Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

RHODE ISLAND'S MANAGED CARE CONTRACT SETTLEMENTS WITH NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND DID NOT ALWAYS COMPLY WITH FEDERAL AND STATE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Michael J. Armstrong
Regional Inspector General

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Office of Inspector General

https://oig.hhs.gov

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EXECUTIVE SUMMARY

Rhode Island's managed care contract settlements with Neighborhood Health Plan of Rhode Island did not always comply with Federal and State requirements.

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews found that some States did not comply with managed care contract settlement requirements, which resulted in refunds due to the Federal Government. The Rhode Island Executive Office of Health and Human Services, Department of Human Services (State agency), contracts with managed care organizations (MCO) to provide medical services to recipients enrolled in the Medicaid program for a fixed monthly capitation payment. The State agency's contract with Neighborhood Health Plan of Rhode Island (Neighborhood), the largest MCO in the State, includes contract settlement provisions for each of the four Medicaid population groups. For the contract period ended June 2010, the State agency made capitation payments for medical care totaling $339 million to Neighborhood.

Our objective was to verify whether the State agency's managed care contract settlements with Neighborhood complied with Federal and State requirements.

BACKGROUND

The State agency's contract with Neighborhood details the capitation payment rates set for the contract period for each Medicaid population, the reporting requirements for Neighborhood, and the contract settlement methodology. In addition, the State agency's policies and procedures outline its oversight of the financial terms of the contract, including the State agency's contract settlement process. The State agency determines the final contract settlements for the contract period by comparing Neighborhood's reported medical expenses and the medical expense portion of the capitation payments paid to Neighborhood. If the medical expenses are greater than the medical expense portion of capitation payments, a settlement payment may be due from the State agency to Neighborhood. If the medical expenses are less, a settlement payment may be due from Neighborhood to the State agency.

HOW WE CONDUCTED THIS REVIEW

We reviewed the monthly medical expense reports submitted by Neighborhood to the State agency for each of the four Medicaid population groups for the contract period July 2009 through June 2010. We also reviewed the State agency's contract settlement calculations for the contract period.

WHAT WE FOUND

The State agency did not always make managed care contract settlements in accordance with Federal and State requirements. Specifically, the State agency did not always determine the managed care contract settlements in accordance with the terms of its contract with Neighborhood. In addition, the State agency did not consistently follow its policies and

procedures regarding the calculation of the final contract settlement amounts and the reporting requirements for Neighborhood. Accordingly, we do not have reasonable assurance that:

- the State agency has refunded the Federal share of all contract settlements due from Neighborhood,
- the contract settlements were calculated using consistent and reliable capitation payment data, and
- the contract settlements were calculated using accurate medical expense data.

WHAT WE RECOMMEND

We recommend that the State agency:

- improve its existing policies and procedures to ensure that any refunds due to the Federal Government are identified and returned in a timely manner,
- follow its existing policies and procedures to ensure that managed care contract settlements are based on consistent and reliable capitation payment data, and
- strengthen its oversight of the Medicaid medical expenses reported by Neighborhood to ensure that managed care contract settlements are based on accurate medical expense data.

STATE AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the State agency agreed with our first and second findings and recommendations but disagreed with our third finding and recommendation. Specifically, the State agency disagreed with our recommendation to strengthen its oversight of the Medicaid medical expenses reported by Neighborhood. The State agency stated that it receives attestation statements from Neighborhood monthly. In addition, the State agency stated that it validates Neighborhood's premium and claims data submissions with several financial data sources and that it relies on Neighborhood's outside auditors who attest to the accuracy and validity of Neighborhood's financial statements.

In response to the State agency's comments, we maintain that our findings and recommendations are valid. The State agency's policies and procedures require that all medical expense reports be accompanied by a document attesting to the accuracy and completeness of the report. However, the State agency did not explain why it could not provide the monthly attestations that Neighborhood submitted during our audit period.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews found that some States did not comply with managed care contract settlement requirements, which resulted in refunds due to the Federal Government. The Rhode Island Executive Office of Health and Human Services, Department of Human Services (State agency), contracts with managed care organizations (MCO) to provide medical services to recipients enrolled in the Medicaid program for a fixed monthly capitation payment. The State agency's contract with Neighborhood Health Plan of Rhode Island (Neighborhood), the largest MCO in the State, includes contract settlement provisions for each of the four Medicaid population groups. For the contract period ended June 2010, the State agency made capitation payments for medical care totaling $339 million to Neighborhood.

OBJECTIVE

Our objective was to verify whether the State agency's managed care contract settlements with Neighborhood complied with Federal and State requirements.

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) requires the Medicaid program to provide medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Rhode Island, the State agency administers the State's Medicaid program.

The Federal Government pays a share of a State's expenditures for medical assistance under the Medicaid State plan (the Act § 1903(a)). The method of calculating the Federal share, called the Federal Medical Assistance Percentage (FMAP), is set forth in sections 1905(b) and 1101(a) of the Act. After a State has calculated the medical assistance it furnishes under its State plan, it must return to the Federal Government the Federal share of the net amount it has recovered (the Act § 1903(d)(3)(A)). States report Medicaid expenditures to CMS, and credit CMS with any refunds due, on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

Rhode Island's Medicaid Managed Care Program

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services (Secretary) with broad authority to authorize demonstration projects to assist in promoting the objectives of the Medicaid program. Rhode Island's Section 1115 waiver allows the State

agency to contract with MCOs to provide medical services to recipients enrolled in the Medicaid program.

Managed care is a system for delivering health care that is intended to improve the quality of care and to control costs. In this regard, the State agency pays MCOs a fixed monthly capitation payment for each enrollee to provide Medicaid-covered services. This approach is different from a fee-for-service system, in which the State agency pays providers for each service they furnish.

Monthly Medical Expense Reporting

The State agency's contract with Neighborhood requires the MCO to report the paid medical expenses and capitation payments to the State agency within 45 days after the end of each month. The State agency also requires that all medical expense reports must be accompanied by a document attesting to the accuracy and completeness of the report. The contract requires Neighborhood to submit separate monthly medical expense reports for each of the Medicaid populations it covers:

- RIte Care core,
- Children with Special Health Care Needs,
- Children in Substitute Care arrangements, and
- Rhody Health Partners.

After a 12-month period (run-out period) to account for any outstanding claims or adjustments related to the contract period, the State agency evaluates the reasonableness of the medical expenses reported by Neighborhood in order to determine if the monthly reports are acceptable.

Managed Care Contract Settlements

As an incentive to manage costs, the State agency includes settlement provisions in Neighborhood's managed care contract. Through this mechanism, known as "risk share and gain share," the State agency shares in any financial losses and gains experienced by Neighborhood if actual medical expenses during the contract period are less than or exceed predetermined threshold amounts defined in the contract. The medical expense portion of the capitation payments made to Neighborhood determines the threshold amounts.

After the run-out period, the State agency determines the final contract settlements for the contract period by comparing Neighborhood's reported medical expenses and its medical expense portion of the capitation payments. If the medical expenses are greater than the medical expense portion of capitation payments, a risk share payment may be due from the State agency to Neighborhood. If the medical expenses are less, a gain share payment may be due from Neighborhood to the State agency.

HOW WE CONDUCTED THIS REVIEW

We reviewed the monthly medical expense reports submitted by Neighborhood to the State agency for each of the four Medicaid population groups for the contract period July 2009 through June 2010. We also reviewed the State agency's contract settlement calculations for the contract period. Based on these calculations, the State agency claimed risk share payments to Neighborhood totaling $7,965,028 ($4,918,873 Federal Share) and returned gain share payments from Neighborhood totaling $6,009,160 ($3,131,974) on Form CMS-64.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

See Appendix A for the details of our audit scope and methodology.

FINDINGS

The State agency did not always make managed care contract settlements in accordance with Federal and State requirements. Specifically, the State agency did not always determine the managed care contract settlements in accordance with the terms of its contract with Neighborhood. In addition, the State agency did not consistently follow its policies and procedures regarding the calculation of the final contract settlement amounts and the reporting requirements for Neighborhood. Accordingly, we do not have reasonable assurance that:

- the State agency has refunded the Federal share of all contract settlements due from Neighborhood,
- the contract settlements were calculated using consistent and reliable capitation payment data, and
- the contract settlements were calculated using accurate medical expense data.

FEDERAL AND STATE REQUIREMENTS

Federal Regulations

The Federal Government is entitled to the proportionate share, determined by the Secretary, of the net amount recovered by the State with respect to medical assistance furnished under the State plan (the Act § 1903(d)(3)(A)).

Federal regulations require States that provide managed care using risk-based contracts to develop actuarially sound capitation rates based on the cost and utilization of Medicaid State plan services. The contract also must specify the payment rates and any risk-sharing

mechanisms, and the actuarial basis for computation of those rates and mechanisms (42 CFR § 438.6(c)).

Contract Requirements

The State agency's contract with Neighborhood details the capitation payment rates set for the contract period for each Medicaid population, the reporting requirements for Neighborhood, and the contract settlement methodology. The contract also requires Neighborhood to submit historical encounter data, which details all claims paid for services rendered to enrollees during the contract period. In addition, the contract requires that the two parties resolve any questions regarding the medical expense reports 30 days after they are submitted to the State agency and that settlements be made 45 days after the reports have been accepted by the State agency.

State Agency's Policies and Procedures

The State agency's policies and procedures outline its oversight of the financial terms of the contract, including Neighborhood's reporting requirements and the State agency's contract settlement process. The policies and procedures also require that the State agency use the capitation payment figures from its Medicaid Management Information System (MMIS) to determine the final contract settlement amounts. In addition, the State agency is required to obtain from Neighborhood a signed document attesting to the accuracy and completeness of the medical expense reports.

CONTRACT SETTLEMENTS NOT DETERMINED IN ACCORDANCE WITH CONTRACT AND STATE AGENCY'S POLICIES AND PROCEDURES

Contract Settlements Not Made in a Timely Manner

The State agency did not always comply with the contract requirements regarding the timeliness of the contract settlements. Specifically, the contract requires both parties to resolve any questions within 30 days after the submission of the monthly reports and then to make the settlement payments 45 days after the reports have been accepted by the State agency. Although the State agency completed the final settlements for three of the population groups, it had not determined by the time of this review the final settlement for the Rhody Health Partners group even though the run-out period ended in June of 2011. According to the State agency, the delay was caused by a discrepancy between the Medicaid medical expenses reported by Neighborhood for the contract period and the State agency's analysis of the historical encounter data. Federal regulations state that the Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. However, the State agency has been unable to determine if it should make a final settlement payment to Neighborhood or if it is owed a final payment. As a result, we do not have reasonable assurance that the State agency has refunded the Federal share of all contract settlements due from Neighborhood.

Contract Settlements Not Calculated Consistently

The State agency did not always follow its policies and procedures regarding the data source of the capitation payment figures used to determine the final contract settlement amounts. Specifically, the State agency's policies and procedures require that it use the capitation payment figures from MMIS. MMIS is the most appropriate data source to determine the settlements amounts, since it processes the Medicaid claims that are reported on Form CMS-64. While the State agency used MMIS data to calculate the settlement amount for the Rite Care population group, it used the capitation payment totals submitted by Neighborhood on the monthly medical expense reports to calculate the settlement amounts for the Children with Special Health Care Needs and Children in Substitute Care population groups. As a result, we do not have reasonable assurance that the capitation payment data used to calculate the final settlement amounts was consistent and reliable.

Signed Attestations Not Obtained

The State agency did not always follow its policies and procedures regarding the monthly attestations obtained from Neighborhood. Specifically, the State agency's policies and procedures require that all medical expense reports be accompanied by a document attesting to the accuracy and completeness of the report. However, the State agency could not provide the monthly attestations for our audit period. Instead, it provided a signed document from Neighborhood dated November 2012 that attested to the accuracy of the reported information for State fiscal years 2010 and 2011. Moreover, the State agency did not validate the historical encounter data submitted by Neighborhood or reconcile the medical expenses reported by Neighborhood to detailed source documentation. Although the State agency completed an analytical review of the reported medical expenses at an aggregate level, this review was not as effective as monthly attestations, data validation, or a complete reconciliation would have been in ensuring the completeness of the monthly reports. As a result, we do not have reasonable assurance that the medical expense data used to calculate the final settlement amounts was accurate.

RECOMMENDATIONS

We recommend that the State agency:

- improve its existing policies and procedures to ensure that any refunds due to the Federal Government are identified and returned in a timely manner,

- follow its existing policies and procedures to ensure that managed care contract settlements are based on consistent and reliable capitation payment data, and

- strengthen its oversight of the Medicaid medical expenses reported by Neighborhood to ensure that managed care contract settlements are based on accurate medical expense data.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our first and second findings and recommendations but disagreed with our third finding and recommendation. Specifically, the State agency disagreed with our recommendation to strengthen its oversight of the Medicaid medical expenses reported by Neighborhood. The State agency stated that it receives attestation statements from Neighborhood monthly. In addition, the State agency stated that it validates Neighborhood's premium and claims data submissions with several financial data sources and that it relies on Neighborhood's outside auditors who attest to the accuracy and validity of Neighborhood's financial statements.

OFFICE OF INSPECTOR GENERAL RESPONSE

In response to the State agency's comments, we maintain that our findings and recommendations are valid. The State agency's policies and procedures require that all medical expense reports be accompanied by a document attesting to the accuracy and completeness of the report. However, the State agency did not explain why it could not provide the monthly attestations that Neighborhood submitted during our audit period. Moreover, we agree with the State agency's assertion that it reviews the data submitted by Neighborhood at an aggregate level by comparing the data to internal financial statements and encounter data. However, the State agency's review process does not include a detailed reconciliation of the paid claims submitted by Neighborhood. For example, the State agency does not review a sample of paid claims in order to verify their accuracy and allowability. Therefore, the monthly attestations are important to ensure the completeness of the monthly reports submitted by Neighborhood.

The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the monthly medical expense reports submitted by Neighborhood to the State agency for each of the four Medicaid population groups for the contract period July 2009 through June 2010. During the period, Neighborhood reported paid medical expenses of approximately $346 million, and the medical portion of capitation payments received from the State agency totaled $339 million.[1] We also reviewed the State agency's contract settlement calculations for the contract period. Based on these calculations, the State agency claimed risk share payments to Neighborhood totaling $7,965,028 ($4,918,873 Federal Share) and returned gain share payments from Neighborhood totaling $6,009,160 ($3,131,974) on Form CMS-64.

Our objective did not require an understanding or assessment of the complete internal control structures at the State agency. Rather, we limited our review to those controls that were significant to the objective of our audit.

We performed our fieldwork at the State agency in Cranston, Rhode Island, from June 2012 through January 2013.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- interviewed officials from CMS, the Rhode Island Office of the Auditor General, and the State agency;
- reviewed previous audits of the State agency;
- reviewed the State agency's contract with Neighborhood to determine the capitation payment rates per member per month, the monthly reporting requirements, and the methodology for calculating the contract settlements for each of the four Medicaid population groups;
- reviewed the monthly medical expense reports and other supporting documentation submitted by Neighborhood to the State agency;
- reviewed the State agency's contract settlement calculations and the State agency's reconciliations of the total medical expenses and capitation payments reported by Neighborhood;

[1] The State agency calculated the contract settlements for Rhody Health Partners for the period April 2009 through June 2010. Therefore, Neighborhood also included the medical expenses and capitation payments for April 2009 through June 2009 in its monthly reports submitted to the State agency for this Medicaid population group.

- recalculated and validated the contract settlements for each of the Medicaid population groups; and

- determined whether funds returned to the State agency were properly credited on Form CMS-64.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: STATE AGENCY COMMENTS

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Executive Office of Health and Human Services
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March 25, 2013

Michael J. Armstrong
Regional Inspector General
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region 1
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15 New Sudbury Street, Room 2425
Boston, MA 02203

Re: Report Number: A-01-12-00011

Dear Mr. Armstrong:

The Rhode Island Executive Office of Health and Human Services (EOHHS) values the opportunity to comment on the Office of Inspector General's (OIG) Draft Report, dated February 27, 2013 and entitled *Rhode Island's Managed Care Contract Settlements With Neighborhood Health Plan of Rhode Island Did Not Always Comply With Federal and State Requirements.*

The EOHHS appreciates that there were no financial or material procedural findings that violated federal and/or state regulations. EOHHS makes every effort to ensure that the terms of its managed care contract agreements are followed and that the managed care settlements are in accordance with all the terms and conditions of the contract. EOHHS takes the responsibility of safeguarding federal and state funds very seriously and makes every effort to ensure that disbursements are accurate and timely. Compliance with federal and state regulations is a priority for EOHHS, as well as a strong program of oversight and monitoring for the entire managed care Medicaid program.

Thank you for the recommendations that have been put forth and please be advised that EOHHS has updated internal policies and procedures to more accurately reflect processes that are in place.

EOHHS's responses to the OIG audit report recommendations are as follows:

OIG Finding #1: Contract Settlement not made in a Timely Manner

OIG Recommendation: We recommend that the State agency improve its existing policies and procedures to ensure that any refunds due to the federal government are identified and returned in a timely manner.

EOHHS Response: The EOHHS concurs with this finding and has modified its procedures to reflect its actions when claims data discrepancies occur. More specifically, the EOHHS and

Neighborhood Health Plan of Rhode Island (NHPRI) had not completed their final settlement for the Rhody Health Partners group due to a claims data discrepancy. The EOHHS and NHPRI are working on resolving this issue, and the targeted date to complete the final settlement is scheduled for May 31, 2013. Going forward, a new claims encounter data system, scheduled for implementation in July 2013, will allow for a speedier resolution of claims data discrepancies.

OIG Finding #2: Contract Settlements not Calculated Consistently

OIG Recommendation: We recommend the State agency follow its existing policies and procedures to ensure that managed care contract settlements are based on consistent and reliable capitation payment data.

EOHHS Response: The EOHHS concurs with this finding and has amended its procedures to account for specific capitation rate adjustments when settling managed care contracts. To detail, in order to ensure that the financial statements for the current contract period were accurate, the current contract premium capitation rates for NHPRI final settlement for the Children with Special Health Care Needs and Children in Substitute Care were adjusted for retroactive, prior year, capitation rate adjustments.

OIG Finding #3: Signed Attestations not Obtained

OIG Recommendation: We recommend that the State agency strengthen its oversight of the Medicaid medical expenses reported by Neighborhood to ensure that managed care contract settlements are based on accurate medical expense data.

EOHHS Response: The EOHHS respectfully disagrees with this finding. The EOHHS confirms that it receives attestation statements from NHPRI monthly. As outlined in the policies and procedures, the EOHHS validates NHPRI's premium and claims data submissions with several financial data sources including NHPRI's internal financial statements, regulatory financial reports filed with the Rhode Island Department of Business Regulation, the MMIS, claims encounter data, and actuarial forecasts. EOHHS also relies on NHPRI's outside auditors who attest to the accuracy and validity of NHPRI's financial statements, which incorporate the values of the managed care contract financial statements and calculations.

If you have any questions or require any additional information please do not hesitate to contact me directly.

Sincerely,

Steven M. Costantino
Secretary