provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23. The state should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud in its model contract with MCOs.

Summary of Managed Care Recommendations:

- Provide formal trainings on Medicaid program integrity issues. These could be conducted at the quarterly meetings with the state's MCO unit, PIU, MCOs, and the MFD or in other settings.
- Work with plans to improve the encounter data reported by MCO contractors and perform state-initiated data mining activities to assist MCOs in identifying fraud, waste, and abuse issues with MCO network providers.
- Require the MCOs to submit their investigation logs as part of the annual report. The state should also review the activities of the MCO SIUs to determine if cases are unreported. Where managed care network provider cases are referred to law enforcement for possible prosecution, the state should work with the MFCU to provide information on when plans can undertake administrative actions to curb the flow of fraudulent or abusive payments.
- Require contracting MCOs to develop SIUs (or functional equivalents) with sufficient resources commensurate with plan size to conduct the full range of program integrity functions, including the review, investigation and auditing of provider types where Medicaid dollars are most at risk. Review the reporting requirements for MCO audit and investigation activity and ensure that the broadest possible reporting is shared with the PIU and MCO unit as well as with other components in the state assigned to the performance of rate-setting functions. In addition, the state agency should provide for enhanced reciprocal communications on the status of fraud and abuse cases reported by managed care contractors.
- Ensure that MCOs comply with the requirements of the model contract which stipulate that site visits must be conducted before providers can be accepted as network providers.
- Develop policies and procedures to ensure that MCOs report all fraud-related provider terminations or denials of credentialing to the state in a timely manner. Ensure further that the information on such terminations is shared with other MCOs, the FFS program, HHS-OIG, the MFD, CMS as other authorities as needed.
- Provide training to contracted MCOs on the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23. The state should further require the reporting of plan-initiated payment suspensions based upon credible allegations of fraud in its model contract with MCOs.

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:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing System for information provided by other states including best practices and managed care contracts.
- Consult with other states on methods of conducting out-of-state site visits to provider applicants. Consider using other available state, county, and local government resources

to assist in the provider screening process in order that the state can comply with the requirements of 42 CFR 455.432 listed in Section 1.

- Consult the managed care plan compliance toolkit developed for CMS by a private contractor. This is available at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/managedcare-toolkit.html.
- 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 assistance as needed to conduct exclusion searches and training of managed care staff in program integrity issues.
- Regarding the development of viable encounter data systems, consult the Encounter Data Toolkit developed for CMS by a private contractor in November 2013. This is available on the CMS website at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/Medicaid-Encounter-Data-toolkit.pdf.
- Consult CMS's Medicaid Payment Suspension Toolkit at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidGuidance.html to develop a payment suspension process for MCOs that is consistent with federal regulations and guidance. CMS can also refer Massachusetts to states that are further along in this process to address risks identified is Section 2.
- 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 based on its identified risks include those related to provider enrollment and oversight of managed care. More information can be found at http://www.justice.gov/usao/training/mii/training.html.
- 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.
- Access the annual program integrity review summary reports on the CMS's website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html. These reports contain information on noteworthy and effective program integrity practices in states. We recommend that Massachusetts review the noteworthy practices on provider enrollment and disclosures and the effective practices in program integrity and consider emulating these practices as appropriate. The state should also review effective practices related to the handling of terminated providers to address the issues identified in the ACA section of this report.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately. However, CMS supports Massachusetts's efforts and encourages it to look for additional opportunities to improve overall program integrity.

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. The State Medicaid agency should also 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 Medicaid agency has already taken action to correct compliance deficiencies or vulnerabilities, then those corrections should be identified as well.

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

Addendum: Review of Massachusetts's Corrective Action Plan

On July 17, 2014, the CMS review team interviewed the Chief Compliance Officer regarding corrective actions Massachusetts had taken and any open issues related to its CAP from the CMS comprehensive program integrity review of in March 2012. The state's original CAP response reasonably addressed their issues found in the 2012 review. The CMS review team sought to determine if corrections envisioned after the comprehensive review had been fully implemented or were on pace to be made. The state responded as follows to the CMS review team's questions:

1. ***The state does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)***
    - The Chief Compliance Officer indicated that a Federally Required Disclosure (FRD) Form addresses all the federal disclosure requirements which are in place in the new MCO contracts. The effective date of this was October 2012.
        - ***I.*** The FRD form is in place in the new senior care options (SCO) contracts. The effective date of this was June 2012.
        - ***II.*** The FRD form is in place in the new behavioral health organization (BHO) contract. The effective date of this was October 1, 2012.

    I. Has the FRD form been incorporated into the Personal Care Attendant (PCA) Fiscal Intermediary (FI) and Dental Third Party Administrator (TPA) contracts?
        - ***III.*** The FRD form is being used by DentaQuest (the dental TPA). The effective date was November 26, 2012.
        - ***IV.*** The PCA FI also began using the form with an effective date of October 2012.

    - ***Have the non-emergency medical transportation broker contracts been modified to include the FRD form?*** *(according to the CAP this was supposed to be done in July 2012)*
        - The FRD forms were incorporated in the broker contracts during FY 13.

2. ***The state does not conduct complete searches for individuals and entities excluded from participating in Medicaid. (Uncorrected Partial Repeat Finding)***

    I. When did the dental TPA start using the FRD form and start searching for exclusions and debarments?
        - The FRD was incorporated into the contract and application on November 26, 2012.

    II. When did individual and group providers have to start filling out the Ownership and Control section of the revised FRD?
        - The effective date was March 6, 2013.

3. The state does not provide notice of exclusion consistent with the regulation.

I. Did the state create the publicly accessible web page containing excluded provider information which it indicated would be completed by early 2013?

- Yes, the state has a public website that contains excluded providers. The effective date was March 6, 2013. The URL is: http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/list-of-suspended-or-excluded-masshealth-providers.html

4. The state does not comply with its state plan regarding false claims education monitoring.

I. When were the policies put in place to monitor provider compliance with existing statutory requirements on the provision of False Claim Act education?

- The state developed policies for monitoring provider compliance with the requirements of the False Claim Act education provision after the 2012 comprehensive program integrity review. However, Massachusetts did not implement them until the FFY 2012 attestation notices for providers concerning their False Claims Act education activities were completed in 2014.

5. State program integrity oversight is decentralized.

I. When did the quarterly standing meetings start with the Director and the Program Integrity units at University of Massachusetts Medical School (UMMS)? (according to the CAP this was supposed to begin in October 2012)

- In October 2012 the state started meeting internally with UMMS.

II. Is the new database that is to track all program integrity activities up and running and when was the effective date?

- The database is not up and running at this time.
  - The Provider Compliance Unit has a new database system, the Predictive Modeling Unit has its own database system, and the Office of Clinical Affairs tracks its own cases.
  - The state signed a new contract with contractor.
  - All of the above mentioned units will be utilizing the new case tracking system beginning in June 2015.
  - The state has also enhanced its pre- and post-predictive analytic efforts within program integrity.

III. Has the Provider Compliance Unit (PCU) started its quarterly meetings with UMMS components?

- Yes, the PCU is having quarterly meetings with UMMS. The Office of Clinical Affairs also meets with UMMS on a regular basis.

6. Limited program integrity oversight over contracted health plans.

I. Who at MassHealth is reviewing the operations of the MCOs, BHO and SCO for program integrity issues, such as implementing compliance plans, enrolling network providers, checking for people who are excluded and debarred?

- The reviewing operations are done by the combination of the MCOs, PCU, and program integrity.
  - The PCU is responsible for reviewing the compliance plans for the MCOs, BHOs and SCOs related to the Medicaid program. However, no one in PCU is looking at those compliance plans.
  - The PCU has limited resources and is looking to hire three more full time equivalents for its internal audit unit.
  - State staff told the CMS review team that the compliance plans will be reviewed by PCU and the EOHHS, Office of Compliance.
  - They also indicated that they will work closely with their vendors and contractors so they will be aware of problems.
  - They noted that this practice is not in a written policy but said they would codify their actions into one.

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

I. Is there a provision in the MCO, BHO, and SCO contracts that require direct verification of service provision by enrollees?

- There is a provision in the MCO, BHO, and SCO contracts that requires direct verification by enrollees
  - The service verification language was inserted in all the contracts in May 2013.

8. Not capturing ownership and control disclosures from network providers.

I. Is there a provision in the MCO, BHO, and SCO contracts that require the capturing ownership and control disclosures from network providers?

- Yes, there is a provision in the MCO, BHO and SCO contracts that requires the capturing of ownership and control disclosures from network providers.

9. Not adequately addressing business transaction disclosures in network provider contracts.

I. Is there a provision in the MCO, BHO, and SCO contracts that requires network provider agreements to contain language on the disclosure of business transaction information that reflects the language of 42 CFR 455.105?

- Yes, there is such a provision in the MCO, BHO, and SCO contracts.

10. Not capturing criminal conviction disclosures from network providers.

I. Is there a provision in the MCO, BHO, and SCO contracts that requires the collection of criminal conviction disclosures from network providers?

- Yes, there is such a provision in the MCO, BHO, and SCO contracts. Its effective date for the following types of managed care contracts was as follows:
  - MCO: effective date, July 1, 2011
  - CarePlus: effective date, January 1, 2014
  - BHO: effective date, October 1, 2012
  - SCO: effective date, July 1, 2012

- The disclosure provisions in these contracts are as follows:

  - **BHO contract (Mass Behavioral Partnership) Section 13.2.C:**
    The Contractor shall ensure that its Network Provider enrollment forms require Provider applicants to disclose complete ownership, control, and relationship information, and that Network Applicants and Network Providers fully and accurately complete the required portions of the EOHHS form developed for such purpose. Further, the Contractor shall require persons with an ownership or control interest, or persons who are agents or managing employees of Network Providers, to utilize the EOHHS form developed for such purpose to fully and accurately disclose health care-related criminal convictions, and to notify EOHHS of such disclosures within 20 working days

  - **MCO Program Contract Section 5.1.O.2(c):**
    O. Disclosure Requirements - with 42. CFR § 455.100, et seq. and 42 U.S.C.§1396b(m)(4)(A) in the form and format specified by EOHHS.
    c. Criminal Convictions
    Upon any renewal or extension of this Contract and at any time upon a written *request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.*

  - **SCO Section 5.1.F52(c):**
    c. Criminal Convictions
    Upon any renewal or extension of this Contract and at any time upon a written *request by EOHHS, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.106 regarding persons convicted of crimes.*

II. Is there a provision in the MCO, BHO, and SCO contracts that requires the performance of complete searches for individuals and entities excluded from participating in Medicaid corresponding to the requirements of 42 CFR 455.436?

- Yes, there is such a provision in the MCO, BHO, and SCO contracts, with an effective date of July 2012.

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

I. Was the SCO contract changed on July 1, 2012 to meet this requirement?

- Yes, in July 2012.

Summary:

The state has addressed all questions related to the 2012 CAP, and no additional follow-up is needed at this time. Going forward, the state's managed care oversight should take into account the recommendations in this report. CMS will periodically monitor the state's activities in this regard.

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February 11, 2015

Letita Leaks, Director
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Re: Medicaid Integrity Program: Massachusetts Focused Program Integrity Review Report
Final Report – December 2015

Dear Ms. Leaks:

Thank you for the opportunity to respond to the above-referenced Final Report that describes the CMS Medicaid Integrity Group's focused review of Massachusetts's Medicaid Program Integrity procedures and processes. The Executive Office of Health and Human Services is committed to ensuring the integrity of the MASSHealth program. Accordingly, we appreciate the extensive review of whether Massachusetts has fully implemented the requirements of federal regulations at 42 CFR 455 Subpart E that implemented the enhanced provider screening and enrollment provisions of the Affordable Care Act; and your assessment of the State's oversight of program integrity activities of the state managed care program as well as the program integrity activities performed by the managed care organizations under contract with the Commonwealth.

In the attached response to the Final report, we have reproduced your team's findings, vulnerabilities and recommendations and describe our corrective action plans. MassHealth is working to implement these plans as quickly as possible. MassHealth will be in compliance with the re-validation of all providers by the March 25, 2016 federal deadline. Please note that there are certain plans that cannot be competed in the 90-day timeframe outlined by CMS, but as detailed in the individual corrective action plans attached, MassHealth will implement these steps as soon as is feasible.

If you have any questions or would like to discuss, please contact Joan Senatore at (617) 847-3122.

Sincerely,

Daniel Tsai
Assistant Secretary, MassHealth

Attachment