Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Puerto Rico Focused Program Integrity Review

Final Report

August 2016

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Objectives of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Puerto Rico 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 Commonwealth's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2010.

Background: State Medicaid Program Overview

The CMS review team conducted the onsite portion of the review at the offices of the Puerto Rico state 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).

Puerto Rico operates a title XXI funded Medicaid expansion program and provides Medicaid services to approximately 1.6 million Medicaid beneficiaries through a 100 percent managed care network. The Medicaid beneficiaries are enrolled into a managed care plan contracted for the service region where they reside. This review focused on the managed care program integrity activities of ASES, which has oversight responsibility for the five MCOs serving the Commonwealth of Puerto Rico. The state agency's Federal Medical Assistance Percentage is 55 percent. The total Medicaid expenditures for state fiscal year (SFY) 2015 totaled approximately $2.4 billion dollars. However, unlike states, Puerto Rico's Medicaid expenditures are federally capped by Congress at $329 million dollars. Upon reaching the cap, Puerto Rico is responsible for the full cost of services provided to Medicaid beneficiaries.

The ASES has demonstrated a commitment to addressing the program integrity issues identified in a previous CMS program integrity review conducted in December 2010. In May 2013, the ASES created an anti-fraud unit and signed a Memorandum of Understanding (MOU) with the U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG), to look into beneficiary fraud, waste, and abuse and provide oversight of the MCO program integrity units.

Methodology of the Review

In advance of the onsite visit, CMS requested that Puerto Rico 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 March 7, 2016, the CMS review team visited the DOH and the offices of the ASES. It conducted interviews with numerous Commonwealth 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 Commonwealth and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the Commonwealth's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the Commonwealth 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 Commonwealth's Managed Care Program

The Puerto Rico Managed Care Compliance Division within ASES is principally responsible for providing oversight of the managed care program. As mentioned earlier, approximately 1.6 million beneficiaries representing 100 percent of the Commonwealth's Medicaid population were enrolled in five MCOs during SFY 2015. The state spent approximately $2 billion on managed care contracts in SFY 2015. Since the last review, the state Medicaid agency has transitioned to contracting with five MCOs: First Medical; Molina Healthcare of Puerto Rico, Inc., Triple-S Salud, PMC, and MMM Multi Health. The MCOs span of coverage is divided into eight geographical regions and a virtual region. Currently, the Medicaid program has integrated physical and mental health care coverage.

The state has contracted with Mercer to help provide consultation services in regards to program integrity efforts of the state. Mercer has made a positive impact, as evidenced by the quality of the MCO evaluation tools that have resulted since CMS's previous review. However, in spite of having these program integrity evaluation tools, there is a need for more oversight of the Medicaid program's contracted program integrity activities that are being performed by the MCOs. Developing better MCO oversight is obtainable for the Commonwealth with its current resources. The need for more MCO oversight is demonstrated by the deficiencies in the number of full investigations, referrals, and proactive fraud prevention measures across the entire Medicaid managed care program. Consequently, the need for more MCO oversight is present throughout the system, permeating all the way down to the provider level and becoming a systemic problem that requires the Commonwealth's attention.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review. The program integrity staff of Molina Healthcare, Triple-S Salud, and MMM Multi Health discussed their program integrity activities at length. Each MCO is operating under a contract with ASES as of April 2015.

Molina Healthcare of Puerto Rico, Inc., is a subsidiary of Molina Healthcare, Inc. Molina Healthcare was contracted to operate the Commonwealth's Medicaid-funded government health plan program in the east and southwest regions. As indicated on their website, Molina Healthcare has more than 30 years of experience serving Medicaid beneficiaries and ensuring the delivery of high-quality healthcare to Puerto Rico's Medicaid participants. Molina Healthcare generally contracts with hospitals, physicians, and ancillary providers on a capitation basis. Molina Healthcare also works with delegated contractors for behavioral health and dental coverage, with oversight provided by its Delegation Oversight Department.

Triple-S Salud has been in existence since 1959 and is the largest MCO in Puerto Rico. The MCO operates both a Medicaid and a commercial line of business under its scope of operations. Triple-S Salud provides health care coverage for two regions in Puerto Rico, with its commercial line of business generating the greatest volume of claim activity.

MMM Holdings, Inc., operates as a subsidiary of InnovaCare Health Solutions, LLC to provide high-quality healthcare to the elderly and disabled populations in Puerto Rico since 2004. MMM Healthcare, Inc. or MMM Multi Health began operations as a Medicaid-funded government health plan on April 1, 2015. The plan was contracted to serve the northeast and southeast regions of the Commonwealth.

Enrollment information and expenditure data for each MCO as of November 2015 is summarized below:

Table 1.

	Molina Healthcare	**Triple-S Salud**	**MMM Multi Health**
Beneficiary enrollment total	344,852	426,000	131,281
Provider enrollment total	2,735	2,779	2,338
Year originally contracted	2015	1995	2015
Size and composition of SIU	2	12*	3
National/local plan	National	Local	Local

*All positions may not be full-time equivalents positions.

Table 2.

MCOs	**SFY 2013**	**SFY 2014**	**SFY 2015**
Molina Healthcare	**	**	$160 million
Triple-S Salud	$1.8 billion	$1.9 billion	$1.8 billion
MMM Multi Health	**	**	$57 million

**Molina and MMM Multi-Health were contracted to do business in the Commonwealth in 2015.

Commonwealth Oversight of MCO Program Integrity Activities

The Managed Care Compliance Division is the unit within ASES that is responsible for providing oversight of MCO program integrity activities. The ASES performs annual MCO compliance reviews to ensure that the five MCOs meet their contract requirements for the eight individually contracted regions within the Commonwealth.

Even with MCO program integrity evaluation tools, the CMS review team observed a need for more MCO program integrity activity oversight by ASES that can be achieved through utilization of its current resources. The ASES's heavy reliance on the MCOs' SIUs have allowed the MCOs to exercise a high level of control over Medicaid program integrity activities. The ASES relies heavily on the SIU personnel of each MCO to analyze billing patterns from claims data in an attempt to identify and detect fraudulent activity in the Medicaid managed care program, leaving the state solely dependent on the MCOs to conduct data mining or more sophisticated data analysis. This has led to MCOs making internal fraud determinations without consultation with ASES and resulting in no fraud referrals being made from two of the three MCOs interviewed. The need for more oversight issue is

prevalent throughout the following identified managed care risk areas and is illustrated throughout this report.

Staffing:
There are five positions dedicated to program integrity responsibilities; however, these positions are not completely utilized for Medicaid program integrity activities. There are four program integrity full-time equivalent positions filled, including the compliance director and the executive director of managed care operations. The state Medicaid agency's program integrity staffing is extremely low for a Medicaid oversight agency, which causes the Commonwealth to delegate much of its oversight functions to the contracted MCOs. An analysis of other state Medicaid programs revealed that Puerto Rico's Medicaid program has the lowest number of FTEs among similarly sized programs. For example, Montana had 12 FTEs and Alaska had 22.5 FTEs dedicated to program integrity activities, during their last program integrity reviews in FFY 2013. However, even with this reduced number of program integrity staff, there are improvements needed in MCO oversight and accountability that should be addressed. The program integrity staff for ASES must be proactive in optimizing available partnerships and external resources and should ensure that program integrity staff is involved in the policy development process.

Policies and Procedures:
In some cases, there is a need to create or revise policies and procedures that will ensure effective oversight of specific managed care program areas, but in other instances policies and procedures already in existence are not enforced. Although program integrity tools and written policies and procedures were often in place, Puerto Rico's Medicaid program still lacked evidence of any robust program integrity activities being performed.

Provider Enrollment:
The state Medicaid agency does not enroll Medicaid managed care providers centrally, but rather they rely on the MCOs to fulfill all provider enrollment functions. In addition, ASES does not ensure MCOs and MCO delegates conduct complete database searches for individuals and entities participating in Medicaid. The CMS review team found that MCOs were not checking the Social Security Administration Death Master File (SSA-DMF) at the time of initial enrollment and reenrollment, or monthly as specified at 42 CFR 455.436 for MCO delegate individuals and entities. Furthermore, the MCO delegates themselves were not conducting the required federal database exclusion checks to ensure excluded individuals or entities are not participating in the Medicaid program.

Medicaid beneficiaries and the program at large are at risk when providers have not been adequately screened and enrolled. Having centralized enrollment allows the state Medicaid agency to have proper oversight of providers ensuring that fewer beneficiaries are exposed to risks and potential harm and that taxpayer monies are spent appropriately. In an attempt to offset these deficiencies, the state agency is analyzing the feasibility of implementing a central provider enrollment system for their Medicaid managed care program.

Credentialing and Recredentialing:

Additionally, approximately 700 Humana health plan providers who transitioned to Molina Healthcare in April 2015 have not been recredentialed by Molina Healthcare nor is it clear as to the timeframe when these providers were previously credentialed by Humana. The state agency has requested the

development of a corrective action plan (CAP) from Molina Healthcare to ensure that the contractor implements procedures ensuring the verification of provider credentials. This verification would include, but not be limited to conducting the required federal database exclusion checks prior to contracting with prospective Medicaid providers.

MCO Investigations of Fraud, Waste, and Abuse

As specified by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the Commonwealth does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs. Puerto Rico's MCO contract outlines the fraud reporting requirements in Articles 13 and 18 of the general contract, specifically in sections 13.5 and 18.2.2.3. The ASES delegates the tracking of suspected network provider fraud or abuse to the MCOs and only receives the tracked case information, if it is required for a specific case development.

The Commonwealth of Puerto Rico does not have a Medicaid Fraud Control Unit. Therefore, ASES has brought together the HHS-OIG, the Department of Justice (DOJ), and other partners to help in the fight against Medicaid fraud, waste, and abuse. The ASES has formed a coalition with these partnering organizations, referred to as the Puerto Rico Medicaid Integrity Group, and meets on a quarterly basis.

The MCOs submit quarterly reports of fraud, waste, and abuse activity to ASES for review. The contract does include language that requires the MCOs to report suspected provider fraud, waste, and abuse to ASES.

Molina Healthcare of Puerto Rico, Inc.'s program integrity requirements related to fraud, waste, and abuse detection and prevention are met by the SIU of their parent company, Molina Healthcare Inc. The parent company's SIU is centrally located at the corporate offices in Long Beach, CA and is a part of the corporate compliance department. The parent company's SIU provides fraud, waste, and abuse investigative services to the following Molina health plans located in: Florida, Michigan, New Mexico, Puerto Rico, Ohio, South Carolina, and Texas. Investigative services have also been recently been extended to Washington state and California.

Molina Healthcare informed the CMS review team that the main function of the SIU is to review clean claims prospectively at the time of claim payment and, if applicable, reduce the claim amount paid to providers. However, some claims may require a medical record review to determine any claim deduction. Molina Healthcare has also identified Health Management Systems, Inc., as their subcontractor to perform certain SIU functions such as data mining, analytics, and the use of the Automated Claims Evaluator System, which is a proprietary forensic editing system. Molina Healthcare has no physical presence in Puerto Rico to fully dedicate to their program integrity activities.

The Triple-S Salud SIU has several methods of prevention and detection of fraud. The MCO uses claims evaluator system software to detect coding errors such as unbundling, modifier appropriateness and duplicate claims. In addition, the MCO maintains open lines of communication with its employees, members, and providers in an effort to educate all parties regarding fraud matters and how they should be reported. This relationship is intended to make providers and members more inclined to report any allegation of fraud to the MCO. Triple-S Salud uses methods such as peer-to-peer

comparison, members billed per day, cost per service, and utilization profiles to identify suspects of fraud.

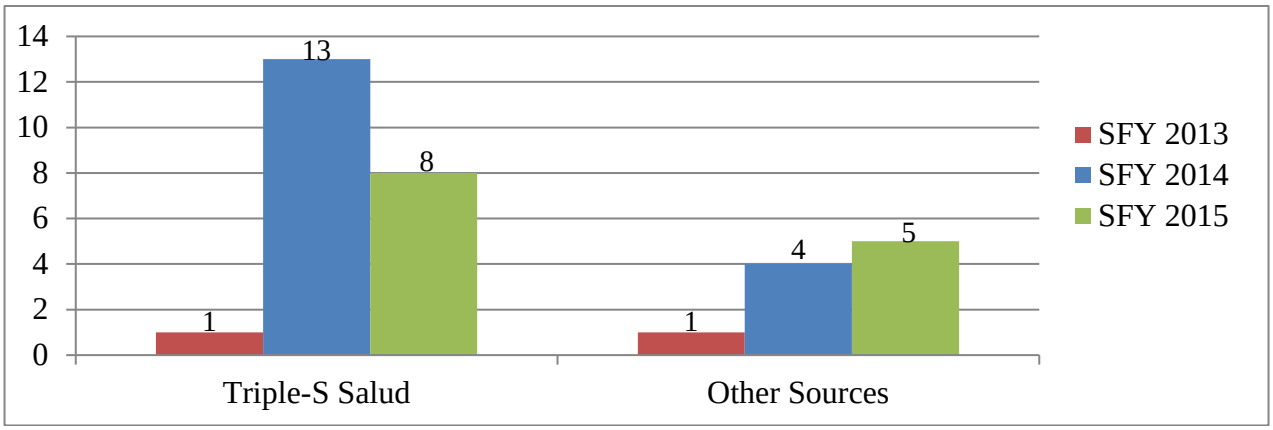
Triple S-Salud also relies on external sources to detect fraud such as the Puerto Rico Medicaid Integrity Group; alerts from agencies; and through fraud, waste, and abuse Medicare/Medicaid workgroups. Once a suspected case of fraud is identified, a preliminary investigation process is put in place. The SIU opens and documents the case, gathers information, validates the information, issues a findings report, and determines if a full investigation is required. If a full investigation is warranted, the provider is then notified and a sampling of medical records is requested. Consequently, the SIU will discuss findings with the provider and present the audit results to the utilization committee.

The utilization committee is made up of the board of directors; the chief medical officer; the chief financial officer; the clinical management vice president; the network management director; the legal affairs office director; the compliance and privacy officer; and the audit and investigation office director. Once the utilization committee meets, the SIU notifies the provider of the final determination and refers the claims to the finance department for management of all collections resulting from the audit, if applicable. Cases of suspected fraud are referred to ASES and may potentially be forwarded to the HHS-OIG; DOJ; Drug Enforcement Agency; Office of Personnel Management; Food and Drug Administration; CMS; State Insurance Commission; and Health Integrity Protection Data Bank.

MMM Multi Health program integrity requirements related to fraud, waste, and abuse prevention are mostly handled in-house and are conducted by their SIU. The SIU is comprised of a compliance integrity officer, a Medicaid compliance integrity manager, and three compliance integrity analysts fully dedicated to Medicaid program integrity. In addition, MMM Multi Health has subcontracted with Humana to conduct claim analysis, prepayment, and medical records review. Furthermore, the MCO has a separate SIU dedicated to the Medicare Advantage and Platino lines of business under MMM Holdings.

Table 3 lists the number of referrals that Triple-S Salud's SIU made to the Commonwealth in the last three SFYs. The other selected MCOs made no referrals. A few referrals were made over the past three years by other sources, which include MCOs not represented in this review and internal ASES organizations. Overall the number of Medicaid provider investigations and referrals by each of the MCOs is low, compared to the size of the plan. The level of investigative activity has not changed over time. Overall, the MCOs interviewed had little or no referrals to ASES or to law enforcement agencies over the past SFY.

Table 3.



*MMM Multi-Health and Molina Healthcare data indicated that no referrals were made to the state agency during the past three SFYs.

MCO Compliance Plans

The state Medicaid agency does require its MCOs to have a compliance plan to guard against fraud and abuse in accordance with the requirements at 42 CFR 438.608. As previously mentioned, the ASES compliance department is responsible for the oversight, monitoring, and auditing activities of all

MCO program integrity compliance. The state Medicaid agency does have a process to review the compliance plans and programs. The ASES compliance plan calls for an annual audit of each MCO's compliance plan and program.

As required by 42 CFR 438.608, ASES does review the managed care entity's (MCE's) compliance plan and communicates approval or disapproval to the MCE. Prior to contracting with any new MCO, the ASES reviews all program integrity policies and procedures in what they refer to as "readiness reviews". During these onsite readiness reviews, MCO compliance plans are evaluated. For SFY 2016, an audit tool was developed for the onsite readiness review. Additionally, the ASES Anti-Fraud Unit monitors the MCO compliance within its daily operations.

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

Encounter Data

The state Medicaid agency does receive all encounter data from the MCOs and runs program integrity related analysis of that data. The MCOs use several tools to detect and track potential fraudulent activities such as Lexis-Nexis and Intelligent Investigator. These systems deliver performance standards and ad hoc reports. If ASES finds any aberrant practices, they will either inform the MCO to open an investigation or they may investigate the issue themselves. The state agency is also analyzing the feasibility of implementing a central provider enrollment system for their Medicaid managed care program which would ultimately enhance their Medicaid provider oversight efforts.

Overpayment Recoveries, Audit Activity, and Return on Investment

The Commonwealth requires MCOs to return or report on overpayments recovered from providers as a result of MCO fraud and abuse investigations or audits. Only one of the three MCOs selected by the CMS review team reported any overpayments. Triple-S Salud reported identified overpayments for the last four SFYs; however, during a random sampling of cases, the CMS review team examined a closed fraud case with an estimated Medicaid overpayment of approximately $14,000. The commercial portion of this overpayment was approximately $54,000.

The CMS review team was informed that this case was closed at the direction of the MCO's internal committee and was not to be referred to the Commonwealth. Therefore, the Commonwealth never received this case as a fraud referral. As a result of the CMS focused review, the Commonwealth is looking into this particular case and has requested the records and the identification of each member serving on the MCO's internal committee. CMS plans to follow up with the Commonwealth to ensure corrective actions are taken and that any applicable Medicaid overpayments are correctly processed by the Commonwealth.

Since this issue was only revealed through sampling case investigations, the CMS review team was unable to ascertain whether this was a single incident or part of a larger scale issue involving the program integrity practices of this particular MCO.

Molina Healthcare does have an established methodology to calculate their SIU's return on investment (ROI) related to program activities by taking the amount recovered per quarter and dividing this by the cost to administer the SIU. Likewise, MMM Multi Health's ROI methodology consists of calculating unit cost versus actual recoveries. This methodology is also shared by Triple-S Salud, which calculates an ROI of 3.4 for SFY 2015. Molina Healthcare and MMM Multi Health will be able to calculate their ROI once they begin to recover overpayments.

The table below shows the respective amounts reported by Triple-S Salud for the past four SFYs.

Table 4.

SFY	Number of Preliminary Investigations*	Number of Full Investigations**	Amount of Overpayments Identified	Amount of Overpayments Collected***
2012	09	09	$17,550	$17,550
2013	106	94	$860,042	$447,214
2014	379	371	$1,053,845	$817,308
2015	45	13	$1,429,530	$777,998

*The MCO defines preliminary investigations as complaints that do not develop into full investigations.
**The MCO's definition of a full investigation is essentially a preliminary investigation involving complaint analysis or review.

Overall, the number of investigations for Triple-S Salud has dropped significantly since SFY 2014. In addition, the fact that two out of the three selected MCOs had no identified overpayments to report, since being awarded the contract, was of concern to the CMS review team. For a program of this size with Medicaid expenditures totaling more than $2 billion dollars, the amount of overpayments is quite low.

Payment Suspensions

In Puerto Rico, Medicaid MCOs are contractually required to suspend payments to providers at the Commonwealth's request. The Commonwealth confirmed that there is general contract language regarding the payment suspension regulation at 42 CFR 455.23. However, the managed care contract language does not contain the complete payment suspension requirements specified at 42 CFR 455.23. In addition, the CMS review team found that ASES does not require MCOs to suspend payments in cases of credible allegations of fraud and that payment suspensions were not being conducted across the entire Medicaid program. Administrative actions are authorized by all of the MCOs, based on decisions from their internal corporate committees.

The CMS review team did find at least one MCO, Triple-S Salud, with some elements of 42 CFR 455.23 in their SIU provider payment suspension policy and procedure. However, the payment suspension policy that was in place was not being utilized throughout the entire managed care network. Furthermore, the payment suspension policy and procedure did not outline all of the requirements of 42 CFR 455.23, leading to other systemic problems such as ASES not being made aware prior to administrative actions being taken against Medicaid providers.

The ASES desk audit review form is an evaluation tool used to assess the MCOs' policies and procedures pertaining to network provider investigations, suspensions, and debarment; however, the CMS review team could not ascertain whether any MCOs had been audited using this form and whether any corrective actions had ever resulted from such an audit.

Terminated Providers and Adverse Action Reporting

The general MCO contract states, "The Contractor shall submit a quarterly *Provider Suspensions and Terminations Report* that lists by name all network provider suspensions or terminations."

None of the MCOs interviewed claimed to be required to share this information with other plans. According to the MCOs interviewed, there were no for cause terminations, since implementation of the new contract in April 2015. All MCOs claimed to possess the authority to terminate providers for fraud or for business reasons and do not have to wait to be notified of actions taken at the state level before taking action against providers. For each MCO, all termination requests are submitted to their internal corporate committee for approval prior to the termination action taking place.

The CMS review team found that ASES does not ensure MCOs report all adverse actions taken against provider participation. The MCOs do not report denials of credentials due to integrity or quality. The state agency also needs the necessary access to the established CMS secure web-based portal, the TIBCO MFT server, which facilitates the sharing of information by states regarding terminated Medicaid providers; therefore, the state agency cannot fulfill the full requirements of 42 CFR 455.416.

In addition, Molina Healthcare and Triple-S Salud had no terminations this contract period, while MMM Multi Health had terminated a Medicaid provider without informing ASES. MMM Multi Health made an internal corporate decision to terminate a Medicaid provider suspected of fraudulent activity and only informed ASES after the termination action had taken place.

This was the provider termination process in place at the time of the CMS review; therefore, the CMS review team concluded that ASES needs to address the managed care contract language that stipulates

how Medicaid terminations that result from MCO fraud investigations will be handled by the MCO. As a result of this review, ASES is looking into the termination action taken by the MCO and determining an appropriate course of action to improve this process.

Table 5.

MCOs	Total # of Providers Disenrolled or Terminated in SFY2013- 2015		# of Providers Terminated For Cause in SFY 2013-2015	
Molina	SFY 2013	*	SFY 2013	*
	SFY 2014	*	SFY 2014	*
	SFY 2015	0	SFY 2015	0
Triple-S Salud**	SFY 2013	1,119	SFY 2013	0
	SFY 2014	616	SFY 2014	0
	SFY 2015	560	SFY 2015	0
MMM Multi-Health	SFY 2013	*	SFY 2013	*
	SFY 2014	*	SFY 2014	*
	SFY 2015	0	SFY 2015	0

* Molina and MMM Multi-Health were contracted to do business in the Commonwealth in 2015. At the time of the review, no providers had been disenrolled, de-credentialed, or terminated for any reason.
** Triple-S Salud totals represent providers not renewing their contracts or who are disenrolled, de-credentialed, or terminated without cause.

When considering the total number of providers enrolled in each MCO network and the volume of providers disenrolled or terminated by Triple-S Salud, it should be noted that no providers were terminated specifically for cause.

Recommendations for Improvement

- Strengthen MCO program integrity oversight by conducting monthly meetings with the MCO SIU staff with participation from the program integrity and managed care compliance staff in order to improve communications with the MCOs. The appropriate external partners involved in the state Medicaid agency's program integrity activities should also be included.
- Ensure that appropriate policies and procedures currently in place are implemented in practice. Develop and implement policies and procedures where none are in place to meet the identified risks to the Medicaid program.
- Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud. Work with the MCOs to develop specific program integrity training on how to meet all Medicaid program integrity requirements and how to develop and enhance case referrals from the MCOs. Ensure that all SIU staff and support staff are receiving appropriate training in identifying and investigating potential fraudulent billing practices by Medicaid providers. Continue efforts to improve the state agency's ability to analyze information from surveillance and utilization review systems and encounter data reported by MCOs and perform Commonwealth-initiated data mining activities to drive improvement with identifying fraud, waste, and abuse issues by Medicaid providers.
- Develop written credentialing policies and procedures that outline requirements for MCO delegates to search the List of Excluded Individuals and Entities (LEIE); Excluded Parties List

System (EPLS); SSA-DMF; and National Plan & Provider Enumeration System upon contract execution, and check the LEIE and EPLS monthly thereafter for the names of any person with an ownership or control interest or who is an agent or managing employee.
    - Amend the standard contract with the MCOs, to require these searches upon credentialing, re-credentialing and at the appropriate intervals, if necessary.
    - Train and inform all Medicaid managed care providers on how to search their employee's for any exclusions from federal programs.
- The ASES should update CMS on the compliance status of all MCOs placed on a credentialing CAP.
- Ensure that MCOs refer all suspected fraud and abuse cases for their Medicaid line of business, so that ASES can conduct an investigation or refer the matter to the appropriate law enforcement agency.
- Verify that overpayments are fully reported by the MCOs and incorporated into the rate setting process along with overpayments determined by Commonwealth-initiated reviews.
- Contractually require MCOs to suspend payment to providers against whom an MCO or ASES can document a credible allegation of fraud. The payment suspension requirements in 42 CFR 455.23 should be consulted in designing this provision.
    - Ensure contracted MCOs understand the circumstances in which payment suspensions are appropriate pursuant to 42 CFR 455.23.
    - Require the reporting of plan-initiated payment suspensions based on credible allegations of fraud.
- Distinguish between mandatory and discretionary termination/denial reasons in the standard managed care contract with MCOs and ensure that all MCOs report each of the termination/denial reasons which are considered "for cause" under 42 CFR 455.416.
- The state Medicaid agency should ensure that termination notifications are reported in a timely manner as stipulated under 42 CFR 1002.3(b)(3).

- The ASES should obtain access to the established CMS secure web-based portal (TIBCO MFT) to ensure the implementation of terminations based on Medicare administrative actions or another state's administrative actions, and report terminations by submitting the completed CMS Medicaid termination notification template along with the termination letter to CMS at the following email address: ProviderTerminations@cms.hhs.gov.
- Document the findings for the two cases referenced in this report:
    - The Triple–S Salud fraud case not referred to ASES.
    - The MMM Multi Health case involving the discretionary termination of a Medicaid provider without ASES's involvement in the termination process.

Section 2: Status of Corrective Action Plan

Puerto Rico's last CMS program integrity review was in December 2010, and the report for this review was issued in January 2012. The report contained eight findings and six vulnerabilities. As a result of working with CMS staff, the state Medicaid agency successfully met all the requirements of their FY 2011 comprehensive program integrity review CAP in December 2015. The 2016 CMS program integrity review team also reviewed all 14 issues with the Commonwealth during the onsite focused review and verified that all outstanding issues were corrected. The findings of this review are described below.

Findings

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

   Status at time of the review: Corrected

   - The state has revised developed a manual anti-fraud unit and revised the guidelines for program integrity activities.
   - Revised the audit process to review all the contract requirements so they comply with all the federal guidelines.
   - Amended the external quality review organization (EQRO) contract to review program integrity policies and procedures.
   - Established a memorandum of understanding (MOU) between ASES and program integrity partnering agencies and meet monthly.

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

   Status at time of the review: Corrected

   - The state has guidelines that describe the regulations and guidelines to conduct investigations.
   - The state has establish MOU with the Department of Justice for cases done by HHS-OIG.

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

   Status at time of the review: Corrected

   - The state has revised its disclosure forms in the application.
   - Language is now in the contract requiring the MCOs to comply with all of 42 CFR 455.

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

   Status at time of the review: Corrected

   - The state has revised its contract language requiring the MCOs to comply with all of 42 CFR 455.

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

   Status at time of the review: Corrected

   - The state has revised its contract language requiring the MCOs to comply with all of 42 CFR 455.

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

   Status at time of the review: Corrected

   - The state has revised its compliance of the regulation by contract.
   - Instructed MCO to be in compliance with the FCA education to the employee's and the protection of the whistleblower; and from the MCO to the providers, each provider that is paid more the 5M dollars they provide training and same protections. They must certify to the state that each provider is in compliance. They send an excel spreadsheet that includes all the providers and the certifications.

Vulnerabilities

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

   Status at time of the review: Corrected

   - The state has corrected this through the modifications to the standard contract and through the units and all the functions they are doing and monitoring of the reports that are required by program integrity, including the termination of the provider and also through the audits.

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

   Status at time of the review: Corrected

   - The credentialing forms have all been modified to capture the managing employee information from network providers.

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

   Status at time of the review: Corrected

   - The credentialing forms have all been modified to capture the managing employee information from network providers.

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

   Status at time of the review: Corrected

   - The credentialing forms have all been modified to capture the managing employee information from network providers.

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

   Status at time of the review: Corrected

   - The credentialing forms have all been modified to capture the managing employee information from network providers.

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

   Status at time of the review: Corrected

   - The state performs readiness reviews to verify the MCOs are doing the search in the database and have to include the verification they have searched the database monthly.
   - The NPL report that plans submit to ASES has a certification that the CEO has to sign that the report is valid and true and that the plans meets all the requirements.

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

   Status at time of the review: Corrected

   - As a part of the readiness review, the ASES verified that the MCOs have the ability to issue the EOBs to the member.
   - Additionally, there is an ASES call center or the call center maintained by the MCOs, which perform some periodic validations of services provided.

8. ***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)***

   Status at time of the review: Corrected

   - The state modified the standard contract language to ensure MCOs report adverse actions on managed care provider applications for participation or on network provider terminations.

Technical Assistance Resources

To assist the Commonwealth in strengthening its program integrity operations, CMS offers the following technical assistance resources for Puerto Rico 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 Commonwealth'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 Puerto Rico 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 team did not find any instances of noncompliance with federal managed care program integrity regulatory requirements; however, areas of concern were identified and should be addressed immediately.

We require the Commonwealth 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 Commonwealth will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state Medicaid agency expects will take place and identify which area of the agency is responsible for correcting the issue. We are also requesting that the Commonwealth 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 Commonwealth 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 Commonwealth has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Puerto Rico to build an effective and strengthened program integrity function.

Official Response from Puerto Rico
September 2016

ESTADO LIBRE ASOCIADO DE
PUERTO RICO
Administración de Seguros
de Salud de Puerto Rico (ASES)

September 29, 2016

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Dear Mr. Majestic,

The Puerto Rico Medicaid Program acknowledges the receipt of the 2016 On-Site Review Final Report dated August 10, 2016. On September 2, 2-16, Puerto Rico requested and extension of 20 calendar days in addition to the initial required timeframe. The additional time request was grated on letter dated September 6, 2016 and due date was updated to September 30, 2016. In addition, the letter clarified that Puerto Rico's 2010 Corrective Action Plan (CAP) has been fully corrected.

Attached you will find Puerto Rico's action plan for the recommendations included in the 2016 On-Site Review Final Report. If you need additional information on the plan contact Milagros Soto (msoto@asespr.org) or Naomi Iglesias (niglesias@asespr.org).

Cordially,

Sandra V. Peña Pérez, PT, MHSA
Deputy Executive Director

C Lurie Battaglia, Director, CMS Division of State Program Integrity
Jackie Garner, CMCHO Consortium Manager
Michael Melendez, DMCHO Associate Regional Administrator
Ricardo A. Colon, PR Medicaid Program Director
Luz Cruz-Romero, PR Medicaid Program Integrity Manager
Ricardo A. Rivera Cardona, Executive Director PR Health Insurance Administration

Enclosure: PR Medicaid Program Action Plan for March 2016 On-Site Review

Aprobado por la Comisión Estatal de Elecciones #CEE-SA-16-2758

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