Department of Health and Human Services
Office of Inspector General
Office of Audit Services

February 2025 | A-04-22-04091

Massachusetts Generally Claimed Safety Net Care Pool Costs That Complied With Federal Requirements

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- Massachusetts operates its Safety Net Care Pool (SNCP) under MassHealth, its waiver established under section 1115 of the Social Security Act. The SNCP allows the State to make expenditures for, among other things, certified public expenditures (CPEs) for State-owned hospitals and payments to institutions for mental diseases (IMDs) and community-based detoxification centers (CBDCs) to reduce the uncompensated care incurred by these providers.
- Previous OIG audits of uncompensated care programs found that States were significantly overpaid.
- Our audit objective was to determine whether the Massachusetts claimed SNCP expenditures for certain providers for State Fiscal Years (SFYs) 2015–2018 that complied with Federal requirements.

What OIG Found

- Massachusetts generally claimed SNCP expenditures that complied with Federal requirements under its section 1115 waiver.
- Of the $706.1 million in SNCP expenditures we audited, $678.3 million complied with Federal requirements. However, $27.8 million ($13.9 million Federal share) did not comply. This includes $21.6 million in SNCP payments to IMDs and CBDCs that exceeded the uncompensated care for Medicaid-eligible and uninsured patients, and $6.2 million in CPEs that exceeded the uncompensated care for uninsured patients in state-owned hospitals.
- Massachusetts claimed unallowable costs because it did not have policies and procedures in place to ensure that personnel performed the required reconciliations of the expenditures.

What OIG Recommends

We made five recommendations, including that Massachusetts, recover $21.6 million in overpayments to IMDs and CBDCs, correct its $6.2 million overstatement of CPEs and refund the $13.9 million Federal share, develop and implement policies and procedures to perform interim and final reconciliations, and perform reconciliations for SFYs subsequent to our audit period. The full recommendations are in the report.

Of our five recommendations, Massachusetts agreed with two, partially agreed with two, and disagreed with one.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 1995, the Centers for Medicare & Medicaid Services (CMS) approved Massachusetts' managed care waiver, MassHealth (the waiver), which Massachusetts operates under Section 1115 of the Social Security Act (the Act). In 2005, CMS and the State agreed to include the Safety Net Care Pool (SNCP) in the waiver to reduce the uninsurance rate in the State and provide residual funding for uncompensated care and care for Medicaid patients. In 2014, the waiver included a new requirement that provider payments for uncompensated care be limited on a provider-specific basis to the cost of caring for Medicaid-eligible individuals and uninsured individuals minus the payments received for providing care.

For State fiscal years (SFYs) 2015 through 2018, the Massachusetts Executive Office of Health and Human Services (State agency) claimed SNCP expenditures totaling $706,114,325 relating to State-owned hospitals, institutions for mental diseases (IMDs), and community-based detoxification centers (CBDCs).[1, 2, 3, 4] Summary data provided by the State for these institutions indicated that some of the facilities may have been overpaid.

In addition, prior OIG audits found two states with programs for uncompensated care had improperly claimed expenditures totaling $1.1 billion ($767 million Federal share) and $686 million ($412 million Federal share).[5]

[1] Section 1905(i) of the Act defines an IMD as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

[2] CBDCs provide health care services for substance use disorder under contract with the State agency, Medicaid managed care organizations, and the State's Bureau of Substance Addiction Services. CBDCs are licensed by the State's Bureau of Substance Addiction Services.

[3] Massachusetts' State fiscal year is July 1 through June 30.

[4] The State-owned hospitals are operated by the State's Department of Public Health and Department of Mental Health.

[5] OIG, *Tennessee Medicaid Claimed Hundreds of Millions of Federal Funds for Certified Public Expenditures That Were Not in Compliance With Federal Requirements* (A-04-19-04070), Oct. 19, 2021; and OIG, *Florida Medicaid Paid Hundreds of Millions in Unallowable Payments to Jackson Memorial Hospital Under Its Low-Income Pool Program* (A-04-17-04058), Aug. 30, 2019.

OBJECTIVE

Our audit objective was to determine whether the State agency claimed SNCP expenditures for State-owned hospitals, IMDs, and CBDCs for SFYs 2015 through 2018 in compliance with Federal requirements.[6]

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. Federal and State governments jointly fund and administer the Medicaid program. At the Federal level, CMS administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. A State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

The Federal Government pays its share of a State's medical assistance costs based on the Federal medical assistance percentage (FMAP), which varies depending on a State's relative per capita income.[7] In Massachusetts, the State agency administers the Medicaid program.

The Waiver

The State agency operates the waiver, which CMS approved in 1995 under section 1115 of the Act. The waiver gives CMS authority to approve experimental, pilot, or demonstration projects that it considers likely to assist in promoting the objectives of the Medicaid program. The purpose of these projects, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate State-specific policy approaches to better serve Medicaid populations.

[6] Hospital cost reports are not due until 5 months after the hospital fiscal-year end. Medicare administrative contractors (MACs) are not required to finalize the cost reports until 12 months after the cost reports are accepted, or longer if the MAC audits the cost reports. The State is not required to perform final reconciliation of the SNCP expenditures for hospitals until 12 months after the Medicare cost reports are finalized.

[7] The FMAP is used to determine the Federal share of State expenditures for most health care services and is based on a formula that provides higher reimbursement to States with lower per capita incomes relative to the national average (The Act § 1905(b)). Massachusetts' FMAP for all years in the audit period was 50 percent, the statutory minimum FMAP.

Special Terms and Conditions of Waivers

To implement a demonstration project, States must comply with the special terms and conditions (STCs) of the agreement between CMS and the State.[8] STCs specify the nature, character, and extent of Federal involvement in the waiver and outline the State's obligations to CMS during the life of the waiver.

Authorization of Safety Net Care Pool Expenditures

The STCs established the SNCP effective July 1, 2005, to reduce the State's uninsurance rate and provide funding for the uncompensated care for Medicaid and uninsured patients. Effective July 1, 2014, SNCP expenditures for the uncompensated care of providers were limited on a provider-specific basis to the cost of providing services to Medicaid and uninsured individuals minus the payments received for providing care. Included in the expenditures authorized under the SNCP were certified public expenditures (CPEs) for certain types of public hospitals and payments to IMDs and CBDCs.

Certified Public Expenditures for Certain Public Hospitals

The STCs authorize CPEs for State-owned hospitals.[9] While the STCs authorized the State agency to claim CPEs based on the uncompensated care for Medicaid and uninsured individuals, the State agency claims CPEs only for the uncompensated care for uninsured individuals.[10] Costs are determined by applying cost factors from the hospitals' Medicare cost reports to the uninsured patient data.[11, 12] The State agency claims uncompensated care as CPEs on the CMS-64 as a means of obtaining Federal financial participation (FFP), the Federal

[8] Five versions of the STCs were in effect during our audit period: STC-a, which had an original effective period of Dec. 20, 2011, through June 30, 2014, and remained in effect through extension approvals until Oct. 30, 2014; STC-b, which was effective Oct. 30, 2014, until it was amended on Nov. 4, 2016; STC-c, which was effective Nov. 4, 2016, until it was amended Dec. 14, 2017; STC-d, which was effective Dec. 14, 2017, until it was amended June 27, 2018; and STC-e, which was effective June 27, 2018, and remained in effect through the remainder of the audit period.

[9] Public funds may be considered part of the State's share in claiming FFP if they are certified by the contributing public agency (in this case the public hospitals) as representing expenditures eligible for FFP (42 CFR § 433.51).

[10] The State agency said it does not claim CPEs for the uncompensated care for Medicaid patients. Rather, it reprocesses the Medicaid claims to compensate providers for actual costs when a variance exists between the payments and the cost of caring for Medicaid patients.

[11] The cost factors used in the calculations of uncompensated care are cost-to-charge ratios and costs per patient day as obtained from the Medicare cost reports.

[12] The Medicare cost report is a form that hospitals must submit to CMS to determine Medicare program payments and support Federal program management.

government's share of a State's Medicaid expenditures. The CPEs do not represent actual payments to hospitals.[13]

Payments to Institutions for Mental Diseases

The SNCP expenditures that the STCs authorized included payments that would not otherwise be eligible for FFP for services furnished to individuals in IMDs. The Act prohibits Federal funding of IMD services for individuals between the ages of 21 and 64, but under the waiver, the expenditures for these individuals are authorized for Federal funding.[14] Costs are determined by applying cost factors from the IMDs' Medicare cost reports to the Medicaid and uninsured patient data.

Payments to Community-Based Detoxification Centers

The STCs authorize payments for inpatient services at CBDCs. CBDCs do not file Medicare cost reports; instead, they file Uniform Financial Reports (UFRs).[15] Costs are determined by applying cost factors from the CBDCs' UFRs to the Medicaid and uninsured patient data.

Calculations of Uncompensated Cost of Care

According to Attachment H of the STCs, State-owned hospitals and IMDs are required to calculate uncompensated care using the Medicare cost report and the Uniform Medicaid and Uncompensated Care Cost and Charge Report (UCCR).[16, 17] CBDC providers are required to use the UFR to calculate uncompensated care.

[13] The CMS-64 "Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program" is a summary of expenditures derived from source documents such as invoices, cost reports, and eligibility records that Medicaid State agencies use to report program costs to CMS for FFP.

[14] The Act, § 1905(a)(14), (16), and (30)(B).

[15] The UFR is a report that CBDCs file that includes their expenditures and units of service. CBDCs are required to file the UFR on or before the 15th day of the fifth month after the end of their fiscal year.

[16] Attachment H of the STCs contains the protocols prescribing the methodology for calculating uncompensated care.

[17] The UCCR is a spreadsheet in which the hospital determines costs for Medicaid and uninsured patients by applying costs per patient day and cost-to-charge ratios obtained from the Medicare cost report to the hospital's Medicaid and uninsured patient data. Hospitals are required to file the UCCR 3 months after the Medicare cost report is filed.

Reconciliation of Safety Net Care Pool Expenditures

The STCs require the State agency to perform interim and final reconciliations of SNCP expenditures. For IMDs and CBDCs, the State agency must compare the providers' actual costs of caring for Medicaid and uninsured patients to the payments the providers received for providing care. If the IMDs and CBDCs received SNCP payments in excess of their costs of caring for Medicaid and uninsured patients, the State agency is required to recover the excess SNCP payments from the providers and refund the Federal share. In addition, if the CPEs claimed by the State agency exceed the actual uncompensated care for uninsured patients, the State agency is required to correct the CPEs on the CMS-64.[18]

For State-owned hospitals, the State agency is required to complete the interim reconciliation within 12 months after the filing of the Medicare cost reports and the final reconciliation within 12 months after the final audited Medicare cost reports are available. For IMDs, the State agency is required to complete the interim reconciliation within 12 months after the IMDs file their UCCRs and the final reconciliation within 12 months after the final audited Medicare cost reports are made available. For CBDCs the State agency is required to complete the interim reconciliation within 12 months after the filing of the provider's UFR and the final reconciliation within 12 months after the provider's audited UFR is made available.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $706,114,325 in SNCP expenditures, including CPEs for State-owned hospitals and payments to IMDs and CBDCs from July 1, 2014, through June 30, 2018 (audit period). For each SFY in the audit period, we identified expenditures claimed on the CMS-64s for the audited categories of SNCP expenditures. We also obtained summary schedules showing the following: for State-owned hospitals, the cost of caring for uninsured patients; for IMDs and CBDCs, the costs of caring for Medicaid and uninsured patients; and for all three provider categories, the total payments received for providing care.

For State-owned hospitals, we recalculated the uncompensated care using Medicare cost report data and summary totals for uninsured patient data (patient days and charges). We also matched the uninsured patient data to the totals of supporting details for 1 year for 3 State-owned hospitals that accounted for 72 percent of the total CPEs claimed. We compared the recalculated uncompensated care to the CPEs claimed on the CMS-64s.

For IMDs and CBDCs that appeared to have received overpayments according to the State's summary schedule, we recalculated the uncompensated care using Medicare cost report data

[18] While the STCs' interim reconciliation instructions for CPEs say that the State agency must recover overpayments from providers, CMS and the State agency both confirmed that this is a misstatement. In claiming CPEs, the State agency does not make payments to providers. Rather, the State agency claims on the CMS-64 an estimate of the public hospitals' uncompensated cost of caring for uninsured patients. The State agency's final step in the reconciliation process is not to recover overpayments and refund the Federal share but to adjust the estimated CPEs to actual costs on the CMS-64.

(for IMDs) or the UFR data (for CBDCs) and identified the SNCP payments that were made to the providers.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our audit scope and methodology and Appendix B for applicable Federal requirements.

FINDINGS

The State agency generally claimed SNCP expenditures that complied with Federal requirements under its section 1115 waiver. Of the $706,114,325 in SNCP expenditures that we audited, $678,268,502, or 96 percent, complied with Federal requirements. However, $27,845,823 ($13,922,912 Federal share) in SNCP expenditures, or 4 percent, did not. That amount included the following:

- $18,972,297 ($9,486,149 Federal share) in payments to IMDs that exceeded the net costs of caring for Medicaid-eligible and uninsured patients;

- $6,239,386 ($3,119,693 Federal share) in CPEs claimed for State-owned hospitals that exceeded the net costs of caring for uninsured patients; and

- $2,634,140 ($1,317,070 Federal share) in payments to CBDCs that exceeded the net costs of caring for Medicaid-eligible and uninsured patients.

The State agency did not comply with the STCs that required the State agency to perform interim and final reconciliations for CPEs and payments made to IMDs and CBDCs. The State agency did not perform these reconciliations because they did not have policies and procedures in place to ensure that personnel would do so.

See Appendix C for a schedule of unallowable and total claimed SNCP expenditures by year.

CRITERIA

Effective July 1, 2014, the STCs limited expenditures on a provider-specific basis to the cost of providing care to Medicaid-eligible individuals and uninsured individuals minus the payments received for providing care. According to cost limit protocols contained in Attachment H of the STCs, the State agency is required to perform interim and final reconciliations in which it must compare expenditures claimed to actual costs. The actions required as part of the

reconciliations and the required timing of the reconciliations varied between the three categories of SNCP expenditures that we audited.

Payments to Institutions for Mental Diseases

The State agency is required to complete an interim reconciliation of SNCP payments within 12 months after the IMDs file their UCCRs and a final reconciliation within 12 months after the final audited Medicare cost reports become available. The State agency is required to compare the payments received for services provided to Medicaid and uninsured patients to the actual costs of caring for those patients. If IMDs received payments in excess of costs, the State is required to recover the portion of the overpayment related to SNCP payments and refund the Federal share.

Certified Public Expenditures

The State agency is required to perform an interim reconciliation of the CPEs within 12 months after the filing of the Medicare cost reports and a final reconciliation within 12 months after the final audited Medicare cost reports become available. If the reconciliations reveal a difference between the CPEs claimed by the State agency and actual uncompensated care for uninsured patients, the State agency is required to adjust the CPEs on the CMS-64 to agree with actual costs.

Payments to Community-Based Detoxification Centers

The State agency is required to complete an interim reconciliation within 12 months after the CBDCs file their UFRs and a final reconciliation within 12 months after the audited UFRs become available. The reconciliation process requires the State agency to compare the payments received for services provided to Medicaid and uninsured patients to the actual costs of caring for those patients, as calculated using the UFR. If CBDCs received payments in excess of costs, the State agency is required to recover the portion of the overpayment related to SNCP payments and refund the Federal share.

See Appendix B for a listing of applicable criteria.

THE STATE AGENCY DID NOT COMPLETE RECONCILIATIONS OF EXPENDITURES FOR INSTITUTIONS FOR MENTAL DISEASES, WHICH RESULTED IN OVERPAYMENTS

The State agency has not completed the final reconciliation of expenditures for the six IMDs that had overpayments reflected on the State's summary schedules for 4 to 7 years since the finalization of the Medicare cost reports, despite the STCs' requirement that the reconciliations

be completed within 1 year.[19] The State agency did not recover the SNCP-related overpayments to IMDs or refund the Federal share because it did not have written policies and procedures to ensure that its staff performed the interim and final reconciliation processes required by the STCs. As a result, the State agency incurred $18,972,297 ($9,486,149 Federal share) in SNCP expenditures in excess of the uncompensated care for Medicaid and uninsured patients and did not recover these overpayments from the IMDs or refund the Federal share.

THE STATE AGENCY DID NOT COMPLETE RECONCILIATIONS OF CERTIFIED PUBLIC EXPENDITURES, WHICH RESULTED IN OVERPAYMENTS

The State agency has not performed final reconciliations of CPEs for the nine State-owned hospitals for 5 to 8 years since the finalization of the Medicare cost reports, despite the STCs' requirements that reconciliations be completed within 1 year.[20] The State agency did not adjust its CPE estimates for State-owned hospitals to actual costs on the CMS-64 because it did not have policies and procedures in place to ensure that its staff performed the interim and final reconciliation processes required by the STCs. As a result, the State agency claimed CPEs for these hospitals that exceeded by $6,239,386 ($3,119,693 Federal share) the actual uncompensated care for uninsured patients for the audit period.

THE STATE AGENCY DID NOT COMPLETE RECONCILIATIONS OF EXPENDITURES FOR COMMUNITY-BASED DETOXIFICATION CENTERS, WHICH RESULTED IN OVERPAYMENTS

The State agency has not completed interim reconciliations of expenditures for the three CBDCs that had overpayments reflected on the State's summary schedules for 5 to 9 years since the required filing date for the UFRs, despite the STCs' requirement that the reconciliations be completed within 1 year of that filing date.[21, 22] The State agency did not recover the SNCP-related overpayments to CBDCs or refund the Federal share because it did not have written policies and procedures to ensure that its staff performed the interim reconciliation process required by the STCs. As a result, the State agency incurred $2,634,140 ($1,317,070 Federal share) for these three CBDCs in SNCP expenditures in excess of the costs of caring for Medicaid

[19] Four of the IMDs had overpayments relating to SFYs 2015 and 2016. One of the IMDs had overpayments relating to all 4 SFYs in the audit period and the other IMD had overpayments relating to SFYs 2017 and 2018. The relevant Medicare cost reports for the IMD overpayments were finalized between Oct. 2017 and July 2020.

[20] The cost reports for the State-owned hospitals for the audit period were finalized between June 2016 and Oct. 2019.

[21] For CBDCs, we cited the State agency's failure to comply with the interim, and not final, reconciliation requirements because the State agency personnel said that the date of the audited UFRs, required for final reconciliation, is not always clear.

[22] All three of the CBDCs had overpayments related to SFY 2018, and one of the three CBDCs had overpayments related to all SFYs in the audit period. The required filing dates for the relevant UFRs were between December 2015 and December 2019.

and uninsured patients and did not recover these overpayments from the CBDCs or refund the Federal share.

RECOMMENDATIONS

We recommend that the Massachusetts Executive Office of Health and Human Services:

- recover from IMDs and CBDCs $21,606,437 in SNCP payments that exceeded the cost of caring for Medicaid and uninsured patients;

- correct its $6,239,386 overstatement of CPEs on the CMS-64, which represents the difference between its CPE estimates and the actual uncompensated care provided to uninsured patients for State-owned hospitals;

- refund to the Federal government the $13,922,912 Federal share of the total $27,845,823 in SNCP expenditures that did not comply with Federal requirements;

- develop and implement policies and procedures that instruct personnel to perform interim and final reconciliations required by the STCs; and

- perform reconciliations for the SFYs following our audit period, where the required Medicare cost reports or UFRs are available. In addition, it should refund the Federal share of any overstated CPEs, as well as recover any overpayments to IMDs and CBDCs and refund the Federal share.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with two of our recommendations, partially agreed with two others, and disagreed with one. The State agency readily acknowledged that overpayments to providers and overclaiming for CPEs requires the return of the Federal share of such overpayments or overclaiming. However, it reserved the right to further adjust the final overpayments based on the final reconciliation process for the CBDCs and the completion of the State's overpayment recoupment administrative process.

In addition, the State agency disagreed with OIG's assertion that it "did not have written policies and procedures" to ensure compliance with the reconciliation process but said that some of its policies and procedures can be improved to ensure more timely reconciliation and timely return of the Federal share corresponding to overpayments or overclaiming.

After reviewing the State agency's comments, we maintain that our recommendations are valid.

The State agency's comments are included in their entirety as Appendix D.

RECOMMENDATION TO RECOVER $21.6 MILLION FROM INSTITUTIONS FOR MENTAL DISEASES AND COMMUNITY-BASED DETOXIFICATION CENTERS

State Agency Comments

The State agency agreed with OIG's overpayment findings with respect to the IMDs and intends to seek recoupment of funds from the IMD providers for the identified amount of overpayment. The State agency said it will follow its standard overpayment recoupment and administrative process, which includes an appeal process for IMDs disputing an overpayment. This process could change the amount the State agency ultimately recoups. The State agency said if the amount identified as an overpayment by OIG changes during the administrative process, it would work with CMS to correct the Federal claiming accordingly.

The State agency considers the overpayment attributable to the CBDCs to be an interim amount and therefore disagrees that OIG has identified a final overpayment to CBDCs. The State agency said that it requested supplemental cost reporting templates from the CBDCs, which it will use to determine a final overpayment amount.[23]

The State agency said that it intends to recoup the final overpayment amounts from the IMDs and CBDCs. However, the State agency said that if it determines during the overpayment recoupment administrative process that recoupment would put members at risk of losing access to inpatient psychiatric care or community-based detox services, it reserves the right to forego recoupment or settle for a lesser amount. The State agency said that if it reduced the amount it recouped from IMDs and CBDCs, it would still return the Federal share of the full overpayment.

Office of Inspector General Response

We maintain that Attachment H of the STCs requires the State agency to recoup the full amount of the $18,972,297 in IMD overpayments, based on finalized cost reports, and the $2,634,140 in CBDC overpayments, based on interim reconciliations. However, provided that the State refunds the Federal share of the total cited overpayments, we will consider the recommendation implemented, regardless of whether the State recoups the full amount from the providers.

[23] The State agency said that it finalized a supplemental cost reporting template in 2024 for the UFR that improves the reconciliation process and obtains more detailed information than is available on the UFR alone. The State agency said it is requiring CBDCs to submit the supplemental template for the SFYs in the audit period and that going forward it will require the CBDCs to do so annually.

RECOMMENDATION TO CORRECT THE $6.2 MILLION OVERSTATEMENT OF CERTIFIED PUBLIC EXPENDITURES ON THE CMS-64

State Agency Comments

The State agency agreed with this recommendation and said it will work with CMS to correct the CMS-64 in a future quarter.

Office of Inspector General Response

We are pleased that the State agency agrees with this recommendation and plans to correct the overstatement of CPEs on a future CMS-64.

RECOMMENDATION TO REFUND THE $13.9 MILLION FEDERAL SHARE OF THE TOTAL $27.8 MILLION OF OVERSTATED SAFETY NET CARE POOL EXPENDITURES

State Agency Comments

The State agency agreed to refund to the Federal government the Federal share of the overpayment associated with IMDs after the completion of the overpayment recoupment administrative process and the overstatement of the CPEs for the State-owned hospitals. However, the State agency considers the CBDC overpayment cited by OIG to be an interim amount and does not plan to refund the Federal share. Instead, it plans to use an improved cost reporting template to determine a final CBDC overpayment amount for which it will return the Federal share.

Office of Inspector General Response

The Federal share of the IMD overpayments and overstated CPEs that the State agency agreed to refund comprise only $12.6 million of the total $13.9 million Federal share of overstated SNCP expenditures. We maintain that the State agency should refund the entire $13.9 million as required by the STCs, including the $1.3 million Federal share of CBDC overpayments determined through interim reconciliation.

RECOMMENDATION TO DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES FOR PERFORMING INTERIM AND FINAL RECONCILIATIONS

State Agency Comments

The State agency disagreed with OIG's assertion in multiple instances that the State "did not have written policies and procedures" to ensure compliance with the reconciliation process. However, the State agency said that the existing policies and procedures can be improved, particularly with respect to conducting the interim and final reconciliations for CBDCs and CPEs

for State-owned hospitals and with ensuring the timely return of the Federal share associated with overpayments. Although recoupment from providers based on interim and final reconciliation is required by Attachment H, the State agency said it is inappropriate to recoup from providers on an interim basis. Instead, the State agency said that it intends to recoup payments from providers based on final reconciliation. The State agency said that it will address any issues with this approach with CMS.

The State agency described steps it had taken to improve policies and procedures, including updating its CPE final reconciliation process to follow Attachment H more strictly. The State agency also said it had developed a supplemental template for cost reporting for CBDCs to ensure timelier interim and final reconciliation processes. The State agency contended that its policies and procedures for IMD reconciliations are adequate and cited the overpayment recoupment process in State Administrative and Billing regulations as a clear process to follow for recouping overpayments.

Office of Inspector General Response

The State agency said multiple times during the audit that it did not have written policies and procedures for performing interim and final reconciliations of SNCP expenditures and did not provide any policies and procedures with its comments on our draft report. During the audit resolution process, the State agency should provide to CMS any existing policies and procedures and any planned improvements to those policies and procedures. In addition, the State regulations regarding the administrative process for overpayment recoupments to which the State agency referred do not constitute a State agency policies and procedures document. The State agency should follow Attachment H, which requires it to perform interim and final reconciliations, including recouping overpayments from providers for both reconciliations.

RECOMMENDATION TO PERFORM RECONCILIATIONS FOR THE STATE FISCAL YEARS FOLLOWING THE AUDIT PERIOD

State Agency Comments

The State agency agreed with the recommendation to perform reconciliations for the IMDs, CBDCs, and the State-owned hospitals. The State agency said that it is reviewing the SFYs following the audit period where the required UCCRs and UFRs are available and that it is implementing the newly established improvements to its procedures for such years. The State agency said that if it identifies any final overpayments to IMDs and CBDCs for the SFYs following the audit period, it will return the Federal share of the overpayments. The State agency also said that it will work with CMS to correct the CMS-64s if it identifies any overclaiming related to CPEs for the SFYs following the audit period.

Office of Inspector General Response

We are pleased that the State agency agrees with and is working to implement this recommendation and plans to return the Federal share of IMD and CBDC overpayments and work with CMS to correct CPE overclaiming for the SFYs following the audit period.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $706,114,325 in SNCP expenditures, including CPEs for State-owned hospitals and payments to IMDs and CBDCs, from July 1, 2014, through June 30, 2018.

We conducted our audit from June 2022 to October 2024. In planning and performing our audit, we limited our review of the State agency's internal controls to those controls related to verifying that the SNCP expenditures that we audited complied with Federal requirements.

METHODOLOGY

To accomplish our objective, we reviewed the waiver's STCs, which contained governing guidance for SNCP expenditures. We discussed with the State agency whether it had internal controls in place to ensure that SNCP payments complied with Federal requirements. In addition, we performed varying steps depending on the type of provider.

For State-owned hospitals we:

- reviewed the CMS-64s for all quarters from September 30, 2014, through September 30, 2024, to identify SNCP expenditures related to our audit period;[24]

- reviewed Statewide summary schedules showing providers' total costs of caring for uninsured patients and payments received for providing care;

- recalculated the uncompensated care for State-owned hospitals using cost factors from the finalized Medicare cost reports, which we applied to the uninsured patient data included in the UCCRs;

- corrected the uncompensated care on Statewide summary schedules where OIG-calculated costs differed from the State agency's schedule;

- matched the uninsured summary totals for patient data for SFY 2018 to the totals of supporting details for three of the State-owned hospitals that accounted for 72 percent of the total CPEs claimed;

- compared OIG-calculated uncompensated care to the CPEs claimed on the CMS-64s;

[24] Because States can make adjustments on CMS-64s that apply to prior periods, we reviewed all of Massachusetts' CMS-64s after our audit period through Sept. 30, 2024.

For IMDs and CBDCs we:

- reviewed the CMS-64s for all quarters from September 30, 2014, through September 30, 2024, to identify SNCP expenditures related to our audit period;

- reviewed statewide summary schedules showing the total costs of caring for Medicaid and uninsured patients and payments made by or on behalf of those patients;

- recalculated the overpayments using cost factors derived from the finalized Medicare cost reports and the UFRs which we applied to the uninsured and Medicaid patient summary data;[25] and

- compared OIG-calculated overpayments to the SNCP payments received by the providers.

We also discussed the results of our audit with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[25] We used the Medicare cost reports for the IMDs and the UFRs for the CBDCs.

APPENDIX B: FEDERAL REQUIREMENTS

SPECIAL TERMS AND CONDITIONS

Cost Limitation

STC-a, paragraph 50(f), STC-b paragraph 51(f), STC-c, paragraph 53, STC-d, paragraph 53, and STC-e, paragraph 56

The cited paragraphs of the various STCs state that all payments for uncompensated care are limited on a provider-specific basis to the cost of providing Medicaid services (and any other additional allowable uncompensated costs of care) to uninsured and Medicaid-eligible individuals minus the payments received for providing care.

ATTACHMENT H OF THE SPECIAL TERMS AND CONDITIONS

Attachment H contains detailed instructions for the calculation of provider costs and the requirements to reconcile SNCP expenditures to actual costs on an interim and final basis.

Certified Public Expenditures

Interim Reconciliation Timing
Attachment H, page 51—The interim reconciliation must be done within 12 months after the filing of the Medicare cost report.

Final Reconciliation Timing
Attachment H, page 52—The final reconciliation must be done within 12 months after all final audited Medicare cost reports become available online.

Action Required
Attachment H, pages 51 and 52—As indicated in the body of the report, both CMS and the State agency agree that the action required because of the reconciliations is not stated correctly in Attachment H. The correct action is for the State to adjust the CPEs claimed on the CMS-64 if a difference exists between the CPEs claimed by the State agency and the actual costs of caring for uninsured patients.

Payments to Institutions for Mental Diseases

Interim Reconciliation Timing
Attachment H, page 80—The interim reconciliation must be done within 12 months after providers file the UCCRs.

Final Reconciliation Timing

Attachment H, page 81—The final reconciliation must be done within 12 months after all final, audited Medicare cost reports become available online.

Interim & Final Reconciliations—Action Required

Attachment H, pages 79 and 80—The State agency must compare the IMD's uncompensated care for Medicaid and uninsured patients to the SNCP payments made to the IMD. To the extent that overpayments related to the SNCP expenditures, the State agency must recoup the overpayment and refund the Federal share.

Payments to Community-Based Detoxification Centers

Interim Reconciliation Timing

Attachment H, page 81—The interim reconciliation must be done within 12 months after providers file the UFRs.

Final Reconciliation Timing

Attachment H, page 82—The final reconciliation must be done within 12 months after the audited UFR is made available.

Interim & Final Reconciliations—Action Required

Attachment H, pages 81 and 82—The State agency must compare the CBDC's uncompensated care for Medicaid and uninsured patients to the SNCP payments made to the CBDC. If SNCP payments exceed the actual uncompensated care of the provider, then the State agency must recoup the overpayment and refund the Federal share.

APPENDIX C: SCHEDULE OF UNALLOWABLE AND TOTAL AUDITED SAFETY NET CARE POOL EXPENDITURES BY YEAR

UNALLOWABLE AUDITED EXPENDITURES	2015	2016	2017	2018	Total
Unallowable CPEs—Department of Mental Health	2,345	4,733,118	(11,239,649)	-	(6,504,186)
Unallowable CPEs—Department of Public Health	246,808	6,676,570	2,121,836	3,698,358	12,743,572
Total Unallowable CPEs for State-owned Hospitals	249,153	11,409,688	(9,117,813)	3,698,358	6,239,386
Unallowable Payments to IMDs	8,661,674	6,536,812	1,157,923	2,615,888	18,972,297
Unallowable Payments to CBDCs	13,918	69,546	128,931	2,421,745	2,634,140
Total Unallowable Expenditures	8,924,745	18,016,046	(7,830,959)	8,735,991	27,845,823
Federal Share of Unallowable Expenditures (50 percent)	4,462,373	9,008,023	(3,915,480)	4,367,996	13,922,912

TOTAL AUDITED EXPENDITURES	2015	2016	2017	2018	Total
CPEs—Department of Mental Health	97,946,082	108,756,308	97,081,584	118,433,682	422,217,656
CPEs—Department of Public Health	39,466,490	41,014,194	39,906,632	36,566,535	156,953,851
Total Claimed CPEs for State-owned Hospitals	137,412,572	149,770,502	136,988,216	155,000,217	579,171,507
Payments to IMDs	23,143,726	15,924,212	23,102,707	21,192,275	83,362,920
Payments to CBDCs	10,495,819	8,130,795	10,780,931	14,172,353	43,579,898
Total Audited Expenditures	171,052,117	173,825,509	170,871,854	190,364,845	706,114,325

ALLOWABLE AND UNALLOWABLE PERCENTAGE OF EXPENDITURES	2015	2016	2017	2018	Total
Total Audited Expenditures	171,052,117	173,825,509	170,871,854	190,364,845	706,114,325
Total Unallowable Expenditures	(8,924,745)	(18,016,046)	7,830,959	(8,735,991)	(27,845,823)
Total Allowable Expenditures	162,127,372	155,809,463	178,702,813	181,628,854	678,268,502
Unallowable Percentage					3.94%
Allowable Percentage					96.06%

COMMENTS ON THE FEDERAL OFFICE OF THE INSPECTOR GENERAL'S DRAFT AUDIT REPORT: *MASSACHUSETTS GENERALLY CLAIMED SAFETY NET CARE POOL COSTS THAT COMPLIED WITH FEDERAL REQUIREMENTS FOR STATE FISCAL YEARS 2015 THROUGH 2018*

The Federal Office of the Inspector General ("OIG") conducted an audit of certain payments and claiming under the 1115 Demonstration approved for the Massachusetts Medicaid program, MassHealth. Specifically, the OIG audited MassHealth Safety Net Care Pool ("SNCP") expenditures, claiming, and reconciliation processes for private inpatient psychiatric hospitals (for the purposes of this audit response, referred to herein as Institutions for Mental Disease ("IMDs"), Community Based Detoxification Centers ("CBDCs"), and certified public expenditures ("CPEs") for state fiscal years 2015 through 2018 (the period of July 1, 2014 through June 30, 2018). The purpose of this audit was to determine whether MassHealth ensured that expenditures and claiming related to SNCP expenditures complied with federal requirements. The OIG found that Massachusetts generally complied with federal requirements.

As summarized in the OIG's draft audit report, *Massachusetts Generally Claimed Safety Net Care Pool Costs that Complied With Federal Requirements for State Fiscal Years 2015 through 2018* (the "Draft Report"), the audit examined the expenditures associated with IMDs and CBDCs, and the claiming related to the CPEs for Department of Mental Health and Department of Public Health hospitals. Of the $706,114,325 in expenditures that were audited by the OIG, the OIG found 96% to be claimed in compliance with federal requirements. The OIG found that 4% of the audited amount, a total of $27,845,823 in expenditures, did not comply with federal requirements. Of this $27.8 million, the OIG found $18,972,297 was due to overpayments to IMDs, $2,634,140 was due to overpayments to CBDCs, and $6,239,386 was due to overclaiming for CPEs on the CMS-64. The OIG recommends the state recoup the amounts identified in the Draft Report as overpayments from providers, correct the Draft Report's identified CPE overclaiming, and return the federal share of $13,922,912, identified by the Draft Report, to the federal government.

The Draft Report details, and MassHealth agrees, that MassHealth is subject to the requirements of Massachusetts' 1115 Demonstration, including the 1115 Demonstration Special Terms and Conditions ("STCs") relating to the SNCP and Attachment H to the 1115 Demonstration, the Uncompensated Care Cost Limit Protocol ("Attachment H"). Therefore, Massachusetts is required to ensure that payments to the providers described above remain within the providers' limits established by the STCs and Attachment H. Massachusetts is required to return the federal share received for any payments to a provider subject to Attachment H that exceed such limits.

Further, Attachment H details interim and final reconciliation processes that MassHealth is expected to follow with respect to the IMD and CBDC payments, and CPE claiming for state-owned hospitals.

Massachusetts appreciates and agrees with the OIG's conclusion that the state substantially complies with its SNCP requirements under the 1115 Demonstration. Massachusetts also welcomes the opportunity to improve on its SNCP processes and this audit's identification of areas for improvement The state readily acknowledges that overpayments to providers and overclaiming for CPEs requires the return of the federal share of such overpayments or overclaiming, but reserves the right to further adjust the final overpayments based on the final reconciliation process for the CBDCs and the completion of the state's overpayment recoupment administrative process.

Additionally, the state agrees that some of its policies and procedures can be improved to ensure more timely reconciliation and timely return of federal share corresponding to overpayments or overclaiming. Indeed, the state has already begun implementing improvements to its SNCP internal controls and procedures. However, Massachusetts disagrees with the Draft Report that the state lacks policies and

procedures to ensure compliance with the 1115 Demonstration, accurate reconciliation, or federal claiming. To the contrary, the state has a clear and thorough overpayment recoupment administrative process, which is described in state regulation and applies to all MassHealth providers. Further, the OIG's finding that the state was 96% compliant with the SNCP requirements in the 1115 Demonstration strongly indicates that the state has effective internal controls and review processes for the SNCP requirements.

Finally, the state asserts that it is the state's prerogative to decide whether recoupment of overpayments from providers is in the best interest of its members or the MassHealth program. While federal share of overpayments or overclaiming must be returned to the federal government, the Centers for Medicare and Medicaid Services (CMS) does not have the authority to restrict, through the 1115 Demonstration or other avenues, how the state makes all-state-cost expenditures.

The OIG's recommendations and Massachusetts's responses to each are listed below.

Recommendation 1: "Recover from IMDs and CBDCs $21,606,437 in SNCP payments that exceeded the cost of caring for Medicaid and uninsured patients."

Response:

The $18,972,297 amount identified by the OIG as an overpayment to the IMDs is based on the IMD's final audited UCCRs for the state fiscal year 2015-2018 audit period. MassHealth agrees with the OIG's overpayment findings with respect to the IMDs and intends to seek recoupment of funds from the IMD providers for the identified amount of overpayment. MassHealth will follow its standard overpayment recoupment administrative process, described in MassHealth regulations at 130 CMR 450.000: *Administrative and Billing Regulations*, specifically the provisions at 130 CMR 450.235-236 and, if applicable, 130 CMR 450.241-248.

Importantly, this administrative process provides every provider with due process rights, which include an opportunity to dispute the overpayment amounts, with supporting documentation. If any of the IMDs timely dispute the overpayment, MassHealth is required to consider the dispute materials and, as necessary, adjust the overpayment amount through a final notice. An IMD that timely disputes the overpayment also has appeal rights. Therefore, while MassHealth intends to seek recoupment, an overpayment recoupment is not final until the administrative process has been exhausted. In the event the amount identified as an overpayment by the OIG changes during the administrative process, MassHealth will recoup only the final overpayment amount and will work with CMS to correct the federal claiming accordingly.

MassHealth considers the $2,634,140 amount, identified by the OIG as an overpayment attributable to the CBDCs, to be an interim amount and therefore disagrees that the OIG has identified a final overpayment to CBDCs. The interim amount was identified using the uniform financial reports (UFRs) submitted by the CBDCs. However, the (UFR) tool is not designed for the level of cost reconciliation it is contemplated to be used for under Attachment H. To account for this reporting issue, in 2024, MassHealth requested each CBDC to submit a supplemental cost reporting template for the audit period[1] through which MassHealth will finalize its overpayment calculation. Upon receipt of such supplemental cost reporting, MassHealth will initiate the overpayment recoupment administrative process against the CBDCs, in accordance with 130 CMR 450.000: *Administrative and Billing Regulations*, as described above. Further, if the CBDCs' supplemental cost reporting is not forthcoming, MassHealth intends to use

[1] As described in the response to recommendation #4, this supplemental template is also being used to improve reconciliation processes for the period after the audit period and on a prospective basis.

the interim overpayment amounts to initiate the overpayment recoupment administrative process and will instead finalize the overpayment amount through the dispute and, as applicable, appeals procedures of the administrative process.

Finally, while MassHealth intends to recoup the final overpayment amounts from the IMDs and CBDCs, if MassHealth determines during the overpayment recoupment administrative process that it would put members at risk of losing access to inpatient psychiatric care or community-based detox services, MassHealth reserves the right to forego recoupment or settle for a lesser recoupment amount. At that point, MassHealth would ensure that the federal share of the full final overpayment is returned and would accept the overpayment as an all-state-cost expenditure.

Recommendation 2: "Correct its $6,239,386 overstatement of CPEs on the CMS-64, which represents the difference between its CPE estimates and the actual uncompensated care provided to uninsured patients for State-owned hospitals."

Response:

MassHealth agrees with this recommendation. MassHealth will work with CMS to make the correction for the overstatement of CPEs associated with state-owned hospitals on the CMS-64 in a future quarter.

Recommendation 3: "Refund to the Federal government the $13,922,912 Federal share of the total $27,845,823 in SNCP expenditures that did not comply with Federal requirements."

Response:

MassHealth agrees to refund to the federal government the federal share of the overpayment associated with IMDs after the completion of the overpayment recoupment administrative process under 130 CMR 450: *Administrative and Billing Regulations*, and the overstatement of the CPEs for the state-owned hospital. As noted in the response to recommendation #1, MassHealth is making a final determination for the CBDCs, using its improved cost reporting template developed during this audit to supplement the UFR. Once the final determination of overpayment has been made for the CBDCs, the state will return the federal share associated with any final overpayment.

Recommendation 4: "Develop and implement policies and procedures that instruct personnel to perform interim and final reconciliations required by the STCs."

Response:

MassHealth currently has policies and procedures that staff utilize when making payments authorized by the SNCP provisions of the 1115 Demonstration and claiming these expenditures on the CMS-64. Due to these existing policies and procedures, the state does generally comply with the 1115 Demonstration SNCP federal requirements. The OIG Draft Report's primary finding, that the state's claiming for SNCP costs generally complied with federal requirements, indicates that the state has existing robust policies and procedures to monitor overpayments and federal claiming reconciliation. Thus, MassHealth disagrees with OIG's assertion in multiple instances that the state "did not have written policies and procedures" to ensure compliance with the reconciliation processes. However, MassHealth agrees that the existing policies and procedures can be improved, particularly with respect to conducting the interim

and final reconciliations for CBDCs and CPEs for state-owned hospitals, and with ensuring the timely return of federal share associated with overpayments.

Additionally, while MassHealth acknowledges that Attachment H technically requires recoupment from IMDs and CBDCs for both interim reconciliation and final reconciliation, MassHealth strongly asserts that conducting recoupments from providers based on interim reconciliations is inappropriate and would result in a highly inefficient and confusing system. MassHealth intends to continue its policy to recoup only after final reconciliation and will address any issues with this approach with CMS, as necessary. Further, as stated in response to recommendation #1, notwithstanding Attachment H, MassHealth continues to reserve the right to accept overpayments at all state cost, if MassHealth reasonably believes recouping such overpayments will result in reduction in access to needed services, including inpatient psychiatric services or community-based detox services. To the extent these positions are not incorporated into our existing written policies and procedures regarding the SNCP requirements of the 1115 Demonstration, MassHealth will work to update such written policies and procedures.

MassHealth has begun to make improvements to IMD, CBDC, and CPE reconciliation processes, as described more fully below. The state will continue to monitor and adjust these policies and procedures as necessary to ensure overpayments to IMD and CBD providers and overstatement of CPEs are appropriately addressed in a more timely manner, going forward, with the timely return of any corresponding federal share.

- For the existing processes for the CPEs for state-owned hospitals, MassHealth uses the providers' UCCRs and hospital data to perform a detailed calculation to determine each provider's cost of uninsured care. The interim calculation and claiming are based on estimates from prior years, which is then reconciled to actual costs once that data is available. As few changes typically occur as a result of Medicare desk reviews for the final reconciliation, MassHealth's original process to implement Attachment H for CPEs did not include the submission of new "final" UCCRs for the state-owned facilities. Though they were not submitted for the first few years after the implementation of Attachment H, a detailed final reconciliation occurred annually to determine the actual uninsured costs.

  As described in the response to recommendation #1, beginning with state fiscal year 2018, the state updated its CPE final reconciliation processes to more strictly follow Attachment H by requiring the submission of an interim and a final UCCR. MassHealth's current processes now ensure that final UCCRs are submitted within 12 months after CMS Medicare cost reports are finalized, as required by Attachment H. This adjustment to the state's process has enabled more timely correction of overstatement of CPEs for state-owned hospitals.

- Regarding the existing process for CBDCs, Attachment H directs MassHealth to use the UFR to determine whether each provider's payments are within the cost limits established by the 1115 Demonstration. However, the UFR does not allow MassHealth to easily determine each provider's Medicaid and uninsured costs and revenues. This has led to delays in reconciliations and recoupments. As noted in response to recommendation #1, MassHealth has improved its processes by requesting more detailed information from the CBDCs. This information is collected using a supplemental template for the UFR that each provider is required to complete and return to MassHealth for each state fiscal year.

  MassHealth began developing this supplemental template for improved cost reporting during the course of the OIG's audit and finalized the template in 2024. The supplemental template has been sent to the CBDCs to facilitate their submission of more detailed cost reporting data for the state fiscal years covered by the audit period, 2015 through 2018, as well as subsequent state

fiscal years. Going forward, CBDCs will be required to submit this supplemental template annually with its UFRs to ensure more timely interim and final reconciliation, identification of final overpayment amounts, and appropriate return of the associated federal share.

- With respect to IMDs, MassHealth believes it has strong policies and procedures in place to comply with the 1115 Demonstration reconciliation requirements. The UCCRs are the correct tool to ensure collection of necessary cost reporting data with interim reconciliation, and the Medicare desk review audits are typically completed in a timely manner to allow for final reconciliation. Further, MassHealth's overpayment recoupment administrative process in 130 CMR 450.000: *Administrative and Billing Regulations*, is a clear step by step process that allows MassHealth to finalize overpayments and recoupments and ensures due process for providers. While MassHealth has clear processes to follow in the event it identifies an overpayment, MassHealth had not yet recouped the overpayments from the IMDs out of concern for members' access to the IMD services.

  MassHealth has since determined that member access to services would likely not be at risk and that the overpayments can be recouped. Therefore, MassHealth will begin the overpayment recoupment administrative process as described in 130 CMR 450.000: *Administrative and Billing Regulations*. Further, MassHealth will develop and memorialize in writing a procedure for the return of the federal share of overpayments in the event that access concerns cause MassHealth to forego recoupment or settle for a lesser recoupment in the future.

Recommendation 5: "Perform reconciliations for the SFYs following our audit period, where the required Medicare cost reports or UFRs are available. In addition, it should refund the Federal share of any overstated CPEs, as well as recover any overpayments to IMDs and CBDCs and refund the Federal share."

Response:

MassHealth agrees with the recommendation to perform reconciliations for the IMDs, CBDCs, and for state-owned hospitals. MassHealth is reviewing the state fiscal years following the audit period where the required UCCRs and UFRs are available and is implementing the newly established improvements to our procedures for such years. If MassHealth identifies any final overpayments to IMDs and CBDCs for the state fiscal years following the audit period, MassHealth will return the federal share of such overpayments. If MassHealth identifies any overclaiming related to the CPEs for the state fiscal years following the audit period, EOHHS will work with CMS to correct the CMS-64.

Conclusion:

MassHealth appreciates the OIGs thorough review of the state's compliance with the SNCP requirements in the 1115 Demonstration, and the opportunity to correct mistakes and improve processes. Further, MassHealth recognizes the time and effort the OIG dedicated to this audit and to completing the Draft Report. MassHealth broadly agrees with the OIG's findings and will diligently work to return appropriate amounts of federal share associated with overpayments or overstatements of CPEs. MassHealth will also continue to implement and improve upon its SNCP internal control processes, as described above.

While the OIG finalizes its review and completes its Final Report, MassHealth respectfully requests that the OIG consider the following adjustments to the OIG's findings described in the Draft Report:

- Adjust the language to acknowledge that MassHealth currently does have policies and procedures to implement the SNCP requirements in the 1115 Demonstration, and instead focus the recommendation on improvements to those policies and procedures.
- Acknowledge that the UFRs are an imprecise tool for calculating providers' uninsured costs and that final reconciliation is not feasible using UFRs alone, and the final overpayment amount is dependent on MassHealth's review of the supplemental cost reporting tool developed by MassHealth or through the overpayment recoupment administrative process under 130 CMR 450.000: *Administrative and Billing Regulations*.
- Acknowledge that MassHealth has a responsibility to ensure continued access to services for its members and may determine that recoupment from providers is not in the best interest of the MassHealth program or its members, if access is threatened by such recoupment action.

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