



Report to the Ranking Member,  
Committee on Homeland Security and  
Governmental Affairs, U.S. Senate

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April 2016

# MEDICAID PROGRAM INTEGRITY

## Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers

Accessible Version

# GAO Highlights

Highlights of [GAO-16-402](#), a report to the Ranking Member, Committee on Homeland Security and Governmental Affairs, U.S. Senate

## Why GAO Did This Study

GAO has reported that Medicaid remains a high-risk program, partly due to concerns about improper payments. Screening of providers is important to help prevent improper payments. Under managed care, states contract with plans to provide services to beneficiaries.

GAO was asked to examine the screening of managed care providers. GAO examined (1) states' and plans' experiences using federal databases to screen providers; and (2) how states and plans share data about ineligible providers. GAO interviewed officials from 10 states, selected generally based on enrollment and geography, and representatives from 16 plans from among these states. GAO reviewed those states' Medicaid program websites and plan contracts, and relevant federal laws, regulations, and guidance; and interviewed officials from CMS and the Department of Health and Human Services' Office of Inspector General.

## What GAO Recommends

GAO recommends that CMS (1) consider additional databases used in screening, (2) collaborate with the Social Security Administration to improve access to the Death Master File, (3) coordinate with other agencies to develop a common identifier across databases, and (4) provide state Medicaid programs with guidance that establishes expectations and best practices on sharing provider screening data among states and plans. HHS concurred with our recommendations.

View [GAO-16-402](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

April 2016

## MEDICAID PROGRAM INTEGRITY

### Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers

## What GAO Found

GAO found that the selected states and Medicaid managed care plans face significant challenges in screening providers for eligibility to participate in the Medicaid program. Based on information we received from two selected states and 16 selected plans, GAO found that the states and plans used information that was fragmented across 22 databases managed by 15 different federal agencies to screen providers. These databases included databases that the Centers for Medicare & Medicaid Services (CMS) had not identified for use in screening providers. Officials from some states noted that these additional databases provided better assurance they would not enroll ineligible providers—i.e., providers who have been barred from participating in federal health care programs. Federal internal control standards stress the importance of collecting quality information to achieve objectives and assess risks. However, the variety of databases used for screening purposes beyond those identified by CMS, along with the current rate of improper payments to Medicaid providers, suggests that CMS might not have identified all reliable sources of information about ineligible providers that could help states and plans achieve program objectives. State officials and plan representatives also said that accessing and using fragmented information from multiple and disparate federal databases challenged their screening efforts. For example, they reported difficulties accessing certain databases, such as the Social Security Administration's Death Master File, and conducting and confirming identified provider matches across databases, particularly those not based on a unique national provider identifier. CMS has not coordinated with other agencies to address these challenges. Federal internal control standards state that agencies should use quality data that are complete, current, accurate, and accessible—and have a logical connection to the program—to achieve agency goals to reduce fraud. However, the difficulties states and plans experienced accessing databases and confirming matches could result in provider screening efforts that do not ensure that ineligible providers are accurately and consistently identified.

GAO also found that the selected states reviewed used inconsistent practices to make data on ineligible providers publicly available. States must ensure that none of their providers has been determined to be ineligible anywhere in the United States. Although CMS has issued guidance encouraging states to share data on ineligible providers through its Medicaid provider termination notification system, doing so is optional, not all states are using the list, and it is not available to Medicaid managed care plans. Moreover, CMS has not provided states with guidance on other ways to share their data on ineligible providers or how to access other states' data on ineligible providers. The 10 states GAO selected varied in how they shared data on ineligible providers. Plans are not required to make their own data on ineligible providers publicly available, and the 16 selected plans shared their data with states at differing intervals and, in rare cases, with other plans. The inconsistency with which this information is shared across states and plans creates the potential that providers could be ineligible in some states while still receiving payments from Medicaid in other states.

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## Abbreviations

CMS	Centers for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DMF	Death Master File
EAR	Export Administration Regulations
EPLS	Excluded Parties List System
FEHBP	Federal Employees Health Benefits Program
FFS	fee for service
GSA	General Services Administration
HCERA	Health Care and Education Reconciliation Act of 2010
HHS	Department of Health and Human Services
HHS-OIG	Department of Health and Human Services Office of Inspector General
LEIE	List of Excluded Individuals and Entities
MED	Medicare Exclusion Database
MMC	Medicaid managed care
NPI	National Provider Identifier
NCQA	National Committee for Quality Assurance
NPDB	National Practitioner Data Bank
NPPES	National Plan and Provider Enumeration System
OPM	Office of Personnel Management
PACER	Public Access to Court Electronic Records
PECOS	Provider Enrollment Chain and Ownership System
PPACA	Patient Protection and Affordable Care Act
SAM	System for Award Management
SSA	Social Security Administration
TIN	Taxpayer Identification Number

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April 22, 2016

The Honorable Thomas R. Carper  
Ranking Member  
Committee on Homeland Security and Governmental Affairs  
United States Senate

Dear Senator Carper:

The Medicaid program financed health care coverage for an estimated 69 million beneficiaries with estimated expenditures of \$529 billion in fiscal year 2015.<sup>1</sup> This federal-state health care program for low-income and medically needy individuals finances the delivery of health care services to beneficiaries through fee-for-service (FFS) payments to participating providers and capitated payments to Medicaid managed care (MMC) plans under the terms of their contracts with the state. Under the managed care delivery model, states typically contract with MMC plans to provide a specific set of Medicaid-covered services to beneficiaries and pay the MMC plans a set amount per beneficiary per month—referred to as capitation payments—to provide those services. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services (HHS), is responsible for broad oversight of the Medicaid program, while states are responsible for the daily administration of their individual Medicaid programs, including program integrity activities. In its broad oversight role, CMS develops guidance and provides assistance to the states in administering their Medicaid programs. In February 2015, we reported that Medicaid remains a high-risk program because of concerns about the adequacy of fiscal oversight, including improper payments to Medicaid providers.<sup>2</sup> CMS estimated that

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<sup>1</sup>Office of the Actuary, Centers for Medicare & Medicaid Services, *United States Department of Health and Human Services: 2014 Actuarial Report on the Financial Outlook for Medicaid*, (Washington, D.C.: 2014).

<sup>2</sup>See GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: Feb. 11, 2015).

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\$29.12 billion, or 9.78 percent, of federal Medicaid expenditures for fiscal year 2015 were improper payments.<sup>3</sup>

Because provider actions can be a major factor behind improper payments, the integrity of the Medicaid program depends, in large part, on ensuring that only eligible providers participate in the program. Consequently, screening providers is important in helping prevent improper payments, including fraud and abuse. In 2000, we raised concerns about the effectiveness of states' screening and enrollment processes in preventing potentially fraudulent providers from enrolling in the Medicaid program.<sup>4</sup> More recently, we examined approximately 881,000 Medicaid providers in four states and found that in fiscal year 2011 hundreds of these providers were potentially receiving improper Medicaid payments. The providers had suspended or revoked medical licenses, had invalid addresses, were identified as deceased in federal death files, or had been excluded from federal health care programs, including Medicaid.<sup>5</sup> Our prior work has also concluded that comprehensive state screening and enrollment processes that prevent fraudulent providers from billing Medicaid are more efficient in protecting Medicaid funds than attempting to recover these funds once payments have been made.<sup>6</sup> For the purposes of this report, an "ineligible or potentially ineligible provider" means a provider who has been, or could be, excluded by HHS's Office of Inspector General (HHS-OIG) or terminated by a state from participating in Medicaid under any applicable requirements.

As states move their Medicaid programs to managed care, the screening of MMC plan providers becomes increasingly important and increasingly

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<sup>3</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible service, any duplicate payment, payment for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

<sup>4</sup>See GAO, *Medicaid: HCFA and States Could Work Together to Better Ensure the Integrity of Providers*, [GAO/T-HEHS-00-159](#) (Washington, D.C.: July 18, 2000).

<sup>5</sup>See GAO, *Medicaid: Additional Actions Needed to Help Improve Provider and Beneficiary Fraud Controls*, [GAO-15-313](#) (Washington, D.C.: May 14, 2015).

<sup>6</sup>See GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments*, [GAO-04-707](#) (Washington, D.C.: July 16, 2004); and [GAO/T-HEHS-00-159](#).

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complex. As of July 2013, the date of the most recent enrollment data available, about 55 percent of total Medicaid enrollment was in managed care, a percentage that has likely grown since.<sup>7</sup> In addition, MMC expenditures are growing at a faster rate than FFS expenditures because of the Medicaid expansions under the Patient Protection and Affordable Care Act (PPACA).<sup>8</sup> Further, the HHS-OIG has noted the emergence of MMC fraud, citing the increase in the agency's workload on MMC fraud cases, some of which resulted in inflated payments to MMC plans. The flexibility states have in setting up their Medicaid programs—in the case of screening MMC plan providers, states either screen providers, or they delegate screening to plans, or use a combination of both approaches—makes identifying ineligible providers across multiple states a complex task. According to a 2016 estimate by the Congressional Budget Office, managed care providers who have been determined to be ineligible for the Medicaid program, but continue to participate, receive \$3 million in federal Medicaid payments annually.

You asked us to examine the availability and use of databases and information necessary to screen MMC plan providers. This report examines

1. selected states' and MMC plans' experiences using federal databases to screen providers; and
2. how states and MMC plans share data about ineligible providers.

To obtain information on the federal databases that states and MMC plans use to screen providers and their experiences using these databases, we first selected 10 states—California, Florida, Illinois, Minnesota, Missouri, New Jersey, New York, Tennessee, Texas, and Washington—generally based on MMC beneficiary enrollment and geographic distribution. We contacted Medicaid program officials in these

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<sup>7</sup>States may have different types of managed care arrangements in Medicaid. In this report, where we refer to Medicaid managed care, we are generally referring to comprehensive, risk-based managed care, the most common type of managed care arrangement.

<sup>8</sup>Pub. L. No. 111-148, 124 Stat.119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029 (2010), which we refer to collectively as PPACA. PPACA permitted states to expand their Medicaid programs by covering certain low-income adults not historically eligible for Medicaid coverage; as of May 2015, 29 states elected to do so. States that choose to expand their Medicaid programs under PPACA have generally done so with managed care arrangements.

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states to discuss whether the state or the MMC plans primarily screen MMC plan providers. We determined that 2 states conduct their own provider screening and 8 states primarily delegate provider screening to MMC plans. We then contacted state Medicaid officials in the two states that primarily screen providers, and representatives from the 16 plans in states where plans primarily screen providers. We discussed which federal databases they use to screen providers in order to help prevent ineligible providers from enrolling and their experiences with using the databases. The experiences of the Medicaid officials in the selected states and the representatives in the selected MMC plans are not generalizable to all plans in the states or to other states. In addition, we reviewed applicable federal laws and regulations; CMS reviews of state program integrity activities; CMS guidance on database use for the screening of MMC plan providers; and Medicaid managed care contracts in the 10 states. Further, we evaluated the sufficiency of CMS guidance related to provider screening against our fraud prevention framework and relevant federal internal control standards.<sup>9</sup> Finally, we interviewed CMS and HHS-OIG officials to obtain information about their databases, and obtained and reviewed documentation on the various federal databases identified by the states and plans.

To obtain information about how states and MMC plans share information and data on ineligible providers with other MMC plans and states, we contacted Medicaid officials in all 10 selected states and plan representatives from the 16 selected plans. In addition, we searched the Medicaid program websites in each of the 10 states to determine whether state data on terminated providers were publicly available; the type of information provided; and the ease of searching, finding, and downloading state information. The experiences of the Medicaid officials in the selected states and the representatives in the selected MMC plans are not generalizable to all plans in the states or to other states. We also reviewed CMS guidance on sharing data regarding these providers and relevant federal internal control standards.

We conducted this performance audit from March 2015 to April 2016 in accordance with generally accepted government auditing standards.

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<sup>9</sup>See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, [GAO-15-593SP](#) (Washington, D.C.: July 28, 2015). Also see, GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014). Internal control is a process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.



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Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

Federal laws require both state and federal entities to protect the Medicaid program from fraud, waste, and abuse. States have primary responsibility for reducing, identifying, and recovering improper payments. Federal entities typically provide oversight, guidance, and program and law enforcement support.

States' program integrity activities include a screening process to help ensure that ineligible providers do not participate in the Medicaid program. Federal regulations establish screening requirements that apply when states enroll FFS providers into their Medicaid program. Because states are required to enroll FFS providers, but have discretion on whether to enroll MMC plan providers, MMC plan providers would not be subject to the same screening requirements as FFS providers unless the state opted to enroll them.<sup>10</sup> States that do not enroll MMC plan providers have flexibility in how they screen them.<sup>11</sup> This occurs when states require the MMC plans to screen and enroll providers directly into their networks by delegating these responsibilities to the plans in their contracts. In past work, we concluded that states that maintain centralized control over the provider screening process and require MMC plan providers to enroll with the state Medicaid agency may be better positioned to ensure the integrity of their Medicaid programs.<sup>12</sup>

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<sup>10</sup>See 42 C.F.R. § 455.410 (2015).

<sup>11</sup>In June 2015, CMS issued a proposed rule that would, if finalized, require all MMC plan providers to enroll with the state Medicaid agency and, as a result, subject all MMC plan providers to the same screening requirements as Medicaid FFS providers. See Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions to Third Party Liability, 80 Fed. Reg. 31098 (proposed June 1, 2015).

In addition, Congress is considering legislation, The Ensuring Removal of Terminated Providers from Medicaid and CHIP Act, which would require all providers participating in Medicaid to enroll with the state, regardless of whether the provider services Medicaid beneficiaries on a FFS basis or through a managed care entity. See H.R. 3716, 114<sup>th</sup> Cong. (2<sup>nd</sup> Sess. 2016).

<sup>12</sup>See [GAO-15-313](#).

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Federal health programs, including Medicaid, are prohibited from paying for any items or services rendered by an ineligible provider. The HHS-OIG determines which providers are excluded from the federal health programs, and thus ineligible, and maintains the List of Excluded Individuals and Entities (LEIE).<sup>13</sup> Grounds for exclusion include convictions for program-related fraud and patient abuse, and suspension or revocation of a medical license for reasons bearing on professional competence or performance. While states may delegate provider screening to the MMC plans, the states remain responsible for ensuring that they do not pay ineligible providers for Medicaid health care items and services. CMS is prohibited by federal law from making payments to states for any amount expended for items or services provided by an ineligible provider.<sup>14</sup> Any such payments constitute overpayments and are therefore subject to recoupment. In addition, civil monetary penalties may be imposed against MMC plans that employ or enter into contracts with ineligible providers.

Further, PPACA and its implementing regulations require state Medicaid agencies to terminate the participation of any provider that has been terminated on or after January 1, 2011, under Medicare or under any other state Medicaid program or Children's Health Insurance Program.<sup>15</sup> CMS defines termination to mean that a state Medicaid program, Children's Health Insurance Program, or the Medicare program has taken action to revoke a provider's billing privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.<sup>16</sup> A termination for cause may include, but is not limited to, terminations based upon fraud, integrity, or quality issues.<sup>17</sup> Prior to PPACA, if one state terminated a provider from its Medicaid program, the provider could potentially enroll in or

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<sup>13</sup>In this report, we focus on individuals and entities providing Medicaid services. We do not cover directors, officers, partners, and other persons with ownership and control in an MMC plan.

<sup>14</sup>See 42 U.S.C. § 1396b(i)(2).

<sup>15</sup>See 42 U.S.C. § 1396a(a)(39), 42 C.F.R. § 455.416(c) (2015).

<sup>16</sup>See 42 C.F.R. § 455.101 (2015).

<sup>17</sup>See 42 C.F.R. § 455.101 (2015). In the preamble to its final rule, CMS stated that for cause does not include cases where a state terminates an inactive provider from its enrollment files, or where a provider takes voluntary action to end its participation in the program, except where that voluntary action is taken to avoid sanction. See Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 76 Fed. Reg. 5862, 5943 (Feb. 2, 2011).

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continue participation in another state's Medicaid program, leaving the latter state's program vulnerable to potential fraud, waste, and abuse. In response to the PPACA requirement for CMS to establish a process for sharing information about terminated providers with state agencies, CMS established a web-based portal—the Medicaid provider termination notification system—where CMS and state Medicaid agencies can submit information about providers that meet CMS's criteria for having been terminated for cause from Medicare, Medicaid, or the Children's Health Insurance Program. However, according to CMS officials, states' use of this portal to report terminations is voluntary.

In response to PPACA's requirement to establish procedures for screening providers, CMS issued regulations that set forth minimum requirements applicable to the screening of Medicaid FFS providers, although states have flexibility to establish more stringent screening requirements.<sup>18</sup> Among other requirements, CMS designated four federal databases that states must use to screen providers: (1) the Social Security Administration's (SSA) Death Master File (DMF), (2) HHS's National Plan and Provider Enumeration System (NPPES), (3) the LEIE, and (4) the Excluded Parties List System (EPLS) maintained by the General Services Administration.<sup>19</sup> In December 2014, CMS issued guidance to assist states when conducting required federal database checks on FFS providers.<sup>20</sup> In the guidance, CMS noted that MMC plans are not mandated by regulation to screen providers who enroll in their networks. However, CMS stated that it considered the requirements under its regulation to be program safeguards that would be prudent in managed care settings. CMS also noted that states may delegate these requirements to their MMC plans through their contracts with them. In

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<sup>18</sup>See 42 U.S.C. § 1395cc(j)(2); 42 C.F.R. § 455.410 (2015). As previously noted, these regulations would also apply to any states that elected to enroll MMC plan providers. Two of the states in our review enrolled MMC plan providers and were subject to these minimum requirements, although they had flexibility to establish more stringent requirements. 42 C.F.R. § 455.452 (2015).

<sup>19</sup>42 C.F.R. § 455.436(b) (2015) requires states to check the Excluded Parties List System (EPLS). However, the General Services Administration discontinued EPLS in 2012 and moved its content to the System for Award Management (SAM). In August 2012, CMS officials instructed states to use SAM instead of EPLS to fulfill their regulatory responsibilities.

<sup>20</sup>See Toolkits for Frequent Findings: 42 CFR 455.436 (December 2014).

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guidance issued to MMC plans, CMS recommended that plans use the LEIE and EPLS to identify ineligible providers.<sup>21</sup>

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**Selected States and Medicaid Managed Care Plans Face Significant Challenges Screening Providers**

According to two selected states and 16 selected MMC plans that screen MMC plan providers, their efforts are challenged by fragmented information and difficulty accessing and using particular databases.

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**Efforts to Screen Providers Are Based on Information that Is Fragmented across Multiple and Disparate Federal Databases**

According to the two selected state officials and 16 selected MMC plan representatives we contacted, the information they use to screen MMC plan providers is fragmented across multiple and disparate federal databases. Overall, these two selected states and 16 selected plans identified a total of 22 databases managed by 15 different federal agencies. Representatives from 13 of the 16 plans reported using between 5 and 8 of these federal databases, while officials from the two states that directly screen managed care providers reported using 5 and 6 databases. Table 1 lists the 22 databases that these selected state officials and plan representatives said they used in their screening of MMC plan providers, the agencies that managed them, and the role the databases play in the screening of providers. (See appendix I for additional details on each of these federal databases.)

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<sup>21</sup>See Centers for Medicare & Medicaid Services, *The Medicaid Managed Care Plan's Role in Preventing, Detecting, and Reporting Fraud, Waste, and Abuse* (October 2014); and Centers for Medicare & Medicaid Services, *Managed Care Plans: Critical Partner in the Fight against Fraud Waste, and Abuse in Medicaid-Presentation* (September 2014).

**Table 1: Federal Databases Identified by Two Selected States and 16 Selected Medicaid Managed Care (MMC) Plans for Screening MMC Plan Providers**

	Managing agency and database	Use in screening providers	Entity conducting screening	
			States (2)	Plans in 8 states (16)
<b>Department of Health and Human Services (HHS) Office of Inspector General (HHS-OIG)</b>	List of Excluded Individuals and Entities (LEIE) <sup>a</sup>	Identifies providers that the HHS-OIG has excluded from participation in federal health care programs.	2	16
	OIG Most Wanted Fugitives	Identifies providers who are on HHS-OIG's list of most wanted health care fugitives.	0	2
<b>HHS Centers for Medicare &amp; Medicaid Services (CMS)</b>	Medicare Exclusions Database	Provides information on excluded providers and is CMS's equivalent to HHS-OIG's LEIE.	2	11
	Medicare Opt-out	Lists providers who voluntarily request, and are permitted, to opt-out of the Medicare program.	0	3
	National Plan & Provider Enumeration System (NPPES) <sup>a</sup>	Contains a directory of providers with active National Provider Identifiers. <sup>b</sup>	2	16
	Provider Enrollment, Chain and Ownership System (PECOS)	Is an Internet-based system to which Medicare providers submit and update their enrollment data. States use PECOS to obtain information on whether providers are eligible to participate in Medicare and Medicaid.	2	0 <sup>c</sup>
<b>HHS Health Resources and Services Administration</b>	National Practitioner Data Bank (NPDB)	Among other things, identifies health care providers who have been disciplined by a state licensing board, professional society, or health care provider, or have been named in a medical malpractice settlement or judgment.	0	16
<b>Department of Commerce, Bureau of Industry and Security</b>	Denied Persons List	Identifies individuals and entities that have been denied export privileges by written order to the Department of Commerce.	0	1
	Entity List	Identifies foreign parties that are subject to specific license requirements for the export, re-export and/or transfer (in-country) of specific items.	0	1
	Unverified List	Identifies parties that are ineligible to receive items subject to the Export Administration Regulations by means of a license exception.	0	1
<b>Department of Justice, Drug Enforcement Administration (DEA)</b>	Administrative Actions Against Registrants	Identifies those providers registered with the DEA, against whom the agency has taken administrative action.	0	1

	Managing agency and database	Use in screening providers	Entity conducting screening	
			States (2)	Plans in states (16)
	DEA Number	Provides proof of providers' DEA registration number.	0	2
<b>Department of State</b>	Designated Foreign Terrorist Organizations	Lists foreign organizations that are designated by the Secretary of State as Foreign Terrorist Organizations, in accordance of section 219 of the Immigration and Nationality Act, as amended.	0	1
<b>Department of Treasury, Office of Assets Control</b>	Specially Designated Nationals List	Identifies those providers whose assets are blocked and with whom U.S. entities are generally prohibited from dealing.	0	5 <sup>u</sup>
<b>Federal Bureau of Investigation</b>	Wanted Fugitives	Provides a list of Federal Bureau of Investigation fugitives.	0	1
<b>Federal Judiciary</b>	Public Access to Court Electronic Records (PACER)	Is a centralized, electronic public access service, provided by the federal judiciary, which allows users to obtain case and docket information online from federal appellate, district, and bankruptcy courts, and the PACER Case Locator.	0	1
<b>Federal Financial Institutions Examination Council</b>	Politically Exposed Persons	Lists current or former senior foreign political figures, their immediate family, and their close associates, who potentially pose a risk that their funds may be the proceeds of foreign corruption.	0	1
<b>General Services Administration</b>	Excluded Parties List System (EPLS)/System for Award Management (SAM) <sup>a,e</sup>	Identifies parties that have been suspended or debarred from receiving a wide range of federal funds.	2	16
<b>Internal Revenue Service</b>	Taxpayer Identification Number Matching	Allows authorized users to match taxpayer identification numbers with names.	0	1
<b>Office of Personnel Management</b>	Federal Employees Health Benefits Program Administrative Sanctions	Lists providers who have been suspended and debarred by the Office of Personnel Management's Office of Inspector General because they have, among other things, lost professional licenses, violated provisions of a federal program, been debarred by another federal agency, or been convicted of a crime related to delivery of or payment for health care services.	0	1
<b>Social Security Administration</b>	Death Master File <sup>a</sup>	Identifies Social Security number holders who are deceased.	1	14 <sup>g</sup>

	Managing agency and database	Use in screening providers	Entity conducting screening	
			States (2)	Plans in 8 states (16)
<b>United States Postal Service</b>	Look Up A Zip Code	Allows zip code searches by address, city, and state.	0	1

Source: GAO analysis of information from the two selected states that conduct the screening of MMC plan providers and 16 selected plans . | GAO-16-402

Notes: According to information we obtained from Medicaid program officials in each of the 10 selected states, 2 of these states conduct the screening of MMC plan providers. In the other 8 states, the MMC plans are primarily responsible for this screening. In these 8 states, we obtained information from representatives from each of the two MMC plans with the most Medicaid beneficiaries.

<sup>a</sup>CMS regulations require state Medicaid agencies to use this federal database when screening fee-for-service providers. 42 C.F.R. § 455.436 (2015).

<sup>b</sup>The National Provider Identifier (NPI) is a national, unique 10-digit identification number assigned to health care providers that CMS specified must be used in specified administrative and financial transactions for its health care providers and suppliers, in accordance with the Health Insurance Portability and Accountability Act.

<sup>c</sup>As of February 2016, this database is only available to states, not to plans.

<sup>d</sup>Representatives from one plan told us that in addition to the Specially Designated Individuals list, they use another five related Office of Foreign Assets Control databases that generally focus on U.S. sanctions against specific countries.

<sup>e</sup>In July 2012, the General Services Administration migrated the Excluded Parties List System (EPLS) into the System for Award Management, a comprehensive database that combines a number of federal procurement data sources, including EPLS.

<sup>f</sup>Officials from the state that did not use the Death Master File at the time of our review told us that they were in the process of procuring a subscription for it.

<sup>g</sup>Representatives from one plan that did not use the Death Master File at the time of our review told us that they intend to use it in the future.

According to state Medicaid officials in the two selected states that do their own screening of providers, both states used the LEIE, EPLS, and NPPES, and one also used the DMF.<sup>22</sup> In addition, both states checked CMS’s Medicare Exclusions Database and its Provider Enrollment, Chain and Ownership System (PECOS).

<sup>22</sup>These two states also enroll their MMC plan providers, which means that they are subject to the same regulatory requirements for database use that apply to the screening of FFS plan providers, i.e., states should check all four databases—Death Master File, National Provider Enumeration System, List of Excluded Individuals and Entities, and the Excluded Parties List System. Officials from the state that did not use the Death Master File at the time of our review told us that they were aware of this requirement and they were in the process of procuring a subscription for the Death Master File.

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Almost all of the selected MMC plans reported using three databases—NPDES, DMF, and HHS’s National Practitioner Data Bank—in addition to the two databases recommended by CMS guidance. Plans also reported using several other of the federal databases identified in table 1. Officials from some states noted that plans checking more databases than recommended by CMS provided better assurance they would not enroll ineligible providers and helped provide a more comprehensive background on a provider. For example, by checking federal databases beyond the two recommended by CMS for MMC plans (LEIE and EPLS), plans may find background on a provider’s termination or identify a past administrative action taken against the provider by the Drug Enforcement Administration. However, this also means that provider screenings within a state may not always be conducted consistently, as the additional databases checked may vary by plan.

Additionally, all 10 selected states use the health plan accreditation requirements of the National Committee for Quality Assurance (NCQA) in their monitoring of state MMC plans, because it includes provider screening guidelines, such as assessing providers’ practice history, verifying their credentials, education, training, malpractice history and disciplinary actions, and monitoring providers’ sanctions, complaints, and quality issues. Half of the states require that their plans be accredited by NCQA, and the rest recognize NCQA accreditation as compliance with federal guidance for screening MMC plan providers. In particular, to meet the NCQA accreditation requirements, plans need to obtain information beyond what the LEIE and EPLS provide. For example, to meet NCQA’s requirement that they verify provider history and other disciplinary actions, plans must check the National Practitioners’ Data Bank, a large central federal data bank of all reports made against all health care professionals, including fraud, abuse, licensure actions, or malpractice reports.

Federal internal control standards stress the importance of collecting quality information to achieve objectives and assess risks. To do this, the standards state that it is necessary to identify information requirements and use data from reliable sources.<sup>23</sup> However, the variety of databases checked by states and MMC plans beyond those specified by CMS, the use of NCQA’s accreditation requirements in all 10 states, along with the

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<sup>23</sup>See [GAO-14-704G](#).



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current rate of improper payments to Medicaid providers, suggests that CMS might not have identified all reliable sources of information about ineligible providers. This makes it difficult for the states and MMC plans to achieve the Medicaid program's objectives. Moreover, the variety of databases that the states and MMC plans have chosen to check raises the possibility that they might be using information of varying quality to screen providers. All of the states and MMC plans that screened providers checked more databases than are currently specified by CMS for this purpose, but CMS has not assessed whether there are benefits to checking the additional databases. Without an assessment of these additional databases and their potential contribution to improving the effectiveness of screening providers, and ultimately reducing improper Medicaid payments, CMS cannot be certain that states and MMC plans are using information of sufficient quality to screen providers.

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### Screening Efforts Are Hampered by Difficulties Accessing and Using Databases

State Medicaid officials and MMC plan representatives said that accessing and using information that is fragmented across multiple and disparate federal databases hampered them in their efforts to screen providers. CMS has not collaborated with other agencies to explore options for enhancing the ability of states and plans to access and use comprehensive information during the screening process, including information about deceased providers, and thus better ensure that ineligible or potentially fraudulent providers do not bill Medicaid.

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## Accessing Particular Databases

State officials and plan representatives noted problems accessing two specific databases. Officials from one state and representatives from one plan identified cost as a challenge to using the DMF, which is only available with a paid subscription.<sup>24</sup> CMS officials told us that they are interested in collaborating with SSA to facilitate sharing DMF data with states. Additionally, representatives from one plan said that having access to PECOS—a CMS database currently unavailable to plans—would help improve their screening process because it would help corroborate information from providers.

Representatives from two plans said that they experienced challenges obtaining assistance when they had general problems using federal databases. For example, representatives from one plan said that it could be difficult to identify an individual at a federal agency who could not only assist them, but also who understands Medicaid. Plan officials said that if they were able to contact someone, the agency might be hesitant to provide the plan with additional information about a provider termination, because MMC plans are not government entities.

## Confirming Identified Matches

Representatives from seven selected plans said that the technical process of conducting the matches and confirming identified matches was challenging. For example, some plan representatives said they check the eligibility status of thousands of providers at regular intervals, typically monthly, and said that these checks can be particularly challenging if the database does not allow the user to compare multiple provider names at one time.

Plan representatives said that confirming the accuracy of identified matches was also challenging, because some databases contained limited provider data, particularly if a match is not based on a unique identifier, such as the national provider identifier (NPI). The lack of a consistent, unique identifier meant that it could be difficult to accurately match a potentially ineligible provider across databases.<sup>25</sup> Relying solely on basic information for matching, such as providers' names and addresses, can

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<sup>24</sup>Cost of the Death Master File was also identified as an impediment to access by participants in a forum sponsored by GAO. See GAO, *Data Analytics for Oversight & Law Enforcement*, [GAO-13-680SP](#) (Washington, D.C.: July 15, 2013).

<sup>25</sup>Participants in a 2013 forum sponsored by GAO also identified the lack of a common identifier across databases as a challenge to accurately identifying individuals and entities. See [GAO-13-680SP](#).

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cause additional problems; for example, false positive matches for common names such as John Smith. In these instances, plans may have to take additional steps to confirm the match, such as contacting the provider or federal agency managing the database to obtain additional information that is not included in the database. Several plans told us that they would prefer to use the NPI to search the databases, because most providers are required to have an NPI. However, because NPI is a health-care specific unique identifier, it may not be used in databases external to HHS. Other unique identifiers that state officials and plan representatives suggested could be used across databases include Social Security numbers and taxpayer identification numbers, although the officials noted the sensitivity involved with using these numbers.

These challenges affect states' ability to ensure that only eligible providers in good standing participate in the Medicaid program. Federal internal control standards state that agencies should use quality data that are complete, current, accurate, and accessible, and have a logical connection to the program, such as the data regarding deceased individuals in the DMF, to achieve agency goals to reduce fraud.<sup>26</sup> Without consistent access to the DMF, states and plans risk paying deceased providers—a potential concern that we have identified in prior work.<sup>27</sup> The use of a consistent identifier would also help states and plans ensure that they are accurately identifying ineligible providers. However, CMS officials said they have not coordinated with other agencies to address these challenges. For example:

- Sharing CMS's DMF data: SSA officials told us that they recently received a request from CMS asking for permission to share DMF information with states and said that they are willing to work with CMS to develop a process to do so. CMS officials told us that they have had preliminary conversations with SSA and are interested in collaborating with SSA to develop a process to share the DMF with states. In addition to helping to ensure that states have access to DMF data and protecting the federal government from fraudulent payments to deceased providers, this arrangement could decrease federal and Medicaid expenditures. For example, SSA officials told us that in fiscal year 2014 CMS paid nearly \$25,200 for the DMF data, including weekly updates, and states reported annual DMF

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<sup>26</sup>See [GAO-14-704G](#), 13.01–13.06.

<sup>27</sup>See [GAO-15-313](#).

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subscription and implementation costs ranging from about \$2,700 to \$67,000. Since one state and most of the plans reported using the DMF, CMS sharing its DMF subscription would likely produce state and federal savings for Medicaid.

- Collaborating with other agencies to use a unique identifier: CMS officials said that they have not considered collaborating with other agencies to explore using a unique identifier—such as the NPI—that would serve to improve the ability of states and plans to confirm the accuracy of matches across databases. Such collaboration could help to mitigate challenges experienced by states and MMC plans in confirming database matches efficiently and effectively, which potentially place federal dollars at risk for waste, fraud, and abuse.

Recent legislation has the potential to address some—but not all—of the challenges related to states’ and health plans’ use of federal databases. The Department of Treasury’s Do Not Pay database is designed to reduce improper payments in federal programs and incorporates information from several of the federal databases states and plans use to screen providers. The Do Not Pay database is a source of centralized data that agencies must use to verify eligibility for federal payments and awards. The Do Not Pay database provides access to—among other data sources—EPLS, and the public version of the DMF. Officials from one state that delegates provider screenings to MMC plans said that having access to the Do Not Pay database would streamline their screening process. While the Do Not Pay database is currently only available to federal agencies, a recently enacted law will allow states and state contractors, including MMC plans, to access the database.<sup>28</sup> Other states and plans also indicated that a centralized database would be ideal, although they did not refer directly to the Do Not Pay database. CMS officials told us they are considering suggesting to states and plans that they use the Do Not Pay database for Medicaid managed care provider screening.

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<sup>28</sup>Federal Improper Payments Coordination Act of 2015, Pub. L. No. 114-109, § 2, 129 Stat. 2225 (2015).

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## Selected States and Medicaid Managed Care Plans Use Inconsistent Practices to Make Data on Ineligible Providers Publicly Available

States must ensure that none of their providers has been determined to be ineligible anywhere in the United States. CMS issued guidance in 2012 encouraging states to share data on ineligible providers through its Medicaid provider termination notification system; however, doing so is optional, not all states are using the list, and the list is not available to MMC plans.<sup>29</sup> In addition, CMS officials said they have not provided states with guidance on other ways to share their data on ineligible providers or how to access other states' data on ineligible providers.<sup>30</sup>

Our 10 selected states varied in how they shared data on ineligible providers, the location and usability of the data they shared, and the type of information they shared. All of our 10 selected states made data on their ineligible providers publicly available.<sup>31</sup> Specifically, they made their data available online, although they varied in where they posted these data on their websites and in the consistency of the information posted. For example, our review of the states' websites found that 5 states made the data available through their state's Office of Inspector General's website, while the 5 other states had these data on their Medicaid websites. Within these two groups, the data were sometimes displayed

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<sup>29</sup>CMS established the Medicaid provider termination notification system, commonly referred to as TIBCO, an online portal, in response to a PPACA requirement to establish a process to make available to state agencies information about providers terminated for cause from the Medicare, Medicaid, and CHIP programs, which could help to prevent a provider who has been terminated for cause in one state from enrolling in another state. According to CMS officials, states can upload information on providers they have terminated and download data on providers other states have terminated; however, neither action is required. According to the officials, the Medicaid provider termination notification system is the most centralized source of data available on state ineligible providers. The HHS-OIG raised this issue in a 2014 report and recommended that CMS require each state to submit terminated provider reports. See Department of Health and Human Services, Office of Inspector General, *CMS's Process for Sharing Information About Terminated Providers Needs Improvement*, March 2014 (OEI-06-12-00031).

<sup>30</sup>Congress is considering legislation that would require that states report to the Secretary of Health and Human Services identifying information about a provider terminated for cause or other reasons specified by the Secretary from participating in the state's Medicaid program. The bill also proposed that the Secretary of HHS include providers terminated from participation in Medicare, Medicaid, or CHIP in a termination database or similar system, within 21 days of notification of the termination. See H.R. 3716, 114<sup>th</sup> Cong. (2<sup>nd</sup> Sess. 2016).

<sup>31</sup>According to a vendor that performs MMC plan screenings, only 37 states and the District of Columbia made their data on ineligible providers publicly available, as of November 2015. CMS officials said they do not track this information. However, various third party vendors specialize in the collection of ineligible provider information. States and MMC plans can contract with these vendors to monitor provider eligibility status continuously.

on a homepage and other times required users to click through a number of webpages to locate the data. All the states provided at least some export function as part of accessing their data on ineligible providers, which can facilitate the ease with which other states can access and use the information on the website. However, 2 states limited their data exports to PDF files, which have less search functionality than other formats like Microsoft Excel, which was used by the other 8 states. Eight of the selected states had a database search feature as part of their website and an export function, which allowed users to search for individual providers. Two websites allowed for verification of a Social Security number online. (See fig. 1.)

**Figure 1: Usability Features on Publicly Available State Data on Ineligible Medicaid Providers from 10 Selected States**

	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9	State 10
<b>Features</b>										
Exportable Data	●	●	●	●	●	●	●	●	●	●
Database Search Feature	●	●	●	●	●	●	●	○	●	○
Social Security Number Verification Online	○	○	○	○	○	○	●	○	●	○

- Yes
- No

Source: GAO. | GAO-16-402

The 10 selected states also varied in the types of data they made available about their ineligible providers. All 10 states included providers' first names, last names, and middle names or initials. Seven states included providers' NPI in their information on ineligible providers. Seven states included a category for a medical license number in their information on ineligible providers, but these data were not consistently presented across states. Four states included provider addresses, and seven states included provider type or specialty. One state included alias that the ineligible providers might be using, and one state provided information on ineligible providers' affiliations with other provider groups or practices. (See fig. 2.)

**Figure 2: Provider Identifiers for Publicly Available State Data on Ineligible Medicaid Providers from 10 Selected States**

	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9	State 10
Last Name, First Name, and Middle Initial	●	●	●	●	●	●	●	●	●	●
Also Known As (AKA)/ Doing Business As (DBA) Names	●	○	○	○	○	○	○	○	○	○
Affiliations (Provider Groups)	○	○	●	○	○	○	○	○	○	○
Address(es)	●	○	●	●	○	●	○	○	○	○
Provider Type/ Specialty	●	●	●	●	●	○	●	○	●	○
National Provider Identifier (NPI)	●	●	○	○	●	●	●	●	●	○
License Number <sup>a</sup>	●	●	●	○	●	○	●	○	●	●

● Yes  
○ No

Source: GAO. | GAO-16-402

<sup>a</sup>The License Number field varied across states, with some states using a provider’s state license number, while others used NPI.

The 10 states also varied in the information they provided about why providers became ineligible and in the terminology they used. All 10 states included the effective date providers became ineligible. Five states provided information on the action type that led to the provider becoming ineligible, which included, among other things, the terms “exclusion,” “terminated,” and “voluntary withdrawal.” While the HHS-OIG defines excluded providers as those providers it has determined to be ineligible for participation in federal health programs, states used varying terminology.<sup>32</sup> Six states also included the reason for the exclusion. (See fig. 3.)

<sup>32</sup>The HHS-OIG also raised this issue in a 2015 report that found that inconsistent terminology on exclusions among the states and HHS-OIG made it difficult for states to distinguish between providers who were eligible to participate in Medicaid and those that were excluded. See Department of Health and Human Services, Office of Inspector General, Providers Terminated from One State Medicaid program Continued to Participating in Other States, August 2015 (OEI-06-12-00030).

**Figure 3: Background Information on Publicly Available State Data on Ineligible Medicaid Providers from 10 Selected States**

	State 1	State 2	State 3	State 4	State 5	State 6	State 7	State 8	State 9	State 10
<b>Exclusion Background</b>										
Date of Exclusion	●	●	●	●	●	●	●	●	●	●
Action Type	○	●	●	○	○	●	●	○	○	●
Reason for Exclusion	○	●	○	○	●	●	●	●	●	○

- Yes
- No

Source: GAO. | GAO-16-402

Note: State data on ineligible Medicaid providers used a variety of action types, including but not limited to: "exclusion," "terminated," "voluntary withdrawal," "debarment," and "disqualification." For the purposes of this category, we are including all actions that appear on states' exclusion data.

Unlike states, MMC plans are not required to make their data on ineligible providers publicly available.<sup>33</sup> The 16 selected MMC plans reported sharing these data with their state Medicaid agencies at varying intervals and in rare cases, with other plans. Representatives from the 16 selected plans said they might share their data on ineligible providers with their states during periodic meetings that covered a variety of issues. However, the frequency and scope of these meetings varied. According to plan representatives, 1 plan met with the state at least monthly, 3 plans met with the state quarterly, 7 plans met with the state annually, and 3 plans met with the state biennially; officials from 1 plan said they met with the state frequently but did not provide a specific frequency for the meetings; and 1 plan did not provide this information. Representatives from the MMC plans said they generally did not share these data with other plans, with a few exceptions. For example, representatives from 1 plan said that they share information on ineligible providers with another plan they contract with in their state. Similarly, representatives from 3 MMC plans that were subsidiaries of large health care corporations with MMC plans in multiple states told us that they shared data on ineligible providers with the other plans in their networks. However, there is no process or requirement from CMS for them to share on a consistent basis.

<sup>33</sup>42 C.F.R. § 1002.212 (2015) requires that when a state agency initiates an exclusion, it must notify other state agencies, the state medical licensing board (where applicable), the public, and beneficiaries.



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Because states and MMC plans are prohibited from paying federal funds to providers that have been determined to be ineligible anywhere in the United States, sharing data on ineligible providers is an important control activity for preventing providers who are ineligible to participate in Medicaid in one state from enrolling in or billing Medicaid programs in other states. Federal internal control standards emphasize the importance of performing control activities routinely and consistently.<sup>34</sup> The inconsistency with which this information on ineligible providers is shared across states and MMC plans creates the potential that providers could be determined to be ineligible in some states, while still receiving payments from Medicaid in other states.

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## Conclusions

States and MMC plans rely on fragmented information from multiple and disparate databases to screen managed care providers to ensure that they are not paying providers determined to be ineligible to do business with the federal government. Currently, CMS guidance to states and MMC plans only touches upon a small subset of the 22 disparate databases that states and MMC plans check when screening providers, and does not provide information on what other databases would be helpful for screening providers. Because MMC plans we reviewed are using a variety of databases beyond those specified by CMS, it suggests that CMS might not have identified all reliable sources of information about ineligible providers that would be helpful to meet program objectives and assess risks. Without an assessment of these additional databases and their potential contribution to improving the effectiveness of screening providers, CMS cannot be certain that its guidance to states and MMC plans is comprehensive for screening providers.

States and plans have also been hampered in their efforts to access and use databases maintained by various federal agencies, because of differences in the characteristics of the databases, including difficulty accessing databases and conducting provider matches. CMS has not coordinated with other agencies to explore what options may exist to address these challenges.

CMS guidance on how states should share data on ineligible providers is also limited, resulting in significant inconsistency in how such information is shared across states. All 10 selected states made their data on

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<sup>34</sup>See [GAO-14-04G](#).

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ineligible providers publicly available, although they varied in where they posted the data on their websites and the consistency of the information posted. While all 10 states included providers' names, other data—such as NPI or other identifiers—were not consistently available. Anyone checking these data would be required to do additional work to confirm a provider match and state websites would require that the states conducting the screenings know how to locate the ineligible provider list. The inconsistency with which this information is shared across states and MMC plans creates the potential that providers could be determined to be ineligible in some states, while still receiving payments from Medicaid in other states.

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## Recommendations for Executive Action

To improve the effectiveness of states' and plans' MMC plan provider screening efforts, we recommend that the Acting Administrator of CMS take the following three actions:

1. Consider which additional databases that states and MMC plans use to screen providers could be helpful in improving the effectiveness of these efforts and determine whether any of these databases should be added to the list of databases identified by CMS for screening purposes.
2. Collaborate with SSA to facilitate sharing CMS's DMF subscription with state Medicaid programs.
3. Coordinate with other federal agencies, as necessary, to explore the use of an identifier that is relevant for the screening of MMC plan providers and common across databases used to screen MMC plan providers.
4. Provide state Medicaid programs with guidance that establishes expectations and best practices on sharing provider screening data among states and MMC plans.

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## Agency and Third-Party Comments and Our Evaluation

We provided a draft copy of this report to HHS. HHS provided written comments, which are reprinted in appendix II. In its written comments, HHS described the actions it will take to address our first three recommendations. In response to our fourth recommendation to provide state Medicaid programs with guidance that establishes expectations and best practices on sharing provider screening data among states and Medicaid managed care plans, HHS commented that it developed the Medicaid provider termination notification database to assist states with the requirement to deny or terminate the enrollment of any provider that has been terminated for cause under Medicare or another state's

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Medicaid program or CHIP. It added that its Medicaid managed care proposed rule, issued in June 2015, if finalized, will require that state Medicaid programs enroll providers participating in Medicaid managed care. HHS stated that this will help ensure that all Medicaid managed care providers are screened against the Medicaid provider termination notification database. However, states' use of the Medicaid provider termination notification database is not required, not all states are using it, plans do not have access to the database, and the proposed rule does not address use of the database. Therefore, HHS's reported actions will not address these specific issues. HHS also provided technical comments, which we incorporated as appropriate.

We also provided relevant draft portions of this report to SSA, state Medicaid program offices for California, Florida, Illinois, Minnesota, Missouri, New Jersey, New York, Tennessee, Texas, and Washington, and representatives of the MMC plans. SSA provided technical comments which we incorporated as appropriate. States and plans were also in agreement with the draft portions they received, and provided some technical comments, which we incorporated as appropriate.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to our requestor, the Secretary of Health and Human Services, the Acting Commissioner of Social Security, officials from the states and plans included in our study, and other interested parties. In addition, the report will be available at no charge on GAO's website at <http://www.gao.gov>

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at [YocomC@gao.gov](mailto:YocomC@gao.gov). Contact points for our Office of Congressional Relations and Office of Public Affairs can be found on the last page of this report. Other major contributors to this report are listed in appendix III.

Sincerely yours,



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Descriptions of Federal Databases Selected States and Medicaid Managed Care Plans Use to Screen Providers

Database	Description
<b>Administrative Actions Against Registrants</b>	The Drug Enforcement Administration (DEA) administers a provision of the Controlled Substances Act of 1970 that, among other things, requires all health care providers entitled to dispense, administer, or prescribe controlled pharmaceuticals; and all pharmacies entitled to fill prescriptions to register with the DEA. The Controlled Substances Act authorizes the DEA to take enforcement actions, such as administrative actions, against the registrant, for various reasons, such as materially falsifying the registration application filed; having been convicted of a felony relating to a controlled substance; having had its state license or registration suspended, revoked, or denied; or having been excluded from participation in a Medicaid or Medicare program. DEA's Administrative Actions Against Registrants shows, by year, DEA's administrative actions.
<b>DEA Number</b>	DEA Number is DEA's complete official database of persons and organizations certified to handle controlled substances under the Controlled Substances Act. DEA authorizes the use of this database, and the inclusion of any individual or organization in the database, as proof of that entity's registration with the DEA.
<b>Designated Foreign Terrorist Organizations</b>	The Department of State compiles a list of foreign organizations that are designated by the Secretary of State as Foreign Terrorist Organizations, in accordance with section 219 of the Immigration and Nationality Act, as amended.
<b>Death Master File (DMF)</b>	The Social Security Administration (SSA) compiles death information about Social Security number-holders in order to ensure it does not pay Social Security benefits to deceased individuals and to establish benefits for survivors. This information is in the agency's DMF. SSA obtains death reports from a variety of sources, including family members, funeral directors, post offices, financial institutions, other federal agencies, and states. To get death reports from the states, SSA has established formal agreements that set forth a payment structure for the states' death reports and limit SSA's ability to share this information. However, the Social Security Act requires SSA to share death information, to the extent feasible, including data reports by the states, with federal agencies to ensure proper payment of benefits to individuals. The act also prohibits SSA from sharing state-reported death information for any other purposes. As a result, SSA maintains two versions of the DMF. The full DMF, which contains all death records, is available to federal benefit payment agencies. The partial DMF, which excludes state-reported death information, is available publicly.
<b>Denied Persons List</b>	The list identifies individuals and entities that have been denied export privileges, by written order to the Department of Commerce.
<b>Entity List</b>	The Export Administration Regulations (EAR) contain licensing requirements for the export, re-export and/or transfer (in-country) of specified items. The Entity List contains names of certain foreign persons—including businesses, research institutions, government and private organizations, individuals, and other types of legal persons—that are subject to the EAR. On an individual basis, the persons on the Entity List are subject to licensing requirements and policies supplemental to those found in the EAR. The list is found on the Department of Commerce's Bureau of Industry and Security website.

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<b>Excluded Parties List System (EPLS)/ System of Award Management (SAM)</b>	The General Services Administration (GSA) maintains the EPLS, an online system that includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving federal funds; in 2012, GSA migrated the EPLS into SAM. All federal agencies are required to send information to the EPLS on parties they have debarred or suspended. The EPLS provides only the name and address of excluded entities, but no other unique identifiers. The HHS-OIG also sends GSA monthly updates of the LEIE for inclusion in the EPLS, but the LEIE information included in EPLS does not provide all of the information from LEIE. For example, EPLS does not provide more details on LEIE excluded providers, such as the statutory basis for the exclusion action, date of birth, and address.
<b>Federal Employees Health Benefits Program (FEHBP) Administrative Sanctions</b>	The FEHBP provides coverage to federal employees, retirees, and their dependents through health insurance carriers that contract with the federal government. The Office of Personnel Management (OPM) negotiates these contracts and requires that each of these carriers establish a program to prevent, detect, and eliminate fraud and abuse. OPM's Office of Inspector General suspends and debar health care providers from the FEHBP who have, among other things, lost professional licenses, been convicted of a crime related to the delivery of or payment for health care services, violated provisions of a federal program, or been debarred by another federal agency. The names of such providers are available through the secure OPM Debar Webpage. The list of sanctioned providers is also available to the public through SAM—GSA's government-wide list of exclusions.
<b>List of Excluded Individuals and Entities (LEIE)</b>	The Department of Health and Human Services Office of Inspector General (HHS-OIG) maintains and updates monthly the LEIE, a database of providers it has excluded. The LEIE includes information on excluded providers, such as providers' names, addresses, dates of birth, occupation at the time of exclusion, provider type, and the statutory basis for the exclusion. The LEIE is publicly available to search or download on the HHS-OIG website, and available in two formats: online and downloadable. The online search engine identifies currently excluded individuals and entities. When a match is identified, it is possible to verify the accuracy of the match using a Social Security number or employer identification number. The downloadable version of the database may be compared against state enrollment files. However, unlike the online version, the downloadable version does not include Social Security number or employer identification number.
<b>Look Up a Zip Code</b>	A United States Postal Service website that allows zip code searches by address, city, and state.
<b>Medicare Exclusion Database (MED)</b>	CMS developed the MED in 2002 to collect and retrieve information that aided in ensuring that no payments are made to excluded individuals and entities for services furnished during the exclusion period. According to CMS, MED files contain a variety of identifiable and general information including names, Social Security numbers, National Provider Identifiers, addresses, exclusion types, and reinstatement dates, if applicable. CMS uses the HHS-OIG's LEIE to populate the MED; the HHS-OIG sends monthly updates of the LEIE to CMS.
<b>Medicare Opt-out List</b>	The Medicare Opt-out List is a list of physicians and practitioners who do not wish to enroll in the Medicare program and have "opted-out" of Medicare. This means that neither the provider, nor the beneficiary submits the bill to Medicare for services rendered. Instead, the beneficiary pays the provider out-of-pocket and neither party is reimbursed by Medicare.
<b>National Plan and Provider Enumeration System (NPPES)</b>	The National Provider Identifier (NPI) is a national, unique 10-digit identification number assigned to health care providers that CMS adopted to be used in specified administrative and financial transactions for its health care providers and suppliers in accordance with the Health Insurance Portability and Accountability Act. CMS uses NPPES to assign NPIs to providers.

**Appendix I: Descriptions of Federal Databases  
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<b>National Practitioner Data Bank (NPDB)</b>	NPDB, maintained by the Health Resources and Services Administration, an agency within HHS, is an information clearinghouse containing information related to the professional competence and conduct of healthcare providers. The NPDB is intended to facilitate a comprehensive review of professional credentials of health care providers and collects information on adverse licensing and certification actions, criminal convictions (health care related), civil judgments, exclusions from federal or state health care programs, and other adjudicated actions or decisions, medical malpractice payments, and any negative actions or findings taken by peer review organizations. It includes LEIE exclusions and related reinstatement actions taken by the HHS-OIG. However, because the criteria for inclusion in the NPDB are different than the criteria for inclusion in the LEIE, not all LEIE exclusions are listed in the NPDB.
<b>OIG Most Wanted Fugitives</b>	This HHS-OIG webpage includes the names of its most wanted fugitives on charges related to health care fraud and abuse.
<b>Politically Exposed Persons</b>	This is the Federal Financial Institutions Examination Council’s list of current, senior foreign political figures, their immediate family, and their close associates, who potentially pose a risk that their funds may be the proceeds of foreign corruption.
<b>Provider Enrollment, Chain and Ownership System (PECOS)</b>	PECOS is an Internet-based system to which Medicare providers submit and update their enrollment data. In response to the Patient Protection and Affordable Care Act’s requirement for CMS to establish a process for sharing information about terminated Medicare providers with state agencies, CMS provided states direct access to PECOS, where they can view specific enrollment data for each provider including identifying information such as National Provider Identifiers, tax identification numbers (TINs), and legal business names. PECOS also includes information on revoked licenses and terminated Medicare providers. While the data stored in the system are specific to Medicare providers, they are useful to state Medicaid programs. For example, states may use the data when screening providers during enrollment processes to determine whether a provider has ever been excluded from participation in Medicare and, thus, whether they should be allowed to participate in Medicaid. They also use PECOS data during provider screening to determine whether a Medicare screening has already taken place, thus eliminating the need to screen further for Medicaid participation.
<b>Public Access to Court Electronic Records (PACER)</b>	PACER is an electronic public access service that allows users to obtain case and docket information online from federal appellate, district, and bankruptcy courts, and the PACER Case Locator. PACER is provided by the federal judiciary in keeping with its commitment to providing public access to court information via a centralized service.
<b>Specially Designated Nationals List</b>	As part of its enforcement efforts, the Office of Foreign Assets Control, within the Department of Treasury, publishes a list of individuals and companies owned or controlled by, or acting for or on behalf of, targeted countries. It also lists individuals, groups, and entities—such as terrorists and narcotics traffickers—designated under programs that are not country-specific. Collectively, such individuals are blocked and U.S. persons are generally prohibited from dealing with them.
<b>Taxpayer Identification Number Matching</b>	The Internal Revenue Service’s TIN Matching is part of a suite of Internet based pre-filing e-services that allows “authorized payers” the opportunity to match 1099 payee information against Internal Revenue Service records prior to filing information returns. An authorized payer is one who has filed forms 1099-B, 1099-DIV, 1099-INT, 1099-K, 1099-MISC, 1099-OID, or 1099-PATR with the Internal Revenue Service in at least one of the two past tax years. Interactive TIN Matching will accept up to 25 payee TIN/name combinations on-screen, while Bulk TIN Matching will allow up to 100,000 payee TIN/name combinations to be matched via a text file submission. Both programs will match the payee name and TIN with Internal Revenue Service records; decrease backup withholding and penalty notices; and reduce the error rate in TIN validation.

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**Appendix I: Descriptions of Federal Databases  
Selected States and Medicaid Managed Care  
Plans Use to Screen Providers**

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**Unverified List**

Parties listed on the Department of Commerce's Unverified List are ineligible to receive items subject to the Export Administration Regulations by means of a license exception. In addition, exporters must file an Automated Export System record for all exports to parties listed on the Unverified List and obtain a statement from such parties prior to exporting, re-exporting, or transferring to such parties any item subject to the Export Administration Regulations that is not subject to a license requirement.

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**Wanted Fugitives**

This is the Federal Bureau of Investigation's list of wanted fugitives.

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Source: GAO review of documentation on various federal databases identified by selected states and Medicaid managed care plans. | GAO-16-402

# Appendix II: Agency Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

APR 08 2016

Carolyn Yocom  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Ms. Yocom:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers*" (GAO-16-402).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PROGRAM INTEGRITY: IMPROVED GUIDANCE NEEDED TO BETTER SUPPORT EFFORTS TO SCREEN MANAGED CARE PROVIDERS (GAO-16-402)**

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in Medicaid.

As part of continuing to strengthen the Medicaid provider enrollment process, in February 2011, HHS issued regulations to implement categorical risk-based screening of newly enrolling and re-enrolling Medicaid providers and to revalidate all current Medicaid providers under the categorical risk-based screening requirements, as authorized by the Affordable Care Act. Categories of risk include factors such as the type of service provided and history of previous adverse actions. Providers in the limited risk category undergo verification of licensure, verification of compliance with federal regulations and state requirements, and are checked against various databases. Providers in the moderate and high risk categories undergo additional screening, including unannounced site visits. Additionally, as a condition of enrollment, states must require providers in the high risk providers category or persons with five percent or greater ownership interest in such providers to consent to criminal background checks including fingerprinting.

These regulations also require State Medicaid agencies to deny or terminate the enrollment of any provider that has been terminated for cause under Medicare or another state's Medicaid or Children's Health Insurance Program (CHIP) on or after January 1, 2011. In order to assist states with this requirement, HHS developed the Medicaid termination notification database. Under this new process, states may submit information to HHS regarding Medicaid provider terminations. HHS reviews submitted termination letters to verify that the termination was for cause and then enters those that are for cause into the termination notification database. State Medicaid programs can access this repository of state-submitted Medicaid provider terminations and Medicare provider revocations. This allows states to access current provider termination information and assists them in terminating potentially fraudulent Medicaid providers more quickly.

HHS has also taken steps to make sure Medicaid managed care providers are directly enrolled in Medicaid. Since 2011, HHS has periodically published guidance to states that identifies as a best practice requiring all managed care network providers to be enrolled in Medicaid in the same manner as fee-for-service providers. In June 2015, HHS published a Notice of Proposed Rulemaking that, if finalized, will require that state Medicaid programs enroll providers participating in Medicaid managed care. The proposed rule would require that state Medicaid agencies apply the same risk-based screening standards and procedures that they currently apply to providers in fee-for-service Medicaid to providers in the networks of Medicaid managed care plans.

GAO's recommendations and HHS' responses are below.

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PROGRAM INTEGRITY: IMPROVED GUIDANCE NEEDED TO BETTER SUPPORT EFFORTS TO SCREEN MANAGED CARE PROVIDERS (GAO-16-402)**

**GAO Recommendation**

Assess the additional databases states and Medicaid managed care (MMC) plans use to screen providers and their potential contribution to improving the effectiveness of these efforts to determine whether any of these databases should be added to the list of databases identified by HHS for screening purposes.

**HHS Response**

HHS concurs with GAO's recommendation. HHS will examine the list of additional databases states and MMC plans use to screen providers provided by GAO and determine whether any of the databases merit further action.

**GAO Recommendation**

Collaborate with the Social Security Administration (SSA) to facilitate sharing CMS's Death Master File subscription with state Medicaid programs and coordinate with other federal agencies, as necessary, to explore the use of an identifier common across databases that is relevant for the screening of MMC plan providers.

**HHS Response**

HHS concurs with GAO's recommendation. HHS will work with SSA to improve States' access to the Death Master File. HHS will also explore the use of a common identifier for databases that States are required to check as part of their Medicaid provider enrollment screening process.

**GAO Recommendation**

Provide state Medicaid programs with guidance that establishes expectations and best practices on sharing provider screening data among states and Medicaid managed care plans.

**HHS Response**

HHS concurs with GAO's recommendation. In order to assist states with the requirement to deny or terminate the enrollment of any provider that has been terminated for cause under Medicare or another state's Medicaid program or CHIP, HHS developed the Medicaid termination notification database. In June 2015, HHS published a Notice of Proposed Rulemaking that, if finalized, will require that state Medicaid programs enroll providers participating in Medicaid managed care. If finalized, this rule will help make sure that all Medicaid managed care providers are screened against the Medicaid termination notification database.

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

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Carolyn L. Yocom, (202) 512-7114 [yocomc@gao.gov](mailto:yocomc@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Thomas Conahan, Assistant Director; Pauline Adams; Drew Long; Reed Meyer; Dawn Nelson; and Jennifer Whitworth made key contributions to this report.

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# Appendix IV: Accessible Data

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## Agency Comment Letter

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Text of Appendix II:  
Agency Comments from  
the Department of Health  
and Human Services

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Page 1

DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation

Washington , DC 20201

APR 08 2016

Carolyn Yocom

Director, Health Care

U.S. Government Accountability Office

441 G Street NW

Washington, DC 20548

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The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea

Assistant Secretary for Legislation

Attachment

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Page 2

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND  
HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNT

ABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PROGRAM INTEGRITY: IMPROVED GUIDANCE NEEDED TO BETTER SUPPORT EFFORTS TO SCREEN MANAGED CARE PROVIDERS (GA0-16-402)

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GAO's recommendations and HHS' responses are below.

Page 3

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GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICAID PROGRAM INTEGRITY: IMPROVED GUIDANCE NEEDED TO BETTER SUPPORT EFFORTS TO SCREEN MANAGED CARE PROVIDERS (GA0-16-402)

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