Department of Health and Human Services

Centers for Medicare & Medicaid Services

Rhode Island Focused Program Integrity Review

Final Report

April 2022

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Rhode Island Focused Program Integrity Review Draft Report
February 2022

Executive Summary

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, the Centers for Medicare & Medicaid Services (CMS) set forth its strategy to safeguard the integrity of the Medicaid program.[1] State Medicaid programs are required to have a fraud detection and investigation program and oversight strategy that meet minimal federal standards. To ensure states are meeting these requirements, CMS conducts focused program integrity reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. The value of performing focused program integrity reviews include: (1) providing states with effective tools/strategies to improve program integrity operations and performance; (2) providing the opportunity for technical assistance related to program integrity trends; (3) assisting CMS in determining/identifying future guidance that would be beneficial to states; and (4) assisting with identifying and sharing promising practices related to program integrity.

This report summarizes information gathered during a focused review of the Rhode Island Medicaid managed care program. The primary objective of the review was to assess the state's program integrity oversight efforts for Medicaid managed care. A secondary objective was to provide the state with useful feedback, discussions, and technical assistance resources that may be used to enhance program integrity in the delivery of these services.

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

In July 2021, CMS conducted a virtual focused review of Rhode Island's single state Medicaid agency, the Executive Office of Health and Human Services (EOHHS). This focused review helped CMS 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 MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed a sample of program integrity cases investigated by the MCOs Special Investigations Units (SIUs), as well as other primary data, to assess the state and selected MCOs' program integrity practices. CMS also evaluated the status of Rhode Island's previous corrective action plan, which was developed by the state in response to a managed care focused review conducted by CMS in 2016.

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

During this review, CMS identified a total of **four** recommendations based upon the completed focused review modules, supporting documentation, and discussions and/or interviews with key staff. CMS also included technical assistance resources for the state to consider utilizing for its oversight of managed care. The review and recommendations encompass the following six areas:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse
4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

Overview of Rhode Island Medicaid

The Executive Office of Health and Human Services (EOHHS) is the single state agency charged with overseeing of the medical assistance plans in Rhode Island. The state's Medicaid managed care program is referred to as Rhody Health, which provides comprehensive health benefits to eligible beneficiaries through three designated MCOs. Within EOHHS, the Office of Program Integrity (PIU) is the organizational unit responsible for the overall program integrity operations. The EOHHS Medicaid Managed Care Oversight team is responsible for monitoring contractual oversight of the Medicaid managed care program. PIU, in collaboration with the MCOs and MFCU, is responsible for the overall program integrity functions.

In FY 2019, Rhode Island's Medicaid expenditures were approximately $2.6 billion, and the state had approximately 308,955 beneficiaries enrolled. The Federal Medical Assistance Percentage matching rate was 53 percent for standard Medicaid, 90 percent for CHIP, and 93 percent for the Medicaid Expansion population. Approximately 260,414 (monthly average) beneficiaries, or 86 percent of the Medicaid population, were enrolled in three MCOs. Rhode Island managed care expenditures were approximately $1,658,368,626, which includes both Medicaid and the Children's Health Insurance Program (CHIP), cumulatively representing approximately 63.78 percent of Rhode Island's total Medicaid expenditures.

All three of the operating MCOs in the state were interviewed: Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Public Plan (Tufts), and United Healthcare of New England, Inc. (UHC). Table 1 and Table 2 below provide enrollment, SIU, and expenditure data for each MCO that CMS interviewed.

Table 1. Summary Data for Rhode Island MCOs[2]

	Neighborhood Health Plan of Rhode Island	Tufts Health Public Plan	United Healthcare of New England, Inc.
Beneficiary enrollment total	177,746	15,442	83,016
Provider enrollment total	8,760	7,296	6,461
Year originally contracted	1994	2017	1993 or 1994
Size and composition of SIU	NHPRI SIU is comprised of a team of 5: an SIU Manager, 2 Clinical Auditors, 1 CPC Auditor, and 1 FWA Investigator.	15 FTEs (as of FFY 2019) 21 FTEs (currently, after HPHC consolidation)	The UHCNE SIU maintains a staff of 70+ FTEs Optum SIU maintains a staff of 61 FTEs
National/local plan	Local	Local	National

Table 2. Medicaid Expenditure Data for Rhode Island MCOs[3]

MCO	FFY 2017	FFY 2018	FFY 2019
Neighborhood Health Plan of Rhode Island	$657,876,599	$675,720,577	$755,090,144
Tufts Health Public Plan	$424,265.47	$22,891,987.11	$36,131,774.95
United Healthcare of New England, Inc.	$530,164,302	$536,950,730	$515,754,244

Results of the Review

CMS evaluated the following six areas of Rhode Island's managed care program:

1. State oversight of managed care program integrity activities
2. Provider screening and enrollment
3. MCO investigations of fraud, waste, and abuse

[2] The beneficiary enrollment numbers for each plan are as of 12/31/2020.
[3] Each of the MCOs submitted the expenditure data reported in Table 2. The State confirmed expenditure data during the review process. Discrepancies (if identified) were clarified prior to development of this report.

4. Encounter data
5. Payment suspensions based on credible allegations of fraud
6. Terminated providers and adverse action reporting

CMS identified four areas of concern within Rhode Island's managed care program integrity oversight that may create 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 through implementation of a corrective action plan. These areas of concern and CMS' recommendations for improvement are described in detail below.

1. *State Oversight of Managed Care Program Integrity Activities*

The Executive Office of Health and Human Services (EOHHS) currently administers the state's Medicaid program through five internal offices: the Program Integrity, Legal, Budget and Finance, Policy and Innovation, and Healthcare Administration units. Comprised of eight full-time equivalents (FTEs), the EOHHS PIU is responsible for managed care contract monitoring and oversight, as well as all program integrity, audit, and fraud investigation activities. **However, several key positions were vacant at the time of this review.** Key positions include the Director (*vacant*), Supervisor of Financial Management Reporting (Data Analytics), Chief Implementation Aide, Principal Rate Analyst, Chief of Investigations (*vacant*), Health Program Administrator (*vacant*), and the Chief of Provider Credentials (*vacant*).

Gainwell Technologies subcontracts with EOHHS to operate a Surveillance Utilization Review Services (SURS) program for the Medicaid Fee-For-Service (FFS) program. The EOHHS PIU receives monthly reports from the SURS unit and has regularly scheduled monthly and quarterly meetings to discuss SURS cases with the MCFU and the Rhode Island Office of the Inspector General (OIG). This is an improvement from CMS' FY 2016 review.

In Rhode Island, MCOs are contractually required to have administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, and report known or suspected fraud, waste, and abuse activities in accordance with the requirements at 42 CFR 438.608(a)(1). Section 2.18 of Rhode Islands' model contract states that, "…an electronic copy of the Contractor's written compliance plan, including all relevant operating policies, procedures, workflows, and relevant chart of organization must be submitted to the EOHHS for review and approval within ninety (90) days of the execution of this Agreement and then on an annual basis thereafter."

The EOHHS Medicaid Managed Care Oversight Team is the division responsible for the review and written approval of compliance plans, in accordance with § 438.608(a)(1) and the state's contract requirements. CMS observed that all three MCOs interviewed had compliance programs that met the minimum requirements outlined in § 438.608(a)(1). Each of the MCOs were also able to demonstrate fraud, waste, and abuse plans that comprehensively addressed continuity in practices that provide safeguards that protect the state's program integrity environment.

Recommendation #1: The EOHHS should ensure that their levels of staffing are adequate to conduct all necessary program integrity activities. Although staffing resources are sufficient to assist with day-to-day program integrity operations, activities, and contract performance, key positions should be filled to maintain high levels of oversight of all required program integrity activities.

2. *Provider Screening and Enrollment*

§§ 438.602(b)(1)-(2), 438.608(b), 455.100-106, 455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, the Rhode Island model contract states that,

EOHHS self-reported non-compliance with federal provider screening and enrollment requirements. The state also reported that, in partnership with Gainwell Technology, MCO providers not already enrolled in the Medicaid FFS program will be enrolled in the future. At the time of CMS' review, this project was in the planning stages and due to be fully implemented by Fall 2021. Upon full implementation, Gainwell Technology will assume responsibility for screening MCO providers as it does FFS providers. The screening will include all federally-mandated database checks for all disclosed parties, including the Social Security Administration's Death Master File. On a monthly basis, EOHHS reviews MCOs' List of Excluded Individuals and Entities (LEIE) submissions.

Pursuant to Rhode Island's model contract, Section 2.12.05 (Provider Credentialing), MCOs perform the credentialing for all providers with whom they contract. MCOs must ensure that all providers are registered in Rhode Island's provider enrollment system prior to contracting and credentialing with the provider. This rule applies to all provider types and specialties and is inclusive of the billing, rendering, ordering, prescribing, referring, sponsoring, and attending providers.

Within ten business days of any action taken to deny a provider application, EOHHS requires the MCO to promptly notify EOHHS in writing the reasons for denying a provider's application for enrollment or participation (e.g., a request for initial credentialing or for re-credentialing) when the denial action is based on, through MCOs internal credentialing process, concern about Medicaid program integrity or quality.

Recommendation #2: The EOHHS should continue to develop and implement provider screening and enrollment processes and procedures in compliance with § 438.602(b) and CMS' Medicaid Provider Enrollment Compendium.[5] Full resources should be allocated to the current enrollment project to fully comply with CMS requirements.

3. *MCO Investigations of Fraud, Waste, and Abuse*

State Oversight of MCOs

[4] https://eohhs.ri.gov/providers-partners/provider-enrollment
[5] https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf

As required by § 438.608(a)(1)(vii), Rhode Island has an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by MCOs, providers, and beneficiaries. Rhode Island's Medicaid MCO model contract states in Section 2.13.06 (Fraud and Abuse Reports) that MCOs are required to submit written Fraud and Abuse and Program Integrity policies and procedures prior to readiness, annually thereafter, and upon request from EOHHS. All fraudulent activities or other program abuses shall be subject to the laws and regulations of the EOHHS and/or the federal government.

The contracts also specify that the Fraud and Abuse and Program Integrity policies and procedures must define how the MCO will adequately identify and report suspected fraud, waste, and abuse by members, network providers, and the subcontractors. The MCO must develop a written integrity plan specific to the contract that identifies the specific resources dedicated to program integrity activities related to claims, members, providers, and subcontractors involved in delivering the services outlined in this contract.

The PIU conducts monthly and quarterly Program Integrity Collaborative sessions with the MCOs and other stakeholders to discuss pertinent program integrity issues pertaining to fraud, waste, and abuse matters and relevant contractual concerns. The attendees include representatives from the MCOs' program integrity divisions (the designated program integrity lead), MFCU, and Rhode Island OIG. During these meetings, EOHHS staff provides educational guidance to all of the MCOs on MFCU referral standards to ensure only quality cases are being referred.

Additionally, on a quarterly basis, the MCOs submit electronically to EOHHS all activities conducted on behalf of program integrity by the MCO and include findings related to these activities. The report, titled the Quarterly Fraud/Waste/Abuse Overpayment Report, includes: allegations received and results of the preliminary review, investigations conducted and outcome, payment suspension notices received and suspended payments summary, claims edits/automated review summary, coordination of benefits/Third-Party Liability savings and recoveries, service authorization/medical necessity savings, provider education savings, provider screening reviews and denials, providers terminated, unsolicited refunds (Provider-Identified Overpayments), archived referrals (Historical Cases), and other activities.

Upon submission, EOHHS reviews the Quarterly Fraud/Waste/Abuse Overpayment Report. This evaluation examines ongoing reporting, as well as the contents of the report to ensure that all contractual requirements are being met. The EOHHS evaluates progress towards the Internal Monitoring and Audit Plan required under section 2.18.01 of the contract to identify any major changes or shortcomings to projected program integrity activity. According to the MCO contract, "[t]he Contractor will have methods and criteria for identifying and monitoring suspected Medicaid fraud and abuse as required by § 456.3, 456.4, and 456.23. When the MCO identifies suspected fraud (as defined in § 455.2) by one of its providers or subcontractors, it shall be reported to the Department within five business days of discovery to the EOHHS Medicaid Contract Officer and/or designee as well as the Office of Program Integrity (PI). Any case sent to EOHHS as a Referral of Suspected Medicaid Fraud will be reviewed by

the PIU unit for determination and/or escalation to the Medicaid Fraud Control Unit (MFCU) and OIG simultaneously."

All referrals submitted by the MCOs are submitted to EOHHS PIU for quality review before being sent to the MFCU. CMS confirmed that each of the MCOs interviewed have SIUs. The SIU staffing levels reported by all three national plans ranged from 10 to 70+ FTEs.

In accordance with § 455.20, the Rhode Island general MCO contract requires the MCOs to establish procedures to verify with beneficiaries whether services billed by providers and vendors were received. Beneficiary verification requirements specific to workflows for the generation and dissemination of explanation of member benefits (EOMB) are addressed further in Section 3.07.03.04 (Recipient Verification Procedures) and Section 3.07.03.05 (Explanation of Member Benefits), which states, "The Contractor will, in conformance with sampling requirements established by EOHHS, issue individual notices within forty-five (45) days of the payment of claims, to a sample of enrollees who received goods or services." **Although this requirement is being met by UHC and NHPRI, CMS noted during the review that Tufts does not complete Recipient Verification (beneficiary verification) as specified by state contract, section 3.07.03.04. and in accordance with § 455.20.** Beneficiary verifications are an effective tool for identifying billing irregularities that may be due to fraud, waste or abuse. Failure to complete adequate beneficiary verification could potentially expose the Rhode Island Medicaid program to increased risk of overpayment.

MCO Oversight of Network Providers

Tufts Health Plan maintains a comprehensive internal Fraud and Abuse program to prevent, identify, evaluate, investigate, resolve, and report instances of fraud, waste, and abuse. The Tufts SIU identifies leads from external and internal sources, including "tips," data analysis, industry trends and intelligence, and information generated from prior investigations. When a lead is received through any channel, an SIU Manager, Data Analyst and/or Senior Investigator shall conduct a preliminary analysis of claims and other data to determine if the matter is a beneficiary, pharmacy, or provider matter, and if the lead warrants additional investigation. If a lead does not warrant additional investigation, the case is entered into the internal database and closed, with an explanation as to why it was closed. If credible allegation of fraud is determined to exist, the case is referred to an investigator bases on area of specialty. Upon completion of the investigation, the Investigator will make and document recommendations of the next steps to take. The investigator will then refer the case to are referred the Office of Program Integrity for OHHS. Tufts reported that OHHS provides a reporting template for this to be completed. Members of the MFCU and HHS-OIG are included on the email communication to the Office of Program Integrity.

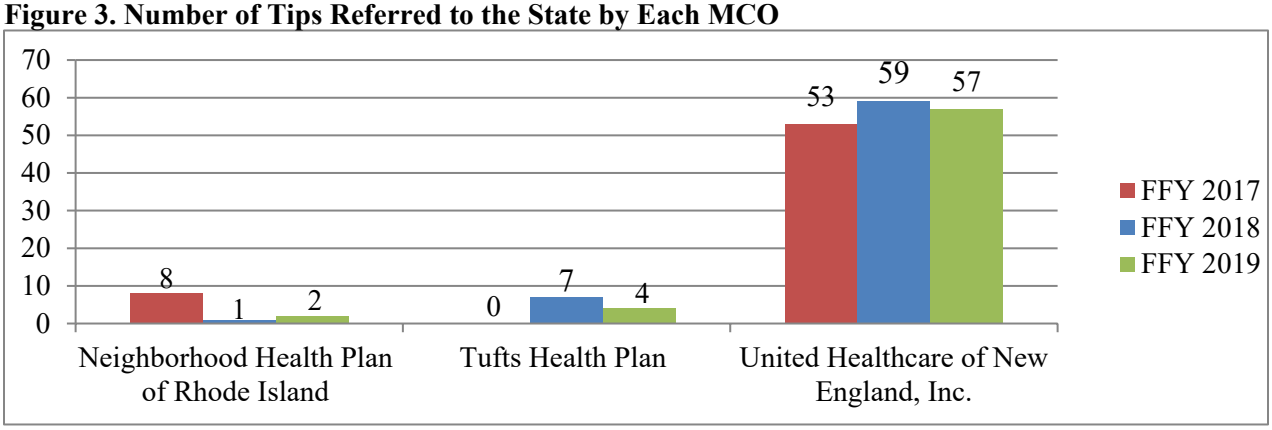
NHPRI intakes referrals from multiple sources, known internally as "leads," and submits these leads to the SIU for triage. The investigator performs a preliminary review of facts against the allegation to determine if the lead is appropriate, and whether it will be closed or full investigated as a "case." Once a credible allegation of fraud is determined, NHPRI reports the case to the state via email.

UHC reported that it conducts a preliminary review of all tips received through its contracted SIU.

Preliminary Investigation is a review of a tip to determine if the allegation is substantiated by reviewing claims data and other sources. Once a tip is determined to be credible, the SIU conducts a full investigation. UHC reported that investigations are conducted in order to achieve a final outcome of the case. An outcome would either be one in which the result would result in a substantiated finding or one in which that would result in an unsubstantiated finding when evidence is insufficient to validate the allegation. UHC reported that the plan is required to report any suspected cases of provider or member fraud, waste or abuse to the EOHHS Medicaid Office of Program Integrity, Rhode Island Attorney General MFCU and Office of Inspector General.

Figure 3 details the number of referrals that Neighborhood Health Plan of Rhode Island, Tufts Health Plan, and United Healthcare of New England made to the state in the last three FYs. Overall, the number of MCO provider case referrals of the reviewed SIUs appears to be low in relation to the Medicaid expenditures and beneficiary/provider enrollment for both NHPRI and Tufts. UHC referred more cases to the state, but this higher relative number of referrals may be attributable to how cases are classified internally; after review by the state, many of the referred cases were not accepted.

Figure 3. Number of Tips Referred to the State by Each MCO



Additionally, even though the three MCOs submitted 191 tips to PI between FYs 2017-2019, CMS discovered that the PIU referred 22 cases to MFCU. Specifically, during the period between FYs 2017-2019, the MFCU accepted 20 case referrals related to the MCO's investigations.

Overpayments

Consistent with § 438.608(d), the state MCO contract must specify that MCOs must have an overpayment retention policy in place. Rhode Island contract § 3.07.03.06 (Investigating and Reporting Suspected Fraud and Abuse), states, “While all recoveries related to overpayments due to fraud, waste or abuse, except of whistle blower cases, are retained by the Contractor, the Contractor will develop retention policies for the treatment of recoveries. The Contractor must provide an annual report of any monetary recoveries that result from reconciliation of cases of fraud.” Additionally, Rhode Island MCO general contract § 2.13.08.01 Recovery Reporting further clarifies the reporting process and requirements for the MCO.

Overall, the amount of overpayments identified and recovered by UHC appears to be exceedingly low in relation to the number of investigations conducted. NHPRI and Tufts overpayments identified and recovered appears to be in alignment with the number of reported MCO investigations for the review period. UHC attributes this significant difference to overpayments being identified outside of the lookback period of 18 months. Although the MCOs are not normally required to return overpayments from their network providers to the state, the state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process. . (§ 438.608(d)(4)) Without these adjustments, MCOs could be receiving inflated rates per member per month. Tables 4-A, 4-B, and 4-C describe each MCO's recoveries from program integrity activities.

Table 4-A. Neighborhood Health Plan of Rhode Island's (NHPRI) Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	14	14	$3,046,724.72	$568,500.75
2018	8	8	$298,738.70	$386,719.37
2019	34	34	$351,509.22	$264,498.31

Table 4-B. Tufts Health Plan's Recoveries from Program Integrity Activities[6]

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	0	0	$0	$0
2018	13	12	$0	$0
2019	8	7	$65,418.50	$9,763.49

Table 4-C. United Healthcare of New England, Inc.'s Recoveries from Program Integrity Activities

FFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2017	53	24	$361,945.92	$10,708.13
2018	59	28	$1,839,520.00	$24,761.02
2019	57	29	$152,408.23	$11,730.72

Recommendation #3: The state should ensure that beneficiary verifications are being conducted by all MCOs according to contractual requirements.

[6] Tufts did not begin overpayment recovery efforts until FY 2019.

Recommendation #4: The state should ensure that its MCOs are being proactive in identifying and collecting overpayments and accurately reporting all overpayments to the state. The state should obtain evidence from its MCOs in support of any statements attributing a decline in the overpayments as the direct result of cost avoidance activities or proactive measures in place. The

state should also ensure that the MCOs develop and maintain appropriate overpayment identification/collection/reporting policies and procedures consistent with § 438.608(d).

4. Encounter Data

The MCO contract with the state requires the submission of an electronic record for every claims level record for all billed services provided to Medicaid enrollees. Through an edit and load cycle, encounter data is examined for a variety of factors, including enrollment, covered services, provider licensing, and claims payment according to the established fee schedule. The encounter data from each of the MCOs is collected electronically on monthly basis and algorithms based on the state's established utilization metrics have been developed to compare submitted MCO data to Medicaid Management Information System (MMIS) encounter data.

In addition to the MMIS comparison, the state also uses a variety of tools that can be used to provide comprehensive analysis of all encounter data. These tools include SQL scripts, Power Business Intelligence (BI), Business Objects, SAS and LexisNexis' Intelligent Investigator and Provider of Interest Predictive Modeling SaaS.

CMS did not identify any recommendations regarding Rhode Island's use of encounter data for Medicaid oversight and noted that this is an area of improvement since the FY 2016 review.

5. Payment Suspensions Based on Credible Allegations of Fraud

Consistent with § 438.608(a)(8), Rhode Island's MCO model contract includes a provision regarding the suspension of payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23. Specifically, Rhode Island's MCOs are contractually required to suspend payments to network providers at the state's request if the state determined a credible allegation of fraud exists in accordance with § 455.23. Suspension of payments must be implemented upon notification from the state and applies to all Medicaid claims (FFS and encounter/managed care) submitted by the network provider.

The EOHHS contract states that, "[t]he Contractor will have a process for the suspension of payments to a network provider for which the State determines there is a credible allegation of fraud." Upon notification from the EOHHS that such a determination has been made, and provided the EOHHS has not determined good cause exists to not suspend payments or to suspend payment only in part, the MCO must suspend payment as soon as possible and no later than the date indicated in the notice from the EOHHS. If the MCO believes there is a good cause, as defined in § 455.23, to not suspend payments or to suspend payment only in part to a provider or subcontractor, the MCO must verify "…with both the

Office of Program Integrity, (OPI) and EOHHS before initiating any recoupment related to the outcome of a program integrity audit or prior to implementing any withhold of any funds for program integrity related issues."

The EOHHS will evaluate all requests for good cause exemption and notify the MCO of the decision. Upon notification from the EOHHS of a determination that good cause does not exist, the MCO shall suspend payments as of the date in the EOHHS's notice. The MCO must send a letter of the suspension of program payments to the suspended provider and a copy of the letter to the agency within five business days of receiving notice from the EOHHS unless requested in writing by a law enforcement agency to temporarily withhold such notice. The letter must address all points in § 455.23(b)(2) and must set forth the provider's right to the state's administrative appeals process."
All three MCOs have a suspension policy and comply with the terms of their contract. As such, CMS did not identify any recommendations regarding Rhode Island's payment suspension policies and processes.

6. *Terminated Providers and Adverse Action Reporting*

Consistent with §§ 438.608(b) and 455, subparts B and E, Rhode Island's MCO model contract requires MCOs to meet CMS' provider enrollment and screening requirements, including the requirement at § 455.416 to terminate network providers in certain circumstance, including for cause, which may include, but is not limited to, fraud, integrity, or quality. Specifically, section 2.13.07 of the Rhode Island MCO contract states, "The MCO will report to EOHHS promptly those providers that have been terminated from the network." This information is also reported on a quarterly basis by the MCOs on the MCO Program Integrity Quarterly Report.

The three MCOs interviewed by CMS reported that they currently submit providers terminated, either for or not for cause, to EOHHS on both a monthly and quarterly basis as well as during the MFCU meetings. The state notifies the MCOs of any terminated providers from other plans or providers who have lost Rhode Island Medicaid eligibility. This ensures that these terminated providers are not operating in any plan contracted with the state. In addition, the MCOs receive the notices from the Rhode Island Board of Medical Licensure and Discipline. EOHHS provided evidence of compliance with the monthly requirement and process for submitting terminated providers for inclusion in CMS' Data Exchange System (DEX).

Overall, the number of providers terminated "for cause" by the plans appears low, compared to the number of providers enrolled with the MCOs and compared to the number of providers dis-enrolled or terminated; however, CMS has no recommendations related to provider terminations. Table 5 depicts the number of provider terminations by MCO.

Table 5: Provider Terminations in Managed Care

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs	Total # of Providers Terminated for Cause in Last 3 Completed FFYs
Neighborhood Health Plan of Rhode Island	2017 365 2018 499 2019 537	2017 0 2018 0 2019 0
Tufts Health Plan	2017 10 2018 290 2019 582	2017 0 2018 32 2019 71
United Healthcare of New England, Inc.	2017 142 2018 148 2019 434	2017 7 2018 13 2019 12

CMS did not identify any recommendations regarding Rhode Island's terminated providers and adverse action reporting policies and procedures.

Status of Rhode Island's 2016 Corrective Action Plan

Rhode Island's previous focused program integrity review was in June 2016, and the report for that review was issued in June 2017. The report contained seven recommendations for programmatic improvement. CMS completed a desk review of the corrective action plan in December 2018 that indicated three findings had not yet been satisfied; however, during this review, it was noted two out of the three had been satisfied.

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:

- Access COVID-19 Program Integrity educational materials at the following links:
  - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
  - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
  - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Provider Requirements website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Provider-Requirements to address site visit requirements.
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCU.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address Overpayment and Recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- 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. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Conclusion

CMS supports Rhode Island's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified four areas of concern and instances of non-compliance with federal regulations that should be addressed immediately.

We require the state to provide a corrective action plan for each of the recommendations within 30 calendar days from the date of issuance of the final report. The corrective action plan should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies have been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action 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 corrective action plan, 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 issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

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