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OFFICE OF INSPECTOR GENERAL

PROVIDERS TERMINATED FROM ONE STATE MEDICAID PROGRAM CONTINUED PARTICIPATING IN OTHER STATES

Suzanne Murrin
Deputy Inspector General for Evaluation and Inspections

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EXECUTIVE SUMMARY: PROVIDERS TERMINATED FROM ONE STATE MEDICAID PROGRAM CONTINUED PARTICIPATING IN OTHER STATES OEI-06-12-00030

WHY WE DID THIS STUDY

Prior to passage of the Patient Protection and Affordable Care Act (ACA), if a State terminated a provider's participation in its Medicaid program, the provider could potentially participate in another State's Medicaid program, leaving the second State's program vulnerable to fraud, waste, or abuse committed by that provider. To prevent this from happening, the ACA requires States to terminate a provider's participation in their respective State Medicaid programs if that provider is terminated for cause (i.e., for reasons of fraud, integrity, or quality) from another State Medicaid program. In 2014, the Office of the Inspector General (OIG) published a report that recommended improvements to address weaknesses in CMS's process for sharing termination information among the States. This study builds on the prior report by determining whether Medicaid providers that States reported as having been terminated for cause continued to participate in Medicaid in other States.

HOW WE DID THIS STUDY

Because the termination data collected through CMS's process was not comprehensive and complete, we went directly to each State Medicaid agency and requested rosters of all individual Medicaid providers terminated in 2011 for cause. We also requested rosters of individual Medicaid providers participating in Medicaid fee-for-service and managed care on January 1, 2012. We compared these State-submitted rosters to determine if providers had been terminated. In January 2014, we followed up with State Medicaid agencies to determine if and when each provider's participation in Medicaid ended, and the amount that Medicaid paid each provider for services performed after the provider's termination for cause from another State program. We obtained information from State Medicaid agency staff about challenges in implementing the termination requirement.

WHAT WE FOUND

Despite the ACA requirement for States to terminate any providers already terminated for cause in another State, we found continued participation from such providers in other States' Medicaid programs. Specifically, we found that 12 percent of providers (295 of 2,539) terminated for cause in 2011 were still participating in other States' Medicaid programs in January 2012, and many continued to participate as late as January 2014. These Medicaid programs paid $7.4 million to 94 providers for services performed after each provider's termination for cause by the initial State. The challenges that States face in meeting the intent of the ACA legislation include not having a comprehensive data source for identifying all terminations for cause and difficulty differentiating such terminations from other administrative actions that a State reports. Further complicating States' ability to terminate providers is that, of the 41 States that used managed care to deliver Medicaid services, 25 States did not require providers who participated via managed care to be directly enrolled with the State Medicaid agency. If a State has not directly enrolled a provider, it cannot terminate that provider, and it may not even be

aware that the provider is participating in its Medicaid program. Also challenging for some States is their misunderstanding that if a provider has an active license from the relevant State board, the State Medicaid agency should defer to the judgment of that board and not terminate the provider for cause.

WHAT WE RECOMMEND

In March 2014, OIG recommended that CMS require State Medicaid agencies to report all terminations for cause. We reiterate this prior recommendation as we found the lack of a comprehensive data source of providers terminated for cause creates a challenge for State Medicaid agencies. To address the remaining issues identified in this report, we recommend that CMS (1) work with States to develop uniform terminology to clearly denote terminations for cause, (2) require that State Medicaid programs enroll all providers participating in Medicaid managed care, and (3) furnish guidance to State agencies that termination is not contingent on the provider's active licensure status. CMS concurred with our recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To determine the extent to which individual providers who were terminated for cause from one or more State Medicaid programs continued participating in Medicaid in other States.
2. To determine the amount Medicaid paid to such providers, if any, for services performed after their terminations for cause in other States.
3. To describe challenges faced by State Medicaid agencies in ensuring that providers terminated for cause from Medicaid do not continue participating in Medicaid in other States.

BACKGROUND

The Patient Protection and Affordable Care Act[1] (ACA) provided the Centers for Medicare & Medicaid Services (CMS) and State Medicaid agencies with new tools to strategically reduce the risk of fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[2] One of these tools relates to providers who were terminated from Medicare or from State Medicaid programs for program integrity reasons. Before the ACA was passed, if one State terminated the participation of a provider from its Medicaid program, the provider could potentially enroll in or continue participation in another State's Medicaid program, leaving the second State's program vulnerable to potential fraud, waste, and abuse committed by that provider.[3] Section 6501 of the ACA requires that effective January 1, 2011, each State must terminate the participation of a provider from its State Medicaid program if that provider's participation was terminated from Medicare or from another State Medicaid program.[4] This requirement strengthens Medicaid program integrity across States, so that providers found to warrant termination in one State may not continue to treat (or begin to treat) Medicaid beneficiaries in another State and receive Medicaid payments for doing so.

Regulation and guidance define three terms that are critical to understanding section 6501 of the ACA: "provider," "termination," and "for cause." The term "provider" refers to individuals or entities

[1] P.L. No. 111-148 § 6501 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

[2] CMS, Center for Program Integrity, *New Strategic Direction and Key Antifraud Activities*, November 3, 2011. Accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/MedicaidIntegrityProgram/downloads/cpiinitiatives.pdf on February 7, 2013.

[3] 76 Fed. Reg. 5862, 5943 (Feb. 2, 2011).

[4] ACA § 6501, Social Security Act § 1902(a)(39), 42 U.S.C. § 1396a(a).

furnishing services to Medicaid beneficiaries under fee-for-service or managed care arrangements.[5] A "termination" occurs when the Medicare, Medicaid, or Children's Health Insurance Program (CHIP) programs revoke a provider's billing privileges for cause, the provider exhausts all appeal rights, and there is no expectation that the revocation of billing privileges is temporary.[6, 7] As defined by the Centers for Medicare & Medicaid Services (CMS), terminations "for cause" are terminations for reasons of fraud, integrity, or quality.[8] Terminations for cause do not include cases in which a program terminates a provider as a result of billing inactivity or those in which a provider voluntarily ends participation in the program, except when a provider takes this voluntary action to avoid a sanction, such as revocation or termination.[9]

In practical terms, after a State terminates a provider for cause, other States' implementation of section 6501 of the ACA involves three steps: learning, identifying, and acting. First, a State agency must **learn** about providers who were terminated for cause from Medicare or other State Medicaid or CHIP programs. Second, the agency must **identify** whether any of those terminated providers are participating in the State's Medicaid program, taking steps to verify a provider's identity, if it is in question. Third, the agency must **act** appropriately to terminate the provider's participation in its own State Medicaid program. (See Figure 1.)

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[5] Pursuant to 42 CFR § 400.203, "provider" means either of the following: (1) for the fee-for-service program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; (2) for the managed care program, any individual or entity that is engaged in the delivery of health care services and is authorized to do so by the State in which it delivers the services.

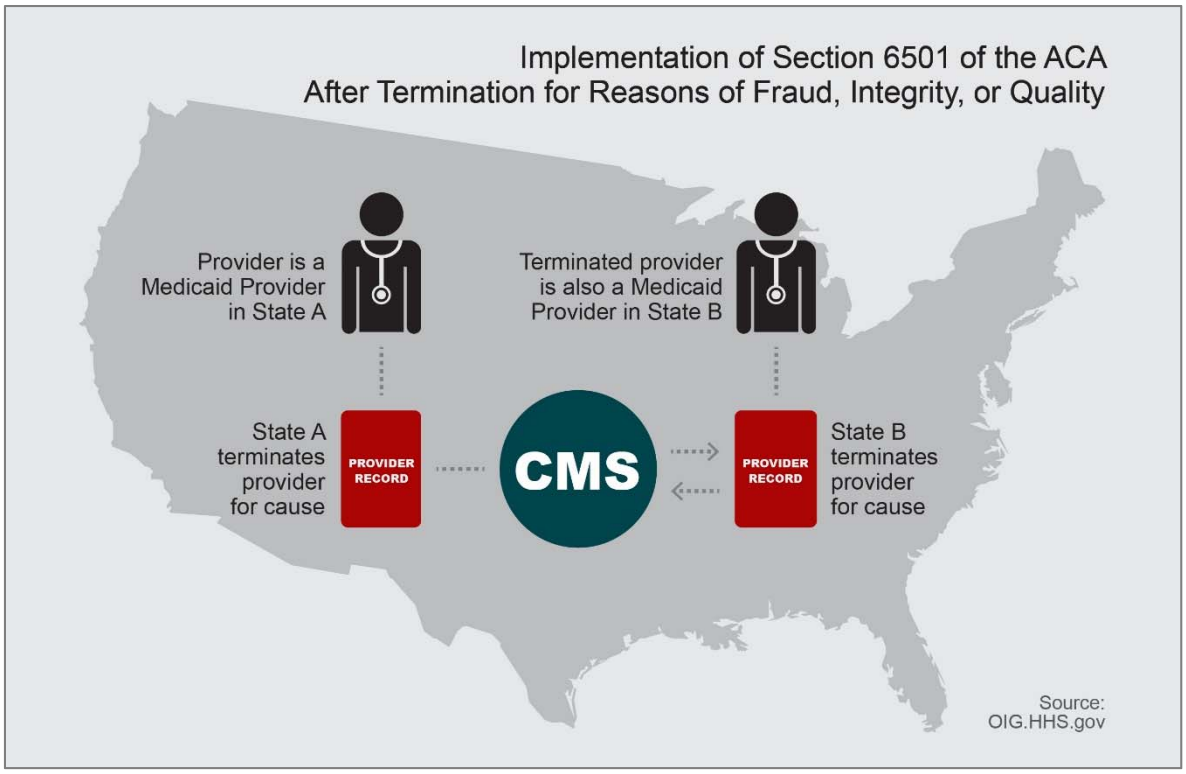
[6] 42 CFR § 455.101, definition of "Termination," (1–3).

[7] In guidance, CMS noted that terminations differ from exclusions. "Generally, "exclusion" from participation in a federal health care program, including Medicare, Medicaid, and CHIP is a penalty imposed on providers and suppliers by the Department's Office of Inspector General (HHS-OIG). Individuals and entities may be excluded from participating in federal health care programs for misconduct ranging from fraud convictions to patient abuse to defaulting on health education loans." CMS, CPI-B 11-05.

[8] 42 CFR § 455.101, definition of "Termination," (3); CMS, CPI-B 12-02, *Affordable Care Act Program Integrity Provisions–Guidance to States–Section 6501–Termination of Provider participation under Medicaid if Terminated under Medicare or other State Plan*, January 20, 2012.

[9] CMS, CPI-B 11-05, *ACA Program Integrity Provisions—Guidance to States—Section 6501—Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan*, May 31, 2011.

Figure 1.



Note: State A refers to the State that initiates a provider's termination for cause. State B refers to any other State where this provider is currently providing services or to where the provider could move.

CMS Processes Were Ineffective for Sharing Information about Providers Terminated For Cause

To facilitate learning about termination actions by Medicare and by other State Medicaid agencies, section 6401(b)(2) of the ACA requires CMS to establish a process to make available to these agencies information about providers terminated for cause from the Medicare, Medicaid, and CHIP programs.[10] To address this requirement, CMS established a data-sharing process that used a secure Web-based portal. This process allowed State Medicaid agencies to voluntarily report providers whom the agencies terminated for cause from their programs and to retrieve information about providers who were terminated for cause by Medicaid programs in other States.[11]

[10] Most of the available data sources are designed for purposes other than identifying providers terminated for cause.

[11] This Web-based portal was the Medicaid and CHIP State Information Sharing System (MCSIS). In February 2014, CMS replaced MCSIS with the Termination Notification database.

However, a March 2014 report by the Office of Inspector General (OIG) found that CMS's process to share termination information among the States needed improvements.[12] Three problems undermined the effectiveness of the process established by CMS: (1) many State Medicaid agencies did not report any terminations for cause; (2) of those reported, many records did not relate to providers terminated for cause; and (3) many records did not contain sufficient information—such as the National Provider Identifier (NPI) or a Social Security Number (SSN)—to confidently identify the providers who were terminated for cause. OIG recommended that CMS make improvements to its process and require that State Medicaid agencies report all terminations for cause (rather than continuing with the prior voluntary reporting approach) and take action to improve the completeness of termination records.[13] CMS concurred with each of our recommendations and reported changes that it had underway and future plans for its process for sharing information on terminated providers. For example, CMS implemented procedures intended to improve the completeness of the records, such as requiring States to submit a copy of the Medicaid termination letter issued to the provider as well as information such as the provider's NPI or SSN.[14] Additionally, CMS reported that it reviews each termination to assure that it meets CMS criteria for inclusion in the Termination Notification database.[15]

METHODOLOGY

This report examines individual providers (hereafter referred to as "providers") who were participating in Medicaid fee-for-service and managed care in all 50 States, the District of Columbia, and the five territories (hereafter referred to collectively as "States").[16,17] Although section 6501 applies to Medicare, Medicaid and CHIP providers, we

[12] OIG, *CMS's Process for Sharing Information About Terminated Providers Needs Improvement*, OEI-06-12-00031, March 2014.

[13] Ibid.

[14] CMS, *Email to State Program Integrity Directors*, February 7, 2014.

[15] OIG, *CMS's Process for Sharing Information About Terminated Providers Needs Improvement*, OEI-06-12-00031, March 2014. See CMS Response, p. 22.

[16] The study includes individual business owners, employees, and caretakers who were reported as terminated for cause and who were not allowed to bill for services performed for Medicaid beneficiaries. It does not include provider organizations (nursing homes, home health agencies, ambulatory surgical centers, etc.).

[17] The five territories are American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands.

limited this study to individual Medicaid providers.[18] (See Appendix A for a detailed methodology.)

To perform this review, we obtained from each State agency a roster of all providers (fee-for-service and managed care) who were participating in that State's Medicaid program as of January 1, 2012. We also obtained from each State agency a roster of all providers (fee-for-service and managed care) who were terminated for cause from the State's Medicaid program during 2011. We based our report findings on a review of 2,539 unique individual providers who were reported as terminated for cause from State Medicaid programs during 2011.[19] (See Appendix B for detailed information about providers reported as terminated for cause in 2011 from State Medicaid Programs by State and by provider type.)

For each of the 2,539 providers reported as terminated for cause during 2011, we examined all other States' rosters of providers participating in Medicaid as of January 2012. We then followed up with State Medicaid agencies in January 2014 to determine whether and when each provider's participation in Medicaid ended. In response to original terminations that occurred very late in 2011, our 2014 followup ensured that we captured provider terminations that occurred after the collection of participation rosters in January 1, 2012.

We calculated the frequency and percentage of providers who were terminated for cause in 2011 yet were still participating in Medicaid in January 2012 and in January 2014. We also obtained data from States and calculated the amount that State Medicaid programs paid providers for services performed after their terminations for cause from other States' Medicaid programs through January 2014.

We contacted State Medicaid agency staff to discuss our data requests and to follow up on specific providers. We reviewed additional information that agencies provided in their responses to our data request. We also administered a structured questionnaire to State Medicaid agencies. Through these efforts, we identified challenges that they encountered in complying with section 6501 of the ACA.

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[18] We did not include in our analysis any of the providers whom CMS terminated for cause from Medicare because the data that we obtained from CMS regarding such providers were not sufficiently complete for purposes of our analysis. We decided not to separately collect data about CHIP providers because of the variation among States in how CHIP services are delivered relative to Medicaid—some States have separate CHIP programs, some expanded Medicaid to include CHIP, and some States offer a combination of separate CHIP programs and Medicaid expansion that included CHIP.

[19] Twenty-nine providers were reported by more than one State as having been terminated for cause.

Limitations

The analysis and findings presented in this report rely on the information submitted to OIG by State Medicaid agencies regarding individual providers who were participating in, and were terminated for cause from, their Medicaid programs. We did not verify the completeness or accuracy of the data submitted to OIG by State agencies. For example, although we requested that the agencies submit rosters of providers who were terminated for cause, it was outside the scope of our methodology to verify that each termination submitted by State agencies aligned with the definition of termination for cause specified in CMS guidance.

Our findings may have underestimated the number of providers who continued participating in State Medicaid programs after their terminations for cause from Medicaid programs in other States and the associated Medicaid payments to these providers. In some instances, records on terminated providers did not contain sufficient information for us to make a definitive match. For example, if a State submitted a terminated provider record with an SSN but not an NPI, and the same provider participated in Medicaid in another State that submitted neither SSN nor NPI, our comparison would not identify the provider. Additionally, the records that were sent for 145 terminated providers did not contain any data elements needed to determine whether the providers were participating in other States. Further, we may have underestimated the amount of Medicaid payments made to managed care providers, because we did not collect payment data directly from Medicaid managed care entities and some States did not report this information.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General in Integrity and Efficiency.

FINDINGS

Twelve percent of providers who were reported as terminated for cause from State Medicaid programs continued participating in Medicaid in other States

State agencies reported that 295 of the 2,539 providers (12 percent) were participating in their Medicaid programs as of January 1, 2012, after the same provider was terminated for cause from another State Medicaid program.[20] Further, 172 of the 295 providers continued their participation in Medicaid as late as January 2014, more than 2 years after they were terminated for cause from another State program. (See Appendix C for the number of providers who were terminated for cause in 2011 and were still participating in Medicaid in 2012, by State and by provider type.) The continued participation of these providers after their terminations for cause from other State programs presents a vulnerability to Medicaid.

State Medicaid programs paid approximately $7.4 million to providers for services performed after the providers had each been terminated for cause in 2011 by another State Medicaid program

Ninety-four of the two hundred ninety-five providers received total Medicaid payments of $7,410,568 for services performed after the providers had been terminated for cause in 2011 by other States. Fifteen of these providers each received payments totaling $100,000 or more. Medicaid paid one provider just over $1 million for services performed after the provider's termination for cause. (See Appendix D for payments to terminated providers by State and provider type.)

State agencies reported that they did not make any Medicaid payments to the remaining 201 of the 295 providers.[21] Nonetheless, it remains concerning that these providers continued as participating providers who could treat Medicaid beneficiaries.

[20] The remaining 2,244 providers were not reported as participating in Medicaid in any States as of January 1, 2012.

[21] Among the 201 providers with no reported payments after their terminations for cause, 125 were participating in Medicaid through managed care. Thus, it is possible these providers were paid by the Medicaid managed care organization, rather than by the State agency. As we have noted, we did not collect payment data directly from Medicaid managed care entities and some States did not report this information to us.

State Medicaid agencies faced challenges in ensuring that providers terminated for cause from Medicaid in other States did not continue participating in Medicaid in their own States

We identified significant challenges that can hamper a State Medicaid agency's ability to implement the requirement in section 6501 of the ACA to terminate the Medicaid participation of providers who were terminated for cause by other State Medicaid programs.

State Medicaid agencies face challenges getting information about providers terminated for cause by other State agencies. These challenges consist of (1) not having a comprehensive data source for identifying all terminations for cause and (2) differentiating terminations for cause from other administrative terminations in the data sources that are available.

State Medicaid agencies also face challenges terminating providers once they learn of a provider's termination for cause by another State agency. These challenges consist of (1) the inability to terminate providers who are participating in Medicaid managed care but are not enrolled by the State Medicaid program and (2) a misunderstanding that if a provider has an active license from the relevant State licensing board, then the State Medicaid agency should defer to the judgment of the State licensing board and not terminate the provider for cause.

The lack of a comprehensive centralized data source that identifies providers terminated for cause create challenges for State agencies seeking to learn about such providers

Despite the existence of several potential data sources, to date there has been no single source that is comprehensive enough to allow States to identify all the fee-for-service and Medicaid managed care providers enrolled in State Medicaid programs whose terminations for cause warrant action pursuant to section 6501 of the ACA. Most of the available data sources are designed for purposes other than identifying providers terminated for cause, and therefore do not attempt to identify all such providers. Although the CMS Termination Notification database is designed for this purpose, States' participation is encouraged, rather than required.

State agencies reported using several strategies to learn about terminated providers. One common strategy is to examine existing Federal data sources to identify such providers. (See Appendix E for data sources that State Medicaid agencies reported using to learn about terminated providers.) Other strategies that State agencies reported using involved their checking State Websites and State licensing board rosters, directly

contacting other State Medicaid agencies, and receiving alerts from other entities about providers terminated for cause. The drawback to these strategies, according to State agencies, is that they can be arduous, time consuming, and inconclusive as to whether a State agency learns about *all* Medicaid providers terminated for cause by other States or only a portion of such providers.

Lack of uniform terminology in existing data sources regarding the reasons for provider terminations can create challenges in differentiating provider termination status

The lack of uniform terminology concerning termination reasons in existing information sources—such as Federal and State databases and Web sites—can create challenges for State agencies in identifying terminations for cause by other States. State agencies use a variety of terms to describe reasons for provider terminations. Table 1 lists examples of termination reasons that State agencies submitted to OIG about providers terminated for cause in 2011. As indicated in Table 1, most of the termination reasons reference the *action* taken by the State agency (i.e., debarment, exclusion, revocation), rather than the *reason* for the termination (i.e., credentialing violation, policy violation, criminal conviction). (See Appendix F for the types of termination reasons that State Medicaid agencies submitted to OIG.)

Table 1: State Medicaid Agencies Used Many Different Terms to Describe Reasons for Terminations

Termination Reasons		
• Banned	• Disciplinary action	• Revocation
• Canceled	• Exclusion	• Sanction
• Conviction	• Indictment	• Suspension
• Credentialing violation	• Licensure modification	• Termination
• Debarment		

Source: OIG analysis of Medicaid termination data (2011).

In their databases, some State agencies applied the same reason code to terminations for cause as they did to terminations for administrative reasons. The latter category includes actions such as removing a provider from participation in Medicaid because of the provider's billing inactivity or an inactive license. Because some State agencies do not distinguish in their reporting between terminations for cause and terminations for administrative reasons, there is a risk that those agencies could report inaccurate information (both to CMS and to other States) about terminations of providers. In turn, this could make other State Medicaid agencies reluctant to terminate a provider that such a State reports as terminated for cause.

State Medicaid agencies that do not enroll all providers can face challenges in identifying their managed care providers and terminating Medicaid participation

Of the 41 States that used managed care in 2012 to deliver Medicaid services, 25 States did not require providers who were participating in Medicaid managed care to be directly enrolled with their State Medicaid agencies.[22,23] Of the 295 providers who were reported by States as terminated for cause but who continued to participate—or began participating—in other States, 91 were not directly enrolled in the Medicaid programs of the States where they continued or began participating. Rather, they were participating in Medicaid in those States via contracts with managed care entities. (See Appendix G for more information on State Medicaid agency enrollment of Medicaid managed care providers.)

When States do not require providers who participate in Medicaid managed care to enroll directly in their Medicaid programs, two problems result. First, some of these States do not maintain rosters of all providers who participate in their Medicaid managed care plans. Without such a roster, a State Medicaid agency would have trouble determining whether a provider who was terminated for cause by another State was participating in its own State Medicaid program via one or more managed care plans. Second, even if a State Medicaid agency determined that such a provider *was* participating in one or more of its Medicaid managed care plans, it may have limited authority to terminate that provider's participation in Medicaid. If a provider is not in a legal relationship with (i.e., enrolled in) a State Medicaid program—as with the previously mentioned 91 providers who were not directly enrolled by State Medicaid programs—the State may have limited authority to terminate the provider's participation in any of the State's Medicaid managed care plans. Therefore, such a provider could continue to participate in Medicaid and treat Medicaid patients, despite having been terminated for cause from Medicare or from another State's Medicaid or CHIP programs.

The other 16 States that used Medicaid managed care required all participating providers—both those in managed care plans and those participating on a fee-for-service basis—to enroll with the State agency.[24]

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[22] The remaining 11 States did not use managed care for their Medicaid programs as of June 1, 2012.

[23] Memo to the OIG from the CMS Division of Field Operations/Medicaid Integrity Group. The memo provided information on 52 States, including the District of Columbia and Puerto Rico. June 4, 2012.

[24] Ibid.

Therefore, these State agencies could use the same processes to terminate participation in Medicaid both for managed care providers and fee-for-service providers.

The active status of a provider's professional license can cause misunderstanding for some State Medicaid agency staff

Some State Medicaid agency staff appeared to misunderstand the significance of a provider's State-issued professional license in making their decisions about whether to terminate a provider under section 6501 of the ACA. When asked about providers whom we identified as having continued in Medicaid after they were reported as terminated for cause from another State program, staff from 11 States noted that 1 or more of those providers had active medical licenses in their States. During followup discussions, some of these staff members expressed a belief that if a State licensing board permitted a provider to have an active license to practice in the State, they should defer to the judgment of the licensing board and not terminate the provider from Medicaid. However, under section 6501 of the ACA, termination is not contingent on a provider's licensure status. Although a State board may continue to grant a license to a provider, the State agency is nonetheless required to terminate the provider's Medicaid participation based on the provider's termination for cause from Medicare or from another State's Medicaid or CHIP program.

CONCLUSION AND RECOMMENDATIONS

Section 6501 of the ACA added an important program integrity provision to help ensure that providers who are found to warrant terminations for cause from Medicare, State Medicaid, or CHIP programs do not continue treating Medicaid beneficiaries and receiving Medicaid payments in other States. However, we found that 12 percent of providers who were terminated for cause from State Medicaid programs in 2011 continued participating in Medicaid in other States. About half of these providers remained listed as participating in Medicaid as late as January 2014, and about one-third received payments for services provided to Medicaid beneficiaries after the providers' terminations for cause.

We found that State Medicaid agencies faced challenges in getting information about providers terminated by other States. Further, State Medicaid agencies faced challenges terminating providers once they learned of the provider's termination for cause by other State agencies.

In March 2014, OIG recommended that CMS require State Medicaid agencies to report all terminations for cause (rather than continuing with the prior voluntary-reporting approach) and that CMS improve the accuracy and completeness of termination records.[25] In response to our recommendation, CMS implemented procedures intended to improve the completeness of the records. Nevertheless, we reiterate our prior recommendation for CMS to require reporting of all terminations for cause, as we found that the lack of a comprehensive data source of providers terminated for cause creates a challenge for State Medicaid agencies.

To address the remaining issues identified in this report, we recommend that CMS:

Work with States to develop uniform terminology to clearly denote terminations for cause

States' efforts to comply with the requirements of section 6501 of the ACA can be hampered by the lack of uniform terminology across States for denoting a termination for cause. CMS should work with State Medicaid agencies to develop uniform terminology denoting such terminations for cause that could be applicable across all States and all sources of data on terminated providers. This would allow States to more easily differentiate between reasons that constitute a termination for cause under section 6501 of the ACA—where the provider has exhausted all appeal rights, and there

[25] OIG, *CMS's Process for Sharing Information About Terminated Providers Needs Improvement*, OEI-06-12-00031, March 2014.

is no expectation that the termination is temporary—and terminations for other reasons, such as administrative reasons.

Require that State Medicaid programs enroll all providers participating in Medicaid managed care

The lack of a legal relationship with the State Medicaid program exempts a large number of providers who participate through managed care in the 25 States that do not directly enroll these providers. Requiring State Medicaid programs to enroll Medicaid managed care providers would ensure that State agencies can identify all providers who deliver care to Medicaid beneficiaries. Moreover, enrollment would give State agencies a mechanism for terminating a provider's participation in Medicaid when the provider was previously terminated for cause from another program for reasons of fraud, integrity, or quality.

Furnish guidance to State Medicaid agencies that termination is not contingent on the provider's active licensure status

Some State Medicaid agencies need clarification regarding providers who were terminated for cause from another program yet continue to have an active license to practice in their States. CMS should provide guidance regarding how State agencies should handle these situations. The guidance should clarify that the termination of a provider's participation from Medicaid, when required under section 6501 of the ACA, is not contingent on the provider's licensure status, but instead required as a result of the prior termination for cause from Medicare or from other State Medicaid or CHIP programs.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with our recommendations and stated that it is committed to improving program integrity efforts in the Medicaid program. CMS also stated that it has taken a number of steps to improve States' ability to address the concerns identified in this report.

Our first recommendation reiterated a prior recommendation that CMS require reporting for all terminations for cause, as we found that the lack of a comprehensive data source of providers terminated for cause creates a challenge for State Medicaid agencies. Although CMS described steps it had taken to improve the process of sharing information regarding terminated providers, it did not indicate that it planned to require State reporting of terminations. Unless CMS requires such reporting, we believe that a centralized data source will not be comprehensive.

In response to our second recommendation—that CMS work with States to develop uniform terminology to clearly denote terminations for cause—CMS stated that it now reviews Medicaid termination letters prior to entering the information into the Termination Notification database. If CMS finds that the State has terminated the provider for cause, that information is entered into the database.

In response to our third recommendation—that CMS require that State Medicaid programs enroll all providers participating in Medicaid managed care—CMS described the Notice of Proposed Rulemaking published in June 2015 which, if finalized, will require State Medicaid programs to enroll these providers.

In response to our fourth recommendation—that CMS furnish guidance to State Medicaid agencies that termination is not contingent upon the provider's active licensure status—CMS stated that it will work with States and educate them on its policies for terminating providers who have been terminated for cause, yet continue to have an active license to practice in their respective State.

We support CMS's efforts to improve program integrity in the Medicaid program. For the full text of CMS's response, see Appendix H.

APPENDIX A: DETAILED METHODOLOGY

Data Collection and Analysis

State Medicaid Programs' Data on Individual Providers. We obtained from each State Medicaid agency its data on all individual providers who were participating in the program as of January 1, 2012, on a fee-for-service basis and/or as part of a Medicaid managed care plan. We requested the following information:

- Provider name
- Medicaid provider identification number
- Provider type
- Provider specialty
- NPI
- SSN
- Tax identification number
- Legacy provider identification numbers
- State license or certification numbers
- Date of birth
- Practice address(es)
- Billing address(es)

We followed up with State agencies when we noticed anomalies or inconsistencies in the submitted data. As a result, some agencies provided explanations to help ensure that we interpreted their data appropriately and some agencies resubmitted data in response to our inquiries. Some agencies also had to request additional data from their Medicaid managed care plans.

State Medicaid Programs' Data on Terminated Providers. From each of the State Medicaid agencies, we requested data on individual providers who were terminated for cause from their programs during 2011. These data included the same variables contained in the data on individual participating providers, with the addition of the Medicaid termination date and reason for termination.

Combined, 56 States submitted data for a total of 2,684 unique providers terminated for cause during 2011.[26] We followed up with State agencies when we noticed anomalies or inconsistencies in the submitted data on terminated providers, and we removed from the analysis 145 providers' records that were missing critical identifying information. The report findings are based on our review of 2,539 unique individual providers who were terminated for cause from 46 State Medicaid programs during 2011.[27]

[26] Among the 56 States, 10 reported that no Medicaid providers were terminated "for cause" in 2011. These States were Alabama, Alaska, American Samoa, Delaware, Guam, Idaho, Northern Mariana Islands, South Carolina, South Dakota, and the Virgin Islands.

[27] Twenty-nine providers were reported as terminated by more than one entity or by more than one State.

We used CMS's National Plan and Provider Enumeration System (NPPES) and the Medicare Exclusion Database (MED) as tools to supplement information submitted by the States. Using these data sources allowed us to confirm providers' identification information in cases where State program data did not include an NPI or SSN. For example, if a State submitted a physician's SSN but did not include the physician's NPI, we compared the physician's SSN to NPPES and MED to determine and verify the physician's NPI, when possible.

Comparing Terminated Provider Data to Participating Provider Data. To identify any providers who continued participating in Medicaid after their terminations for cause, we compared the submitted rosters of Medicaid providers terminated for cause during 2011 to the submitted rosters of providers participating in each other States' Medicaid program as of January 1, 2012. We determined the number of these providers and calculated their percentage among all providers terminated for cause from Medicaid during 2011. We also followed up with State Medicaid agencies an additional 2 years later—in January 2014—to determine whether and when each provider's participation from Medicaid ended, and the amount, if any, that Medicaid paid these providers for services performed after their respective termination dates. We calculated the frequency and percentage of terminated providers who were still participating in any State Medicaid program as of January 2014.

State Medicaid Payments Data. For each provider who continued participating in Medicaid after being terminated for cause, we obtained Medicaid payment data from the associated State Medicaid agency. Agencies reported data that reflected amounts paid to terminated providers for services performed after the termination date through January 2014. Using Medicaid payment data submitted by the States, we determined which providers terminated for cause were paid for services performed after their 2011 terminations, and we calculated the amounts paid.

Data on Implementation Challenges. To gather information about challenges that State Medicaid agencies encountered in implementing the ACA requirement, we used three primary sources: the State Medicaid agency staff, with whom we discussed our data requests and followed up regarding specific providers; agency responses in the data submitted to OIG; and the responses to questionnaires sent to State Medicaid agencies. These efforts allowed us to gain an understanding of challenges faced by State agencies. In responses to our questionnaire, which we received from April to July 2013, State Medicaid agencies reported the data sources that they used to learn about providers terminated for cause from other programs.

APPENDIX B: PROVIDERS REPORTED BY STATE MEDICAID AGENCIES AS TERMINATED FOR CAUSE

Table B-1: Number of Providers Reported as Terminated For Cause in 2011 from State Medicaid Programs by State

State	Number of Providers*
New York	609
New Mexico	431
Oregon	256
Tennessee	197
Ohio	138
Illinois	116
Pennsylvania	99
Arkansas	79
Georgia	64
Texas	56
Kentucky	48
Florida	47
Louisiana	42
New Jersey	41
Massachusetts	37
California	37
Washington	25
Maryland	24
Oklahoma	19
Nebraska	18
Iowa	16
Arizona	15
Utah	15
Michigan	14
Wisconsin	14
Wyoming	12
Minnesota	10
Missouri	10
North Carolina	9
North Dakota	9

Source: OIG analysis of Medicaid termination data (2011) submitted by State Medicaid agencies.
*Some providers were reported terminated by more than one State.

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APPENDIX B

Table B-1: Number of Providers Reported as Terminated For Cause in 2011 from State Medicaid Programs by State (Continued)

State	Number of Providers *
New Hampshire	8
West Virginia	8
Colorado	7
Kansas	6
Mississippi	6
Nevada	6
Hawaii	4
Rhode Island	4
Maine	3
Virginia	3
Connecticut	2
Indiana	2
Puerto Rico	2
District of Columbia	1
Montana	1
Vermont	1
Alabama	0
Alaska	0
American Samoa	0
Delaware	0
Guam	0
Idaho	0
Northern Mariana Islands	0
South Carolina	0
South Dakota	0
Virgin Islands	0
Total	**2,571**
Total unique providers terminated	**2,539**

Source: OIG analysis of Medicaid termination data (2011) submitted by State Medicaid agencies.
*Some providers were reported terminated by more than one State Medicaid program.

APPENDIX B

Table B-2: Number and Percentage of Providers Reported as Terminated For Cause in 2011 from State Medicaid Programs, by Provider Type

Provider Type	Number of Providers	Percentage (n = 2,539)*
Physician**	819	32%
Personal Care Attendant	463	18%
Mental Health Provider (e.g., Psychologist, Counselor, Social Worker, Behavioral Health Worker)	422	17%
Nurse	200	8%
Dentist	143	6%
Nonphysician Practitioner (e.g., Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Certified Nurse Midwife)	96	4%
Therapist (e.g., Physical, Occupational, Speech and Language, Respiratory)	51	2%
Business Owner	50	2%
Chiropractor	48	2%
Podiatrist	44	2%
Business Employee	43	2%
Nurse's Aide	40	2%
Pharmacist	40	2%
Unknown	28	1%
Business Employee/Manager	17	<1%
Ophthalmologist	9	<1%
Massage Therapist	8	<1%
Hearing Service Provider (e.g., Audiologist)	7	<1%
Acupuncturist	6	<1%
Medicaid Beneficiary (Who Billed for Care That He/She Provided Family Members)	3	<1%
Eye and Vision Service Provider (e.g., Optometrist)	2	<1%
Total	**2,539**	**100%**

Source: OIG analysis of Medicaid termination data (2011) submitted by State Medicaid agencies.
*Percentages do not sum to 100% due to rounding.

APPENDIX C: PROVIDERS REPORTED BY STATE MEDICAID AGENCIES AS TERMINATED FOR CAUSE AND STILL PARTICIPATING IN OTHER STATES

Table C-1: Number of Providers Reported as Terminated for Cause in 2011 and Participating in Medicaid as of January 1, 2012, by State

State	Number of Participating Providers Terminated by Other States*
New Mexico	33
Massachusetts	30
South Carolina	26
Texas	26
Washington	21
California	20
Alabama	12
Kentucky	12
Arizona	11
Florida	10
Ohio	10
Virginia	10
Colorado	9
Indiana	9
Mississippi	9
New York	9
Georgia	8
Idaho	8
Nebraska	8
New Hampshire	8
Tennessee	8
West Virginia	8
Illinois	7
Maine	7
Maryland	7
Delaware	6
Kansas	6
Minnesota	6
Missouri	6
North Carolina	6

Source: OIG analysis of Medicaid termination data (2011) and participating provider data (January 1, 2012) submitted by State Medicaid agencies.
*Some providers were reported as participating by more than one State.

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APPENDIX C

Table C-1: Number of Providers Reported as Terminated for Cause in 2011 and Participating in Medicaid as of January 1, 2012, by State (Continued)

State	Number of Participating Providers Terminated by Other States*
Oklahoma	6
Oregon	6
Utah	6
Arkansas	5
Iowa	5
Michigan	5
Pennsylvania	5
Wisconsin	5
Louisiana	4
Wyoming	4
Hawaii	3
Montana	3
Nevada	3
Rhode Island	3
Connecticut	2
District of Columbia	1
New Jersey	1
Alaska	0
American Samoa	0
Guam	0
North Dakota	0
Northern Mariana Islands	0
Puerto Rico	0
South Dakota	0
Vermont	0
Virgin Islands	0
Total	**295**

Source: OIG analysis of Medicaid termination data (2011) and participating provider data (January 1, 2012) submitted by State Medicaid agencies.
*Some providers were reported as participating in more than one State Medicaid program.

APPENDIX C

Table C-2: Number and Percentage of Providers Reported as Terminated for Cause in 2011 and Participating in Medicaid in Other States as of January 1, 2012, by Provider Type

Provider Type	Number of Providers	Percentage (n = 295)*
Physician**	222	75%
Mental Health Provider (e.g., Psychologist, Counselor, Social Worker, Behavioral Health Worker)	33	11%
Dentist	16	5%
Nonphysician Practitioner (e.g., Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Certified Nurse Midwife)	10	3%
Ophthalmologist	3	1%
Podiatrist	3	1%
Therapist (e.g., Physical, Occupational, Speech and Language, Respiratory)	3	1%
Hearing Service Provider (e.g., Audiologist)	2	<1%
Acupuncturist	1	<1%
Nurse's Aide	1	<1%
Personal Care Attendant	1	<1%
Total	**295**	**100%**

Source: OIG analysis of Medicaid termination data (2011) and participating provider data (January 1, 2012), submitted by State Medicaid agencies.
*Percentages do not sum to 100% due to rounding.
**States were more likely to submit an NPI or SSN for the physicians in our sample than for other health care providers. Because our provider comparison was heavily dependent on the matching of NPIs and SSNs, this may account for the greater number of physicians identified.

APPENDIX D: PAYMENTS TO PROVIDERS REPORTED AS TERMINATED FOR CAUSE

Table D-1: State Medicaid Program Payments for Services Delivered by Terminated Providers After Dates of Terminations For Cause, by State

State	Number of Providers Paid*	Total Payments
California	7	$1,691,573
Mississippi	4	$1,204,999
Wyoming	4	$919,087
Idaho	6	$821,219
Kansas	2	$807,828
Arkansas	2	$397,887
Connecticut	2	$316,847
Florida	4	$292,644
Kentucky	9	$193,680
Maine	4	$175,207
Tennessee	3	$145,200
Oklahoma	2	$119,484
Utah	4	$62,536
Wisconsin	5	$61,272
Illinois	6	$43,852
Ohio	1	$40,906
South Carolina	16	$32,849
West Virginia	3	$24,186
Missouri	3	$18,782
Hawaii	2	$13,043
Georgia	2	$8,274
New Jersey	1	$7,309
Pennsylvania	2	$5,402
Iowa	1	$2,021
Nebraska	1	$1,621
Virginia	2	$1,304
Alabama	1	$695
Delaware	1	$381
North Carolina	1	$301
Minnesota	1	$82
Massachusetts	1	$45
Michigan	1	$39
New York	1	$11
Total Unique Providers	**94**	**$7,410,568**

Source: OIG analysis of Medicaid termination data (2011), participating provider data (January 1, 2012), and payment data (as of January 2014) submitted by State Medicaid agencies.
*Some providers were paid by more than one State.

APPENDIX D

Table D-2: Number and Percentage of Providers Reported as Terminated for Cause in 2011 and Paid for Services Delivered after Termination Date, by Provider Type

Provider Type	Number of Providers	Percent (n = 94)*
Physician**	78	83%
Dentist	6	6%
Nonphysician Practitioner (e.g., Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Certified Nurse Midwife)	4	4%
Mental Health Provider (e.g., Psychologist, Counselor, Social Worker, Behavioral Health Worker)	4	4%
Ophthalmologist	1	1%
Therapist (e.g., Physical, Occupational, Speech and Language, Respiratory)	1	1%
Total	**94**	**100%**

Source: OIG analysis of Medicaid termination data (2011), participating provider data (January 1, 2012), and payment data (as of January 2014) submitted by State Medicaid agencies.
*Percentages do not sum to 100% due to rounding.
**States were more likely to submit an NPI or SSN for the physicians in our sample than for other health care providers. Because our provider comparison was heavily dependent on the matching of NPIs and SSNs, this may account for the greater number of physicians identified.

APPENDIX E: DATA SOURCES USED BY STATE MEDICAID AGENCIES

Table E-1: Data Sources State Medicaid Agencies Reported Using to Learn About Terminated Providers

Data System	Information Provided	Entities with Access
CMS Termination Notification Database (formerly MCSIS)[1]	Providers terminated for cause from the Medicare, Medicaid, and CHIP programs	State Medicaid agencies and CMS staff
Fraud Investigation Database[2]	Fraudulent activity and payment suspensions related to Medicare and Medicaid providers	State Medicaid agencies and CMS staff; Medicare contractors; law enforcement agencies
General Services Agency (GSA) System for Award Management[3]	Individuals and entities barred from receiving Federal contracts, certain subcontracts, and certain types of Federal financial and nonfinancial assistance and benefits	State Medicaid agencies and CMS staff and contractors; general public; grant officials
Medicare Exclusion Database[4]	All the OIG exclusion data that is updated monthly—the data are used to deny claims submitted from excluded providers	State Medicaid agencies and CMS staff and contractors; other approved entities
OIG List of Excluded Individuals and Entities[5, 6]	Information on providers excluded by OIG from participation in a Federal or State health care program	State Medicaid agencies and CMS staff and contractors; general public
Provider Enrollment, Chain and Ownership System[7]	Medicare final adverse actions (e.g., revocation of billing privileges; licensure suspension or revocation; exclusion or debarment from participation in a Federal or State healthcare program)	State Medicaid agencies and CMS staff and contractors; providers; suppliers; other authorized users

Sources:

[1] CMS, CPI-B 11-05, *ACA Program Integrity Provisions—Guidance to States—Section 6501—Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan,* May 31, 2011.

[2] CMS, Fraud Investigation Database: Overview, January 15, 2013. Accessed at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/FID-2/Overview.html on May 7, 2014.

[3] GSA, *System for Award Management User Guide.* Accessed at https://www.sam.gov/sam/transcript/System_for_Award_Management_v2.8.pdf on May 7, 2014.

[4] CMS, *Medicare Exclusion Database (MED) FAQs*. Accessed at http://www.eushelpdesk.com/IACS/med.html on May 7, 2014.

[5] CMS, CPI-B 11-05, *ACA Program Integrity Provisions—Guidance to States—Section 6501—Termination of Provider Participation Under Medicaid if Terminated Under Medicare or Other State Plan,* May 31, 2011.

[6] OIG, *List of Excluded Individuals and Entities*. Accessed at www.oig.hhs.gov on May 7, 2014.

[7] CMS, *The Basics of Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners*, ICN 903764, May 2013. Accessed at www.cms.gov on May 7, 2014. *National Provider Call: Streamlined Access to PECOS, EHR, and NPPES*, November 15, 2013. Accessed at http://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/NPC-PECOS-11-15-13-Transcript.pdf on July 21, 2014.

APPENDIX F: REASONS FOR TERMINATIONS FOR CAUSE

State Medicaid agencies provided termination reasons, which we then collapsed into categories based upon additional descriptive information included in the State agency's data submission.

Table F-1: Termination Reasons Submitted by State Medicaid Agencies

Termination Reason	Number of Providers*	Percentage (n = 2,570)**
Reason listed simply as "termination"	1,021	40%
State regulation cited	611	24%
License suspension, revocation, surrender, or other State action	329	13%
Federal exclusion	129	5%
Criminal charges, indictment, or conviction	100	4%
Suspension	80	3%
Sanction	69	3%
State exclusion	60	2%
Reasons related to fraud, quality, or integrity	58	2%
Termination by CMS	35	1%
Policy violation	20	1%
Other	16	1%
Credential related	15	1%
OIG and State exclusion	12	<1%
Unknown	9	<1%
Failure to disclose required information or criminal charges	7	<1%
Termination by Medicaid managed care plan due to improper billing concerns	5	<1%
OIG or CMS sanction	2	<1%
Total	**2,576**	**100%**

Source: OIG analysis of Medicaid termination data (2011) submitted by State Medicaid agencies.
*Some providers were reported as terminated by more than one State or by both the State Medicaid agency and Medicaid managed care organizations within the same State.
**Percentages do not sum to 100% due to rounding.

APPENDIX G: STATE MEDICAID AGENCY ENROLLMENT OF MEDICAID MANAGED CARE PROVIDERS

Table G-1: State Agencies That Enroll Medicaid Managed Care Providers In the Same Manner as Fee-For Service Medicaid Providers, June 2012

State	Yes	No	Did Not Use Medicaid Managed Care
Alabama	✓		
Alaska			✓
Arizona	✓		
Arkansas			✓
California		✓	
Colorado		✓	
Connecticut		✓	
Delaware		✓	
District of Columbia		✓	
Florida		✓	
Georgia	✓		
Hawaii		✓	
Idaho			✓
Illinois	✓		
Indiana	✓		
Iowa	✓		
Kansas		✓	
Kentucky	✓		
Louisiana			✓
Maine			✓
Maryland		✓	
Massachusetts		✓	
Michigan		✓	
Minnesota		✓	
Mississippi	✓		
Missouri		✓	
Montana			✓
Nebraska	✓		
Nevada	✓		

Source: Memo to OIG from the CMS Division of Field Operations/Medicaid Integrity Group, June 4, 2012

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APPENDIX G

Table G-1: State Agencies That Enroll Medicaid Managed Care Providers the Same as Fee-For Service Medicaid Providers, June 2012 (continued)

State	Yes	No	Did Not Use Medicaid Managed Care
New Hampshire			✓
New Jersey	✓		
New Mexico		✓	
New York		✓	
North Carolina		✓	
North Dakota			✓
Ohio		✓	
Oklahoma			✓
Oregon		✓	
Pennsylvania	✓		
Puerto Rico		✓	
Rhode Island		✓	
South Carolina		✓	
South Dakota			✓
Tennessee	✓		
Texas	✓		
Utah		✓	
Vermont	✓		
Virginia		✓	
Washington		✓	
West Virginia		✓	
Wisconsin	✓		
Wyoming			✓
Total	**16**	**25**	**11**

Source: Memo to OIG from the CMS Division of Field Operations/Medicaid Integrity Group, June 4, 2012

APPENDIX H: AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: JUN 19 2015

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Providers Terminated from One State Medicaid Program Continued Participating in Other States" (OEI-06-12-00030)

The Centers for Medicare and Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to improving program integrity efforts in the Medicaid program.

While OIG has analyzed data from 2011, CMS has since taken a number of steps to enhance states' ability to terminate potentially fraudulent providers and address the concerns identified in this report. In February 2011, CMS issued regulations under which states must implement categorical risk-based screening of newly enrolling Medicaid providers and revalidate all current Medicaid providers under new requirements established by the Affordable Care Act. Providers are assigned to categorical screening levels based on factors such as the type of service provided and history of previous adverse actions.

These regulations also require state Medicaid agencies to deny or terminate the enrollment of any provider that has been terminated for cause under Medicare or another state's Medicaid program or CHIP after January 1, 2011. In order to assist states with this requirement, CMS provided states with tools to view information on Medicare providers and suppliers in a denied or revoked status and to share information about Medicaid providers terminated from Medicaid programs in other states. In 2014, this process was further improved through the implementation of a new Medicaid termination system. Under this new process, states submit information to CMS regarding provider terminations, including a copy of the Medicaid termination letter issued to the provider as well as critical data fields, such as the National Provider Identifier. CMS reviews submitted termination letters to verify that the termination was for cause and then enters those that are for cause into the termination notification database. State Medicaid programs can access this repository of all state-submitted Medicaid provider terminations and Medicare provider revocations. This allows states to access current provider termination information and assists them in terminating potentially fraudulent Medicaid providers more quickly.

CMS has also taken steps to make sure Medicaid managed care providers are directly enrolled in Medicaid. Since 2011, CMS has periodically published guidance to states that identifies as a best practice requiring all managed care network providers to be enrolled in Medicaid in the same

manner as fee-for-service providers. In June 2015, CMS published a Notice of Proposed Rulemaking that, if finalized, will require that state Medicaid programs enroll providers participating in Medicaid managed care. The proposed rule provides that state Medicaid agencies apply the same risk-based screening standards and procedures that they currently apply to providers in fee-for-service Medicaid to providers in the networks of managed care plans. In addition, the proposed rule, if finalized, would require managed care plans to implement procedures to detect and prevent fraud, and to promptly refer any cases of potential fraud, waste, or abuse that the plan identifies to the state Medicaid program integrity unit or directly to the state Medicaid Fraud Control Unit.

OIG Recommendation
Work with states to develop uniform terminology to clearly denote for cause terminations.

CMS Response
CMS concurs with OIG's recommendation. Under the Termination Notification process, CMS reviews Medicaid termination letters submitted by states to verify that the termination was for cause. If the provider was found to be terminated for cause, CMS enters those that are for cause into the Termination Notification database which can then be accessed by state Medicaid agencies.

OIG Recommendation
Require that state Medicaid programs enroll all providers participating in Medicaid managed care.

CMS Response
CMS concurs with OIG's recommendation. In June 2015, CMS published a Notice of Proposed Rulemaking that, if finalized, will require that state Medicaid programs enroll providers participating in Medicaid managed care. The proposed rule provides that state Medicaid agencies apply the same risk-based screening standards and procedures that they currently apply to providers in fee-for-service Medicaid to providers in the networks of managed care plans.

OIG Recommendation
Furnish guidance to state Medicaid agencies that termination is not contingent upon the provider's active licensure status.

CMS Response
CMS concurs with OIG's recommendation. CMS will work with states to educate them on CMS policies for terminating providers that have been terminated for cause from Medicare or state Medicaid programs yet continue to have an active license to practice in their respective state.

CMS thanks OIG for its efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Kevin Golladay, Regional Inspector General for Evaluation and Inspections in the Dallas regional office, Blaine Collins, Deputy Regional Inspector General, and Ruth Ann Dorrill, Deputy Regional Inspector General.

Deborah Cosimo served as the team leader for this study. Other Office of Evaluation and Inspections staff from the Dallas regional office who conducted the study include Nathan Dong and Malinda Hicks. Office of Evaluation and Inspections staff who provided support include Janna Sayer from the Atlanta regional office and Vincent Greiber from the New York regional office. Central office staff who provided support include Clarence Arnold, Eddie Baker, Kevin Manley, and Christine Moritz. Office of Management and Policy staff who contributed to this report include Jessica Swanstrom.

Office of Inspector General

http://oig.hhs.gov

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