Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EXCLUDED PROVIDERS IN MEDICAID MANAGED CARE ENTITIES

Daniel R. Levinson
Inspector General

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Executive Summary: Excluded Providers in Medicaid Managed Care Entities
OEI-07-09-00630

WHY WE DID THIS STUDY

The Office of Inspector General (OIG) is authorized to exclude certain individuals and entities (providers) from participating in federally funded health care programs. These programs, such as Medicaid managed care, are prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider or paying anyone who contracts with an excluded provider. Nationally, approximately 70 percent of Medicaid recipients receive some or all of their Medicaid services through managed care. However, little was known about how Medicaid managed care entities (MCE) prevent excluded providers from entering their provider networks, or how successful MCEs are in preventing excluded providers from entering their provider networks.

HOW WE DID THIS STUDY

For 12 selected MCEs in 10 States, we matched OIG exclusions data, including approximately 46,000 providers, and MCE provider network data, including approximately 277,000 providers, to identify excluded providers. We also interviewed MCE and State Medicaid staff, and we reviewed contracts between MCEs and States to identify their safeguards to prevent excluded providers from enrolling in Medicaid. Finally, we asked each MCE to provide information on payments made to each excluded provider identified.

WHAT WE FOUND

Four of the twelve MCEs reviewed had 11 excluded providers enrolled in their provider networks in 2009. Four of these providers were paid a total of $40,306 in 2009; the remaining seven providers received no payments during our review. In 2009, approximately 46,000 individuals and entities were listed on OIG's exclusion list. All 12 MCEs and all 10 States reviewed had safeguards to identify excluded providers. Eleven of the twelve selected MCEs checked OIG's List of Excluded Individuals and Entities to identify excluded providers. MCEs checked providers' exclusion statuses at initial enrollment and rechecked them at varying frequencies ranging from monthly to every 3 years. Six of the ten States required providers enrolled in MCE networks to first enroll in the State fee-for-service Medicaid program. Two other States had databases that combined several sources of exclusion information available to their MCEs. In the two remaining States, each provider was required to undergo an extensive background check as part of the provider enrollment process.

WHAT WE RECOMMEND

We recognize that the number of excluded providers that we identified is small. CMS cited the small number of providers identified as its reason for not concurring with the recommendation made in the draft report. We updated the final report, recommending that CMS periodically remind States of their obligation to ensure that no excluded providers receive Medicaid payments. CMS could develop a State Medicaid Director letter that includes information from this report on how certain failures led to the inclusion of excluded providers in MCE provider networks.

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OBJECTIVES

To determine the extent to which:

1. selected Medicaid managed care entities (MCEs) enrolled Office of Inspector General (OIG)-excluded individuals and entities in their provider networks in 2009; and
2. selected Medicaid MCEs and States have safeguards in place to prevent excluded individuals and entities from enrolling in their Medicaid managed care provider networks.

BACKGROUND

Medicaid Managed Care

Nationally, approximately 70 percent of Medicaid recipients receive some or all of their Medicaid services through managed care. Capitated managed care is the most common arrangement for Medicaid managed care. Unlike claims for services paid on a fee-for-service basis—in which State Medicaid programs pay providers for each service rendered—in capitated managed care, State Medicaid programs pay MCEs a fixed rate per enrolled Medicaid beneficiary in exchange for all services included in the plan.

Office of Inspector General Exclusions

To protect patients and the integrity of federally funded health care programs such as Medicaid managed care, OIG is authorized to exclude certain individuals and entities (e.g., physician group practices, transportation companies, hospitals) from participating in such programs.[1] The bases for exclusions commonly include convictions for program-related fraud and patient abuse, and actions by licensing boards (e.g., suspension or revocation of a medical license). When OIG excludes individuals or entities (providers), it notifies the excluded providers, the Centers for Medicare & Medicaid Services (CMS), and State Medicaid agencies in the States in which the providers were enrolled in Medicaid. OIG also reports the exclusion to a number of databases used for licensing and credentialing providers (described further below). In 2009, approximately 46,000 individuals and entities were listed on OIG's exclusion list.

Medicaid and other federally funded health care programs are prohibited from paying for any items or services furnished, ordered, or prescribed by

[1] OIG exclusion authorities can be found in Sections 1128, 1128A, 1156, and 1867 of the Social Security Act.

an excluded provider.[2] This prohibition applies to payments to the excluded provider and anyone who contracts with the excluded provider. The payment prohibition also applies to all administrative and management services furnished by an excluded provider, regardless of which entity submits the claim for reimbursement. OIG can impose civil monetary penalties on entities that contract with excluded providers.[3]

Limited exceptions allow payments for certain services (e.g., emergency services) furnished by excluded providers. Additionally, States can request that the Secretary of Health and Human Services waive a provider's exclusion from a State health program.[4]

Sources of Exclusion Information

OIG makes exclusion information available on its Web site. OIG also provides exclusion information to a number of other agencies that in turn make the information available through databases they administer.

List of Excluded Individuals and Entities (LEIE). When OIG excludes a provider from participation in federally funded health care programs, it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider's name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).

Excluded Parties List System (EPLS). The General Services Administration (GSA) maintains the EPLS, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the EPLS on parties they have debarred or suspended as described above; OIG sends monthly updates of the LEIE to GSA for inclusion in the EPLS. The EPLS does not include any unique identifiers; it provides only the name and address of excluded entities. If EPLS users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.

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[2] 42 CFR Section 1001.1901.

[3] 42 U.S.C. 1320a-7a(a)(6).

[4] The limited exceptions are described in 42 CFR § 1001.1901(c); authority to grant waivers is set forth in § 1128(d)(3)(B)(i) of the Social Security Act (42 U.S.C. 1320a-7(d)(3)(B)(i)).

Medicare Exclusions Database (MED). CMS maintains the MED as a way of providing exclusion information to its stakeholders, including State Medicaid agencies and Medicare contractors.[5] OIG sends monthly updates of the LEIE to CMS. CMS uses the OIG updates to populate the MED (formerly Publication 69). Unlike the LEIE and the EPLS, the MED includes unique identifiers (e.g., SSNs, EINs, NPIs), but is available only to certain users to protect sensitive information.

National Practitioner Data Bank (NPDB). The NPDB, maintained by the Health Resources and Services Administration, is an information clearinghouse containing information related to the professional competence and conduct of physicians, dentists, and other health care practitioners. OIG reports exclusions to the NPDB monthly. Although the NPDB includes unique identifiers, to protect sensitive information it is available only to registered users whose identities have been verified. The NPDB will also include information that is in the Healthcare Integrity and Protection Data Bank (HIPDB) when the two data banks are consolidated.[6] The HIPDB is also a source of exclusion information.

State Sanctions and Licensure Databases. States have authority to exclude providers from their Medicaid programs.[7] Many States maintain a database—often called a State sanctions list—of providers that they have excluded. State sanctions lists may also include OIG-excluded providers. Many States also maintain databases of providers to whom they have issued licenses; if a provider loses his or her license because of exclusion, either by OIG or by a State, the licensing database reflects that status. Data included in these databases vary by State.

CMS Guidance to State Medicaid Agencies

In a State Medicaid Director letter dated May 16, 2000, CMS reminded States to check Publication 69 (the forerunner of the MED) to ensure that no excluded providers receive Medicaid payments. A subsequent State Medicaid Director letter dated June 12, 2008, clarified that while States

[5] The MED contains information on all OIG-excluded providers and is used by stakeholders of multiple CMS programs, including Medicaid managed care plans.

[6] Section 6403 of the Patient Protection and Affordable Care Act (P.L. 111-148) amended § 1128E of the Social Security Act to provide for consolidating the HIPDB information into the NPDB and terminating the HIPDB. Implementation was to occur not later than 1 year after enactment (March 23, 2010) or the effective date of final regulations, whichever occurred later. Final regulations have not been issued as of the date of this report.

[7] Under § 1902(p)(1) of the Social Security Act (42 U.S.C. 1396a(p)(1)), a State may exclude a provider from the State Medicaid program for any reason that OIG could exclude a provider from Federal health care programs.

may delegate many provider enrollment or credentialing[8] functions to MCEs, each State remains responsible for ensuring that it and its contracted MCEs do not pay an excluded provider for Medicaid-funded health care items or services. Most recently, on January 16, 2009, CMS issued a State Medicaid Director letter advising States of their obligations to direct providers to screen their employees and contractors for excluded persons. The letter advised States to communicate these obligations to providers on enrollment in Medicaid, to require compliance as a condition of enrollment, and to require providers to conduct monthly searches of OIG's LEIE.

Related Studies

Two previous OIG studies examined Medicare provider exclusions. In August 2000, OIG reported that for a subset of excluded providers (1,594) for which unique numerical identifiers were available (Unique Physician Identification Number and/or SSNs), Medicare made improper payments totaling $35,833 to 21 physicians over the course of 1 year. The study also found that Medicare contractor staff responsible for making payments to providers raised some concerns regarding the timeliness, completeness, and reliability of exclusion data.[9] In May 2010, OIG reported that 188 OIG-excluded Medicaid providers had, prior to their exclusion, enrolled in 26 State Medicaid programs. This study identified potential weaknesses in States' provider enrollment procedures by examining whether these providers had questionable financial and criminal histories prior to enrolling in Medicaid. Twenty-four of these 188 excluded providers had histories of tax debt, criminal convictions, or false disclosures prior to enrolling as Medicaid providers.[10] OIG concluded that additional reviews and oversight were warranted to ensure that Medicaid enrollment standards are sufficient to protect the program from fraud and abuse.

METHODOLOGY

We used mixed methods, including data matches, interviews, and reviews of contracts, to conduct this evaluation. We conducted data matches to identify excluded providers. We then interviewed MCE and State staff about the safeguards that prevent excluded providers from enrolling in Medicaid. We also reviewed the contracts between the MCEs and the

[8] Credentialing is a general term for the process of ensuring that a provider is qualified to participate in a particular program. Specific qualifications vary by MCE and State, but credentialing generally includes checking a provider's exclusion status, ensuring that a provider has a valid license, and verifying a provider's education, training, criminal history, and ownership information.

[9] *Medicare Payments to OIG Excluded Physicians* (OEI-07-98-00380).

[10] *Excluded Medicaid Providers: Analysis of Enrollment* (OEI-09-08-00330).

States for information relating to safeguards. We looked for relationships between the presence of safeguards and the presence of excluded providers in each network, but found no such relationships. Finally, we asked the MCEs to provide information on payments made to each excluded provider that we identified.

Scope

The data matches we conducted between the OIG exclusion data and MCE provider network data included all providers enrolled in the networks of the selected MCEs. We did not independently verify whether these providers had contracts with the MCEs in question, nor did we determine whether the excluded providers that we identified had received payments from other federally funded health care programs, such as Medicare. The OIG exclusion data used in these data matches included information on OIG-excluded providers; the data do not include State-excluded providers or providers listed on the EPLS or the NPDB but not also listed in the LEIE.

This evaluation was limited to those enrolled in the provider networks of the MCEs selected for this study; in another study, we will evaluate the extent to which excluded individuals are employed by the reviewed providers.[11]

Identification of OIG-Excluded Providers

We collected OIG exclusion data representing all providers excluded at any time from January 1 through December 31, 2009.[12] These data included providers whose exclusions began before or during the review period. In addition to the periods of exclusion, OIG's exclusion data included each provider's name, provider type, provider specialty, date of birth (for individual providers), address, State, SSN or EIN, Medicaid provider number, and/or NPI. The data also included the dates of any reinstatements for the excluded providers.

Selection of MCEs

We selected 12 MCEs for inclusion in this study based on our review of data included in the *2008 National Summary of State Medicaid Managed Care Programs* and the *2008 Medicaid Managed Care Enrollment*

[11] In this study, we determined whether the providers enrolled in the selected MCEs were excluded. Providers who receive Medicaid funds are also required to screen their employees for excluded individuals, as stated in the State Medicaid Director letter dated January 16, 2009. We will evaluate the extent to which excluded individuals are employed by the MCE providers in another study (OEI-07-09-00632). Data collection for this evaluation began in January 2012.

[12] This data was collected from the same database used to populate the LEIE; however, the SSNs and EINs that we obtained are not available in the downloadable version of the LEIE.

Report.[13] We selected MCEs that represented a variety of covered services, operating authorities, and managed care types, as shown in Appendix A.[14] We excluded primary care case management plans.[15] The 12 MCEs that we selected provided services in 10 States: Alabama, California, Georgia, New York, Ohio, Oklahoma, Oregon, Tennessee, Texas, and Washington. They represent 15.8 percent of total Medicaid national managed care enrollment in 2008.[16]

Identification of MCE Providers

From each selected MCE, we requested data on all providers that were enrolled in the MCE's provider network from January 1 through December 31, 2009. These data included providers whose enrollment began before or during the review period. In addition to beginning and ending dates of enrollment, these data included each provider's name and/or business name, provider type, provider specialty, date of birth (if applicable), address, State, SSN or EIN, Medicaid provider number, and NPI.

Identification of Excluded MCE Providers

To identify any excluded providers that were enrolled in the selected MCEs' provider networks, we matched the OIG exclusion data to the MCE provider network data, primarily using SSN or EIN. If an SSN or EIN was not available for a particular provider, we attempted to match the OIG exclusion data and MCE provider network data using other identifying information, such as the Medicaid provider number, NPI, or name and date of birth. For the excluded providers identified, we compared their exclusion dates and reinstatement dates, if any, to the beginning and ending dates of their enrollment in the selected MCE. We also asked MCE officials:

- how each excluded provider enrolled in their network;

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[13] The *National Summary of State Medicaid Managed Care Programs* provides descriptions of all Medicaid managed care programs in all States. The *Medicaid Managed Care Enrollment Report* provides enrollment data by State and by MCE for all Medicaid managed care programs in all States. Both documents are published annually by CMS.

[14] States can establish contracts with different types of MCEs to provide specific subsets of services—for example, covered services can be limited to inpatient, mental health, or transportation services. Different sections of the Social Security Act authorize States to contract with different types of MCEs. These sections are known as operating authorities.

[15] Primary care case management (PCCM) is a system under which a State contracts to furnish case management services (which include the location, coordination, and monitoring of primary health care services) to Medicaid recipients. We excluded PCCM plans from our study because in some cases States contract directly with the providers; a third-party plan is not always involved.

[16] Although the scope of our study is 2009, only 2008 data were available at the time of MCE selection. In 2009, the 12 selected MCEs represented 15.8 percent of national Medicaid managed care enrollment.

- whether each excluded provider's services fit one of the limited exceptions, or if the excluded provider had been granted a waiver, and for documentation to support any exception or waiver; and
- the total amount paid to each excluded provider for services to Medicaid recipients in 2009.

Finally, we looked for trends or patterns in the characteristics of the excluded providers we identified in MCE provider networks, but we found no such trends or patterns.

Identification of MCE Safeguards

We conducted structured interviews with officials from the 12 selected MCEs to determine the extent to which they had implemented safeguards to ensure that excluded providers were not enrolled in their provider networks. We also asked if they had difficulties or concerns regarding the exclusions data available to them. We looked for relationships between MCE safeguards and the number of identified excluded providers in provider networks, but we found none.

Identification of State Safeguards

We conducted interviews with 1 or more Medicaid officials in the 10 States in which the 12 selected MCEs operate. These interviews identified the safeguards that States use to prevent excluded providers from enrolling in MCE provider networks and also identified difficulties or concerns State officials had with the exclusions data available to them. We looked for relationships between State safeguards and the number of excluded providers in MCE provider networks, but we found none.

Review of Contracts

We collected and reviewed copies of the contracts between the States and the selected MCEs for information relating to safeguards used to prevent excluded providers from enrolling in MCE provider networks. We looked for relationships between contract requirements and the number of excluded providers in MCE provider networks, but we found none.

Limitations

We selected a purposive sample of 12 MCEs for this study. The results can be applied only to the 12 MCEs that were reviewed; they cannot be projected to any other MCEs or States.

Standards

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

FINDINGS

Four of the twelve MCEs reviewed had 11 excluded providers enrolled in their provider networks; 4 of these providers were paid a total of $40,306

We identified 11 excluded providers in the networks of 4 MCEs. A total of $40,306—a State share of $19,755 and a Federal share of $20,551—was paid to 4 of the 11 providers after the dates of their exclusions by 2 MCEs (i.e., MCEs 1 and 2 in Table 1 below). We identified these providers by checking the 277,835 providers enrolled in the 12 selected Medicaid MCEs against the 45,432 OIG-excluded providers as of January 1, 2009. Table 1 shows the amounts paid to the four providers. The 11 excluded providers identified were as follows: 5 physicians, 3 durable medical equipment (DME) suppliers, 2 pharmacies, and 1 mental health clinic. Their dates of exclusion ranged from December 18, 1997, to April 20, 2009.

Table 1: Payments to Excluded Providers

MCE	Provider Type	Total Payments in 2009	State Share	Federal Share
MCE 1	Physician (M.D.)	$26,044.12	$13,022.06	$13,022.06
MCE 1	Physician (M.D.)	$11,100.58	$5,550.29	$5,550.29
MCE 1	Physician (M.D.)	$372.10	$186.05	$186.05
MCE 2	DME supplier	$2,788.75	$996.14	$1,792.61
Total:		**$40,305.55**	**$19,754.54**	**$20,551.01**

Source: MCE reports of payment information to OIG, 2009.

Seven of the eleven excluded providers were enrolled in MCE provider networks, according to the data that MCEs gave us, but rendered no services and received no payments during the period of our review. For five of these seven providers, the corresponding MCEs—MCEs 1 and 3—explained that the providers had joined their networks through their acquisitions of other MCEs and had not yet signed contracts with the new MCE, or the providers had simply not been removed from the enrollment data when their last contracts expired or were terminated. It is unclear whether these providers would have been paid if they had submitted requests for reimbursement to the MCEs. For the remaining two providers, staff from MCE 4 stated that they did not pay any claims but did not explain further.

Gaps in provider credentialing processes and LEIE information contributed to the enrollment of excluded providers

The four MCEs that had excluded providers in their networks gave the following explanations about those enrollments.

MCE 1. This MCE confirmed that five physicians enrolled in its network were excluded. Upon investigation, the MCE found that its credentialing department had correctly identified the excluded providers. However, the information was not entered into the MCE's provider database. This MCE reported that it has taken steps to streamline the process and create greater accountability to prevent excluded providers from enrolling in the network.

MCE 2. A second MCE confirmed that one DME provider enrolled in its network was excluded. MCE officials explained that an external contractor credentials providers in the MCE's network, including checking providers' exclusion status. The contractor follows the guidelines of a national organization for improving health care quality in identifying what types of providers require credentialing. The MCE explained that these guidelines do not require DME providers to be credentialed and, therefore, this provider was not credentialed upon enrolling in the network. Regardless of external organizations' guidelines, this MCE was prohibited by its contract with the State from enrolling excluded providers in its Medicaid provider network.

MCE 3. A third MCE confirmed that two excluded DME providers and an excluded mental health clinic were enrolled in its provider network. These three providers joined the MCE's network when it acquired another MCE in October 2005. These providers' contracts were assigned to the MCE as part of the acquisition. The providers were not recredentialed during the acquisition, and therefore the MCE was not aware of their exclusion status.

MCE 4. The fourth MCE confirmed that two excluded pharmacies were enrolled in its network. The MCE explained that it had mistakenly identified the pharmacies as "false positive" matches with the LEIE and had allowed them in its network despite their exclusion status. The MCE further explained that the downloadable file from the OIG Web site does not contain unique identifiers such as a National Association of Boards of Pharmacy number or an NPI. Therefore, the MCE matches records without such unique identifiers based on specific criteria. The match criteria this MCE used for pharmacies are the first 10 characters of the pharmacy name and the ZIP Code, or the first 10 characters of the pharmacy address and the ZIP Code. Comparisons between two databases

based on nonunique identifiers, such as names or portions of addresses, will likely produce "false positive" matches. For example, common names, such as John Smith, are likely to appear in both databases even if the records associated with the name John Smith in each database reference different individuals. Therefore, the comparison between the two databases will yield a match, but the match will be incorrect—a "false positive." Officials from this MCE stated that each month, that staff must manually review approximately 100 matches based on names or addresses. Despite the additional steps necessary to confirm whether matches are false positives, this MCE was still obligated to confirm that no excluded pharmacies were enrolled in its network.

The MCEs for all four networks in which we identified excluded providers reported that they have removed the providers from their networks.

All 12 MCEs and all 10 States reviewed had safeguards to identify excluded providers; the specific safeguards varied among MCEs and States

All selected MCEs and the Medicaid agencies in 10 States had safeguards to prevent excluded providers from enrolling in their provider networks. In our review of the contracts between States and MCEs, we found that all contracts reiterated the prohibition on enrolling or using excluded providers in federally funded health care programs; however, the contracts did not specify how the MCEs should identify excluded providers to avoid enrolling them.

MCE safeguards. The safeguard most commonly used by the selected MCEs to prevent excluded providers from enrolling in their networks was checking the LEIE. Eleven of the twelve selected MCEs checked the LEIE.[17] Other databases that the 12 selected MCEs used to identify excluded providers included the EPLS, the MED, the NPDB, and the State sanctions or licensure databases. MCE officials indicated that these databases are checked at providers' initial enrollment and rechecked at varying frequencies ranging from monthly to every 3 years. Tables 2 and 3 show how many of the selected MCEs check each database, and how frequently these MCEs recheck each database for providers enrolled in their networks. We did not identify any relationship between the databases checked, or the frequency at which they were checked, and the presence of excluded providers in a particular MCE's network.

[17] The one MCE that did not check the LEIE provided only inpatient hospital services and enrolled only hospitals in its provider network. Rather than have its staff check the exclusion status of each enrolled hospital, the MCE required that every enrolled hospital be accredited by the State hospital association. One of the requirements for accreditation was not being excluded.

Table 2: Number of MCEs Checking Databases at Initial Enrollment

	LEIE	EPLS	MED	NPDB/ HIPDB	State Sanctions or Licensure Database
Checked	14	6	5	7	8
Not checked	1	8	10	7	7
No response	0*	1	0	1	0

Source: OIG interviews with selected MCEs, 2009.

*Note: The columns add up to a total of 15, rather than 12 MCEs. This is because the MCE in Washington was separated into four regional plans, each with slightly varying safeguards in use.

Table 3: Frequency of MCEs Checking Databases After Initial Enrollment

	LEIE	EPLS	MED	NPDB/ HIPDB	State Sanctions or Licensure Database
Monthly	9	4	4	1	4
Yearly	2	0	0	0	0
Every 3 years	3	2	1	4	3
Upon receipt of updates*	0	0	0	2	1
Never	1	8	10	7	7

Source: OIG interviews with selected MCEs, 2009.

*Note: The NPDB and HIPDB offer a service to subscribers that supplies information on particular individuals as it is entered into the database. Two MCEs took advantage of these services to receive in real time any information entered into these databases on all of their enrolled providers. One State updated its State sanctions list in the same way, sending out updates to subscribers as they occurred.

State safeguards. Six of the ten States that contracted with the selected MCEs required that providers seeking enrollment in MCE networks first enroll in the State's fee-for-service Medicaid program.[18] The checks that these six States conducted on providers enrolling in the fee-for-service program were similar to those that MCEs conducted on providers enrolling in their networks. In effect, providers in MCE networks in these

[18] Two minor variations in this requirement were found among the six States. In one State, approximately 1 percent of providers enrolled in the MCE were not also enrolled as fee-for-service providers. In another State, the only provider type that the MCE was allowed to enroll was community mental health centers (CMHCs). This State required CMHCs to undergo an extensive State licensing process, rather than requiring them to enroll in the fee-for-service Medicaid program.

six States underwent two complete checks, one conducted by the State and one conducted by the MCE. Two other States maintained a State database that combined several sources of exclusion information (e.g., LEIE, MED, State sanctions list) and made these databases available to their contracted MCEs. In the two remaining States, which contracted with MCEs to provide transportation services, each provider of transportation services was required to undergo a check for any exclusions and an extensive background check.

RECOMMENDATIONS

Our review identified 11 excluded providers in the networks of 4 of the 12 MCEs that were included in this study. Although Medicaid and other Federally funded health care programs are prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider, 2 MCEs paid a total of $40,306 to 4 of these 11 providers. Although all 12 MCEs had safeguards to prevent excluded providers from enrolling in their networks, various factors—such as gaps in the MCEs' provider credentialing processes—led to their inclusion in the networks.

We recognize that the number of excluded providers that we identified is small. Further, we note that CMS issued State Medicaid Director letters in 2000, 2008, and 2009 reminding States of their obligation to ensure that no excluded providers receive Medicaid payments.

To ensure that no excluded providers receive Federal health care funds through Medicaid managed care contracts, we recommend that CMS:

Periodically remind States of their obligation to ensure that no excluded providers receive Medicaid payments

To fulfill this recommendation, CMS could develop a State Medicaid Director letter as it has done in the past. The letter could include information from this report on how certain failures led to the inclusion of excluded providers in MCE provider networks. Such failures could include failure to communicate information about excluded providers between credentialing and enrollment staff; failure to check the exclusion status of all providers entering networks because of gaps in external organizations' guidelines; or failure to check the exclusion status of providers entering networks as a result of one MCE acquiring another. Alternatively, CMS could include this information in the next State Program Integrity Review Summary report.

We are reviewing the excluded providers we identified and the MCEs in which they were enrolled to determine appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on the report, CMS acknowledged that continuing review and improvement is always needed and discussed ongoing CMS activities. In response to the recommendation in the draft report, CMS stated that it "does not concur that the particular suggestions contained in the report are warranted." CMS also stated that the findings did not indicate any systemic failings and that the cost of implementing the

OIG-suggested actions would outweigh the benefits that would accrue from those actions.

In 2009, fewer than 46,000 of the millions of U.S. health providers were federally excluded, yet 11 of these excluded providers found their way into the handful of MCE provider networks we reviewed. OIG does not exclude providers lightly; the 11 providers we identified were excluded because they were convicted of health care-related crimes. Therefore, payments to these providers are more serious than simple payment errors. Furthermore, in its 2009, 2010, and 2011 State Program Integrity Review Summary reports, CMS highlighted effective practices as well as inadequacies in States' processes to identify excluded providers both in fee-for-service Medicaid and Medicaid managed care. This indicates that CMS is also seeking ways to identify and prevent excluded providers from participating in Medicaid.

In the draft report, we recommended that CMS develop processes to allow MCEs to efficiently check their entire provider networks to prevent excluded providers from enrolling or remaining in their networks. We revised the recommendation and the suggested actions to implement it based on CMS comments.

We ask that in its final management decision, CMS indicate whether it concurs with our revised recommendation and suggested actions, and what steps, if any, it will take to implement the recommendation.

The full text of CMS's comments can be found in Appendix B.

APPENDIX A

Table A-1: Selected Medicaid Managed Care Entities

State	Program Name	Name of Managed Care Entity	Type of Managed Care	Covered Services	Social Security Act Operating Authority	Number of Enrollees in 2008
Alabama	Partnership Hospital Program	Partnership Hospital Program	prepaid inpatient health plan	inpatient hospital	1915(a)	484,288
California	Two-Plan Model Program	Health Net Community Solutions, Inc.-TPMP	managed care organization	comprehensive	1915(b), 1932(a)	528,037
California	Two-Plan Model Program	LA Care Health Plan	managed care organization	comprehensive	1915(b), 1932(a)	741,817
Georgia	Non-Emergency Transportation Brokerage Program	Non-Emergency Transportation Brokerage Program	prepaid ambulatory health plan	nonemergency transportation	1902(a)(70)	1,167,887
New York	Partnership Plan - Family Health Plus	NYS Catholic Health Plan	managed care organization	comprehensive	1115	270,393
Ohio	Full-Risk Managed Care Program	CareSource	managed care organization	comprehensive	1932(a)	607,118
Oklahoma	SoonerRide	Logisticare, Inc.	prepaid ambulatory health plan	nonemergency transportation	1902(a)(70)	510,768
Oregon	Oregon Health Plan Plus	CareOregon, Inc.	managed care organization	comprehensive	1115	107,294
Tennessee	TennCare II	Americhoice	managed care organization	comprehensive	1115	525,185
Tennessee	TennCare II	First Health Services Corporation	pharmacy benefit manager	prescription drugs	1115	1,207,136
Texas	STAR	Amerigroup	managed care organization	comprehensive	1915(b)	333,423
Washington	Integrated Mental Health Services	Regional Support Network	prepaid inpatient health plan	mental health	1915(b)	858,331
Total:						**6,134,541**

Source: *2008 National Summary of State Medicaid Managed Care Programs*; *2008 Medicaid Managed Care Enrollment Report*.

APPENDIX B

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 0 8 2011

TO: Daniel R. Levinson
Inspector General

FROM: Donald M. Berwick, M.D. /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Excluded Providers in Medicaid Managed Care Entities (OEI-07-09-00630)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to comment on this subject OIG draft report. The purpose of the report was to determine the extent to which selected--(1) Medicaid managed care entities (MCEs) enrolled OIG-excluded individuals and entities in their provider networks in 2009; and (2) Medicaid MCEs and States have safeguards in place to prevent excluded individuals and entities from enrolling in Medicaid managed care provider networks. For 12 selected MCEs, the OIG matched OIG exclusions data and MCE provider network data to identify excluded providers, and then requested each MCE to provide information on payments made to those excluded providers. The OIG also interviewed MCE and State Medicaid staff, and reviewed contracts between MCEs and States to identify the safeguards which prevented excluded providers from enrolling in Medicaid programs. In total, 10 States were reviewed.

The OIG's report found that four of the twelve MCEs reviewed had 11 total excluded providers enrolled in their provider networks. Seven did not bill and the remaining four of these 11 excluded providers were paid a total of $40,306. The OIG report also found that all 12 MCEs and all 10 States reviewed had safeguards in place to identify excluded providers, although the specific safeguards varied among MCEs and States.

OIG Recommendation

The OIG recommended that CMS should work with the States to develop processes that allow MCEs to efficiently check their entire provider networks to prevent excluded providers from enrolling or remaining in their networks.

The OIG also made the following suggestions as to how CMS could implement this recommendation:

- CMS could encourage States to make the Medicare Exclusion Database (MED) available directly or indirectly (through States) to Medicaid MCEs, or by encouraging States to check MCE provider network data against the MED. The unique identifiers available in the MED could reduce errors associated with name-based matches necessitated by the

limitations of the downloadable OIG List of Excluded Individuals/Entities (LEIE) database.

- CMS could work with States to ensure that all provider types enrolled in Medicaid MCEs are included in credentialing requirements.
- CMS could establish a minimum frequency at which Medicaid MCEs must check their enrolled providers against the LEIE.
- CMS could ensure that States make their contracted MCEs aware of all sources of exclusion information, including the Excluded Parties List System (EPLS), the National Practitioner Data Bank (NPDB), and State sanctions and licensure databases.

CMS Response

The goal of this study is laudable, since Medicaid is prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider. We believe that continuing review and improvement is always needed. Indeed, CMS' Medicaid Integrity Group has been working diligently over the past five years to provide education to States, identify material weaknesses in States' fraud, waste and abuse prevention efforts, and support criminal investigations where necessary. CMS also plays a critical role in supporting the anti-fraud efforts of senior level Departmental officials in the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. However, at this point, CMS does not concur that the particular suggestions contained in the report are warranted. Our reasons for not concurring are set forth below.

First, we are extremely pleased that OIG's study revealed the enormous success of the current safeguards that both States and managed care entities have in place. The study clearly demonstrates an extraordinarily high degree of accuracy (in excess of 99.99 percent) of the methods used by Medicaid MCEs to identify and exclude prohibited providers and prevent inappropriate payments thereto. Both the States and the Medicaid MCEs which were surveyed should be congratulated for instituting vigorous and successful provider exclusion identification methodologies.

Second, the report does not suggest any systematic failings, and the added costs and administrative burden for States, plans, and CMS that would be required to implement the OIG recommendations far outweigh the very modest errors identified in the report and the small possible benefit that might result from OIG's recommended actions. However, we will continue to monitor these issues and evaluate whether some further action is advisable.

We commend OIG for focusing its efforts on identifying potential abuses of Federal funds in Medicaid MCEs. More than 70 percent of Medicaid beneficiaries receive at least some of their benefits through a managed care delivery system. It is, therefore, critical that the managed care delivery system is as vigilant regarding program integrity as Medicaid's fee-for-service system.

CMS would again like to thank the OIG for its work. We are pleased that it shows that both States and MCEs have instituted appropriate safeguards and procedures to virtually eliminate payment to excluded providers by Medicaid managed care programs. We look forward to working with the OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Deborah K. Walden, Deputy Regional Inspector General.

Michala Walker served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Kansas City regional office who contributed to the report include Michael Barrett and Rae Hutchison; central office staff who contributed include Kevin Manley and Kevin Farber.

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