Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Rhode Island Comprehensive Program Integrity Review

Final Report

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INTRODUCTION

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Rhode Island Medicaid Program. The MIG review team conducted the onsite portion of the review at the Rhode Island Department of Human Services (DHS) offices. The MIG also conducted a telephone interview with the Rhode Island Medicaid Fraud Control & Patient Abuse Unit (MFCU).

This review focused on activities within DHS' Health Care Quality & Purchasing unit and Center for Finance and Administration. These units are responsible for Medicaid program integrity activities within the Rhode Island Medicaid Program. This report describes one effective practice, three regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

THE REVIEW

Objectives of the Review

1. Determine compliance with Federal program integrity laws and regulations;
2. Identify program vulnerabilities and effective practices;
3. Help Rhode Island improve its overall program integrity efforts; and
4. Consider opportunities for future technical assistance.

Overview of Rhode Island's Medicaid Program

The DHS administers the Rhode Island Medicaid program. As of December 2008, the program served 217,101 recipients. Rhode Island has enrolled 105,652 recipients, or 48.66 percent of its Medicaid population, in managed care programs. Rhode Island also delivers dental services through a dental managed care entity. The Rite Smiles dental program has 39,941 enrolled recipients.

At the time of the review, the Rhode Island Medicaid program had 11,674 participating Medicaid providers. Medicaid expenditures in Rhode Island for the State fiscal year (SFY) ending September 30, 2008 totaled $1,772,422,618.84. The Federal medical assistance percentage for Rhode Island for Federal fiscal year 2008 was 52.51 percent.

Program Integrity Division

The Center for Finance and Administration, within DHS, is the organizational component dedicated to fraud and abuse activities. At the time of our review, the Center's Program Integrity Division had approximately 14 full-time equivalent employees focusing on Medicaid program integrity. During SFY 2005 through SFY 2008, Division staff conducted an annual average of 14 preliminary investigations. During SFY 2006 through SFY 2009, Division staff conducted an annual average of four full investigations. The table below presents the total number of

overpayments and overpayment amounts identified and collected for the last four SFYs as a result of program integrity activities.

Table 1

SFY	Number of Overpayments	Amount of Overpayments Collected from MFCU Cases	Amount of Overpayments Collected from Non-MFCU Cases	Total Amount of Overpayments Recovered By Administrative Actions
2006	41	$24,615.85	$1,507,321.05	$ 1,531,936.90
2007	30	$439,205.00	$50,681.14	$489,886.14
2008	35	$82,930.38	$380,209.50	$463,139.88
2009	42	$138,896.68	$335,142.59	$474,039.27

Methodology of the Review

In advance of the onsite visit, the review team requested that Rhode Island complete a comprehensive review guide and supply documentation in support of its answers. The review guide included such areas as program integrity, provider enrollment/disclosures, managed care, and the MFCU. A five-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of September 14, 2009, the MIG review team visited the DHS and MFCU offices. The team conducted interviews with numerous DHS officials, as well as with staff from the State's provider enrollment contractor, multiple managed care contractors, and the MFCU. In order to determine whether managed care plans were complying with the contract provisions and Federal regulations relating to program integrity, the MIG team reviewed the State's managed care organization (MCO) contracts. The team conducted in-depth interviews with four MCOs and met with State staff to discuss managed care oversight and monitoring efforts. The team also conducted sampling of provider enrollment applications, case files, selected claims, and other primary data to validate the State's program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of the DHS Center for Finance and Administration. Rhode Island's Children's Health Insurance Program operates under Title XXI of the Social Security Act and was, therefore, not included in this review.

Unless otherwise noted, DHS' Center for Finance and Administration provided the program integrity-related staffing and financial information cited in this report. For purposes of this review, the review team did not independently verify any staffing or financial information that was provided.

RESULTS OF THE REVIEW

Effective Practices

The Rhode Island DHS has highlighted one practice that demonstrates its commitment to program integrity. This involves exceptional communication practices between the State agency and the MCOs and transparent program integrity practices within the State's MCOs regarding open fraud and abuse cases and investigations.

Exceptional communication practices between the State agency and the MCOs and transparency within the State's MCOs regarding open cases and investigations

The DHS Division of Health Care Quality, Financing and Purchasing has developed a multi-faceted approach to facilitating effective interactions with their four managed care plans. Each plan has a designated State Liaison responsible for the day-to-day communications, plan oversight and identification of any concerns within the plan operations. The State conducts monthly meetings with each individual MCO where a set rotating agenda covers such topics as plan operations, compliance and quality management. Contractual requirements between the State and the MCOs require the health plans to report suspected fraud and abuse to the MFCU and to the Rhode Island DHS within five business days of the plans' conclusion of an initial investigation. Additionally, representatives from each MCO meet on a regular basis with the Rhode Island DHS Plan Oversight Steering Committee to discuss open fraud and abuse cases, which allows for cross-plan sharing of trends and current issues.

The State contractually requires each MCO to send a quarterly report directly to the MFCU, as well as to the State, containing all open and closed fraud and abuse investigations. The MCO reporting is done in addition to the referrals of suspected fraud and abuse that the State sent to the MFCU. The State developed a reporting template which is shared with the State and directly with the MFCU. This practice allows identification of fraud or aberrant billing trends across plans, and allows the MFCU to intervene in cases early on in the investigation process.

Regulatory Compliance Issues

The State is not in compliance with Federal regulations regarding the disclosure of ownership and control information, disclosure of business transactions, and capture of criminal conviction information.

Rhode Island does not require disclosure of ownership and control information in its fee-for-service operations (FFS), from transportation providers, and from its fiscal agent. (Repeat Issue)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity

has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

The State's FFS provider enrollment application does not request all of the required disclosure information in 42 CFR § 455.104(a). Specifically, the forms do not ask for the names of owners with 5 percent or more ownership interest or family relationships of those named persons. This was previously cited in the CMS 2003 Medicaid Alliance for Program Safeguards (MAPS) review.

The State does not require the fiscal agent to provide updated disclosures of ownership and control information as required by 42 CFR § 455.104(c). Although this information was requested in the initial Request for Proposal, it was not updated when there was a change of ownership.

Also, non-emergency medical transportation (NEMT) providers are not enrolled in Rhode Island Medicaid and do not complete enrollment applications; therefore no disclosure information is obtained.

Recommendations: Modify all provider enrollment applications and contracts to capture the required ownership, control, and relationship information. Obtain necessary disclosures from all providers and from the fiscal agent.

The State does not require FFS providers, MCOs, and NEMT providers to disclose required business transaction information upon request.

The regulation at 42 CFR § 455.105(b)(2) requires that, upon request, providers furnish to the State or U.S. Department of Health and Human Services information about certain business transactions with wholly owned suppliers or any subcontractors.

Provider agreements do request a portion of the information required by 42 CFR § 455.105; however, the language in the FFS provider agreement does not contain the necessary phrase, "during the 5-year period ending on the date of request."

The contracts between the State and the MCOs are vague and do not require the MCOs to submit information related to business transactions as mandated by 42 CFR §455.105. The State's

contracts with the MCOs only require the State have access to various types of each MCO's information, including financial information.

Transportation providers do not complete provider applications or agreements; therefore, no reporting requirements are conveyed or agreed to by the provider.

Recommendations: Modify the FFS provider agreement and language in the State-MCO contract to require disclosure upon request of the information identified in 42 CFR § 455.105(b). Develop and implement procedures to ensure NEMT providers disclose the required information upon request.

Rhode Island's FFS provider enrollment applications do not capture required criminal conviction information. Criminal conviction information is not collected from NEMT providers. (Repeat Issue)

The regulation at 42 CFR § 455.106 stipulates that providers must disclose to Medicaid agencies any criminal convictions related to Medicare, Medicaid, or Title XX programs at the time they apply or renew their applications for Medicaid participation or at any time on request. The regulation further requires that the Medicaid agency notify U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) whenever such disclosures are made.

The State does not request disclosures related to managing employees or agents. Therefore, the State is unable to search for exclusion of these individuals and cannot report such disclosures to HHS-OIG. Although the provider enrollment form indicates this responsibility is contractually delegated to the provider to "self certify," that the regulation is met, the language in the provider agreement is inconsistent with the Federal regulation. Additionally, sampling of provider enrollment files revealed that not all enrollment files contained the updated enrollment forms and contained even more limited information related to criminal convictions. This finding was previously cited in the CMS 2003 MAPS review.

Also, NEMT providers do not report criminal convictions because they do not complete provider enrollment forms or provider agreements.

Recommendations: Modify provider enrollment applications to meet the full criminal conviction disclosure requirements of the regulation. Develop and implement procedures to ensure NEMT providers disclose the required information. Develop and implement a procedure to report criminal conviction information to HHS-OIG within 20 working days.

Vulnerabilities

The review team identified four areas of vulnerability within Rhode Island's program integrity practices regarding the lack of business transaction language, the lack of recipient verification of services received by managed care members, not capturing managing employee or agent information on provider enrollment forms, and the reporting to HHS-OIG of adverse actions taken on provider enrollment applications.

Not requiring managed care providers to disclose business transactions upon request.
The DHS does not contractually require MCOs to require their network providers to submit business transaction information within 35 days of the request for information. Four out of four MCOs interviewed do not require their network providers to submit the required business transaction information within the necessary time frame.

Recommendation: Modify the language of the DHS contract with the MCOs to require network providers to disclose business transactions within 35 days of the request for the information.

Not verifying with enrollees whether managed care services billed by providers were received.
The DHS does not contractually require the MCOs to verify that services were received as billed. Three out of four MCOs interviewed do not send Explanation of Medical Benefits forms nor do they have another mechanism to verify receipt of services. The Rhode Island DHS does not independently verify receipt of those Medicaid managed care services.

Recommendation: Revise and enforce MCO contracts to ensure that MCOs are undertaking some form of verification of services.

Not capturing managing employee or agent information on provider enrollment forms.
Under 42 CFR § 455.101, a managing employee is defined as "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency." The DHS provider enrollment forms do not solicit information on managing employees or agents and DHS would have no way of knowing if excluded individuals are working for providers or health care entities in such positions as billing managers and department heads.

Recommendations: Modify DHS provider enrollment forms to require the disclosure of managing employee and agent information. Maintain such information in a database where it can be used to search for exclusions at the point of initial enrollment and periodically thereafter.

Not reporting to HHS-OIG adverse actions taken on managed care provider applications.
The regulation at 42 CFR §1002.3(b) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program. The State Medicaid agency does not require its MCOs to inform them when the MCOs have denied enrollment or credentialing of a provider due to program integrity concerns, and the State is therefore unable to make the required report to the HHS-OIG.

Recommendation: Require MCOs to report all denials of enrollment or credentialing or terminations of providers based on program integrity concerns to DHS.

CONCLUSION

The State of Rhode Island applies an effective practice that demonstrates program strength and the State's commitment to program integrity. This effective practice relates to Rhode Island's exceptional communication practices between the State agency and the MCOs and transparency within the State's MCOs in regards to open cases and investigations.

The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of three areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, four areas of vulnerability were identified. The CMS encourages DHS to closely examine each area of vulnerability that was identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require DHS to provide a corrective action plan for each area of non-compliance within 30 calendar days from the date of the final report letter. Further, we will request the State include in that plan a description of how it will address the vulnerabilities identified in this report.

The corrective action plan should address how the State of Rhode Island will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the State expects will occur. Please provide an explanation if correcting any of the regulatory compliance issues or vulnerabilities will take more than 90 calendar days from the date of the letter. If Rhode Island has already taken action to correct compliance deficiencies or vulnerabilities, the plan should identify those corrections as well.

The Medicaid Integrity Group looks forward to working with the State of Rhode Island on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practice.