



October 2019

MEDICAID PROVIDERS

CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements

Why GAO Did This Study

A crucial component of protecting the integrity of the Medicaid program is ensuring that only eligible providers participate in Medicaid. States' non-compliance with provider screening and enrollment requirements contributed to over a third of the \$36.3 billion estimated improper payments in Medicaid in 2018. To improve the integrity of the Medicaid program, PPACA and the 21st Century Cures Act established new requirements for screening and enrolling providers and expanded enrollment to include additional provider types.

In this report, GAO (1) describes challenges states faced implementing provider screening and enrollment requirements; and (2) examines CMS support for and oversight of states' implementation of these requirements. GAO reviewed federal laws and CMS guidance. GAO also reviewed CMS documents, including reports resulting from CMS oversight activities published from 2014 through 2018 for seven states. These states were selected based on their use of CMS's contractor site visits, among other things. GAO also interviewed officials from CMS and the seven selected states.

What GAO Recommends

GAO recommends that CMS (1) expand its review of states' implementation of provider screening and enrollment requirements to include states that have not participated in optional consultations; and (2) for states not fully compliant with the requirements, annually monitor the progress of those states' implementation. The Department of Health and Human Services, the department that houses CMS, concurred with both recommendations.

View [GAO-20-8](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

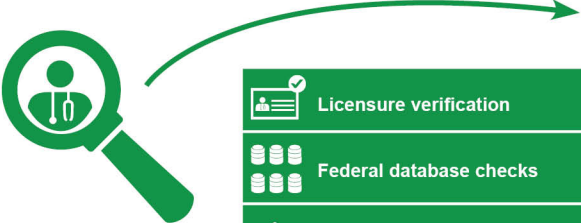
MEDICAID PROVIDERS





CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements

What GAO Found

Officials from seven selected states that GAO interviewed described challenges they faced implementing new Medicaid provider screening and enrollment requirements, established by the Patient Protection and Affordable Care Act (PPACA) in 2010 and the 21st Century Cures Act in 2016. These challenges included establishing procedures for risk-based screenings, using federal databases and collecting required information, and screening an increased volume of providers. Due in part to these challenges, officials from five of the seven selected states told GAO they had not implemented certain requirements. For example, one state plans to launch its new information technology system, which automates screenings, before it will enroll providers under contract with managed care organizations, as required under these laws.

Summary of Provider Screening Activities for Medicaid Enrollment



	Risk level for fraud, waste, and abuse		
	Limited	Moderate	High
 Licensure verification	✓	✓	✓
 Federal database checks	✓	✓	✓
 Provider site visit		✓	✓
 Fingerprint background check			✓

Required provider screening activities based on risk level

Source: GAO analysis of Centers for Medicare & Medicaid Services guidance. | GAO-20-8

The Centers for Medicare & Medicaid Services (CMS)—the federal agency that oversees Medicaid—supports states' implementation of new requirements with tailored optional consultations, such as CMS contractor site visits that examine the extent of states' implementation. Yet, because these are optional, states that need support might not participate, and CMS would not have information on those states. CMS uses other methods to oversee states' compliance, such as, the Payment Error Rate Measurement (PERM) process for estimating improper payments, and focused program integrity reviews.

- PERM. This process assesses states' compliance with provider screening and enrollment requirements, but does not assess compliance for all providers and all requirements, and occurs once every 3 years.
- Focused program integrity reviews. These reviews examine specific areas in Medicaid, like state compliance with provider screening and enrollment requirements, but have not been done in all states. CMS conducted reviews in 39 states in fiscal years 2014 through 2018.

Collectively, CMS's oversight methods do not provide it with comprehensive and timely reviews of states' implementation of the provider screening and enrollment requirements or the remediation of deficiencies. As a result, CMS lacks assurance that only eligible providers are participating in the Medicaid program.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
CHIP	Children's Health Insurance Program
DEX	Data EXchange
DMF	Death Master File
FFS	fee-for-service
LEIE	List of Excluded Individuals/Entities
MCO	managed care organization
NPPES	National Plan and Provider Enumeration System
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PPACA	Patient Protection and Affordable Care Act
SAM	System for Award Management

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October 10, 2019

The Honorable Charles E. Grassley
Chairman
Committee on Finance
United States Senate

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Michael C. Burgess, M.D.
Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

A crucial component of protecting the integrity of the Medicaid program is ensuring that only eligible providers participate in Medicaid—a federal-state health care program for low-income and medically needy individuals.¹ However, errors related to states’ non-compliance with provider screening and enrollment requirements comprised over one-third of Medicaid improper payments in 2018.² That year, estimated improper payments in Medicaid were \$36.2 billion, or nearly 10 percent of federal

¹Ineligible providers include, but are not limited to, providers that have been terminated under the Medicaid or Children’s Health Insurance Program (CHIP) of any other state on or after January 1, 2011; or that have been convicted of a criminal offense related to Medicare, Medicaid, or the CHIP in the last 10 years or fail to submit timely or accurate information, unless the state Medicaid agency determines that denial or termination of enrollment is not in the best interests of the program.

²Errors due to states’ non-compliance with provider screening, enrollment, and National Provider Identifier requirements accounted for over 40 percent of total Medicaid improper payments in fiscal year 2018. See Department of Health and Human Services, *FY2018 Agency Financial Report* (Washington, D.C.: November 2018). 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 ineligible recipients, any payment for an ineligible service, any duplicate payment, payments for services not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

Medicaid expenditures. At the federal level, the Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services, is responsible for overseeing states' administration of Medicaid, including their efforts to screen and enroll providers.³ Our work has identified Medicaid as a high-risk program since 2003 due to concerns about improper payments, the appropriate use of Medicaid dollars, and the need for more accurate and complete data to effectively manage and oversee this multibillion dollar program.⁴

To strengthen program integrity, federal laws have changed how and whom states must screen and enroll into their Medicaid programs. In 2010, the Patient Protection and Affordable Care Act (PPACA) included provisions requiring CMS to establish procedures for screening and enrolling providers according to their risk for fraud, waste, and abuse, as well as activities that must or may be included in these procedures—such as verifying provider licensure, conducting checks in federal databases to identify providers who have been excluded from participating in federal programs, and conducting on-site visits to provider practices.⁵ PPACA also included provisions expanding provider enrollment; for example, by requiring states to enroll providers who only order and refer services for beneficiaries. The year following enactment of these changes, CMS issued regulations establishing the screening and enrollment requirements that states must perform to enroll providers.⁶ In 2016, the 21st Century Cures Act included provisions that further expanded provider enrollment requirements.⁷ Under these requirements, states must screen and enroll all Medicaid managed care providers into their

³States have flexibility within broad federal guidelines to design and implement their Medicaid program, resulting in 56 distinct state-based programs with one in each state, the District of Columbia, and five territories.

⁴See GAO, *High-Risk Series: Substantial Efforts Needed to Achieve Greater Progress on High Risk Areas*, [GAO-19-157SP](#) (Washington, D.C.: Mar. 6, 2019).

⁵Pub. L. No. 111-148, § 6401(b), 124 Stat. 119, 751 (2010) (codified, as amended, at 42 U.S.C. § 1396a(a)(77), (kk)).

⁶Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers; Final Rule; 76 Fed. Reg. 5862 (Feb. 2, 2011) (codified at 42 C.F.R. Part 455).

⁷This act also expanded provider termination requirements. Pub. L. No. 114-255, § 5005, 130 Stat. 1033, 1191 (2016).

programs by January 1, 2018.⁸ While states and CMS have taken steps to implement requirements in PPACA and the 21st Century Cures Act, questions have been raised regarding the timeliness of these steps.

You asked us to examine states' and CMS's efforts to implement provider screening and enrollment requirements. This report

1. describes challenges selected states face implementing provider screening and enrollment requirements, and their steps to address these challenges; and
2. examines CMS support for and oversight of states' implementation of provider screening and enrollment requirements.

To describe challenges selected states faced implementing provider screening and enrollment requirements, and steps taken to address these challenges, we reviewed applicable laws and CMS's guidance on provider screening and enrollment, including the Medicaid Provider Enrollment Compendium.⁹ We also interviewed officials from the District of Columbia, Kentucky, Maine, Minnesota, Nebraska, New Jersey, and Oregon.¹⁰ We selected these seven states to obtain a mix of experiences with CMS's optional consultations that help states implement provider screening and enrollment requirements; and other factors including their total managed care spending and their improper payment rates in fiscal year 2017, and geographic location.¹¹ CMS's optional consultations include the following:

⁸In May 2016, CMS updated its regulations for managed care programs which required states to enroll managed care providers into states' Medicaid programs for managed care contracts beginning on July 1, 2018. In managed care, states typically contract with managed care plans to provide a specific set of Medicaid-covered services to beneficiaries and pay them a set amount per beneficiary per month to provide those services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27, 498, 27,890 (May 6, 2016). The 21st Century Cures Act codified these requirements and moved up their effective date to January 2018. Pub. L. No. 114-255, § 5005(b)(2), 130 Stat. at 1193 (codified at 42 U.S.C. § 1396u-2(d)(6)).

⁹The Medicaid Provider Enrollment Compendium is CMS's formal, consolidated guidance on screening and enrolling Medicaid providers.

¹⁰In this report, "states" refers to the 50 states and the District of Columbia.

¹¹The 2017 managed care spending data was the most recently available and complete data at the time we selected states.

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- A multi-day CMS contractor site visit that assesses states' progress toward implementing the provider screening and enrollment requirements.
 - A data compare service, in which states submit a list of all their active providers, and CMS provides a full report of the state's providers who were previously screened by Medicare. The service also identifies providers states may need to take action on because they were revoked, terminated, reported as deceased, or had their National Provider Identifier deactivated.¹²

We interviewed officials from each of the selected states to learn about their screening and enrollment procedures as of February 2019, and included any vendors the state contracted with to screen and enroll Medicaid providers.¹³ We also reviewed documents from the selected states, including provider enrollment manuals, policies, provider applications, and contracts with Medicaid managed care organizations (MCO)—some of which also performed provider screening activities—and vendors that screen and enroll providers. Further, we collected available data from each of our selected states on the number of providers enrolled, number of providers screened, and costs associated with provider screening and enrollment activities for fiscal years 2015 through 2018. We interviewed state officials and reviewed the documentation they provided to assess the reliability of these data. We determined that these data were sufficiently reliable for the purposes of this reporting objective. Our findings on the challenges states face are specific to our selected states and cannot be generalized.

¹²Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. We selected states based on their participation in CMS's contractor site visits as of August 2018 and their participation in CMS's data compare as of October 2018. We also selected states based on their participation in a CMS site visit as of August 2018. This type of site visit lasts a few hours during which state and CMS officials discuss provider screening and enrollment challenges, and approaches to address these challenges. We selected states that participated in one or more of CMS's optional consultations, as well as states that did not participate in any optional consultations.

¹³States may choose to delegate screening activities to a third party to screen and enroll providers on their behalf, and states contract with vendors to perform these activities. Such vendors perform screening and enrollment activities as stipulated in their contract, which may include verifying licensure, conducting checks in federal databases, and performing site visits.

To examine CMS support for and oversight of states' implementation of provider screening and enrollment requirements, we reviewed relevant laws and CMS's guidance on provider screening and enrollment. To examine CMS's support for states, we reviewed CMS documents, including reports resulting from CMS contractor site visits conducted in calendar years 2016 through 2018; CMS's data compare templates for provider data; and documents related to other optional consultations, such as monthly Provider Enrollment Technical Assistance Group calls, during which CMS and state officials discuss issues and share best practices. To examine CMS oversight of states' compliance with provider screening and enrollment requirements, we reviewed the most recently available CMS documents on the Payment Error Rate Measurement (PERM)—CMS's methodology for estimating improper payments in the Medicaid programs. We also examined information CMS obtains through program integrity reviews on relevant topics—such as provider screening and enrollment, and managed care—from fiscal years 2014 through 2018 and were completed as of June 2019.

For our selected states, we also examined information CMS obtains through other oversight activities, such as states' PERM corrective action plans from fiscal years 2016 through 2018, and CMS desk reviews published from fiscal years 2014 and 2015, which examined the status of states' progress toward implementing corrective actions related to provider screening and enrollment. We also interviewed officials from CMS, its site visit contractor, and our selected states. We also collected information from CMS and state officials on any limitations in CMS's support for states and evaluated CMS's oversight of states' implementation of provider screening and enrollment requirements within the context of federal requirements and internal controls.¹⁴

We conducted this performance audit from July 2018 to October 2019 in accordance with generally accepted government auditing standards. 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.

¹⁴Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. See GAO, *Standards for Internal Control in the Federal Government*, [GAO-14-704G](#) (Washington, D.C.: Sept. 10, 2014).

Background

The size and complexity of states' Medicaid programs have implications for program administration and oversight, including provider screening and enrollment. States have flexibility, within broad federal guidelines, in how they design, administer, and oversee their Medicaid programs. For example, states have the option to pay for care through fee-for-service (FFS) payments to participating providers, contract with managed care organizations (MCO) to deliver services based on a fixed amount per beneficiary, or a combination of both. In fiscal year 2018, total Medicaid spending was \$629 billion, about half of which was estimated to be spent for services delivered under managed care.

CMS and states each have a role to play in protecting the integrity of the Medicaid program and preventing fraud, waste, and abuse. States administer their Medicaid programs, including implementing federal requirements for screening and enrolling Medicaid providers. CMS has a role overseeing states' compliance with federal requirements. CMS's oversight activities include measuring improper payments in the Medicaid program, and conducting focused program integrity and desk reviews. Other federal and state entities also have a role in oversight of the Medicaid program. For example, state auditors—state agencies that typically conduct the annual single state audit of federal programs—may also conduct program integrity reviews and identify Medicaid improper payments.¹⁵ We have previously testified that state auditors are uniquely qualified to partner with CMS in its oversight of Medicaid.¹⁶ In our testimony, we noted that CMS could help improve program integrity by providing state auditors with a substantive and ongoing role in auditing state Medicaid programs.

¹⁵Organizations based in the United States with expenditures of federal funding of \$500,000 or more (\$750,000 or more for fiscal years beginning on or after December 26, 2014) within the organization's fiscal year are required to send an audit report to the Office of Management and Budget, in accordance with the Single Audit Act, as amended, and Office of Management and Budget implementing regulations. See 31 U.S.C. §§ 7501-7506; 2 C.F.R., pt. 200, subpt. F. (2017) (as added by 78 Fed. Reg. 78590, 78608 (Dec. 26, 2013)). A single audit consists of (1) an audit and opinions on the fair presentation of the financial statements and the schedule of expenditures of federal awards; (2) gaining an understanding of and testing internal control over financial reporting, and the entity's compliance with laws, regulations, and contract or grant provisions that have a direct and material effect on certain federal programs (i.e., the program requirements); and (3) an audit and an opinion on compliance with applicable program requirements for certain federal programs.

¹⁶See GAO, *Medicaid: CMS Has Taken Steps to Address Program Risks but Further Actions Needed to Strengthen Program Integrity*, [GAO-18-687T](#) (Washington, D.C.: Aug. 21, 2018).

Provider Screening and Enrollment Requirements

To limit payments to ineligible providers—such as those convicted of program-related fraud and abuse, or with a suspended or revoked medical license for reasons of bearing on professional competence or performance—federal regulations require states to screen and enroll all providers, whether the provider furnished, ordered, or referred services to an eligible beneficiary or whether the service was paid for under FFS or Medicaid managed care contracts. Providers subject to these requirements include individual practitioners—such as physicians, nurse practitioners, and physical therapists—as well as any physicians and other professionals who may only order or refer beneficiaries to services, but do not render services; for example, providers who only prescribe medications or order imaging services, such as an x-ray. Providers also include provider organizations—such as hospitals, group practices, and skilled nursing facilities—and providers and suppliers of medical equipment or goods.

All providers must be screened when they (1) initially apply for and submit an application, and (2) upon reenrollment in a state’s Medicaid program. Further, states must screen all providers at least once every 5 years to revalidate their enrollment. States may rely on the results of providers’ screenings performed by the Medicare program or another state’s Medicaid program. States may also choose to delegate screening activities to vendors that screen providers on the states’ behalf or MCOs. If a state chooses to delegate screening activities, it must ensure that the screenings are conducted in accordance with the Medicaid program requirements.

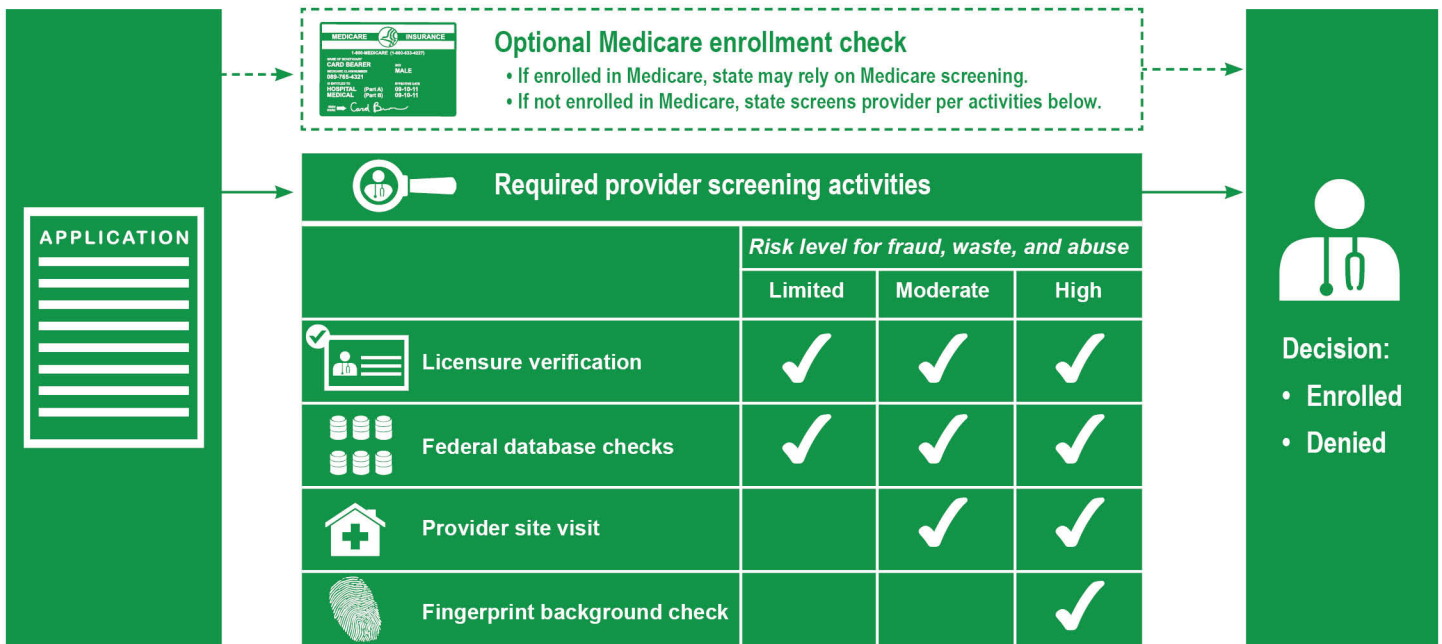
States must also collect certain information from providers to enroll them into their Medicaid programs, such as their Social Security numbers, dates of birth, and National Provider Identifiers, if applicable.¹⁷ States must also collect disclosure information for owners, managing employees, and others with controlling interests in provider organizations meeting certain criteria. For example, states must collect disclosure information for those with direct or indirect ownership totaling 5 percent or more, or who are agents or managing employees of a provider organization. These owners and others with controlling interests who are subject to disclosure

¹⁷The National Provider Identifier is a national, unique 10-digit identification number assigned to health care providers, that CMS specified must be used in accordance with the Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, § 262(a), 110 Stat. 1936, 2025 (1996) (codified, as amended, at 42 U.S.C. § 1320d-2(b)); 45 C.F.R. §§ 162.404, *et. seq.* (2018).

requirements must undergo certain required screening activities, such as federal database checks, and states must perform these screening activities to enroll the provider organization.

Federal regulations require states to perform several screening activities prior to enrolling providers. The provider’s categorical risk level for fraud, waste, and abuse determine the required screening activities. The screening activities may include conducting checks in federal databases; verifying licensure; and performing site visits and fingerprint-based background checks. In addition to required activities, states may also choose to conduct other screening activities in order to identify providers ineligible for participating in Medicaid. See figure 1 for an overview of Medicaid provider screening activities and appendix II for a full list of provider screening requirements.

Figure 1: Overview of Provider Screening Activities for Enrollment in Medicaid



Source: GAO analysis of Centers for Medicare & Medicaid Services guidance. | GAO-20-8

Note: States must screen all participating Medicaid providers and individuals subject to disclosure requirements—such as owners and those with controlling interest in provider organizations—in accordance with federal requirements. States may rely on screenings conducted by Medicare contractors or other state Medicaid agencies, or choose to perform additional screening activities, such as checking the Centers for Medicare & Medicaid Services’ Medicare provider enrollment database—Provider Enrollment, Chain and Ownership System.

Risk-based screening. States must screen providers according to the provider’s categorical risk level for fraud, waste, and abuse.¹⁸ The regulations establish screening requirements for three risk levels—limited, moderate, and high risk—and each risk level includes a range of provider types. (See table 1.) In addition, providers’ risk levels can change. For example, limited- or moderate-risk providers may be categorized as high risk if the state Medicaid agency imposes a payment suspension based on a credible allegation of fraud, waste, or abuse.

Table 1: Examples of Provider Types by Risk Level for Fraud, Waste, and Abuse as Defined by CMS

Risk level for fraud, waste, and abuse	Examples of provider types
Limited	<ul style="list-style-type: none"> • Physician or nonphysician practitioners—including nurse practitioners and occupational therapists—and medical groups or clinics • Ambulatory surgical centers • Hospitals • Pharmacies • Skilled nursing facilities
Moderate	<ul style="list-style-type: none"> • Ambulance suppliers • Community mental health centers • Hospice organizations • Independent diagnostic testing facilities and laboratories • Physical therapists and physical therapy groups • Currently enrolled home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies
High	<ul style="list-style-type: none"> • Prospective (newly enrolling) home health agencies • Prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics, and supplies

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) guidance. | GAO-20-8

Note: States must revalidate providers’ enrollment at least every 5 years and some providers, such as home health agencies, are re-categorized as moderate risk providers when their enrollment is revalidated. Risk levels for provider types exist both in Medicaid and Medicare, and states are required to assign providers to the same or higher risk category as applicable under Medicare, if the provider type exists for both. Certain Medicaid provider types are not recognized by Medicare. For these provider types, which are not listed above, states are required to assign Medicaid-only providers to an appropriate risk level.

¹⁸CMS determined risk levels based on its assessment of the provider types’ potential for fraud, waste, and abuse; and designated specific screening activities for each risk category. Risk levels for provider types exist both in Medicaid and Medicare, and states must assign providers to the same or higher risk category as applicable under Medicare, if the provider type exists for both. Certain provider types are recognized by Medicaid, but not Medicare. For these Medicaid-only providers, states are required to assign them to an appropriate risk level.

Federal database checks. States must confirm the identity of prospective providers, providers seeking revalidation, and individuals subject to disclosure requirements to determine if they have been excluded from participating in Medicaid by checking four federal databases:

1. the Social Security Administrations' Death Master File (DMF);
2. the National Plan and Provider Enumeration System (NPPES);
3. the List of Excluded Individuals/Entities (LEIE); and
4. the General Services Administration's System for Award Management (SAM).¹⁹

In addition, states must conduct at least monthly checks in the LEIE and SAM.²⁰ States may also check other federal and state databases. For example, states may check CMS's database containing Medicare provider enrollment data—the Provider Enrollment, Chain and Ownership System (PECOS)—prior to conducting their own database checks to determine if a provider is enrolled in Medicare and was previously screened. For providers enrolled in Medicare, states may choose to rely on the results of the screening conducted for the Medicare program and enroll the provider without conducting any further screening activities. For providers not enrolled in Medicare, states must screen the provider prior to enrolling them. (See table 2.)

¹⁹SAM was previously known as the Excluded Parties List System, which was discontinued in 2012 and its content was moved to SAM. CMS guidance instructed states to use SAM to fulfill their regulatory responsibilities.

²⁰States may not rely on Medicare or another state to conduct required monthly database checks.

Table 2: Federal Databases States May Check To Screen Medicaid Providers

Federal database	Federal agency that manages the database	Description of federal database	Required to check at initial enrollment and revalidation? ^a	Required to check monthly? ^b
Death Master File (DMF)	Social Security Administration	Lists Social Security numbers of deceased individuals.	Yes	No
National Plan and Provider Enumeration System (NPPES)	Centers for Medicare & Medicaid Services (CMS)	Lists providers with active National Provider Identifiers. ^c	Yes	No
List of Excluded Individuals/Entities (LEIE)	Department of Health and Human Services Office of Inspector General	Identifies providers that the Department of Health and Human Services Office of Inspector General has excluded from participation in federal health care programs.	Yes	Yes
System for Award Management (SAM) ^d	General Services Administration	Identifies parties that have been suspended or debarred from receiving a wide range of federal funds.	Yes	Yes
Provider Enrollment, Chain and Ownership System (PECOS)	CMS	A national enrollment database that allows Medicare providers to submit and update their enrollment data, and houses all provider and supplier enrollment data.	No	No
Data EXchange (DEX)	CMS	Identifies providers who have been revoked from Medicare and terminated from states' Medicaid programs.	No	No

Source: GAO analysis of CMS guidance. | GAO-20-8

Notes: In addition to checking required federal databases, states may choose to conduct checks in other federal and state databases, such as PECOS or DEX.

^aStates must screen providers to revalidate their enrollment in the states' Medicaid programs at least once every 5 years.

^bTo screen providers at initial enrollment and when revalidating their enrollment, states may choose to rely on screenings completed for Medicare or other state Medicaid programs, including checks conducted in federal databases. However, states may not rely on Medicare or other state Medicaid agencies to conduct required monthly database checks.

^cThe National Provider Identifier is a national, unique 10-digit identification number assigned to health care providers that CMS specified must be used in accordance with the Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, § 262(a), 110 Stat. 1936, 2025 (1996) (codified, as amended, at 42 U.S.C. § 1320d-2(b)); 45 C.F.R. §§ 162.404, et seq. (2018).

^dSAM was previously known as the Excluded Parties List System, which was discontinued in 2012 and its content was moved to SAM. CMS guidance instructed states to use SAM to fulfill their regulatory responsibilities.

Licensure verification. States must verify that providers have a current, valid medical license in the states in which they are licensed. Further, states must confirm that the providers' license does not have any limitations, such as a suspension or probation.

Site visits and fingerprint-based criminal background checks. States must conduct on-site visits for moderate- and high-risk providers to verify that the information submitted is accurate and to determine providers' compliance with federal and state enrollment requirements. Further, states must collect fingerprints from high-risk providers, and these providers must consent to a criminal background check.²¹

CMS Oversight of States' Provider Enrollment

CMS developed the PERM to estimate the national Medicaid improper payment rate, including improper payments due to states' non-compliance with provider screening and enrollment requirements. CMS computes the national improper payment rate as the weighted average of states' improper payment rate estimates from the PERM using three key components of the Medicaid program: FFS, managed care, and beneficiary eligibility determinations. Each component of the PERM is estimated differently, and only the FFS component is used to oversee states' compliance with provider screening and enrollment requirements.

- When calculating the FFS component, CMS measures improper payments in a sample of FFS claims, which record services provided. Specifically, CMS reviews the sample of FFS claims and examines related state documents to identify any errors resulting from a failure to meet federal and state policies, including provider screening and enrollment requirements. For example, CMS verifies the provider was eligible to render and bill for the services by reviewing provider information, including the provider's name and license, and whether the provider was screened in accordance with risk-based screening requirements. Any FFS claims paid for services furnished, ordered, referred, or prescribed by a provider who was not screened in compliance with requirements or not enrolled with the state is considered an improper payment.
- The managed care component of the PERM measures any improper payments in the capitated payments that state Medicaid agencies

²¹Individuals subject to disclosure requirements associated with high risk provider organizations also must submit fingerprints and consent to a criminal background check.

make to MCOs on behalf of enrollees. It does not examine whether providers in managed care were appropriately screened and enrolled within a state.²²

- The eligibility component focuses solely on measuring improper payments related to state determinations of whether Medicaid enrollees meet categorical and financial criteria for Medicaid benefits.²³

CMS conducts the PERM across all states on a 17-state, 3-year rotation cycle and computes an annual rolling average of improper payment rates from the 3 years of data. At the conclusion of each PERM cycle, CMS develops reports for each state, which include any findings related to provider screening and enrollment. Following each PERM cycle, states must prepare a corrective action plan to address errors found.

CMS also conducts other oversight activities to protect the integrity of the Medicaid program and assess states' compliance with Medicaid provider screening and enrollment requirements. These activities include the following:

- **Focused program integrity reviews.** CMS conducts these reviews to examine specific areas of Medicaid, including provider screening and enrollment and managed care. These reviews may include a full or partial review of states' compliance with provider screening and enrollment requirements.
- **Desk reviews.** CMS conducts these off-site reviews on specific aspects of states' program integrity activities, such as a state's progress toward implementing corrective action plans in response to PERM findings and payments made to providers terminated from Medicaid.

²²Capitated payments are periodic payments approved by CMS that state Medicaid agencies make to contracted MCOs to cover the provision of medical services, as well as administrative expenses and their profits and earnings.

²³This enrollee eligibility component of the PERM has not been calculated since 2014. CMS has resumed calculating this component, and will begin reporting it in the 2019 reporting year.

Selected States Faced Challenges Implementing Provider Screening and Enrollment Requirements; Some States Have Not Implemented Certain Requirements

Officials from all seven selected states told us they faced challenges building the capacity and establishing the administrative processes needed to implement the new and expanded provider screening and enrollment requirements under PPACA and the 21st Century Cures Act. These challenges included establishing procedures for risk-based screenings, using federal databases and collecting information from providers, and screening and enrolling an increased volume of providers. Due, in part, to these challenges, officials from five selected states told us they have not yet implemented some of the requirements.

Challenges Establishing Procedures for Risk-Based Screenings

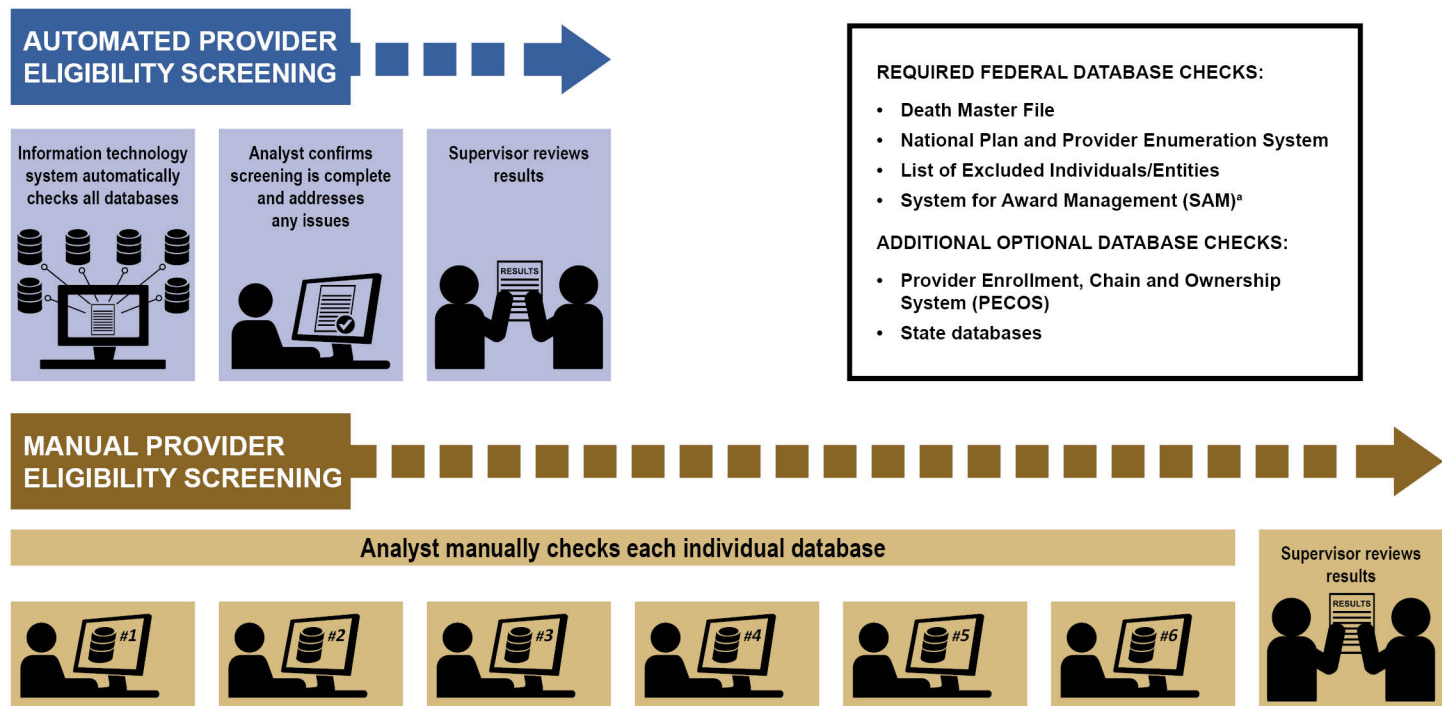
Officials from all seven selected states described challenges building their capacity to conduct risk-based provider screenings prior to enrollment into their Medicaid programs. To incorporate database checks, site visits, fingerprint-based background checks, and other risk-based screening activities into state screening procedures; state Medicaid officials said they needed financial resources, leadership support, and time. Specifically, officials from the selected states told us they used one of the following three approaches to build capacity to implement the screening and enrollment requirements.

1. **Developing new information technology systems.** Officials from two of the seven selected states told us they developed new state information technology systems that automated screening and enrollment activities. For example, officials from one state told us they spent \$5.9 million from 2015 through 2018 to develop a new provider screening and enrollment system that included an online provider application portal and automated screening activities, such as conducting database checks and flagging high-risk providers for site visits and fingerprint-based background checks. According to state officials, this new system helped the state implement provider screening and enrollment requirements, yielding efficiencies by allowing staff to focus on analyzing provider screening results rather than clarifying data entry errors and manually checking each database. (See fig. 2.)
2. **Contracting with vendors.** Officials from four other selected states told us they initiated or modified existing contracts with vendors to screen new provider applications and conduct revalidations on their behalf. For example, officials from one state told us their contract with

a vendor resulted in screening and enrolling about 10,000 providers in 2018, more than five times the number the state had processed in the previous year. Another state used a vendor to revalidate more than 9,000 providers in 2016; about 12 percent of the state’s enrolled provider population.

3. **Modifying existing procedures.** Officials from our seventh selected state told us that they modified their existing state information technology system and procedures to manually screen and enroll providers. However, according to state officials, this approach has put pressure on their resources. Officials said that they were working to automate some database checks as much as possible without requiring services from a contractor.

Figure 2: Automated and Manual Database Checks for Screening Providers



Source: GAO analysis of federal regulations and state documents. | GAO-20-8

Notes: Federal regulations require states to screen providers and individuals subject to disclosure requirements—such as owners and those with a controlling interest in provider organizations. Required screening activities include conducting checks in databases, verifying licensure, and conducting site visits for certain providers. States may also choose to check other federal and state databases, such as PECOS—the Centers for Medicare & Medicaid Services’ (CMS) database for Medicare provider data. Supervisory review typically occurs after all necessary screening activities are complete.

^aSAM was previously known as the Excluded Parties List System, which was discontinued in 2012 and its content was moved to SAM. CMS guidance instructed states to use SAM to fulfill their regulatory responsibilities.

Challenges Using Federal Databases and Collecting Required Information for Screening and Enrollment

Officials from six of the seven selected states told us they experienced challenges using federal databases, and all seven of the states described challenges collecting required information for screening and enrollment. To mitigate challenges using federal databases, the state Medicaid agencies took actions including accessing data from alternate sources, manually verifying information, and collecting information from providers. (See table 3.)

Table 3: Examples of Challenges Selected States Faced Conducting Provider Eligibility Checks in Selected Federal Databases, and State Steps to Mitigate their Effects

Federal database	Description of federal database	Challenge	State mitigation step
Social Security Administration's Death Master File (DMF)	Lists Social Security numbers of deceased individuals.	Data access. DMF was sometimes unavailable from the distributor.	Alternate way to access data. Officials from two states told us they accessed DMF through the Centers for Medicare & Medicaid Services' (CMS) terminations database to perform provider checks.
General Services Administration's System for Award Management (SAM)	Identifies parties that have been suspended or debarred from receiving a wide range of federal funds.	Provider searches. States conduct name-based searches, which may result in multiple false positives.	Manual verification. Officials from one state told CMS they spend an average of 100 hours a month manually checking search results to rule out possible matches. ^a
CMS's Medicare Provider Enrollment, Chain and Ownership System (PECOS)	A national enrollment database that allows Medicare providers to submit and update their enrollment data, and houses all provider and supplier enrollment data.	Data reliability. PECOS includes Medicare-specific information, such as provider addresses, which may differ from the information providers submit for Medicaid enrollment.	Collecting information from providers. Officials from four states told us they continue to collect information from all providers while also checking PECOS.
CMS's Data EXchange (DEX)	Identifies providers who have been revoked from Medicare and terminated from states' Medicaid programs.	Training staff to report terminations. CMS does not provide states with training materials to train new staff members.	Requesting materials. Officials from one state told us they requested training materials from CMS. CMS stated that it does not provide materials to states as part of the training, but tutorials on using the database are available in DEX.

Source: GAO analysis of CMS documents and interviews with state officials. | GAO-20-8

Notes: States are required to conduct provider checks in four federal databases: (1) DMF, (2) the National Plan and Provider Enumeration System, (3) the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities, and (4) SAM. SAM was previously known as the Excluded Parties List System, which was discontinued in 2012 and its content was moved to SAM. CMS guidance instructed states to use SAM to fulfill their regulatory responsibilities. States must perform required checks on providers and those subject to disclosure requirements—

such as owners and those with a controlling interest in provider organizations. As part of their screening activities, states may also check other federal and state databases, such as PECOS, CMS's database containing Medicare provider data, and DEX, CMS's provider termination database.

³According to CMS, the General Service Administration has not allowed states to access data with unique identifiers, such as Social Security numbers.

Recent CMS actions could also improve states' ability to search databases. In April 2019, CMS officials told us they have partnered with the Treasury Department, which is conducting a pilot that will offer states access to its Do Not Pay Business Center services. Do Not Pay is a resource developed by the Treasury Department to detect and prevent improper payments. This resource allows federal agencies to automate screenings by searching for excluded parties using common identification numbers, such as Social Security numbers. Do Not Pay also allows users to search DMF, LEIE, and SAM from a single portal. CMS referred seven states, including two of our selected states, to take part in Treasury's pilot.²⁴

Officials from all seven selected states told us that they faced challenges collecting required information from providers for screening and enrollment, such as Social Security numbers or fingerprints. These states took steps—such as educating providers and developing or updating forms, procedures, and statutory provisions—to address some of the challenges associated with collecting the information necessary to screen and enroll providers. For example, one state told us that some providers have been hesitant to disclose Social Security numbers and their date of birth on applications, as well as other information that states are required to collect for enrollment. In response, the state has offered provider education on the requirements to facilitate collecting this information. State Medicaid officials also noted that their agencies worked with CMS, state legislatures, and state law enforcement agencies to implement fingerprint-based background check requirements to, for example, collect fingerprints and check them against Federal Bureau of Investigation

²⁴In April 2016, we made four recommendations related to the screening and enrollment of managed care providers, which CMS has fully implemented. One of these recommendations asked CMS to coordinate with federal agencies to improve provider screening across databases. As of July 2019, CMS actions to fully address this recommendation included coordinating with the Treasury Department, the Social Security Administration, and other federal agencies to facilitate use of a unique identifier to strengthen provider screening and enrollment in Medicaid. See GAO, *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers*, [GAO-16-402](#) (Washington, D.C.: Apr. 22, 2016).

records. Officials from two selected states told us their agencies did not have the authority under state law to collect fingerprints from providers or submit them to the Federal Bureau of Investigation prior to PPACA, and officials from one of these states told us changes to state statute were needed before they could implement this requirement.²⁵

Challenges Screening and Enrolling an Increased Volume of Providers

Officials from five of the seven selected states described challenges having sufficient capacity to screen an increased volume of providers and enroll certain provider types. Officials from one state told us that the new requirement to screen managed care providers more than doubled the number of providers the state needed to screen and enroll. Further, officials from three states told us about challenges obtaining information needed to conduct screenings from prescribers and other professionals who only order and refer services. Previously, such providers were not required to enroll in Medicaid and some were not responsive to the state Medicaid agency's requests for information. Officials from the five selected states that faced these challenges told us they had taken steps to address these challenges. Yet, four of the five selected states that faced these challenges continued to make payments to these types of providers even though they were not enrolled in their Medicaid programs, because they wanted to maintain beneficiary access to the services.

- **Managed care providers.** Officials from three of the selected states told us they faced challenges enrolling managed care providers. For example, officials from one state told us that they could not process the large number of applications they needed to screen before enrolling these providers, and attempted to delegate some required database checks for managed care providers to its MCOs. However, officials told us these MCOs do not have state-level access to all required databases; therefore, the managed care providers have not been screened as required and are not all enrolled with the state. The officials told us the state has about 80,000 managed care providers to screen and enroll as part of implementing the 21st Century Cures Act requirements. However, officials said they have chosen to wait until the state launches a new information technology system that automates screenings before screening and enrolling these providers.

²⁵Officials from another state told us they were uncertain if changes in the state statute are needed to implement the fingerprint-based background check requirement, and are working with their Attorney General to make such a determination.

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- **Prescribers and other professionals who may only order and refer services to beneficiaries.** Officials from three selected states told us they had not enrolled all prescribers and other professionals who may only order and refer services, but do not render them. These states have taken steps to address this challenge. Officials from one state told us they took steps to screen and enroll medical residents—hospital providers who are not providing services to Medicaid beneficiaries, but may prescribe medication during a beneficiary’s hospital stay. These officials told us they did not screen and enroll medical residents prior to PPACA, because of differences in licensure. Officials from all three states said they continue to pay for prescriptions written by these providers who are not enrolled in their Medicaid programs.

CMS’s Optional Consultations Are Tailored to Support States; Oversight Does Not Provide Comprehensive, Timely Information on States’ Compliance

CMS offers optional consultations that are tailored to support states’ implementation of the Medicaid provider screening and enrollment requirements. However, these consultations are optional, regardless of whether states have implemented the federal requirements. CMS also conducts several oversight activities—the PERM, focused program integrity reviews, and other activities—to oversee states’ compliance with provider screening and enrollment requirements. Collectively, these activities do not ensure CMS has comprehensive and timely information on the extent of states’ compliance with the requirements.

CMS's Optional Consultations Are Tailored to Support States' Implementation of Medicaid Screening and Enrollment Requirements

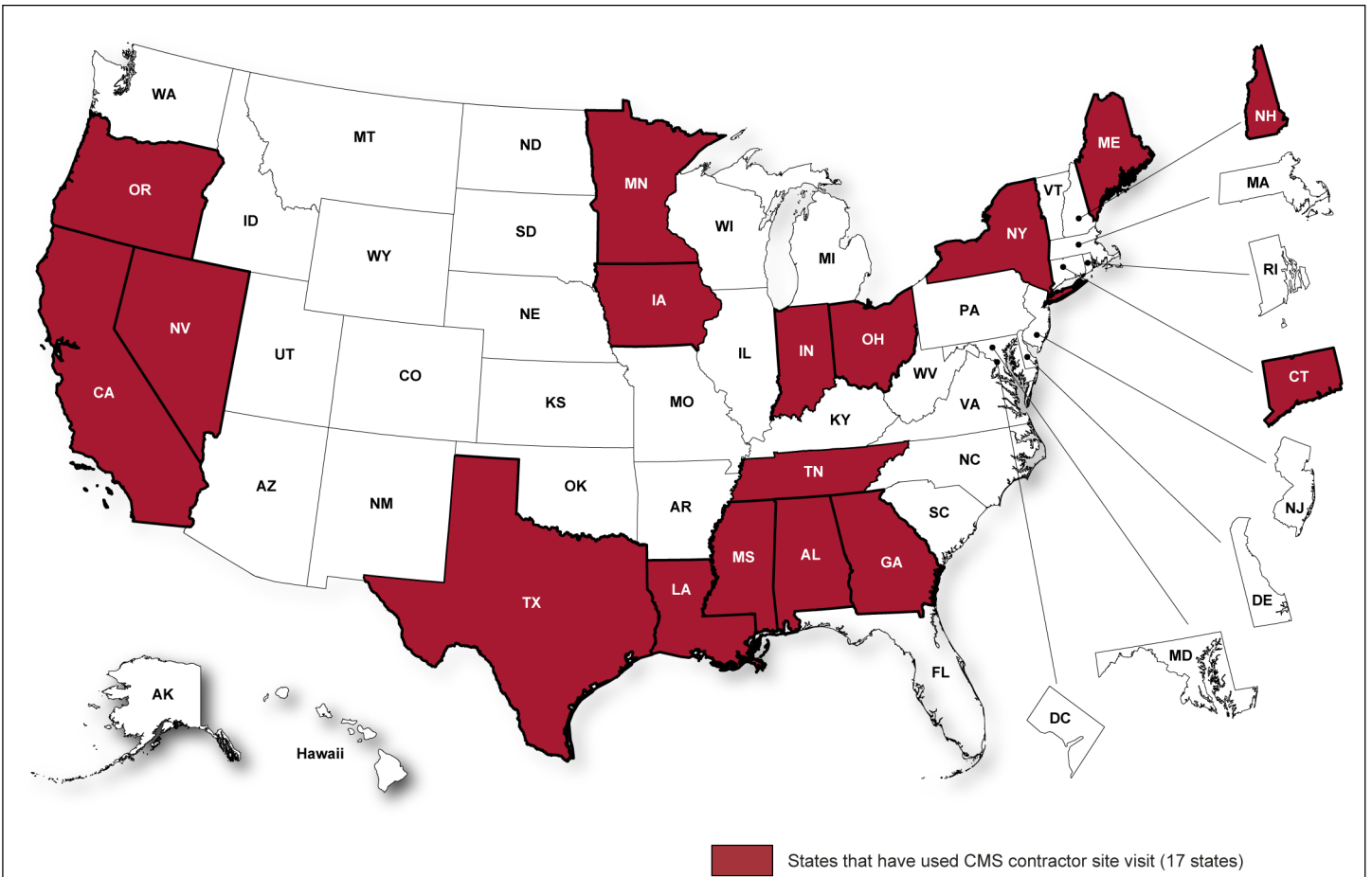
In 2016, CMS began offering optional consultations tailored to support states' implementation of Medicaid screening and enrollment requirements. Optional consultations include CMS contractor site visits to states that examine the extent to which states have implemented the requirements, and the data compare service to assist states with screening providers.²⁶ While most states (38) have used one or more of these consultations, 13 states have not used any. Because some states do not avail themselves of the optional consultations, these consultations do not provide CMS with information on all states' progress in implementing the requirements. Officials from some of the seven selected states reported limitations affecting their use of the consultations.²⁷

CMS contractor site visits. One-third of states (17), including three of the seven selected states, participated in at least one multi-day CMS contractor site visit, as of June 2019. Officials from CMS and its contractor told us that during the site visit, the state completes a self-assessment, followed by the contractor's assessment on the implementation status of all provider screening and enrollment requirements to identify requirements that have not been implemented and opportunities for improving the states' screening and enrollment procedures. (See fig. 3 for a map of states that participated in the CMS contractor site visit.)

²⁶CMS also began offering CMS site visits that are shorter visits, during which CMS officials discuss provider screening and enrollment requirements, suggest other CMS supports, and aim to understand the challenges states face in implementing the requirements. About 16 states, as of June 2019, have participated in a CMS site visit.

²⁷As of June 2019, the 13 states that did not use any optional consultations include Alaska, Arkansas, Colorado, Florida, Illinois, Massachusetts, Montana, Nebraska, Oklahoma, South Dakota, Utah, West Virginia, and Wyoming.

Figure 3: States that Participated in Optional CMS Contractor Site Visits as of June 2019







CMS CONTRACTOR SITE VISIT		
GOAL	DURATION	PRODUCT
Assess a state's implementation of the Medicaid provider screening and enrollment requirements.	2 to 4 days.	An assessment of the state's status of implementing the requirements, improvements it can make to its screening and enrollment procedures, and a proposed schedule for implementing improvements.

Sources: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data (data); Map Resources (map). | GAO-20-8

After the visit, the contractor provided a report that summarizes the state's status toward implementing each requirement, such as full, partial, nearly complete, and not started. (See fig. 4.) CMS officials consider any requirements that are not fully implemented as "opportunities for improvement." CMS contractor site visits are not required and are not considered audits; the agency does not track states' progress on implementing requirements and opportunities for improvement unless the state engages CMS in follow-up. At the time of their contractor site visit, 16 of the 17 states that opted for this service had not fully implemented all provider screening and enrollment requirements.

Figure 4: Example of a Summary Excerpt from the CMS Contractor Site Visit

Regulatory overview	
Provider enrollment requirements and implementation status	Details
<p>Enrolling and screening <i>Full</i></p> 	<ul style="list-style-type: none"> All providers, including prescribers and other professionals who may only order and refer services to beneficiaries, are required to enroll. Prescribers and other professionals who may only order and refer services use an abbreviated application. The state has completed enrolling managed care providers.
<p>Database checks <i>Nearly complete</i></p> 	<ul style="list-style-type: none"> The four required federal databases are checked manually prior to enrollment and during revalidation; however, due to reliance on manual processes, the state was cited several Payment Error Rate Measurement (PERM) errors related to missed database checks largely attributed to staff error or access issues.^a
<p>Risk screening levels <i>Partial</i></p> 	<ul style="list-style-type: none"> Managed care organizations are responsible for conducting the required screenings of managed care providers, including moderate- and high-risk, before sending to the state agency.^b All provider enrollment units have a process to increase a provider's risk level when required.
<p>Revalidation <i>Not started</i></p> 	<ul style="list-style-type: none"> The state has not initiated revalidation of its provider population, but plans to institute a 3-year revalidation schedule. The state may need to adjust the revalidation schedule to spread out volume, which may require moving up some providers' deadlines.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-20-8

Notes: All providers must be screened when they initially apply for and reenroll in Medicaid. Further, states must screen all providers at least once every 5 years to revalidate their enrollment.

^aThe PERM is CMS's method for estimating the national Medicaid improper payment rate, including improper payments made to fee-for-service providers who were not screened and enrolled according to requirements.

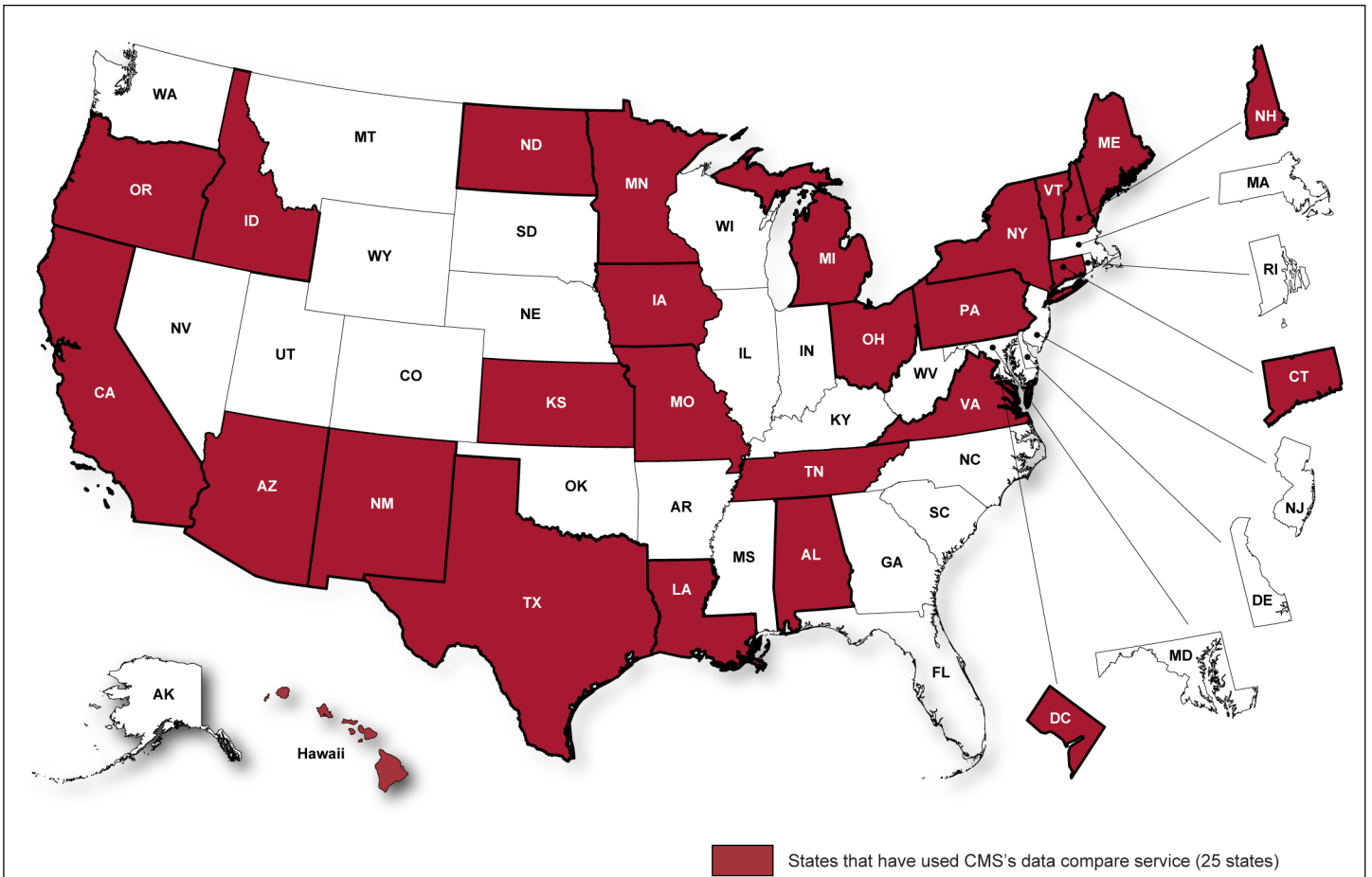
^bStates must screen providers according to their categorical risk level for fraud, waste, and abuse. The regulations establish screening requirements for three risk levels—limited, moderate, and high risk—and each risk level includes a range of provider types.

Officials from the three selected states that received a CMS contractor site visit told us that the visit helped (1) accurately identify requirements that their state had not fully implemented, or (2) establish priorities for making changes. Two of these states found it helpful to learn from the contractor about other states' best practices and requested a return visit. Officials from another state told us they were able to make positive changes to their screening and enrollment procedures immediately after the visit, such as improving documentation of database checks through the use of screenshots to record search results.

Data compare service. About half of all states (25), including four of the seven selected states, used the data compare service as of June 2019—a process by which states submit a list of all their active providers, and CMS provides a full report of the state's providers who were previously screened by Medicare, as well as identify providers the state may need to take action on, because, among other reasons, they were terminated from Medicaid.²⁸ For the states that have used the data compare service, CMS officials reported being able to screen between 40 to 80 percent of their providers. Officials from the four selected states said it was also useful for testing their provider screening and enrollment procedures to see whether the service would identify any providers they should have excluded in their screening, and three of these states said it was useful for streamlining their provider revalidations. Additionally, officials from one state that had not yet used the service told us they would consider using it in the future for both of these purposes. For example, officials from one state reported that CMS's data compare service screened half of the approximately 80,000 providers they needed to revalidate. (See fig. 5 for a map of states that opted for the data compare service.)

²⁸Puerto Rico has also used this service.

Figure 5: States that Used CMS’s Optional Data Compare Service as of June 2019



CMS’s DATA COMPARE SERVICE		
GOAL	DURATION	PRODUCT
A process by which states submit a list of all their active providers to CMS in order to determine whether they may rely on screenings already conducted by Medicare.	An average of 4 weeks.	A full report from CMS of the state’s providers who were previously screened by Medicare, as well as providers the state may need to take action on, because they were revoked, terminated, reported as deceased, or had their National Provider Identifier deactivated. ^a

Sources: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data (data); Map Resources (map). | GAO-20-8

Notes: States must confirm providers’ identity and determine if they have been excluded from participating in federal programs, including Medicaid, by conducting checks in four federal databases: (1) the Social Security Administration’s Death Master File, (2) the National Plan and Provider

Enumeration System, (3) the Department of Health and Human Services Office of Inspector General's List of Excluded Individuals/Entities, and (4) the System for Award Management (SAM). SAM was previously known as the Excluded Parties List System, which was discontinued in 2012 and its content was moved to SAM; CMS guidance instructed states to use SAM to fulfill their regulatory responsibilities. States may rely on screenings conducted by Medicare or other states' Medicaid programs. Medicare provider enrollment data is contained in CMS's Medicare Provider Enrollment, Chain and Ownership System database.

As of March 2019, Puerto Rico also used the data compare service.

^aThe National Provider Identifier is a national, unique 10-digit identification number assigned to health care providers that CMS specified must be used in accordance with the Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, § 262(a), 110 Stat. 1936, 2025 (1996) (codified, as amended, at 42 U.S.C. § 1320d-2(b)); 45 C.F.R. §§ 162.404, *et seq.* (2018).

However, officials from all seven selected states identified limitations of the data compare service that led some states to use the service less frequently and three states to not use the service at all.²⁹ CMS officials acknowledged the three limitations reported by state officials:³⁰

1. **Time for receiving results.** The results from the data compare service were not timely enough to help states with screening newly enrolling providers. Officials from one state explained that some provider information may become outdated by the time the results are received 6 to 8 weeks later, which makes the service less useful than it could be.
2. **Different Medicare and Medicaid address entries.** The data compare service's addresses reflected Medicare practice or billing locations that may be different from providers' Medicaid addresses. Because these addresses do not match, they could not be relied upon for updating the state's provider records or to help states conduct site visits required for screening and enrolling moderate- and high-risk providers.
3. **Additional burden for manual enrollment systems.** Officials from two selected states told us that manually extracting provider data from

²⁹In early spring 2019, CMS launched a pilot project similar to the data compare in two states—Iowa and Missouri—to screen providers applying to enroll only in Medicaid. The service uses Medicare's Advanced Provider Screening System, which queries federal, state, and local systems for medical licenses, felony convictions, and payment sanctions.

³⁰In addition, CMS officials noted that the data compare service is more effective at decreasing states' workload for individual providers—which tend to be the largest proportion of a state's workload—than for practitioners who work for provider organizations—including hospitals, group practices, and skilled nursing facilities—because it is more difficult to screen owners, managing employees, and others with controlling interests in provider organizations.

their system—including names, addresses, Social Security numbers, and National Provider Identifiers—and manually re-entering the results from CMS for each provider into their system was burdensome and resource-intensive, leading one of these states to stop using the service.

CMS's Guidance and Other Supports for States

CMS offers the following guidance and other supports to states:

- issuing its Medicaid Provider Enrollment Compendium in 2016, which consolidated formal guidance to states on provider screening and enrollment requirements;
- conducting monthly Provider Enrollment Technical Advisory Group calls with states;
- assigning each state to a CMS contact—a business function lead who provides technical assistance and ongoing support on at least a monthly basis;
- providing training through Medicaid Integrity Institute seminars; and
- providing state-specific resources in the Provider Enrollment, Chain and Ownership System.

Source: GAO analysis of information from the Centers for Medicare & Medicaid Services (CMS). | GAO-20-8

CMS offers guidance and other supports to states on a regular and periodic basis, including monthly calls with states, and assigning states to a CMS contact (see sidebar). These services also assist states with implementing the Medicaid provider screening and enrollment requirements. Officials from all of our selected states told us the guidance and other supports were helpful. According to CMS officials, the extent to which states participate in these other supports varies, because the level of participation is optional. CMS officials also told us that they use these other supports, including monthly calls and ad hoc emails, to discuss progress and keep a record of information provided; however, the agency does not revisit or require corrective actions unless the state initiates it.

CMS's Oversight Does Not Provide Comprehensive and Timely Information on States' Compliance with All Provider Screening and Enrollment Requirements

The PERM and other methods CMS uses to oversee states' efforts to screen and enroll Medicaid providers do not provide CMS with comprehensive and timely information on states' compliance with the requirements. Some methods do not fully track whether states have enrolled all types of providers and are in compliance with all the requirements; other program integrity oversight methods have not been conducted on all states. Further, these methods do not ensure timely follow-up to address identified concerns.

The PERM's components—FFS, managed care, and beneficiary eligibility determinations—measure improper payments across all states; as previously noted, the FFS component is the only component CMS uses to assess states' compliance with provider screening and enrollment

requirements. However, using the PERM to oversee states' compliance with the requirements has limitations, including the following:

- The PERM does not examine whether providers under contract with MCOs are appropriately screened and enrolled. The PERM assesses states' compliance with the provider screening and enrollment requirements by reviewing provider information for claims paid under FFS; it does not review such information for services financed under managed care.³¹
- Currently, the PERM does not examine ownership disclosure and certain other provider screening and enrollment requirements.³² CMS officials told us the agency plans to assess the feasibility of including ownership disclosure requirements in the PERM over the next 3 years.
- The PERM does not ensure that CMS identifies areas of non-compliance in a timely manner. CMS conducts the PERM in each state every 3 years, and states develop corrective action plans in response to findings from the PERM; thus, it may be years before CMS identifies—and states resolve—areas of non-compliance with the provider screening and enrollment requirements. (See fig. 6.)

³¹CMS has said that assessing whether any capitated payments—the payments from state agencies to MCOs—were improper is the lowest transaction level at which the agency can clearly identify federal funds without making significant assumptions. See GAO, *Medicaid: CMS Should Take Steps to Mitigate Program Risks in Managed Care*, [GAO-18-291](#) (Washington, D.C.: May 7, 2018).

³²Provider terminations and application fees are other requirements that the PERM does not examine. See appendix I for further information about these requirements.

Figure 6: Timeline of Payment Error Rate Measurement (PERM) Corrective Actions

		First PERM cycle			Second PERM cycle		
		YEAR 1	YEAR 2	YEAR 3	YEAR 1	YEAR 2	YEAR 3
CMS ACTIVITIES	Review a sample of claims from 17 states.	Develop findings. Calculate improper payment rates.	Notify states of findings. ^a	Review findings from first cycle. Repeat Year 1 activities with new sample from the 17 states. ^b	Repeat Year 2 activities.	Repeat Year 3 activities.	
	Submit sample of claims and support federal activities.	Respond to questions.	Develop corrective actions with agency to address findings. Implement corrective actions, which vary, as shown below.	Continue implementing corrective actions from first cycle, as needed. Repeat Year 1 activities with a new sample.	Continue implementing corrective actions from first cycle, as needed.	Continue implementing corrective actions from first cycle, as needed.	Repeat Year 3 activities.
STATE ACTIVITIES	<p>EXAMPLES OF CORRECTIVE ACTIONS^c</p> <p>State A: Accessed federal databases to perform required checks. ----- <input checked="" type="checkbox"/></p> <p>State B: Established fingerprint-based background check procedures. ----- <input checked="" type="checkbox"/></p> <p>State C: Continue to enroll ordering and referring providers. ----- <input type="checkbox"/></p>						

----- Estimated length of time to perform corrective action Corrective action implemented Corrective action not implemented

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-20-8

Notes: CMS developed the PERM to estimate the national Medicaid improper payment rate, which include improper payments made to fee-for-service (FFS) providers who were not screened and enrolled according to requirements.

CMS conducts the PERM across all states on a 17-state, 3-year rotation cycle. The agency computes the national improper payment rate as the weighted average of states' improper payment rate estimates using three components of the Medicaid program: FFS, managed care, and beneficiary eligibility determinations. CMS uses only the FFS component to oversee states' compliance with provider screening and enrollment requirements.

An improper payment is defined as 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 good or service, any duplicate payment, or any payment for a good or service not received (except for such payments where authorized by law) and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.

^aCMS notifies states of findings by November in year 3 of the PERM cycle and states must submit a finalized corrective action plan to address findings to CMS within 90 days.

^bThe same 17 states that begin the PERM cycle in year 1 start a new cycle three years later—year 1 of a second PERM cycle.

^cExamples of corrective actions states have taken to address PERM findings related to provider screening and enrollment.

Although CMS follows up annually with states regarding their corrective action plans, it does not fully assess states' progress toward implementing their plans until the next PERM cycle, which is 3 years later. Further, while four of our selected states had implemented all their corrective action plans regarding provider screening and enrollment requirements within 1 year of PERM findings, the other three states had not fully implemented their plans about 2 years after PERM findings. CMS officials emphasized that developing and tracking corrective action plans was a collaborative process and that states may change corrective action plans in response to competing priorities.

CMS uses other methods to oversee states' compliance with the provider screening and enrollment requirements—focused program integrity reviews and desk reviews—that are not optional and have resulted in findings. However, these methods do not provide the agency with comprehensive and timely information on states' compliance with the requirements. Specifically, these methods have not been conducted in all states, performed in a timely manner, or included a systematic review of states' compliance with all the provider screening and enrollment requirements. For example:

- **Focused program integrity reviews.** CMS has not conducted focused program integrity reviews examining specific areas in Medicaid for all states. Most of the reviews performed did not include a comprehensive or timely examination of states' compliance with provider screening and enrollment requirements. Overall, CMS has

conducted 42 focused program integrity reviews in fiscal years 2014 through 2018 in 39 states.³³ Among these reviews, nine of the 42 focused program integrity reviews examined states' compliance with provider screening and enrollment requirements, the last of which was completed in fiscal year 2015. CMS also conducted focused program integrity reviews on managed care for 34 of the 41 states with managed care expenditures in fiscal year 2017. However, nearly all of these reviews (33) were conducted prior to January 2018 when states were required to screen and enroll all managed care providers, as required by the 21st Century Cures Act. CMS also conducted seven focused reviews examining personal care services in seven states—which include examining screening and enrollment requirements for providers of these services.³⁴

- **Desk reviews.** Off-site desk reviews that examine specific aspects of states' program integrity activities do not include a comprehensive or timely examination of states' compliance with the provider screening and enrollment requirements. CMS has conducted desk reviews examining activities related to provider screening and enrollment, such as corrective actions states have taken in response to PERM findings. However, desk reviews on corrective action plans are limited to examining findings on provider screening and enrollment identified during the PERM and are not conducted until 3 years after the PERM has occurred. For example, CMS told us that in 2018 the agency conducted desk reviews on the 17 states that underwent the PERM in fiscal year 2015. CMS also conducted 35 desk reviews on potential payments to terminated providers since fiscal year 2014.

The PERM and CMS's other oversight methods do not provide CMS with sufficient or timely information about states' screening and enrollment procedures for all Medicaid provider types, and most states with managed care expenditures have not undergone a managed care-focused program integrity review since the 21st Century Cures Act screening and enrollment provisions went into effect. The lack of complete information

³³Some focused program integrity reviews examine more than one area in Medicaid. For example, eight reviews examined managed care and provider screening and enrollment. CMS officials told us that they completed an additional 10 focused program integrity reviews in 2018. However, the agency was not able to provide us with these reports as of June 2019.

³⁴CMS officials told us they had conducted an additional five focused program integrity reviews on personal care services during 2018. However, the agency was not able to provide us with these reports as of June 2019.

on whether states are screening and enrolling all providers according to requirements is inconsistent with federal internal controls on assessing risk, which note that management should consider the potential for fraud when identifying, analyzing, and responding to risks.³⁵ Without complete information, CMS cannot ensure that only eligible providers are participating in the Medicaid program, leaving the program vulnerable to improper payments.

Further, CMS does not obtain timely information on all states' actions to address areas of non-compliance or track progress toward addressing these areas. The length of the PERM cycle—3 years—and time for performing corrective actions to address PERM findings, limits CMS's awareness of states' progress, or lack thereof, toward implementing requirements. As a result, CMS lacks assurance that states are addressing areas of non-compliance or if such actions are being taken in a timely manner. This is inconsistent with federal internal controls on monitoring, which note that management should remediate deficiencies in the internal control system on a timely basis.

Conclusions

CMS has a range of activities that provide the agency with some knowledge of states' implementation of required provider screening and enrollment under PPACA and the 21st Century Cures Act; however, the agency's oversight activities are not designed to systematically examine compliance with all the requirements for all providers in a timely manner. Notably, the PERM does not examine managed care providers, and CMS's assessment of compliance and monitoring of corrective actions are not timely, because they are based on the 3-year PERM cycle. Also, focused program integrity reviews—which may examine states' oversight of MCOs and their compliance with provider screening and enrollment requirements for providers participating in managed care—have not been conducted on all states.

The one activity that can provide CMS and states with a complete and timely assessment of states' implementation with provider screening and enrollment requirements is optional. While CMS does some tracking of state-reported information on the status of states' implementation of the requirements, this oversight does not include states that have not availed themselves of the support CMS provides. Since states are not required to

³⁵See [GAO-14-704G](#).

participate in these optional consultations, the states that may face the greatest challenges with implementing the provider screening and enrollment requirements might not volunteer to participate in the consultations. Without a thorough review of states' implementation of the provider screening and enrollment requirements, as well as processes to monitor states to ensure timely remediation of deficiencies, the agency lacks assurance that only eligible providers are participating in the Medicaid program, leaving the program at risk for improper payments.

Recommendations

We are making the following two recommendations to CMS:

The Administrator of CMS should expand its review of states' implementation of the provider screening and enrollment requirements to include states that have not made use of CMS's optional consultations. Similar to CMS's contractor site visits, such reviews should include any necessary steps to address areas of noncompliance for all types of enrolled providers, including those under contract with MCOs. (Recommendation 1)

The Administrator of CMS should annually monitor progress toward addressing any areas of noncompliance related to the provider screening and enrollment requirements for any state with one or more corrective action plans. (Recommendation 2)

Agency Comments

We provided a draft of this report to HHS for review and comment. In its written comments, HHS concurred with our recommendations; the full text of which are reproduced in appendix I.

- Regarding our first recommendation, HHS stated that it will reach out to states that have not yet participated in optional consultations to discuss their progress and outline steps that the states should take to come into full compliance with the provider screening and enrollment requirements.
- Regarding our second recommendation, HHS stated that it is in the process of instituting more frequent reviews of corrective action plans resulting from one of CMS's oversight activities—the PERM—stating that such reviews will now be performed quarterly. However, HHS's comments did not discuss monitoring areas of noncompliance that are identified through other oversight activities, such as focused program integrity reviews, which

include reviews of states' screening and enrollment of providers who are under contract with MCOs. We recommend that CMS annually monitor progress toward addressing any areas of noncompliance related to the provider screening and enrollment requirements, which would include areas of noncompliance identified through the PERM, optional consultations, and other oversight activities.

HHS also provided technical comments, which we incorporated as appropriate.

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 to the Secretary of Health and Human Services, the Administrator of CMS, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or at yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff that made key contributions to this report are listed in appendix III.



Carolyn L. Yocom
Director, Health Care

Appendix I: 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

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

SEP 19 2019

Dear Ms. Yocom:

Attached are *comments* on the U.S. Government Accountability Office's (GAO) report entitled, "*MEDICAID PROVIDERS: CMS Oversight Should Ensure State Implementation of Screening and Enrollment Requirements*" (GAO-20-08).

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Sarah Arbes".

Sarah Arbes
Acting Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — MEDICAID PROVIDERS: CMS OVERSIGHT SHOULD ENSURE STATE IMPLEMENTATION OF SCREENING AND ENROLLMENT REQUIREMENTS (GAO-20-8)

The U.S. Department of Health & Human Services (HHS) appreciates the opportunity provided by the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to ensuring that all Medicaid providers are screened and enrolled appropriately.

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

Specifically, HHS uses the Payment Error Rate Measurement (PERM) process to identify improper payments related to states' non-compliance with provider screening and enrollment requirements. HHS institutes PERM corrective action plans, which include provider enrollment findings when applicable. HHS is in the process of instituting more frequent reviews of PERM corrective action plans to evaluate the progress states are making, which will now be performed quarterly. In addition, HHS conducts focused state Program Integrity Reviews on specific areas of Medicaid annually in a select number of states. If these reviews find non-compliance with federal regulatory requirements, including provider enrollment and screening requirements, HHS requires the state to draft a corrective action plan.

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

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

GAO's recommendations and HHS' responses are below.

GENERAL COMMENTS FROM THE DEPARTMENT OF HEALTH & HUMAN SERVICES ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED — MEDICAID PROVIDERS: CMS OVERSIGHT SHOULD ENSURE STATE IMPLEMENTATION OF SCREENING AND ENROLLMENT REQUIREMENTS (GAO-20-8)

Recommendation 1

HHS should expand its review of states' implementation of the provider screening and enrollment requirements to include states that have not made use of HHS optional consultations. Similar to HHS's contractor site visits, such reviews should include any necessary steps to address areas of noncompliance for all types of enrolled providers, including those under contract with MCOs.

HHS Response

HHS concurs with this recommendation. HHS will reach out to states that have not yet participated in optional consultations to discuss their progress and outline steps that the state should take to come into full compliance with the provider screening and enrollment requirements.

Recommendation 2

HHS should annually monitor progress toward addressing any areas of noncompliance related to the provider screening and enrollment requirements for any state with one or more corrective action plans.

HHS Response

HHS concurs with this recommendation. HHS is in the process of instituting more frequent reviews of Payment Error Rate Measurement corrective action plans, which will now be performed quarterly.

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

Appendix II: Summary of Medicaid Provider Screening and Enrollment Requirements

Table 4: Summary of Medicaid Provider Screening and Enrollment Requirements

Requirement	Description
Screening and enrolling of providers	The state Medicaid agency must require all enrolled providers to be screened in accordance with applicable requirements.
Verification of provider licenses	The state Medicaid agency must have a method for verifying that a provider is licensed without restrictions in accordance with the laws of that state.
Revalidation of enrollment	The state Medicaid agency must complete revalidation of enrollment for all providers, regardless of provider type, at least every 5 years.
Termination and denial of enrollment	The state Medicaid agency must deny enrollment to any provider and disclosing entity that does not successfully pass or comply with the screening process, and the agency must terminate providers who no longer meet the requirements for enrollment.
Reactivation of enrollment	The state Medicaid agency must rescreen a provider who has been deactivated for any reason prior to the provider's reactivation.
Appeal rights	The state Medicaid agency must share with providers who are terminated or denied enrollment the process for appealing the decision.
Site visits	The state Medicaid agency must conduct site visits for providers who are designated as moderate or high-risk levels.
Fingerprint criminal background checks	The state Medicaid agency must complete fingerprint-based criminal background checks for providers and disclosing entities in the high-risk category.
Federal database checks	The state Medicaid agency must confirm the identity and determine the exclusion status of providers, any person with an ownership or control interest, and any agent or managing employee of the provider.
National Provider Identifier ^a	The state Medicaid agency must require all claims for payment for items and services that were ordered or referred to contain the National Provider Identifier of the physician or other professional who ordered or referred such items or services.
Screening levels for Medicaid providers	The state Medicaid agency must screen all initial applications based on a categorical risk level of "limited," "moderate," or "high."
Application fees	The state Medicaid agency must collect an application fee from institutional providers during a new enrollment or revalidation, unless Medicare or another Medicaid agency has already collected an application fee.
Temporary moratoria	Allows CMS and states to implement temporary moratoria pausing the enrollment of new provider types in a given location.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) guidance. | GAO-20-8

Notes: A disclosing entity is an entity other than a provider that is required to disclose certain ownership and controlling information.

^aThe National Provider Identifier is a national, unique 10-digit identification number assigned to health care providers that CMS specified must be used in accordance with the Health Insurance Portability and Accountability Act of 1996. Pub. L. No. 104-191, § 262(a), 110 Stat. 1936, 2025 (1996) (codified, as amended, at 42 U.S.C. § 1320d-2(b)); 45 C.F.R. §§ 162.404, et seq. (2018).

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or at yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, Leslie V. Gordon (Assistant Director), Kristin Ekelund (Analyst-in-Charge), Manuel Buentello, Drew Long, Giao N. Nguyen, and Chris Zakroff made key contributions to this report. Also contributing were Marissa Coloske, Vikki Porter, and Jennifer Whitworth.

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