

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**STATE AND CMS OVERSIGHT OF
THE MEDICAID MANAGED CARE
CREDENTIALING PROCESS**



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EXECUTIVE SUMMARY: State and CMS Oversight of the Medicaid Managed Care Credentialing Process
OEI-09-10-00270

WHY WE DID THIS STUDY

The Centers for Medicare & Medicaid Services (CMS) issued regulations that States must comply with to ensure the delivery of quality health care to Medicaid beneficiaries under managed care. To do so, States must establish uniform provider credentialing policies and include Federal credentialing provisions in contracts with Medicaid Managed Care Entities (MCEs). States must also monitor MCEs' compliance with these Federal provisions and any additional State credentialing requirements in contracts.

HOW WE DID THIS STUDY

We purposively sampled 6 States and 234 MCEs that included the 3 types of MCEs subject to the Federal credentialing regulations. To determine the extent to which States complied with the Federal regulations, we reviewed State documents, such as laws, administrative codes, State-issued policy letters, and 32 State contracts with MCEs. To determine whether States monitored MCE compliance with contracts, we reviewed States' auditing documents and interviewed State staff. To examine CMS's oversight of States' contracts, we reviewed 32 checklists used by CMS regional office staff to evaluate compliance of the 32 State contracts with the Federal credentialing provisions.

WHAT WE FOUND

All six States' credentialing policies and MCE contract provisions met Federal standards. However, five of six States did not monitor MCEs' compliance with the Federal provider nondiscrimination contract provision. This provision requires that MCEs not discriminate against providers that serve high-risk populations or that specialize in conditions requiring costly treatment. Also, CMS oversight to ensure the compliance of State contracts was inconsistent. Our review of 32 checklists showed that CMS regional office staff did not indicate whether 25 percent of contracts met all Federal credentialing provisions and many checklists were missing other required contract information.

WHAT WE RECOMMEND

We recommend that CMS issue guidance to States on monitoring MCE compliance with the Federal provider nondiscrimination contract provision. We also recommend that CMS regional office staff accurately complete the checklist to ensure State compliance with the Federal credentialing provisions.

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OBJECTIVES

1. To determine the extent to which States establish uniform credentialing policies and include the Federal credentialing provisions in contracts with Medicaid Managed Care Entities (MCEs).
2. To determine the extent to which States monitor MCEs' compliance with the Federal credentialing contract provisions and State credentialing requirements.
3. To examine the Centers for Medicare & Medicaid Services' (CMS) oversight of the compliance of State contracts with the required Federal credentialing provisions.

BACKGROUND

Medicaid Managed Care

States are increasingly adopting managed care as a response to growing Medicaid expenditures.^{1, 2} Nationally, Medicaid enrollment grew from 36.5 million³ in 2001 to 57.1 million in 2011.⁴ Of these 57.1 million Medicaid beneficiaries, 74 percent were enrolled in managed care.⁵ During a similar period, State Medicaid expenditures increased from \$89 billion to an estimated \$156 billion, accounting for an estimated 24 percent of States' expenditures in 2011.⁶ Total Medicaid expenditures more than doubled from approximately \$200 billion in 2000 to \$432 billion in 2011.⁷

MCEs

States contract with MCEs to provide or arrange for health care services on a Statewide or community basis. On the basis of these contracts, an MCE is paid a fixed prospective payment for each beneficiary enrolled

¹ Robert Wood Johnson Foundation, *Medicaid Managed Care: Cost, Access, and Quality of Care*, Research Synthesis Report No. 23, September 2012. pp. 1-4.

² Managed care is a health care delivery system that aims to maximize efficiency by negotiating rates, coordinating health care, and managing the use of services.

³ CMS, *National Summary of Medicaid Managed Care Programs and Enrollment as July 2010*. Accessed at <http://www.cms.gov> on April 30, 2013.

⁴ CMS, *National Summary of Medicaid Managed Care Programs and Enrollment as July 2011*. Accessed at <http://www.cms.gov> on April 30, 2013.

⁵ CMS, *2011 Medicaid Managed Care Enrollment*. Accessed at <https://www.cms.gov/> on April 23, 2012.

⁶ National Association of State Budget Officers, *2010 State Expenditure Report*, pp. 44-45. Accessed at <http://www.nasbo.org/publications-data/state-expenditure-report> on March 28, 2012.

⁷ CMS, *2011 Actuarial Report on the Financial Outlook for Medicaid*, 2012. Accessed at <http://www.cms.gov> on June 22, 2012.

with the MCE. This fixed payment amount is referred to as the “capitated rate.”

There are various types of MCEs, including Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs).^{8, 9} An MCO provides health care services through a comprehensive risk contract with the State.^{10, 11} PIHPs and PAHPs provide health care services under a managed care contract with the State, but those entities do not have comprehensive risk contracts. PIHPs generally provide inpatient or institutional services (e.g., mental health services), and PAHPs generally provide outpatient services (e.g., dental services). For purposes of this report, we refer to MCOs, PIHPs, and PAHPs collectively as MCEs.

Federal Credentialing Contract Provisions

The Balanced Budget Act (BBA)¹² provided a framework for CMS and States to improve the oversight of managed care. (In 2002, consistent with the BBA, CMS issued a final rule that mandated new Federal provisions that States must include in their contracts with MCEs.¹³) These provisions address provider selection standards that States must follow to ensure the delivery of quality health care.¹⁴

Federal regulations give States considerable latitude to create their own uniform credentialing and recredentialing policies and procedures (which we refer to in this report collectively as “credentialing policies”). However, these Federal regulations established provider selection standards that require States to (1) establish uniform credentialing policies

⁸ The other four types of MCEs identified by CMS for purposes of tracking enrollment include: (1) Primary Care Case Management Providers, (2) Health Insuring Organizations, (3) Programs for All-Inclusive Care for the Elderly, and (4) Other.

⁹ MCOs, PIHPs, and PAHPs are subject to the Federal requirements for provider credentialing. 42 CFR § 438.214.

¹⁰ Comprehensive risk contracts cover inpatient hospital services and three or more of the following services: outpatient hospital services; rural health clinic services; federally qualified health center services; laboratory and x-ray services; nursing facility services; early and periodic screening, diagnostic, and treatment services; family planning services; physician services; and home health services.

¹¹ MCOs are defined in Federal regulations as entities that meet certain Federal requirements and have a comprehensive risk contract with the State. In a risk contract, the MCE assumes risk for the cost of the services covered under the contract and incurs loss if the cost exceeds the payments. 42 CFR § 438.2.

¹² BBA, P.L. 105-33, §§ 4701-4710.

¹³ 67 Fed. Reg. 40989-40990 (June 14, 2002). Accessed at <https://www.federalregister.gov> on April 23, 2012.

¹⁴ 67 Fed. Reg. 40989, 41031 (June 14, 2002).

and (2) in State contracts with MCEs, require that MCEs do the following:^{15, 16, 17}

- follow the States' uniform credentialing policies,¹⁸
- follow a documented process for credentialing providers that have signed contracts or participation agreements with MCEs,¹⁹
- not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment,^{20, 21} and
- follow any additional requirements established by the State.²²

Provider Credentialing and Recredentialing

Although Medicaid regulations do not define credentialing or recredentialing, for the purposes of this report, we define credentialing as an evaluation of the qualifications of health care providers (providers) that seek contracts or participation agreements with an MCE.²³ The credentialing process typically includes steps such as the verification of information on provider applications, site reviews of provider offices, and determination of eligibility for payment under Medicaid. Recredentialing is the periodic update of credentialing information and may also include provider performance data, such as beneficiary complaints, and pay-for-performance and value-driven health care outcomes²⁴ to ensure that providers furnish quality health care.

State Monitoring of MCEs

States are responsible for monitoring MCE compliance with contract provisions, including the Federal provider selection standards and any credentialing requirements established by the State.²⁵ States decide how

¹⁵ 42 CFR §§ 438.200 and 438.204(g).

¹⁶ 42 CFR § 438.214(a) and (b).

¹⁷ One additional requirement is that MCEs may not employ or contract with providers excluded from participation in Federal health care programs. 42 CFR § 438.214(d).

¹⁸ 42 CFR § 438.214(b)(1).

¹⁹ 42 CFR § 438.214(b)(2).

²⁰ 42 CFR § 438.214(c).

²¹ High-risk populations include, but are not limited to, adults and children with special needs, such those with: mental illness, substance abuse problems, developmental disabilities and functional disabilities, or complex problems involving multiple medical and social needs like HIV/AIDS and homelessness.

²² Federal regulations authorize the States to establish additional standards for their credentialing policies. 42 CFR § 438.214(e).

²³ We based our definition of credentialing on CMS's *Medicare Managed Care Manual*, Pub. No. 100-16, ch. 6, § 60.3.

²⁴ Pay-for-performance links health care spending to quality and effectiveness. The Commonwealth Fund, *Pay-For-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*, April 2007.

²⁵ 42 CFR §§ 438.8(b)(6), 438.202(c), and 438.12.

they monitor MCEs.²⁶ For example, States may conduct compliance audits of MCEs. Typically these audits include the use of compliance tools, such as procedural documents and checklists. Federal regulations require States with certain types of MCE contracts to conduct external quality reviews (EQRs) to ensure the delivery of quality health care.^{27, 28} These regulations mandate that States conduct three types of EQR activities, one of which includes a review to determine MCE compliance with the Federal provider selection standards.^{29, 30, 31}

CMS Oversight of States

Federal regulations specify that CMS regional offices must review and approve State contracts with MCEs.^{32, 33} CMS implemented the use of a Checklist for Managed Care Contract Approval (checklist) that regional office staff use when evaluating State contracts with MCEs.³⁴ Figure 1 illustrates this review process.

²⁶ States do not perform credentialing functions. States, in their contracts with MCEs, include all credentialing requirements for MCEs to perform. States must monitor how MCEs comply with contract provisions.

²⁷ MCOs and PIHPs are subject to EQR regulation. 42 CFR pt. 438.

²⁸ States may choose an external quality review organization (EQRO), a qualified non-EQRO organization, or may designate another State department to perform the EQR. However, an independent agency, such as an EQRO, must draft the final EQR report. 42 CFR § 438.354.

²⁹ The review to determine compliance with Federal standards, State requirements, and other applicable contract provisions includes the previous 3-year period. 42 CFR pt. 438.

³⁰ The other two mandatory activities include validation of performance measures outlined by the State during the previous 12 months and validation of performance improvement projects required by the State. 42 CFR §§ 438.240(b)(1) and 438.240(b)(2).

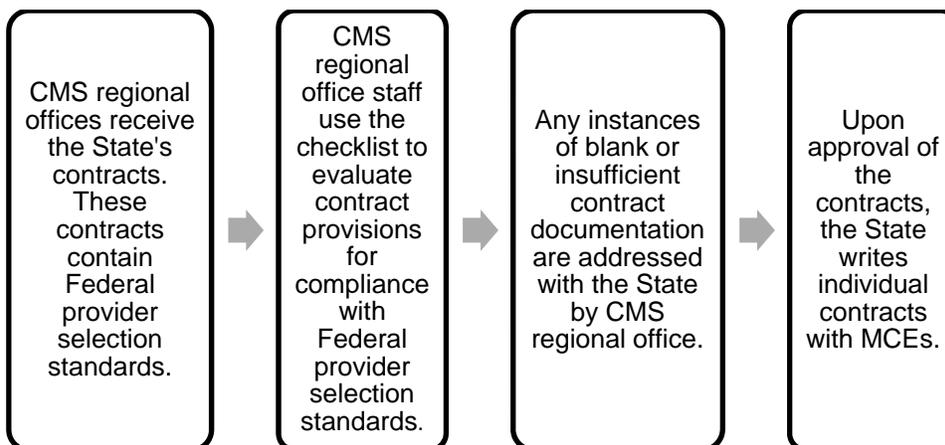
³¹ There are five optional EQR activities to assess MCO and PIHP performance. 42 CFR pt. 438.

³² In some cases, CMS may review and approve model contracts. Model contracts exist where there are multiple types of health care plans that a State contracts with MCEs for, such as acute-care and long-term-care plans. After being approved by CMS, the model contract serves as the template for States to write individual MCE contracts. For example, a model contract may exist for all acute-care MCOs within a county or for all MCOs in the entire State.

³³ Federal regulations specify that CMS must review and approve all MCO, PIHP, PAHP, and PCCM contracts. 42 CFR § 438.6(a).

³⁴ Although there is no regulatory requirement for CMS to use a checklist in the review process, CMS has an internal policy that staff must use the checklist for the contract to be approved and released to the State.

Figure 1: CMS Review Process



Source: OIG analysis of 32 CMS checklists and interviews with CMS regional office staff, 2011–2012.

The checklist is intended to assist CMS regional office staff in determining whether the contracts comply with all Federal statutory and regulatory requirements, including the Federal provider selection standards.³⁵ When completing the checklist, CMS regional staff are required to cite evidence from the contract (e.g., section and page number from the contract or supporting documentation) to support their assessment that the contract was compliant with each requirement. Regional office staff address any instances of absent or insufficient contract documentation with State staff during contract reviews.

The checklist also requires the contract to include the following: the name of the CMS reviewer, the name of the State, the contract period, the name of the MCE, the type of program, the type of MCE (e.g., MCO, PIHP, or PAHP), the type of review (e.g., initial contract or contract renewal), and the date that CMS staff reviewed the contract. (See Appendix A for credentialing checklist items.) Multiple CMS reviewers may complete portions of the checklist during contract review. CMS is revising the checklist and expects to complete the revisions in 2013.

METHODOLOGY

Scope

Our evaluation determined the extent to which the six selected States established uniform credentialing policies and included the required

³⁵ Statutory references and regulatory requirements include applicable sections of the Code of Federal Regulations, the *State Medicaid Manual*, State Medicaid Directors Letters, and the Social Security Act (SSA).

Federal credentialing provisions in contracts with MCEs.³⁶ All of the State policy documents and contracts with MCEs that we collected were in effect during 2011. We also determined the extent to which States monitored MCE compliance with Federal credentialing contract provisions and any State-established credentialing requirements. We collected States' most recent compliance audits of MCEs,³⁷ which were from 2010; States' most recent compliance tools, which were from 2011 and 2012; and States' most recent EQRs, which were from 2010 and 2011.³⁸

We examined CMS's oversight of the compliance of State contracts with Federal credentialing provisions. We focused on the credentialing section of the checklist and collected checklists for active contracts with States. Finally, we analyzed data from interviews we conducted with CMS and State staff during 2011 and 2012.

Sample Selection

We purposively selected six States—Arizona, California, Florida, New York, Pennsylvania, and Texas. We selected Arizona because it has some of the oldest contracts with MCEs in the United States. We selected five additional States to include those with the greatest total numbers of MCEs per State and the largest percentages of Medicaid beneficiaries enrolled in these MCEs as of July 2010 (see Table 1).^{39, 40} Collectively, these six States represented 37 percent of total Medicaid managed care enrollment and 46 percent of the total number of Medicaid MCEs nationwide.⁴¹

Within the six States, we included only the three types of MCEs that are subject to the Federal credentialing provisions: MCOs, PIHPs, and PAHPs. These totaled 234 MCEs. Collectively, these three types of MCEs represent 86 percent of Medicaid beneficiaries enrolled in managed care in the six States. (See Appendix B for details about the number of Medicaid beneficiaries enrolled in all types of MCEs.)

³⁶ For the purposes of this report, we did not assess compliance with the provider selection standard relating to excluded providers. A February 2012 OIG report—*Excluded Providers in Medicaid Managed Care Entities*, OEI-07-09-00630—focused on this requirement.

³⁷ Some States conduct compliance audits annually, whereas other States conduct them at intervals ranging from 1 to 3 years.

³⁸ EQRs are conducted every 3 years.

³⁹ CMS, *2010 Medicaid Managed Care Enrollment Report*, 2011.

⁴⁰ For sampling purposes, we included all seven types of MCEs that CMS identifies for purposes of tracking enrollment: (1) Medicaid and Commercial MCOs, (2) PIHPs, (3) PAHPs, (4) Primary Care Case Management Providers, (5) Health Insuring Organizations, (6) Programs for All-Inclusive Care for the Elderly, and (7) Other.

⁴¹ CMS, *2010 Medicaid Managed Care Enrollment Report*, 2011.

The 6 States are under the oversight of 5 of the 10 CMS regional offices. As part of our evaluation, we interviewed staff from these five regional offices.

Table 1: Medicaid Managed Care Enrollment in Six Sampled States

State	Total Number of MCEs in State	Medicaid Beneficiaries		
		Total Number Enrolled in Medicaid	Total Number Enrolled in Medicaid Managed Care	Percent Enrolled in Medicaid Managed Care
California	47	7,326,862	4,033,378	55%
New York	61	4,740,518	3,226,755	68%
Texas	25	3,763,896	2,520,307	67%
Florida	69	2,853,392	1,839,940	64%
Pennsylvania	67	2,029,591	1,658,059	82%
Arizona	30	1,322,359	1,196,192	90%
Purposive Sample of Six States	299⁴²	22,036,618	14,474,631	66%
All Other States	356	32,575,775	24,545,244	75%
Total	655	54,612,393	39,019,875	71%

Source: CMS, 2010 Medicaid Managed Care Enrollment Report, 2011.

Data Sources and Data Collection

State establishment of uniform policies and inclusion of the required Federal credentialing provisions in contracts with MCEs. From the six States, we collected State contracts with MCEs and other State documents, such as State laws, administrative codes, and State-issued policy letters. We grouped the contracts into 32 types; each type corresponded to a contract or model contract that the States used for writing individual MCE contracts.

State monitoring of MCE compliance with contract provisions. To determine whether States monitored MCEs, we conducted onsite and followup telephone interviews with State staff who were responsible for contract oversight and MCE monitoring. We collected documents that substantiate States' monitoring of MCEs, including compliance audits; audit compliance tools, such as procedures and checklists; and EQRs. From these six States, we collected only the credentialing sections of audits from 2010. In addition, the six States provided us with their credentialing policy documents, such as manuals, for all MCEs.

⁴² Although there was a total of 299 MCEs among the 6 sampled States, we included only the 3 types of MCEs subject to the Federal credentialing provisions. These totaled 234 MCEs.

CMS oversight of the compliance of State contracts with required Federal credentialing provisions. We collected 32 checklists from the 5 CMS regional offices that had oversight of the 6 sampled States. These 32 checklists were used by CMS to review the 32 contracts used by the States to write individual MCE contracts. We conducted telephone interviews with CMS staff in the five CMS regional offices and in the central office about their use of the checklists to review and approve managed care contracts. We also asked CMS central office staff whether they provided guidance to regional offices about checklist use.

Data Analysis

State establishment of uniform policies and inclusion of the required Federal credentialing provisions in contracts with MCEs. We reviewed State documents, such as State laws, administrative codes, and State-issued policy letters, to determine whether States established uniform credentialing policies. We then reviewed the 32 contracts to verify that the States required MCEs to:

- follow the States' uniform credentialing policies,
- follow a documented process for credentialing providers that have signed contracts or participation agreements with MCEs,
- not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, and
- follow any additional requirements established by the State.

State monitoring of MCE compliance with contract provisions. We analyzed our interview responses from State staff to understand how the six States monitored MCEs' compliance with Federal contract provisions and any State-established credentialing requirements. We then reviewed compliance audits and audit compliance tools provided by the six States and EQRs provided by two States to substantiate our onsite interview responses.⁴³ In addition, we reviewed all the MCEs' credentialing policy documents to verify that each MCE had written credentialing policies. To determine whether these documents complied with the Federal credentialing provisions, we compared them to the State contracts with MCEs.

CMS oversight of the compliance of State contracts with required Federal credentialing provisions. We reviewed the 32 CMS checklists to determine whether regional office staff completed the checklists accurately when reviewing the contracts. To determine whether staff

⁴³ We excluded EQRs from four of our six States because their most recent EQRs were conducted prior to 2010.

verified that the contracts complied with the Federal credentialing requirements, we compared the checklists with the contracts. We analyzed our interviews with CMS regional and central office staff to supplement and validate our understanding of how regional office staff evaluate compliance of State contracts and complete the checklists.

Limitations

The results of our analyses are limited to the purposive sample of the 6 States we selected and their 234 MCEs. We do not project these results on a national basis.

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

All six States' credentialing policies and MCE contract provisions met Federal standards

All six States established uniform credentialing policies, such as State laws, administrative codes, and State-issued policy letters. (See Appendix C for the criteria that these States required in their uniform policies.) In addition, all six States included the required Federal credentialing provisions in their contracts with MCEs, which required MCEs to:

- follow the States' uniform credentialing policies,
- follow a documented process for credentialing providers that have signed contracts or participation agreements with MCEs,
- not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment, and
- follow additional requirements established by the State.

With respect to the additional requirements established by the States, all six States required that MCEs: use a peer review credentialing committee to evaluate provider credentialing files, conduct onsite reviews of physician offices, use provider performance data during recredentialing, and notify the State if a provider is suspended or terminated from the MCE network. (See Appendix D for more information about the States' additional requirements.)

Five of six States did not monitor MCEs' compliance with the Federal provider nondiscrimination contract provision

All six States monitored MCE compliance with three of the four Federal credentialing contract provisions and all State-established credentialing requirements. However, five of six States did not monitor MCEs' compliance with the Federal contract provision to not discriminate against providers that serve high-risk populations or that specialize in conditions that require costly treatment. These five States' 2011 and 2012 auditing tools (e.g., procedures and checklists) did not address MCE compliance with this requirement, nor did their 2010 compliance audits or the 2010 and 2011 EQRs. In addition, during our initial onsite interviews and followup interviews, staff from the five States could not indicate how they monitored this requirement. During followup interviews with staff from the five States, some staff reported that MCEs complied because it was required in contracts. Other States' staff reported that MCEs would not need to comply because the MCEs would not discriminate against

providers. In those instances, the MCEs had contracts or participation agreements only with providers that served specialized populations (i.e., children under 21 with social and behavioral problems).

In addition, in three of the five States that did not monitor MCE compliance with the provider nondiscrimination contract provisions, nine MCEs lacked the nondiscrimination requirement in their policies. Our interviews with State staff and our review of MCE credentialing policy documents showed that staff in these three States were unaware that the nine MCEs lacked this requirement in their policies.

CMS oversight of the compliance of State contracts was inconsistent

CMS regional office staff are required to indicate on the checklist whether State contracts with MCEs comply with all Federal credentialing provisions. However, CMS staff did not always indicate whether contracts with MCEs met Federal credentialing provisions, and many checklists were missing other required information.

CMS regional office staff did not indicate whether 25 percent of State contracts with MCEs met Federal credentialing provisions

In 25 percent of CMS' reviews (8 of 32 checklists), we found that regional office staff did not indicate whether contracts were compliant with all Federal credentialing provisions. Our review of the checklists identified three ways in which staff did not indicate whether contracts were compliant:

- (1) *Checklists were incomplete.* Staff in two CMS regional offices only partially completed State contract reviews of six checklists. Although staff indicated that they reviewed State contracts, they did not indicate whether these contracts complied with all Federal credentialing provisions on the checklists.
- (2) *Checklist documentation was contradictory.* Staff in one CMS regional office indicated on a checklist that a State's contract with an MCE was both compliant and noncompliant with the Federal credentialing provisions. For example, on one section of the checklist, staff indicated that the contract included the Federal provider nondiscrimination provision; on another section of the checklist, staff indicated that this contract provision was missing. In this instance, CMS regional office staff could not explain this internal contradiction.
- (3) *Checklist incorrectly indicated compliance with Federal provision.* Staff in one CMS regional office incorrectly indicated on the

checklist that the Federal provider nondiscrimination provision was not an applicable contract requirement. In this instance, staff indicated that these were contracts with MCEs that, upon enrollment, served high-risk populations and thus did not need to comply with this Federal provision. However, all State contracts are subject to the Federal credentialing provisions and must be evaluated for compliance by CMS. Failure to indicate on the checklist whether contracts comply with all Federal credentialing provisions may lead to inconsistent oversight by staff within the CMS regional offices.

Many checklists were missing other required contract information

All 5 CMS regional offices approved 15 of the 32 contracts (47 percent) with checklists that were missing required information other than whether the MCEs met Federal credentialing provisions. The 4 most common types of information missing from the 15 checklists were the name of the CMS reviewer, the contract period, the date of contract review, and the type of review (see Table 2).

Table 2: Required Information Missing on CMS Checklists for Reviews of State Contracts With MCEs

Required Items on the Checklist	Number of Checklists Missing Items (n=32)
Name of CMS reviewer	11
Period of State contract with MCE	6
Date of CMS review of State contract with MCE	5
Type of review (e.g., initial, renewal, amendment)	5
Type of program ⁴⁴ (e.g., waiver type or State plan amendment)	3
Name of State	1
Name of MCE	1
Type of entity (e.g., PIHP, PAHP, MCO)	0

Source: OIG analysis of 32 CMS checklists, 2011.

⁴⁴ States provide services to eligible Medicaid beneficiaries through MCEs under State plan amendments or waiver programs. Amendments and waivers must conform to the Medicaid program requirements specified in the SSA. Waivers allow States more flexibility and also control Medicaid spending.

Five of the fifteen checklists were missing two or more types of information. For example, one checklist did not include the name of the CMS reviewer who completed the contract review, the dates of contract review, and the name of the State. These 15 checklists were used to review and approve contracts between all 6 States and MCEs. The lack of required contract information on the checklist could contribute to ineffective oversight. For example, when a State amends its contracts with MCEs, CMS regional office staff will reference the checklists and the contracts. In one instance, a new staff member from one CMS regional office could not identify a previously approved State contract because information was missing from the corresponding checklist.

CONCLUSION AND RECOMMENDATIONS

All six States' credentialing policies and provisions for contracts with MCEs met Federal standards. However, States are also required to monitor MCEs' compliance with these contracts. Five of six States did not monitor MCEs' compliance with the Federal provider nondiscrimination contract provision. This provision requires that MCEs not discriminate against providers that serve high-risk populations or that specialize in conditions requiring costly treatment. Also, CMS oversight of the compliance of State contracts was inconsistent. Our review of 32 checklists showed that CMS regional office staff did not indicate whether 25 percent of contracts met all Federal credentialing provisions, and many checklists were missing other required contract information. We recommend that CMS:

Issue Guidance to States on Monitoring MCE Compliance With the Federal Provider Nondiscrimination Contract Provision

CMS could issue a State Medicaid Directors' letter emphasizing States' obligation to monitor MCEs' compliance with the provider nondiscrimination provision. Guidance could include methods for monitoring compliance with this provision. In addition, CMS could work with States to help identify methods for monitoring compliance with this provision. CMS could also require that States include the provider nondiscrimination requirement as part of their existing monitoring activities, such as compliance audits, compliance tools, or protocols.

Have CMS Regional Office Staff Accurately Complete the Checklist To Ensure State Compliance With the Federal Credentialing Provisions

To ensure that regional offices oversee the compliance of State contracts with the Federal credentialing provisions, CMS could implement a process to ensure that its regional office staff complete the checklist when evaluating compliance with the Federal credentialing requirements. CMS could also provide additional education and training to all regional office staff on how to document whether State contracts with MCEs are compliant with all Federal credentialing provisions.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with both of OIG's recommendations and will implement changes to address them.

CMS concurred with our first recommendation, that it issue guidance to States on monitoring MCE compliance with the Federal provider nondiscrimination contract provision. CMS stated that it is preparing such guidance, which may be issued as soon as mid-2014.

CMS concurred with our second recommendation, that it have regional office staff accurately complete the checklist to ensure State compliance with the Federal credentialing provisions. CMS stated that to better ensure that regional office staff complete the checklist accurately and thoroughly when evaluating compliance with the Federal credentialing provisions, it is developing an electronic checklist. This improved checklist template is expected to be operational in early 2014. CMS will train regional office staff on the purpose and use of the template. In the interim, CMS will reiterate the importance of fully completing the checklist to each of its 10 regional offices.

We did not make any changes to the report based on CMS's comments. The full text of CMS's comments is provided in Appendix E.

APPENDIX A

The Centers for Medicare & Medicaid Services' Checklist for Review of States' Contracts With Managed Care Entities

The Centers for Medicare & Medicaid Services' (CMS) regional offices must review and approve States' contracts with Medicaid Managed Care Entities' (MCEs).⁴⁵ The Checklist for Managed Care Contract Approval (checklist) is intended for use by regional office staff to evaluate these contracts. The checklist instructions indicate that CMS regional office staff are to compare the "Subject" column in the checklist with the language in the contract to determine whether the contract contains the required language. CMS regional office staff are to enter in the "Where Found" column the location of the required language in the contract or other State documents. If the language is present and fulfills the requirement, CMS regional office staff should place a check in the "Met" column. If the language is absent, CMS regional office staff should leave the column blank or indicate "no." Table A-1 shows the provider selection items we reviewed for this study.

Table A-1: Provider Selection Checklist Items for States' Contracts with MCEs

Checklist Item	Regulatory Basis	Subject	Entity Type	Where Found	Met	Comments
D.2.01	42 CFR 438.12(A)(2); 42 CFR 438.214	<u>Contracts with Health Care Providers.</u> In all contracts with health care professionals, an MCE must comply with the requirements specified in 42 CFR 438.214, which include: selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.	MCE			
D.2.02	42 CFR 438.214(a); 42 CFR 438.214(b)(1); 42 CFR 438.214(b)(2)	<u>Selection and Retention of Health Care Providers.</u> Each contract must require the entity to have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the State's policy for credentialing and recredentialing.	MCE			
D.2.04	42 CFR 438.214(c)	<u>Nondiscrimination.</u> The contract must require that the entity's provider selection policies and procedures not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.	MCE			

Source: Office of Inspector General analysis of 32 selected CMS checklists, 2011.

⁴⁵ 42 CFR § 438.6(2).

APPENDIX B

Types of Medicaid Managed Care Enrollment by Selected States

States may contract with up to seven different types of Medicaid managed care entities (MCEs). For sampling purposes, we included only the three types of MCEs subject to the Federal credentialing requirements: Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs). Table B-1 shows the number of Medicaid beneficiaries enrolled in the three types of MCEs in our sample and the number of beneficiaries in the other four types of MCEs, as of June 2010.

Table B-1: Number of Medicaid Beneficiaries Enrolled in MCEs by Entity Type⁴⁶

State	MCO ⁴⁷		PIHP	PAHP	Four other types of MCEs ⁴⁸	Total
	Commercial	Medicaid-only				
Arizona	0	1,196,192	116,014	0	0	1,312,206
California	3,211,912	8,201	106	556,741	782,485	4,559,445
Florida	756,125	334,754	846,885	331,953	590,594	2,860,311
New York	881,942	2,293,891	28,574	0	22,348	3,226,755
Pennsylvania	1,094,568	0	1,629,152	479,596	293,005	3,496,321
Texas	240,119	1,430,435	365,127	62,980	849,756	2,948,417
Total of six States	6,184,666	5,263,473	2,985,858	1,431,270	2,538,188	18,403,455
All Other States	5,013,645	9,433,306	6,378,372	10,014,871	7,612,348	38,452,542
Total of 50 States	11,198,311	14,696,779	9,364,230	11,446,141	10,150,536	56,855,997

Source: Office of Inspector General analysis of the Centers for Medicare & Medicaid Services' *2010 Medicaid Managed Care Enrollment Report*, 2011.

⁴⁶ Total number of enrollees includes those who were enrolled in more than one managed care plan. Figures also include individuals enrolled in State health care reform programs that expand eligibility beyond traditional Medicaid eligibility standards.

⁴⁷ A commercial MCO provides comprehensive services both to commercial enrollees and to Medicaid beneficiaries and/or Medicare beneficiaries. A Medicaid-only MCO provides comprehensive services only to Medicaid beneficiaries, not to commercial enrollees or Medicare beneficiaries.

⁴⁸ The other four types of MCEs include: Health Insuring Organization, Program for All-Inclusive Care for the Elderly, Primary Care Case Management Provider, and Other.

APPENDIX C

Selected Criteria for Six States' Uniform Credentialing and Recredentialing Policies

Although States are required to establish uniform credentialing and recredentialing (credentialing) policies and include these policies in contracts with Medicaid managed care entities, States have the authority to determine the specific criteria for their policies. Table C-1 shows the credentialing criteria for each of the six States in our study. States do not necessarily limit their requirements to the criteria reflected in the table. We grouped together common requirements for all provider types (e.g., physicians and nonphysicians); however, some States specify other requirements for each provider type.

Table C-1: Selected Credentialing Criteria for Six Sampled States

Provider Credentialing	Arizona	California	Florida	Pennsylvania	New York	Texas
<i>Verification of the following:</i>						
1. Current license, certifications (or practitioner number), degree(s), and residency or specialty training	Y ⁴⁹	Y	Y	Y	Y	Y
2. Status with Medicare and Medicaid Programs, including sanctions and the Health and Human Services Office of Inspector General list of excluded individuals/entities	Y	Y	Y	Y	Y	Y
3. Evidence of malpractice/liability insurance and pending lawsuits or litigations	Y	Y	N	Y	Y	Y
4. Sanctions or limitations from State agencies or licensing boards	Y	Y	Y	Y	Y	Y
5. A valid Drug Enforcement Administration certification or number	Y	Y	Y	Y	Y	Y
6. Present in the National Provider/Practitioner Databank. In lieu of this, verify the following: any disciplinary action with regulatory board, State sanctions, or disciplinary claims resulting in a judgment or settlement.	Y	Y	Y	Y	Y	Y
7. Adherence to the ethics of the appropriate professional organization (e.g., American Medical Association)	N	N	N	Y	N	Y
8. Work history	Y	Y	Y	Y	N	Y
<i>Attestation of the following:</i>						
9. Any limitations in ability to perform essential position functions	Y	Y	Y	N	N	Y
10. History of loss of license or felony convictions	Y	Y	Y	N	N	Y
11. Lack of loss or limitation of privileges or disciplinary activity	Y	Y	Y	N	N	Y
12. Lack of present illegal drug use	Y	Y	Y	N	N	Y
<i>Provider Recredentialing</i>						
13. Occurs at least every 3 years	Y	Y	Y	Y	Y	Y
14. Involves verifying/updating information obtained during credentialing	Y	Y	Y	Y	Y	Y
15. Is a documented process that includes provider performance data, such as complaints, quality of care issues, and results of medical record reviews	Y	Y	N	Y	Y	Y

Source: Office of Inspector General analysis of State documents, 2011–2012.

⁴⁹ “Y” indicates that the State requires this credentialing criterion. “N” indicates that the State did not require this credentialing criterion.

APPENDIX D

Additional State Credentialing and Recredentialing Requirements

Federal regulations authorized States to establish additional standards for their credentialing and recredentialing policies.⁵⁰ Our review of six States' credentialing and recredentialing policies for Medicaid managed care entities (MCEs) showed that all six States established additional credentialing and recredentialing requirements and included them in their contracts with MCEs. We developed four categories to describe these requirements:

- (1) Credentialing committee. All six States specified that MCEs must designate a credentialing committee that uses a peer review process to evaluate provider credentialing files (including recredentialing files). These States typically required that a medical director (a physician) oversee the credentialing committee. One State's policy required that the medical director delineate the credentialing roles within the committee. The credentialing committee, including the medical director, is responsible for credentialing decisions and is required to document its steps in the decision process and maintain individual provider files.
- (2) Onsite reviews. All six States required onsite reviews of physician offices during initial credentialing; however, only two of the six States required onsite reviews during recredentialing. One of these six States required onsite reviews during recredentialing for dental providers only. In addition, in four States, MCEs may conduct onsite reviews of physician offices for any reason, including complaints from Medicaid beneficiaries. During this site review, the MCEs evaluate medical records and confidentiality practices and investigate any type of complaints (e.g., complaints from beneficiaries, the public, or providers).
- (3) Provider performance data during recredentialing. All six States required MCEs to have a documented process for monitoring provider performance. In addition, all six States required MCEs to have procedures that consider provider performance data during the recredentialing process. Examples of provider performance data included complaints from Medicaid beneficiaries; quality of

⁵⁰ 42 CFR § 438.214(e).

care issues; pay-for-performance data;⁵¹ and utilization management information, such as emergency room use and beneficiaries' lengths of stay in hospitals.

- (4) Notification requirement. All six States required MCEs to have a documented process for reporting to appropriate authorities—such as the State and the State medical board—serious issues or quality deficiencies that result in suspension or termination of a provider. For example, MCEs in one State were required to document their disciplinary actions against providers, including suspension or termination of a provider's privileges. In such a case, the MCE must notify the provider and the State.

⁵¹ Pay-for-performance links health care spending to quality and effectiveness. The Commonwealth Fund, *Pay-For-Performance in State Medicaid Programs: A Survey of State Medicaid Directors and Programs*, April 2007.

APPENDIX E

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG -9 2013

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "State and CMS Oversight of the Medicaid Managed Care Credentialing Process" (OEI-09-10-00270)

Thank you for the opportunity to review and comment on the subject OIG draft report. The Centers for Medicare & Medicaid Services (CMS) has reviewed this report and offers the following comments.

Federal regulations require states to ensure the delivery of quality health care to Medicaid beneficiaries under managed care. The purpose of this study was to determine the extent to which states comply with the federal regulations to establish uniform provider credentialing policies and include federal credentialing provisions in contracts with Medicaid Managed Care Entities (MCEs). States must also monitor MCEs' compliance with these federal provisions and any additional state credentialing requirements in contracts.

The OIG sampled six states (Arizona, California, Florida, New York, Pennsylvania, and Texas) and 234 MCEs that included the three types of MCEs subject to the federal credentialing regulations (Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans). To determine the extent to which states complied with the federal regulations, OIG reviewed state documents such as laws, administrative codes, state-issued policy letters, and 32 contracts. To determine whether states monitored MCE compliance with contracts, OIG reviewed states' auditing documents and conducted interviews with state staff. To examine CMS's oversight of states' contracts, OIG reviewed 32 checklists used by CMS regional office staff to evaluate compliance of the 32 state contracts with the federal credentialing provisions.

All six states' credentialing policies and provisions for contracts with MCEs met federal standards. However, states are also required to monitor MCEs' compliance with these contracts.

The OIG found that five of six states did not monitor MCEs' compliance with the federal provider nondiscrimination contract provision. This provision requires that MCEs not discriminate against providers that serve high-risk populations or specialize in conditions

requiring costly treatment. They also found that CMS's oversight of the compliance of state contracts was inconsistent. OIG's review of 32 checklists showed that CMS regional office staff did not indicate whether 25 percent of contracts met all federal credentialing provisions and many checklists were missing other information.

OIG Recommendation

The OIG recommends that CMS issue guidance to states on monitoring MCE compliance with the Federal provider nondiscrimination contract provision.

CMS Response

The CMS concurs with OIG's recommendation to emphasize to states their obligation to monitor MCEs' compliance with the provider nondiscrimination provision, and is preparing such guidance that may be issued as soon as mid-2014.

OIG Recommendation

The OIG recommends that CMS have CMS regional office staff accurately complete the checklist to ensure state compliance with the Federal credentialing provisions.

CMS Response

The CMS concurs that regional office staff must complete the checklist accurately and thoroughly when evaluating the federal credentialing requirements, and to better ensure this, CMS is developing an electronic checklist. The improved checklist template, expected to be operational in early 2014, will ensure that any required fields are complete prior to the submission of the final contract review. Once operational, CMS will train regional office staff on the purpose and use of the improved checklist template, and as an interim measure until then, CMS will reiterate the importance of fully completing the contract checklist to each of its 10 regional offices.

The CMS appreciates the opportunity to review and comment on this OIG report, and we look forward to working with OIG on this and other issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Anthony Guerrero-Soto served as the team leader for this study. Other Office of Evaluation and Inspections staff from the San Francisco regional office who conducted the study include Marcia Wong. Central office staff who provided support include Kevin Farber, Meghan Kearns, and Christine Moritz. Leah Bostick of the Dallas regional office also provided support.

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