U.S. Department of Health and Human Services

Office of Inspector General

States Could Do More To Prevent Terminated Providers From Serving Medicaid Beneficiaries

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Report in Brief
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States Could Do More To Prevent Terminated Providers From Serving Medicaid Beneficiaries

To avoid paying providers whose actions pose a threat to Medicaid and its beneficiaries, States must terminate providers from their Medicaid programs for certain reasons such as fraudulent activity and criminal convictions. Moreover, States must terminate a provider if that provider has been terminated for cause in Medicare or in another State's Medicaid program or Children's Health Insurance Program (CHIP). This requirement helps ensure that providers whose actions threaten the Medicaid program and its beneficiaries in one State do not continue to treat Medicaid beneficiaries in other States.

Key Takeaway
Terminated providers are still serving Medicaid beneficiaries despite the requirements of the 21st Century Cures Act that were designed to strengthen Medicaid program integrity.

What OIG Found

Nearly 1,000 terminated providers—or 11 percent of all terminated providers—were inappropriately enrolled in State Medicaid programs or were associated with $50.3 million in Medicaid payments after being terminated. These providers had been terminated for reasons such as criminal convictions, licensure issues, and provider misconduct and thus potentially posed a risk to beneficiaries' safety and quality of care.

In addition, only eight States' managed care contracts all clearly included the provision—required by the 21st Century Cures Act (Cures Act)—that prohibits terminated providers from participating in Medicaid managed care networks. This vulnerability may allow terminated providers to serve Medicaid beneficiaries and reduce States' ability to limit these providers' participation in Medicaid managed care networks. At the time of our review, the Centers for Medicare & Medicaid Services (CMS) did not check for this Cures Act-required provision when reviewing States' contracts with managed care organizations (MCOs). Overall, States paid at least $62.3 billion in capitation payments to plans under contracts that did not include the required provision.

Finally, States did not always provide complete and accurate Medicaid data to CMS, which limited the breadth of our analysis of claims, encounter records, and payments associated with terminated providers. Therefore, our findings understate the payments associated with contracts that did not contain the required Cures Act provision and may understate the payments associated with terminated providers.

Why OIG Did This Review

The Cures Act includes specific program integrity requirements to ensure that States do not spend Medicaid funds on items and services associated with terminated providers. In addition, as of July 1, 2018, the Cures Act requires State contracts with MCOs to include a provision that providers who were terminated from Medicare, Medicaid, or CHIP cannot participate in their Medicaid managed care networks. The Cures Act required OIG to determine the following: (1) whether providers in CMS's termination database are terminated from Medicaid in all States, (2) the amount of Medicaid payments associated with terminated providers, (3) whether State contracts with MCOs included a required provision that prohibits providers terminated from Medicare, Medicaid, or CHIP from participating in Medicaid managed care networks, and (4) the amount of Medicaid payments to MCOs that did not have the required provision in their contracts.

How OIG Did This Review

From CMS, we requested its termination database, which contains information on terminated providers reported by States. We requested rosters of enrolled providers from States. We reviewed State enrollment rosters dated between January and May 2019. We compared terminated providers listed in CMS's February 2019 termination database to the providers in

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What OIG Recommends and How the Agency Responded

To promote States' compliance with the requirements of the Cures Act, we recommend that CMS (1) recover from States the Federal share of inappropriate fee-for-service Medicaid payments associated with terminated providers, (2) implement a method to recover from States the Federal share of inappropriate managed care capitation payments associated with terminated providers, (3) follow up with States to remove terminated providers that OIG identified as inappropriately enrolled in Medicaid, (4) confirm that States do not continue to have terminated providers enrolled in their Medicaid programs, (5) safeguard Medicaid from inappropriate payments associated with terminated providers, and (6) review States' contracts with MCOs to ensure that they clearly and specifically include the required provision that prohibits terminated providers from participating in Medicaid managed care networks. CMS concurred with all six of our recommendations.

Full report can be found at oig.hhs.gov/oei/reports/oei-03-19-00070.asp

States' rosters of enrolled Medicaid providers.

We also identified fee-for-service claims and managed care encounter records associated with terminated providers on or after July 1, 2018. We determined whether these providers were enrolled in Medicaid. Finally, we examined State contracts with MCOs to determine whether States included in their contracts with MCOs a provision that terminated providers are terminated from all Medicaid managed care networks.

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BACKGROUND

Objectives

1. To determine the extent to which providers terminated for cause continued to be enrolled in State Medicaid programs and the amount that Medicaid paid for items or services associated with providers terminated for cause.
2. To determine the extent to which States included provisions in their contracts with managed care organizations requiring that terminated providers be prohibited from participating in Medicaid managed care networks, and the amount that Medicaid paid to managed care organizations with contracts that did not include the provision.

The Medicaid program provides health coverage to approximately 74 million people at an annual cost of nearly $600 billion. Given the number of beneficiaries and the amount of expenditures, Medicaid program integrity is critical to preventing inappropriate payments and protecting beneficiaries. Accordingly, to avoid paying providers whose actions pose a threat to Medicaid and its beneficiaries, States must terminate providers that engage in behavior related to fraud, integrity, or quality issues. These providers are terminated from Medicaid "for cause."[1, 2] For example, States must terminate a provider for cause if the provider has a recent criminal conviction related to Medicaid.[3] We use the term "providers" to mean Medicaid providers that are individuals, institutions, or organizations, such as doctors, hospitals, and pharmacies.

Federal rules require States to terminate a provider if that provider has been terminated for cause in Medicare, or another State's Medicaid

[1] 42 CFR § 455.101, § 455.416. CMS, *Medicaid Provider Enrollment Compendium*, §§ 1.10.1(a)(4) and 1.10.2. Accessed at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf on August 3, 2018.

[2] For the purposes of this report, we are referring to terminations for cause when we use "terminations" or "terminated providers."

[3] 42 CFR § 455.416; See also CMS, *Medicaid Provider Enrollment Compendium* § 1.10.2(b)(3)(ii). Accessed at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf on August 3, 2018. The criminal conviction must be related to the provider's involvement with Medicare, Medicaid, or CHIP within the preceding 10 years.

program or State's Children's Health Insurance Program (CHIP).[4, 5] This requirement helps ensure that providers whose actions threaten the Medicaid program and its beneficiaries in one State do not continue to treat Medicaid beneficiaries and receive Medicaid payments in other States.

Despite this requirement, a 2015 Office of Inspector General (OIG) report found that 12 percent of Medicaid providers terminated by a State in 2011 were still enrolled in other States in 2012. The report also found that, as of January 2014, States paid $7.4 million to providers that had been terminated from Medicaid in 2011.[6]

Since OIG issued the 2015 report, Congress passed the 21st Century Cures Act (Cures Act) in December 2016, which aimed to strengthen Medicaid program integrity by requiring CMS and States to take appropriate action to safeguard Medicaid from terminated providers.

The Cures Act also requires OIG to complete a study and submit a report to Congress on the implementation of specific provisions of the Cures Act related to terminated providers. The Cures Act requires OIG to (1) determine the extent to which providers included in CMS's termination database are terminated from participation in all State Medicaid programs; (2) determine the amount of Medicaid payments associated with terminated providers; (3) assess the extent to which State contracts with managed care organizations (MCOs) included a required provision that prohibits providers that were terminated from Medicare, Medicaid, or CHIP from participating in Medicaid managed care networks; and (4) determine the amount of Medicaid payments to MCOs that did not have the required provision in their contracts.

The Medicaid Program

States administer and finance Medicaid using State and Federal funds. Each State has the flexibility to administer its Medicaid program within broad Federal guidelines, resulting in various combinations of health care delivery and payment systems in each State. Generally, States offer Medicaid services through a fee-for-service (FFS) model, by contracting with MCOs, or through a combination of both.

The FFS and managed care models differ in how they pay providers for items and services. Under the FFS model, providers submit claims to the

[4] P.L. No. 111-148 § 6501. 42 CFR § 455.416.
[5] CMS, *Medicaid Provider Enrollment Compendium* § 1.10.2(b)(3)(iii). Accessed at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf on August 3, 2018.
[6] OIG, *Providers Terminated from One State Medicaid Program Continued Participating in Other States*, OEI-06-12-00030, August 2015.

State for Medicaid items or services and the State directly reimburses them. Under managed care, a State pays an MCO a per-member, per-month fee—known as a capitation payment—for each person enrolled with the MCO. The MCO then pays network providers for all Medicaid services included in the MCO's contract with the State. The MCO submits encounter records to the State for the items and services provided to Medicaid beneficiaries.

Medicaid Enrollment

Provider enrollment is an important program integrity tool that assists States in preventing Medicaid fraud, reducing inappropriate payments, and protecting beneficiaries. Providers in FFS and managed care networks must enroll in Medicaid.[7] Each State is required to screen providers' enrollment applications to ensure they meet all requirements for participation in the Medicaid program. If a State approves a provider's enrollment application, the provider is considered active and may serve Medicaid beneficiaries.[8]

Transformed Medicaid Statistical Information System

The Transformed Medicaid Statistical Information System (T-MSIS) contains Medicaid claims and encounter data as well as other important program information such as capitation payments and data on beneficiary eligibility and provider enrollment. CMS established T-MSIS to create a national Medicaid database that modernized and enhanced the previous reporting system.

Medicaid Requirements Regarding Terminated Providers

The Cures Act includes specific program integrity requirements to ensure that States do not spend Medicaid funds on terminated providers. Beginning July 1, 2018, the Cures Act prohibits States from making Medicaid payments to terminated providers. Specifically, Federal payments to States cannot be made for Medicaid items or services associated with a terminated provider more than 60 days after CMS publishes that provider's termination.[9] In addition, as of July 1, 2018, the Cures Act requires State contracts with MCOs to include a provision that providers terminated from Medicare, Medicaid, or CHIP cannot participate in Medicaid managed care networks.

[7] P.L. No 114-255 § 5005(b)(1),(2).
[8] We use the term "enrolled" to mean that a provider has an active enrollment status.
[9] P.L. No. 114-255 § 5005(a)(4)(A)(iii).

Termination Database

The Cures Act includes requirements for both States and CMS regarding the reporting and publication of information on terminated providers. As required by the Cures Act, a State must notify CMS that it has terminated a provider within 30 days of the termination. CMS, in turn, generally must publish information on these providers in a termination database accessed by all States (Adverse Actions Report).[10] CMS maintains the termination database within a Web-based interface—the Data Exchange System, or DEX—and it is updated in real-time.

The database contains information on all terminated Medicaid providers including, but not limited to, the provider's name, National Provider Identifier (NPI), Employer Identification Number (EIN), Social Security Number (SSN), the reason for termination, and the date CMS published the termination, hereafter referred to as the published date.[11] The termination database also includes providers whose Medicare billing privileges have been revoked; these providers must therefore be terminated from Medicaid as well.[12]

Related OIG Work

A 2014 report found that not all States submitted information on terminated providers to CMS's Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS).[13, 14] OIG found that more than half of the records in MCSIS did not contain NPIs or other identifying information. OIG recommended that CMS require each State to report all terminated providers, ensure that this information meet CMS's criteria for inclusion, and improve the completeness of records.

As noted previously, a 2015 OIG report found that 12 percent of Medicaid providers terminated by one State in 2011 were still enrolled as providers in other States in 2012. OIG again recommended that States be required to report terminated providers and recommended that CMS work with

[10] P.L. No. 114-255 § 5005(a)(3). Section 6401(b)(2) of P.L. No. 111-148 (the Affordable Care Act) required CMS to establish a process to make termination information available to State Medicaid agencies. Section 5005(a)(3) of P.L. No. 114-255 (the Cures Act) required CMS to include appropriate terminations in the "database or similar system" developed pursuant to the Affordable Care Act provision.

[11] CMS, *Medicaid Provider Enrollment Compendium* § 1.10.4(c), (d). Accessed at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf on August 3, 2018.

[12] Hereafter when we refer to terminated providers listed in CMS's database, we include the providers revoked by Medicare.

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

[14] MCSIS was a system in place before the DEX system was established.

States to develop uniform terminology to clearly denote terminations for cause.

CMS concurred with OIG's recommendations in both reports, and requirements in the Cures Act helped to address these recommendations.

Methodology

Terminated Providers Enrolled in State Medicaid Programs

To determine whether any terminated providers were enrolled in State Medicaid programs, we collected information from State Medicaid agencies and from CMS's termination database. We collected a roster of enrolled Medicaid providers from all 50 States and the District of Columbia (States). To determine the number of terminated providers still enrolled in States' Medicaid programs, we then compared the providers on States' enrollment rosters to terminated providers included in CMS's termination database. We received enrollment roster information from the States covering time periods between January and May 2019. CMS's termination database was current as of February 2019.

Payments Associated with Terminated Medicaid Providers

To identify FFS claims, managed care encounter records, and payments associated with terminated providers, we compared provider information in CMS's termination database to provider information on Medicaid final action claims and encounter records.[15] From CMS's T-MSIS data, we obtained Medicaid final action claims and encounter records as well as the capitation rate paid to MCOs by States.

We calculated how much Medicaid paid for items or services associated with terminated providers in two ways. For FFS claims associated with terminated providers, we aggregated total Medicaid paid amounts. For managed care encounter records associated with terminated providers, we aggregated the monthly capitation amounts that States paid for each beneficiary associated with these encounter records. For both FFS and managed care payments, we applied the State's Federal Medical Assistance Percentage (FMAP) to calculate the Federal portion of the payments.[16]

In conducting this analysis, we also determined whether terminated providers associated with Medicaid payments were appropriately enrolled, inappropriately enrolled, or not enrolled in Medicaid at the time of our enrollment review.

[15] A final action record is the version of the record in which all adjustments to earlier versions of the record have been resolved.

[16] The Federal government uses the FMAP to calculate the share of total Medicaid expenditures—including both FFS and managed care—that it will pay to the States.

Inclusion of the Required Provision in Managed Care Contracts

For the States that reported that they contract with MCOs and submitted contracts, staff in OIG's Office of Counsel to the Inspector General reviewed the States' contracts with MCOs to determine whether they included the required provision that providers terminated from Medicare, Medicaid, and CHIP be prohibited from participating in each MCO's managed care networks.

For contracts that did not contain the required provision, we calculated the total capitation payments each State made for the plans associated with these contracts.

Appendix A provides a more detailed methodology.

Limitations

We did not verify the accuracy or completeness of States' enrollment rosters, States' managed care information, State-reported plan IDs, CMS's termination data, or T-MSIS data. T-MSIS data is dynamic and is updated by States periodically. Therefore, the data used for our analyses may be subject to future updates.

States differed in the completeness of their T-MSIS data, which limited our analyses. Therefore, the data does not account for all claims, encounter records, and payments associated with terminated providers and it does not account for all capitation payments to managed care plans under contracts that did not contain the required Cures Act provision.

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

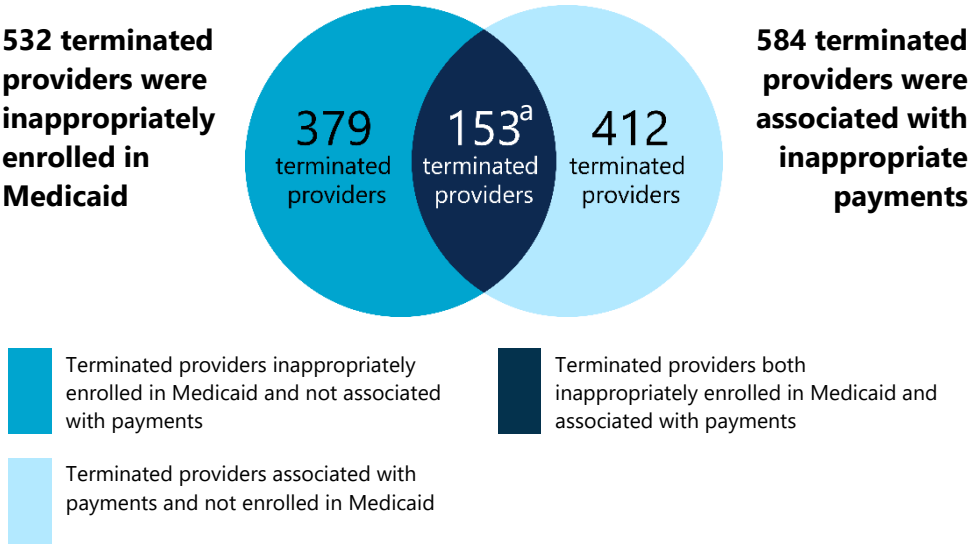
Eleven percent of terminated providers were still able to serve Medicaid beneficiaries

Of the 9,047 terminated providers included in CMS's data, 963 providers—or 11 percent of terminated providers—were still able to serve Medicaid beneficiaries.[17]

Terminated providers inappropriately enrolled in Medicaid. Five-hundred thirty-two terminated providers were still enrolled in State Medicaid programs—i.e., included on a State enrollment roster—which would allow them to serve Medicaid beneficiaries. Medicaid made payments associated with 153 of these 532 terminated providers.

Terminated providers associated with inappropriate payments. Five-hundred eighty-four terminated providers were associated with Medicaid payments—i.e., associated with claims or encounter records—since July 2018. Of these 584 terminated providers, 412 were not enrolled in Medicaid, 153 were inappropriately enrolled, and 19 were appropriately enrolled at the time of our enrollment review.

Exhibit 1: Terminated providers continued to be enrolled in State Medicaid programs and/or associated with Medicaid payments



Source: OIG analysis of State enrollment rosters from January to May 2019, T-MSIS data from July 2018 to June 2019, and CMS's termination database from February 2019.

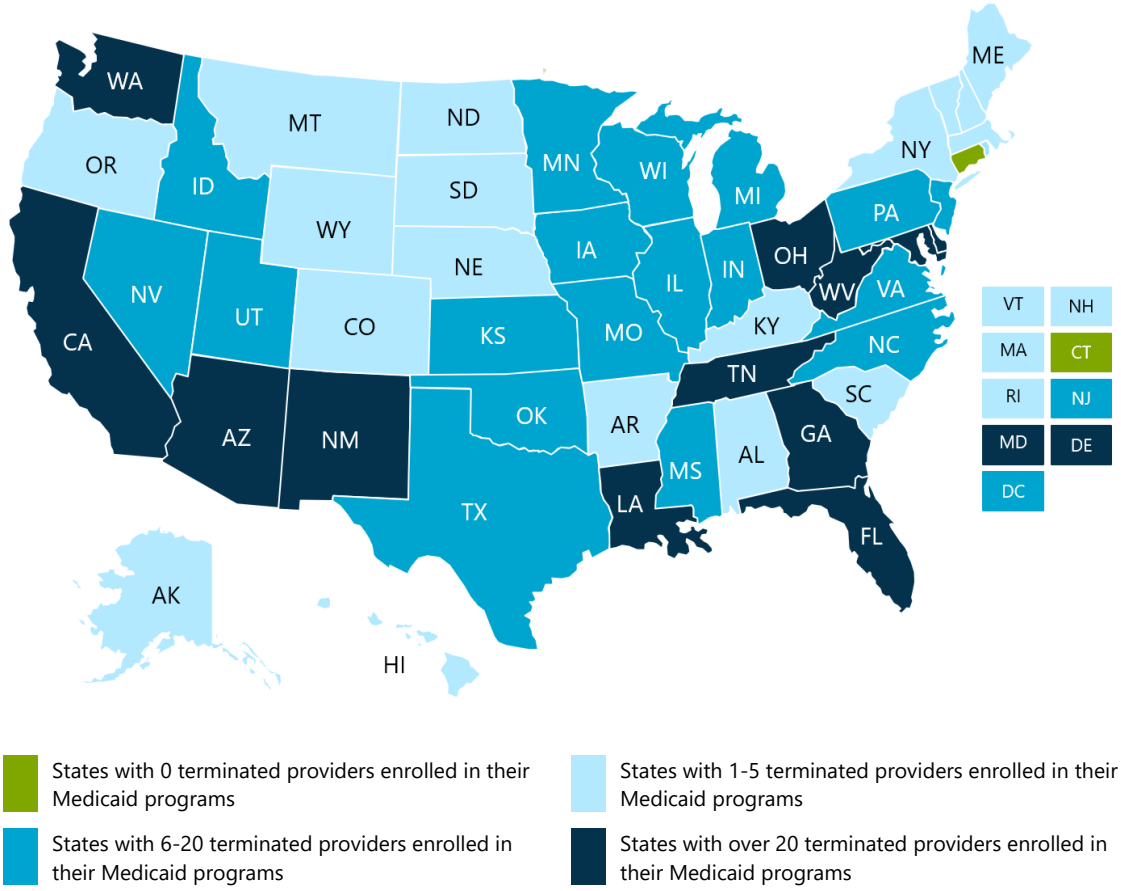
[a] The dates used for our enrollment and payment reviews sometimes differed. Therefore, there were an additional 19 terminated providers associated with inappropriate payments that we found to be appropriately enrolled.

[17] This 11-percent figure is similar to an earlier OIG finding that 12 percent of Medicaid providers terminated by one State in 2011 were still enrolled as providers in other States in 2012. OIG, *Providers Terminated from One State Medicaid Program Continued Participating in Other States*, OEI-06-12-00030, August 2015.

Six percent of terminated providers were still enrolled in at least one State Medicaid program

Of the 9,047 terminated providers included in CMS's data, 532 (6 percent) were enrolled in State Medicaid programs. As shown in Exhibit 2, most States had 20 or fewer terminated providers enrolled in their State's Medicaid program.

Exhibit 2: Nearly all States had at least one terminated provider enrolled in their State Medicaid programs.[a]



Source: OIG analysis of State enrollment rosters from January to May 2019, and CMS's termination database from February 2019.

[a] Florida also submitted separate rosters of "registered" individual and organizational providers. Managed care plans screen and credential these providers and send information on these providers to the State. Because these providers serve Medicaid beneficiaries, we included them in our analysis.

Of these 532 terminated providers—322 individuals and 210 organizations—68 providers were still enrolled in multiple State Medicaid programs. In fact, 1 terminated organization was enrolled in 28 State Medicaid programs, and 3 additional terminated organizations were each enrolled in over 10 State Medicaid programs.

Nearly one-third of the 532 terminated providers were still enrolled in the State that reported the termination. Thirty-two percent of terminated providers (168 of 532 providers) were still enrolled in the State that terminated them. This occurred in 26 States. For example, 45 of the 62 terminated providers that we found on Maryland's current enrollment roster had been reported to CMS as terminated by that State.

Appendix B provides the number of terminated providers enrolled in each State's Medicaid program and the number that were terminated by and still enrolled in the same State.

Seventy-one percent of the terminated providers associated with Medicaid payments were not enrolled in a Medicaid program

In total, 584 terminated providers were associated with Medicaid payments since July 2018. Of the 584 terminated providers associated with Medicaid payments, 412 were not enrolled in a State Medicaid program.[18] This is despite the fact that States and their MCOs are not supposed to pay for services provided, ordered, or prescribed by unenrolled providers.[19] Therefore, not only did these States and MCOs make payments associated with terminated providers, they made payments associated with unenrolled providers.

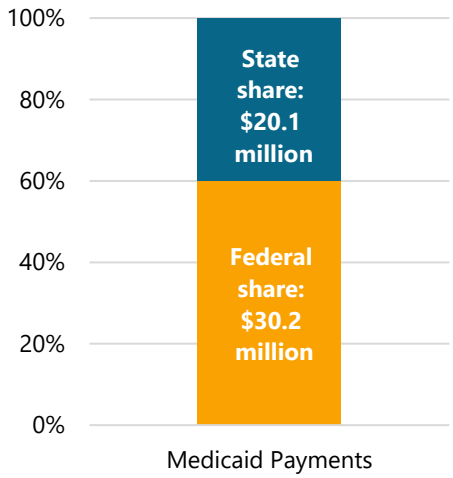
Payments associated with unenrolled providers may indicate that States' and their MCOs' payment systems did not reject claims and encounter records associated with providers not enrolled in Medicaid. OIG's report related to the enrollment requirements mandated by the Cures Act, found that 23 States reported allowing unenrolled providers to serve Medicaid beneficiaries.[20] These lapses represent a significant program integrity vulnerability and non-compliance with legal requirements that prohibit Federal payments for terminated or unenrolled providers.[21]

[18] Four of these 412 providers had NPIs, SSNs, and/or EINs that appeared on States' enrollment rosters. However, the provider name listed on the States' enrollment rosters did not match the provider name listed in CMS's termination database. Because of this, we did not consider these four providers to be enrolled.
[19] P.L. No. 114-255 § 5005(a)(4) and (b). 42 CFR part 455, subparts B and E.
[20] OIG, *Twenty-three States Reported Allowing Unenrolled Providers to Serve Medicaid Beneficiaries*, OEI-05-19-00060, March 2020.
[21] P.L. No. 114-255 § 5005(a)(4) and (b). 42 CFR part 455, subparts B and E.

Medicaid made $50.3 million in payments associated with 584 terminated providers

States made $50.3 million in Medicaid payments for nearly 300,000 claims and/or encounter records associated with 584 terminated providers.[22, 23] Forty States made these payments for claims and encounter records.[24] Ten of the 40 States accounted for $40.98 million or 81 percent of the $50.3 million in payments associated with terminated providers.

Exhibit 3: Medicaid payments associated with terminated providers totaled $50.3 million.



Source: OIG analysis of T-MSIS data from July 2018 to June 2019 and CMS's termination database from February 2019.

Of the $50.3 million in Medicaid payments that States allowed for terminated providers, the State share totaled $20.1 million and the Federal share totaled $30.2 million, as shown in Exhibit 3. Appendix C provides information on each State's payments for claims and encounter records associated with terminated providers.

Fifteen terminated providers accounted for nearly two-thirds of Medicaid payments associated with all terminated providers. These 15 providers (6 individuals and 9 organizations) were associated with $32.4 million of the $50.3 million in Medicaid payments associated with terminated providers. One organizational provider alone was linked to $6.1 million in Medicaid payments.

Appendix D provides additional information on the provider types of the terminated providers and the types of services associated with them.

[22] The $50.3 million figure—$16.3 million in FFS claims and $34 million in managed care capitation payments—may understate the financial impact of payments associated with terminated providers. For further explanation regarding the limitations of the payment data, please see page 14 and Appendix A.

[23] Because Medicaid pays a monthly capitation payment for managed care, we could not determine the portion of the payment specifically related to terminated providers.

[24] Our analyses of T-MSIS data found that seven States did not make any payments for claims or encounter records associated with terminated providers.

Two-thirds of terminated providers who were still able to serve Medicaid beneficiaries posed a potential risk to Medicaid beneficiaries

All providers within CMS's termination database have been terminated "for cause." The "for cause" reasons range from Medicaid policy violations to more egregious concerns, such as criminal convictions and misconduct. Exhibit 4 lists all the termination reasons for the 963 terminated providers enrolled in State Medicaid programs and/or associated with Medicaid payments.

Two-thirds of these terminated providers (634 of 963) were terminated for (1) criminal convictions, including illegal distribution of drugs; (2) licensure issues, such as license loss or suspension; and (3) provider misconduct, including unprofessional conduct and patient neglect. In fact, one provider, terminated for patient negligence and inappropriate treatment, was still enrolled in nine States' Medicaid programs. Providers terminated for cause pose potential risks to beneficiaries' safety and quality of care.

Exhibit 4: The reasons providers were terminated included those that may pose a potential risk to Medicaid beneficiaries.[a]

Number of Providers	Reason for Termination
300	Issues related to licensure (loss, suspension, etc.)
258	Termination/exclusion from a State/Federal health care program
251	Criminal conviction(s)
113	Provider misconduct
57	Abuse of billing privileges
47	Non-operational provider
32	Falsified information
18	Medicaid policy violation
12	Failure to repay overpayment
10	Other

Source: OIG analysis of State enrollment rosters from January to May 2019, T-MSIS data from July 2018 to June 2019, and CMS's termination database from February 2019.
[a] The sum of the number of providers is 1,098, rather than 963, because 124 providers were terminated for multiple reasons.

Only eight States had managed care contracts that all clearly included the required provision that prohibits terminated providers from participating in Medicaid managed care networks

Of the 42 States that reported contracting with MCOs, only 8 States had contracts that all clearly included the required provision that providers terminated from Medicare, Medicaid, or CHIP are terminated from all Medicaid managed care networks.[25] As shown in Exhibit 5, another 21 States had contracts that all included some related language but did not clearly include the required provision. For example, some plans' contracts stated that providers that were "excluded" should be terminated from the Medicaid managed care network. However, the term "exclusion" generally refers to exclusion by OIG or exclusion by a State.[26] Further, exclusion is not the only reason that a provider might be terminated. The contract language did not make it clear whether the term "excluded" was being used to refer to exclusion by OIG or a State—or was intended as a synonym for terminated.

Exhibit 5: Only eight States' contracts all clearly included the provision that the Cures Act requires regarding terminated providers.

8 States' contracts clearly included the required provision regarding terminated providers

21 States' contracts did not clearly include the required provision regarding terminated providers

8 States' contracts did not include the required provision regarding terminated providers

5 States had at least one contract that did not include the required provision regarding terminated providers or did not clearly include it

Source: OIG analysis of State MCO contracts, 2019

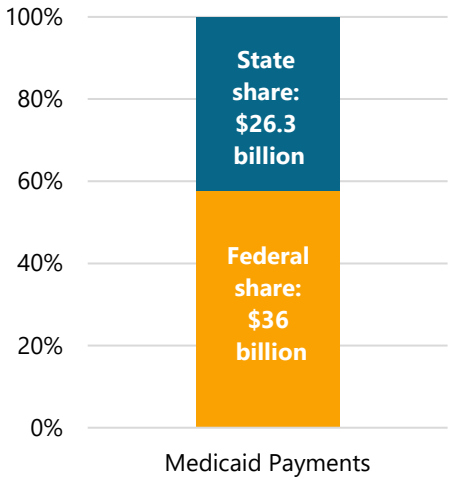
None of the contracts in eight States included the required provision, and the remaining five States had at least one contract that either did not include the required provision or did not clearly include it. Contracts that do not include or do not clearly include the required provision present a

[25] We considered a State contract to include the required provision if it included language stating that the MCO would terminate a Medicaid network provider if that provider were terminated from Medicare, Medicaid, or CHIP, even when the contract did not specifically include the term "CHIP."

[26] Exclusion by OIG refers to exclusion from participation in Federal health care programs under sections 1128 or 1128A of the Social Security Act; States may also exclude providers from their Medicaid programs under State law or pursuant to 42 CFR § 1002.2. CMS, *Medicaid Provider Enrollment Compendium,* § 1.1.2.C.2. Accessed at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-7242018.pdf on August 3, 2018.

vulnerability because they may allow terminated providers to continue to serve Medicaid beneficiaries and reduce States' ability to enforce legal prohibitions on these providers' participation in Medicaid managed care networks.

Exhibit 6: Medicaid payments to plans under contracts that did not include the required contract provision totaled $62.3 billion.



Source: OIG analysis of T-MSIS data from July 2018 to July 2019 and State MCO contracts, 2019.

States paid at least $62.3 billion in capitation payments to plans under contracts that did not include the required provision

States paid at least $62.3 billion in capitation payments to plans under contracts that did not have the required provision.[27] Of the $62.3 billion, the Federal share was $36 billion, and the States' share was $26 billion, as shown in Exhibit 6.

An additional $45.5 billion was paid to plans under contracts with language that was not definitive enough for us to determine whether the provision was included. Appendix E provides the individual States' capitation payments made to plans under contracts that did not include or did not clearly include the required provision.

CMS does not check for the required Cures Act provision when reviewing States' contracts with MCOs

CMS has developed a Contract Review Tool or "checklist" to aid in the review of States' contracts with MCOs, but the checklist does not include a check to determine whether the contract includes the required provision regarding terminated providers.[28] CMS requires States to submit their Medicaid MCO contracts for review and approval. CMS regional staff use the checklist to determine whether these contracts meet requirements related to such issues as enrollment, payment, and program integrity. Although CMS implemented a new checklist in January 2019 and updated

[27] For beneficiaries covered under Medicaid managed care, Medicaid does not pay individually for services rendered; rather, it pays a monthly capitation payment per beneficiary to a managed care plan. The financial amounts provided for contracts included in this finding are understated because we did not identify any capitation payments in T-MSIS for some State-reported plan IDs.

[28] Although CMS does not check for the required Cures Act provision regarding terminated providers, it does check to see whether the contracts include language prohibiting MCOs from employing or contracting with excluded providers.

it in April 2019, the checklist still does not include a check for the required provision related to terminated providers.

Most States include a provision in their contracts with MCOs that requires MCOs to report to the State any providers that are terminated from their networks

A significant part of Medicaid program integrity involves States' ability to monitor providers and be aware of any actions that MCOs take against those providers. However, a 2018 OIG report found that MCOs were not reporting provider terminations to the State.[29] In that report, OIG recommended that CMS work with States to clarify the information that MCOs are required to report regarding providers that are terminated or otherwise leave the MCO network.

Most States (38 States) reported that they currently include a provision in all their contracts requiring MCOs to report to the State any providers terminated from their networks. Three States—Indiana, New York, and South Carolina—did not include this provision in their contracts with MCOs. One State, Wisconsin, had some contracts that contained the provision and others that did not include it.

States' incomplete reporting of required Medicaid data prevented a comprehensive assessment of the financial impact of terminated providers on Medicaid

A comprehensive assessment of the financial impact of terminated providers on Medicaid was compromised by the lack of complete and accurate data in T-MSIS. As a result, our findings understate the payments associated with contracts that did not contain the required Cures Act provision. They also may understate the payments associated with terminated providers. These limitations echo previous OIG findings that raised concerns about the completeness of T-MSIS data.[30]

The most significant limitation was related to calculating the financial impact related to terminated providers associated with managed care encounter records. Entire States had to be removed from our assessment of the financial impact. Specifically, Virginia did not report any managed care encounter records or capitation payments to T-MSIS for the period of our review. In addition, Kansas did not report any managed care

[29] OIG, *Weaknesses Exist in Medicaid Managed Care Organizations' Efforts to Identify and Address Fraud and Abuse*, OEI-02-15-00260, July 2018.
[30] OIG, *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System,* OEI-05-12-00610, September 2013; OIG, *Status Update: T-MSIS Data Not Yet Available for Overseeing Medicaid,* OEI-05-15-00050, June 2017; OIG, *National Review of Opioid Prescribing in Medicaid is Not Yet Possible*, OEI-05-18-00480, August 2019.

capitated payments to T-MSIS for the period of our review even though Kansas reported contracting with three MCOs.

Even when States reported capitation payment data to T-MSIS, the data may not have been complete. In 19 States, we could not identify in T-MSIS all the monthly capitation payments for every beneficiary with encounter records associated with terminated providers.

In total, we could not identify monthly capitation payments in T-MSIS for nearly 2,000 beneficiaries, or 7 percent of all the beneficiaries we identified with encounter records associated with terminated providers. Therefore, our financial impact amount of $50.3 million may understate the total capitation amount related to encounter records associated with terminated providers.

We also had to exclude certain claims and encounter records from our analysis because the T-MSIS record was missing the data necessary to perform final action procedures. These are procedures that, for example, adjust claims to the final payment amount and remove duplicate claims. For example, Missouri's T-MSIS claims and encounter records were sometimes missing key variables that we needed to conduct the final action procedure.

In addition, we encountered some limitations determining the FFS payments associated with terminated providers. For example, Virginia did not report any claims data to T-MSIS for the period of our review.

Missing monthly capitation payment data in T-MSIS also had an impact on the analysis of capitation payments related to contracts that did not include or did not clearly include the required Cures Act provision. Three States—Kansas, Virginia, and North Dakota—did not submit any Medicaid managed care capitation payment data during the period of our review.

CONCLUSION AND RECOMMENDATIONS

Despite the Cures Act's requirements that were designed to strengthen Medicaid program integrity, terminated providers continue to serve Medicaid beneficiaries. According to our analysis of enrollment rosters and Medicaid claims and encounter data, nearly 1,000 terminated providers (11 percent of terminated providers) remained enrolled in State Medicaid programs and/or were associated with $50.3 million in Medicaid payments. Some of these providers were terminated for criminal convictions, licensure issues, and provider misconduct, representing a risk to beneficiaries' safety and their quality of care.

Previous OIG work similarly found that 12 percent of Medicaid providers terminated by a State were still enrolled in other States and Medicaid paid millions to these providers.[31] This earlier work, coupled with these latest findings, indicates that States and CMS can do more to protect Medicaid beneficiaries from terminated providers and prevent millions in inappropriate payments associated with these providers.

Additionally, this analysis identified payments associated with unenrolled providers, indicating that States' and their MCOs' payment systems may not have rejected claims and encounter records associated with providers not enrolled in Medicaid. OIG's report *Twenty-Three States Reported Allowing Unenrolled Providers to Serve Medicaid Beneficiaries* similarly found that States reported allowing unenrolled providers to serve Medicaid beneficiaries and offers recommendations to strengthen efforts to prevent unenrolled providers from participating in Medicaid.[32] These lapses indicate another vulnerability for CMS and States to address.

Finally, only eight States clearly included in their contracts with MCOs the required provision that prohibits terminated providers from participating in Medicaid managed care networks. The missing provision may allow terminated providers to continue to serve Medicaid beneficiaries and reduce States' ability to enforce legal prohibitions on these providers' participation in managed care networks. To date, CMS has not ensured that all States have the required language in their managed care contracts.

[31] OIG, *Providers Terminated from One State Medicaid Program Continued Participating in Other States*, OEI-06-12-00030, August 2015.
[32] OIG, *Twenty-Three States Reported Allowing Unenrolled Providers to Serve Medicaid Beneficiaries*, OEI-05-19-00060, March 2020.

Underlying these findings are limitations to the analyses because States did not report all required data to T-MSIS. Therefore, the data understate the payments associated with contracts that did not contain the required Cures Act provision and may understate the payments associated with terminated providers. These limitations echo previous OIG findings that T-MSIS data is not complete or accurate enough to conduct Medicaid oversight.[33] We reiterate the importance of ensuring the accuracy and completeness of T-MSIS data.

To protect taxpayer dollars and the beneficiaries served by the Medicaid program, we recommend that CMS take the following steps.

Recover from States the Federal share of inappropriate fee-for-service Medicaid payments associated with terminated providers

We will provide CMS with the claims associated with terminated providers associated with Medicaid FFS payments. After reviewing this information, CMS should determine whether States made inappropriate payments and seek to recover the Federal share of any inappropriate Medicaid FFS payments made by States.

Implement a method to recover from States the Federal share of inappropriate managed care capitation payments associated with terminated providers

States made capitation payments to MCOs for items and services associated with terminated providers. CMS stated that it cannot partially disallow the Federal share of capitation payments associated with terminated providers. To the extent that CMS determines that it cannot partially disallow capitation payments associated with terminated providers, CMS should implement an alternative method to recover these payments.

Follow up with States to remove terminated providers that OIG identified as inappropriately enrolled in Medicaid

Barring a compelling access to care concern, CMS should work with States to remove the terminated providers we identified as still enrolled from their State Medicaid enrollment rosters. We will provide CMS the list of terminated providers enrolled in States' Medicaid programs to share with

[33] OIG, *Early Outcomes Show Limited Progress for the Transformed Medicaid Statistical Information System,* OEI-05-12-00610, September 2013; OIG, *Status Update: T-MSIS Data Not Yet Available for Overseeing Medicaid,* OEI-05-15-00050, June 2017; OIG, *National Review of Opioid Prescribing in Medicaid is Not Yet Possible*, OEI-05-18-00480, August 2019.

States. CMS should alert States that these providers are still enrolled and inform the States that they should be terminated from enrollment.

Confirm that States do not continue to have terminated providers enrolled in their Medicaid programs

To prevent future terminated providers from remaining enrolled in State Medicaid programs, CMS could work with States to overcome any challenges they may face in removing terminated providers from their enrollment rosters. Finally, CMS could conduct periodic reviews comparing States' enrollment rosters and/or T-MSIS claims and encounter records to the termination database to confirm that States' efforts to remove terminated providers from Medicaid have been effective.

Safeguard Medicaid from inappropriate payments associated with terminated providers

To ensure that State safeguards effectively prevent inappropriate payments, CMS could determine during its payment error rate measurement (PERM) process whether States made FFS payments associated with providers who should have been terminated. The PERM process measures and reports improper payment rates for Medicaid primarily through the review of a sample of paid FFS claims and ensures that a State does not make payments to providers terminated by that State. Currently, PERM does not determine whether a State made FFS payments associated with a provider who should have been terminated because the provider had been terminated in another State. If PERM were to include an assessment of FFS payments associated with providers who should have been terminated, this information could help CMS identify and recoup the Federal share of funds associated with these providers. CMS also could develop and implement other methods to safeguard against Medicaid payments associated with terminated providers.

Review States' contracts with managed care organizations to ensure that they specifically include the required provision that prohibits terminated providers from participating in Medicaid managed care networks

CMS should ensure that States' contracts with MCOs specifically and clearly include the termination provision by adding a check for this required provision to its contract review checklist.

AGENCY COMMENTS AND OIG RESPONSE

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

In response to our first recommendation, CMS stated that it will review OIG's findings and take appropriate action to determine whether States made inappropriate payments and seek to recover the Federal share of any inappropriate Medicaid FFS payments made by States, in accordance with CMS policies and procedures.

In response to our second recommendation, CMS stated that it has requested legislative authority to reduce States' administrative match rates for noncompliance with provider screening, enrollment, and revalidation requirements in Medicaid and CHIP for both managed care and FFS in the President's fiscal year 2021 budget.

In response to our third recommendation, CMS stated that it will share the findings of our report with States and offer technical assistance if needed.

In response to our fourth recommendation, CMS stated that it provides technical assistance to States to help them overcome challenges in removing terminated providers from their Medicaid programs. CMS also noted that it will complete terminated provider desk reviews for all States in fiscal year 2020. In addition, CMS will, upon State request, periodically match state enrollment rosters to the termination database and share the results with States.

In response to our fifth recommendation, CMS stated that it conducts State program integrity desk reviews of terminated providers. While payments from managed care plans to providers are outside the scope of CMS's PERM authority, CMS stated that it will investigate the possibility of expanding PERM to include an assessment of a State's FFS payments associated with providers who have been terminated for cause by another State Medicaid or CHIP program, who also should have been terminated by the State that made the payment.

In response to our sixth recommendation, CMS stated that it will add the required provision that prohibits terminated providers from participating in Medicaid managed care networks to its contract review tool.

OIG and CMS share the goal of preventing terminated providers from serving Medicaid beneficiaries. 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 F.

APPENDIX A: Detailed Methodology

This appendix provides more detailed information on our data collection and analyses.

Data Collection

States. We requested the following information from all 50 States and the District of Columbia (States):

- a roster of active and enrolled Medicaid providers including all provider identification information such as names, addresses, National Provider Identifiers (NPIs), Social Security Numbers (SSNs), and State Medicaid IDs.[34] This included providers that are approved to bill, order, certify, refer, prescribe, render, attend, treat, provide items and/or services for Medicaid beneficiaries under fee-for-service (FFS) and/or managed care;[35]
- whether they contracted with managed care organizations (MCOs) to provide services to Medicaid beneficiaries;
- sections of State contracts (and amendments) with Medicaid MCOs that include the provision that providers terminated from Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are terminated from all Medicaid managed care networks; and
- State plan IDs used when submitting capitation payments to T-MSIS for all managed care plans within a State.

CMS. We obtained the termination database from CMS, which provides a list of terminated providers. This report provides identifying information for all terminated providers including NPIs, SSNs, Employer Identification Numbers (EINs), names, and the date CMS published the termination (published date). The report also provides the entity that terminated the provider and the reason for the provider's termination.

Using CMS's T-MSIS data available in OIG's data warehouse, we obtained Medicaid FFS claims and managed care encounter records for all types of claims and encounter header records: inpatient, long-term care,

[34] States' rosters of active and enrolled Medicaid providers were from January through May 2019. CMS's termination database was current as of February 2019.

[35] Florida also submitted separate rosters of "registered" individual and organizational providers. Managed care plans screen and credential these providers and send information on these providers to the State. Because these providers serve Medicaid beneficiaries, we included them in our analysis.

pharmacy, and other (which includes physician services). In addition, we obtained data on monthly capitation payments paid by States.

We performed a final action procedure to identify final action claims, encounter records, and capitation records and used these claims and records for our analysis. When data needed to perform the final action procedure were missing, we excluded these claims, encounter records, and capitation records from our analysis. Although we were unable to perform the final action procedure on the entirety of North Carolina's pharmacy claims/encounter records, we did include North Carolina's pharmacy claims/encounter records in our analysis. We conducted an additional data-cleaning step on these claims and records. We identified duplicate pharmacy claims/encounter records in North Carolina's data, and we removed both instances of the duplicates from our analysis because we were unable to determine which claim or encounter record was the final action claim or encounter record.

We obtained all Medicaid final action claims and encounter records associated with providers in CMS's terminations database that had an admission date (for inpatient claims and encounter records), prescription fill date (for pharmacy claims and encounter records), or beginning date of service (for long-term claims and encounter records and all other claims and encounter records) on or after July 1, 2018 (the implementation date for the Cures Act requirements).

We excluded denied claims and encounter records. We also removed claims and encounter records designated by CMS as supplemental payment records, service tracking claims, CHIP claims or encounter records, and claims or encounter records designated as "other."

We also collected State Medicaid IDs for terminated providers from the provider enrollment file housed in T-MSIS. We used these State Medicaid IDs to identify claims or encounter data associated with terminated providers.

Data Analysis

Terminated Providers Enrolled in State Medicaid Programs. The analysis of terminated providers enrolled in State Medicaid programs included all 51 States.

To determine whether any terminated providers were enrolled in State Medicaid programs, we compared the terminated providers in CMS's termination database to States' enrollment rosters. Specifically, we matched the NPIs, SSNs, and EINs from CMS's termination database to the same identifiers in States' enrollment rosters. We confirmed the match by reviewing the matched providers' names listed in both the State rosters and CMS's termination database to ensure that the correct provider had been identified in our comparison.

We removed providers from the termination database that were not currently terminated as of June 30, 2018. This resulted in a total of 9,047 terminated providers.[36]

We considered a terminated provider to be inappropriately enrolled in Medicaid if the State's enrollment roster's "as-of date"[37] was more than 95 calendar days after the published date in the termination database for that provider. CMS requires States to terminate providers within 60 business days of the published date. We used 95 calendar days to account for the required 60 business days.

We determined the total number of terminated providers enrolled in Medicaid as well as the number of terminated providers enrolled in each State. We also determined the reason for each provider's termination.

Payments Associated With Terminated Medicaid Providers. The analysis of payments associated with terminated providers did not include all States, as shown in Exhibit A-1.

To determine whether Medicaid paid for items and/or services associated with terminated providers, we matched the NPIs and State Medicaid IDs for 8,913[38] providers in the termination database to the same identifiers on the header record of T-MSIS final action claims and encounter records.[39] This match included all eight NPI fields and all five State Medicaid ID fields within the header record.[40, 41] Our analysis of Rhode

[36] For the purposes of our analysis, we determined which providers were in the termination database using a unique combination of NPI, SSN, and/or EIN—depending on which of these variables were available. We then performed an additional check comparing these unique combinations with their associated provider names.

[37] We asked States to provide the date they last updated the information contained in their rosters (i.e., the date as of which the information was current). We refer to this date as the "as-of date."

[38] For this analysis, we removed 135 terminated providers that had only an EIN listed in the termination database. We did not use EINs to obtain State-specific Medicaid provider IDs from T-MSIS because one EIN may be associated with multiple providers. Without a State-specific provider ID, we were unable to match the provider in the database of terminated providers to the corresponding claims and encounter records.

[39] The Cures Act prohibits payments associated with terminated providers. However, there is an exception made for payments related to emergency items/services not furnished in a hospital emergency room. We requested from CMS any information it would use to identify emergency services not provided in an emergency room setting. However, CMS could not provide any codes for items or services that would fall under this exception. In addition, there is no field in T-MSIS that would indicate whether a claim or encounter record is related to an emergency item/service not furnished in a hospital emergency room. Therefore, we were unable to determine which items/services would fall under this exception.

[40] T-MSIS includes NPIs for eight provider types within the header record: admitting, billing, directing, dispensing, health home, prescribing, referring, and supervising.

[41] T-MSIS includes State Medicaid IDs for five provider types within the header record: admitting, billing, dispensing, prescribing, and referring.

Island's provider enrollment file as well as its claims and encounter records indicated that its State Medicaid IDs may not be correct. Therefore, we were unable to identify problematic claims and encounter records using State Medicaid IDs for Rhode Island.

Exhibit A-1: Number of States included in and excluded from the analysis of FFS claims and managed care encounter records associated with terminated providers

FFS Claims	Number of States included in this analysis that submitted FFS claims to T-MSIS	50
	Number of States excluded from this analysis because they did not submit FFS claims to T-MSIS	1[a]
Managed Care Encounter Records	Number of States included in this analysis that submitted managed care encounter records to T-MSIS	42
	Number of States excluded from this analysis because they did not contract with MCOs and did not submit managed care encounter records to T-MSIS	8[b]
	Number of States excluded from this analysis because they contract with MCOs but did not submit any managed care encounter records to T-MSIS	1[a]

Source: OIG analysis of T-MSIS data from July 2018 to June 2019 and CMS's termination database from February 2019.
[a] Virginia had not submitted any FFS claims or managed care encounter records to CMS for our review period.
[b] Alaska, Connecticut, Maine, Montana, Oklahoma, South Dakota, Vermont, and Wyoming.

We included 50 States in our analysis of FFS claims. FFS claims for one State (Virginia) were not included in this analysis because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), Virginia had not submitted any FFS claims to CMS for our review period.

We included 42 States in our analysis of managed care encounter records. Eight States reported that they do not contract with MCOs.[42] Managed care encounter records for one additional State (Virginia) were not included in this analysis because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), Virginia

[42] These eight States are Alaska, Connecticut, Maine, Montana, Oklahoma, South Dakota, Vermont, and Wyoming. In addition, although Alabama reported that it does not contract with MCOs, we included Alabama in our analysis of encounter records because it submitted managed care encounter records.

had not submitted any managed care encounter records for our review period.

We considered a claim or encounter record to be associated with a terminated provider only if the date of service on the claim or encounter record was more than 95 calendar days after the date that the termination was published in the termination database. Because CMS prohibits States from making payments for items and services associated with terminated providers more than 60 business days after the published date, we used 95 calendar days to account for the 60 business days.

We performed additional analyses on long-term care and pharmacy claims and encounter records. For long-term care claims and encounter records that were associated with terminated providers, we further checked that the admission date occurred 95 calendar days after the admitting provider's published termination date. Similarly, for pharmacy claims and encounter records that were associated with terminated providers, we checked that the date of the prescription occurred 95 calendar days from the prescribing provider's published termination date.[43]

We then calculated the amount that Medicaid paid for items or services associated with terminated providers. For FFS claims associated with terminated providers, we aggregated total Medicaid paid amounts (including any adjustments, i.e., negative payment amounts). For managed care encounter records associated with terminated providers, we aggregated the monthly Medicaid capitation amounts (including negative payment amounts) that States paid for each beneficiary associated with these encounter records. To do this, we matched the plan ID and beneficiary ID from the encounter record with the plan ID and beneficiary ID listed on the capitation payment records included in T-MSIS. For our payment calculations, we included only Medicaid capitation payments that occurred during the same month as the date of the encounter record with the terminated provider.

We did not identify any encounter records associated with the terminated providers in 8 of the 42 States with encounter data submissions. For 21 of the remaining 34 States that had encounter records associated with terminated providers, we were unable to obtain all the corresponding monthly capitation payments. There were no capitation payments at all for Kansas because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), Kansas had not submitted any capitation payment data for our review period. In total,

[43] This analysis excludes 482 claims and encounter records on which States did not report the prescription date.

monthly capitation payment data corresponding to encounter records associated with terminated providers did not exist in T-MSIS for 1,989 beneficiaries, or 7 percent of all beneficiaries whose encounter records were associated with a terminated provider.

To calculate the Federal share for both FFS and capitation payments, we applied the State's FMAP for fiscal year 2018 or 2019, depending on the date of service.

We also determined the number of claims and encounter records associated with terminated providers as well as the number of terminated providers that were associated with these claims and encounter records. For this analysis, we did not include (1) claims where the Medicaid paid amount was less than or equal to zero or (2) encounter records where the capitation paid for the month the encounter occurred was less than or equal to zero. We excluded these claims and encounter records because we did not want to count claims and encounter records when a State did not make a payment.

Managed Care Contract Provisions. The analysis of State contracts with MCOs did not include all States, as shown in Exhibit A-2.

Exhibit A-2: Number of States included in and excluded from the analysis of States' MCO contracts

Number of States included in this analysis that reported contracting with MCOs	42
Number of States excluded from this analysis because they reported that they do not contract with MCOs	9[a]

Source: OIG analysis of State MCO contracts, 2019.

[a] Alabama, Alaska, Connecticut, Maine, Montana, Oklahoma, South Dakota, Vermont, and Wyoming.

For the States that reported that they contract with MCOs and submitted contracts, Office of Counsel to the Inspector General staff reviewed the States' contracts with MCOs to determine whether they included the required provision that providers terminated from Medicare, Medicaid, and CHIP are terminated from all Medicaid managed care networks. We did not include contracts related to CHIP, Primary Care Case Management (PCCM) programs, Program for All-Inclusive Care for the Elderly (PACE), Prepaid Inpatient Health Plans (PIHPs), and Prepaid Ambulatory Health Plans (PAHPs) in our review, as these requirements are not applicable to these contracts. If a State did not specifically indicate that a managed care plan was a CHIP, PACE, PIHP, PAHP plan, or a PCCM program, we were unable to exclude it from our analysis.

We determined the number of States that had contracts that:

- contained the provision required under the Cures Act,
- did not contain the provision required under the Cures Act, and
- did not clearly include the provision required under the Cures Act (i.e., because of the language in the contract we were unable to conclusively determine that the contract contained the required provision). For example, one or more contracts might prohibit providers that were "excluded"—rather than "terminated"—from participating in a Medicaid managed care network.

For the 34 States that had contracts that did not include or did not clearly include the required provision, we calculated the total capitation payments each State made for the plans associated with these contracts. We matched State-reported plan IDs to the plan ID on capitation payment records in T-MSIS to calculate total capitation payments associated with plans that did not clearly include the required provision in their contracts. Capitation payments for Kansas and Virginia were not included because, as of July 2019 (the date we obtained capitation payments for our analysis of contracts), these States had not submitted capitation payment records for our review period. Overall, our total capitation payment amount is understated because we did not identify, any capitation payments in T-MSIS for some State-reported plan IDs.

We aggregated Medicaid final action capitation payments (including negative payment amounts) for each plan reported in T-MSIS on or after July 1, 2018. For the purposes of our analysis, we did not include CHIP, "other," or denied capitation payments.

We then aggregated these capitation payments for each State. To calculate the Federal share for capitation payments, we applied the State's FMAP for fiscal year 2019.

We also analyzed State responses about whether their contracts with MCOs include a provision that requires MCOs to report to the State any providers that the MCO terminates from its network.

APPENDIX B: Number of Terminated Providers Enrolled in Each State Medicaid Program

Exhibit B-1: Number of Terminated Providers Enrolled in Each State Medicaid Program

State	Number of terminated providers enrolled in State Medicaid program	Number of terminated providers still enrolled after the State reported the termination to CMS
CA	64	43
MD	62	45
FL	51	10
DE	50	2
GA	43	1
AZ	30	0
WA	28	2
NM	26	0
TN	26	0
WV	25	0
LA	23	11
OH	21	6
MN	20	11
IL	18	2
NJ	16	3
VA	15	0
IA	12	0
MO	12	4
NV	12	5
IN	11	2
MI	11	1
NC	11	2
WI	11	4
OK	9	0
KS	8	0
PA	8	1
UT	8	0
ID	7	0

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Exhibit B-1: Number of Terminated Providers Enrolled in Each State Medicaid Program (continued)

State	Number of terminated providers enrolled in State Medicaid program	Number of terminated providers still enrolled after the State reported the termination to CMS
MS	7	2
TX	7	1
DC	6	0
AR	5	0
KY	5	2
MA	5	3
NY	5	1
AL	4	0
HI	4	0
NE	4	1
OR	4	1
CO	3	0
SC	3	2
MT	2	0
ND	2	0
RI	2	0
VT	2	0
WY	2	0
AK	1	0
ME	1	0
NH	1	0
SD	1	0
CT	0	0

Source: OIG analysis of State enrollment rosters from January to May 2019 and CMS's termination database from February 2019.

APPENDIX C: Medicaid Payments Associated With Terminated Providers, by State

Exhibit C-1: Medicaid Payments Associated With Terminated Providers, by State

State	Total Medicaid Payments[a]	Federal Share of Payments	State Share of Payments	Number of Paid Claims	Number of Encounter Records
FL[c]	$14,173,379	$8,699,383	$5,473,996	3,589	55,249
NY[c]	$7,621,422	$3,810,711	$3,810,711	1,681	9,085
GA	$3,992,922	$2,715,352	$1,277,569	17,233	2,042
MI[c]	$2,856,588	$1,845,344	$1,011,244	5,100	21,793
MT[b]	$2,571,128	$1,682,903	$888,225	6,275	N/A
TX[c]	$2,531,533	$1,460,099	$1,071,434	945	3,869
IN[c]	$2,217,734	$1,461,121	$756,613	1,017	8,406
OH[c]	$1,842,636	$1,160,319	$682,317	354	4,541
PA[c]	$1,837,709	$955,943	$881,765	595	3,795
AL[b,c]	$1,333,241	$955,499	$377,742	7,818	55
NJ[c]	$998,673	$499,337	$499,337	10	3,192
MD	$981,148	$490,574	$490,574	4,588	1,865
WY[b]	$934,273	$467,137	$467,137	1,700	N/A
SC	$813,181	$581,427	$231,754	0	1,232
LA[c]	$691,063	$442,215	$248,848	72	3,834
OK[b]	$618,790	$377,932	$240,858	7,050	N/A
KY	$588,965	$420,954	$168,012	58	2,707
MN[c]	$516,190	$258,095	$258,095	197	1,341
NC	$487,043	$328,262	$158,781	3,605	27
NV[c]	$449,346	$295,015	$154,331	1,539	2,337
WA[c]	$445,408	$222,704	$222,704	41	1,958
IL[c]	$437,554	$220,989	$216,565	43,281	48,511
WI	$310,537	$183,366	$127,171	1,748	181
TN[c]	$209,531	$137,959	$71,573	1,776	272
WV	$172,879	$127,414	$45,465	4,359	0
MS	$143,550	$109,243	$34,307	615	163
NM	$137,446	$99,267	$38,179	13	237
CO	$113,403	$56,701	$56,701	1,350	0
AZ[c]	$98,974	$69,165	$29,809	11	623

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Exhibit C-1: Medicaid Payments Associated With Terminated Providers, by State (continued)

State	Total Medicaid Payments[a]	Federal Share of Payments	State Share of Payments	Number of Paid Claims	Number of Encounter Records
AK[b]	$87,977	$43,989	$43,989	494	N/A
HI[c]	$43,191	$23,288	$19,902	0	2,261
NE	$14,968	$7,868	$7,100	0	57
MA[c]	$11,591	$5,795	$5,795	9	7
DC	$5,649	$3,954	$1,695	22	5
CT[b]	$2,293	$1,147	$1,147	10	N/A
VT[b]	$1,763	$943	$820	53	N/A
UT[c]	$1,581	$1,109	$471	9	3
IA	$983	$582	$401	0	4
NH	$867	$433	$433	1	4
MO	$44	$28	$16	3	0
AR	$0	$0	$0	0	0
CA	$0	$0	$0	0	0
ID	$0	$0	$0	0	0
KS[d]	$0	$0	$0	0	8
ME[b]	$0	$0	$0	0	N/A
ND[e]	$0	$0	$0	0	1
OR	$0	$0	$0	0	0
RI	$0	$0	$0	0	0
SD[b]	$0	$0	$0	0	N/A
DE[f]	-	-	-	0	10
VA[g]	N/A	N/A	N/A	N/A	N/A

Source: OIG analysis of T-MSIS data from July 2018 to June 2019 and CMS's termination database from February 2019.

[a] The Federal and State share amounts may not sum to the total Medicaid payment amount in a State because of rounding.

[b] State reported it does not contract with managed care plans.

[c] Some capitation payments are not included in this State's Medicaid payments because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), the State had not submitted monthly capitation payments for some of the beneficiaries related to encounter records associated with terminated providers.

[d] There are no capitation payments included in this State's Medicaid payments because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), the State had not submitted capitation records to T-MSIS for our review period.

[e] There are no capitation payments included in this State's Medicaid payments because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), the State had not submitted monthly capitation payments for any of the beneficiaries related to encounter records associated with terminated providers.

[f] State reported capitation payments that, in the aggregate, were negative for encounter records associated with terminated providers.

[g] There are no claims or encounter records included for this State because, as of June 2019 (the date we obtained T-MSIS data for our analysis of claims and encounter records), the State had not submitted any claims or encounter records to T-MSIS for our review period.

APPENDIX D: Number of Claims and Encounter Records Associated With Terminated Providers, by Service Type and Provider Type

Exhibit D-1: Number of Claims and Encounter Records Associated With Each Service Type

Service Type	Inpatient services	Long term services	Other services[a]	Pharmacy services	Total
Total Number of Claims and Encounter Records	179	1,849	136,787	158,081	296,896

Source: OIG analysis of T-MSIS data from July 2018 to June 2019 and CMS's termination database from February 2019.
[a] Includes physician services.

Exhibit D-2: Number of Claims and Encounter Records Associated With Each Provider Type

Provider Type	Number of claims/encounter records[a]
Billing provider	193,763
Admitting provider	219
Referring provider	43,667
Health home provider	5,933
Supervising provider	407
Directing provider	462
Dispensing provider	93,640
Prescribing provider	54,420

Source: OIG analysis of T-MSIS data from July 2018 to June 2019 and CMS's termination database from February 2019.
[a] These numbers do not total 296,896 because a single claim/encounter record could be associated with multiple provider types that were terminated.

APPENDIX E: Medicaid Payments for Managed Care Contracts That Did Not Clearly Include the Required Provision That Prohibits Terminated Providers From Participating in Managed Care Networks

Exhibit E-1: Medicaid Payments for Managed Care Contracts That Did Not Clearly Include the Required Provision That Prohibits Terminated Providers From Participating in Provider Networks

State	Total Medicaid Capitation Payments[a]	Federal Share	State Share
NY[b]	$20,228,031,354	$10,114,015,677	$10,114,015,677
TX[b]	$19,811,329,921	$11,528,212,881	$8,283,117,040
OH	$12,197,784,585	$7,695,582,294	$4,502,202,290
NJ	$6,248,648,969	$3,124,324,484	$3,124,324,484
LA	$5,618,949,959	$3,652,317,473	$1,966,632,486
TN	$5,564,572,912	$3,665,384,177	$1,899,188,735
MN	$4,669,409,828	$2,334,704,914	$2,334,704,914
MI	$4,631,994,938	$2,985,320,737	$1,646,674,200
IN[b]	$4,608,460,253	$3,039,740,383	$1,568,719,870
MD	$3,431,563,025	$1,715,781,513	$1,715,781,513
GA	$3,254,107,693	$2,200,427,622	$1,053,680,071
NM	$2,733,456,906	$1,975,195,960	$758,260,946
WA	$2,614,398,943	$1,307,199,472	$1,307,199,472
SC	$2,416,356,373	$1,720,929,009	$695,427,364
MS[b]	$1,957,387,514	$1,495,248,322	$462,139,192
OR	$1,579,840,491	$988,348,211	$591,492,280
FL[b]	$1,380,465,820	$840,289,545	$540,176,275
WV	$769,730,743	$572,217,834	$197,512,909
NE	$687,142,458	$361,299,505	$325,842,954
CO	$612,968,212	$306,484,106	$306,484,106
NV	$586,348,038	$380,363,972	$205,984,066
DC	$575,398,016	$402,778,611	$172,619,405
UT	$530,411,384	$369,749,776	$160,661,608

continued on next page

Exhibit E-1: Medicaid Payments for Managed Care Contracts That Did Not Clearly Include the Required Provision That Prohibits Terminated Providers From Participating in Provider Networks (continued)

State	Total Medicaid Capitation Payments[a]	Federal Share	State Share
AR	$356,203,784	$251,159,288	$105,044,496
NH	$308,394,700	$154,197,350	$154,197,350
HI	$188,456,651	$101,615,826	$86,840,825
IL	$141,974,145	$71,427,192	$70,546,953
RI[b]	$44,096,708	$23,181,639	$20,915,068
ID	$25,169,457	$17,903,035	$7,266,422
WI[b]	$17,396,051	$10,328,035	$7,068,015
MO	$2,605,615	$1,704,072	$901,543
KS[c]	N/A	N/A	N/A
ND[c]	N/A	N/A	N/A
VA[c]	N/A	N/A	N/A

Source: OIG analysis of T-MSIS data from July 2018 to July 2019 and State MCO contracts, 2019.

[a] The Federal and State share amounts may not sum to the total Medicaid payment amount in a State because of rounding.

[b] As of July 2019 (the date we obtained capitation payments for our analysis of contracts), there were no capitation records for some of the State-reported plan IDs for plans that did not clearly have the required provision in their State contracts.

[c] There are no capitation payments because, as of July 2019 (the date we obtained capitation payments for our analysis of contracts), the State had not submitted any Medicaid managed care capitation records to T-MSIS for our review period.

APPENDIX F: Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 3, 2020

TO: Christi A. Grimm
Acting Principal Deputy Inspector General

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: States Could Do More To Prevent Terminated Providers From Serving Medicaid Beneficiaries, OEI-03-19-00070

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 program integrity within Medicaid.

Both the Patient Protection and Affordable Care Act and 21st Century Cures Act establish requirements to prevent payments to terminated providers and to ensure that states remove terminated providers from their state Medicaid enrollment rosters.

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' working relationships with state partners.

To further ensure that states do not pay terminated providers, CMS uses the Payment Error Rate Measurement (PERM) program to identify improper fee-for-service payments a state has made to providers that it has terminated. After a state's PERM review, CMS works with the state to establish a state-specific PERM corrective action plan (CAP). The CAP includes provider enrollment errors and deficiencies when applicable. CMS' robust PERM CAP process allows for continuous oversight and monitoring of states' implementation of the PERM CAPs.

In addition, CMS conducts State Program Integrity desk reviews of terminated providers. These desk reviews are designed to identify program vulnerabilities that might permit providers who have been revoked by Medicare or terminated for cause by a state Medicaid or Children's Health Insurance Program (CHIP) to subsequently bill and receive payments from Medicaid. The reviews compare provider enrollment data with information posted on the nationwide terminated providers database, and identify any payments made to revoked or terminated providers listed therein. CMS shares the results of those reviews with states, who are given the opportunity to review the results and provide additional documentation demonstrating the payments were proper. CMS requests that states develop corrective action plans to address any findings. Since 2015, CMS has completed terminated provider desk reviews in 45 states, and by the end of FY 2020 CMS will have reviewed each state at least once.

CMS also offers optional technical support services to help states ensure that their process for removing terminated Medicaid providers is consistent with federal regulations. This assistance includes performing site visits at states' request. 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, and CMS continues to reach out to states to help ensure they are in compliance with federal requirements.

OIG's recommendations and CMS' responses are below.

OIG Recommendation
CMS should recover from states the Federal share of inappropriate fee-for-service Medicaid payments associated with terminated providers.

CMS Response
CMS concurs with this recommendation. We will review OIG's findings and take appropriate action in accordance with CMS policies and procedures.

OIG Recommendation
CMS should implement a method to recover from states the Federal share of inappropriate managed care capitation payments associated with terminated providers.

CMS Response
CMS concurs with this recommendation. CMS has requested the legislative authority 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 follow up with states to remove terminated providers that OIG identified as inappropriately enrolled in Medicaid.

CMS Response
CMS concurs with this recommendation. CMS will share the findings of this report with states and offer technical assistance if needed.

OIG Recommendation
CMS should confirm that states do not continue to have terminated providers enrolled in their Medicaid programs.

CMS Response
CMS concurs with this recommendation. CMS already provides technical assistance to states to help them overcome challenges in removing terminated providers, and in FY 2020 will have completed terminated provider desk reviews on all states. In addition, CMS will, upon state request, periodically match state enrollment rosters to the termination database and share the results with states.

OIG Recommendation
CMS should safeguard Medicaid from inappropriate payments associated with terminated providers.

CMS Response
CMS concurs with this recommendation. CMS already conducts State Program Integrity desk reviews of terminated providers. While payments from managed care plans to providers are outside the scope of CMS' PERM authority, CMS will investigate the possibility of expanding PERM to include an assessment of a state's fee-for-service payments associated with providers who have been terminated for cause by another state Medicaid or CHIP, who therefore should also have been terminated by the state that made the payment.

OIG Recommendation
CMS should review states' contracts with managed care organizations to ensure that they specifically include the required provision that prohibits terminated providers from participating in Medicaid managed care networks.

CMS Response
CMS concurs with this recommendation and will add this provision to our contract review tool.

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This report was prepared under the direction of Linda Ragone, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office; and Edward K. Burley, Deputy Regional Inspector General.

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

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