



May 5, 2010

TO: Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of Rhode Island's Compliance With the American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements (A-01-09-00007)

Attached, for your information, is an advance copy of our final report on Rhode Island's compliance with the American Recovery and Reinvestment Act of 2009 Medicaid eligibility requirements. We will issue this report to the Rhode Island Department of Human Services within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-09-00007.

Attachment



Office of Audit Services
Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

May 12, 2010

Report Number: A-01-09-00007

Mr. Gary Alexander
Director, Department of Human Services
Louis Pasteur Building
600 New London Avenue
Cranston, RI 02920

Dear Mr. Alexander:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Rhode Island's Compliance With the American Recovery and Reinvestment Act of 2009 Medicaid Eligibility Requirements*. We will forward a copy of this report to the HHS action official noted below.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please direct them to the HHS action official. Please refer to report number A-01-09-00007 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF RHODE ISLAND'S
COMPLIANCE WITH
THE AMERICAN RECOVERY AND
REINVESTMENT ACT OF 2009
MEDICAID ELIGIBILITY REQUIREMENTS**



Daniel R. Levinson
Inspector General

May 2010
A-01-09-00007

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

INTRODUCTION

BACKGROUND

Medicaid Program

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

Pursuant to section 1905(b) of the Act, the Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal medical assistance percentage (FMAP), which varies depending on the State's relative per capita income. Although FMAPs are adjusted annually for economic changes in the States, Congress may increase FMAPs at any time.

Temporary Increase in Federal Medical Assistance Percentages

The American Recovery and Reinvestment Act of 2009 (the Recovery Act), P.L. No. 111-5, enacted February 17, 2009, provides fiscal relief to States to protect and maintain State Medicaid programs in a period of economic downturn. For the recession adjustment period (October 1, 2008, through December 31, 2010), the Recovery Act provides an estimated \$87 billion in additional Medicaid funding based on temporary increases in States' FMAPs. Section 5000 of the Recovery Act provides these increases to help avert cuts in health care provider payment rates, benefits, or services and to prevent changes in income eligibility requirements that would reduce the number of individuals eligible for Medicaid.

To qualify for the increased FMAP, States must meet various criteria. One of these addresses eligibility. Pursuant to section 5001(f)(1)(A) of the Recovery Act, a State is not eligible for an increase in its FMAP for quarters during the recession adjustment period in which its Medicaid eligibility standards, methodologies, or procedures are more restrictive than those in effect on July 1, 2008.

Rhode Island's Temporary Increase in Federal Medical Assistance Percentage

In accordance with provisions in the Recovery Act, CMS made \$144.6 million in additional Medicaid funding available to the Rhode Island Department of Human Services (the State agency) for the first three quarters of Federal fiscal year (FY) 2009 (October 2008 through June 2009). For that period, CMS increased the State agency's FMAP 11.3 percentage points, from 52.6 percent to 63.9 percent.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's Medicaid eligibility standards, methodologies, and procedures during the first three quarters of FY 2009 were more restrictive than those in effect on July 1, 2008.

Scope

We reviewed the State agency's Medicaid eligibility standards, methodologies, and procedures in effect during the period October 1, 2008, through June 30, 2009, to determine whether they were more restrictive than those in effect on July 1, 2008. We did not review a sample of eligibility case files to validate that standards, methodologies, or procedures were consistently used in determining Medicaid eligibility. We did not determine if the State agency increased its Medicaid eligibility income standards (expressed as a percentage of the poverty line) or if it applied the increased FMAP to expenditures for individuals made eligible for Medicaid as a result of increased income standards. We did not review the State agency's overall internal control structure. We limited our review to obtaining an understanding of the procedures that the State agency used for changing eligibility standards, methodologies, and procedures and for communicating these procedures to the staff members who made eligibility determinations.

We performed our fieldwork at the State agency in Cranston, Rhode Island, from July through September 2009.

Methodology

To accomplish our objective, we:

- reviewed the Recovery Act and applicable CMS guidance;
- reviewed all Medicaid eligibility-related changes made to Rhode Island's State plan after July 1, 2008;
- reviewed all changes made to Rhode Island's *Medicaid Eligibility Manual* after July 1, 2008;
- interviewed CMS regional office officials;
- interviewed State agency management and Medicaid eligibility policy officials;
- interviewed Medicaid field office staff members who made eligibility determinations to determine how changes in eligibility standards, methodologies, and procedures were communicated to them and what changes they implemented after July 1, 2008; and

- compared all revised eligibility standards, methodologies, and procedures implemented after July 1, 2008, with those in effect on July 1, 2008.

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

RESULTS OF REVIEW

Although the State agency made changes to its Medicaid eligibility standards, methodologies, and procedures after July 1, 2008, the standards, methodologies, and procedures in effect during the first three quarters of FY 2009 were not more restrictive than those in effect on July 1, 2008.

The eligibility changes included:

- updates to Federal guidelines, such as poverty level charts and standards used to determine applicants' needs in relation to their resources;
- editorial changes that did not affect the eligibility process; and
- changes that made the eligibility process less restrictive.

This report contains no recommendations.