

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Medicaid Integrity Program

Rhode Island Comprehensive Program Integrity Review

Final Report

December 2012

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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 Executive Office of Health and Human Services (EOHHS) offices. The MIG also conducted a telephone interview with the Rhode Island Medicaid Fraud Control & Patient Abuse Unit (MFCU).

This review focused on the activities within EOHHS and the fiscal agent. These units are responsible for program integrity activities within the Rhode Island Medicaid Program. This report describes one noteworthy practice, one effective practice, four regulatory compliance issues, and four vulnerabilities in the State's program integrity operations.

The CMS is concerned that the review identified one partial repeat finding from its 2009 review of Rhode Island. The CMS plans on working closely with the State to ensure that all issues, particularly those that remain from the previous review, are resolved as soon as possible.

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 EOHHS administers the Rhode Island Medicaid program. As of January 1, 2011, the program served 188,009 beneficiaries, 76 percent of whom were enrolled in three managed care entities (MCEs). Rhode Island also delivers dental services through a pre-paid ambulatory health plan. The State had 12,361 fee-for-service (FFS) enrolled providers and 10,218 MCE providers. Medicaid net expenditures in Rhode Island for the State fiscal year (SFY) ending June 30, 2011 totaled \$1,824,000,000. This figure includes \$690,763,086 in payments to MCEs.

Medicaid Program Integrity Division

In Rhode Island, the Division of Health Care Quality Financing and Purchasing within EOHHS is the organizational component dedicated to fraud and abuse activities. At the time of the review, the EOHHS had two full-time equivalent positions allocated to Medicaid program integrity functions. The program integrity activities are contracted to the fiscal agent who supports core functions and provides additional staffing to EOHHS. The table below presents the total number of preliminary and full investigations, administrative sanctions, and recoupments in the last four SFYs.

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Table 1

FY	Number of Preliminary Investigations*	Number of Full Investigations**	Number of State Imposed Administrative Sanctions	Amounts Recouped as a Result of State Imposed Administrative Sanctions
2008	8	2	37	\$380,209.50
2009	11	4	47	\$346,344.13
2010	7	6	81	\$472,413.25
2011	15	4	130	\$477,487.77

* Preliminary investigations of fraud or abuse complaints determine if there is sufficient basis to warrant a full investigation.

**Full investigations are conducted when preliminary investigations provide reason to believe fraud or abuse has occurred. They are resolved through a referral to the MFCU or administrative or legal disposition.

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, and managed care. A four-person team reviewed the responses and materials that the State provided in advance of the onsite visit.

During the week of March 26, 2012, the MIG review team visited the EOHHS and the fiscal agent offices. The team conducted interviews with numerous EOHHS officials as well as with staff from the fiscal agent. The review team interviewed MFCU staff by telephone during the week prior to the onsite review. To determine whether MCEs were complying with contract provisions and other Federal regulations relating to program integrity, the MIG team reviewed the State’s managed care contracts. The team conducted in-depth interviews with representatives from three MCEs and met separately with EOHHS and contracted staff to discuss managed care oversight and monitoring. In addition, the team conducted sampling of provider enrollment applications, program integrity cases, and other primary data to validate Rhode Island’s program integrity practices.

Scope and Limitations of the Review

This review focused on the activities of EOHHS, but also considered the work of other components and contractors responsible for a range of program integrity functions, including provider enrollment and contract management. Rhode Island operates its Children’s Health Insurance Program (CHIP) as both a Medicaid expansion program and a stand alone Title XXI program. The expansion program operates under the same billing and provider enrollment policies as Rhode Island’s Title XIX program. The same effective practices, findings, and vulnerabilities discussed in relation to the Medicaid program also apply to the CHIP expansion program. The stand alone CHIP program operates under the authority of Title XXI and is beyond the scope of this review.

Unless otherwise noted, Rhode Island 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 EOHHS provided.

Results of the Review

Noteworthy Practice

As part of its comprehensive review process, the CMS review team identified one practice that merits consideration as a noteworthy or "best" practice. The CMS recommends that other States consider emulating this activity.

Enhanced program integrity oversight of MCE investigations

The State's managed care division provides enhanced oversight of managed care provider investigations. There is a close working relationship between the State, MCEs, and MFCU. The State has developed a quarterly report and requires MCEs to report all active and closed investigations during the quarter. The reports are sent to both the State and the MFCU. During quarterly meetings between the State's program integrity staff and MCEs, cases are reviewed and findings discussed. In addition, MCEs refer all cases of suspected fraud to the MFCU within five days of determination and simultaneously notify the State. Overall, the enhanced monitoring ensures timely investigations and allows the MFCU to be involved in providing guidance and follow up as needed.

Notwithstanding the State's efforts to monitor MCE investigations more closely, the review team found certain problems in the collection of MCE network provider disclosures, exclusion searches, and reporting of adverse actions. These are discussed in the Vulnerabilities section of the report.

Effective Practice

As part of its comprehensive review process CMS invites each State to self-report practices that it believes are effective and demonstrate its commitment to program integrity. The CMS does not conduct a detailed assessment of each State-reported effective practice. Rhode Island reported the utilization of fiscal agent services to compensate for limited program integrity staff.

Utilization of contractors' data capability for program integrity oversight

The EOHHS compensates for limited staff by using its fiscal agent for data mining, claims analysis, and audit capabilities. The fiscal agent performs surveillance and utilization and postpayment reviews using targeted queries. Targeted queries help to identify providers who have double-billed for the same services in addition to identifying outliers in standard ranking reviews. Rhode Island's use of targeted queries has improved its ability to recoup overpayments for billed services.

In addition, the fiscal agent reviews billing policies for Federally Qualified Health Centers (FQHCs). Based upon this review, the fiscal agent is able to determine which services billed to the Medicaid agency are for non-reimbursable services. Although these non-reimbursable services are paid to the FQHC as part of its encounter fee for services rendered, this review allows the Medicaid agency to easily identify non-reimbursable services. As a result of this process, the Medicaid agency recoups incorrectly billed encounters and conducts provider education. A procedure manual for FQHCs has been written to include billing processes for Medicaid reimbursable encounters such as medical,

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psychiatric, and dental services. At the time of the review, the State reported that to date it had recouped \$71,672 for non-reimbursable services.

Regulatory Compliance Issues

The State does not comply with Federal regulations relating to the suspension of Medicaid payments in credible allegation of fraud cases, provider disclosures, and searches for excluded and debarred individuals and entities.

The State does not suspend payments in cases of credible allegations of fraud.

The Federal regulation at 42 CFR 455.23(a) requires that upon the State Medicaid agency determining that an allegation of fraud is credible, the State Medicaid agency must suspend all Medicaid payments to a provider, unless the agency has good cause to not suspend payments or to suspend payment only in part. Under 42 CFR 455.23(d) the State Medicaid agency must make a fraud referral to either a MFCU or to an appropriate law enforcement agency in States with no certified MFCU. The referral to the MFCU must be made in writing and conform to the fraud referral performance standards issued by the Secretary.

The CMS team's review of five FFS cases referred to the MFCU after March 25, 2011 revealed that the State did not suspend payments or invoke a good cause exception not to suspend payments. During the interview, the State indicated that when suspected fraud or abuse is identified, a referral is made to the MFCU. At that time, the State recoups the overpayment instead of suspending payment. Furthermore, the team reviewed FFS cases referred to the MFCU that were still awaiting a decision to suspend payments in excess of 30 days. The amount paid to these providers after the referral to the MFCU totaled approximately \$8,217,396.

Recommendations: Develop and implement policies and procedures to suspend payments to providers when an investigation determines there is a credible allegation of fraud or document a good cause exception not to suspend. Refer such cases to the MFCU and comply with the documentation requirements of 42 CFR 455.23.

The State does not capture all required ownership and control disclosures from disclosing entities. (Uncorrected Partial Repeat Finding)

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or MCE, must disclose to the State Medicaid agency the name, address, date of birth (DOB), and Social Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address. Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or MCE must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or MCE as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or MCE in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or MCE has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address,

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DOB, and SSN of any managing employee of the disclosing entity, fiscal agent, or MCE. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and MCEs prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The State was cited in MIG's 2009 review for not collecting fiscal agent disclosures. Although the State is currently collecting most fiscal agent disclosures, the contract has not been updated to reflect information required by the revised regulation effective March 25, 2011. For example, the State-fiscal agent contract fails to request all business locations in the state, whether there are any other disclosing entities in which the fiscal agent has an ownership or control interest, and is missing information on DOB, SSN, and managing employees.

The State is not collecting complete disclosures from the MCEs. The MCE disclosures are missing DOB, SSN, and address for persons with an ownership or control interest in the disclosing entity. Also, the State does not require MCEs to disclose whether persons with an ownership or control interest in the disclosing entity is related to another person with an owner or control interest in the disclosing entity. In addition, one of three MCEs interviewed provided an extensive board and key employee list, but the list did not include DOB, SSN, and addresses for the individuals named. A second MCE did not list managing employees and the third MCE did not provide the primary residential address for parties named (only the corporate business address) or information about owners.

Recommendations: Develop and implement policies and procedures or modify contracts for the appropriate collection of disclosures from disclosing entities, fiscal agents, and MCEs regarding persons with an ownership or control interest, or who are managing employees of the disclosing entities, fiscal agents, or MCEs. Modify disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not capture required criminal conviction disclosures from contractors.

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 the HHS Office of Inspector General (HHS-OIG) whenever such disclosures are made. Pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

At procurement, the MCEs attest to not having any affiliation with persons otherwise debarred, excluded, or convicted of health care crimes. However, criminal conviction disclosures are not collected from MCEs about their owners, persons with control interest, managing employees, and agents as required by the regulation.

Recommendations: Develop policies and procedures for the appropriate collection of disclosures from MCEs regarding persons with an ownership or control interest, or persons who are agents or managing employees of the MCEs, who have been convicted of a criminal offense related to Medicare, Medicaid, or Title XX since the inception of the programs. Modify

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disclosure forms as necessary to capture all disclosures required under the regulation.

The State does not conduct complete searches for individuals and entities excluded from participating in Medicaid.

The Federal 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 HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's Excluded Parties List System (EPLS¹) no less frequently than monthly.

Rhode Island's fiscal agent checks the LEIE and the EPLS at enrollment and at revalidation for providers and other names disclosed on provider enrollment applications. However, the State does not do subsequent checks monthly. Specifically, names of persons with ownership or control, managing employees, and agents are not checked monthly against the LEIE and the EPLS. The State is only checking names disclosed by MCEs at procurement and monthly against the LEIE, but not the EPLS.

In addition, the State has not yet developed a searchable database for collecting ownership and control disclosures captured by the State. Accordingly, scanned attachments containing this information are not yet searchable against the LEIE and EPLS.

Recommendations: Develop and implement policies and procedures for appropriate collection and maintenance of disclosure information about the provider, any person with an ownership or control interest, or who is an agent or managing employee of the provider. Search the LEIE (or the Medicare Exclusion Database (MED)) and the EPLS upon enrollment, reenrollment, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities in accordance with 42 CFR 455.436.

Modify the managed care contract to require MCEs to search the LEIE and EPLS upon contract execution and monthly thereafter by the names of any person with an ownership or control interest in the MCE, or who is an agent or managing employee of the MCE.

Vulnerabilities

The review team identified four areas of vulnerability in the State's practices. These are related to not collecting disclosures from network providers, not conducting complete exclusion searches and not reporting all adverse actions taken on provider participation to HHS-OIG.

Not capturing ownership and control disclosures from network providers.

Under 42 CFR 455.104(b)(1), a provider (or "disclosing entity"), fiscal agent, or managed care entity, must disclose to the State Medicaid agency the name, address, date of birth, and Social

¹ On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf> for assistance in accessing the database at its new location.

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Security Number (SSN) of each person or entity 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. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

Additionally, under 455.104(b)(2), a disclosing entity, fiscal agent, or managed care entity must disclose whether any of the named persons is related to another disclosing entity, fiscal agent, or managed care entity as spouse, parent, child, or sibling. Moreover, under 455.104(b)(3), there must be disclosure of the name of any other disclosing entity, fiscal agent, or managed care entity in which a person with an ownership or controlling interest in the disclosing entity, fiscal agent, or managed care entity has an ownership or controlling interest. In addition, under 455.104(b)(4), the disclosing entity must provide the name, address, date of birth, and SSN of any managing employee of the disclosing entity, fiscal agent, or managed care entity. As set forth under 455.104(c), the State agency must collect the disclosures from disclosing entities, fiscal agents, and managed care entities prior to entering into the provider agreement or contract with such disclosing entity, fiscal agent, or MCE.

The State's contracts with MCEs still reflect the old language from 42 CFR 455.104 and have not been updated to include new provisions under the regulation that went into effect March 25, 2011. In addition, a review of three MCEs' disclosure forms revealed that they have not updated their forms to capture required information.

Recommendations: Modify the managed care contract to require, or ensure that managed care provider enrollment forms require, the disclosure of complete ownership, control, and relationship information from all managed care network providers. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis.

Not capturing criminal conviction disclosures from network providers.

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 HHS-OIG whenever such disclosures are made. In addition, pursuant to 42 CFR 455.106(b)(1), States must report criminal conviction information to HHS-OIG within 20 working days.

The State's managed care contract requires MCE network providers to disclose those convicted of a criminal offense related to that person's involvement in any Medicare, Medicaid, or Title XX programs since the inception of those programs. However, review of MCE credentialing forms revealed that the disclosure sections for two MCEs did not meet requirements for capturing criminal conviction disclosures.

The dental credentialing form does not directly require the provider to disclose any criminal conviction related to participation in Medicare, Medicaid, or Title XX programs since the inception of those programs or "ever." In addition, criminal conviction information is not requested for agents and managing employees. Another MCE utilizes the standard National Committee for Quality Assurance managed care application which does not directly query the

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applicant to disclose any criminal convictions for their owners, persons with control interest, agents, or managing employees in reference to the Medicare, Medicaid, or Title XX programs since the inception of these programs.

Recommendations: Modify and implement the dental disclosure form to ensure the disclosure of health care-related criminal convictions on the part of persons with an ownership or control interest, or persons who are agents or managing employees of network providers. Include contract language requiring MCEs to notify the State of such disclosures on a timely basis.

Not conducting complete searches for individuals and entities excluded from participating in Medicaid.

The regulations at 42 CFR 455.104 through 455.106 require States to solicit disclosure information from disclosing entities, including providers, and require that provider agreements contain language by which the provider agrees to supply disclosures upon request. The CMS issued a State Medicaid Director Letter (SMDL) #08-003 dated June 16, 2008 providing guidance to States on checking providers and contractors for excluded individuals. That SMDL recommended that States check either the LEIE or the MED upon enrollment of providers and monthly thereafter. States should check for providers' exclusions and those of persons with ownership or control interests in the providers. A follow-up SMDL dated January 16, 2009 provided further guidance to States on how to instruct providers and contractors to screen their own employees and subcontractors for excluded parties, including owners, agents, and managing employees. A new regulation at 42 CFR 455.436, effective March 25, 2011, now requires States to check enrolled providers, persons with ownership and control interests, and managing employees for exclusions in both the LEIE and the EPLS² on a monthly basis.

The MCEs conduct EPLS searches at intervals specified by the contract and not monthly as recommended by the regulation at 42 CFR 455.436, nor do they require contractors to conduct monthly searches. As a result, one MCE made Medicaid payments to a behavioral health organization where an excluded individual was employed by four treatment centers. The excluded physician was discovered when reinstatement letters were sent to the MCEs and the sister State agency notified them of the provider's reinstatement for Federal participation. An analysis of the system's exclusion checking revealed that the centers had failed to check this employee for exclusion prior to hiring or subsequently thereafter. Also, the behavioral health organization and the sister State agency had not checked if the physician was excluded, and therefore had no knowledge of his exclusion.

In addition, a second behavioral health organization credentialed the provider in error by mistakenly transposing the physician's name when it was checked against the LEIE, thus not revealing his exclusion. Subsequent monthly exclusion checks by this behavioral health organization were queried only against the LEIE updates of newly excluded providers on which he was not listed. The behavioral health organization was enrolled in both managed care and

² On July 30, 2012, the EPLS was migrated into the new System for Award Management (SAM). State Medicaid agencies should begin using the SAM database. See the guidance at <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-01-12.pdf> for assistance in accessing the database at its new location.

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with a sister State agency who oversees the behavioral health programs in Rhode Island³. The sister State agency had contracted directly with the centers where the physician was employed. Total dollars at risk for payments made on behalf of this individual are estimated at \$1.8 million. At the time of the review, the State had recovered approximately \$500,000 from the MCEs.

Recommendation: Require the contractor to search the LEIE and the EPLS upon enrollment, reenrollment, credentialing or recredentialing of network providers, and at least monthly thereafter, by the names of the above persons and entities, to ensure that the State does not pay Federal funds to excluded persons or entities.

Not reporting all adverse actions taken on provider participation to the HHS-OIG.

The regulation at 42 CFR 1002.3(b)(3) requires reporting to HHS-OIG any adverse actions a State takes on provider applications for participation in the program.

The State has developed contractual requirements requiring MCEs to report adverse actions taken on the denial of enrollment, de-credentialing, or termination of providers from managed care networks for fraud, integrity, or quality reasons and these cases are reported to the State agency. However, during sampling, the team found instances where adverse actions were taken against providers but were not reported to the HHS-OIG. In one case, a physician that had previously disenrolled attempted to re-enroll in 2010 in an MCE network. In a second case, a provider was impermissibly billing for physical therapy services with insufficient documentation and terminated from the plan. The CMS review team confirmed that such adverse actions are reported by MCEs to the State staff that oversees managed care. Nevertheless, the State did not report those cases to the HHS-OIG.

Although it appears the State and MCEs take affirmative steps to protect the program from problem providers, and the providers in question are otherwise known or reported to the State agency, Rhode Island has not yet developed a clear protocol with the regional HHS-OIG office as to what is a reportable action. Having this protocol in place will protect the State Medicaid program and ensure that Rhode Island is reporting providers that could be a threat elsewhere.

Recommendation: Develop and implement procedures for reporting adverse actions to HHS-OIG.

³ The sister State agency pays its providers FFS; however, this physician was not enrolled directly with the State as a FFS provider.

Conclusion

The State of Rhode Island applies some noteworthy and effective practices that demonstrate program strengths and the State's commitment to program integrity. The CMS supports the State's efforts and encourages it to look for additional opportunities to improve overall program integrity.

However, the identification of four 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 is particularly concerned that the review identified one partial repeat finding from its 2009 review of Rhode Island.

To that end, we will require Rhode Island 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 practices.

**Official Response from Rhode Island
February 2013**



Executive Office of Health and Human Services

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SENT BY ELECTRONIC MAIL ON 02/06/2013

02/06/2013

Ms. Elizabeth Linder
CMS Center for Program Integrity
Data Analytics and Control Group
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233 N. Michigan Ave.
Suite 600
Chicago, IL 60601

Dear Ms. Linder:

This correspondence has been prepared as Rhode Island's formal response to the final report that the CMS Medicaid Integrity Program set to the Rhode Island Executive Office of Health and Human Services (RI EOHHS) on 01/03/2013. CMS' final report addressed key findings from the triennial Program Integrity site visit that was conducted in Rhode Island during the week of March 26, 2012. The RI EOHHS was pleased to see that the Review Team recognized Rhode Island for a noteworthy practice. (Enhanced program integrity oversight of MCE investigations) and an effective practice (Utilization of contractors' data capability for program integrity oversight).

As requested on page 12 of the Final Report. Rhode Island has prepared the appended consolidated corrective action plan, which focuses upon the four (4) areas of non-compliance which were cited in the Medicaid Integrity Program's Rhode Island Comprehensive Program Integrity Review Final Report. The State's corrective action plan also addresses the four (4) areas of vulnerability which were identified in the Final Report.

Please do not hesitate to contact Ralph Racca by telephone at 401-462-1879 or by electronic mail at RRacca@ohhs.ri.gov if there are any questions about Rhode Island's response to Medicaid Integrity Program's Rhode Island Comprehensive Program Integrity Review Final Report or to the State's Corrective Action Plan. On behalf of the State, please convey my thanks to the Medicaid Integrity Program's site visit team that conducted the triennial review.

Sincerely,

Elena Nicolella,
Medicaid Director

cc: Ralph Racca
Deborah Florio
James Dube, Esq.