DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

May 3, 2024

TO: Daniel Tsai
Deputy Administrator and Director
Centers for Medicaid and CHIP Services

FROM: Amy J. Frontz /s/
Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership With the State of Rhode Island, Office of the Auditor General: Medicaid Capitation Paid for Members Residing in Other States (A-01-23-00001)

This memorandum transmits the findings of the State of Rhode Island, Office of the Auditor General (Auditor General) audit report entitled, *Medicaid Capitation Paid for Members Residing in Other States*, issued March 26, 2024. The Auditor General performs a variety of auditing functions for the State of Rhode Island's departments and agencies. The Auditor General's financial and performance audits provide objective and timely information to General Assembly members on the operations of State government. The Auditor General's Medicaid performance audits are conducted to determine whether agencies are carrying out their functions efficiently and effectively and are using their resources in compliance with applicable laws and regulations.

The objective of the Auditor General's audit was to determine whether the Rhode Island Medicaid Assistance Program (RI Medicaid) made capitation payments to managed care organizations (MCOs) on behalf of ineligible members who resided and received benefits in another State or territory for the period January 1, 2019, through December 31, 2021.

As part of the Office of Inspector General's (OIG's) efforts to partner with State auditors and enhance oversight of the Medicaid program, OIG assisted the Auditor General with its audit by:

- matching Medicaid claims from the Centers for Medicare & Medicaid Services' (CMS's) Transformed Medicaid Statistical Information System (T-MSIS) to identify RI Medicaid capitated payments for whom a capitated payment was also made in another State or territory for the same month;

- providing the resulting Medicaid matches to the Auditor General;

- assessing the reliability of select Medicaid MCO claims data;

- developing a statistically valid methodology for the Auditor General and evaluating the results of the sample;
- attending key meetings with the Auditor General auditors; and
- monitoring the progress of the Auditor General's audit.

To accomplish its audit objective, the Auditor General analyzed the results of OIG's data match and reviewed the stratified random sample of 100 Medicaid members for whom RI Medicaid made capitated payments with a concurrent capitated payment made in another State or territory.

The Auditor General found that for 60 (60 percent) of the 100 sampled claims, the members were residing in at least 1 of 9 other States or Puerto Rico and had enrolled in, and received their health care benefits under the other State's or Puerto Rico's Medicaid programs. Based on its analysis, the Auditor General concluded that RI Medicaid made approximately $38.4 million in capitated payments to MCOs for members who did not meet the residency requirement.

The Auditor General concluded that the following factors contributed to the improper capitated payments it identified:

- RI Medicaid did not have effective internal controls to ensure compliance with State and Federal eligibility requirements for residency,
- RI Medicaid's procedures regarding the use of Public Assistance Reporting Information System (PARIS) notifications to identify member changes in residency were not operating effectively during the audit period, and
- RI Medicaid did not utilize data available through Accurint (a commercial source of public records) in a consistent manner to ensure compliance with residency requirements.

The Auditor General recommended that RI Medicaid:

- improve internal controls over member residency requirements for Medicaid eligibility,
- improve effectiveness of PARIS automated controls over residency verification, and
- utilize Accurint address data as a second validation to substantiate returned mail and the National Change of Address (NCOA) database information indicators that a member has relocated out of State.

RI Medicaid is administered by the Rhode Island Executive Office of Health and Human Services (EOHHS). In its comments on the Auditor General's report, EOHHS agreed with the Auditor General's recommendations.

Regarding the first recommendation, EOHHS stated that it will review existing internal controls over residency requirements to ensure all interfaces are working as designed, and if required, system enhancements will be implemented to identify, notify, and terminate eligibility for members that are no longer residing in Rhode Island. Regarding the second recommendation, EOHHS acknowledged that the PARIS match was not fully operating as designed during the audit period. It explained that some of the system issues were corrected in late 2019, but it had to implement several system mitigations that suppressed PARIS functionality during the Public Health Emergency to comply with the Federally mandated continuous coverage requirement. In addition, EOHHS clarified that other actions to improve PARIS controls over residency verification will require coordination with the RI Department of Human Services. Regarding the third recommendation, EOHHS stated that it will explore utilization of secondary validation sources for residency, including Accurint, Equifax, and the NCOA database. Furthermore, EOHHS will implement an automated process to request residency verification when a case has their mailing address updated with an out of State address and initiate case closure if no response is received.

The Auditor General is responsible for the attached audit report and the conclusions expressed therein. We are not expressing an opinion on the report or its results; however, we encourage CMS to consider this report and its results, and to work with State Medicaid agencies to prevent such payments from occurring in the future. Although we are not expressing an opinion, we did evaluate the independence, objectivity, and qualifications of Auditor General staff assigned to this audit. Our assessment disclosed no instances in which the Auditor General did not comply with generally accepted government auditing standards.

This memorandum and the Auditor General report will be posted at https://oig.hhs.gov.

If you have any questions or comments about this memo, please do not hesitate to contact John Hagg, Assistant Inspector General for Audit Services, at John.Hagg@oig.hhs.gov. Please refer to report number A-01-23-00001 in all correspondence.

Attachment

cc:

Anne Marie Costello
Deputy Director
Center for Medicaid and CHIP Services

Sara Vitolo
Deputy Director
Center for Medicaid and CHIP Services

Dara Corrigan
Deputy Administrator and Director
Centers for Program Integrity

Jerry Andersen
Director, Division of Audit Management and Resolution
Centers for Medicare & Medicaid Services

STATE OF RHODE ISLAND

MEDICAID CAPITATION PAID FOR
MEMBERS RESIDING IN
OTHER STATES

CAPITATION PERIODS: JANUARY 1, 2019
THROUGH DECEMBER 31, 2021

REPORT DATE: MARCH 26, 2024

David A. Bergantino, CPA, CFE
Auditor General

State of Rhode Island
General Assembly
Office of the Auditor General

Office of the Auditor General
State of Rhode Island - General Assembly
David A. Bergantino, CPA, CFE – Auditor General
oag.ri.gov
33 Broad Street • Suite 201 • Providence, RI • 02903-4177
tel: 401.222.2435 • fax: 401.222.2111

March 26, 2024

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In collaboration with the Office of Inspector General's (OIG) Boston Office, U.S. Department of Health and Human Services (HHS), we provide this report on our audit of capitation payments made by the Rhode Island Medical Assistance Program (RI Medicaid), administered by the Executive Office of Health and Human Services (EOHHS) for the three-year period from January 1, 2019 through December 31, 2021. The objective of this joint audit was to determine whether RI Medicaid effectively discontinued capitation payments to managed care organizations (MCOs) for members (individuals enrolled in RI Medicaid) who were residing and receiving benefits simultaneously in other states, which is a violation of Medicaid program regulations.

Our audit was performed in accordance with the standards applicable to performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Similar state audits have been performed by the OIG solely or in partnership with other state auditors to evaluate Medicaid noncompliance with residency requirements nationally, and to identify effective controls to improve program compliance and provide significant future cost savings to states.

The recommendations and projected cost savings detailed in this report illustrate the importance of improving controls over Medicaid eligibility in cases where members move out-of-state or attempt to establish eligibility in multiple states concurrently. Program controls are necessary to ensure that eligibility is administered in accordance with federal regulations and that vital social service programs are operating efficiently to ensure the continuation of critical services to those that need them the most. As required by *Government Auditing Standards*, we have obtained EOHHS' management responses to our audit findings and have included those in this report.

Sincerely,

David A. Bergantino, CPA, CFE
Auditor General

STATE OF RHODE ISLAND
GENERAL ASSEMBLY
OFFICE OF THE AUDITOR GENERAL

MEDICAID CAPITATION PAID FOR MEMBERS RESIDING IN OTHER STATES

CAPITATION PERIODS: JANUARY 1, 2019 THROUGH DECEMBER 31, 2021

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LIST OF ABBREVIATIONS, ACRONYMS AND DEFINITIONS

Federal programs and regulations utilize a vocabulary of abbreviations and acronyms when referring to specific entities or data sources involved in the operation of federal health and human services programs such as Medicaid. This report also uses terminology that we have defined below to facilitate the readers' understanding. The below table includes explanations of abbreviations, acronyms and key terms defined in this report.

Abbreviation / Acronyms / Terminology		Entity Title, Description, or Definition
Capitation Payment		A payment, similar to a health insurance premium, the State makes periodically to an MCO on behalf of each member enrolled in Medicaid for the provision of medical services covered under the State plan.
CFR		Code of Federal Regulations
CMS		Centers for Medicare and Medicaid Services (Division of DHHS)
EOHHS		RI Executive Office of Health and Human Services
FFCRA		Families First Coronavirus Response Act
FMAP		Federal Medical Assistance Percentage – Percentage of Medicaid costs reimbursed by the federal government.
FPL		Federal Poverty Level – A measure of income issued every year by HHS used to determine eligibility for certain programs and benefits.
HHS		U.S. Department of Health and Human Services
Managed Care Organization (MCO)		Managed Care Organizations, like health insurance providers, provide health benefits and additional services to members through a network of providers for a set per-member monthly (capitation) payment for these services.
Medicaid State Plan		The formal agreement between a state and the federal government submitted in accordance with 42 CFR 431.10 describing how that state administers its Medicaid program.
MMIS		Medicaid Management Information System
NCOA		National Change of Address Database – US Postal Service
OIG		Office of Inspector General, Boston Office
PARIS		Public Assistance Reporting Information System – A data matching service that matches recipients of public assistance to determine if they are receiving duplicate benefits in more than one state.
Patient Encounters (Managed Care)		Encounters are records of the health care services provided to Medicaid members for which MCOs pay providers for those services. MCOs report encounter data to state Medicaid agencies.
RIBridges		RI's Integrated Eligibility System – Eligibility Determination System for Human Services Programs
RI Medicaid		RI Medical Assistance Program
RIOAG		RI Office of the Auditor General
T-MSIS		Transformed Medicaid Statistical Information System

Executive Summary

AUDIT CONCLUSIONS

Rhode Island Medicaid made an estimated $38.4 million in managed care capitation payments in the period from January 1, 2019 through December 31, 2021 for members who were residing in and had enrolled in Medicaid programs in nine other states and Puerto Rico. Federal regulations generally require members to reside in Rhode Island to be eligible for Medicaid benefits in the State. Rhode Island general revenues funded approximated $16.5 million or 43% of these payments.

Internal controls over eligibility were not operating effectively to reasonably ensure that eligibility was limited to members residing in Rhode Island.

Public Assistance Reporting Information System (PARIS) interstate matching service notifications and address history reporting by Accurint (LexisNexis) were found to be reliable data sources in identifying Medicaid members no longer residing in the State.

AUDIT PURPOSE

State Medicaid programs nationwide have struggled with ensuring that eligibility and benefits are limited to members residing in their state. In most cases, this has been caused by ineffective policies and procedures to identify and react to information that supports the likelihood that members have relocated out of state. The goal of this audit was to identify the potential program cost savings to Rhode Island that could be achieved by the State improving internal controls over this eligibility requirement.

RECOMMENDATIONS

1) Improve internal controls over member residency requirements for Medicaid eligibility. Specifically, enhance and monitor existing policies and procedures to (a) identify instances where members have relocated out of State and (b) initiate member notification process and eligibility termination if a member does not respond in the time permitted under federal regulations or does not provide supporting documentation of their current residency in the State.

2) Improve effectiveness of PARIS automated controls over residency verification by (a) generating high priority caseworker tasks when PARIS notifications remain unresolved on a member case for 60 days or more, (b) developing monthly reporting that details the amount of PARIS matches reported, the number of related documentation requests sent to members, and the number of case terminations resulting from member non-response, and (c) implementing caseworker training on resolving PARIS notification tasks within RIBridges.

3) Utilize Accurint address data as a second validation to substantiate returned mail and NCOA database information indicators that a member has relocated out of State. Once substantiated, initiate system tasks to request documentation from the member in support of their current residency and initiate case closure if no response is received within the notification period.

REPORT SIGNIFICANCE

For large federal programs like Medicaid, operating these programs efficiently is vital for states to ensure the financial sustainability of critical benefits to its citizens. In Rhode Island, Medicaid provides medical benefits to one-third of the State's population and represents the largest expenditure category in the State budget. The size and complexity of the program necessitates well designed and effective controls to manage program eligibility and benefits.

This audit specifically highlights the need for improved controls over Medicaid member residency to ensure that the State complies with State and federal regulations and to prevent funding of costly benefits for members ineligible for this program.

RI MEDICAID RESPONSE TO REPORT

As required by *Government Auditing Standards*, we have obtained a response and corrective actions from management of EOHHS, the single State Medicaid agency, and included their response in the Auditee Response and Corrective Actions section of this report on page 14.

Audit Finding, Conclusions, and Recommendations

Finding / Conclusions	Recommendations
RI Medicaid made an estimated $38.4 million in capitation payments on behalf of members who were residing in and had enrolled in Medicaid programs in nine other states and Puerto Rico. Internal controls over eligibility were not operating effectively to reasonably ensure that eligibility was limited to members residing in Rhode Island.	1) Improve internal controls over member residency requirements for Medicaid eligibility. Specifically, enhance and monitor existing policies and procedures to (a) identify instances where members have relocated out of State and (b) initiate member notification process and eligibility termination if a member does not respond in the time permitted under federal regulations or does not provide supporting documentation of their current residency in the State.
PARIS notifications were properly being reflected in member case records in RIBridges. RI Medicaid, however, did not consistently conduct the federally required follow-up with members to update residency documentation or initiate program eligibility termination when the member did not respond in the time period allowed.	2) Improve effectiveness of PARIS automated controls over residency verification by (a) generating high priority caseworker tasks when PARIS notifications remain unresolved on a member case for 60 days or more, (b) developing monthly reporting that details the amount of PARIS matches reported, the number of related documentation requests sent to members, and the number of case terminations resulting from member non-response, and (c) implementing caseworker training on resolving PARIS notification tasks within RIBridges.
Accurint address history data was found to provide accurate member address data for the majority of the cases where we were able to identify the state of residency based on reported encounter data. RI Medicaid did not utilize data available through Accurint, a resource currently available in the Medicaid agency, in a consistent process to ensure federal compliance with residency requirements.	3) Utilize Accurint address data as a second validation to substantiate returned mail and NCOA database information indicators that a member has relocated out of State. Once substantiated, initiate system tasks to request documentation from the member in support of their current residency and initiate case closure if no response is received within the notification period.

AUDIT SCOPE

In collaboration with the HHS Office of Inspector General, the Rhode Island Office of the Auditor General (RIOAG) conducted an audit of capitation payments made to MCOs by the RI Medicaid Program (as administered by EOHHS) for the period January 1, 2019 through December 31, 2021.

Based on findings from audits performed in other States evaluating the same objective, conducting an audit specific to RI Medicaid was deemed likely to provide significant benefits to the State by evaluating its current practices and providing recommendations to improve controls in a Medicaid program area deemed to be susceptible to noncompliance nationally.

The scope of this audit was limited to evaluating the effectiveness of RI Medicaid's policies and procedures for (1) identifying when members have relocated and enrolled in Medicaid in another state or territory and (2) discontinuing eligibility in RI Medicaid in accordance with federal regulations. Our audit did not include evaluation of other federal program requirements relating to member eligibility in RI Medicaid.

AUDIT OBJECTIVE

Our audit objective was to determine whether RI Medicaid made capitation payments to MCOs on behalf of ineligible members who resided and received benefits in another state or territory; such payments would be in violation of Section 2.3, *Cover and Eligibility*, *Residence*, of the Rhode Island Medicaid State Plan and Sections 435.403(a), and (j), and 433.400(d)(3)(ii), of Title 42 of the Code of Federal Regulations.

In conjunction with this audit objective, the RIOAG also evaluated the effectiveness of RI Medicaid's current policies and procedures in discontinuing eligibility when members were identified as no longer residing in the State. This objective included providing recommendations to address the finding and deficiencies noted by our audit.

FEDERAL REGULATIONS SPECIFIC TO AUDIT OBJECTIVE

Capitation payments made to MCOs for members that are not residing in Rhode Island represent noncompliance with State and federal regulations and significant program expenditures that should not be incurred by the State and federal government. Incurring Medicaid expenditures for ineligible members is contrary to the efficient administration of the program and jeopardizes the sustainability of the critical services that Medicaid provides.

As described at 42 CFR section (§) 433.400(d)(3)(ii), members who are identified as receiving benefits in more than one state via a data match with the PARIS interstate matching service in accordance with §435.945(d) and who fail to respond to a request for information to verify their residency in the reasonable period permitted by the state, consistent with §435.952(c)(2)(iii), are generally considered to no longer be residents of the state for purposes of section 6008(b)(3) of the FFCRA, provided that the state takes all available reasonable measures to determine state residency prior to termination.

AUDIT PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

We conducted this performance audit in accordance with generally accepted government auditing standards (*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 provided a reasonable basis for our finding and conclusions based on our audit objective.

PROGRAM INFORMATION

Title XIX of the Social Security Act is a Federal/State entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans; however, some federal requirements are mandatory if federal matching funds are to be received. A state's Medicaid program must offer medical assistance for certain basic services to most categorically needy populations.

States have increased the use of managed care for providing Medicaid benefits as an alternative service to traditional fee-for-service systems where Medicaid reimburses providers directly for medical services provided to members. Under managed care systems, MCOs, prepaid health plans (PHPs), or comparable entities agree to provide a specific set of services to Medicaid enrollees, usually in return for a predetermined periodic payment per enrollee.

In accordance with Rhode Island (RI) General Laws section 42-7.2-2, EOHHS administers the RI Medicaid program as the single State Medicaid agency. RI Medicaid provides access to healthcare services for approximately 360,000 eligible low-income children, families, seniors, and people with disabilities annually. RI Medicaid implemented its initial managed care program, RIte Care, in 1994 for low-income children and families. Over the years, managed care was expanded to most Medicaid members by introducing additional programs that also covered behavioral health services and services for populations with more complex needs under the managed care model.

Medicaid benefit expenditures represented approximately $3.5 billion or 34% of the State's budgeted General Fund expenditures of $10.2 billion in fiscal 2022 - representing the State's largest program expenditure by a wide margin. The costs of providing services to Medicaid members in managed care represent more than 50% of program benefit expenditures. Medicaid expenditures, including managed care capitation, reported by fiscal year during the audit period, are shown in **Table 1** below.

Medicaid managed care programs are intended to increase access to and improve the quality of health care for Medicaid beneficiaries. State managed care programs are authorized through each state's federally approved Medicaid State Plan and administered through the specific contract agreements between the state and the MCOs. States report capitation payments claimed by Medicaid MCOs on the states' Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

The federal government pays its share of a state's medical assistance expenditures (federal share) under Medicaid based on the federal medical assistance percentage (FMAP), which varies

Table 1

Medicaid Enrollment and Expenditures

Fiscal Year	Total Member Enrollment (in thousands)	Total Benefit Expenditures (in millions)	Managed Care Enrollment (in thousands)	Capitation Paid (in millions)	Capitation as a % of Total Benefits
2020	309	$ 2,723	268	$ 1,466	53.8%
2021	342	$ 2,985	299	$ 1,831	61.3%
2022	356	$ 3,458	303	$ 1,865	53.9%

Note: Enrollment numbers are presented as of the fiscal year ending June 30th.

depending on the state's relative per capita income as calculated by a defined formula (42 CFR § 433.10). During the audit period, the federal government's share of eligible Medicaid capitation expenditures ranged from 52.95% to 60.29% for traditional Medicaid members and 90% to 95% for Medicaid Expansion members under the Affordable Care Act.

The RI Medicaid program generally allows members, if eligible for managed care, to enroll with one of three MCOs: Neighborhood Health Plan of Rhode Island, United Healthcare, or Tufts Health Plan. Each managed care plan has a provider network with the goal of providing members with coordinated healthcare services. The doctors and other healthcare providers contractually agree to follow certain federal and State requirements for provided services. MCO enrollees select a primary care physician to provide basic healthcare in addition to making any necessary specialist referrals.

RI Medicaid pays the MCO a capitation payment, based on the age, sex, MCO provider, and managed care program in which the individual was enrolled. A current listing of managed care programs offered by RI Medicaid to qualifying members is included in **Table 2** below. Each program has specific covered services and different actuarially determined capitation rates based on the Medicaid population covered.

The State utilizes an actuary to establish capitation rates with MCO providers. Rates determined by the actuary are based on several considerations, most importantly, the historical costs of providing services to the various Medicaid populations and the number and demographics of members expected to be eligible for the program. Actuarially determined capitation rates can be impacted when ineligible members are covered in managed care.

The State's managed care contracts allow for a 1-year runout (after date of service) for medical claims to be provided to MCOs for reimbursement. The State and MCO settle each contract year in accordance with settlement provisions mandated by the contracts. In general, settlements compare the actual medical expenditures incurred by the plans to the capitation payments made to the plans to determine a medical loss ratio for the contract year. The contract settlement provisions are essentially designed so that the State and MCO share in any gains or losses for the contract year.

As it would be expected for the size of the RI Medicaid program, complex information systems are utilized in the administration of the program. The RIBridges system is responsible for determining member eligibility for Medicaid which it communicates to the Medicaid Management Information System (MMIS). The MMIS is responsible for various aspects of claim and capitation payments, including but not limited to:

- the processing of medical claims,
- the reimbursement of providers for fee-for-service claims,
- managed care enrollment, and
- capitation payments to MCOs.

Table 2

Managed Care Program Categories

Managed Care Program	Description of Population Covered
RIte Care	Low-income children and families
Children with Special Needs	Children with specific healthcare needs
Medicaid Expansion	Medicaid coverage group for adults with no children up to 133% FPL
Rhody Health Partners	Disabled adults
Medicare - Medicaid Plan (Integrated Care Initiative)	Adults eligible for Medicare and Medicaid
RIte Smiles	Medicaid eligible individuals
Nonemergency Transportation	Medicaid eligible individuals

RI MEDICAID POLICIES AND PROCEDURES

This report focuses on the State's effectiveness in terminating RI Medicaid enrollment when members move out of State, thus it is important to understand RI Medicaid's policies and procedures relating to residency verification. RI Medicaid's residency requirements and verification process requires an applicant member to be a resident of the State of Rhode Island. The applicant member must first attest to Rhode Island residency when applying to Medicaid and the residency is then confirmed by supporting documentation such as a utility bill dated within the past 60 days, valid driver's license, or a copy of a lease/rental agreement or receipt.

Under Section 155.335 of Title 45 of the Code of Federal Regulations, Rhode Island must annually redetermine members' eligibility. Rhode Island uses a passive renewal process for annual redeterminations. This process involves RI Medicaid sending a redetermination packet to the member. The redetermination packet asks the member to update the household information included in the packet within a specified period. Members can update information in their RIBridges case record directly or by returning the packet with the updated information to RI Medicaid. RIBridges will redetermine eligibility once the allotted update period has passed. Passive renewal does not require applicants to provide documentation of residency upon renewal. RI Medicaid procedures utilize the following data sources to identify members that have relocated out of State:

- PARIS interstate matching service notifications – an automated process that includes notification in case records that a member may have relocated and applied for benefits in another state and creation of a task for an eligibility caseworker to follow-up with the member. When operating effectively, PARIS matches within RIBridges generate automated requests for documentation to the member and terminate eligibility within 30 days if the member does not respond.
- NCOA database - passive data source utilized by RI Medicaid to research returned mail from Medicaid members. The NCOA database is a secure dataset that includes change of address records reported to the United States Postal Service.

RI Medicaid policy indicates that, upon receiving new or conflicting information from these data matches, a request for information letter is sent to the member. Members who receive a request for information letter have 45 days to respond with verification documents, such as a driver's license, utility bill, or rental agreement, supporting Rhode Island residency. If the member does not respond, they may have their coverage terminated. Member follow-up is not automatically initiated by the RIBridges system – it is dependent on eligibility caseworker action to initiate.

FEDERAL DATA SUPPORT

T-MSIS is a database maintained by the federal Centers for Medicare and Medicaid Services. T-MSIS contains Medicaid data from all 50 states, the District of Columbia, and the United States territories (collectively referred to as state Medicaid agencies) to maintain an accurate, up-to-date, and complete data set, containing eligibility, enrollment, and healthcare service claims data for Medicaid members. The Centers for Medicare and Medicaid Services use this data to manage Medicaid programs and aid in the detection of fraud, waste, and abuse.

RI Medicaid is part of PARIS, which is the product of a partnership between the United States government and state governments. PARIS provides a free service quarterly that state Medicaid agencies can use to cross-reference their public assistance program records to identify any data matches (i.e., recipients who also receive benefits from other state Medicaid agencies). To participate in PARIS and share information about Medicaid members and their healthcare use, state Medicaid agencies must contract with HHS.

Every quarter, the State Medicaid agencies provide data to PARIS to determine if members enrolled in their Medicaid program are also receiving benefits in other states or territories. PARIS is available to participating agencies for several federal programs (i.e., Temporary Assistance for Needy Families, Child Care, Supplemental Nutrition Assistance Program) in addition to Medicaid. HHS's Administration for Children and Families oversees PARIS, facilitates the quarterly cross-referencing

service, and disseminates information about data matches to the participating agencies.

IMPACT OF PUBLIC HEALTH EMERGENCY

Our audit period covered a 15-month period prior to the beginning of the COVID-19 Public Health Emergency (PHE) declaration in March 2020 and a 21-month period during the PHE through December 31, 2021. The PHE officially ended May 11, 2023. The PHE declaration impacted Medicaid program operations and requirements in several ways, including guidelines on how states manage eligibility for members believed to no longer reside in the State.

Congress enacted the FFCRA on March 18, 2020. The FFCRA allowed Rhode Island, and other states that meet certain criteria, to receive a 6.2% increase in its FMAP. In return, it required Medicaid programs to meet a maintenance of eligibility requirement, which necessitated state Medicaid programs to keep current members continuously enrolled until the end of the month in which the PHE ended (May 2023). States could terminate eligibility in certain limited circumstances, deemed exceptions to this requirement, during the PHE. Determination that a member moved out of state was an allowed exception to the continuous eligibility provision.

Federal guidance issued in November 2020 provided states with interpretations on how to adjudicate eligibility in instances where information was received suggesting that the member was no longer residing in the state. This guidance defined the reasonable measures requirement of 42 CFR §433.400(d)(3)(ii) "to include but not be limited to, reviewing existing information in the beneficiary's record to validate state residency, checking available state electronic data sources such as the Department of Motor Vehicles records or other state benefit programs, and coordinating with agencies in the other state(s) in which the PARIS interstate match identified the beneficiary as receiving benefits to determine the state in which the individual is a resident for purposes of Medicaid eligibility. If the state is unable to verify the beneficiary's continued residency in the state because the beneficiary fails to respond to requests for additional information and the state's alternative efforts cannot verify the beneficiary's continued residency in the state through other sources, that beneficiary's Medicaid enrollment may be terminated in accordance with § 435.400(d)(1)(ii)."

In response to this guidance, EOHHS adopted a policy to utilize Accurint (LexisNexis) address search for its second point of validation. If a member was confirmed through both PARIS and Accurint, an additional documentation request would be sent. If the member did not respond providing documentation of legal residency in Rhode Island, the members' eligibility would be terminated.

HOW THE AUDIT WAS PERFORMED

In collaboration with the OIG, we conducted this performance audit of capitation payments made to MCOs by the RI Medicaid Program for the period January 1, 2019 through December 31, 2021 in accordance with *Government Auditing Standards*.

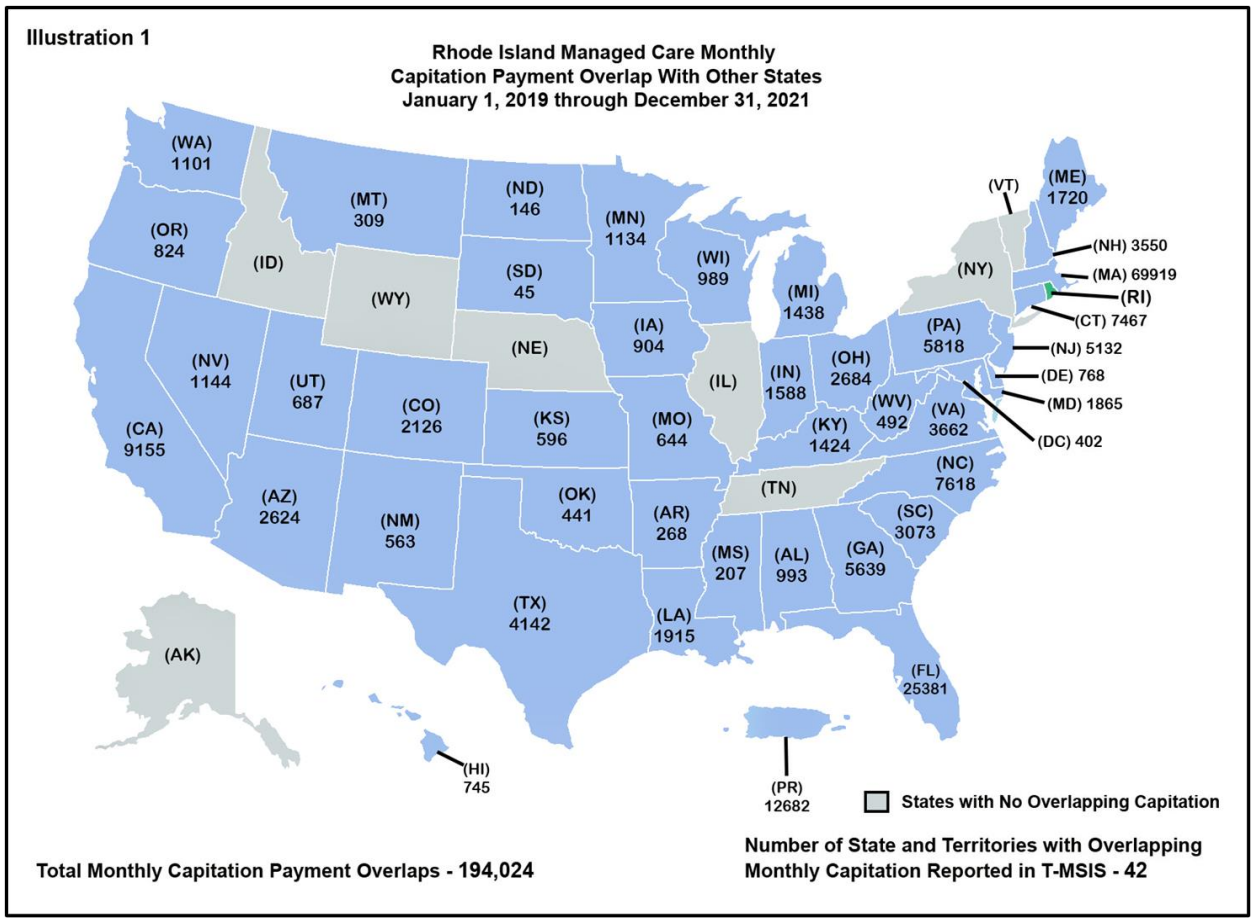
We reviewed RI Medicaid's applicable policies and procedures and met with RI Medicaid officials to discuss how these policies and procedures operated during the audit period. In addition, we performed the following procedures, in conjunction with the OIG, to obtain sufficient and appropriate audit evidence to fully evaluate the audit objective.

DATA VALIDATION AND ANALYSIS

Using data obtained from T-MSIS, the OIG provided the RIOAG with a sample of data to conduct validation procedures with the State's MMIS. The goal of these procedures was to validate the accuracy of the T-MSIS data to ensure that it was consistent with the data in the MMIS System. Validation procedures concluded that the T-MSIS data was consistent with the data reported by the MMIS.

Once validated, the OIG analyzed the T-MSIS data to identify instances where RI had made at least five consecutive monthly capitation payments for members who concurrently had capitation payments made on their behalf by the Medicaid program of another state or territory. The five consecutive months of payments were used to allow for some normal lag that is expected when a member initially relocates.

To determine the test population of RI Medicaid members, the OIG ranked each state and territory based on the total dollar value of the concurrent payments. RI Medicaid members had 194,024 overlapping capitation payments. These concurrent payments occurred in 42 of the 51 Medicaid agencies that reported data to T-MSIS. **Illustration 1** below shows the distribution of those concurrent payments by the state Medicaid agency. The top 10 states and territories with the largest dollar value of concurrent capitation payments made during the audit period were selected as the test population for



the audit. RI Medicaid's final population included instances of overlapping capitation payments with the following states and territory: California, Connecticut, Florida, Georgia, Massachusetts, New Jersey, North Carolina, Pennsylvania, Puerto Rico, and Texas.

SAMPLE SELECTION AND VALIDATION

The RIOAG collaborated with the OIG to design a statistically valid sampling methodology. The OIG and RIOAG chose a sample with a 90% confidence level and a 50% expected error rate. The sampling criteria was designed to select a sample size large enough to provide a high level of confidence in the test results when projected to the entire population.

Based on the sampling methodology, the OIG selected a random, statistical sample of 100 members out of a total of 11,235 members in the audit population. The sample of 100 was separated by the OIG into three strata based on the total dollar value of capitation payments made concurrently with another state or territory. **Table 3** below details each of the three strata to which each member was assigned for our data analysis purposes. The OIG provided the sample to the RIOAG who performed procedures to validate the accuracy of the sample items to RI Medicaid's MMIS. The sample provided by the OIG was validated with no exceptions, allowing the RIOAG to begin testing procedures on the sample of 100 members.

RIOAG AUDIT PROCEDURES

For the 100 members in our sample, the RIOAG performed the following procedures:

1) Sent confirmations to the Medicaid officials of the respective states and territory to validate the accuracy of the T-MSIS information used in our analysis and to ensure that the responding Medicaid agencies provided complete and consistent data. The data requested, designed to allow the RIOAG to reasonably determine each member's specific place of residency during our audit period, included the:
   - Date on which the member enrolled in the other state's or territory's Medicaid program,
   - Time period that the other Medicaid program made capitation payments for each member,
   - Total amount of capitation payments made on behalf of each member by their Medicaid program,
   - Monthly detail of encounter data (actual healthcare claims paid) reported by the MCOs in the other state or territory.
2) Compiled similar information for each member from RI Medicaid utilizing the State's MMIS and RIBridges system and data. These procedures included:
   a) Utilizing the data compiled for each member from both RI Medicaid and the other states and territory to create a timeline for each member based on where the individual was receiving services during the 3-year period. Utilizing MCO encounter data was a primary source of evidence in determining which state or territory the member was residing during the audit period.
   b) For each member case, documented the following additional evidence to support

Table 3

Population Statistics

Stratum	Dollar Range of Stratum	Sample Size	Number of RI Medicaid Members	Population Dollar Value
1	$1,000 - $6,500	34	7,899	$ 23,937,269
2	$6,500 - $20,000	33	2,599	28,025,273
3	$20,000 - $165,287	33	737	24,311,902
	Totals	100	11,235	$ 76,274,444

the likely residency of the member during the audit period:

- RIBridges Public Assistance Reporting Information System (PARIS) data matches that were performed during our audit period as identified in the case notes of the member.
- RIBridges case notes that made note of any eligibility determinations associated with unverified proof of RI residence.
- Historical reports (covering 48 months) provided by Accurint, a licensed product by LexisNexis which is a widely accepted locate-and-research tool utilized by governments, law enforcement, and others. EOHHS has a license for Accurint utilized by its Program Integrity Unit which assisted the RIOAG in obtaining the reports for the 100 members.

3.) Utilizing the data provided for each member case, the RIOAG determined, in most instances from multiple sources (i.e., encounter data, PARIS, Accurint), the likely residence of the member and quantified the amount of capitation that was paid by RI Medicaid or the other state(s) or territory when the member resided out of state. In a small number of cases, evidence to support the residency was not sufficient to make a reasonable determination. Only capitation for periods where residency in another state or territory was reasonably determined were included in the results depicted in **Table 4** on page 11.

During the audit, the RIOAG held meetings with Medicaid officials from each state/territory, and RI Medicaid, as necessary, to:

- Discuss our understanding of program operations and controls;
- Resolve any questions regarding data received during the audit;
- Update RI Medicaid regarding our audit status and testing results; and
- Review our findings, recommendations, and draft report to answer any questions regarding our audit.

We believe that our audit procedures obtained sufficient audit evidence to support the results and conclusions included in our report.

AUDIT FINDING

Finding - RI Medicaid made an estimated $38.4 million in capitation payments on behalf of members who were residing in and had enrolled in Medicaid programs in nine other states and Puerto Rico.

Condition: During the audit period, RI Medicaid made an estimated $38.4 million in capitation payments to managed care organizations (MCOs) on behalf of members who were no longer residing in Rhode Island. Specifically, we found that RI Medicaid made 1,030 capitation payments, totaling $833,082 on behalf of 60 out of the 100 members in our sample. These 60 members were residing in at least one of nine other states or Puerto Rico and had enrolled in, and received their healthcare benefits under, the other state's or Puerto Rico's Medicaid programs. **Table 4** below details the sample results by State to which the Medicaid member was determined to be residing.

The cost savings identified above represent a conservative estimate since it includes only instances with a minimum of 5 months of capitation overlap with another state or territory and limits the period of duplicate payments at 36 months. In addition to the inefficient administration of the program, this condition represents significant noncompliance with federal regulations that could expose the program to sanctions if not addressed.

Chart 1

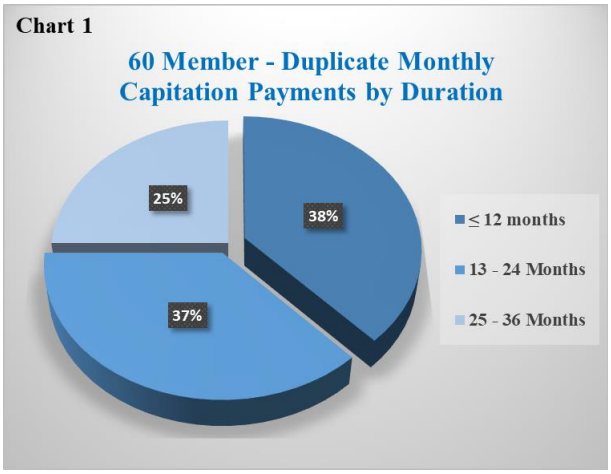


Chart 1 provides further perspective on the length of time by which RI Medicaid incurred costs for members no longer residing in the State by illustrating the duration that monthly capitation was paid for the 60 members determined to be residing in another State or territory. As **Chart 1** indicates, it was common for capitation payments made by Rhode Island to overlap with other states for 2-3 years. This analysis further supported our finding that RI Medicaid's procedures to detect instances where members are no longer residing in the State were ineffective.

As part of our testing, our review of the RIBridges PARIS interface also noted that, for 49 (82%) of these 60 members, RI Medicaid had PARIS data matches that indicated that the members had moved

Table 4

Capitation Paid by RI Medicaid For Individuals Residing in Other States

State / Territory	Number of Medicaid Members	Number of Capitation Payments	Amount of Capitation Paid
California	3	28	$ 15,280
Connecticut	4	27	9,597
Florida	12	196	120,814
Georgia	2	58	28,741
Massachusetts	23	428	416,515
North Carolina	1	32	33,528
New Jersey	3	44	34,231
Pennsylvania	3	43	37,039
Texas	2	41	40,004
Puerto Rico	7	133	97,333
Total	60	1,030	$ 833,082

to another state or Puerto Rico. For these members, RI Medicaid continued to make capitation payments on their behalf for periods ranging from 5 to 30 months after the members had moved. In fact, 26 (53%) of these 49 members had multiple PARIS matches prior to the PHE.

Our audit procedures found that PARIS notifications would be effective in identifying where members relocated and established Medicaid eligibility concurrently in another State or territory. PARIS, however, would not be effective if a member left the State and was not concurrently receiving benefits in another state. In instances where a Medicaid member leaves Rhode Island without applying for benefits in another state (i.e., relocates for a new employment opportunity), additional controls would be needed to identify such situations.

During our audit, we evaluated the reliability of Accurint in providing accurate address information for Medicaid members reported in our sample. For the 80 members where we were able to definitively establish residency by reported encounter data, Accurint reported address history for 73 of these members. Of these 73 members, 67 (92%) matched the state of residency as reported by the encounter data. In the other 20 cases, we could not evaluate the accuracy of Accurint's reported history because the Medicaid member did not have medical encounters reported in Rhode Island or the other state in which they were enrolled (residency was undetermined).

We concluded that Accurint data was reliable and could be utilized for additional evidence in cases where a change in residency was suspected due to returned mail or other indicators. Since EOHHS already licenses Accurint for use in program integrity activities, the resource already exists within the Medicaid agency.

Cause: RI Medicaid does not have effective internal controls to ensure compliance with state and federal eligibility requirements for residency. Specifically, we determined that the PARIS interface worked as designed within the RIBridges system and the data provided by PARIS consistently supported our audit determination of likely residency. RI Medicaid's procedures regarding the use of PARIS notifications to identify member changes in residency, however, were not found to be operating effectively during our audit period. RI Medicaid did not utilize data available through Accurint, a resource currently available in the Medicaid agency, in a consistent manner to ensure federal compliance with residency requirements.

Effect: RI Medicaid is currently paying a significant amount of capitation to managed care organizations for members not residing in the State. Such payments represent noncompliance with State and federal regulations and are not eligible for federal Medicaid funding.

Incurring Medicaid expenditures for ineligible members is contrary to the efficient administration of the program and jeopardizes the sustainability of the critical services that Medicaid provides. The State would experience significant cost savings and enhanced federal compliance over member eligibility with improved internal controls in this area.

Criteria: Section 2.3, *Cover and Eligibility, Residence,* of the Rhode Island Medicaid State Plan states that "Medicaid is furnished to eligible individuals who are residents of the State under 42 CFR 435.403, regardless of whether or not the individuals maintain residence permanently or maintain it at a fixed address."

42 CFR section 435.403(a) mandates that "states are required to provide Medicaid services to eligible residents, including residents who are absent from the State. The conditions under which payment for services is provided to out-of-State residents are set forth in section 431.52 of this chapter."

42 CFR section 435.403(j)(3) states that a Medicaid "agency may not deny or terminate a resident's Medicaid eligibility because of that person's temporary absence from the State if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for purposes of Medicaid."

42 CFR 435.403(m) states that "in instances where residency is disputed, federal regulations define the state of residency as the state where the individual is physically located."

42 CFR section 433.400(d)(3)(ii), members who are identified as receiving benefits in more than one state via a data match with the Public Assistance

Reporting Information System (PARIS) interstate matching service in accordance with §435.945(d) and who fail to respond to a request for information to verify their residency in the reasonable period permitted by the state, consistent with §435.952(c)(2)(iii), are generally considered to no longer be residents of the state for purposes of section 6008(b)(3) of the FFCRA, provided that the state takes all available reasonable measures to determine state residency prior to termination.

AUDIT RECOMMENDATIONS

Recommendation 1 – Improve internal controls over member residency requirements for Medicaid eligibility. Specifically, enhance and monitor existing policies and procedures to (a) identify instances where members have relocated out of State and (b) initiate member notification process and eligibility termination if a member does not respond in the time permitted under federal regulations or does not provide supporting documentation of their current residency in the State.

Recommendation 2 – Improve effectiveness of PARIS automated controls over residency verification by (a) generating high priority caseworker tasks when PARIS notifications remain unresolved on a member case for 60 days or more, (b) developing monthly reporting that details the amount of PARIS matches reported, the number of related documentation requests sent to members, and the number of case terminations resulting from member non-response, and (c) implementing caseworker training on resolving PARIS notification tasks within RIBridges.

Recommendation 3 – Utilize Accurint address data as a second validation to substantiate returned mail and NCOA database information indicators that a member has relocated out of State. Once substantiated, initiate system tasks to request documentation from the member in support of their current residency and initiate case closure if no response is received within the notification period.

AUDITEE RESPONSE

The Rhode Island Executive Office of Health and Human Services (EOHHS) submits our response to the joint audit by the Rhode Island Office of the Auditor General (OAG) and the U.S. Department of Health and Human Services (DHHS) Office of Inspector General (OIG) regarding Medicaid capitation paid for members residing in other states. Based on the three recommendations set forth by the RI OAG and the U.S. DHHS OIG, EOHHS has outlined our response and corrective actions to address each of the audit findings.

Recommendation 1 – Improve internal controls over member residency requirements for Medicaid eligibility. Specifically, enhance and monitor existing policies and procedures to (a) identify instances where members have relocated out of State and (b) initiate member notification process and eligibility termination if a member does not respond in the time permitted under federal regulations or does not provide supporting documentation of their current residency in the State.

EOHHS Response to Recommendation 1:

EOHHS will review existing internal controls over residency requirements to ensure all interfaces are working as designed. If required, system enhancements will be implemented to identify, notify, and terminate eligibility for members that are no longer residing in Rhode Island. See response to recommendation 3 for additional details on how the State plans to integrate the Accurint address data system.

For background, During the Public Health Emergency (PHE), Medicaid was precluded from processing the PARIS interstate matches without implementing additional processes. See excerpt from CMS 9912 Interim Final Rule:

"Additionally, as described at § 433.400(d)(3)(ii), individuals who are identified as receiving benefits in more than one state via a data match with the Public Assistance Reporting Information System (PARIS) interstate matching service in accordance with § 435.945(d) and who fail to respond to a request for information to verify their residency in the reasonable period permitted by the state, consistent with § 435.952(c)(2)(iii), are generally considered to no longer be residents of the state for purposes of section 6008(b)(3) of the FFCRA, provided that the state takes all available reasonable measures to determine state residency prior to termination. These measures include, but are not limited to, reviewing existing information in the beneficiary's record to validate state residency, checking available state electronic data sources such as the Department of Motor Vehicles records or other state benefit programs, and coordinating with agencies in the other state(s) in which the PARIS interstate match identified the beneficiary as receiving benefits to determine the state in which the individual is a resident for purposes of Medicaid eligibility. If the state is unable to verify the beneficiary's continued residency in the state because the beneficiary fails to respond to requests for additional information and the state's alternative efforts cannot verify the beneficiary's continued residency in the state through other sources, that beneficiary's Medicaid enrollment may be terminated in accordance with § 435.400(d)(1)(ii). Such an individual will be considered a non-resident for purposes of section 6008(b)(3) of the FFCRA until such time as the state has information verifying residency. If, after termination, the state obtains information that verifies residency, the state must reinstate the individual's eligibility back to the date of termination."

Since the State did not have the operational capacity to adhere to the full set of requirements outlined in CMS 9912, RI Medicaid decided to pause notification to members received on a PARIS match until the end of the PHE. When the State began its unwinding activities in April 2023 enduring through April 2024, individuals identified by PARIS matches were/are asked to verify their residency via an ADR and were/are consequently terminated if they fail to verify in State residency. For example, there were over 800 residency ADRs sent to members as part of the October 2023 Medicaid renewal cohort.

Recommendation 2 – Improve effectiveness of PARIS automated controls over residency verification by (a) generating high priority caseworker tasks when PARIS notifications remain unresolved on a member case for 60 days or more, (b) developing monthly reporting that details the amount of PARIS matches reported, the number of related documentation requests sent to members, and the number of case terminations resulting from member non-response, and (c) implementing

caseworker training on resolving PARIS notification tasks within RIBridges.

EOHHS Response to Recommendation 2:

RI Medicaid acknowledges that during the OIG-OAG audit period, defined as a three-year period from January 1, 2019 through December 31, 2021, the PARIS Interstate match was not fully operating as designed. RI Medicaid makes distinctions on this timeline in four spans: from January to June 2019, PARIS was not in operation; in July 2019, PARIS was operationalized as part of the Medicaid Verification Batch (MVB) with inconsistent behavior; in December 2019, system behavior improved but still not optimal; and March 2020 – May 2023 marked PHE conditions where several system mitigations suppressed PARIS functionality. During the 15 months prior to the PHE, the end-to-end PARIS process didn't terminate benefits for all individuals who failed to respond to the residency verification due to several system issues. Historical data shows the interface and automated processes were impacted by temporary system mitigations which resulted in some individuals being excluded from closure. These measures were corrected in late 2019; however, the onset of the PHE led to additional mitigations in order to comply with the federally mandated continuous coverage requirement.

RI Medicaid and RIBridges IES does effectively utilize PARIS data to identify members that are potentially residing out of state (OOS). Interstate PARIS matches automatically trigger an ADR seeking verification of residency. Failure by the customer to provide verification of residency results in auto-closure. For Non-MAGI cases, closure will occur if not returned within 15 days; for MAGI cases, closure will occur if not returned within 30 days. If a member responds to the ADR, there is a manual task that must be worked by a DHS worker. The system will not automatically terminate individuals who have responded to the ADR but have not had their verification document reviewed by the State. The other recommended actions (assign PARIS system notifications within RIBridges a high(er) priority task rating, create monitoring reports from RIBridges for supervisors, and implement caseworker training) are considered operational efficiencies that will require coordination with the Department of Human Services (DHS), which serves as the operational workforce for Medicaid.

Recommendation 3 – Utilize Accurint address data as a second validation to substantiate returned mail and NCOA database information indicators that a member has relocated out of State. Once substantiated, initiate system tasks to request documentation from the member in support of their current residency and initiate case closure if no response is received within the notification period.

EOHHS Response to Recommendation 3:

The State will explore utilization of secondary validation sources for residency, to include Accurint address data and employee address data provided by Equifax's "The Work Number" to substantiate returned mail and NCOA database information that indicate a member has relocated OOS, then initiate case closure if no response is received. The State will plan and implement an automated process to request residency verification when a case has their mailing address updated with an OOS address and initiate case closure if no response is received.