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Centers for Medicare & Medicaid Services**

Medicaid Integrity Program

Puerto Rico Comprehensive Program Integrity Review

Final Report

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG) conducted a comprehensive program integrity review of the Commonwealth of Puerto Rico Medicaid Program. The MIG review team conducted the onsite portion of the review at the offices of the Commonwealth's Medicaid agency, which is part of the Puerto Rico Department of Health (DOH), and the offices of the Puerto Rico Health Insurance Administration (in Spanish, Administración de Seguros de Salud or ASES). The review team also met with representatives of the U. S. Department of Justice (DOJ) field office in San Juan.

Medicaid services in Puerto Rico are delivered through capitated managed care organizations (MCOs) and another type of managed care entity (MCE). This review focused on the activities of ASES, which is responsible for the oversight of all managed care plans serving Medicaid beneficiaries in the Commonwealth. Through the development of a required program integrity plan for its contractors, Puerto Rico has demonstrated a strong commitment to addressing the program integrity issues identified in a previous MIG review in July 2008. However, the 2010 review team identified concerns that had not been fully addressed, particularly in parts of the Medicaid program run by ASES and some of the contracted MCOs. This report describes six areas of non-compliance and eight vulnerabilities in Puerto Rico's program integrity operations.

The Review

Objectives of the Review

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

Overview of Puerto Rico's Medicaid Program

The Puerto Rico DOH, the single State agency, is responsible for developing, implementing and managing the State Plan that defines the Medicaid program. Within DOH, the Medicaid agency administers the Medicaid program and is responsible for determining beneficiary eligibility as well as investigating beneficiary fraud and abuse. The Medicaid program integrity director is located organizationally in the Medicaid agency. In 1993, the Commonwealth passed legislation authorizing an island-wide managed care program predominantly for low income citizens, including Medicaid beneficiaries. As part of this change, an interagency collaborative agreement was established to delegate implementation of the law to a new government entity, ASES. The ASES was given the responsibility for contracting with insurance companies and overseeing the operations of the Commonwealth's managed care program, which was known as Reforma. The Reforma program in Puerto Rico was renamed Mi Salud on October 1, 2010. Beneficiaries under Mi Salud include individuals eligible for Medicaid, individuals who meet

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higher income and resource criteria for medical assistance, and government employees. The ASES contracts with two MCOs to provide comprehensive services to Mi Salud enrollees. Mental health coverage is a carve-out provided by a managed behavioral health organization (MBHO) which functions as a prepaid inpatient health plan. The ASES also contracts with two pharmacy benefit management (PBM) companies to implement comprehensive PBM programs for Mi Salud beneficiaries.

In January 2010, ASES contracted with five Medicare Advantage Organizations (MAOs) to provide a supplementary package of Mi Salud benefits for dual eligible beneficiaries. These Medicare MCOs are also referred to as Medicare Platino plans. The Mi Salud benefits “wrap around” the existing Medicare benefit packages offered by the MAOs and are delivered by the Platino plan networks. The two full service Mi Salud MCOs also offer dual eligibles a Platino plan option.

Puerto Rico’s Mi Salud MCEs are reimbursed on a risk capitated basis. Within the two MCOs, primary care services are capitated while specialty services are reimbursed on a fee-for-service (FFS) basis. The delivery of behavioral health services is likewise reimbursed through a combination of capitation and FFS payments. As of January 2010, the number of beneficiaries in Mi Salud plans was 1,320,660, with an additional 173,239 dual eligibles enrolled in Medicare Platino plans. At the time of the review, a total of 17,701 providers participated in the MCO networks to provide services to Mi Salud beneficiaries.

Unlike the 50 States and Washington, D. C., the amount of Federal Medicaid funding which Puerto Rico can receive is subject to a statutory cap. By statute, the Federal medical assistance percentage (FMAP) for Puerto Rico is 50 percent. Based on data from CMS-64 financial management reports for the Commonwealth, Puerto Rico received a total of \$615,037,807 in Federal financial participation (FFP) for Federal fiscal year (FFY) 2009. This figure represented 52 percent of the total computable Medicaid spending listed in the CMS-64 report (\$1,186,559,175). Although Puerto Rico’s Medicaid cap has increased significantly since the last review, its presence continues to impose limits on the resources that the Commonwealth can devote to administrative functions, such as program integrity. Any funding devoted to administrative purposes represents spending that cannot go to health care.

Puerto Rico has not had a Medicaid Fraud Control Unit (MFCU) since the inception of the U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG) Medicaid fraud control program.

Program Integrity Section

Neither DOH nor ASES directly conducts program integrity monitoring or the enrollment of providers. Puerto Rico approaches program integrity through the delegation of anti-fraud and abuse activities to the contracted health plans. This is discussed in greater detail in as both a regulatory compliance issue and a program integrity vulnerability. It represents a major shortcoming in the integrity of the Medicaid program in Puerto Rico.

At the time of the onsite visit, ASES was operating with a Director of Compliance, who is responsible for the oversight of the managed care program. The director, along with a few other

staff members in ASES, has the sole responsibility for coordinating with the Mi Salud and Platino programs on program integrity issues and practices.

Methodology of the Review

In advance of the onsite visit, the review team requested that Puerto Rico complete a comprehensive review guide and supply documentation in support of its answers. Because Puerto Rico does not have a MFCU, DOJ staff were interviewed to determine if their office has a relationship with ASES and the MCOs. A five-person team reviewed the responses and materials that the Commonwealth provided in advance of the onsite visit.

During the week of December 6, 2010, the MIG review team visited the DOH, ASES, and DOJ offices and interviewed numerous officials. The team also interviewed staff from the health plans, including the two full-service Mi Salud MCOs, the MBHO, and three Platino plans. The team also interviewed representatives from the two PBMs to gather information on their pharmacy enrollment practices and program integrity oversight. In addition, the team conducted sampling of managed care case files and other primary data to validate the Commonwealth's program integrity practices.

Scope and Limitations of the Review

This review primarily focused on the activities of ASES, which is responsible for the oversight of the Mi Salud health plans. The team also considered the work of other components and contractors responsible for a range of program integrity functions. Unless otherwise noted, Puerto Rico provided the program integrity-related staffing and financial information cited in the report. Puerto Rico has Federal authorization to use its CHIP allotment as an add-on to its capped Medicaid program dollars. As a result, the Commonwealth's CHIP is part of the Medicaid program and was not separately reviewed. For purposes of this review, the MIG team did not independently verify any staffing, financial, or collections information that the Commonwealth provided.

Results of the Review

Regulatory Compliance Issues

The Commonwealth is not in compliance with Federal regulations regarding the tracking, investigation, and referral of providers suspected of fraud. It also does not meet several provider disclosure requirements and has not adequately monitored providers for compliance with False Claims Act education requirements.

Puerto Rico does not have methods for the identification, investigation, and referral of suspected fraud cases. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.13 requires a State Medicaid agency to have methods and criteria for identifying suspected fraud cases and investigating those cases, and to have procedures for referring suspected cases of fraud to law enforcement officials.

The ASES delegates all program integrity tracking, investigative, and referral responsibilities to its managed care contractors. The agency does not track or investigate complaints against providers on its own, nor does it track and monitor MCO program integrity activities. Although ASES has started reviewing MCO activity reports, it provided no evidence that it conducts investigations or makes or arranges for referrals to any law enforcement agency when participating providers are suspected of fraud or abuse.

As part of the corrective action plan in response to the MIG review in 2008, ASES developed a set of policy standards for all managed care contractors. It issued them in a document called *Guidelines for the Development of Program Integrity Plan (PIP)* and included the document as an amendment to the 2009 MCE contracts. The MIG encouraged the Commonwealth to implement this plan to help strengthen its program integrity efforts. The ASES integrated the PIP standards into the MCE contract language for 2010. However, prior to the MIG team's onsite visit, CMS had not yet formally approved the new managed care contracts. During the onsite review, it was evident to the review team that ASES did not yet have the mechanisms in place to determine whether participating plans had effectively implemented the PIP. For example, ASES had not yet established a tracking mechanism to monitor the progress of potentially significant fraud and abuse cases at the plan level. In addition, ASES had not yet identified personnel within its organization whose job duties involved typical program integrity functions, such as data mining and analysis, case investigations, and auditing.

Recommendations: Develop and implement policies and procedures for identifying and tracking potential provider fraud cases at the plan level. Institute mechanisms to hold plans accountable for conducting preliminary and full investigations when necessary and for referring cases of suspected fraud to an appropriate law enforcement agency.

Puerto Rico's MCOs do not conduct adequate full investigations or refer cases of suspected provider fraud appropriately. (Uncorrected Repeat Finding)

The regulation at 42 CFR § 455.15(a)(2) requires Medicaid agencies in States with no certified MFCU to conduct a full investigation of each case in which Medicaid fraud or abuse is suspected or refer the case to the appropriate law enforcement agency.

The MCEs are contractually required to consult with ASES on pending fraud investigations and possible referrals. The review team found that the process of conducting full investigations is only pursued in a partial and truncated manner in the Mi Salud program. While ASES does not directly pursue any full investigations, it does require the MCEs to report on cases of suspected fraud and reserves the right to give direction on how to pursue subsequent investigations. In practice, ASES is not kept as current on the status of cases as it should be and has limited opportunity to offer plans guidance on next steps. For example, during the onsite interview, one MCO stated that its process for reporting cases of suspected fraud is to notify ASES on the quarterly Preliminary Investigative Report. Yet even after notifying ASES that a case has been placed in suspended status due to suspicion of fraud, the MCO does not wait for directions from ASES on how to proceed with the full investigation. The MCO continues to review the case to determine the appropriate action to take, without ever notifying ASES of any further results.

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It was noted by the review team during case sampling that when the same MCO has substantiated the findings, the provider file is flagged for future monitoring to ensure that no subsequent claims are paid. This in itself may be sound business practice as an interim step. However, the MCO indicated that it makes no efforts to determine if the claims in question would result in an overpayment or refer the case to appropriate law enforcement for further investigation. Among 10 cases sampled, there was a clear indication that many of them warranted further review or referrals to law enforcement, but the MCO failed to take action, other than to monitor future billing.

One case in particular involved a provider who obtained her medical license fraudulently. The ASES was notified of the suspension of the provider on the MCO's quarterly report dated 7/1/08 thru 9/30/08. However, the plan provided no further updates, nor did it terminate the provider from the network. Even though the case was flagged to deny all claims, the provider remained in the MCO's network, with the next review scheduled for May 4, 2011. In addition, the review team identified four other provider cases in the sample where there was evidence of activities that warranted further investigation or referral to law enforcement. In each case, the MCO failed to develop a referral or notify ASES of the outcome of its full investigation. It was noted in the record of one provider that "the provider was too large and important to the Puerto Rico market to be flagged for further monitoring or referral." No further action was taken against this provider.

Based on these observations, the team concluded that the PIP had not yet been effectively implemented to ensure compliance with the regulation at 42 CFR § 455.15.

Recommendations: Enforce the contract provision requiring managed care plans to report suspected fraud and abuse cases to ASES. Provide guidance to plans on how to pursue full investigations to conclusion and where appropriate make referrals to the local DOJ office or another law enforcement agency.

Puerto Rico does not capture all required ownership, control, and relationship information from the Mi Salud health plans and PBMs. (Uncorrected Repeat Finding)

Under 42 CFR § 455.104(a)(1), a provider, or "disclosing entity," that is subject to periodic survey under § 455.104(b)(1) must disclose to the State surveying agency, which then must provide to the Medicaid agency, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. A disclosing entity that is not subject to periodic survey under § 455.104(b)(2) must disclose to the Medicaid agency, prior to enrolling, the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5 percent or more. Additionally, under § 455.104(a)(2), a disclosing entity must disclose whether any of the named persons is related to another as spouse, parent, child, or sibling. Moreover, under § 455.104(a)(3), there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity has an ownership or controlling interest. In addition, under § 455.104(c), the State agency

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may not contract with a provider or fiscal agent that has not disclosed ownership or control information required under this section.

In 2009, ASES amended its contracts with the MCOs and MBHO to include an addendum with the PIP guidelines which required the health plans to disclose ownership and control information about their organizations in accordance with 42 CFR § 455.104. The PIP guidelines were incorporated in the body of the contract in 2010. However, the revised contracts were not signed and officially in effect at the time of the onsite review. Moreover, despite giving the plans advance notice of the new contract requirement on ownership and control disclosures, ASES had not yet asked any plans to submit actual disclosures or the revised enrollment forms to review them for compliance. During the interview with ASES, a representative stated that the health plans would be sent a 30-day notice in January 2011 to comply with the regulation. Regarding the PBMs, the team also observed that the Commonwealth's PBM contract did not require any of the disclosures specified in the regulation, nor did the PBM provider application forms require this information.

NOTE: The CMS team reviewed the managed care contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the Commonwealth takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendations: Modify the PBM contracts to require the disclosure of complete ownership, control and relationship information as provided in 42 CFR § 455.104 and promulgate the MCE contracts with these provisions. Enforce the provisions in both the PBM and Mi Salud MCE contracts requiring complete § 455.104 disclosures from all contracted health plans and PBMs.

Puerto Rico's PBM and MCE contracts do not require the disclosure of specified business transaction information. (Uncorrected Repeat Finding)

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

The ASES contract with the PBMs does not include a statement requiring the PBMs to disclose the specified business transaction information to the Secretary or the Medicaid agency upon request. The contract also contains no reference to a 35-day time frame, although the regulation states that providers must submit business transaction information within 35 days of the date on a request by the Secretary or the Medicaid agency. In addition, although Puerto Rico's new contracts with the Mi Salud health plans incorporate the provisions of 42 CFR § 455.105 as part of the required PIP, the contracts were not signed at the time of the review. Hence, the contract requirement to disclose business transaction information on request was not officially in effect.

Recommendation: Modify the PBM contracts to require the timely disclosure of the specified business transaction information on request and promulgate the Mi Salud health plan contracts with these provisions.

Puerto Rico does not capture all required health care-related criminal conviction disclosure information from MCEs and PBMs. (Uncorrected Repeat Finding)

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-OIG whenever such disclosures are made.

In 2009, ASES amended its MCE contracts to include the PIP guidelines, which require MCEs to disclose health care-related criminal conviction information about the owners, agents, and managing employees of providers in accordance with 42 CFR § 455.106. The PIP guidelines were incorporated in the body of the contract in 2010. However, the revised contracts were not signed and officially in effect at the time of the onsite review. Moreover, despite giving the plans advance notice of the new contract requirement on criminal conviction disclosures, ASES had not yet asked any plans to submit actual disclosures or the revised enrollment forms to review them for compliance. In addition, the PBM contracts did not require any of the criminal conviction information specified in the regulation, nor did the provider application forms solicit this information.

Recommendations: Modify the PBM contracts to require the health care-related criminal conviction disclosures required under 42 CFR § 455.106 and promulgate the MCE contracts with these provisions. Enforce the provisions in both the PBM and Mi Salud health plan contracts requiring complete 455.106 disclosures from all contracted health plans and PBMs.

Puerto Rico has not complied with the State Plan requirement to review providers' policies and employee handbooks pertaining to the False Claims Act.

Section 1902(a)(68) of the Social Security Act [42 U.S.C. 1396a(a)(68)] requires a State to ensure that providers and contractors receiving or making payments of at least \$5 million under a State's Medicaid program have (a) established written policies for all employees (including management) about the Federal False Claims Act, whistleblower protection, administrative remedies, and any pertinent State laws and rules; (b) included as part of these policies detailed provisions regarding detecting and preventing fraud, waste, and abuse; and (c) included in any employee handbook a discussion of the False Claims Act, whistleblower protections, administrative remedies, and pertinent State laws and rules.

Puerto Rico has a State Plan amendment for False Claims Act education in place that was approved on April 16, 2010, with an effective date of January 1, 2007. However, neither ASES nor the Medicaid agency has started conducting compliance reviews with providers receiving or making payments of at least \$5 million as the statute requires. Although ASES has sent a notice to providers requesting baseline compliance information, it has not yet begun to

determine provider compliance with the law as described in subparagraphs (a), (b) or (c). During interviews with the MCEs and PBMs, the majority of plans indicated that they were not monitoring whether their network providers are educating their employees on the False Claims Act.

Recommendation: Develop and implement a process to monitor MCO and PBM compliance with the State Plan.

Vulnerabilities

The review team identified eight areas of vulnerability in Puerto Rico's program integrity practices. These included inadequate monitoring of program integrity issues in the managed care program as well as failure to collect required disclosures from or report adverse actions taken against managed care network providers. The Commonwealth also does not require MCEs to collect managing employee information on network provider credentialing forms, does not require MCEs to perform complete exclusion checks, and does not conduct beneficiary service verifications in the managed care program.

Inadequate program integrity oversight of the managed care program. (Uncorrected Repeat Vulnerability)

Puerto Rico's managed care contracts require that MCEs furnish information on suspected cases of fraud and abuse to ASES as part of their quarterly reporting. Based on interviews with MCE staff, the Mi Salud health plans show a wide divergence in program integrity activity, although all have Special Investigative Units and strategies intended to detect fraud and abuse. In the last four State fiscal years (SFY), the MCEs have reported very few cases of suspected fraud and abuse. Despite some indicators of tangible progress in its monitoring of the Mi Salud plans, ASES' inability to stimulate increased reporting and activity is symptomatic of continuing problems in program integrity oversight of the managed care sector.

At the time of the 2008 CMS review of the Commonwealth's program integrity functions, ASES was operating with a vacancy in the compliance officer position, as well as a 40 percent overall vacancy rate. Since then, a Compliance Director has assumed operational responsibility for the managed care program and has made significant strides in bringing the program into compliance. The Compliance Director developed the PIP and is monitoring the activities of the Mi Salud plans, more closely and exercising a greater degree of oversight than was done in the past. For example, based on discussions with ASES and a study of internal documentation, the review team determined that the Compliance Officer reviewed a sample of MCE fraud and abuse quarterly reports, program integrity policies and procedures, and operational processes for conducting preliminary and full investigations. In areas where deficiencies were found, corrective action plans were required. In addition, ASES reported that as part of its 2010 work plan, it reviewed health plan exclusion processes to determine how well controls and procedures are working to prevent contracting with excluded providers.

Nevertheless, the team found reason to question the actual extent of ASES' monitoring and oversight activities. For example, the review team asked ASES for documents on the review of plan exclusion processes, but to date these have not been provided. Moreover, the team found

that ASES was not apprised of all ongoing MCE investigations or new cases as they occurred. In addition, ASES did not actively review whether MCE providers under the scrutiny of one plan were also causing problems across the entire managed care network. Likewise, ASES has not provided or sponsored training, conferences or periodic meetings with the MCEs, either individually or as a group. Although one MCO developed extensive policies and procedures in direct response to issues raised during the CMS 2008 review, the Commonwealth failed to take advantage of that MCO's initiative in advancing policy beyond those areas articulated in the PIP and has not required the other MCEs to follow this example. Overall, the limited oversight of MCEs reduces the opportunity for ASES to collaborate with its health plans in preventing and identifying fraud and abuse.

In general, the Mi Salud program has continued to lag in its ability to identify, investigate, and develop suspected fraud cases for referral. The agency has not improved its capacity to investigate complaints against providers on its own, nor does it track and monitor the health plans' program integrity activities as the PIP guidelines would require. In addition, ASES has not identified any fraud or abuse cases in the last SFY or referred cases to law enforcement.

The ASES confirmed that before October 1, 2010 it was not aware of any meetings or case referrals between the DOJ and the MCEs. In the absence of a MFCU in Puerto Rico, DOJ serves as the law enforcement authority best suited to investigate credible allegations of Medicaid fraud. While ASES has attempted to address this issue by requiring participating health plans to establish DOJ linkages as part of a corrective action plan, there was no evidence that it has referred any cases of suspected fraud to DOJ on its own or required plans to do so.

The DOH also reported that it currently has no relationship with DOJ and cannot influence the fraud referral practices of ASES and its contracted health plans. However, DOH indicated that it expects to establish a new Office of Investigations by July 2011. The creation of the Office of Investigations was ordered by the Secretary of Health. The mission of the Office will be to conduct and coordinate investigations of suspected criminal violations in the public health realm. It will also maintain liaison and cooperative investigative efforts with various Federal, State, local, and international law enforcement agencies on special projects and assignments. This office will establish anti-fraud policies within DOH and coordinate all activities related to fraud detection and prevention. The office will include a criminal investigation division, administrative investigation office, and intelligence division, staffed with special agents, investigators, intelligence analysts, an attorney, and document examiner. The office will focus on both provider and beneficiary fraud. It is anticipated that the Office of Investigations will help develop a working relationship among DOH, ASES, and DOJ and facilitate more robust program integrity activities in the Mi Salud program. However, at the time of the review, such linkages were not yet evident.

Recommendations: Develop and implement policies and procedures under which ASES will organize periodic meetings with the Mi Salud health plans. Require all plans to report fraud, waste and abuse cases on an ongoing basis, and proactively offer guidance on cases of interest discussed in the reports. Provide MCOs with clear direction on when to report potential provider fraud and abuse cases, to whom such reports should be directed and what to include in the

reports. Develop and implement policies and procedures for the collection, review, and analysis of managed care encounter data by the Mi Salud plans.

Not capturing managing employee information from network providers on credentialing forms. (Uncorrected Repeat Vulnerability)

Under 42 CFR § 455.101, a managing employee is defined as “a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency.”

Neither ASES nor its MCEs solicit managing employee information on any provider enrollment or credentialing forms. The MCEs’ internal credentialing documents only ask for the name of an office manager or a director/manager authorized to sign the contract. These disclosures do not solicit other types of managing employees, such as billing agents or other individuals that may have managerial control over the day-to-day operations of the provider. Thus, the MCEs and ASES would have no way of knowing if excluded individuals are working for providers or entities in such positions.

Recommendation: Modify MCE provider enrollment forms and credentialing packages to capture the identity of managing employees.

Not collecting all required ownership and control disclosure information from MCE network providers. (Uncorrected Repeat Vulnerability)

Not all applications used by Puerto Rico’s MCEs collect the ownership and control disclosures from MCE network providers that Federal regulations at 42 CFR § 455.104 would otherwise require from FFS providers. In their internal credentialing process, the MCOs do not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors.

One MCO claimed to be operating under the new contract with PIP language, which ASES is trying to put in effect. The new contract contains a section which requires managed care contractors to collect the same ownership, control, and relationship information as would be required of FFS providers under 42 CFR § 455.104. However, in its internal credentialing process, this plan’s Participating Provider Credentialing Application does not ask for information on persons with ownership and control interests in the provider, family relationships among such persons, and interlocking relationships of ownership and control with subcontractors. In addition, the contract which this MCO purports to be following has not yet received CMS approval. Consequently, like the PIP which incorporates the 455.104 requirements, it is not officially binding on this MCO or other participating plans. This situation continues to leave the Commonwealth vulnerable to having excluded parties in ownership and control positions of providers or subcontractors serving Medicaid managed care enrollees.

NOTE: The CMS team reviewed the MI Salud health plan contracts and other provider agreements for compliance with 42 CFR § 455.104 as it was effective at the time of the review. That section of the program integrity regulations has been substantially revised and the amendment was effective on March 25, 2011. The amendment adds requirements for provision of Social Security Numbers and dates of birth as well as more complete address information regarding persons with ownership or control of disclosing entities, and requires disclosures regarding managing employees. Any actions the Commonwealth takes to come into compliance with 42 CFR § 455.104 should be with that section as amended.

Recommendation: Revise MCE network provider enrollment forms to collect all information on persons with ownership and control interests in the provider required under 42 CFR § 455.104, including the new information required by the regulation that went into effect on March 25, 2011.

Not requiring the disclosure of business transaction information from MCE network providers. (Uncorrected Repeat Vulnerability)

The MCE provider agreements contain no provision requiring the provider to supply the same type of business transaction information that FFS providers would be required to furnish, at the request of State agencies or the Secretary of the U.S. Department of Health and Human Services under 42 CFR § 455.105. While the PIP does require plans to include this provision in their network provider agreements, the MCO contracts which contain the PIP were not signed or effectively implemented at the time of the onsite review.

Recommendation: Modify the MCE contracts to require network provider agreements to provide timely disclosure, upon request, of the business transaction information stipulated by 42 CFR § 455.105.

Not collecting criminal conviction information from MCE network providers. (Uncorrected Repeat Vulnerability)

The MCEs do not collect the ownership and control disclosures from their network providers that Federal regulations at 42 CFR § 455.106 would otherwise require from FFS providers. The Mi Salud health plan applications used in the internal credentialing process only ask if the provider has been denied, revoked, or suspended from Medicare, Medicaid, or other government program participation within the past five years. The applications do not request health care-related criminal conviction disclosures from the inception of the Federal programs. In addition, they do not request similar disclosures from persons with ownership and control, agents, and managing employees despite the plans' exposure to the PIP guidelines since 2009.

Recommendations: Modify the MCE provider application forms to solicit health care-related criminal conviction information from persons with ownership and control, agents, and managing employees of network providers as specified in 42 CFR § 455.106. Develop and implement a process by which the MCEs must report 455.106 disclosures on a timely basis to ASES or directly to HHS-OIG.

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. If the State neither collects nor maintains complete information on owners, officers, and managing employees in the MMIS, then the State cannot conduct adequate searches of the List of Excluded Individuals/Entities (LEIE) or the Medicare Exclusion Database (MED).

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 (#09-001) 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 Excluded Parties List System (EPLS) on a monthly basis.

The ASES' current managed care contract does not require the Mi Salud plans and PBMs to collect complete information on owners, officers, agents and managing employees. Nor does it require contractors to store collected information in a searchable database where the individuals could regularly be checked for exclusions. The review team found that the Medicare Platino plans which serve dual eligible beneficiaries were, in practice, partially compliant. They conducted regular exclusion checks in accordance with Medicare requirements, although they appeared to be using a Puerto Rico-specific provider list of excluded individuals and entities which was not national in scope. In contrast, the two MCOs, the MBHO, and the two PBMs did not undertake regular checks of their provider networks or affiliated parties through either the LEIE, which is maintained by HHS-OIG, or the MED, which is maintained by CMS. At the time of the review, ASES was in the process of renewing its MCE contracts for SFY 2010 and indicated that it was attempting to incorporate the CMS guidance on exclusion checking in the contract requirements. However, as previously noted, the new contracts are awaiting final CMS approval and are not yet in effect.

Recommendations: Develop policies and procedures for appropriate collection and maintenance of disclosure information about disclosing entities, and about any person with a direct or indirect ownership interest of 5 percent or more, or who is an agent or managing employee of the disclosing entity, or who exercises operational or managerial control over the disclosing entity. Search the LEIE (or the 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.

Not verifying with managed care enrollees whether services billed by MCE network providers were received. (Uncorrected Repeat Vulnerability)

Although it is a PIP requirement, the Mi Salud health plans do not a method in place for verifying with beneficiaries the receipt of services billed by providers. While the Platino plans serving dual eligible beneficiaries do send out Explanations of Benefits (EOBs) to all enrollees consistent with Medicare policy, the two MCOs and MBHO indicated in interviews that they were not performing routine verification of services with beneficiaries. One health plan stated that it does not generate EOBs because enrollees can go to the corporate website to contact the call center to verify services. The use of service verification techniques with beneficiaries could give ASES and its contractors leads on likely fraud and abuse cases and could be a potentially valuable source of case identification.

Recommendation: Enforce and monitor the contract requirement that MCEs have a method for verifying with beneficiaries whether billed services were received.

Not requiring MCEs to report adverse actions taken on managed care provider applications for participation in the program or on network provider terminations. (Uncorrected Repeat Vulnerability)

The current ASES-MCE contract does not specifically require the reporting to HHS-OIG of all MCE provider applicants whose credentialing requests are denied for program integrity reasons. The contract also does not require the reporting of MCO network providers that plans terminate or otherwise force out of their programs for program integrity reasons. The review team determined that one MCO and the MBHO were providing this information to ASES in practice, but a second MCO was not. The failure to share this information prevents ASES, in turn, from sending it to the HHS-OIG, as Federal regulations at 42 CFR § 1002.3(b)(3) would otherwise require States to do for similar adverse actions against FFS providers. The second MCO claimed to be following Section 9.4.9 of ASES' new managed care contract, which requires MCOs to report to ASES network provider terminations and credentialing denials within 20 days of notifying the provider. This would seem to conform to the regulation. However, while the health plan in question does report terminations to ASES on its quarterly reports, it was not clear that this reporting included application denials. In addition, the 20 working day requirement in the § 1002.3 regulation and the contract would not always be met by quarterly reporting.

Recommendations: Require all contracted MCEs to notify the Commonwealth when they terminate or deny credentialing to a provider for program integrity-related reasons. Develop and implement policies and procedures for reporting these adverse actions to HHS-OIG.

Conclusion

Although Puerto Rico has started to employ strategies that should improve its program integrity capabilities going forward, the identification of six areas of non-compliance with Federal regulations is of concern and should be addressed immediately. In addition, eight areas of vulnerability were identified. The CMS encourages the Medicaid agency in DOH and ASES to closely examine the vulnerabilities that were identified in this review.

It is important that these issues be rectified as soon as possible. To that end, we will require Puerto Rico 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 Commonwealth 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 Commonwealth of Puerto Rico will ensure that the deficiencies will not recur. It should include the timeframes for each correction along with the specific steps the Commonwealth 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 Puerto Rico 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 Commonwealth of Puerto Rico on correcting its areas of non-compliance, eliminating its areas of vulnerability, and building on its effective practices.

**Official Response from Puerto Rico
May 2012**



May 17, 2012

Mr. Joel Truman
Deputy Director (East)
CMS/Center for Program Integrity
Medicaid Integrity Group/Division of Field Operations
Room 37-130
26 Federal Plaza
New York, NY 10278

Dear Mr. Truman:

Attached for your consideration is our Corrective Action Plan (CAP) in response to the CMS Medicaid Integrity Program (MIP) final review report issued on January 11, 2012. In addition we have included copies of all of the supporting Exhibits referenced in the CAP. We appreciate your willingness to work with us on this very important issue and to extend to us the additional time necessary to respond to the report.

We note that the review was conducted by CMS in December 2010, and reflected the situation that was in place at that time, even though the final report was not issued until January 2012. Subsequent to the review PR has taken many actions to implement a compliant Medicaid Integrity Program and we understand that we still have much to do. So, in our CAP we indicate both the actions that we have taken in response to the findings and recommendations contained in the report and we also indicate the additional actions we are taking or, are planning to take, on each issue identified.

In addition, while the MIP final report focused on the activities of ASES we would like to inform CMS of several other fraud, waste, and abuse activities that are operating within the Medicaid agency. First, the Medicaid Anti-Fraud Unit focuses on eligibility related fraud. This unit performs eligibility quality control reviews of eligibility worker determinations at the local offices and formally investigates cases of eligibility fraud. An automated case management system to track their cases is currently under development to allow the unit to move from a fully manual to a fully automated case tracking process. Second, the Medicaid agency uses the Public Assistance reporting Information system (PAIS) to do data matches for duplicate eligibility and to verify eligibility data items reported by applicants.

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Third, a data matching module is being implemented within the new Medicaid automated eligibility system (MEDITI) that will enable the Medicaid agency to cross check eligibility data between various agencies within Puerto Rico such as Treasury, Transportation, Lottery, etc.. Lastly, there is an anti-fraud tip line (787-641-4224) within the Medicaid call centers for anyone to be able to report suspected fraud activities within the program.

Finally, there is currently within the Department of Health a plan being developed to establish an Office of Investigation which is expected to cover Medicaid, HIP, WIC, and the State-only program within the Department. It is hoped that as part of this plan Puerto Rico will move to the establishment of a formal Medicaid Fraud Control Unit (MFCU).

We will be pleased to discuss the CAP with you and to provide any additional information that may be needed. Please feel free to contact me if you have any questions.

Cordially,

Frank Diaz-Ginés
Executive Director, ASES


Walter Dobek-Barreiro
Acting Medicaid Director