

# Report in Response to

**PL 116-94: Further Consolidated Appropriations Act,  
2020:(133 STAT 3110), Division N, Title 1, Subtitle B,  
§202(f)(3)**

## **Audits of Managed Care Payments**

**Government of Puerto Rico  
Office of the Governor**

**December 20, 2020**



**GOVERNMENT OF PUERTO RICO**

**Office of the Governor**

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# 1. EXECUTIVE SUMMARY

## Congressional Requirement

On December 16, 2019, the U.S. Congress came to a bipartisan agreement on 12 appropriation packages. On December 17, 2019, the House passed H.R. 1865 with a vote of 297-120; this bill became Public Law 116-94 on December 20, 2019.

On behalf of the Puerto Rico Government and the agencies that oversee the delivery of Medicaid and Children's Health Insurance Program (CHIP) services, including the Puerto Rico Department of Health (PRDOH), Medicaid and the Puerto Rico Health Insurance Administration (PRHIA), thank you for this opportunity to report on Puerto Rico's progress towards compliance with the conditions and requirements set forth in ***P.L. 116-94: Division N, Title 1, Subtitle B, (133 STAT 3110) - §202(f)(3) – Audit of Managed Care Payments***. The requirement within the law reads as follows:

*"...the Inspector General shall develop and submit ...a report identifying payments made under Puerto Rico's Medicaid Program to managed care organizations that the Inspector General determines to be at high risk for waste, fraud, or abuse and a plan for auditing and investigating such payments. Such report shall:*

- a. Examine-
  - i. The process used by Puerto Rico to make payments to the Managed Care organizations
  - ii. Which, if any, current processes represent risks of fraud, waste, or abuse
- b. Include any recommendations or findings for Congress, relating to changes that the Office of Inspector General determines necessary to improve the program integrity of such plan."

This report provides the Government of Puerto Rico's response to comply with the specific requirement listed above. For the purposes of this report submission and related reports, this requirement is hereinafter referred to in our documents as: **Requirement 8 – Oversight of Managed Care Payments<sup>1</sup>**

## Puerto Rico's Current Efforts for Oversight of Managed Care

Puerto Rico has made significant strides towards developing and expanding the Program Integrity Unit's (PIU) oversight of managed care payments. Further, Puerto Rico is going beyond these requirements to deploy a comprehensive approach to program integrity and MCO payment oversight. Our current efforts involve coordination between PRDOH and ASES which has led to a collaborative approach and more defined roles in oversight responsibilities. To draft our plan, Puerto Rico considered leading practices from other state Medicaid programs as guidance in establishing plans to enhance our oversight capabilities. The current plan is to deploy a continuous improvement approach to enhance fraud, waste, and abuse prevention and detection efforts.

Advances in the form of data mining, leveraging analytics, and identifying high risk transactions from our MMIS team have already begun and established baseline metrics for Puerto Rico to track going forward. Additional accelerators including the Comprehensive Oversight and Monitoring Plan (COMP) performance measurement tools have been developed to increase the transparency and visibility into

<sup>1</sup> PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3110), Division N, Title 1, Subtitle B, §202(f)(3)

an expanding list of Key Performance Indicators (KPIs). These tools enable Puerto Rico to further monitor MCOs and have greater insight into fraud, waste, and abuse activities.

Supplementing this fraud, waste, and abuse mitigation process is the quality control review of beneficiary eligibility data. Puerto Rico is working on enhancing its eligibility determination quality assurance process, and details of this effort will be outlined in the forthcoming MEQC report due to CMS in June 2021.

Ultimately, Puerto Rico has the processes, tools, and resources in place to demonstrate compliance towards this requirement. Our current efforts, established processes, and planned enhancements will enable us to increase the maturity of our program and improve our oversight of managed care payments.

### Puerto Rico's Response to Congressional Requirement

In response to the requirements and reports noted above, Puerto Rico has made significant strides towards developing and expanding the Program Integrity Unit's (PIU) oversight of managed care payments. Improvements in coordination between PRDOH and ASES have led to a collaborative approach and more defined roles in oversight responsibilities. The PIU and ASES Compliance teams are both working to coordinate responses and corresponding activities given the Congressional and OIG directives. This commitment to a collaborative approach should strengthen the capacity and efficiency of both groups going forward.

In response to the Congressional requirement, the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) conducted a high-level risk assessment for the Puerto Rico Medicaid program controls and processes, titled '**A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program**', to comply with P.L. 116-94.<sup>2</sup> This assessment outlines risk areas and other high-risk factors that could contribute to improper Medicaid program payments. The OIG determined audits of Puerto Rico's Medicaid program are warranted and the results will set their priorities for performing future audits of the Medicaid program in Puerto Rico.

We reviewed the draft brief in October 2020 and the final report in December 2020 and have summarized our response to the risk areas highlighted in this assessment.

Risk Area	Description of Area	Summary of Response
<b>Program Integrity</b>	<p>As of July 2020, program integrity efforts were not coordinated between ASES and the Medicaid Fraud Control Unit (MFCU) preventing them from sharing information and defining responsibilities.</p> <p>The OIG also noted that while responsibilities were designated to the MCOs, no procedures were put in place to monitor and provide oversight of these MCOs.</p>	<ul style="list-style-type: none"><li>• Puerto Rico released the Compliance Plan as an appendix to the FY2020 Annual Report, on October 30, 2020 which addresses the second component of this OIG finding</li><li>• The Compliance Plan establishes a coordinating plan for Program Integrity efforts between ASES and the newly formed Program Integrity Unit to enhance oversight and monitoring activities over MCO payments</li></ul>

<sup>2</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.  
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Risk Area	Description of Area	Summary of Response
<b>Beneficiary Eligibility</b>	<p>There are weaknesses in Puerto Rico’s post-eligibility determination process because agreements that allow Puerto Rico to assess the relevant data lapsed 3 years ago.</p> <p>Since 2009, about 75 percent of fraud cases were the result of beneficiaries having higher incomes than what is reported.</p>	<ul style="list-style-type: none"> <li>• Puerto Rico’s Program Integrity Unit is responsible for monitoring and risk reviewing Medicaid recipients’ eligibility.</li> <li>• The next step is to analyze and review the recipient population and we are working to establish metrics and measures to implement Medicaid eligibility quality checks in MMIS</li> <li>• Details of this effort will be outlined in the forthcoming MEQC report due to CMS in June 2021</li> </ul>
<b>Provider Enrollment</b>	<p>Puerto Rico can improve the monitoring of providers’ eligibility and their enrollment in Medicaid by verifying that the right searches are being conducted. Previously, there were instances where ineligible providers could remain enrolled in PRMP.</p>	<ul style="list-style-type: none"> <li>• To mitigate this risk, the Department of Health (DOH) assumed this responsibility and implemented a provider enrollment portal (PEP) into MMIS in April 2020</li> <li>• This tool will be fully implemented in December 2020 and will help in screening/rescreening providers on a monthly basis</li> </ul>
<b>Overpayment Reporting</b>	<p>Puerto Rico did not report, and has no procedures to report, any overpayments on form CMS-64. This creates a risk that CMS will make funding decisions for PRMP with incomplete information.</p>	<ul style="list-style-type: none"> <li>• As the Program Integrity Unit makes progress towards fully implementing their processes and reporting capabilities, they will be able to report the total amount of their overpayment recoveries. Details are outlined in: Congressional Requirement 7: Contracting Oversight and Approval Report for inclusion in the CMS-64.</li> <li>• Enhanced coordination and communication between the PIU, MFCU and OIG will give the PIU the ability to aggregate recovered overpayment dollars and include the complete information in the required CMS-64 entry.</li> </ul>
<b>Contracting</b>	<p>Puerto Rico was assessed as high-risk because of recent arrests, referrals, and investigations related to contract fraud in Puerto Rico.</p>	<ul style="list-style-type: none"> <li>• Puerto Rico has conducted its own assessment of its contracting processes to respond requirements P.L. 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3109), Division N, Title 1, Subtitle B, §202(f)(2), outlined in the report titled “Requirement 7: Contract Oversight and Approval” which required us to evaluate the bids and awards for our competitive and non-competitive bids.</li> <li>• Based on the above examination of processes and in response to PL 116-94: Further Consolidated Appropriations Act, 2020:(133 STAT 3105), Division N, Title 1 §202(a)(7)(A)(iii), we have developed a report Requirement 3: Contracting Reform Plan which outlines our plan to combat fraudulent, wasteful, or abusive contracts under Puerto Rico’s Medicaid program. We establish our vision to be recognized as a leader in ethics and transparency in procurement and contracting by identifying opportunities for our improvement, as well as, implementation plans to help Puerto Rico achieve our vision and reform the contracting processes of our Medicaid Enterprise.</li> </ul>

Risk Area	Description of Area	Summary of Response
<b>Other Risk Factors</b>	<p><b><u>Medicaid Program Payment Reviews</u></b></p> <p>Due to extremely low staffing of program integrity positions, ASES and DOH rely heavily on MCOs to identify and detect fraudulent billing activity and perform provider enrollment screening functions. In addition, OIG cited that a that the number of investigations, criminal referrals, and overpayment recoveries by the MCOs was small given the size of the program.</p> <p><b><u>MMIS Implementation</u></b></p> <p>Puerto Rico’s MMIS is not fully implemented, which increases the risk of improper payments.</p> <p><b><u>Program Management</u></b></p> <p>The limitations in hiring and reductions in training opportunities prevent development of institutional knowledge and skill necessary to effectively operate the Puerto Rico Medicaid program.</p>	<ul style="list-style-type: none"> <li>• Puerto Rico has established a Program Integrity Unit and continues to evaluate and grow the PI function within Medicaid program. Additionally, both DOH and ASES have invested in technology solutions to further enhance their fraud prevent and detection capabilities. This report outlines Puerto Ricos efforts in the areas of Medicaid program payment oversight.</li> <li>• While the MMIS was not fully implemented during the OIG’s review, MMIS has made substantial improvements in the latter half of 2020, including improvements in analytics and reporting. Puerto Rico plans to have the entire second phase of MMIS implemented by the end of the year 2021.</li> <li>• Puerto Rico has partially mitigated this risk by hiring subcontractors to provide short-term continuity to program operations, including establishing a Program Integrity Unit.</li> <li>• PR is continuing to enhance its Medicaid program offices, including investing in MMIS, establishing a PIU, investing in technology solutions. Furthermore, planned coordination and collaboration efforts between PRHIA and ASES will continue to increase efficiency.</li> <li>• Additional details on enhancements supporting Program Management are outlined in this report and in the above mentioned “<b>Report on Contract Oversight and Approval</b>” report.</li> </ul>

Puerto Rico is going beyond the requirements outlined by CMS to deploy a comprehensive approach to program integrity and MCO payment oversight, building on our response to the OIG findings above, Puerto Rico has put into motion a plan that encompasses both DOH and ASES. The remainder of this report summarizes the current state of the program, including our current fraud, waste, and abuse approach, and highlights the upcoming planned enhancements, knowing that this leaves room for even more maturing of our oversight practices. This report also discusses leading practices used by other state Medicaid programs and potential opportunities to enhance Puerto Rico’s Medicaid Program.

This report includes the following sections throughout each of the fraud, waste, and abuse approaches:

- **Differences in Medicaid Program Funding between Puerto Rico and the Other States and Territories:** There are significant differences in Medicaid program funding between states and territories, either due to an annual cap on the federal Medicaid spending in territories and a set federal Medicaid matching rate for territories in statute. This limited funding limits our ability to dedicate resources to improving program integrity and contract reform processes. For example, Puerto Rico sometimes has only one employee evaluating an RFP because staff are busy maintaining operations. While Puerto Rico remains committed to meeting all the Congressional requirements that have been added as part of Public Law 116-94, we are concerned that without parity in the Medicaid program or, at a minimum, additional administrative funding, we may not be able to enact long-term plans and changes that are essential to maintaining Puerto Rico’s Medicaid program. **Section 2** of this report highlights additional details related to these funding disparities, and we sincerely request Congress to consider providing the requisite federal Medicaid funding needed to fully implement the opportunities identified in these reports.
- **An Introduction to the Puerto Rico Medicaid Enterprise:** It is worth considering the unique nature of our Medicaid program given the number of departments and agencies involved. The PRDOH is the Single State Agency (SSA) for administering our State Medicaid Program. For purposes of the Medicaid program administration, PRDOH is the State Medicaid Agency (SMA). The Medicaid Program is administered by PRDOH and the Puerto Rico Health Insurance Administration (PRHIA), which collectively is referred to as the Medicaid Enterprise. We have detailed all the agencies involved and that collaborate with our Medicaid Enterprise in **Section 3** of this report.
- **Puerto Rico’s oversight over Managed Care payments and approach to address Fraud, Waste, and Abuse:** Advances in the form of data mining, leveraging analytics, and identifying high risk transactions from our MMIS team have already begun and established baseline metrics for Puerto Rico to track going forward. The Comprehensive Oversight and Monitoring Plan (COMP) performance measurement tools that have been developed could increase the transparency and visibility into an expanding list of Key Performance Indicators (KPIs). These accelerator tools could enable Puerto Rico to further monitor MCOs and have greater insight into fraud, waste, and abuse activities.
- **Enhancing oversight and fraud, waste, or abuse (FWA) approach via Prevention, Detection, and Response:** We have outlined our FWA approach and areas of potential enhancements leveraging a flexible framework based on a three-pillar strategy – prevention, detection, and response three pillar. A solution that has been widely adopted by Medicaid programs.
  1. **Prevent:** aimed to be a proactive approach in identifying potential fraud, waste, and abuse transactions before payment
  2. **Detect:** designed to find those behaviors that are not prevented in the first pillar. Includes implementing an evolutionary approach that builds on traditional methods of pattern detection with sophisticated strategies
  3. **Response:** designed to address fraud, waste, and abuse that bypasses the first two pillars – it facilitates collaboration and information sharing across organizations and establishes a risk assessment framework that enables better positioning to combat fraud, waste, and abuse

Puerto Rico plans to deploy a continuous improvement approach to enhance fraud, waste, and abuse efforts and is considering leading practices from other state Medicaid programs. Puerto Rico’s Medicaid program can pivot to a more streamlined framework that detects, prevents and responds to fraud, waste, and abuse, and enables us to get ahead of the risk management cycle by identifying emerging vulnerabilities. To achieve this goal, Puerto Rico can enhance each reporting pillar with additional data components such as including member level encounter data and denials, enhancing the MCO monitoring processes, implementing predictive analytics, and further defining our proposed compliance plan.

## 2. DIFFERENCES IN MEDICAID PROGRAM FUNDING BETWEEN STATES AND PUERTO RICO/OTHER TERRITORIES

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The Medicaid program is arguably the most consequential federal program in Puerto Rico because it provides health care services to 1.6 million people, or 46 percent of the Island's population. However, our program differs in fundamental ways when compared to state Medicaid programs. Federal Medicaid funds for United States Territories are limited in two ways:

1. Total federal Medicaid spending in the territories is subject to an annual Medicaid Cap pursuant to section 1108 of the Social Security Act. As a result, the Federal government will match every Medicaid dollar spent by the territories up to each jurisdiction's cap, and any spending above the cap is provided solely by the territory.
2. The federal Medicaid matching rate for territories is set in statute at 55 percent, unlike states which receive unrestricted matching federal funds between 50 percent and 83 percent of their Medicaid costs according to the state's Federal Matching Assistance Percentage (FMAP).

The following table shows the disparity between Puerto Rico and comparable state Medicaid programs on administrative spending per member per year (PMPY) and per member per month (PMPM). Comparing Medicaid programs of similar size (1-2 million enrollees) and with a high proportion of enrollment in managed care (over 80 percent in comprehensive managed care), it demonstrates that Puerto Rico is getting approximately one-third (1/3) of the administration expenditures of similar programs.

State <sup>3</sup>	2018 Medicaid Enrollment <sup>4</sup>	2018 Percent Comprehensive Managed Care <sup>5</sup>	2019 Administration Expenditures <sup>6</sup>	PMPY	PMPM
(A)	(B)	(C)	(D)	(E)=(D)/(B)	(F)=(D)/(B)/12
Virginia	1,063,122	82%	\$437,968,202	\$411.96	\$34.33
Kentucky	1,385,239	91%	\$266,167,884	\$192.15	\$16.01
Maryland	1,401,781	83%	\$505,358,312	\$360.51	\$30.04
Tennessee	1,510,045	92%	\$564,787,478	\$374.02	\$31.17
Louisiana	1,640,075	84%	\$337,092,213	\$205.53	\$17.13
New Jersey	1,668,451	94%	\$898,752,077	\$538.67	\$44.89
Arizona	1,849,465	84%	\$277,807,148	\$150.21	\$12.52
<b>Average<sup>7</sup></b>	<b>1,502,597</b>	<b>88%</b>	<b>\$469,704,759</b>	<b>\$312.60</b>	<b>\$26.05</b>
Puerto Rico	1,505,610	100%	\$156,284,437	\$103.80	\$8.65

Table 1. Medicaid Enrollment and Administration Expenditures for Comparable State Medicaid Programs

Puerto Rico is committed to meeting all the Congressional requirements that have been added as part of Public Law 116-94. However, we are concerned that without parity in the Medicaid program or, at a minimum, additional administrative funding, the full and permanent implementation of these changes will be challenging. For example, Puerto Rico can sometimes have only one employee evaluating a request for proposal (RFP) since the day to day operational needs and limited administration funding doesn't support additional resources aligned to the RFP evaluation process.

Puerto Rico is requesting that Congress consider application of the FMAP as used with states. In addition, Congress is requested to consider removing the Medicaid Cap on federal Medicaid funds through 1108(g). If only the FMAP formula is applied, then Puerto Rico will, as a result, reach the Medicaid Cap sooner. Funding parity would help Puerto Rico plan for long term structural changes and allow for real transformational changes to our Medicaid Enterprise.

<sup>3</sup> Includes states where 2018 Medicaid enrollment is between 1,000,000 to 2,000,000 and over 80% enrollment in comprehensive managed care. Excluded the State of Washington which had administrative costs in excess of \$1.3 billion.

<sup>4</sup> Medicaid.Gov. *The FY 2018 Medicaid Managed Care Enrollment Report*, Latest available report retrieved from: <https://data.medicare.gov/Enrollment/2018-Managed-Care-Enrollment-Summary/gn4b-7d7q/data>

Total Medicaid Enrollees represents an unduplicated count of all beneficiaries in FFS and any type of managed care, including Medicaid-only and Medicare-Medicaid ("dual") enrollees.

<sup>5</sup> Medicaid Enrollment in Comprehensive Managed Care represents an unduplicated count of Medicaid beneficiaries enrolled in a managed care plan that provides comprehensive benefits (acute, primary care, specialty, and any other), as well as PACE programs. It excludes beneficiaries who are enrolled in a Financial Alignment Initiative Medicare-Medicaid Plan as their only form of managed care.

<sup>6</sup> Medicaid.Gov. *FY 2019 Financial Management Report, Total Computable Net Administrative Expenditures*, Latest available report retrieved from: <https://www.medicare.gov/medicaid/financial-management/state-expenditure-reporting-for-medicare-chip/expenditure-reports-mbscbs/index.html> Excludes administrative costs for the following service categories: Family Planning, Skilled Professional Medical Personnel - Single State Agency, Skilled Professional Medical Personnel - Other Agency, Peer Review Organizations, TPL - Recovery, TPL - Assignment Of Rights, Nurse Aide Training Costs, Preadmission Screening, Resident Review, Drug Use Review, School Based Administration, Interagency Costs (State Level), Planning for Health Home for Enrollees with Chronic Conditions, and Non-Emergency Medical Transportation

<sup>7</sup> The average administration expenditure is weighted based on Medicaid enrollment.

## 3. INTRODUCTION TO THE PUERTO RICO MEDICAID ENTERPRISE

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PRDOH is the SSA for administering our State Medicaid Program. For purposes of the Medicaid program administration, PRDOH is the SMA. The Medicaid program is administered by PRDOH and PRHIA, which collectively is referred to as the Medicaid Enterprise. This is a long-standing sister agency relationship, defined by an interagency memorandum of understanding (MOU). PRHIA (commonly referred to as Administración de Seguros de Salud [ASES]), was created in 1993 to oversee, monitor and evaluate services offered by the managed care organizations (MCOs) under contract with PRHIA. PRHIA is a public corporation overseen and monitored by a Board of Directors (BOD). Puerto Rico’s Medicaid Program (PRMP), a department under the PRDOH, oversees the Medicaid State Plan, determines Medicaid eligibility of residents, and is responsible for the operation of the Medicaid Management Information System (MMIS) for the program.

In addition, PRHIA, PRMP and the Government of Puerto Rico at large follow guidance issued each year by the federally appointed Financial Oversight and Management Board for Puerto Rico (FOMB). In addition to meeting federal requirements, PRHIA and PRMP must also abide by regulations established by the Government of Puerto Rico.

### **Puerto Rico Department of Health**

The PRDOH’s administration of its Medicaid program under Title XIX of the Social Security Act is structured as a categorical program called the “Medicaid Program.” The PRDOH Medicaid program is chartered with ensuring appropriate delivery of health care services under Medicaid, CHIP, and the Medicaid Preferred Drug Program (PDP); the latter two structured as extended Medicaid programs.

Since the inception of the Medicaid program in Puerto Rico, and up until the early 1990s, PRMP’s role was mostly limited to providing the categorically needy access to Medicaid services by operating local offices throughout all the municipalities on the Island. In these offices, residents could apply for Medicaid coverage by providing demographic and socio-economic information for their family unit. Based upon federal Medicaid program eligibility rules, the family’s eligibility for Medicaid would be determined. If eligible, the individual and family were certified and enrolled into the Medicaid program. Health care services to Medicaid-eligible individuals and families were delivered through the Puerto Rico government’s public health service facilities.

### **Puerto Rico Health Insurance Administration**

In 1993, the Government of Puerto Rico enacted transformation of the entire public health system. The Puerto Rico Health Reform Program (referred to initially as Reforma and now known as Plan Vital) marked the creation of a government health insurance program under a managed care delivery system. These reforms expanded Medicaid coverage for individuals and families with incomes between 50 -100 percent of the federal poverty guideline—significantly increasing the number of residents with government-subsidized health coverage.

In 1993, an interagency MOU (since then updated multiple times), was established to delegate the implementation of the Medicaid State Plan’s managed care delivery model to PRHIA, a public corporation established by Law No. 72 on September 7, 1993, as amended. Under this agreement, the

PRMP retained responsibility for eligibility determination, policy, Medicaid State Plan maintenance, and financial administration. This agreement requires PRHIA to implement and deliver services through a managed care delivery system. The process of selecting the insurance carriers, negotiating and managing those contracts was assigned to PRHIA pursuant to Law No. 72. The Medicaid program retained the role of eligibility determination for Medicaid and Reforma.

In 2006, PRHIA implemented the Medicare Platino program to provide additional coverage benefits to beneficiaries of Medicaid and Reforma who are also eligible for Medicare (i.e., “dually eligible”) and enrolled in a Medicare Advantage Organization (MAO). Medicare Platino wraps around Medicare Advantage benefits, giving the dually eligible enrollees any additional benefits provided by the Medicaid program. PRHIA holds contracts with the MAOs.

### **The Puerto Rico Health Insurance Administration Board of Directors**

PRHIA is governed by a Board of Directors (BOD) made up of eleven (11) members, six (6) that are Ex-Officio Members and five (5) that are appointed by the Governor of Puerto Rico with the advice and consent of Puerto Rico’s Senate. The Ex-Officio Members include the Secretary of Health, the Treasury Department Secretary, the Administrator of the Administration of Mental Health and Addiction Services (ASSMCA), the Director of the Office of Management and Budget (OMB), the Executive Director of The Puerto Rico Fiscal Agency and Financial Advisory Authority (AAFAP) and the Insurance Commissioner, or their delegates. The Governor of Puerto Rico appoints the President of the Board of Directors from among its members. The primary purpose and functions of the BOD include:

- Implementation of medical services based on health insurance.
- Negotiation and contracting for medical insurance coverage.
- Negotiation and contracting with health service plans for health services.
- Organization of alliances and groups of beneficiaries with the purpose of representing them in the negotiation and contracting of their health plans.
- Maintenance of an administrative and financial structure to manage funds and revenues, administer cash and make disbursements.
- Establishment of guidelines for the appointment, contracting and remuneration of its personnel.
- Negotiation and awarding of contracts, documents and other public instruments with juridical persons and entities.
- Direction to insurers to keep a record of services rendered in categorical programs subsidized by the Federal government, and documentation of the relationship of their beneficiaries, payment claims and the pertinent financial and statistical reports.
- Approval, amendment and repeal of regulations that govern the business and activities of PRHIA.
- Appointment of an Executive Director for PRHIA.
- Facilitation of Contracting Committee to evaluate each contracting proposal and the recommendations. The Contracting Committee evaluates each proposal, the necessity of it, the amount for each service and the maximum amount for the contract year.
- Facilitation of an Internal Audit Committee to monitor PRHIA’s audit work, corrective action plans, and executions of internal and external processes

### **Financial Oversight and Management Board for Puerto Rico**

The Financial Oversight and Management Board for Puerto Rico (FOMB) was created under the Puerto Rico Oversight, Management and Economic Stability Act (PROMESA) of 2016. FOMB consists of seven members appointed by the President of the United States and one Ex-Officio Member designated by

the Governor of Puerto Rico. FOMB is tasked with working with the people and Government of Puerto Rico to create the necessary foundation for economic growth and to restore opportunity to the people of Puerto Rico.

FOMB works to fulfill the mandate of the PROMESA to ensure fiscal sustainability and restore access to capital markets. In the first instance, due to a series of unpredictable disasters, the effort has focused on utilizing certified fiscal plans and budgets to ensure Puerto Rico is able to respond to these crises while also moving toward medium and long-term fiscal and economic sustainability. FOMB established a contract review policy pursuant to Section 204(b)(2) of the PROMESA to require the Oversight Board's approval of certain contracts to assure that they "promote market competition" and "are not inconsistent with the approved fiscal plan.

In its oversight of the Medicaid Enterprise, the FOMB must approve all government contracts and amendments with an aggregate value of \$10,000,000 or more. FOMB may review any contract below such threshold at its sole discretion. All proposed contracts or amendments stemming from the rate negotiations between PRHIA and the "Plan Vital" MCOs must be submitted to the FOMB for review and approval prior to execution. Also, pursuant to PROMESA section 204(b)(4), certain proposed rules, regulations, administrative orders, and executive orders must be submitted for FOMB review prior to enactment.

## 4. OVERVIEW OF PUERTO RICO'S APPROACH TO FWA: OVERSIGHT OF MANAGED CARE PAYMENTS

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### Process of Making Managed Care Payments

Puerto Rico makes payment to managed care entities on a monthly basis. Payment terms are outlined in detail as part of the MCO contract with Puerto Rico. The two main parts that drive the payment is the negotiated capitation rate and the number of eligible lives covered by the MCO. Outlined below is the process in which fraud mitigation is conducted throughout Puerto Rico's MCO oversight process to include reviews on encounter data that drive the capitation rate. The oversight of this process includes an eight-step approach that is discussed in detail throughout this report. Supplementing this fraud, waste, and abuse mitigation process is the quality control review of beneficiary eligibility data. Puerto Rico is working on enhancing its eligibility determination quality assurance process, and details of this effort will be outlined in the forthcoming MEQC report due to CMS in June 2021.

### Current Eight-Step Approach to FWA

As defined in the Program Integrity Unit Manual published in 2018, Puerto Rico has implemented an eight-step approach to handling fraud, waste, and abuse in managed care payments. These steps include prevention, detection, investigation, evaluation, referral to law enforcement, registration of cases, internal referral, and payment suspension process. This process is detailed throughout the manual and is designed to directly address the components of suspicious fraud, waste, and abuse activities.

In the current prevention efforts, Puerto Rico identifies program vulnerabilities and validates that MCOs perform verification of excluded providers. Additionally, Puerto Rico reviews monthly and quarterly reports from each MCO to help identify patterns and conduct a cross comparison of identified issues.

In current detection efforts, Puerto Rico works with the MCOs to investigate reports of suspicious charging habits to determine if the charges are fraudulent. Guidance is also provided to MCOs throughout the identification process. For MCO oversight, ASES provides guidance in their contracts that requires the MCOs to conduct oversight and report on potential leads. These requirements are also incorporated in the COMP tool, which is detailed in section 5 below. Further, as part of the detection effort, the Surveillance and Utilization Review Subsystem (SURS) within the MMIS, does peer comparisons for like providers and identifies outliers.

In addition to fraud, waste, and abuse prevention and detection efforts, Puerto Rico has a set of six separate initiatives that resemble the response framework found in many state Medicaid programs. Following detection or suspicion of fraud, Puerto Rico has an established plan to respond. Puerto Rico evaluates reports received from MCOs to collect enough evidence and determine if further legal action is needed. Subsequently, Puerto Rico manages referrals to law enforcement, specifically, recommending cases to OIG for further investigation. Puerto Rico also maintains a registry of cases and assigns a Compliance Officer responsible for managing investigations to each case. These two processes help facilitate a smooth and effective transition of cases from Puerto Rico to the OIG. In addition to the traditional referral process from the MCO's, Puerto Rico also directly investigates internal referrals. Finally, there is a payment suspension process for credible allegations of fraud, waste, and abuse. Under the ACA, credible allegations must result in temporary suspension of payment to the party under investigation.

Many organizations use the prevent, detect, respond framework as their approach to fraud, waste, and abuse as it is highly successful in capturing activity, while also being simple to understand and agile enough to be effective as programs evolve.

## 5. PREVENTION

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### Description of Prevention Pillar

Prevention of fraud, waste, and abuse is critical to avoiding overpayments. Puerto Rico's prevention activities include analyzing encounter data for pre-payment edits, binary rules-based edits, and contractual requirements defined for both MCOs and providers. Advancements in analytic capabilities on reviewing beneficiary and encounter data will only enhance our capacity to prevent fraud.

### Current State and Planned Activities for Prevention

A detailed Compliance Plan was developed by ASES and included in the FY2020 Annual Report submitted to Congress on October 2020. The Compliance Plan describes many of Puerto Rico's planned activities to improve the integrity of the Medicaid Program and reduce fraud, waste, and abuse. The Compliance Plan includes a summary of the processes designed to address the targeted compliance elements.

Many of the fraud, waste, and abuse monitoring functions are the contractual responsibility of the MCOs, so it is critical that Puerto Rico monitors their activities and compliance. In the Compliance Plan, Puerto Rico highlights the implementation of a new Comprehensive Oversight and Monitoring Plan (COMP) tool that can collect data from MCOs and monitor their behavior for increased prevention of fraud, waste, and abuse.

Puerto Rico has also planned analytic and reporting capabilities that will advance program integrity once fully implemented. Since May 2020, Puerto Rico has been working to upgrade its Medicaid Management Information System (MMIS) and create the capability to generate – on a daily to annual basis – over 100 reports focused on various utilization metrics. Twelve metrics will be summarized in a dashboard and presented for executive-level monitoring. Puerto Rico will utilize these dashboards to initiate the detection and potential prevention of fraud cases that have historically been found by on-site visits. Both MMIS and the ASES reporting tools, including the COMP tool, will be fully implemented in the first quarter of 2021. Once fully implemented, these tools will generate a large variety of reports and the possibility of proactive monitoring based on predictive behaviors of MCOs. Additionally, the reporting capability enhancements will enable the PIU to calculate the total overpayment amounts and total amounts recovered from improper payments. This aggregation can then be used for CMS-64 reporting, as required.

Puerto Rico is continuously looking for opportunities to improve the integrity and efficiency of the data being reported. In May 2020, we developed a plan to expand our data analytics capabilities. While implementation of the plan is ongoing, we have made significant strides in recent months to expand our reporting capabilities, such as adding the ability to report at the provider level. We intend to start incorporating financial data into the analytics on top of the utilization already being analyzed. Before this can be accomplished, Puerto Rico needs to reconcile the MMIS data with the COMP tool data to validate consistency across the two sources. This will give Puerto Rico more confidence in the data sets and the ability to perform innovative analyses on the data to continue improving our capabilities. Having both utilization and encounter files that reconcile with COMP Tool's data is necessary for future enhancements to the system, including the implementation of artificial intelligence for ongoing monitoring of fraud, waste, and abuse.

## Opportunities to Enhance Fraud, Waste, and Abuse Prevention Efforts

### Challenge

Puerto Rico's primary focus in this area is on provider fraud, on a post-payment basis. There is limited capacity and analytic capability to understand trends of suspicious behaviors that focus on prevention and cost avoidance. Further, reporting data is limited to the provider level, and, as a result, the eligibility system and data sets cannot track fraudulent activity conducted by beneficiaries, which was highlighted in the Beneficiary Eligibility risk area by the OIG report titled 'A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program'<sup>8</sup>.

### Leading Practice:

In leading organizations, the prevention pillar is a proactive approach that aims to identify potential fraudulent or wasteful transactions before payment. This includes pre-pay edits for common errors to identify and prevent payments on known violations. This would build on our requirements that MCOs review suspicious providers and provide many benefits, including leveraging targeted interventions to integrate training, building partnerships, improving internal controls, complying with regulations, and optimizing standard operating procedures. Taking the prevention pillar a step further may include the use of advanced analytics to identify anomalous transactions and trend behaviors and flag them as potential issues. With this data, our Program Integrity teams can then utilize behavioral nudging in the form of letters and educational materials sent to providers to warn them of the flagged behaviors and prevent improper payments.

### Opportunities:

#### **Enhancing MMIS Reporting Analytics**

Our MMIS reports monitor paid encounter data to identify anomalous or suspicious behavior. By expanding the scope of data analysis to include denied claims reports as available, additional patterns of risk could emerge, enabling further enhancement to Puerto Rico's overall response to fraud, waste, and abuse. The need for advanced analytics has been identified as an important capability that will enable detection and prevention of improper payments before they are made, thus improving financial outcomes and avoiding overpayments. Further, if analytic rules and models are applied to denials, new patterns of suspicious billing behaviors from providers can be identified that may otherwise be undetected in a review of only paid records. Understanding the universe of denials is a valuable component to detecting fraud, waste, and abuse.

#### **Increase MCO Monitoring Processes**

As a further enhancement, it could be beneficial for our team to meet with MCO representatives quarterly to discuss and address fraud, waste, and abuse issues that have been flagged. This is a practice that is routinely done in many other Medicaid programs, where the Office of the Medicaid Inspector General meets quarterly with Puerto Rico staff and MCO representatives to discuss fraud, waste, and abuse issues; updates to procedures; and upcoming changes or enhancements to the program. Doing this in Puerto Rico would result in an increased communication stream

<sup>8</sup> Office of Inspector General, Department of Health & Human Services. (December 11, 2020). A-02-20-01011 Risk Assessment Puerto Rico Medicaid Program. Retrieved from <https://oig.hhs.gov/oas/reports/region2/22001011.asp>.

between Puerto Rico, the MMIS Division, and MCOs to evaluate new activities such as analysis of pending claims reports as available and then review of denials and pre-payment edits.

### **Report on Member Level Encounter Data**

As it relates to MCO payments, improved monitoring of encounter data at the beneficiary level could help expand the scope of waste, fraud and abuse prevention and detection efforts. Once the MMIS can strengthen its data governance and provide reporting and tracking of encounter data at the member-level, we can have greater insight and understanding of both utilization trends and billing trends. Using more granular data may allow for the discovery of more potential abusers of the Medicaid program as well as providers who may be fraudulently charging across multiple MCOs.

Puerto Rico is currently focused on ensuring that MCOs are doing the proper tracking themselves. This reliance on the MCOs hampers our ability to discern troubling patterns of use by individual members because we cannot map and review trends and patterns of providers across MCOs. This is a leading practice for other Medicaid programs, which can detect items such as overbilling done by providers across multiple MCOs. By changing the scope of our fraud, waste, and abuse efforts, Puerto Rico may be able to have a more holistic understanding of the landscape across all levels.

## 6. DETECTION

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### Description of Detection Pillar

Detection is a key phase in our approach to fraud, waste, and abuse. It is critically important that PIU have established processes, along with analytics, that enable the detection of fraud, waste, and abuse within the data. This can be achieved through many approaches, including prepayment edits, outlier detection through trend analysis, and advanced machine learning. Our Medicaid Enterprise is working to advance all three approaches to further develop our detection capabilities.

### Current State and Planned Activities for Detection

#### FWA Responsibilities for MCOs

Puerto Rico outlines MCO's responsibilities surrounding fraud, waste, and abuse in our contracts with the MCOs. Currently, standard MCO contracts consist of seven main components: general provisions, a compliance plan, a program integrity plan, Stark Law compliance, prohibited affiliations, reporting and investigations, and service verification with enrollees. The general provisions outline the MCO's responsibilities surrounding fraud, waste, and abuse, and their responsibility to have the necessary infrastructure in place to prevent it. These contracts also require MCOs to submit a compliance plan to ASES outlining their educational/training plans and detailing their compliance monitoring plans.

MCOs are also required to implement a program integrity plan which outlines the following: staff responsibilities regarding fraud, waste, and abuse; a systematic data analysis approach; a plan to monitor and investigate utilization; and reporting the top 3 areas most vulnerable to fraud, waste, and abuse. In compliance with Stark Law, MCOs should ensure providers do not have any financial interest during the referral process. Likewise, MCOs are expected to monitor their relationships, making sure they do not have a relationship with an individual banned from procurement activities or working with Federal programs. MCOs are also required to follow the reporting processes outlined by Puerto Rico as well as ensure that no payments are made to providers until providers have made necessary disclosures to the MCOs. Lastly, Puerto Rico requires MCOs to create a process for identifying provider groups at risk for billing for unutilized services and allowing for a more effective use of service verification with enrollees.

#### Upcoming COMP Tool Innovations

The upcoming COMP tool enhancements will serve as a crucial component piece to enhance our Medicaid Enterprise new approach to fraud, waste, and abuse. The COMP tool will enable us to strengthen our monitoring of MCOs and have greater insight into the detection of fraudulent or wasteful activity. Once fully implemented in 2021, the COMP tool will include a process for monitoring and collecting data from MCOs. Specifically, the COMP tool enhancements will further enable ASES and PIU to detect potential fraud through the following provider interventions: trend identification, historical data mining, possible punitive sanctions, or other agencies referrals for forensic legal investigation (MFCU, OIG, Office of the Commissioner).

MCOs will be supplied with a reporting package that they must complete with real-time information regarding a variety of areas. This data is organized into six unique fields addressing provider networks; program integrity; quality of care; financial data, including solvency and profitability; claims and

encounters; and pharmacy benefit managers (PBMs). More specifically, the COMP tool consists of the following:

- Evaluation and monitoring of the providers’ network relations areas (accessibility, availability and adequacy, and evaluation of full contracting and credentialing status of providers)
- Evaluation and monitoring of Integrity and Compliance Programs - comparing programs based on reported data, and the proper identification of possible cases and suspicious behaviors. Monitoring validates the integrity and promotes appropriate management of federal Medicaid programs and funds
- Evaluation and monitoring of quality and clinical programs in relation to national and state standards
- Evaluation and monitoring of financial data, measuring solvency, efficiency and profitability of the MCOs
- Evaluation and monitoring of claims and encounters, oversight of complaints, timeliness, completeness, accuracy of processing and payment of claims
- Evaluation and monitoring of the PBM, evaluation of the operation of the PBM, the costs of prescriptions and drug treatments, trends in use and exceptions to standards and, costs of branded versus generic drugs and their financial impact

This reporting package will also include at least 10 unique KPIs that will be monitored through the new COMP tool. A list of these KPIs can be found in Appendix 8.1. COMP tool trainings began on October 1, 2020 for ASES middle management staff and other MCO staff, as applicable.

As the COMP tool is implemented and further developed, ASES and Puerto Rico should increase coordination on metrics and KPIs allowing both groups to consistently track and measure the same statistics. The utilization of the COMP tool metrics will also allow the program integrity team to better track trends, understand seasonality, and assist with the development of predictive analytics which will continue to increase the maturity level of the program.

## Opportunities to Enhance Fraud, Waste, and Abuse Prevention Efforts



### Challenge

Important to the fraud, waste, and abuse detection pillar, is the ability of the Medicaid program to find suspicious activity consistently and efficiently. Currently, Puerto Rico relies on encounter data provided by the MCOs, experience held by the teams themselves, and the MCOs’ monitoring efforts to detect fraud, waste, and abuse. As a result, we are highly reliant on past experience and the MCOs’ infrastructure to maintain the integrity of the Medicaid program.



### Leading Practice:

The detection pillar is designed to find those behaviors that are not prevented in the first pillar. Leading practices for detection include implementing an evolutionary approach that builds on traditional methods of pattern detection with sophisticated strategies. High performing program integrity units implement tools that complement existing business rules with predictive analytics and cognitive artificial intelligence (AI) to enhance the detection of fraudulent, wasteful and abusive behavior. Predictive analytics focuses on the likelihood of improper payments being made. Reviewing past trends, coupled with known outcomes, allows the analyst to predict potential areas of suspicion based on real-time analysis. The addition of a robust analytic engine that includes predictive analytics and machine learning allows Program Integrity groups to stay ahead of emerging schemes, as well as the flexibility to continuously adapt to the ever-changing fraud and abuse landscape.

Another advantage of this approach includes the ability to continuously monitor platforms such as social media and the dark web for signals of suspicious behavior. By incorporating third party data, and deploying tools to scan outside data sources, investigators can identify fraudulent activity not detected in the encounter data. For example, a provider may be flagged for billing a very high number of consecutive days, potentially far outside their peers. If an analyst is reviewing this pattern and is also able to see that this same provider was tagged on social media outside of the country when they were supposedly seeing beneficiaries, this could further enhance the case for adverse action. Integration of these types of third-party data sources enhances investigators' ability to see the larger picture and strengthen their cases.



### Opportunities:

#### **Enhance MCO Encounter Data Analysis**

Puerto Rico knows that leveraging advanced and predictive analytics across the entire population of encounter data can provide both data quality and MCO performance insights. Currently, PRMMIS is receiving the encounters/claims data on a daily basis since March 2018, as the source of truth. The PRMMIS encounter/claim processing was certified by CMS on January 10, 2020 and it is the source that Puerto Rico uses to report reliable data to the Transformed Medicaid Statistical Information System (TMSIS). Therefore, we are planning to continue data synchronization efforts between PRMMIS and ASES, as we fully integrate and develop the COMP tool in 2021. Puerto Rico is continuing to mature our data governance in integrating various data sources across ASES and MMIS. The full integration will enable PR to review a uniform dataset and thus further validate the integrity and quality of the data for review purposes.

Reviewing data quality is a critical first step to mitigate potential negative impacts to health care fraud and improper payment indicators. Certain issues may require investigating the source data feeds or necessitate imputing data elements, while others may result in further revising the fraud, waste, and abuse risk indicators to accommodate new patterns within the data. Examples of elements we may prioritize, and further review are:

- **Missing Diagnoses/Procedures:** Identifying providers who are the largest contributor to an “Unknown” diagnosis code; or those with the largest number of primary procedures missing
- **Missing Prescribers:** Comparing MCOs with missing prescribers within the pharmacy records

- **Same Primary and Secondary Diagnosis:** Identifying when there are large numbers of encounters have the same primary and secondary diagnoses

In addition to diving into potential data quality issues at a managed care plan level, leveraging advance analytics to gain comparative analysis of managed care plans will enable Puerto Rico to obtain further insight into the population. By evaluating taxonomies, procedures, diagnoses, and claim types, the analyses will focus in on specific plans or other areas of high risk that could be flagged by the OIG in the future. Examples of this review across MCOs include:

- Areas with significant inconsistencies with the costs of specific services or provider types that may lead to quality-of-care issues
- Potential coverage gaps in a plan’s provider network related to specific provider types or services
- High-cost diagnoses or procedures that may lead to opportunities to research new overpayment indicators and/or focus areas for the preventive review

### **Implement Further Predictive Analytics**

Our PRMMIS Unit has made great strides in their analytics and has been working towards the implementation of advanced analytics. As mentioned earlier in the report, once the COMP tool is fully implemented and data is synchronized with PRMMIS, proactive monitoring of MCOs based on their predicted behaviors will be possible. This is in line with leading practices and has proven to be more effective when developing methods that react to the evolving nature of fraud while driving program integrity and reducing improper payments. Puerto Rico can benefit from becoming more proactive and hands-on when it comes to detection efforts. Also, the Program Integrity Unit is going to request an enhancement in the data analytics tool to leverage artificial intelligence and other tools to ensure proper encounter/claims payment, reduce provider burden, and better align its program activities with emerging technology.

As it relates to detection efforts, KPIs are beginning to be monitored in the COMP tool to start identifying trends for specific metrics. The efficiencies gained in utilizing these new tools could enable the program integrity team to expand analysis to more advanced areas. Implementing an analytics solution could allow the team to go beyond the current KPIs and gain a more granular level understanding of the provider and member-level data.

Activities such as cross-referencing multiple disparate data sets like encounter data, provider lists, member lists, and any external reference data may enable our Medicaid Enterprise to see the full picture in analyzing leads and cases. Running the data against a set of models including risk scores, provider-based risk factors, behavioral models, and record-based rules, could highlight a list of high, moderate, and low risks. Doing this would eliminate our reliance on the MCOs to maintain integrity of the program and better equip us to discover fraud, waste, and abuse leads or areas of exposure before the MCOs can detect it. Incorporating machine learning algorithms into the analysis to unravel sophisticated fraud schemes can also provide opportunities for better quality of care and service to recipient populations.

As discussed, a combined approach could allow Puerto Rico to detect an increased amount of fraud, waste, and abuse not previously detectable by an individual MCO, or all MCOs acting separately. Looking across MCOs may enable our Medicaid Enterprise to see patterns of improper utilization by members –possibly for the first time – and faster and more efficiently than they otherwise might have been. Successful predictive analytic implementations can ease the detection workload and create a much more efficient and streamlined process.

# 7. RESPONSE

## Description of Response Pillar

The response activities for Puerto Rico’s Program Integrity Unit include many avenues to address cases of identified fraud, waste, and abuse. The response is dependent on the type and source identified. We are currently running multiple initiatives to address and respond to identified overpayments, and we are working with ASES on procedural updates and efficiencies as outlined in the Compliance Plan – all of which will increase transparency and measurability of proposed response enhancements.

## Current State and Planned Activities for Response

Puerto Rico has six separate initiatives that resemble the response framework found in many state Medicaid programs. Following detection of fraud, Puerto Rico primarily focuses on evaluating reports received from MCOs. This process is focused on collecting enough evidence to determine if referrals should be made to law enforcement, specifically, recommending cases to OIG for further investigation. Puerto Rico maintains a registry of cases and assigns a Compliance Officer who is responsible for managing the investigation of each case. In addition to the traditional referral process from the MCOs, Puerto Rico also directly investigates internal referrals. Finally, under the ACA, credible allegations of fraud, waste, and abuse result in a temporary suspension of payment to the party under investigation.

### Opportunities to Enhance Fraud, Waste, and Abuse Response Efforts



#### Challenge

The response approach for Puerto Rico includes multiple policies and procedures guidance that involve many different stakeholder groups. Responsibilities for the multiple agencies involved in response are not well defined, which can lead to redundancy and/or oversight in required actions. Appendix C of the FY 2020 Annual Report to Congress, includes Puerto Rico’s Compliance Plan, which outlines the following activities that will enable us to address the challenges in the response pillar:

1. Redefinition of policies and procedures
2. Identification of mirrored policies from other areas of operation that reflect the related guideline, policy, and/or compliance procedure
3. Redefinition of responsibilities for compliance officers as well as assigning compliance officers to specific MCOs to allow for a closer relationship
4. Reinforcement of employees' trainings
5. Review of existing monitoring reports and update to include identification of historical versus actual compliance needs.
6. Open reliable and confidential lines of communication between government agencies
7. Implement a primary cause identification process and risk assessments roadmap to increase compliance in sensitive areas and identify rule violations



## Leading Practice:

The response pillar is designed to address fraud, waste, and abuse that bypasses the first two pillars. In the response phase, leading practice organizations are armed with information and they are empowered to act. To address fraud, waste, and abuse, they can utilize multiple decision points to determine adverse action steps and/or make referrals to law enforcement agencies. Fully documented processes for decision determinations based on the components of a case are another leading practice found in many programs. Designing and then implementing a strong workflow, organized by role, may allow Puerto Rico to track and execute on applicable responses for the caseload. A successful response phase facilitates collaboration and information sharing across organizations and establishes a risk assessment framework that enables better positioning to combat fraud, waste, and abuse.



## Opportunities:

### **Further Defined Compliance Plan**

A leading practice recommendation to enhance the compliance plan response is to go a step further and outline targeted metrics that measure progress against each action. By outlining targeted metrics, we would be able to better understand the current state of compliance in specific areas of concern. Additionally, having measurable targets allows for a quantitative approach to tracking progress over time. By having a set approach based on metrics, Puerto Rico would be able to monitor thresholds that could determine when action needs to be taken. This provides greater consistency in monitoring fraud, waste, and abuse throughout the Medicaid program. Furthermore, plans may be enhanced by updating policy and procedure definitions, revisions and approach for changes based on metrics/measures. For example, one recommendation would be to strengthen Item 1 above by stating specifically which policies and procedures are being redefined as well as what the new definitions are. Another recommendation will be to coordinate reporting efforts across all agencies to help ensure more accurate and complete reporting, especially for Federal reports including the CMS-64 and SURS.

An important component of these types of plans is that they are measurable, actionable and repeatable. We might consider including a description of targeted metrics that measure the state of compliance within the Medicaid program. If these targeted metrics are the KPIs shown in Appendix 8.1 of this report, Puerto Rico can include those specifically in the Compliance Plan for added clarity. Additionally, we may consider establishing targeted responses based on the metrics they implement. Combining the measurability of metrics with an established course of action would create a process that is then repeatable and standard across all areas of compliance. As a result, our Medicaid Enterprise has the opportunity to clarify and further define the fraud, waste, and abuse process to create a framework that is measurable, actionable and repeatable.

### **Enhance Program Integrity Unit technology capabilities**

An important component of response is a PIUs ability to track cases, monitor patterns, and perform referrals and track their outcomes. Introducing advance analytics as a form of additional oversight in the Program Integrity function over both Eligibility data and MCO encounter data –

two elements that drive the MCO payments – would enable the PIU to track an end-to-end picture of the FWA risks in Puerto Rico. This is a leading practice being adopted by Medicaid programs, and is in line with our PIU’s mission and long-term goals and objectives.

## 8. APPENDIX

### Key Performance Indicators (KPIs) Reports Relevant to Program Integrity

KPI	Definition	Reporting Source
<b>FWA Cases</b>	The number of cases (member and provider) opened, closed, referred to ASES and MFCU, OIG during the reporting period.	Report 3a: YTD counts of cases
<b>Overpayments</b>	The amount of overpayments estimated, identified, and recouped	Report 3C: Fiscal YTD Total Overpayment
<b>Provider Terminations</b>	The number, reason, and dollar amount regarding providers who were terminated due to FWA reasons from the MCO's network.	Report 3e: Count of NPI by reason
<b>Appeals overturn rate</b>	Ratio of approved appeals divided by processed determinations for appeals filed by members and providers. Development of trends and baseline for key reasons for appeals.	Report 21: Approved appeals / Processed appeals
<b>Member Grievances</b>	Review of volume of grievances filed by members. Development of trends and baseline for key reasons for grievances and appeals.	Report 21: Enrollee Grievances
<b>Provider Grievances</b>	Review of volume of grievances filed by providers. Development of trends and baseline for key reasons for grievances and appeals.	Report 21: Provider Grievances
<b>Provider Suspensions</b>	The number, reason and dollar amount regarding providers who were suspended due to FWA reasons from the MCO's network.	Report 3f: Courts by reason for action taken
<b>Initial FWA Member Allegations</b>	The number of initial member allegations by topic identified each quarter. Topics include: <ul style="list-style-type: none"> <li>• Misuse of ID cards</li> <li>• Prescription forgeries</li> <li>• Poly-pharmacy abuse</li> <li>• Overutilization of services</li> <li>• Third party liability</li> <li>• REOMB falsifying</li> </ul>	Report 3b: Allegations by reason
<b>Initial FWA Provider Allegations</b>	The number of initial provider allegations by topic identified each quarter. Topics include: <ul style="list-style-type: none"> <li>• Altering or falsifying documents</li> <li>• MCO audit results</li> <li>• Billing for non-covered services</li> <li>• Billing for services not rendered</li> <li>• Billing for services out of scope of practice</li> <li>• Overutilization patterns</li> <li>• Duplicative charge patterns</li> <li>• Kickbacks</li> <li>• System claims coding issues</li> </ul>	Report 3b: Allegations by reason