Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Rhode Island Focused Program Integrity Review

Final Report

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Rhode Island to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2013.

Background: State Medicaid Program Overview

The state of Rhode Island's Medicaid health and dental programs, Rhody Health and RIte Smiles respectively, are administered through the Executive Office of Health and Human Services (EOHHS). Rhode Island does participate in Medicaid Expansion under provisions of the Affordable Care Act. Eligible residents were able to begin enrolling on October 1, 2013, when the state's health insurance exchange opened for business. Additionally, Rhode Island operates the majority of its Medicaid program under Section 1115 Demonstration authority via the Global Consumer Choice Waiver, which assists persons with disabilities in in the state.

As of April 30, 2016, Rhode Island Medicaid served 293,659 beneficiaries. Of that total, approximately six percent, or 17,620 beneficiaries were enrolled in a fee-for-service (FFS) delivery system. The remaining 94 percent, or 276,039 beneficiaries were enrolled in some form of managed care. Rhode Island's total Medicaid expenditures in federal fiscal year (FFY) 2015 were approximately $2.7 billion. The MCO expenditures were approximately $1.5 billion, or 55 percent, during the same time period. The Federal Medical Assistance Percentage for Rhode Island was 50.42 percent in FFY 2016.

Methodology of the Review

In advance of the onsite visit, CMS requested that Rhode Island and the MCOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person review team has reviewed these responses and materials in advance of the onsite visit.

During the week of June 6, 2016, the CMS review team visited the EOHHS. The team conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

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

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 276,039 beneficiaries, or 94 percent of the state's Medicaid population, were enrolled in three MCOs during FFY 2016. The state spent approximately $1.5 billion on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review. The three MCOs contracted by EOHHS to provide services in Rhode Island are: Neighborhood Health Plan of Rhode Island (NHPRI), UnitedHealthcare of New England, Inc., and UnitedHealthcare (dental plan).

The NHPRI is a nonprofit health maintenance organization that was founded in 1994. The NHPRI was started in response to the initiation of RIte Care, which is Rhode Island's Medicaid managed care program. The plan serves the following six Medicaid populations in Rhode Island: families with low to moderate income; children with special health care needs; all children in the Rhode Island foster care system; Medicaid-only adults with disabilities; Medicaid expansion population members; and dually eligible beneficiaries (Medicaid benefits only). The NHPRI's SIU team, supported by its compliance department, has 12 full-time equivalents (FTEs); those FTEs include some the following positions: fraud, waste, and abuse investigator; provider auditors; and staff responsible for first-tier, downstream, and related entities/delegation oversight.

UnitedHealthcare of New England, Inc., is located in Warwick, Rhode Island. UnitedHealthcare of New England, Inc., is a subsidiary of UnitedHealth Group and is doing business as UnitedHealthcare Community Plan. UnitedHealthcare of New England, Inc., is a national health plan that has Medicaid, Medicare, and commercial lines of business. The national SIU has 24 staff members available to investigate Medicaid fraud in Rhode Island; two SIU staff members are dedicated to investigating Rhode Island Medicaid cases eight percent of the time. The SIU is not centrally located and maintains various locations throughout the United States. Providence Health Plan works with United Behavioral Health under the name Optum to administer mental health and substance use disorder benefits and services. Optum conducts Medicaid audits for behavioral health services and collects overpayments resulting from investigative activities. Optum's SIU has ten investigators.

UnitedHealthcare (dental plan) provides dental benefits to children eligible for RIte Smiles through the Rhode Island's Department of Human Services (DHS). The dental plan's program integrity activities are supported by various UnitedHealth Group functions responsible for the detection, prevention, and investigation of health care fraud, waste, and abuse. The MCO's Utilization Management Department performs data analytics and consists of five team members. Two investigators are fully-dedicated to dental payment integrity activities such as reporting, referral, and validation as well as the initial investigation of dental fraud tips. In addition, the SIU has 22 staff members dedicated to investigating dental fraud and abuse activities nationally. No staff members are physically located in Rhode Island.

Enrollment information for each MCO as of May 2016 is summarized below:

Table 1.

	NHPRI	**UnitedHealthcare of New England, Inc.**	**UnitedHealthcare (dental plan)**
Beneficiary enrollment total	167,219	84,208	91,935
Provider enrollment total	5,634	4,219	218.
Year originally contracted	1994	1994	2006
Size and composition of SIU	12	24*	22
National/local plan	Local	National	National

*Two FTEs are dedicated eight percent of the time to program integrity activities for the state plan.

Table 2.

MCOs	**FFY 2013**	**FFY 2014**	**FFY 2015**
NHPRI	$37.2 million	$56.7 million	$72.6 million
UnitedHealthcare of New England, Inc.	$257.8 million	$432.4 million	$486.2 million
UnitedHealthcare (dental program)**	$9.9 million	$12.0 million	$14.0 million

**Amounts reported represent the total claims paid for the SFY.

State Oversight of MCO Program Integrity Activities

The EOHHS is the state unit responsible for program integrity oversight. The state reported that oversight of the managed care system in Rhode Island is a collaborative effort between EOHHS Program Integrity Unit (PIU), the managed care entities, and the Medicaid Fraud Control Unit (MFCU). The PIU consists of nine FTEs and is responsible for all program integrity, audit, and fraud investigation activities.

The state confirmed that it does have operational guidelines, as well as the contract with the MCOs, that govern the interaction between the state's program integrity efforts and programmatic oversight for each managed care program. The state's external quality review organization (EQRO), IPRO, conducts annual reviews of the MCOs, but does not specifically include program integrity provisions for fraud and abuse-related activities.

MCO Investigations of Fraud, Waste, and Abuse

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

Rhode Island's MCO contract states that "the MCO agrees to submit a quarterly fraud and abuse report that conforms to the State's specifications." This report is due no later than 30 days after the end of the reporting quarter.

As indicated in 42 CFR 455.17, the report shall contain the number of complaints of fraud and abuse that warranted preliminary investigation, and each case of suspected provider fraud and abuse that warrants a full investigation. For cases requiring a full investigation, the contractor shall report the following information: the provider's name and number; the source of the complaint; the type of provider; the nature of the complaint; the approximate range of dollars involved; and the legal and administrative disposition of the case including actions taken by law enforcement officials to whom the case has been referred.

The MCOs interviewed are submitting monthly and/or quarterly reports of fraud, waste, and abuse activity to the state's PIU for review. The contract does not include language that requires the MCOs to report suspected provider fraud, waste, or abuse to the MFCU. Fraud and abuse cases reported by the MCOs to EOHHS are reviewed by the PIU to determine if they should be referred to the MFCU as credible allegations of fraud under 42 CFR 455.23.

The state confirmed they do have written policies and procedures to oversee the MCO investigations of fraud, waste, and abuse. Rhode Island's MCO contract states that the MCO must report fraud and abuse information to the state, including the number of fraud and abuse complaints that warrant preliminary investigations. When an MCO identifies an activity or pattern of billing which prompts them to conduct an initial investigation, they complete a "tip" form and forward it to EOHHS to be tracked and shared with both FFS and the other MCOs. The MCO must report this information to the state immediately if the severity of the complaint impacts the care and treatment of the client, and will also add this to their quarterly report with the status or result of their investigation.

The NHPRI's SIU is responsible for initiating a preliminary investigation, upon receipt of an allegation of fraud, and reporting it to the state immediately if the severity of complaint influences the care and treatment of the client, or quarterly upon investigation. According to the NHPRI's contractual requirements with EOHHS, in the event that NHPRI determines that possible provider or vendor fraud and/or abuse has been identified, NHPRI notifies the state within five business days of the conclusion of the initial investigation. Additionally, NHPRI submits quarterly fraud, waste, and abuse reports to EOHHS.

UnitedHealthcare of New England, Inc.'s, SIU investigates reported potential fraud and abuse activities and, as appropriate and contractually required by the state, refers suspected or confirmed fraud or abuse to the appropriate designated oversight agencies. The plan also discusses fraud, waste, and abuse cases, during the quarterly meetings with the MFCU.

UnitedHealthcare (dental plan) investigates reported potential fraud and abuse activities and, as appropriate and contractually required by the state, refers suspected or confirmed fraud or abuse to appropriate designated oversight agencies.

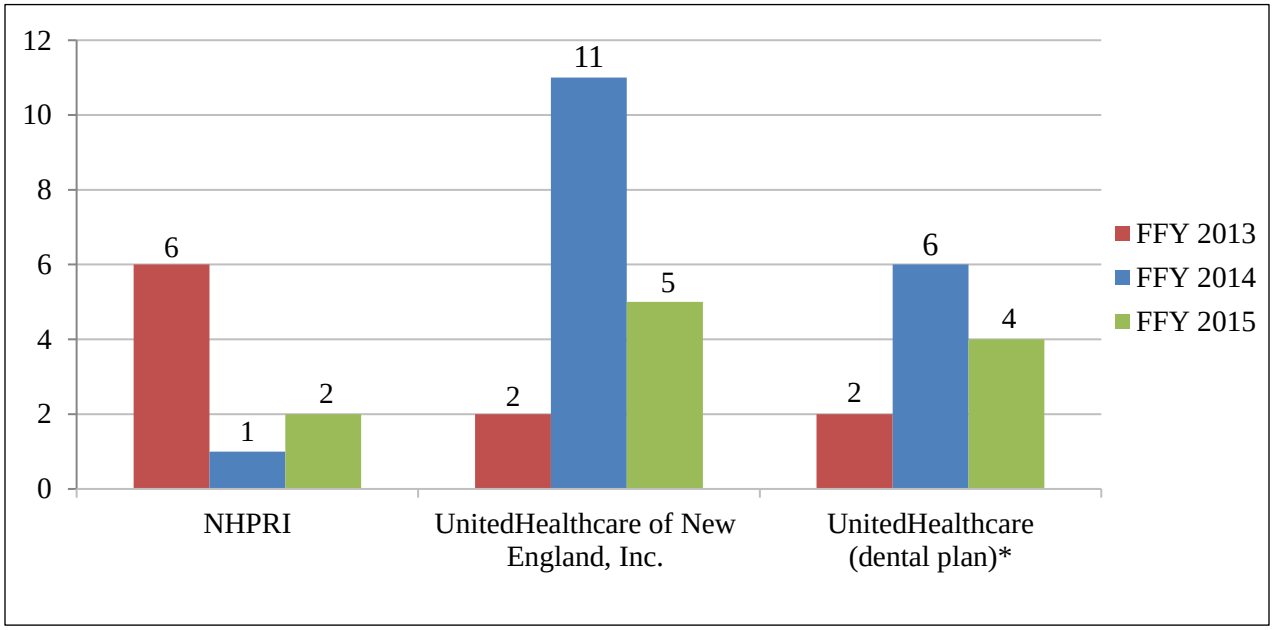
During the onsite review, the PIU discussed the cases referred by the MCOs and considered them to be of adequate quality, and the quantity of cases referred by each MCO is both adequate and consistent with the number of cases historically investigated by the MFCU. However, the MFCU has frequently questioned the quantity of the cases referred by the MCOs. This observation was further discussed with the state during the onsite review. The state reported there are numerous factors that impact the quantity of cases reviewed, including the volume of fraud, waste, abuse, and erroneous payments in the provider types covered by the MCOs. This is a direct result of variations in editing software maintained at the FFS level that identifies and/or prevents that billing from occurring.

The MCOs have additional prevention methods available, such as prior authorization, prepayment review, and limited networks to lessen their exposure to fraud, waste, abuse, and erroneous payments. The MFCU frequently reminds all MCOs of the need to uncover fraudulent behavior and refer it to them for investigation. However, the contract requires the MCOs to notify PIU of any credible allegation of fraud within five days of completing their investigation. The case is vetted by PIU and only sent to the MFCU if deemed credible by PIU.

All of the MCOs report their open and closed cases to the state on quarterly reports. The state confirmed that the number of cases opened and closed, and the disposition of the cases are tracked in a manner that allows for measurement. The state is only aware of the cases which are reported, so it is possible that a case may be opened then closed without intervention or referral.

Table 3 lists the number of referrals that NHPRI and UnitedHealthcare of New England, Inc., made to the state in the last three FFYs. UnitedHealthcare (dental plan) has reported its referrals on a SFY basis. Overall, the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plans. The level of investigative activity has not changed significantly over time.

Table 3.



*The plan is reporting on a SFY basis.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements of 42 CFR 438.608.

The state does have a process to review the MCOs compliance plan and programs.

As required by 42 CFR 438.608, the state does review the MCOs compliance plan and communicates approval/disapproval with the MCEs. The most recent review of the MCOs compliance plans occurred in April 2016.

The state confirmed they do have written policies and procedures of the state's compliance plan review process for the managed care program in the state. While the effectiveness of the compliance plan is not measured, the review of all MCOs is conducted annually, as required by the contract, and specified on the Reporting Calendar. Calendar year 2016 is the first year that EOHHS conducted an onsite compliance review of NHPRI and UnitedHealthcare New England, Inc. This compliance review was performed on specific key elements required of a compliance plan, along with a file review of grievances and appeals. The key elements include: written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable federal and state standards; the designation of a compliance officer and a compliance committee that are accountable to senior management; effective training and

education for the compliance officer and the organization's employees; effective lines of communication between the compliance officer and the organization's employees; enforcement of standards through well-publicized disciplinary guidelines; provisions for internal monitoring and auditing; provision for prompt response to detected offenses; and development of corrective action initiatives relating to the MCO's contract. A policy and procedure was created to specify requirements for completing onsite reviews which are to be conducted annually, at a minimum.

The review of the compliance plans typically reveal minimal issues. However, when the reviews are conducted, the state does inform the MCOs of the areas that require revisions.

All of the MCO's provided the review team with a copy of their compliance plans that have been submitted to the state. A review of these plans revealed they were in compliance with 42 CFR 438.608.

Encounter Data

The MCO contract with the state requires the submission of an electronic record for every encounter between a network provider and an enrollee, when requested. The state does receive encounter data from the MCOs and reported that it does contractually require the MCOs to conduct data mining.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state, but they are required to report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits on both the quarterly report and the tip forms, if they have performed a preliminary investigation.

The state does contractually address overpayment recoveries; the state does have written policies and procedures to conduct oversight of the overpayment recoveries. The state allows the MCOs to collect and retain all identified overpayments, whether or not they are related to fraud, waste, abuse, or billing errors.

The table below shows the respective amounts reported by NHPRI for the past three FFYs.

Table 4-A.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	6	6	$87,982	$3,470
2014	1	1	$0	$84,512*
2015	2	2	$389,182	$0

*The total monies recovered during FFY 2014 also include the MCO's recoupment of monies identified during FFY 2013.

The NHPRI's recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their SIU and reported to the state on a quarterly basis. The SIU is responsible for initiating a preliminary investigation, upon the receipt of an allegation of fraud, and reporting it to the state immediately, if the severity of the complaint influences the care and treatment of the member, or quarterly upon investigation. The NHPRI's preliminary review process for cases determines whether an investigation or referral should occur. There was only one referral made to EOHHS's PIU in FFY 2014. At the time of the referral, NHPRI was in the process of auditing the provider and had not yet identified any overpayments associated with the audit. For this reason, no overpayments were identified and reported for FFY 2014.

The table below shows the respective amounts reported by UnitedHealthcare of New England, Inc., for the past three FFYs.

Table 4-B.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	24	9	$2.3 million	$619,465
2014	9	1	$6,232	$4,588
2015	65	38	$13,354	$0

UnitedHealthcare of New England, Inc.'s, recovered overpayments from providers as a result of its fraud and abuse investigations are tracked by their SIU and reported to the state on a quarterly basis. On a quarterly basis, reports are completed and provided to the health plan for distribution to state regarding recovered overpayments from providers resulting from fraud and abuse investigations. The SIU is responsible for initiating a preliminary investigation upon the receipt of an allegation of fraud and reporting it to the state. According to the contract amendment, the reporting to the state should take place within five days of completion of the initial investigation and determination. Each FFY, UnitedHealthcare of New England, Inc., conducts preliminary investigations that carryover from previous years; the MCO continues to work these cases through resolution. During FFY 2013, the total overpayments identified and recovered were higher than usual, since the monies resulted from investigations initiated in FFY 2009 and were recovered from those prior periods.

The table below shows the respective amounts reported by UnitedHealthcare (dental plan) for the past three SFYs.

Table 4-C.

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013	0	0	$0	$0
2014	0	0	$0	$0
2015	0	0	$0	$0

UnitedHealthcare (dental plan) did not conduct any preliminary or full investigations during the three SFYs reviewed. In addition, no overpayment monies were identified or recovered. Fraud and abuse investigations are tracked by dental utilization management, as well as the SIU, and reported to the state on a quarterly basis. The payment integrity referral and validation team is responsible for initiating a preliminary assessment, upon receipt of an allegation of fraud, and reporting it to the state within five days of its determination. The case is then forwarded to the SIU for further investigation and determination of action. During SFY 2016, the company utilized a new provider performance profile which was developed internally. The performance profile is an individual provider report card that summarizes each provider's claims submissions and quantifies the provider's treatment code submission rate across 60 different treatment categories. The rate for each category is compared to the average for the provider's peers in Rhode Island. The provider's overall rate and individual rate for each category are presented as a percentile rank; this ranking system allows outliers to be easily identified. The process has identified several providers who will be evaluated for inclusion in a prepayment review process.

Overall, the amount of overpayments identified and recovered by the MCOs appears to be low for MCOs with combined expenditures of $572.8 million. Although the MCOs are not contractually required to return overpayments from their network providers to the state, it is important that EOHHS obtain a clear accounting of any recoupments; these dollars must be factored into establishing annual rates. Typically, the state identifies an erroneous payment and directs the MCO to collect and report it through the void and replace process with encounter data; however, overpayment recovery information is neither verified nor monitored by the state.

Under the state's contracts, MCOs are paid an actuarially certified capitation rate for covered benefits. Each year, a downward adjustment is applied to the rate to recognize anticipated savings as a result of the health care compliance programs as mandated by the Healthcare Reform Law of Patient Protection and Affordable Care Act of 2010. This adjustment is applied to each of the covered populations. In addition to the rates being reduced at the start of each contract period, the adjusted claims that occur during the current contracting period as the result of a recoupment for fraud, waste, and abuse are reported on the encounter data and factored into the subsequent contracting period's rates.

Payment Suspensions

In Rhode Island, Medicaid MCOs are not contractually required to suspend payments to providers at the state's request. The state confirmed that there is not any contract language mirroring the payment suspension regulation at 42 CFR 455.23.

The MCOs have been directed to suspend payments in compliance with 42 CFR 455.23; however, the state confirmed there is no contractual requirement that ensures that the MCOs suspend payments. The three MCOs interviewed by CMS reported that they have historically suspended payments to providers, when written notice is received from EOHHS instructing them to do so.

The state has not requested that the MCOs suspend payments to any providers due to a credible allegation of fraud, during the past FFY. The state lacks sufficient program integrity contractual guidelines for payment suspensions within its managed care program.

Terminated Providers and Adverse Action Reporting

The state MCO contract states, "The MCO will report to EOHHS promptly those providers that have terminated from the network." This information is also reported monthly by the MCOs on the *MCO Program Integrity Quarterly Report*.

The three MCOs interviewed by CMS reported that they submit providers terminated either with or without cause to EOHHS on both a monthly basis, and on a quarterly basis during the MFCU meetings. The state does notify the MCOs of any terminated providers from other plans or have lost Rhode Island Medicaid eligibility, so that MCOs can ensure that these terminated providers are not operating in their plan. In addition, the MCOs receive the notices from the Rhode Island Board of Medical Licensure and Discipline. The state confirmed there is no process to ensure that the MCOs are terminating providers either with or without cause.

During the onsite review, the TIBCO process for submitting provider terminations was discussed. The CMS review team provided the EOHHS with the CMS contact who may assist the state with gaining access to the system. In addition, EOHHS stated that they were unaware of the monthly requirement and process for submitting terminated providers for inclusion in TIBCO. The CMS review team also provided the state with the CMS contact information for referring terminated providers.

Table 5.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		Total # of Providers Terminated For Cause in Last 3 Completed FFYs	
NHPRI	2013 2014 2015	200 326 281	2013 2014 2015	0 1 0
UnitedHealthcare of New England, Inc.	2013 2014 2015	84 37 60	2013 2014 2015	7 4 4
UnitedHealthcare (dental plan)	2013 2014 2015	2 0 9	2013 2014 2015	3 2 0

Overall, the number of providers terminated for cause by the three plans appears to be low, compared to the number of providers in each of the MCO's networks and compared to the number of providers disenrolled or terminated for any reason. During onsite interviews, it appeared that the plans rely on both the state and the quarterly MFCU meetings to notify them of actions taken at the state level against providers; the MCOs then take any necessary action against those providers identified.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly. Per the state contract, the MCOs are responsible for provider screening and enrollment. The review noted that all MCOs are adhering to this requirement on a monthly basis, as required.

The state of Rhode Island does not screen MCO providers. It is the responsibility of each plan to screen all applications, including initial enrollment, relocation, and re-enrollment or revalidation. It is the responsibility of each MCO to perform all the required federal database checks for the managed care providers, as well as collecting and storing all required disclosure information.

The state confirmed they do have written policies and procedures for overseeing the screening and enrollment process for FFS providers. The state does not have written policies and procedures to conduct oversight of the screening and enrollment process for the MCO providers, but has language in the contract requiring the MCOs to have written policies and procedures for credentialing and re-credentialing as well as monitoring and disciplining providers who are

found to be noncompliant. The policy and procedure has been reviewed for appropriateness and inclusion of the above cited language.

Recommendations for Improvement

- The state should ensure that both the EOHHS and the MCOs build program integrity units with sufficient resources and staffing commensurate with the size of their managed care programs to conduct a full range of program integrity functions including the review, investigation, auditing of provider types where Medicaid dollars are most at risk, and recovery of monies overpaid.
- The EOHHS should consider establishing a minimal staffing requirement for all contracted MCOs. The requirement should also specify the minimal levels for the number of investigative staff members who are physically located within the state and who are fully-dedicated to Rhode Island's Medicaid program. In addition, the state should define the frequency and level of contact it expects to have with those MCO investigative staff members assigned to the program integrity activities for the state plan.
- The state should consider the inclusion of program integrity provisions for the EQRO's annual review of the MCOs. The program integrity provisions should address fraud and abuse-related activities, and be incorporated into the state's operational guidelines, policies and procedures, or interagency agreements governing the interaction between the state's program integrity efforts and programmatic oversight for each managed care program.
- The EOHHS should obtain feedback from the MFCU regarding the quantity and quality of MCO referrals reviewed. Also, the state should develop a protocol regarding how tips and MFCU referrals should be investigated and/or processed.
- The state should work with the MCOs to develop and provide program integrity training on a routine basis to enhance case referrals from the MCOs. The state should ensure that MCO staff is receiving adequate training in identifying, investigating, and referring potential fraudulent billing practices by providers.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place. Some tangible examples of cost avoidance include a walk-through of the Medicaid Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.
- The state should conduct data mining using encounter data to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, in addition to the data mining contractually required and conducted by the MCOs.The state should consider including or revising language in its model contract regarding the process for identifying, collecting, reporting, and the retention of overpayments by the MCOs which have resulted from fraud and abuse investigations or audits. The state should verify that identified and collected overpayments are fully reported by the MCOs, and that they are incorporated into the rate-setting process along with the overpayments identified by state-initiated reviews. The state should also develop written policies and procedures for oversight of the overpayment recovery process.

- The state should consider developing or amending the model contract language to require the MCOs to suspend payments to providers against whom an MCO or the state can document a credible allegation of fraud. The payment suspension requirements at 42 CFR 455.23 should be consulted when designing this provision. In addition, the state should provide training to its contracted MCOs on the circumstances in which payment suspensions are appropriate, and should further require the reporting of plan-initiated payment suspensions based on credible allegations of fraud. The state should develop written policies and procedures for monitoring payment suspensions within its managed care program.
- The state should develop written policies and procedures to ensure that terminated providers are being removed from all of the MCOs' networks. In addition, the MCOs should be reporting all network provider terminations in a timely manner and not waiting until the quarterly MFCU meetings to notify the state.
- The EOHHS should ensure that they are downloading and checking the monthly Medicare revocation list from TIBCO. The state should also consider providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks and to decrease reliance on disenrollment as the primary method for removal of terminated providers. The state should ensure that terminated providers are being forwarded for entry into the TIBCO system.
- The state should establish written policies and procedures to conduct oversight of the MCO process for screening and enrollment of providers, in addition to the language contained in the contract requiring the MCOs to have their own written policies and procedures for credentialing and re-credentialing as well as monitoring and disciplining providers who are found to be noncompliant.

Section 2: Status of Corrective Action Plan

Status of Corrective Action Plan

Rhode Island's last CMS program integrity review was in March 2012, and the report for this review was issued in December 2012. The report contained three findings and four vulnerabilities. During the onsite review in June 2016, the CMS review team conducted a thorough review of the corrective actions taken by Rhode Island to address all issues reported in calendar year 2012. The findings of this review are described below.

Findings -

1. ***The state does not require disclosure of ownership and control information in its FFS, from transportation providers, and from its fiscal agent. (Repeat Regulatory Compliance Issue)***

   Status at time of the review: Corrected

   - The state implemented an enhanced provider portal in January 2011. This includes transportation providers.
   - All new and active providers are now required to electronically complete the provider agreement and disclosure statements for continued participation.
   - In January 2011, the state established a process for its delegate, HP Enterprise Services, to annually provide the state with ownership and control information.

2. ***The state does not require FFS providers, MCOs, and non-emergency medical transportation (NEMT) providers to disclose required business transaction information upon request.***

   Status at time of the review: Corrected

   - The state implemented an enhanced provider portal in January 2011. This portal includes NEMT providers.
   - All new and active providers are now required to electronically complete the provider agreement and disclosure statements for continued participation.
   - In January 2011, the state established a process for HP Enterprise Services to annually provide the state with ownership and control information.

3. ***The state FFS provider enrollment applications do not capture required criminal conviction information. Criminal conviction information is not collected from NEMT providers. (Repeat Regulatory Compliance Issue)***

   Status at time of the review: Corrected

   - The state implemented an enhanced provider portal in January 2011. This includes NEMT providers.
   - All new and active providers are now required to electronically complete the provider agreement and disclosure statements for continued participation.
   - In January 2011, the state established a process for its delegate, HP Enterprise Services, to annually provide the state with ownership and control information.
   - The state agreed that the fiscal agent must report findings to state's Office of the Inspector General (OIG) within 20 days.

Vulnerabilities -

1. ***The state does not require managed care providers to disclose business transactions upon request.***

   Status at time of the review: Corrected

   - With revisions to the contract in September 2010, Section 2.18.05 of the RI DHS/Health Plan Contract, MCOs now execute this process at the time of enrollment and credentialing/recredentialing.
   - Disclosure forms were updated to include section for disclosing business transactions at the time of enrollment.

2. ***The state does not verify with enrollees managed care services billed by providers.***

   Status at time of the review: Corrected

   - Each MCO proposal was reviewed regarding the issuing EOMBs for services verification to be completed by March 21, 2011.
   - Sections 3.07.03.01 and 3.07.03.05 of the Rhode Island DHS/Health Plan Contract has been updated to include requirements for verification of beneficiary services.

3. ***The state does not capture managing employee or agent information on provider enrollment forms.***

   Status at time of the review: Corrected

   The state implemented an enhanced provider portal that includes disclosure information, during January 2011.

4. ***The state does not report to HHS-OIG adverse actions taken on managed care provider applications.***

Status at time of the review: Corrected

Section 2.12.04 of the RI/DHS Health Plan contract has been updated to include requirements for reporting HHS-OIG adverse actions taken on managed care provider applications.

Technical Assistance Resources

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

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Rhode Island are based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review did not find any instances of non-compliance with federal managed care program integrity regulations which should be addressed immediately; however, areas of concern were identified and should be addressed immediately.

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

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

Official Response of Rhode Island
XXXX 2017

Patrick M. Tigue, Medicaid Program Director
Executive Office of Health and Human Services
74 West Road, Hazard Building
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August 15, 2017

Mark Majestic
Division of State Program Integrity
Investigations and Audits Group
Center for Program Integrity
Centers for Medicare & Medicaid Services
Mailstop AR 21 55
7500 Security Boulevard, Baltimore, MD 21244

Dear Mr. Majestic,

This letter is in response to the Rhode Island Focused Program Integrity Review Final Report dated June21, 2017. This report relates to the focused review conducted during the week of June 6, 2016. EOHHS is pleased that the focused review did not find any instances of non-compliance with federal managed care program integrity regulations.

As required by the final report letter, EOHHS is providing the attached corrective action plan (CAP), in response to the review team's recommendations. Due to limited resources and other business commitments, including readiness activities related to bringing on a new MCO, several of these corrections will not be finalized within the 90-day timeframe. However, EOHHS will prioritize the identified corrective action plans to ensure that they are completed as soon as practical.

If you have any questions, or would like to discuss this response, please contact Bruce McIntyre at Bruce.McIntyre@ohhs.ri.gov or call 401-462-0613.

Sincerely

Patrick M. Tigue
Medicaid Program Director

CC: Kayin Love (HHS)
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