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Twenty-Three States Reported Allowing Unenrolled Providers To Serve Medicaid Beneficiaries

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Christi A. Grimm
Principal Deputy
Inspector General





Twenty-Three States Reported Allowing Unenrolled Providers To Serve Medicaid Beneficiaries

What **OIG** Found

We found that—contrary to Federal requirements—23 States had not enrolled all providers serving Medicaid beneficiaries in their respective Medicaid programs, exposing them to potentially harmful providers that had not been screened for fraud, waste, and abuse.

These 23 States reported that they had not enrolled all providers in Medicaid managed care or that they had not enrolled all ordering, referring, or prescribing (ORP) providers in Medicaid fee-for-service (FFS).

- Twenty-one of the 23 States had not enrolled all providers in Medicaid managed care. The 21st Century Cures Act (Cures Act) required States to enroll these providers as of January 1, 2018. Most States had enrolled some, but not all, providers in the networks of managed care organizations (MCOs). However, four States had not attempted to enroll MCO network providers. The Centers for Medicare & Medicaid Services (CMS) also reported that it was not disallowing reimbursements to States for payments associated with unenrolled providers in MCOs' networks because it does not have the authority to do so.
- The Federal share of these 21 States' expenditures for Medicaid managed care was \$85 billion in 2018; States could not report the exact Federal share for individual unenrolled MCO network providers.
- Ten of the 23 States had not enrolled all ORPs in Medicaid FFS as of January 1, 2017, the enrollment date required by the Cures Act.

Of the 27 States that reported enrolling all providers, 11 States enrolled all providers according to Federal requirements and had enforcement controls. However, 16 of the 27 States reported that they were not collecting the required identifying and ownership information necessary for effectively screening Medicaid providers, or that they lacked enforcement controls to ensure ongoing State compliance with the Federal requirements.

What **OIG** Recommends

We recommend that CMS (1) take steps to disallow Federal reimbursements to States for expenditures associated with unenrolled MCO network providers, including seeking necessary legislative authority; (2) work with States to ensure that unenrolled MCO network providers do not participate in Medicaid managed care and assist States in establishing ways to do so; (3) work with States to ensure that they have the controls required to prevent unenrolled ORPs from participating in Medicaid FFS; and (4) work with States to ensure that they are complying with requirements to collect identifying and ownership information on Medicaid provider enrollment forms. CMS concurred with our recommendations.

Key Takeaway

The Medicaid program and its beneficiaries are exposed to providers that have not been screened by the States.

Why **OIG** Did This Review

An effective provider enrollment process plays a vital role in safeguarding Medicaid from fraudulent and abusive providers. To strengthen Medicaid provider enrollment, the Cures Act stipulated that States must require all Medicaid providers—both those in Medicaid FFS and Medicaid managed care—to enroll with their respective State Medicaid agencies. The Cures Act mandated that **OIG** submit a report to Congress—by March 31, 2020—that assesses the extent to which States had enrolled all providers that serve Medicaid beneficiaries. As part of the request, **OIG** must also provide Congress with information about the amount of Federal financial participation (FFP) that States received for services provided by Medicaid MCOs with unenrolled providers.

How **OIG** Did This Review

We based this study on data from the 49 States and the District of Columbia (States) that responded to our survey. One State (Massachusetts) did not respond. We requested information on the extent to which States had enrolled all providers. We conducted followup with 39 States to clarify their survey responses. We asked States to report the Federal dollars associated with unenrolled providers. Many States could not report FFP associated with unenrolled MCO network providers. As a result, we used information about capitation payments (i.e., payments that States make to MCOs) from the Transformed Medicaid Statistical Information System (T-MSIS). Finally, we queried staff from CMS on their work to enforce the Federal provider enrollment requirements.

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BACKGROUND

Objectives

1. To assess the extent to which States had enrolled providers in their Medicaid managed care and fee-for-service (FFS) programs; and
2. To provide information on the amount of Federal financial participation (FFP) that States reimbursed to managed care organizations (MCOs) with unenrolled network providers.

The Medicaid program serves more people than any other Federal health care program.¹ Approximately 74 million people receive health coverage from Medicaid at an annual cost of nearly \$600 billion.² Given the number of beneficiaries and the amount of expenditures, the Medicaid provider enrollment process is an important tool for protecting Medicaid beneficiaries and the Federal and State governments against fraudulent and abusive providers. As part of the enrollment process, States are supposed to screen providers applying for enrollment to determine whether they have a history of fraud, waste, or abuse.³ States can then deny fraudulent or abusive providers' applications to serve Medicaid beneficiaries. Previous studies from the Office of Inspector General (OIG) and U.S. Government Accountability Office (GAO) have found problems with States' implementation of Medicaid provider enrollment.^{4, 5}

To strengthen Medicaid provider enrollment, the 21st Century Cures Act (Cures Act) required that all providers that serve Medicaid beneficiaries enroll with their State Medicaid agency effective January 1, 2018.⁶ The Cures Act required OIG to submit this report to Congress assessing States' compliance with the provider enrollment requirements by March 31, 2020.⁷ In addition, the Cures Act required that no FFP be paid for managed care expenditures when States have not complied with the requirement to enroll MCO network providers.⁸ The Cures Act also required that OIG provide information in this report about the amount of FFP paid to States for payments to MCOs with unenrolled network providers.⁹

The Medicaid Program

States administer and finance their Medicaid programs through a partnership with the Federal government. States have the flexibility to administer their Medicaid programs within broad Federal requirements, resulting in various combinations of health care delivery and payment systems in each State. Generally, States offer Medicaid services through the FFS model, by contracting with MCOs, or through a combination of

both. States may provide their Medicaid beneficiaries with the option to voluntarily obtain their health care benefits through MCOs, or they may mandate that all Medicaid beneficiaries or categories of beneficiaries obtain their care through MCOs.¹⁰

These models—Medicaid FFS and Medicaid managed care—use distinct payment structures. Under the FFS model, providers submit claims to the State for Medicaid items or services and the State directly reimburses them. Under the managed care model, States pay MCOs a per-member, per-month fee for each Medicaid beneficiary enrolled in the plans administered by the MCO. In return for this amount—known as a capitation payment—MCOs pay network providers for all Medicaid services included in the MCO’s contract with the State. The MCO submits records—known as encounter records—to the State to show the Medicaid items and services received by managed care beneficiaries.¹¹

States report their Medicaid expenditures to the Federal Government every quarter.¹² The Federal Government then calculates its share of States’ Medicaid expenditures—known as the FFP—using States’ Federal Medical Assistance Percentages (FMAPs).¹³ Each State’s FMAP is based on how far that State’s per capita income deviates from the national average per capita income.¹⁴ This formula results in higher Federal funding to States with lower per capita incomes. For fiscal year 2018, FMAP rates for Medicaid expenditures ranged from 50 percent to 75.65 percent.¹⁵ The FMAP applies to both FFS expenditures and managed care capitation payments.

Medicaid Provider Enrollment

The U.S. Congress has passed two laws requiring that all providers serving Medicaid beneficiaries enroll with the State. In 2010, the Affordable Care Act mandated that States screen and enroll all Medicaid providers but did not set a deadline for enrolling these providers.¹⁶ In 2016, the Cures Act established deadlines for States to enroll all providers in FFS and managed care.¹⁷

The Cures Act required all providers that serve beneficiaries in Medicaid FFS to enroll with the State by January 1, 2017.¹⁸ This requirement included all providers that furnish, order, refer, prescribe, or provide items and services to Medicaid beneficiaries. Furnishing providers bill and receive payments from States for services provided to beneficiaries.¹⁹ By contrast, ordering, referring, or prescribing (ORP) providers may serve Medicaid beneficiaries without billing the State Medicaid agency.²⁰ ORP providers refer beneficiaries to other providers for services or write prescriptions for beneficiaries.²¹ For example, a provider employed by the Department of Veterans Affairs (VA) may refer a veteran who is also a Medicaid beneficiary to a Medicaid provider for a service not available at a given VA facility.²²

The Cures Act required States to enroll all MCO network providers by January 1, 2018.²³ To become part of an MCO's network, a provider contracts with the plan to furnish, order, refer, or prescribe items and services for the plan's beneficiaries.²⁴ MCOs pay network providers either for services provided to beneficiaries or with set periodic payments.²⁵ MCOs can also designate providers that provide a limited number of services to the plan's beneficiaries as out-of-network providers. Although States must enroll all MCO network providers, they do not need to enroll MCOs' out-of-network providers.²⁶ According to the Federal rules, States must require (1) managed care contracts to include stipulations that ensure that all MCO network providers enroll with the State as Medicaid providers, and (2) MCOs to remove providers from their networks that fail to submit timely or accurate enrollment information to the State.^{27, 28}

FFS and MCO Provider Definitions

FFS furnishing providers bill and receive payments from States for services provided to Medicaid beneficiaries.

FFS ORP providers serve Medicaid beneficiaries without billing the State Medicaid Agency—these providers refer beneficiaries to Medicaid providers for services or write prescriptions for Medicaid beneficiaries.

MCO network providers contract with MCOs to furnish, order, refer, or prescribe items and services to the plan's beneficiaries—these providers either bill the MCOs for each service they provide or receive set periodic payments from the MCO.

Medicaid Provider Enrollment Process

Before enrolling a provider, States must require the provider to complete a provider agreement with the State. According to the Federal rules, States should ensure that all providers serving Medicaid beneficiaries have (1) completed a provider agreement (application) with the State,²⁹ (2) disclosed the required identifying and ownership information on their enrollment application,³⁰ and (3) undergone the required risk-based screening activities.³¹ Ideally, only after providers satisfy these requirements and pass the screening activities should they be approved to enroll in the Medicaid program.

Provider agreement. According to the Medicaid Provider Enrollment Compendium (MPEC), all providers serving Medicaid beneficiaries must have a provider agreement with the State Medicaid Agency.³² In the

MPEC, CMS states that the provider agreement is the provider enrollment application.³³

Identifying and ownership information. States must require providers to submit identifying information and any applicable ownership information on the enrollment application. Identifying information must include the name, provider specialty, date of birth, Social Security number, National Provider Identifier (NPI), Federal Taxpayer Identification Number, and the State license or other certification number.³⁴ States must also require providers to disclose all individuals with an “ownership or control interest” when submitting their applications for Medicaid enrollment.³⁵ Although some providers may not have owners, States are required to collect ownership information when applicable. According to the MPEC, these requirements apply to ORP providers.³⁶

Risk-based screening. State Medicaid programs must screen providers to ensure that they are eligible to serve Medicaid beneficiaries. States first assign providers to low-, moderate-, or high-risk categories.³⁷ Depending on the risk category, States must conduct a set of screening activities for all newly enrolling providers.³⁸ These screening activities entail checks of Federal databases, including databases containing information on terminated providers, site visits, and fingerprint-based criminal background checks.³⁹ In addition to screening newly enrolling providers, States must periodically re-screen providers that are already enrolled throughout their enrollment.⁴⁰ States can rely on other States or Medicare for screening results or delegate the screening activities to third parties. However, States bear the responsibility for ensuring that providers undergo the screening activities.⁴¹

Ideally, a State would approve a provider’s application after it had completed—and the provider had passed—all required screening activities under both State and Federal rules. However, as demonstrated in past OIG work, some States have approved providers’ applications to serve in the Medicaid program (i.e., enrolled these providers), even though those providers have not undergone all required screening activities. For example, OIG reported in 2019 that 13 States had not implemented fingerprint-based criminal background checks for high-risk providers enrolled with the State.⁴²

Provider Enrollment Requirements: States

States must ensure that provider applications contain all required information, conduct risk-based screenings before enrolling providers, and enroll only eligible FFS furnishing, FFS ORP, and MCO network providers.

States that do not conduct all of these steps are not in compliance with Federal rules. States are also required to prevent payments to providers that are not enrolled, which means that States should have some enforcement controls.

Enrollment status terms and definitions. In this report, OIG uses two terms—enrolled and unenrolled—to describe the enrollment status of providers that serve Medicaid beneficiaries. Please see the definitions below.

Enrollment Status Definitions

Enrolled providers—providers that have completed the State’s provider enrollment application and have been approved to serve Medicaid beneficiaries by the State. For the purposes of this report, enrolled providers may include providers that the State approves to serve Medicaid beneficiaries without having (1) collected all required identifying and ownership information or (2) conducted all required screening activities.

Unenrolled providers—providers that serve Medicaid beneficiaries, even though they have not completed the State’s provider enrollment application and had it approved by the State.

State Oversight and Enforcement Controls

States use a variety of controls to ensure that providers who serve Medicaid beneficiaries are enrolled. CMS grants States flexibility on how they ensure that all providers are enrolled.

For Medicaid FFS furnishing providers, States may use prepayment claims edits to prevent or delay payments for claims submitted by unenrolled FFS furnishing providers. The claims edit would deny or delay payment for submitted claims that do not contain an enrolled furnishing provider’s

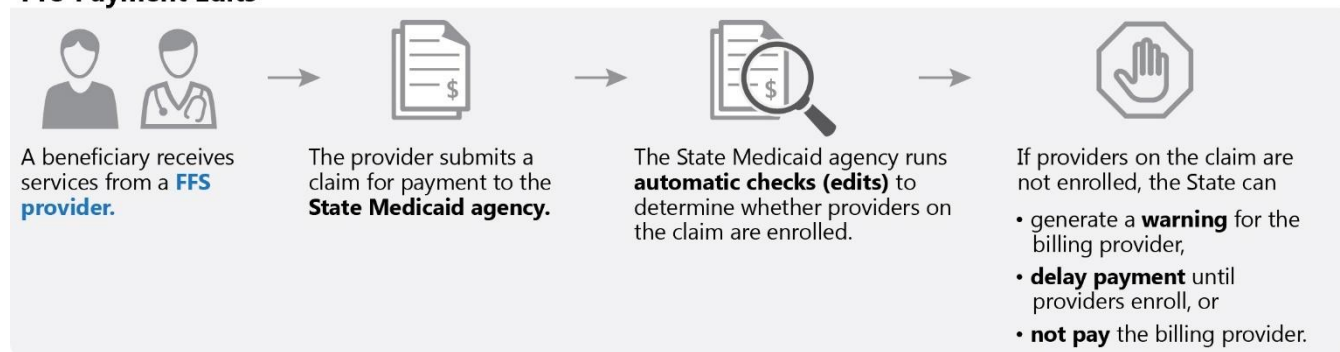
NPI. These prepayment edits are generally performed after a service is provided but before a claim is paid.

States may also use prepayment claims edits or point-of-sale edits for prescriptions to prevent or delay payments for claims associated with items and services ordered, referred, or prescribed by unenrolled FFS ORP providers. These claims edits would deny or delay payments for medical and pharmacy claims that do not contain an enrolled ORP provider's NPI—as required by Federal rules.⁴³ Because ORP providers may not have a billing relationship with the State, the claims edit would deny or delay payments to the (1) furnishing provider that submitted the claim referred or ordered by the unenrolled ORP provider, or (2) pharmacy that dispenses the prescription by the unenrolled ORP provider. The latter point-of-sale edit occurs at the pharmacy before a beneficiary receives their medication.

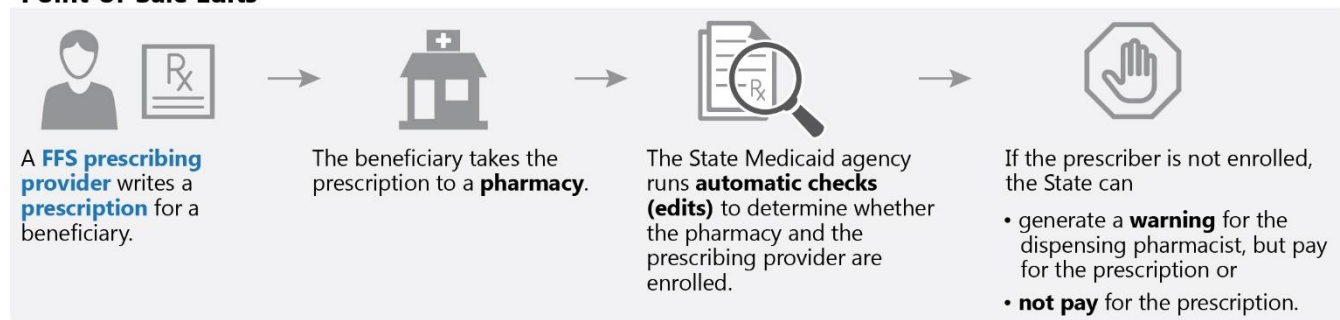
In the case of Medicaid managed care, States cannot directly prevent or delay payments to unenrolled MCO network providers. Instead, States can require that MCOs edit claims and then deny or delay payments to unenrolled network providers. In addition—after MCOs submit encounter records—States can use edits to compare the MCOs' network providers against the States' provider enrollment records.⁴⁴ The State could then deny encounters associated with unenrolled MCO network providers, which may reduce the MCOs' future capitation payment rates. (See Exhibit 1 on the next page for examples of how States may use edits.)

Exhibit 1: Examples of **edits** that States may use to ensure that providers are enrolled

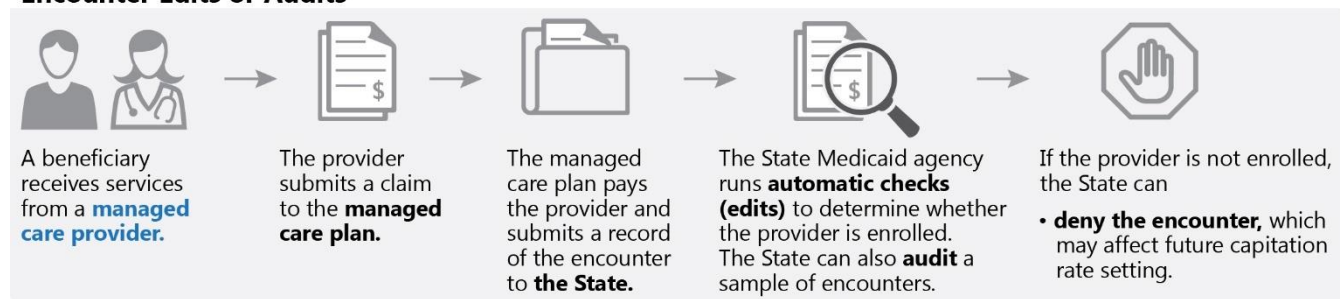
Pre-Payment Edits



Point-of-Sale Edits



Encounter Edits or Audits



Source: OIG review of Federal rules and documents from CMS, Medicaid and the State Children’s Health Insurance Program Payment and Access Commission (MACPAC), and various States.⁴⁵

CMS Oversight and Enforcement Controls

CMS is required to recover or disallow FFP for State Medicaid expenditures if States do not implement provider enrollment requirements. CMS reviews States’ payments for compliance with Federal requirements and may recover FFP paid to the State for claims associated with FFS providers who were not properly enrolled.⁴⁶ CMS must also disallow FFP for States’ payments to MCOs if the State has not complied with the requirement to enroll MCO network providers.⁴⁷ CMS does not currently assess whether MCO network providers were appropriately screened and enrolled when determining whether States have made improper payments to MCOs.⁴⁸

Provider Enrollment Enforcement Requirements: CMS

CMS reviews States' payments to check for compliance with State and Federal policies and identify improper payments. CMS may recover FFP for improper payments associated with unenrolled or improperly screened FFS providers.

CMS must disallow FFP for States' payments to MCOs if the State has not complied with the requirement to enroll and screen all MCO network providers.

Related OIG Work

OIG has repeatedly found problems with States' implementation of provider enrollment screening requirements. These problems entailed (1) States having approved enrollment applications for providers that did not submit the required ownership information as a part of their enrollment application, and (2) States having approved enrollment applications for providers that had not been properly screened.

OIG has found problems with the completeness and accuracy of the information that States have collected from providers and MCOs. In 2018, OIG found that MCOs typically did not provide the State with information about providers terminated or otherwise removed from their networks.⁴⁹ In 2016, OIG found that few State Medicaid programs requested that providers disclose all federally required ownership information. In the same study, 14 State Medicaid programs reported that they did not verify the completeness or accuracy of provider ownership information.⁵⁰ In 2014, OIG found that collecting additional information—such as a Social Security number and date of birth—would help to more effectively screen providers against existing Federal and State termination databases.⁵¹

OIG has also found repeated problems with States' implementation of the required screening activities. In a 2019 report on fingerprint-based criminal background checks, OIG found that 13 States had not implemented required criminal background checks.⁵² In 2016, OIG found that 11 States had not implemented the required site visits.⁵³

CMS has yet to implement key recommendations from these studies. Specifically, CMS has not fully implemented the recommendation that it clarify the information MCOs are required to report when providers are terminated or otherwise leave MCO networks. Further, CMS has not implemented and did not concur with OIG's recommendation to require State Medicaid programs to verify the completeness and accuracy of

provider ownership information. For OIG’s work on the provider enrollment screening activities, CMS has not fully implemented OIG’s recommendations to assist States in implementing background checks and site visits. Additionally, for OIG’s work on terminated providers, CMS has not implemented the recommendation to require that each State Medicaid agency report all terminations.

The requirements in the Cures Act help to address OIG’s outstanding recommendations. Specifically, the Cures Act established requirements to enroll all Medicaid providers by January 1, 2018, and established new requirements related to terminated providers.⁵⁴ OIG is conducting related work on the extent to which providers terminated in one State continued to be enrolled in other State Medicaid programs.⁵⁵

Methodology

For this evaluation, we sent a survey to 50 States and the District of Columbia. We included all States and the District of Columbia in our study to ensure that we had comprehensive information about Medicaid FFS and MCO network provider enrollment. Forty-nine States and the District of Columbia (hereinafter referred to as States) responded to our survey. One State—Massachusetts—did not respond to OIG’s survey. See Appendix B for a summary of OIG’s correspondence with Massachusetts. We conducted followup with 39 States to clarify their survey responses, through either email or an interview, to ensure that we had the most accurate information. We contacted 27 States via email alone to followup on their survey. We interviewed 12 additional States to clarify their survey responses, particularly with regard to the extent to which they had enrolled all providers serving Medicaid managed care beneficiaries. In August 2019, we also sent a set of questions to the CMS officials who oversee Medicaid provider enrollment. Because many States could not report expenditures associated with unenrolled MCO network providers, information on States’ managed care expenditures came from the Transformed Medicaid Statistical Information System (T-MSIS). Appendix B provides a detailed methodology.

Limitations

Our analysis relied on State-reported data, which we did not independently verify for every State.

In addition, we were not able to report all States’ MCO capitation payments because of incomplete T-MSIS data. As a result, the payment amounts we report underestimate actual capitation payments that States made to MCOs with unenrolled network providers. Each State may differ in the completeness of its T-MSIS data. For example, some States did not submit capitation payment records to T-MSIS for all or most of the study period, even though these States have Medicaid managed care programs. In those instances, we did not include an amount for the State’s capitation payments. (See Appendix E for the six States excluded from this analysis.)

Standards

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

FINDINGS

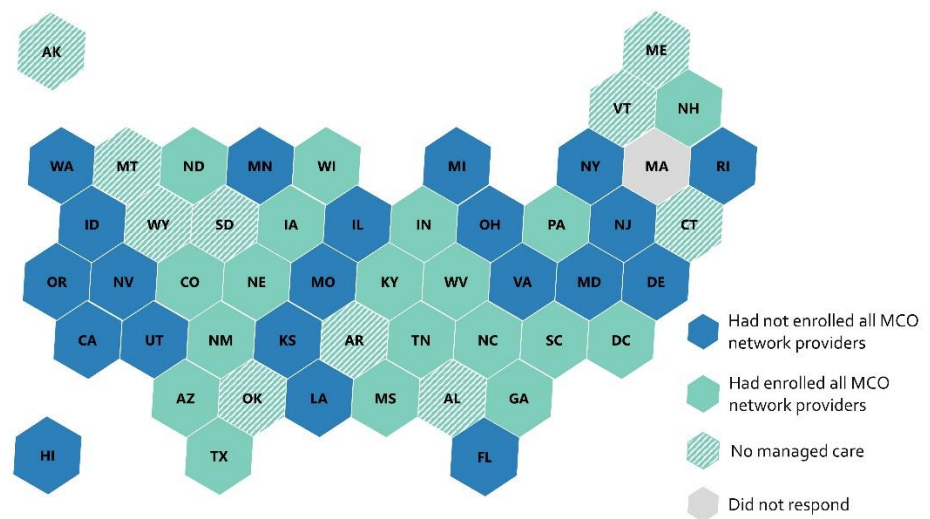
Twenty-three States reported allowing unenrolled providers to serve Medicaid beneficiaries

As of December 31, 2018, a total of 23 States reported that they had not enrolled all MCO network providers or FFS ORP providers. Twenty-one of the 23 States had not enrolled all MCO network providers serving beneficiaries through Medicaid managed care. Although these 23 States had enrolled all FFS furnishing providers, 10 had not enrolled all ORP providers serving beneficiaries through their Medicaid FFS programs.⁵⁶ One State—Massachusetts—did not respond to OIG’s survey for this report despite OIG’s repeated attempts to obtain a response.⁵⁷

Twenty-one States reported that they had not enrolled all MCO network providers because of various challenges

Twenty-one States reported that they had not enrolled all providers serving Medicaid beneficiaries through managed care by December 31, 2018—nearly a full year after the enrollment deadline specified in the Cures Act.⁵⁸ States experienced challenges to (1) enrolling MCO network providers and (2) putting enforcement controls in place to prompt unenrolled MCO network providers to enroll. (See Exhibit 2 for the States that had not enrolled all MCO network providers.)

Exhibit 2: Twenty-one States had not enrolled all MCO network providers as of December 31, 2018.



Source: OIG analysis of State survey and interview responses, 2019.

These 21 States served the majority of their Medicaid beneficiaries through managed care. In these States, 83 percent of Medicaid beneficiaries received services through managed care in 2018.⁵⁹ The Federal share of these States’ expenditures for Medicaid managed care was \$85 billion in 2018, but States could not, in most cases, determine how much of these expenditures were associated with unenrolled

providers. (See Appendix E for a breakdown of Federal expenditures by State.)⁶⁰

Of these 21 States reporting unenrolled MCO network providers, 17 were in the process of enrolling MCO network providers with the State. Four States had not started enrolling MCO network providers. (See Exhibit 3 for details on these 21 States' specific statuses.)

Exhibit 3: States' status enrolling MCO network providers as of December 31, 2018



Had started but not finished enrolling MCO network providers: CA, DE, FL, ID, IL, HI, KS, MD, MI, MO, NV, NJ, NY, OH, OR, UT, WA



Had not started enrolling MCO network providers:
LA, MN, RI, VA

Source: OIG analysis of State survey and interview responses, 2019.

The 17 States that were in the process of enrolling MCO network providers reported a range of estimates for the percentage of unenrolled MCO network providers. These States reported having 50 to 46,000 unenrolled MCO network providers. The following States are at the high, middle, and low points of the reported range:

- Michigan reported that approximately half of its MCO network providers—46,000 providers—were unenrolled.
- Florida reported that about one-third of its MCO network providers—31,000 providers—were unenrolled.
- Utah reported that 1 percent of its MCO network providers—50 providers—were unenrolled.

Of the four States that had not started enrolling MCO network providers, two States each reported over 100,000 unenrolled MCO network providers:

- Minnesota reported that it needed to enroll approximately 120,000 MCO network providers and that it planned to enroll all MCO network providers between July 2019 and July 2022.
- Louisiana reported that it needed to enroll approximately 110,000 MCO network providers and that it planned to enroll all MCO network providers between August 2019 and February 2020.

(See Appendix C for States' estimates of the number of MCO network providers left to enroll.)

Challenges to enrolling MCO network providers. The challenges that States faced differed depending on whether they had started the process of enrolling MCO network providers. The 17 States that were in process often had challenges to identifying which unenrolled MCO providers needed to enroll. The four States that had not started enrolling MCO network providers were redesigning their enrollment systems.

The 17 States that were in the process often experienced challenges accurately identifying which remaining providers needed to enroll. To determine which MCO providers needed to enroll, some of these States initially relied on MCOs to provide them with information about which MCO providers were in-network. However, these States found that MCOs' provider lists (1) did not include indications of providers' network status and (2) included providers that were not in MCOs' networks. Consequently, these States needed more assistance from their MCOs to determine which providers were in-network and, therefore, were required to enroll under the Federal rules.⁶¹

At the time of our review, some of these 17 States were working with their MCOs to identify the remaining network providers that needed to enroll. For example, California planned to require its MCOs to identify the remaining unenrolled providers and exclude them from the monthly report on active network providers sent to the State. Michigan planned to require that MCOs identify network providers not already enrolled with the State by using a claims edit. Enabling this edit required Michigan and the MCOs to share and compare the list of providers billing the MCOs, including network and out-of-network providers, and the State list of providers already enrolled with the State.

The four States that had not started enrolling MCO network providers were redesigning their provider enrollment systems. Both Louisiana and Minnesota reported that they were transitioning from a paper enrollment application to an online application. These States reported that they would not begin enrolling their MCO network providers until they established their online systems. Virginia reported that State Medicaid staff were developing an online enrollment system that MCO network providers would use to enroll with the State. Finally, Rhode Island reported that it had not yet developed an enrollment application for MCO network providers.

Challenges to putting MCO network provider enrollment enforcement controls in place. At the time of our review, 17 States were in the process of determining how and when to begin using enforcement controls for MCOs with unenrolled network providers. Because MCO network providers do not directly receive reimbursements from the States, States use the following enforcement controls: (1) imposing financial penalties on the MCO by denying encounters for unenrolled network providers, thereby decreasing future capitation payments, or requiring the MCO to

deny payments to unenrolled network providers; or (2) requiring MCOs to remove from their networks any providers that fail to enroll with the State in a timely way.⁶² States lacked information from CMS about how it would enforce requirements through its disallowance process.

States reported challenges to imposing financial penalties for services associated with unenrolled MCO network providers. States that had difficulties identifying which unenrolled MCO providers were in-network and needed to be enrolled—as described above—also had difficulties determining which encounters were associated with unenrolled MCO network providers and should be denied. These States may need to rely on their MCOs—as in the example of Michigan above—to edit the claims, identify unenrolled network providers, and suspend payments to those providers until they enroll with the State.

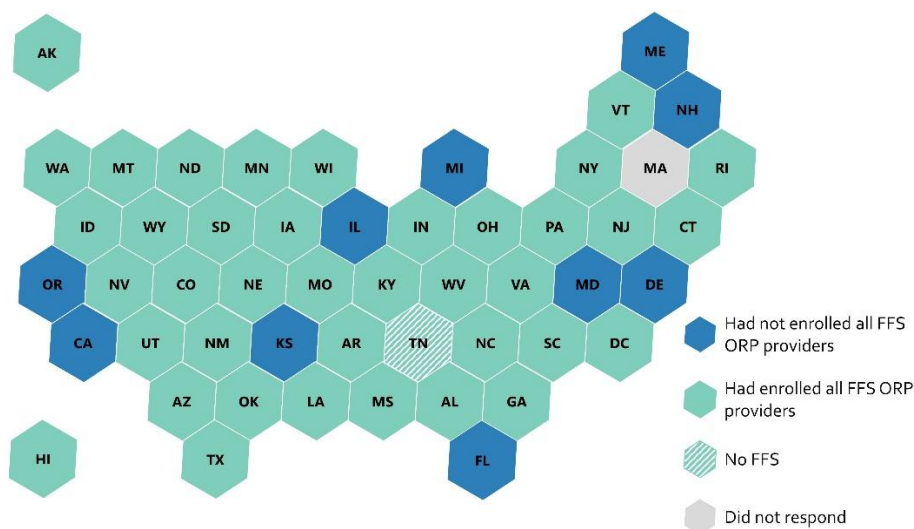
States also reported concerns that requiring MCOs to remove unenrolled providers from their networks before enough providers have enrolled would reduce the number of providers available to serve beneficiaries. The Federal rules generally require that MCOs “terminate” network providers that have not enrolled with the State within 120 days; however, States may determine that denial or termination of enrollment would not be in the best interests of the Medicaid program.⁶³ Some States reported that they had not required MCOs to terminate unenrolled network providers because of concerns about beneficiaries’ access to care. Further, one State had questions about whether the Cures Act requires them to report network providers terminated by MCOs to CMS, which would trigger cascading requirements to terminate those providers from Medicare and other State Medicaid programs.⁶⁴

Finally, some States had not determined when to begin enforcing penalties for noncompliance with MCO network provider enrollment requirements without direction from CMS on its plans for disallowing reimbursements to States. In December 2019, CMS reported that they were not disallowing reimbursements to States for expenditures associated with unenrolled MCO network providers.⁶⁵ CMS’s reasons were twofold: (1) concerns that its authority under the Cures Act requires it to fully disallow reimbursements to States for payments to MCOs with unenrolled providers, regardless of whether some network providers in the MCO were enrolled; and (2) concerns that such disallowances would jeopardize beneficiaries’ access to care. Further, CMS staff reported that they had informally advised States that CMS had not set a date for disallowing reimbursements in cases where States had concerns about beneficiaries’ access to care.

Ten States reported that they had not enrolled FFS providers that ordered, referred, or prescribed items and services for Medicaid beneficiaries because of various challenges

As of December 31, 2018, a total of 10 States reported that unenrolled FFS providers continued to order, refer, or prescribe items and services—nearly 2 years after the enrollment deadline specified in the Cures Act.⁶⁶ States also reported challenges to enrolling FFS ORP providers and establishing enforcement controls. (See Exhibit 4 on the next page for the States that had not enrolled all ORP providers.)

Exhibit 4: Ten States had not enrolled all FFS ORP providers as of December 31, 2018.



Source: OIG analysis of State survey and interview responses, 2019.

These States reported receiving FFP for claims associated with unenrolled FFS ORP providers. Five of the 10 States with unenrolled ORP providers reported receiving approximately \$60 million in Federal money for claims associated with these providers. The remaining five States could not identify the exact FFP for claims associated with unenrolled ORP providers, although they reported receiving Federal dollars for these claims.⁶⁷ (See Appendix D for information on the extent to which States had unenrolled ORP providers. Also, see Appendix F for the FFP reported by each State.)

Challenges to enrolling FFS ORP providers. States reported that enrolling their FFS ORP providers took time because of outdated systems and the need for provider education. These States reported delays to enrolling ORP providers because of necessary upgrades to their enrollment systems, such as moving from paper-based enrollment applications to electronic ones. Further, States reported that outreach efforts to educate providers about the enrollment requirements took time because they lacked contact information for many of these providers. Without a way to

directly contact these providers, States had to coordinate with a number of other stakeholders. For example, Michigan reported that it had conducted years of outreach through professional associations, pharmacies, and licensing boards to contact ORP providers and inform them of the enrollment requirement.

Challenges to putting FFS ORP provider enrollment enforcement controls in place. Similar to MCO network providers, FFS ORP providers presented challenges to enforcement because they do not directly receive reimbursements from the States. Financial penalties designed to enforce ORP provider enrollment requirements directly affect other providers and beneficiaries rather than the unenrolled ORP providers. To enforce ORP provider enrollment requirements, States reported that they needed to deny claims for: (1) services provided by furnishing providers that were originally ordered or referred by unenrolled ORP providers, and (2) beneficiaries' prescriptions that were written by unenrolled ORP providers. Because denying claims for prescriptions at the point of sale affects beneficiaries' access to medications, States specifically struggled to enforce enrollment requirements for ORP prescribing providers.

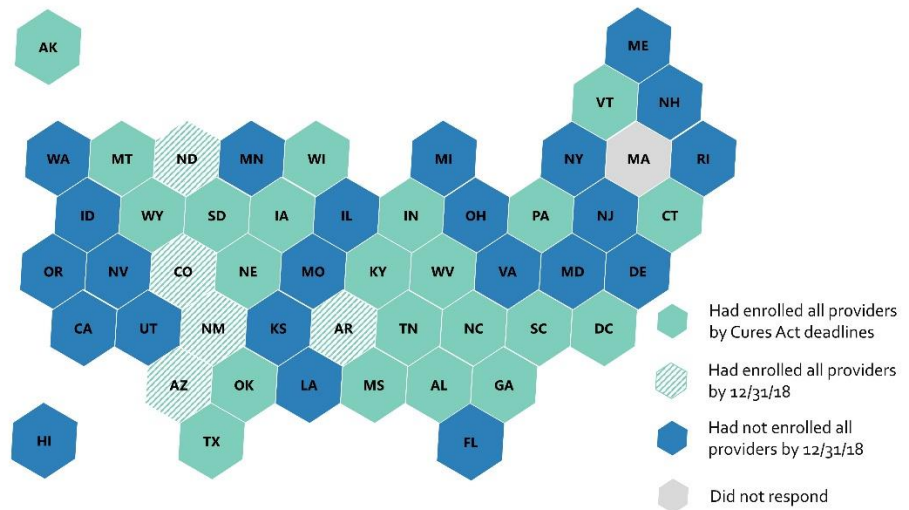
At the time of our review, none of the 10 States with unenrolled FFS ORP providers had started denying payments for prescriptions written by unenrolled ORP providers. Two States—Florida and New Hampshire—were in the process of requiring that ORP providers' NPIs be submitted on claims, which is necessary for identifying claims associated with unenrolled ORP providers and denying payment for them.⁶⁸ The remaining States primarily reported concerns that denying payments would mean that beneficiaries would not receive their prescriptions. When States deny payments for prescriptions written by unenrolled ORP providers, pharmacists do not get paid and may send beneficiaries away without their medication. OIG recognizes that States must balance efforts to enforce the enrollment requirement for ORPs with the need for beneficiaries to receive their medications.

However, some States reported progress in establishing enforcement controls that would prompt the enrollment of FFS ORP providers without disrupting beneficiaries' access to medications. For example, California reported that it was using a warning edit at the point of sale. This edit alerts the pharmacy when an unenrolled ORP provider has written a prescription. Instead of denying payment for the prescription, the edit initiates a process for conducting targeted outreach with the unenrolled provider. California reported that it would eventually introduce an edit that denies claims associated with unenrolled ORP providers—once it had enrolled enough ORP providers to not disrupt access to medications—but it did not specify a date.

Of the 27 States that reported enrolling all providers, 16 reported lacking enrollment processes or enforcement controls to ensure ongoing compliance

Twenty-seven States reported that they had enrolled all providers that serve beneficiaries in their Medicaid programs as of December 31, 2018.⁶⁹ Twenty-two of these 27 States reported that they enrolled all providers by the earlier dates requested in the Cures Act.⁷⁰ Further, 11 of these 27 States reported complying with all Federal provider enrollment requirements, but the remaining 16 States reported that they lacked the enrollment processes or enforcement controls—or both—necessary to ensure ongoing compliance with the requirements.⁷¹ (See Exhibit 5 for each State’s reported enrollment status.)

Exhibit 5: Twenty-seven States reported that they had enrolled all Medicaid providers as of December 31, 2018.



Source: OIG analysis of State survey and interview responses, 2019.

Eleven States reported they enrolled all providers in compliance with Federal requirements and had enforcement controls

Eleven States reported that they had enrolled all providers that serve Medicaid beneficiaries in compliance with the Federal provider enrollment requirements. These 11 States reported collecting all required identifying and ownership information for their MCO network providers, FFS furnishing providers, and FFS ORP providers as well as conducting all the required screening activities for them. Collecting the required identifying and ownership information—and conducting the required screening activities—allows States to confirm the identity of providers applying to enroll; determine whether these providers have a history of fraud, waste, or abuse; and prevent any fraudulent or abusive providers from enrolling in the State Medicaid program.⁷²

These 11 States also reported having enforcement controls to ensure ongoing compliance with the MCO and FFS provider enrollment requirements. The States with managed care reported using (1) reviews of encounter records or (2) comparisons of MCO network provider rosters with State provider enrollment records to identify any unenrolled MCO

network providers on an ongoing basis. The States with FFS programs reported having prepayment edits in place to prevent payments for services provided by unenrolled FFS furnishing providers. They also reported having prepayment and point-of-sale edits in place to deny payments for services and prescriptions ordered, referred, or prescribed by unenrolled FFS ORP providers.

Eight of the 16 States were not in compliance with all provider enrollment requirements

Eight of the 16 States reported that they were not collecting all identifying and ownership information necessary to screen providers and their owners or conducting all screening activities. Seven of these States reported not always collecting all required elements of identifying and ownership information. Four of these States reported allowing providers to serve beneficiaries without having conducted all required screening activities.⁷³ (See Exhibit 6 for which States were not collecting all identifying and ownership information or not conducting all required screening activities.)

Exhibit 6: Eight States reported enrolling providers without all required information or all required screening activities as of December 31, 2018.



Did not collect all identifying or ownership information

AZ, MS, MT, SC, SD, WV, WY



Had not completed all screenings

AZ, AR, SD, WY

Source: OIG analysis of State survey and interview responses, 2019. Three States did not collect all identifying and ownership information and had not conducted all screenings.

These States varied in the degree to which they were collecting providers' identifying and ownership information on enrollment applications. Some States with separate ORP provider application processes were collecting identifying and ownership information for FFS furnishing providers but not for FFS ORP providers. For example, Arizona and West Virginia reported collecting all identifying and ownership information from FFS furnishing providers, but they reported not collecting required identifying information—such as name and date of birth—from their ORP providers. (See Appendix G for a breakdown of missing identifying and ownership information by State.)

States must collect the required identifying information—as well as any applicable ownership information—from providers applying to enroll to

confirm a provider's identity, assess the risk that a provider poses to Medicaid, and screen that provider accordingly.⁷⁴ If States do not collect the required identifying and ownership information needed to properly screen providers—or conduct all screening activities—beneficiaries may be exposed to fraudulent or abusive providers that have been enrolled by the State. For example, Arizona reported not collecting all identifying and ownership information from FFS ORP providers and, as a result, could not assess their risk or screen them accordingly. The State reported that it was developing a system to ensure compliance with provider enrollment requirements for ORP providers. Although many ORP providers enroll as individuals, some ORP providers may have owners that they need to disclose. The MPEC states that ORP providers must comply with the Federal ownership disclosure and provider enrollment screening requirements where applicable.⁷⁵

Eleven of the 16 States lacked enforcement controls necessary for ensuring future compliance with provider enrollment requirements

Eleven of the 16 States reported lacking some controls that would allow them to effectively conduct ongoing oversight of provider enrollment requirements across managed care and FFS. Two States reported not having any controls—such as audits or reviews of encounters—to prevent payments to MCOs with unenrolled network providers. Two States reported that they lacked prepayment edits to prevent payments to unenrolled FFS furnishing providers. These two States also reported they did not have prepayment edits to deny payments for medical services ordered or referred by unenrolled FFS ORP providers. Finally, 10 States reported that they did not have a point-of-sale edit that would deny payments for prescriptions written by unenrolled ORP providers, which is a control that ensures that States are complying with the Federal rules to deny such payments.⁷⁶ Without having such controls in place, these States may continue doing business with unenrolled providers. (See Exhibit 7 on the next page for which States lacked controls in each area.)

Exhibit 7: Eleven States reported enrolling providers without controls to ensure compliance as of December 31, 2018.



No controls—such as reviews of encounter data or MCO provider rosters—to prevent payments to MCOs with unenrolled network providers

NM, SC



No prepayment edit to prevent payment to unenrolled FFS furnishing providers

MT, SC



No prepayment edit to prevent payment for medical services ordered or referred by unenrolled FFS ORP providers

MT, SC



No point-of-sale edit to prevent payment for prescriptions written by unenrolled FFS ORP providers

AL, AZ, CT, IN, MT, NC, OK, SC, TX, VT

Source: OIG analysis of State survey and interview responses, 2019. Some States reported missing more than one of the controls listed above. For example, two States did not have an FFS prepayment edit or an FFS point-of-sale edit.

CONCLUSION AND RECOMMENDATIONS

States must ensure that only enrolled providers serve Medicaid beneficiaries. As of December 31, 2018, States reported enrolling all Medicaid FFS furnishing providers, but 23 States reported that they had not enrolled all Medicaid MCO network providers or all Medicaid FFS ORP providers or both. The Cures Act stipulates that no FFP should be paid to States for managed care expenditures if the State has not complied with the requirement to enroll MCO network providers.⁷⁷ States must also return to CMS the Federal share of overpayments associated with unenrolled FFS providers.⁷⁸ CMS reported that it is not able to disallow reimbursements to States for payments associated with unenrolled MCO network providers because it does not have the specific authority to disallow a portion of capitation payments to MCOs in this case. In contrast, CMS reported that its authority under the Cures Act only allows it to disallow all payments to MCOs that have any unenrolled providers in their networks. Further, CMS reported concerns that disallowing all payments to an MCO would result in many beneficiaries losing access to care.

Twenty-seven States reported that they had enrolled all providers serving Medicaid beneficiaries. However, 16 of these States reported not being compliant with all provider enrollment requirements or lacking enforcement controls to ensure ongoing compliance.

To protect the beneficiaries served by the Medicaid program and taxpayer dollars, CMS must work with States to ensure that only enrolled providers serve Medicaid beneficiaries. To ensure that States enroll all providers, OIG recommends that CMS:

Take steps to disallow Federal reimbursements to States for expenditures associated with unenrolled MCO network providers, including seeking necessary legislative authority

CMS should take steps to disallow Federal reimbursements to States for expenditures associated with unenrolled MCO network providers. The Cures Act requires that no FFP shall be paid to States for managed care expenditures if the State has not complied with the requirement to enroll these providers.⁷⁹ At the time of OIG's review, CMS was not examining whether MCO network providers were appropriately screened and enrolled as part of its process for determining whether States have made improper payments to MCOs. Further, CMS reported that the Cures Act authority only permits it to fully disallow Federal reimbursements to States for entire payments to MCOs with unenrolled providers. CMS reported that it cannot conduct partial disallowances for the payments

associated with unenrolled MCO network providers and that full disallowances would jeopardize beneficiaries' access to care. To the extent that CMS determines that it cannot conduct full disallowances, CMS should seek the necessary legislative authority to conduct partial disallowances.

Work with States to ensure that unenrolled providers do not participate in Medicaid managed care and assist States in establishing ways to do so

CMS should work with States to ensure that unenrolled providers do not participate in Medicaid managed care networks. CMS should determine the most appropriate way to facilitate candid communication with States that have not enrolled all MCO network providers. For example, CMS could reach out to States identified in this report with offers of targeted assistance, particularly for any States that have not already worked with CMS to enroll their MCO network providers. CMS could use this process to share best practices for attaining compliance while maintaining beneficiaries' access to care from States that have enrolled all providers and established systems to ensure ongoing compliance. CMS could also develop a model managed care contract for States that includes language requiring MCOs to implement controls to prevent payments to unenrolled providers.

Work with States to ensure that they have the controls required to prevent unenrolled ordering, referring, or prescribing providers from participating in Medicaid FFS

CMS should work with States to ensure that they have adequate controls in place that prevent unenrolled FFS ORP providers from serving beneficiaries in Medicaid FFS. To implement this recommendation, CMS should first work with States to ensure claims contain the NPI for ORP providers before paying the claim, as required by Federal rules.⁸⁰ Second, CMS should work with States to ensure that they are verifying that ORP providers are enrolled with the State prior to paying claims associated with them. For example, CMS could conduct targeted reviews in States with unenrolled ORP providers. CMS could also communicate regularly with those States about their progress toward compliance. CMS should also establish and communicate to States best practices for ensuring ongoing enforcement of the requirement that all ORP providers enroll with the State. For example, before implementing payment denial edits, States could use warning edits to advise furnishing providers or pharmacies that they will not be paid for future services or prescriptions associated with an unenrolled ORP provider if that provider does not enroll. Warning edits could be a useful tool in prompting ORP providers to enroll.

Work with States to ensure that they are complying with requirements to collect identifying information and ownership information on Medicaid provider enrollment forms

CMS should work with States to ensure that they collect all required identifying information—as well as any applicable ownership information—when enrolling providers. Collecting all required identifying and ownership information is necessary to confirm providers' identities and effectively screen them. CMS should work with the seven States listed in Exhibit 6 that have not collected all required identifying and ownership information for FFS providers and, in one State, MCO network providers, to determine whether they need to update their enrollment applications to obtain this information from providers and screen them accordingly. Using the findings of the outreach with these seven States, CMS should set individual dates for when these States' enrollment applications should collect all outstanding information for effectively screening their providers for Medicaid enrollment.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all four of our recommendations and described steps to implement each.

In response to our first recommendation, CMS has requested legislative authority to issue financial penalties to reduce States' administrative matches for noncompliance with provider enrollment, screening, and revalidation requirements. CMS requested this legislative authority as part of the President's FY 2021 Budget.

In response to our second recommendation, CMS plans to conduct targeted outreach with the States identified in the report. Further, CMS plans to share examples of State managed care contract language and to use program integrity reviews focused on managed care—and any resulting corrective action plans—to rectify issues unresolved by CMS's technical assistance and support.

In response to our third recommendation, CMS plans to continue working with States and conduct program integrity reviews with States. For this recommendation, CMS should work with States to ensure claims contain the NPI for ORP providers before paying the claim, as required by Federal rules. CMS should also work with States to ensure that they are verifying that ORP providers are enrolled with the State prior to paying claims associated with them.

In response to our fourth recommendation, CMS plans to conduct targeted outreach with the seven States identified in the report. CMS believes that setting a separate deadline for collection of information would be duplicative. We understand CMS's concern. We encourage CMS to work with individual States on timelines for collecting all required information.

OIG and CMS share the goal of ensuring that all States have an effective Medicaid provider enrollment screening process. We are encouraged by CMS's current efforts and plans for ensuring that States achieve this goal. We look forward to receiving CMS's updates and progress on these recommendations.

For the full text of CMS's response, see Appendix H.

APPENDIX A: 21st Century Cures Act: Section 5005(e), Public Law 114-255

The text below outlines the OIG report mandated by the Cures Act. OIG has conducted two evaluations in response to the mandate. This evaluation addresses the mandated work regarding the Medicaid provider enrollment requirements. A second OIG evaluation (OEI-03-19-00070) addresses terminated providers.

(e) OIG REPORT.—Not later than March 31, 2020, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the implementation of the amendments made by this section. Such report shall include the following:

(1) An assessment of the extent to which providers who are included under subsection (ll) of section 1902 of the Social Security Act (42 U.S.C. 1396a) (as added by subsection (a)(3)) in the database or similar system referred to in such subsection are terminated (as described in paragraph (8) of subsection (kk) of such section, as added by subsection (a)(1)) from participation in all State plans under title XIX of such Act (or waivers of such plans).

(2) Information on the amount of Federal financial participation paid to States under section 1903 of such Act in violation of the limitation on such payment specified in subparagraph (D) of subsection (i)(2) of such section and paragraph (3) of subsection (m) of such section, as added by subsection (a)(4).

(3) An assessment of the extent to which contracts with managed care entities under title XIX of such Act comply with the requirement specified in paragraph (5) of section 1932(d) of such Act, as added by subsection (a)(2).

(4) An assessment of the extent to which providers have been enrolled under section 1902(a)(78) or 1932(d)(6)(A) of such Act (42 U.S.C. 1396a(a)(78), 1396u-2(d)(6)(A)) with State agencies administering State plans under title XIX of such Act (or waivers of such plans).

APPENDIX B: Detailed Methodology

This appendix provides a detailed methodology on our data sources and analysis.

Scope

We included all 50 States and the District of Columbia in our study to ensure that we could provide comprehensive information about implementation status across State Medicaid programs.

Data Sources and Collection

The data on States' status regarding Medicaid provider enrollment came from an online survey to the States and from a structured questionnaire to CMS. In April 2019, OIG surveyed State Medicaid staff that manage provider enrollment. On the basis of these survey responses, OIG followed up with 39 States to corroborate their respective responses on the survey from May through October 2019—we contacted 27 States by email and conducted structured telephone interviews with 12 additional States. OIG followed up with these 39 States to (1) determine whether they enrolled all Medicaid providers by the end of 2018, (2) obtain additional information about their unenrolled providers, and (3) clarify survey responses that were unclear. In August 2019, OIG also sent questions to CMS staff overseeing Medicaid provider enrollment.

Information on States' managed care expenditures came from the Transformed Medicaid Statistical Information System (T-MSIS). CMS has established T-MSIS as a national database of Medicaid claims and encounter data. In addition to Medicaid claims and encounter data, T-MSIS contains data on beneficiary eligibility, providers, and expenditures.⁸¹ We used T-MSIS data from OIG's data warehouse to obtain final action capitation payments (the per member per month amount) paid to MCOs by States.

Survey to States. We used the survey to ask States about their implementation of provider enrollment requirements for three groups of providers: FFS furnishing providers, FFS ORP providers, and MCO network providers. We asked States to report (1) whether they had enrolled all FFS furnishing, FFS ORP, and MCO network providers by the applicable Cures Act deadlines; (2) the numbers of enrolled and unenrolled providers in the State as of December 31, 2018; and (3) whether the State had completed all required screening activities as of December 31, 2018. We also asked States to describe both the controls they had in place to prevent payments to unenrolled providers and any provider enrollment challenges they faced. Finally, we asked States about the FFP they received for FFS and MCO payments associated with unenrolled providers.

Below is a summary of the questions we asked of States in the survey and in the email followup, grouped by theme.

- **Cures Act deadlines.** We asked States to report whether they had enrolled all FFS furnishing and FFS ORP providers by the January 1, 2017, deadline. We also asked States to report whether they had enrolled all MCO network providers by the January 1, 2018, deadline.
- **Extent to which States had enrolled providers serving Medicaid beneficiaries.** We then asked States to report the numbers of enrolled and unenrolled FFS furnishing, FFS ORP, and MCO network providers for each risk category as of December 31, 2018. We chose this date to provide the most up-to-date status on States' progress on Medicaid provider enrollment. We also asked States to provide (1) an explanation for why providers remained unenrolled, (2) a description of the methods they used to calculate the number of providers, and (3) explanations for when they could not report these numbers.
- **Extent to which States had screened and collected the required identifying and ownership information from all providers serving Medicaid beneficiaries.** We asked States whether they had completed all the required screening activities for all limited-, moderate-, and high-risk providers. To assess whether States had collected all information necessary to conduct provider screening and enrollment, we asked States to select, from a close-ended list, the pieces of information they collect from providers as part of the enrollment process. We created the list based on the identifying information required by the Cures Act (name, Social Security number, date of birth, specialty, Federal Taxpayer Identification Number, NPI, and license or certification number) and the ownership information required by the Affordable Care Act.
- **Controls.** We asked States to select controls they use to monitor FFS furnishing, FFS ORP, and MCO network provider enrollment from close-ended lists. We asked States whether they (1) used prepayment or point-of-sale edits for claims, (2) reviewed or audited encounter data, and (3) compared State provider enrollment and MCO network provider records. We created the lists using feedback from States and controls States reported using in previous OIG work. We also allowed States to report any additional controls they had in place.
- **Federal share.** We asked States to provide information about the FFP received for (1) payments to MCOs associated with unenrolled network providers; (2) claims billed by unenrolled FFS furnishing providers; and (3) claims ordered, referred, or prescribed by unenrolled FFS ORP providers. States with unenrolled providers

that could not report this information were asked to explain why they could not provide this information. As a note, many States could not report this information for unenrolled Medicaid MCO network providers—as a result, we used T-MSIS data to determine expenditures associated with MCOs in States with unenrolled MCO network providers. We used the information from the survey to report the FFP for expenditures associated with claims ordered, referred, or prescribed by unenrolled ORP providers.

- **Challenges.** Finally, we asked States to report their provider enrollment implementation challenges. We asked States to select challenges to enrolling each group of providers from a close-ended list we provided. We created the list using both challenges that States had reported in OIG’s provider enrollment report from 2016 and challenges that States discussed during survey pre-test interviews.
- **Followup emails to States.** To ensure that we had the most accurate data from States, we sent followup data collection emails to 27 States to corroborate their survey responses on their status as of December 31, 2018. We sent followup emails to the following: (1) States that did not clearly indicate whether they had enrolled all FFS and MCO providers as of December 31, 2018; (2) States that reported some conflicting information on their survey (e.g., States that reported having enrolled all FFS providers but reported many unenrolled providers); (3) States that reported an unknown number of unenrolled providers; and (4) States that reported enrolling all providers but not collecting all identifying and ownership information or conducting all screening activities. We conducted followup with these States to ensure that we had the most accurate information.

Fifty States responded to the survey. One State—Massachusetts—did not respond. After we sent five emails and made three phone calls to Massachusetts, provider enrollment staff in Massachusetts reported that they would not respond to the survey, stating that they lacked the staff to provide the requested information in a timely manner.

Structured Interviews With States. We conducted followup interviews with 12 States that were not in compliance with the Cures Act’s MCO network provider enrollment requirements. OIG conducted these interviews to provide additional context regarding States’ implementation status, provider enrollment challenges, and financial risk associated with unenrolled providers. We selected States that (1) had many unenrolled MCO network providers, (2) could not estimate the exact number of unenrolled MCO network providers but reported having many outstanding providers to enroll, and (3) requested to speak with us to

clarify or expand on their survey responses. We conducted these interviews in May and June 2019.

Questions for CMS. To clarify CMS’s guidance on MCO network provider enrollment, we sent a set of questions to CMS staff responsible for provider enrollment in August 2019. Specifically, we asked CMS for an update on whether they were enforcing the requirements in the Cures Act and, if not, why.

Data Analysis

We analyzed surveys, followup emails, and interview responses to understand States’ progress toward enrolling all FFS and MCO network providers. First, we reviewed survey responses to understand whether States had enrolled all Medicaid providers by the Cures Act deadlines. To determine whether States had enrolled all providers by the end of 2018, we followed up with States that had not finished by the Cures Act deadlines and whose survey responses did not clearly indicate their status at the end of 2018. This followup was conducted via emails and interviews.

After identifying States that did not enroll all FFS and MCO network providers by the end of 2018, we reviewed States’ survey and interview responses to gain greater insight into why providers remained unenrolled and the challenges that States faced when enrolling providers. In some cases, we identified additional reasons and challenges during interviews that States had not reported on their surveys.

We analyzed States’ surveys and interview responses to identify whether States reported controls, collected all identifying and ownership information, and completed all provider screenings.

We analyzed data that States submitted to T-MSIS to calculate the amount of capitation payments made to MCOs by States with unenrolled MCO network providers. Because many States could not report expenditures associated with unenrolled MCO network providers, T-MSIS proved the best source of information on capitation payments. We used aggregated Medicaid final action capitation payments (including negative payment amounts) reported in T-MSIS for each State for calendar year 2018. We did not include CHIP capitation payments, “other” capitation payments, or denied capitation payments. To calculate the FFP for capitation payments, we applied each State’s regular FMAP for fiscal year 2018.

APPENDIX C: Extent of Unenrolled MCO Network Providers

Some States provided OIG with numbers of enrolled and unenrolled MCO network providers in their survey responses. For these States, OIG used the reported numbers to calculate a percentage of unenrolled MCO network providers. Other States provided estimated percentages of unenrolled MCO network providers in their narrative survey responses or as part of followup discussions. States often qualified their answers—whether exact numbers or estimated percentages—with explanations for why the numbers were approximations. For example, not all States could identify and exclude out-of-network providers for their analysis. Some States were not able to provide any sort of estimate. Please see the State breakdown on the following pages.

State	Total Unenrolled MCO Providers Reported by State	Total Enrolled MCO Providers Reported by State	Percentage of Unenrolled MCO Providers	Other Information Provided by States
California	—	103,083	30%	California estimated that 30% of MCO providers remain unenrolled by comparing State enrollment records with MCO rosters. California reported that this 30% likely includes some out-of-network providers or providers in the process of enrolling.
Delaware	—	246,682	—	Delaware was not able to report any numbers or estimates for unenrolled MCO network providers.
Florida	31,371	81,562	28%	Florida reported the number of MCO network providers not enrolled with the State.
Hawaii	4,068	12,091	25%	Hawaii reported the number of MCO network providers not enrolled with the State.
Idaho	—	—	—	Idaho was not able to report any numbers or estimates for MCO network provider enrollment.
Illinois	—	—	—	Illinois was not able to report any numbers or estimates for MCO network provider enrollment.
Kansas	—	—	10%	During a followup interview, Kansas estimated that it had 10% of its MCO network providers to enroll.
Louisiana	112,722	—	—	Louisiana had not started to enroll MCO network providers that only serve managed care beneficiaries. Based on an analysis of its MCO provider registry, Louisiana estimated that it needed to enroll up to 112,722 MCO network providers. Louisiana estimated that 11,000 enrolled FFS providers were also MCO network providers.

— Indicates that a State did not provide the information.

State	Total Unenrolled MCO Providers Reported by State	Total Enrolled MCO Providers Reported by State	Percentage of Unenrolled MCO Providers	Other Information Provided by States
Maryland	—	58,428	10%	Based on its MCOs' comparison of network providers and State enrollment records, Maryland estimated that 10% of MCO network providers remain unenrolled.
Michigan	45,911	52,913	46%	Michigan compared MCO network lists with FFS provider records. Michigan reported in narrative responses that some unenrolled MCO providers may no longer be active network providers.
Minnesota	120,138	—	—	Minnesota had not started to enroll any of its MCO network providers that serve only managed care beneficiaries and needed to enroll up to 120,138 MCO network providers. Minnesota could not provide information on the number of MCO network providers already enrolled as FFS providers.
Missouri	—	778	—	Missouri did not report numbers of unenrolled MCO network providers due to inaccuracies in the network provider lists provided by its MCOs.
Nevada	857	13,215	6%	Nevada compared MCO provider lists with FFS provider records. Nevada reported the number of unenrolled likely includes some providers not required to enroll (e.g., provider types not eligible to enroll in Medicaid or single case agreement providers).

— Indicates that a State did not provide the information.

State	Total Unenrolled MCO Providers Reported by State	Total Enrolled MCO Providers Reported by State	Percentage of Unenrolled MCO Providers	Other Information Provided by States
New Jersey	—	—	12–23%	Comparing State provider enrollment records with MCO network providers, New Jersey estimated that 23% of MCO network providers remain unenrolled, while its MCOs estimate that 12% remain unenrolled. They are in the process of reconciling this difference.
New York	—	—	—	New York could not compare State provider enrollment records with MCO network rosters to provide an estimate because the rosters were not in a data format that was compatible with State enrollment records.
Ohio	2,984	62,539	5%	Ohio analyzed encounter data to identify unenrolled NPIs. Ohio reported that the number of unenrolled NPIs likely includes some providers not required to enroll (e.g., out-of-state providers or out-of-network providers).
Oregon	—	2,981	—	Oregon reported that it did not have time to conduct the necessary encounter analysis.
Rhode Island	20,000–50,000	—	—	Rhode Island had not started to enroll MCO network providers that serve only managed care beneficiaries and estimated that somewhere between 20,000 and 50,000 MCO network providers need to be enrolled. Rhode Island had not determined how many MCO network providers were already enrolled as FFS providers.
Utah	54	5,035	1%	Utah analyzed encounter data to identify unenrolled NPIs.

— Indicates that a State did not provide the information.

State	Total Unenrolled MCO Providers Reported by State	Total Enrolled MCO Providers Reported by State	Percentage of Unenrolled MCO Providers	Other Information Provided by States
Virginia	—	—	—	Virginia reported that it had not started to enroll any MCO network providers that serve only managed care beneficiaries and could not calculate the number of MCO network providers already enrolled in FFS before beginning the MCO provider enrollment process.
Washington	—	46,111	—	Washington did not report a number of unenrolled MCO network providers but found 16,352 unduplicated unenrolled NPIs on encounters.

— Indicates that a State did not provide the information.

APPENDIX D: Extent of Unenrolled FFS ORP Providers

Some States provided OIG with numbers of enrolled and unenrolled FFS ORP providers in their survey responses. For these States, OIG used the reported numbers to calculate a percentage of unenrolled ORP providers. Other States reported percentages of claims with unenrolled ORP NPIs in their narrative survey responses. Some States were not able to provide any sort of estimate. Please see the State breakdown on the following page.

State	Total Unenrolled FFS ORP Providers Reported by State	Total Enrolled FFS ORP Providers Reported by State	Percentage of Unenrolled FFS ORP Providers Based on State-Reported Numbers	Other Information Provided by States
California	15,432	2,407	87%	California reported the number of actively enrolled FFS ORP providers by querying its State records. California conducted a claims analysis to identify unenrolled FFS ORP providers.
Delaware	—	681	—	Delaware reported the number of enrolled FFS ORP providers by querying its State enrollment records.
Florida	—	4	—	Florida could not report the exact number of unenrolled FFS ORP providers.
Illinois	—	—	—	Illinois was not able to report any numbers or estimates for FFS ORP enrollment.
Kansas	1,395	326	81%	Kansas conducted a claims analysis to identify unenrolled FFS ORP providers.
Maine	3,788	74	98%	Maine conducted a claims analysis to identify unenrolled FFS ORP providers.
Maryland	32,925	1,378	96%	Maryland conducted a claims analysis to identify unenrolled FFS ORP providers.
Michigan	9,857	83,918	11%	Michigan conducted a claims analysis to identify unenrolled FFS ORP providers.
New Hampshire	—	—	—	New Hampshire was not able to report exact numbers or estimates for FFS ORP enrollment.
Oregon	1,122	—	—	Oregon conducted a claims analysis to identify unenrolled FFS ORP providers.

— Indicates that a State did not provide the information.

APPENDIX E: Federal Share of States' Capitation Payments to MCOs With Unenrolled Network Providers

Federal share of capitation payments to MCOs with unenrolled network providers for 2018.

State	Federal Share of Capitation Payments
NY	\$20,115,146,812
CA	\$13,955,891,080
OH	\$10,135,152,072
FL	\$9,543,534,936
MI	\$5,959,729,583
NJ	\$4,839,174,290
LA	\$4,794,290,381
IL	\$4,521,775,645
MN	\$2,841,403,495
MD	\$2,570,597,036
WA	\$2,185,498,050
OR	\$1,743,827,099
NV	\$973,828,604
UT	\$689,754,855
ID	\$176,239,072
DE ^a	—
HI ^b	—
KS ^c	—
MO ^b	—
RI ^a	—
VA ^c	—

Source: Medicaid MCO Capitation Data From T-MSIS for Calendar Year 2018; FY18 FMAP rates from the *Federal Register*.⁸²

^a State reported negative total capitation payments.

^b OIG determined State capitation payment information was incomplete given the size of its Medicaid managed care program.

^c State was missing months of capitation payments on or after January 1, 2018, when we collected these data from T-MSIS.

APPENDIX F: Federal Share of States' Payments for Items and Services Ordered, Referred, or Prescribed by Unenrolled FFS ORP Providers

Federal share of claims associated with unenrolled FFS ORP providers from July 1, 2018, through December 31, 2018

State	Federal Share of Claims
CA	\$38,143,633
MI	\$13,160,424
ME	\$7,186,549
OR	\$1,129,483
KS	\$423,423
DE^a	—
FL^a	—
IL^a	—
MD^a	—
NH^a	—

Source: OIG analysis of State surveys, 2019.⁸³

^a State did not provide information.

APPENDIX G: States That Enrolled All Providers but Did Not Collect All Required Identifying and Ownership Information

Some of the 27 States that reported enrolling all providers did not collect some or all required identifying and ownership information from these providers. Each State’s missing information is indicated below.

	Arizona	Mississippi	Montana	South Carolina	South Dakota	West Virginia	Wyoming
FFS ORP provider							
DOB	✗			✗	✗	✗	✗
Federal Tax ID Number	✗	✗	✗	✗		✗	
Ownership	✗	✗		✗		✗	
SSN				✗	✗	✗	
Name	✗			✗		✗	
Specialty	✗			✗		✗	
State License or Certification Number (when applicable)	✗			✗		✗	
NPI (when applicable)				✗		✗	
FFS furnishing provider							
DOB					✗		✗
SSN				✗	✗		
MCO network provider							
DOB				✗			
Federal Tax ID Number				✗			
Ownership				✗			
SSN				✗			
Name				✗			
Specialty				✗			
State License or Certification Number (when applicable)				✗			
NPI (when applicable)				✗			

Appendix H: Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: February 18, 2020

TO: Christi Grimm
Principal Deputy Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Twenty-Three States Reported Allowing Unenrolled Providers to Serve Medicaid Beneficiaries, OEI-05-19-00060

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to ensuring that all Medicaid providers are screened and enrolled appropriately.

Both the Patient Protection and Affordable Care Act (PPACA) and the 21st Century Cures Act (Cures Act) established new Medicaid provider screening and enrollment requirements. Specifically, the Cures Act requires states to screen and enroll all Medicaid ordering, referring, and prescribing providers by 2017 and all Medicaid managed care providers by 2018. States have made significant progress towards this requirement, and over half of all states are now enrolling all providers.

CMS has established regulations to implement categorical risk-based screening of newly enrolling Medicaid providers and to revalidate all current Medicaid providers under these requirements. To assist states in implementing these requirements and ensure that only eligible providers participate in Medicaid, CMS employs formal oversight, such as reviews of state payment data, provision of technical assistance and tools, and regular follow-up with states through open channels of communication established by CMS's working relationships with state partners.

CMS uses the Payment Error Rate Measurement (PERM) process to identify improper payments related to states' non-compliance with provider screening and enrollment requirements. CMS institutes PERM corrective action plans, which include provider enrollment findings when applicable. CMS is in the process of instituting more frequent reviews of PERM corrective action plans to evaluate the progress states are making, which will now be performed quarterly.

In addition, as part of CMS' Medicaid managed care focused program integrity reviews for 2019 and 2020, we assess state compliance with the network provider screening and enrollment provisions at 42 CFR 438.602(b). As part of the focused review process, states that are found to be out of compliance are required to develop and implement corrective action plans that ensure compliance with federal regulations.

CMS also offers optional technical support services to help states ensure that their process for screening and enrolling Medicaid providers is consistent with federal regulations. This assistance

includes performing site visits at states' request to advise on implementation of various aspects of provider screening and enrollment. In addition, CMS offers a Data Compare service that allows a state to rely on Medicare's screening in lieu of conducting a state screening. CMS also provides guidance, with updates as needed, via the Medicaid Provider Enrollment Compendium, a consolidated resource for Medicaid provider enrollment policies. CMS also offers substantive training and support to states in a structured learning environment through the Medicaid Integrity Institute. Most states have engaged with CMS to improve their provider screening and enrollment processes, and CMS continues to reach out to states to help ensure they are in compliance with federal requirements.

CMS currently tracks states' progress toward full compliance with the ordering, referring, and prescribing provider enrollment requirements through voluntary, state-reported data and insight gained by CMS staff as a result of ongoing consultation. To ensure that states continue to make progress, CMS schedules monthly conversations with states to discuss their challenges and address any issues preventing them from achieving full implementation.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should take steps to disallow Federal reimbursements to States for expenditures associated with unenrolled MCO network providers, including seeking necessary legislative authority.

CMS Response

CMS concurs with this recommendation. CMS has requested legislative authority to issue financial penalties to reduce states' administrative match rates for noncompliance with provider screening, enrollment, and revalidation requirements in Medicaid and CHIP for both managed care and fee for service in the President's FY 2021 Budget.

OIG Recommendation

CMS should work with States to ensure that unenrolled providers do not participate in Medicaid managed care and assist States in establishing ways to do so.

CMS Response

CMS concurs with this recommendation. CMS already conducts extensive outreach and education to assist states, including sharing best practices. CMS will reach out to states identified in this report to offer targeted assistance. CMS will also ensure that the Medicaid Provider Enrollment Compendium addresses this issue, and share examples of state managed care contract language. In future years, CMS will also use Program Integrity Reviews to follow up on issues that remain unresolved through the technical support and assistance currently provided.

OIG Recommendation

CMS should work with States to ensure that they have the controls required to prevent unenrolled ordering, referring, or prescribing providers from participating in Medicaid FFS.

CMS Response

CMS concurs with this recommendation. CMS already conducts extensive targeted outreach and education to assist states, tracks state progress, and shares best practices. CMS also institutes PERM corrective action plans, which include provider enrollment findings when applicable. CMS will continue to work with states and track compliance with this requirement. In future

years, CMS will also use Program Integrity Reviews to follow up on issues that remain unresolved through the technical support and assistance currently provided.

OIG Recommendation

CMS should work with States to ensure that they are complying with requirements to collect identifying information and ownership information on Medicaid provider enrollment forms.

CMS Response

CMS concurs with this recommendation. CMS will continue to offer assistance to all states and will reach out to the seven states identified in this report. Given that there is already an enrollment deadline in statute, CMS believes that setting a separate deadline for collection of information would be duplicative.

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

ACKNOWLEDGMENTS

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This report was prepared under the direction of Thomas Komaniecki, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Laura Kordish and Kelly Waldhoff, Deputy Regional Inspectors General.

To obtain additional information concerning this report or to obtain copies, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

ENDNOTES

¹ CMS, *2017 Actuarial Report on the Financial Outlook for Medicaid*. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2017.pdf> on October 22, 2019.

² Ibid.

³ Patient Protection and Affordable Care Act, P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010)—known as the Affordable Care Act (ACA). The Affordable Care Act required States to enroll all Medicaid providers. ACA, § 6401(b). See also CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011. Accessed at <https://www.medicare.gov/federal-policy-guidance/downloads/cib-12-23-11.pdf> on December 1, 2017.

⁴ OIG, *Problems Remain for Ensuring That All High-Risk Medicaid Providers Undergo Criminal Background Checks*, OEI-05-18-00070, July 2019; OIG, *Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented*, OEI-05-13-00520, May 2016.

⁵ See also GAO, *Improved Guidance Needed To Better Support Efforts To Screen Managed Care Providers* (GAO-16-402), April 2016. Accessed at <https://www.gao.gov/assets/680/676768.pdf> on October 18, 2018.

⁶ Cures Act, P.L. No. 114-255 (Dec. 13, 2016), § 5005(b)(1),(2); Social Security Act (the Act), §§ 1902(a)(78), 1932(d)(6). ACA, § 6401(b).

⁷ Cures Act, § 5005(e)(4).

⁸ Cures Act, § 5005(a)(4)(B) states “no payment shall be made under this title to a State with respect to expenditures incurred by the State for payment for services provided by a managed care entity ... unless the State ... beginning on January 1, 2018, complies with the [provider enrollment] requirement specified in section 1932(d)(6)(A).”

⁹ Cures Act, § 5005(e)(2). The Cures Act requests information on FFP paid to States that have MCOs with unenrolled providers and does not request any information about FFP provided to States for items and services furnished by unenrolled FFS providers. Another OIG study will address the requirement to provide information on the amount of FFP provided to States for (1) items and services furnished by terminated providers and (2) managed care services when the State does not have a contract that complies with requirements in section 1932(d)(5) of the Act.

¹⁰ Henry J. Kaiser Family Foundation (KFF), *Medicaid: A Primer*, 2013. Accessed at <https://www.kff.org/wp-content/uploads/2010/06/7334-05.pdf> on October 30, 2019.

¹¹ CMS, *Encounter Data Toolkit*, November 2013. Accessed at <https://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/medicaid-encounter-data-toolkit.pdf> on September 12, 2019.

¹² KFF, Issue Brief. *Medicaid Financing: The Basics*. March 2019. Accessed at <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/> on July 15, 2019.

¹³ The Act, § 1905(b).

¹⁴ Ibid.

¹⁵ These rates do not include enhanced FMAPs or increased FMAPs for newly eligible Medicaid beneficiaries under Medicaid expansion. 81 Fed. Reg. 80078 (Nov. 15, 2016).

¹⁶ ACA, § 6401(b). See also CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011. (See Endnote 3 for URL information.)

¹⁷ Cures Act, § 5005(b). See also CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 10. Accessed at <https://www.medicare.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf> on August 6, 2019.

¹⁸ Cures Act, § 5005(b).

¹⁹ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, pp. 41–42. (See Endnote 17 for URL information.)

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- ²⁰ CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011, p. 13. (See Endnote 3 for URL information.)
- ²¹ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 19. (See Endnote 17 for URL information.)
- ²² *Ibid*, p. 39.
- ²³ Cures Act, § 5005(b); 42 CFR § 438.602(b)(1).
- ²⁴ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 87. (See Endnote 17 for URL information.)
- ²⁵ MACPAC, *Medicaid Managed Care Payment*. Accessed at <https://www.macpac.gov/subtopic/medicaid-managed-care-payment/> on August 9, 2019.
- ²⁶ 42 CFR § 438.602(b)(1). See also CMS *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 89. (See Endnote 17 for URL information.)
- ²⁷ 42 §§ CFR 438.608(b), 455.100–107, and 455.400–470. See also CMS, *State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval*, p. 73. Accessed at <https://www.medicaid.gov/medicaid/managed-care/downloads/mce-checklist-state-user-guide.pdf> on September 9, 2019.
- ²⁸ 42 CFR §§ 438.602(b)(2) and 455.416.
- ²⁹ 42 CFR § 431.107. See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 10 and p. 88: “In summary, effective January 1, 2018, providers under all service delivery models may furnish services to Medicaid participants, including as ORPs, only where the state has executed a provider agreement with the provider and performed all applicable screening, unless an exception applies as described herein,” and “CMS interprets the statutory reference to an ‘enrollment application’ as the provider agreement with the state in the Medicaid context.” (See Endnote 17 for URL information.)
- ³⁰ 42 CFR §§ 455.100 through 455.107; Cures Act, § 5005(b); the Act, § 1902(kk). See also CMS *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 9. (See Endnote 17 for URL information.)
- ³¹ 42 CFR § 455.450. See also CMS *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 10. (See Endnote 17 for URL information.)
- ³² 42 CFR § 431.107. See also CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, pp. 10, 41, and 88.
- ³³ *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 88: “CMS interprets the statutory reference to an ‘enrollment application’ as the provider agreement with the state in the Medicaid context.” (See Endnote 17 for URL information.)
- ³⁴ Cures Act, § 5005(b)(1),(2); the Act, §§ 1902(a)(78) and 1932(d)(6). See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 9. (See Endnote 17 for URL information.)
- ³⁵ 42 CFR § 455.104(c). See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 33. (See Endnote 17 for URL information.)
- ³⁶ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 19. (See Endnote 17 for URL information.)
- ³⁷ 42 CFR § 455.450. See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, pp. 21–25. (See Endnote 17 for URL information.)
- ³⁸ 42 CFR § 455.450.
- ³⁹ 42 CFR §§ 455.436, 455.450, and 455.416. See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, pp. 80–82. (See Endnote 17 for URL information.)
- ⁴⁰ 42 CFR § 455.450.
- ⁴¹ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 37 and p. 47. (See Endnote 17 for URL information.)
- ⁴² OIG, *Problems Remain for Ensuring That All High-Risk Medicaid Providers Undergo Criminal Background Checks*, OEI-05-18-00070, July 2019.
- ⁴³ 42 CFR § 455.440; CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011, p. 6. (See Endnote 3 for URL information.)
- ⁴⁴ States could use similar systems logic used for editing encounter data to compare MCO encounters and/or lists of network providers with State records. CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 91. (See Endnote 17 for URL information.)

⁴⁵ 42 CFR § 456.722. See also MACPAC, *The Medicaid Fee-for-Service Provider Payment Process*, July, 2018, pp. 3–4. Accessed at <https://www.macpac.gov/wp-content/uploads/2015/01/Medicaid-fee-for-service-provider-payment-process.pdf> on August 6, 2019. See also CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 91 (see Endnote 17 for URL information) and Georgia Department of Community Health, *New Medicaid Requirements for Ordering, Prescribing, or Referring Providers an Overview*, August 2013, p. 2. Accessed at <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/NOTICES/OPR%20FAQ%2020-08-2013%20163045%2020-03-2015%20163053.pdf> on August 20, 2019.

⁴⁶ The Act, § 1903(d)(2); 42 CFR § 431.1002. Overpayments due to provider enrollment errors are subject to recovery. See CMS, *Payment Error Rate Manual Version 1.7*, January 2018, p. 43 and p. 74. Accessed at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/FY17PERMManual.pdf> on December 4, 2019.

⁴⁷ Cures Act, § 5005(a)(4)(B) states “no payment shall be made under this title to a State with respect to expenditures incurred by the State for payment and services provided by a managed care entity ... unless the State ... beginning on January 1, 2018, complies with the [provider enrollment] requirement specified in section 1932(d)(6)(A).”

⁴⁸ GAO, *CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements* (GAO-20-8), October 2019, p. 28. (See Endnote 5 for URL information.)

⁴⁹ OIG, *Weaknesses Exist in Medicaid Managed Care Organizations’ Efforts To Identify and Address Fraud and Abuse*, OEI-02-15-00260, July 2018.

⁵⁰ OIG, *Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure*, OEI-04-11-00590, May 2016.

⁵¹ OIG, *CMS’s Process for Sharing Information About Terminated Providers Needs Improvement*, OEI-06-12-00031, March 2014.

⁵² OIG, *Problems Remain for Ensuring That All High-Risk Medicaid Providers Undergo Criminal Background Checks*, OEI-05-18-00070, July 2019.

⁵³ OIG, *Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented*, OEI-05-13-00520, May 2016.

⁵⁴ Cures Act, § 5005.

⁵⁵ OIG, *States Need To Improve Their Compliance With Requirements To Prevent Medicaid Payments to Terminated Providers*, OEI-03-19-00070, March 2020.

⁵⁶ Eight of the 10 States referenced in this sentence overlap with the 21 States that had unenrolled MCO network providers. Two States—Maine and New Hampshire—did not have managed care programs but had unenrolled ORP providers in FFS.

⁵⁷ Massachusetts Medicaid staff stated that they could not respond to OIG’s survey questions for this report in a timely way. The Cures Act required OIG to submit this report to Congress by March 31, 2020. See Cures Act, § 5005(e)(4).

⁵⁸ The Cures Act requires that States enroll all MCO network providers by January 1, 2018. P.L. No. 114-255, § 5005(b)(2). Beneficiaries in these States accounted for approximately 67 percent of the beneficiaries enrolled in all States’ Medicaid managed care programs. See CMS, *2017 Managed Care Enrollment Summary*. Accessed at <https://data.medicare.gov/Enrollment/2017-Managed-Care-Enrollment-Summary/uw3d-3r25> on July 31, 2019.

⁵⁹ CMS, *2017 Managed Care Enrollment Summary*. (See Endnote 58 for URL information.)

⁶⁰ Not all of this \$85 billion was for expenditures associated with unenrolled MCO network providers—some of these expenditures were for enrolled MCO network providers. However, quantifying the exact portion associated with these expenditures is complex because of the capitation payment system in Medicaid managed care. Further, CMS reported to OIG that it considers the full amount disallowable under § 5005(a)(4)(B) of the Cures Act. (See EN 8 for relevant Cures Act language.)

⁶¹ 42 CFR § 438.608(b).

⁶² 42 CFR §§ 438.602 and 455.416.

⁶³ 42 CFR §§ 438.602 and 455.416.

⁶⁴ 42 CFR §§ 438.602 and 455.416(c); Cures Act, § 5005(a)(1).

⁶⁵ At the time of OIG's review, CMS was also not examining whether MCO network providers were appropriately screened and enrolled as part of its process for determining whether States' have made improper payments to MCOs. See GAO, *CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements* (GAO-20-8), October 2019. (See Endnote 5 for URL information.)

⁶⁶ The Cures Act requires that States enroll all FFS providers by January 1, 2017. P.L. No. 114-255, § 5005(b)(1). Beneficiaries in these States accounted for approximately 36 percent of the beneficiaries enrolled in all States' FFS Medicaid programs. See CMS, *2017 Managed Care Enrollment Summary*. (See Endnote 58 for URL information.)

⁶⁷ These five States reported not enrolling all FFS ORP providers and also reported lacking the controls necessary to prevent payments associated with unenrolled FFS ORP providers. However, these States could not conduct the analysis to quantify the FFP received for claims associated with these providers in time to submit the survey.

⁶⁸ 42 CFR § 455.440; CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011, p. 6. (See Endnote 3 for URL information.)

⁶⁹ These States had enrolled (1) all network providers in Medicaid managed care, (2) all of their FFS furnishing providers that directly bill the program, and (3) all of their FFS ORP providers. Notably, all States reported enrolling all FFS furnishing providers as of December 31, 2018.

⁷⁰ The Cures Act requires that States enroll all FFS providers by January 1, 2017, and all MCO network providers by January 1, 2018. P.L. No. 114-255, § 5005(b).

⁷¹ These States reported lacking the processes or controls to ensure that all providers applying for enrollment and all providers needing to be rescreened in the future—as part of the revalidation of their enrollment in Medicaid—have met the enrollment requirements. Three of the 16 States referenced in this sentence—Arizona, Montana, and South Carolina—lack both enrollment processes and controls to ensure ongoing compliance. Five States only lack enrollment procedures that comply with Federal requirements, while eight States only lack controls.

⁷² Cures Act, § 5005(b)(1),(2); the Act, §§ 1902(a)(78) and 1932(d)(6). See also 42 CFR § 455.436 for the requirement that States' confirm the identity of providers applying to enroll.

⁷³ OIG asked States whether they had completed required screenings for limited-, moderate-, and high-risk providers. Two States had not completed screenings for any FFS ORP providers, one had not completed screenings for moderate- or high-risk FFS furnishing providers, and one had not completed screenings for high-risk FFS furnishing providers.

⁷⁴ Cures Act, § 5005(b); the Act, § 1902(kk). See also *Medicaid Provider Enrollment Compendium*, July 24, 2018, pp. 46, 57, 58, and 60. (See Endnote 17 for URL information.) See also 42 CFR § 455.436 for the requirement that States' confirm the identity of providers applying to enroll.

⁷⁵ CMS, *Medicaid Provider Enrollment Compendium*, July 24, 2018, p. 19. (See Endnote 17 for URL information.)

⁷⁶ 42 CFR § 455.440. CMCS, *Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011, p. 13. (See Endnote 3 for URL information.)

⁷⁷ Cures Act, § 5005(a)(4)(B).

⁷⁸ 42 CFR § 431.1002; CMS, *Payment Error Rate Manual Version 1.7*, January 2018, p. 43 and p. 74. (See Endnote 47 for URL information.)

⁷⁹ Cures Act, § 5005(a)(4)(B).

⁸⁰ 42 CFR § 455.440.

⁸¹ CMS, *Transformed Medicaid Statistical Information System (T-MSIS)*. Accessed at <https://www.medicaid.gov/medicaid/data-and-systems/macbis/tmsis/index.html> on August 26, 2019.

⁸² 81 Fed. Reg. 80078 (Nov. 15, 2016).

⁸³ These figures are for payments made from July 1, 2018, through December 31, 2018. To ease the burden on States, OIG asked only that States provide these calculations for a 6-month period.

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