Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Credentialing of Medicaid Providers: Fee-for Service

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EXECUTIVE SUMMARY

PURPOSE

To review States' processes for enrolling and credentialing Medicaid fee-for-service non-institutional practitioners and suppliers.

BACKGROUND

Enrollment and credentialing processes for Medicaid practitioners and suppliers (hereinafter referred to as providers) are designed to:

- protect Medicaid beneficiaries from receiving care or services from providers who are unqualified (e.g., individuals or entities who are not licensed in the State, whose licenses are limited or restricted, or who are excluded from Medicare, Medicaid, and other Federal programs); and

- prevent improper payments for services rendered by providers who do not meet Federal and State requirements for participation in the Medicaid program.

Provider enrollment and credentialing are needed to obtain a Medicaid provider identification number. Providers use these numbers to submit claims for services and receive reimbursement from the Medicaid program. However, over the past several years, States' Medicaid Fraud Control Units have investigated situations in which provider identification numbers were associated with efforts to defraud the Medicaid program.

The HCFA requires States, as part of the credentialing process, to determine if a provider applying to participate in the Medicaid program has a valid professional license (and certification by specialty where applicable). It also requires States to obtain from the provider pertinent enrollment and credentialing information for entry into the Medicaid Management Information System, including name, address, Social Security number or Employer Identification Number, and provider type.

We focused our efforts on States' processes for provider enrollment and credentialing, since these efforts serve as first-line defenses in the protection of beneficiaries and in the prevention of Medicaid fraud and abuse.

FINDINGS

Twenty-five States Are Not Collecting All Required Enrollment and Credentialing Information

Twenty five States are not obtaining from the provider pertinent enrollment and credentialing information as required by HCFA for entry into the system. For example,

nine States do not obtain a previously assigned Medicaid provider number. Others do not obtain the type of practice organization, or obtain the name, address, and number of group practices.

States' Verification of Providers' Exclusion Status Is Incomplete

All States independently verify exclusion status through review of the Medicare/Medicaid Sanction-Reinstatement Report, HCFA's notice of Medicare or Medicaid exclusion actions. However, only seven States review the General Services Administration's "List of Parties Excluded from Federal Procurement and Nonprocurement Programs," which should be used in conjunction with HCFA's notice.

Many States Accept Provider Enrollment Statements Without Independently Verifying the Information

Nineteen States do not contact co-lateral sources to independently verify provider enrollment as required by HCFA.

Only Two-thirds of the States Make Use of Information Available from External Sources

Only 33 of the 50 States routinely gather information from external sources concerning past investigations or prior practice patterns. External entities, such as the Medicare carriers, private insurers, other Medicaid State Agencies and Medicaid Fraud Control Units may have important information about providers practicing within the State that would be useful in the credentialing process.

Most States Have Not Established Aggressive Post Credentialing Procedures

Re-enrollment and re-credentialing. The HCFA has implemented national standards for the enrollment and credentialing of Medicare providers and is proposing standards for periodic re-enrollment and re-credentialing. However, HCFA has not imposed similar requirements for Medicaid providers. We found 18 States, on their own initiative, perform some type of provider re-enrollment and re-credentialing; the remaining 32 States do not.

Deactivation of provider numbers. Thirty five States deactivate Medicaid provider identification numbers with no recent claims activity. This time frame ranges from 12 to 60 months with a median of 24 months.

Reactivation of provider numbers. States use diverse processes for reactivation of provider identification numbers. Twenty-eight States require a new application and perform some form of credentialing. The remaining States simply reactivate existing numbers upon the submission of new claims.

Some States Report The Use of Additional Enrollment And Credentialing Safeguards

We found that some States have implemented enrollment and credentialing criteria that exceed the minimum Federal requirements. Many States share information and coordinate with other insurance payers and investigative entities to obtain any additional information on the provider. These additional processes afford additional protections for both Medicaid beneficiaries and program funds. Some examples include:

▸ Criminal background checks (all providers)	1 State
▸ Criminal background checks (some providers)	9 States
▸ Fingerprinting (all providers)	1 State
▸ Fingerprinting (some providers)	3 States
▸ On-site visits to provider office(s)	10 States
▸ Verification that provider telephone numbers are working	8 States

RECOMMENDATIONS

We believe HCFA can do more to strengthen enrollment and credentialing requirements to safeguard the Medicaid program, and support States that implement additional measures to prevent Medicaid provider fraud and abuse.

We recommend HCFA take the following actions to safeguard the Medicaid program:

Strengthen the Enrollment, Re-enrollment, and Credentialing Requirements of Medicaid Providers

The HCFA, in conjunction with States, should strengthen the enrollment and credentialing standards by duplicating or closely paralleling those currently being used for the Medicare program.

Instruct States to Independently Verify the Provider's Exclusion Status from All Federal Programs

States, and third-party enrollment and credentialing organizations, need to determine a provider's exclusion status by reviewing both the monthly "Medicare/Medicaid Sanction-Reinstatement Report" (HCFA Publication 69) and the General Services Administration's "List of Parties Excluded from Federal Procurement and Nonprocurement Programs."

Require States to Obtain Provider Information From Other States and Federal Entities

The HCFA should require States, as part of credentialing, to contact Medicare carrier(s), other Medicaid State Agencies, and the Medicaid Fraud Control Units for information

regarding out-of-State providers and for providers that have recently relocated to the State. These contacts could help identify any past criminal, legal, licensing and utilization issues, thereby reducing inappropriate payments to the provider.

Establish Standards and Processes for the Deactivation and Reactivation of Provider Identification Numbers

The HCFA should establish national standards and protocols for the deactivation and reactivation of Medicaid provider identification numbers similar to those policies being considered for Medicare.

AGENCY COMMENTS

The HCFA generally agreed with the underlying intent of our recommendations for strengthening enrollment and credentialing standards, sharing information among the States and Federal entities, and deactivating inactive provider identification numbers. However, they believe such improvements should be made by working with and advising States rather than adoption of additional stricter Federal requirements. Appendix E contains the complete text of these comments.

We understand HCFA's desire to work collaboratively with States to improve and strengthen Medicaid provider credentialing. However, if this approach is not successful in achieving the needed improvements, HCFA may want to consider implementing more prescriptive credentialing policies.

TABLE OF CONTENTS

INTRODUCTION

PURPOSE

To review States' processes for enrolling and credentialing Medicaid fee-for-service non-institutional practitioners and suppliers.

BACKGROUND

Enrollment and credentialing processes for Medicaid practitioners and suppliers (hereinafter referred to as providers) are designed to:

- protect Medicaid beneficiaries from receiving care or services from providers who are unqualified (e.g., individuals or entities who are not licensed in the State, whose licenses are limited or restricted, or who are excluded from Medicare, Medicaid, and other Federal programs); and

- prevent improper payments for services rendered by providers who do not meet Federal and State requirements for participation in the Medicaid program.

Provider enrollment and credentialing are needed to obtain a Medicaid provider identification number. Providers use these numbers to submit claims for services and receive reimbursement from the Medicaid program. However, over the past several years, States'[1] Medicaid Fraud Control Units have investigated situations in which provider identification numbers were associated with efforts to defraud the Medicaid program.[2] Therefore, we focused our efforts on States' processes for provider enrollment and credentialing, since these efforts serve as first-line defenses in the prevention of Medicaid fraud and abuse.

The General Accounting Office (GAO) also expressed concerns about Medicaid enrollment and credentialing requirements. In a hearing before the House of Representatives, Oversight and Investigations Subcommittee on July 18, 2000, GAO reported the Health Care Financing Administration (HCFA) is doing relatively little to oversee States' efforts at policing provider integrity in the Medicaid program. The GAO further reported that HCFA's efforts to strengthen the Medicare program's provider enrollment processes may provide HCFA an opportunity to do the same for the Medicaid program.

The Medicaid Program

Medicaid (Title XIX of the Social Security Act) is a jointly funded Federal-State health program for eligible low-income and needy individuals. It covers approximately 41 million individuals,[3] including children, the aged, blind, and/or disabled, and people

who are eligible to receive federally assisted income maintenance payments. In Fiscal Year 1999, the Federal and State Governments jointly expended $180.9 billion to provide for medical care to Medicaid beneficiaries. These expenditures are projected to increase to $285 billion by Fiscal Year 2005.[4] The HCFA provides Federal oversight for the Medicaid program.

States are allowed, within Federal laws, regulations, and program policies, to exercise discretion in the methods used to administer, operate, and reimburse services for their Medicaid programs. As a result, States utilize diverse procedures including the processes used to determine if providers are, or continue to be, eligible for participation in the program. Nonetheless, the Federal Government retains an obligation to ensure that Medicaid beneficiaries receive services only from qualified providers and that excluded providers do not receive reimbursement from the Medicaid program.

Medicaid Enrollment and Credentialing Process Requirements

States have more than 35 years of experience enrolling and credentialing Medicaid providers. Whether operating traditional fee-for-service or managed care programs, States must ensure that providers are legally authorized to participate in the program. States accomplish this through enrollment (obtaining information from the provider on an enrollment form) and credentialing (independently verifying the enrollment and other qualifying information). Although States may contract with external entities to perform provider credentialing, they are ultimately responsible for these activities.

The HCFA requires States, as part of the credentialing process, to determine if a provider applying to participate in the Medicaid program has a valid professional license (and certification by specialty where applicable). HCFA also requires States to obtain from the provider pertinent operational information for entry into the Medicaid Management Information System, including name, address, Social Security number or Employer Identification Number, and provider type. (Appendix A contains a list of the enrollment and credentialing information HCFA requires for the Medicaid Management Information System).[5]

The Social Security Act § 1128 prohibits Federal Medicaid funds from being used to pay for services furnished by providers who have been excluded from Medicaid, Medicare, or other Federal programs. Providers can be excluded for convictions for program-related crimes, patient abuse, fraud, or license revocation or suspension. The Act provides that the Secretary is responsible for excluding providers from Federal health care programs, including Medicaid. As part of the credentialing process, States should ascertain whether a provider has been excluded to prevent improper payments to them.

In addition to the legislative and HCFA requirements, States can also establish their own enrollment and credentialing processes. For example, States can utilize a variety of practices, including bonding, background checks, and fingerprinting, to insure that providers are reputable, competent, and accountable.

Upon completion of the Medicaid State Agency's credentialing process, providers are issued a provider identification number, commonly referred to as a PIN. A valid provider identification number implies that the individual or entity using that number meets the legal requirements for participation in the program and that claims submitted by that individual or entity using the number also meet the legal requirements for program participation.

Medicaid Re-credentialing and Provider Identification Number Deactivation

While not required, States can re-enroll and re-credential providers to insure they continue to meet the legal requirements for participation in the Medicaid program. Periodically, States can request individuals or entities to resubmit some or all of the information provided during the initial enrollment and credentialing process. States can then re-verify the provider-supplied information and recheck available electronic data sources. These processes provide additional protections for both Medicaid beneficiaries and the Medicaid program.

States may deactivate provider identification numbers for various reasons. For example, States may deactivate these numbers when providers retire, cease business operations, move their practices or operations, or when they are excluded from Medicare, Medicaid or other Federal health care programs. This process offers additional protections by preventing unscrupulous individuals or entities from using valid provider numbers to imply that they have completed the enrollment and credentialing processes and meet the legal requirements for participation in the program.

Medicare Enrollment and Credentialing

In contrast to HCFA's limited standards for enrollment and credentialing in the Medicaid program, it has recently implemented uniform and comprehensive standards for these processes in the Medicare program (see Appendix B).[6] HCFA requires:

- initial credentialing, which includes a written application that is signed, dated, and includes a statement of attestation;
- verification of license from primary sources; and
- determination of disciplinary status and eligibility of payment under Medicare.

Further, HCFA is proposing regulations to further strengthen Medicare requirements to include:

- site visits to providers' offices, as appropriate;
- re-credentialing at least every 3 years to update the initial credentialing information;
- deactivation of unused provider numbers after 6 months; and
- establishing standard procedures for the reactivation of Provider numbers.

Legislative Changes Impacting Provider Enrollment and Credentialing

On August 21, 1996, Congress passed "The Health Insurance Portability and Accountability Act of 1996," (Public Law 104-191). One aspect of this law calls for the creation of a standard health care provider identifier for all Federal, State, and private health insurance programs. Health care providers will only be enumerated once. The number assigned will be used by all health care payers. In response to this law, HCFA published a Notice of Proposed Rulemaking in the *Federal Register* that will establish such an identifier. At the time of our review, it is unclear what impact the assignment of common identifiers will have on States' enrollment and credentialing efforts.

METHODOLOGY

We utilized mail surveys to obtain information from the managers of Medicaid provider enrollment for the 50 States and the District of Columbia. Tennessee is not included in our calculations, since its Medicaid program is 100 percent managed care. We based our surveys on:

- document reviews (e.g., Enrollment and Credentialing policies, procedures, forms, and pertinent State laws and regulations);
- surveys;
- discussions with HCFA and Medicaid State agencies staff;
- reviews of pertinent Federal laws, regulations, and procedures; and
- reviews of Medicaid Management Information System (MMIS) data elements related to provider enrollment and credentialing.

To provide a more extensive review of States' Medicaid enrollment and credentialing efforts, we developed additional questions based on our review of the Medicare standards. We received a 100 percent response rate from the mailed surveys.

We encoded the survey responses and the information obtained from the documentation reviews into a data file and tabulated the results using SAS® software. We performed cross tabulation analysis to verify the accuracy and consistency of the responses. Using the survey responses, we compared the States' policies and procedures.

We conducted this inspection in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Our study found various areas of vulnerability in States' enrollment and credentialing processes for Medicaid providers. These weaknesses may have negatively impact their on-going program integrity efforts.

States, within Federal Regulations, are allowed to determine how they will credential their providers. These requirements may be stringent in one State, but less stringent in another. States with the least stringent requirements risk having unlicensed, unqualified, or "problem" providers migrating to their States. This could include providers whose licenses have been revoked, restricted, or whose claims are under medical review.

We also found that most States have either partially or fully contracted out the function of enrollment and credentialing to a Fiscal Agent in the private sector. However, States remain ultimately responsible for ensuring providers meet Federal and State program participation requirements.

Twenty-five States are not collecting all required enrollment and credentialing information

While all States report they input enrollment information into the Medicaid Management Information System, 25 States are not obtaining from the provider all pertinent enrollment and credentialing information (e.g., group name, group address, type of provider, and type of organization) as required by HCFA for entry into the system (refer to Appendix A). For example, Alabama collects all of the required data elements, while Oklahoma and Virginia only collect 7 of these elements. Table 1 shows the variance of information not obtained by the States for input into the Medicaid Management Information System.

Table 1

MMIS required data elements	Number of States who do not obtain this data[1]
Previously Assigned Medicaid Provider Number	9
Group Name	3
Group Address	9
Group Number	9
Type of Practice Organization	13
Employer Identification Number	2
Social Security number	2
Medicare Provider Identification Number	2

[1] Tennessee did not respond to this survey because its Medicaid program is 100 percent managed care.
Data Source: Office of Inspector General, Office of Evaluation and Inspections survey.

States' verification of providers' exclusion status is incomplete

States must determine a provider's Medicare, Medicaid, and other Federal programs exclusion status before assigning a Medicaid provider number. We found that all States independently verify that applicants for Medicaid provider numbers have not been excluded from either the Medicare or Medicaid programs. States accomplish this verification primarily through a review of the Medicare/Medicaid Sanction-Reinstatement Report (HCFA publication 69), HCFA's official notice of Medicare or Medicaid exclusion actions. Other sources used include the Inspector General's Internet site and the Healthcare Integrity and Protection Data Bank.

However, this verification alone does not protect the Medicaid program from enrolling providers who have been excluded from all Federal programs, contracts, and funding by the General Services Administration. We found only seven States reviewed the General Services Administration's "List of Parties Excluded from Federal Procurement and Nonprocurement Programs."[7] The list, issued monthly in both hard copy and on the Internet, identifies parties excluded throughout the U.S. Government from receiving Federal contracts or certain subcontracts and from certain types of Federal financial and non financial assistance and benefits. Parties found on this list are individuals, entities, and contractors (e.g., Tri-Care, or VA providers). Information on the list is limited to the name of the individual or company, address, the type of exclusion code, the government agency initiating the exclusion, and the time period for the exclusion. It does not contain unique identifiers normally used for computer matching and comparison, such as Social Security numbers or Employer Identification Numbers.

The "Federal Acquisition Streamlining Act of 1994" (Public Law 103-355) § 2455 states "No agency shall allow a party to participate in any procurement or nonprocurement activity if any agency has been debarred, suspended, or otherwise excluded that party from participation in a procurement or non procurement activity." As a result, States may be incorrectly using Federal funds to pay for services furnished by a provider who is debarred from all Federal programs, including Medicaid.

Many States accept provider enrollment statements without independently verifying the information

The HCFA national standards for Medicare contractors require independent verification of provider enrollment information. However, we found that 19 States do not contact independent sources to verify information for Medicaid providers. In addition, only two States in our survey contact other States' Medicaid Agencies to identify past practice problems. (Refer to Appendix C for further detail.)

In contrast, some States have developed creative mechanisms for verifying enrollment and credentialing information from independent sources, as reported in our inspection report *Medicaid Proactive Safeguards*, OEI-05-99-00070, July 2000. For example,

California obtains the names of manufacturers and suppliers who have business relationships with applicants for Medicaid provider numbers. The State Medicaid Agency then contacts the manufacturers and suppliers to verify application information. In Florida, the State agency compares information provided to the applicant's bonding company with information supplied to them during provider enrollment.

Only two-thirds of the States make use of information available from external sources

Only 33 of the 50 States routinely gather information from external sources concerning past investigations or prior practice patterns. External entities, such as the Medicare carriers, private insurers, other Medicaid State Agencies and Medicaid Fraud Control Units may have important information about providers practicing within the State that would be useful in the credentialing process. Similarly, for providers moving from out of State, the corresponding entities from the previous location will have fundamental historic information on a provider's qualifications, disciplinary issues, and patterns of practice that would assist the new State in properly credentialing and establishing appropriate Medicaid payment utilization controls. Table 2 provides information on the extent of States' information sharing.

Table 2

Medicaid State Agencies Coordination of Information

Coordinating Agencies	Number of States[1]
Medicare Contractor (s) within the State	15
Medicaid Fraud Control Unit within the State	31
State Licensing Agency(s) within the State	25
Private Insurance Companies	2
Other: HCFA, State Offices, Other States, Managed Care Organizations, State Utilization Review Office	5

[1] Tennessee did not respond to this survey because its Medicaid program is 100 percent managed care.

Data Source: Office of Inspector General, Office of Evaluation and Inspections survey.

Most States have not established aggressive post credentialing procedures

Post credentialing includes the re-enrollment and re-credentialing of active providers, the deactivation of numbers no longer being used, and the reactivation of deactivated numbers.

Re-enrollment and re-credentialing

The HCFA has implemented national standards for the enrollment and credentialing of Medicare providers and is proposing standards for periodic re-enrollment and re-credentialing. In contrast, HCFA has not imposed similar requirements for Medicaid providers. On their own initiative, 18 States perform some type of provider re-enrollment and re-credentialing; the remaining 32 States do not. While States like the concept of periodic re-enrollment, they cite the lack of staff, resources, and legislative support for such an undertaking. In support of re-enrollment and re-credentialing, the State of Florida reports that it has re-enrolled all of its Medicaid providers and, as a result, reduced the number of active Medicaid provider numbers from nearly 83,000 in 1995 to about 60,000 in 1999.

Deactivation of provider numbers

We found that 35 States deactivate Medicaid provider identification numbers with no recent claims activity. This time frame for deactivation due to inactivity ranges from 12 to 60 months, with a median of 24 months. In contrast, HCFA requires its Medicare contractors to deactivate numbers after 12 months of no claims activity, and is considering a further reduction to 6 months. Appendix D provides additional details concerning the States' criteria and time periods for the deactivation of provider numbers.

Reactivation of Provider Numbers

States use diverse processes for reactivation of provider identification numbers. Twenty-eight States require a new application and perform some form of credentialing. Others will reactivate the number upon the submission of a new claim. For example, we found that:

- five States will reactivate a provider identification number based upon an abbreviated enrollment application with partial validations of the information.
- five States will reactivate a provider identification number from a new claim that has not been active within 1-2 years.
- four States will reactivate a provider identification number using other procedures (i.e., when providers give a written statement requesting reactivation of number; depending on the time of the deactivation; or if a number was deactivated because of a wrong address).

States that do not re-enroll and re-credential prior to reactivating a provider identification number risk making the Medicaid program accessible to unauthorized persons who could reactivate a provider's number without their knowledge.

Some States report the use of additional enrollment and credentialing safeguards

As shown in Table 3, we found that some States have implemented enrollment and credentialing criteria that exceed the minimum Federal requirements. These additional processes afford additional protections for both Medicaid beneficiaries and program funds.

Table 3

States' Enrollment and Credentialing Criteria that Exceeds Federal Requirements

Enrollment/credentialing process	Number of States[1]
Criminal background checks (all providers)	1
Criminal background checks (some providers)	9
Fingerprinting (all providers)	1
Fingerprinting (some providers)	3
On-site visits to provider office(s)	10
Verify providers' telephone numbers are working	8

[1] Tennessee did not respond to this survey because its Medicaid program is 100 percent managed care.

Data Source: Office of Inspector General, Office of Evaluation and Inspections survey.

RECOMMENDATIONS

We believe HCFA can do more to strengthen enrollment and credentialing requirements to safeguard the Medicaid program, while supporting those States that implement additional measures to prevent Medicaid provider fraud and abuse. Current Federal requirements are insufficient to adequately protect beneficiaries or the Medicaid program.

We recommend HCFA take the following actions to safeguard the Medicaid program.

Strengthen the enrollment, re-enrollment, and credentialing requirements of Medicaid providers

The HCFA, in conjunction with States, should strengthen the enrollment and credentialing standards by duplicating or closely paralleling those currently being used for the Medicare program. Additionally, when proposed enhancements to Medicare's enrollment and credentialing processes are implemented these standards should also be applied to the Medicaid program. Implementing national standards would not limit States from imposing additional enrollment and credentialing requirements on its providers. Rather, they will provide a strong, consistent level of minimum processes for all States. Further, since HCFA is planning the conversion from a variety of provider identification numbers to the National Provider Identifier, establishing accurate and consistent Medicaid enrollment, credentialing, and re-credentialing standards are vital.

Instruct States to independently verify the provider's exclusion status from all Federal programs

States, and third-party enrollment and credentialing organizations, need to determine a provider's exclusion status by reviewing both the monthly "Medicare/Medicaid Sanction-Reinstatement Report" (HCFA Publication 69) and the General Services Administration's "List of Parties Excluded from Federal Procurement and Nonprocurement Programs." As part of a provider's re-enrollment, and re-credentialing processes, the HCFA Publication 69 and the GSA listings should also be checked. The HCFA should encourage the General Services Administration to improve the usability and data matching capability of their "List of Parties Excluded from Federal Procurement and Nonprocurement Programs.

Require States to obtain provider information from other States and Federal entities

In line with the future move toward common provider identification numbers, HCFA should require States, as part of credentialing, to contact Medicare carrier(s), other Medicaid State Agencies, and the Medicaid Fraud Control Units for information regarding out-of-State providers and providers that have recently relocated to the State. These contacts could help identify any past criminal, legal, licensing and utilization issues, thereby reducing inappropriate payments to the provider. For providers with a past history of claim abuse, it will allow States to implement appropriate controls (e.g., system edits) at the point when the provider is enrolled into the State's Medicaid program. In addition, HCFA should require States to maintain ongoing communication with Medicare carrier(s) and the fraud units in the State to similarly identify providers with legal or utilization issues. This communication will help all parties obtain an early alert when aberrant claims, quality of care, utilization, or legal matters are identified and could help to reduce program losses.

Establish standards and processes for the deactivation and reactivation of provider identification numbers

The HCFA should establish national standards and protocols for the deactivation and reactivation of Medicaid provider identification numbers. The current inconsistency in States' methods of deactivating and reactivating numbers is no longer acceptable, since it does not adequately protect Medicaid beneficiaries and program funds from the potential utilization of inactive numbers by unscrupulous individuals and entities. In contrast, the Medicare program is addressing this important issue by considering a policy revision to require the deactivation of inactive provider numbers after 6 months of claims inactivity. HCFA, in conjunction with States, should similarly address this problem in the Medicaid program.

AGENCY COMMENTS

The HCFA generally agreed with the underlying intent of our recommendations for strengthening enrollment and credentialing standards, sharing information among the States and Federal entities, and deactivating inactive provider identification numbers. However, they believe such improvements should be made by working with and advising States rather than adoption of additional stricter Federal requirements. Appendix E contains the complete text of these comments.

We understand HCFA's desire to work collaboratively with States to improve and strengthen Medicaid provider credentialing. However, if this approach is not successful in achieving the needed improvements, HCFA may want to consider implementing more prescriptive credentialing policies.

ENDNOTES

1. The term States, as used in this report, includes the 50 States and the District of Columbia.

2. Source: State Medicaid's Fraud Control Units Annual Report dated June 2000.

3. Source: Health Care Financing Administration, Medicaid Information System (MSIS), HCFA 2082 report (Table 1) produced on January 27, 2000

4. Source: Health Care Financing Administration Internet Site, Publications and Forms, Medicaid Information, Actuarial Products, (http://www.hcfa.gov/pubforms/actuary/ormedmed/default4.htm) January 22, 2001.

5. Source: State Medicaid Manual Part 11 § 11375.

6. Source: Medicare Carriers Manual, Professional Relations, (Pub. 14-4) § 1030.5D.

7. This listing, available through the Internet or by subscription, is a monthly compilation of individuals and entities that are excluded throughout the U.S. Government from receiving Federal contracts or funding.

APPENDIX A

Provider Information Required by The Medicaid Management Information System (MMIS)

The State Medicaid Manual Part 11, Section 11320, specifies that the following provider enrollment and credentialing information outlined in the following table must be obtained and entered into MMIS in order to meet Federal Reporting requirements. However, some States are not obtaining this information.

States	Total Enrollment Data Elements Obtained	Name	Address	Previously Assigned Medicaid Provider Number	Payment Mailing Address	Group Name	Group Address	Group Number	Type of Provider	Type of Practice Organization	Employer Identification Number	Social Security number	Medicare Provider Identification Number
Alabama	12	√	√	√	√	√	√	√	√	√	√	√	√
Alaska	12	√	√	√	√	√	√	√	√	√	√	√	√
Arizona	11	√	√	√	√	√	√	√	√		√	√	√
Arkansas	12	√	√	√	√	√	√	√	√	√	√	√	√
California	11	√	√	√	√	√	√	√	√		√	√	√
Colorado	11	√	√	√	√	√	√	√	√	√	√		√
Connecticut	12	√	√	√	√	√	√	√	√	√	√	√	√
Delaware	10	√	√	√	√	√			√	√	√	√	√
District of Columbia	11	√	√	√	√	√	√	√	√		√	√	√
Florida	12	√	√	√	√	√	√	√	√	√	√	√	√
Georgia	9	√	√	√	√				√	√	√	√	√
Hawaii	12	√	√	√	√	√	√	√	√	√	√	√	√
Idaho	11	√	√	√	√	√	√	√	√		√	√	√
Illinois	12	√	√	√	√	√	√	√	√	√	√	√	√
Indiana	12	√	√	√	√	√	√	√	√	√	√	√	√
Iowa	12	√	√	√	√	√	√	√	√	√	√	√	√
Kansas	12	√	√	√	√	√	√	√	√	√	√	√	√
Kentucky	12	√	√	√	√	√	√	√	√	√	√	√	√
Louisiana	12	√	√	√	√	√	√	√	√	√	√	√	√
Maine	12	√	√	√	√	√	√	√	√	√	√	√	√
Maryland	12	√	√	√	√	√	√	√	√	√	√	√	√
Massachusetts	12	√	√	√	√	√	√	√	√	√	√	√	√

States	Total Enrollment Data Elements Obtained	Name	Address	Previously Assigned Medicaid Provider Number	Payment Mailing Address	Group Name	Group Address	Group Number	Type of Provider	Type of Practice Organization	Employer Identification Number	Social Security number	Medicare Provider Identification Number
Michigan	9	√	√		√	√	√		√		√	√	√
Minnesota	11	√	√	√	√	√	√	√	√	√	√	√	
Mississippi	10	√	√	√	√	√		√	√		√	√	√
Missouri	12	√	√	√	√	√	√	√	√	√	√	√	√
Montana	12	√	√	√	√	√	√	√	√	√	√	√	√
Nebraska	10	√	√		√	√	√		√	√	√	√	√
Nevada	11	√	√	√	√	√	√	√	√	√	√	√	
New Hampshire	12	√	√	√	√	√	√	√	√	√	√	√	√
New Jersey	12	√	√	√	√	√	√	√	√	√	√	√	√
New Mexico	11	√	√	√	√	√	√	√	√		√	√	√
New York	11	√	√	√	√	√		√	√	√	√	√	√
North Carolina	10	√	√	√	√	√		√	√		√	√	√
North Dakota	11	√	√		√	√	√	√	√	√	√	√	√
Ohio	12	√	√	√	√	√	√	√	√	√	√	√	√
Oklahoma	7	√	√		√				√		√	√	√
Oregon	9	√	√		√	√	√		√		√	√	√
Pennsylvania	12	√	√	√	√	√	√	√	√	√	√	√	√
Rhode Island	10	√	√	√	√	√	√		√		√	√	√
South Carolina	10	√	√		√	√	√	√	√		√	√	√
South Dakota	10	√	√	√	√	√	√		√	√		√	√
Tennessee [1]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Texas	10	√	√		√	√	√	√	√	√		√	√
Utah	10	√	√		√	√		√	√	√	√	√	√
Vermont	10	√	√	√	√	√		√	√		√	√	√
Virginia	7	√	√		√				√	√	√		√
Washington	12	√	√	√	√	√	√	√	√	√	√	√	√
West Virginia	12	√	√	√	√	√	√	√	√	√	√	√	√
Wisconsin	12	√	√	√	√	√	√	√	√	√	√	√	√
Wyoming	12	√	√	√	√	√	√	√	√	√	√	√	√
Total		**50**	**50**	**41**	**50**	**47**	**41**	**41**	**50**	**37**	**48**	**48**	**48**

[1] Tennessee did not respond to this survey because its Medicaid program is 100 percent managed care.

Data Source: Office of Inspector General, Office of Evaluation and Inspections survey.

APPENDIX B

Medicare Program Provider Enrollment and Credentialing Requirements

The Health Care Financing Administration requires its intermediaries and carriers to obtain a wide range of provider enrollment and credentialing information including:

- a completed provider enrollment application;
- authenticating their Social Security number;
- validating their Employer Identification Number;
- establishing if the applicant is properly licensed, certified and registered under State law;
- Obtaining independent evidence of qualifying course work from educational institution(s) where the applicant received his medical, professional, or related training, diplomas, or degrees;
- affirming the applicant's board certification(s) and speciality(ies);
- determining if the business name listed on the enrollment form is consistent with the name reported to the Internal Revenue Service;
- authenticating the legitimacy of the applicant's business address;
- determining if there are other business owners;
- establishing that all physicians in group practices are enrolled individually prior to enrolling the group;
- verifying the applicant's listed affiliation with multiple campus units, and off site units;
- authenticating that the applicant and associated entities are not excluded from the Medicare, Medicaid, and other Federal programs;
- determining whether the applicant and associated entities have previously obtained Medicare Provider Identification Numbers (PINs) from other Medicare contractors; and
- establishing whether the applicant has previous overpayments or problems with other Medicare contractors.

Medicare Carriers Manual, Professional Relations (Pub 14-40 § 1030.5D) provides further detail concerning the Medicare program's enrollment and credentialing requirements.

APPENDIX C

Independent Validation of Provider Enrollment and Credentialing Information

Type of information	Number of States[1] validating the information
Business Organizations using contractors, and that the contractor has not been excluded from other Federal programs	3
Business Organizations using contractors, and that the contractor has not been excluded from Medicare/Medicaid	3
Business Organization using Contractor and that Name, Address, Social Security number and Employer Identification Number is correct	2
Contact with the Medicare Carrier for the provider's current practice location to identify current problems, overpayments, etc.	0
Contact with Medicaid Fraud Control for the provider's prior practice location to identify past problems, overpayment, etc	3
Contact with Medicare Carrier of the State for the providers's prior practice location (if out of State) to identify past problems, over payments, etc.	0
Contact with Medicaid State Agency for the provider's prior practice location to identify past problems, overpayment, etc	2
Group practices - the legal business name used to report to the IRS	9
Group applications - that all individuals members are not excluded from other Federal program	11
Group applications - that all individual members are enrolled individually	7

Type of information	Number of States[1] validating the information
Group applications - that all individual members are not excluded from the Medicare/Medicaid	13
Provider speciality	8
Provider's authorized representative	2
Provider's billing agency/management service organization address	4
Provider's change of ownership information	7
Provider's office telephone number	4
Provider's office FAX number	0
Provider's prior practice location	1
Provider's UPIN physicians only, (M.D.'s, D.O.'s, D.P.M.'s, D.C.'s, O.D.'s, and psychologist)	1
Query the National Practitioner Data Bank to identify any license revocations, loss of clinical privileges, loss of professional society memberships, and malpractice settlements	3
Query to the Healthcare Integrity and Protection Data Bank (all providers) to identify civil judgement, Federal or State criminal convictions, actions by licensing and certification authorities, and records of exclusions from Federal and State health care programs	2

[1] Tennessee did not respond to this survey because its Medicaid Program is 100 percent managed care

Data Source: Office of Inspector General, Office of Evaluation and Inspections survey.

APPENDIX D

States' Deactivation of Provider Identification Numbers

State	Retirement	Relocated out of State	Death of Provider	Age	No Recent Claims Activity	Inactive Claim Time Period
Alabama	√	√	√		√	24
Alaska			√		√	60
Arizona	√		√		√	24
Arkansas	√		√		√	12
California	√	√	√		√	18
Colorado	√	√	√		√	60
Connecticut	√	√	√			
Delaware	√	√	√			
District of Columbia	√		√		√	24
Florida	√	√	√		√	36
Georgia	√	√	√		√	12
Hawaii	√	√	√		√	60
Idaho	√	√	√		√	24
Illinois	√	√	√		√	18
Indiana	√	√	√			
Iowa	√	√	√		√	24
Kansas	√	√	√		√	18
Kentucky	√	√	√			
Louisiana	√	√	√		√	12
Maine	√	√	√		√	24
Maryland	√	√	√			
Massachusetts	√	√	√			
Michigan	√	√	√			
Minnesota	√	√	√		√	24
Mississippi	√		√		√	Not Established
Missouri	√		√		√	24
Montana	√	√	√			
Nebraska	√	√	√		√	24
Nevada	√	√	√		√	24
New Hampshire	√	√	√		√	24
New Jersey	√		√			
New Mexico	√		√		√	24
New York	√	√	√		√	24
North Carolina	√	√	√			
North Dakota					√	24
Ohio	√	√	√		√	36
Oklahoma	√		√			
Oregon	√		√		√	18

State	Retirement	Relocated out of State	Death of Provider	Age	No Recent Claims Activity	Inactive Claim Time Period
Pennsylvania			√		√	12
Rhode Island	√		√			N/A
South Carolina	√		√		√	12
South Dakota	√	√	√		√	12
Tennessee [1]	N/A	N/A	N/A	N/A	N/A	N/A
Texas			√		√	12
Utah	√	√	√		√	4
Vermont	√	√	√			N/A
Virginia	√	√	√		√	36
Washington	√		√		√	24
West Virginia	√	√	√		√	24
Wisconsin	√	√	√			N/A
Wyoming	√	√	√			12
State Totals:	**46**	**34**	**49**	**0**	**35**	----------

[1] Tennessee did not respond to this survey because its Medicaid Program is 100 percent managed care.
Data Source: Office of Inspector General, Office of Evaluation and Inspections survey

APPENDIX E

Agency Comments

DATE: JAN - 5 2001

TO: June Gibbs Brown
Inspector General

FROM: Robert A. Berenson, M.D. Robert A. Berenson M.D.
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: Credentialing of Medicaid Providers: Fee-for-Service," (OEI-07-99-00680)

Thank you for the opportunity to review and comment on the above report.

The Health Care Financing Administration (HCFA) recognizes the importance of proper credentialing of those providing health care services to Medicaid beneficiaries. As guardians of the Medicaid program, it is HCFA's undisputed responsibility to assure that high quality health care is provided to Medicaid's beneficiaries, who, almost by definition, are among the most vulnerable members of society.

We are quite concerned about the findings of the OIG that many States are failing to properly determine the professional status of many providers that apply to participate in the Medicaid program. We are also troubled by the finding that "many States accept provider enrollment statements without independently verifying the information," and that States need to do a better job of determining whether a provider has been excluded from Medicare or Medicaid participation before issuing a Medicaid provider number.

Because of our high degree of concern, HCFA is already working closely with State Medicaid programs on strengthening their fraud and abuse control activities. HCFA is taking proactive measures to increase program safeguard activities by strengthening the provider enrollment process in the Medicaid program through its National Medicaid Fraud and Abuse (F&A) Initiative. The Medicaid F&A Initiative concluded program integrity reviews in eight States during FY 2000 and will be conducting eight more during FY 2001. One of the main areas of focus during these reviews was the provider enrollment process in States. The findings from these reviews indicate that many States have already implemented some of the recommendations provided by OIG in this report.

Below are our comments on the report recommendations:

OIG Recommendation
Strengthen the enrollment, re-enrollment, and credentialing requirements of Medicaid

providers.

HCFA Response
We agree that effective and appropriate provider enrollment is a critical aspect of protecting the integrity of the Medicaid program. We also agree with the OIG's recommendation to continue our work to strengthen these functions within States. However, we believe that imposing additional Federal requirements on States may not be the best way to accomplish this goal.

We believe that the path we have chosen to work on this issue with the States will yield the best results in the least amount of time. While we always reserve the option of developing additional Federal requirements, our approach has focused on a series of steps: disseminating information on promising approaches; conducting reviews of provider enrollment in States; and carefully analyzing the possibilities for Medicare-Medicaid interaction on provider enrollment. As the national provider system is developed, additional opportunities may be identified on how the Federal and State governments can best work together to avoid duplication of effort, exchange information, and share responsibilities.

Provider enrollment is composed of three distinct and important parts, for which different solutions may be appropriate. The first is the collection of information—the decision on what information to collect, and the mechanical process of collecting and maintaining the information. The second area is validation—the decision on how to ensure that the information provided is accurate and true, and the mechanical process of carrying out the validation. The third area is standard setting—the decision on where to set the bar for entry into the program, what triggers acceptance or rejection, and the mechanical process for making and enforcing those decisions.

We believe that, at this juncture and based on this analysis, it would be premature for us to agree to new Federal requirements on States. With Medicare changes and other Federal activity (such as the National Provider Identifier) underway, we should carefully assess where and when to apply other Federal mandates, particularly as they relate to the collection of data from providers and programming changes at the State level.

We are in the process of examining the potential benefits of a Medicare "buy-in" for States for part or all of their provider enrollment activity. Under this concept, States could take advantage of Medicare's data collection and validation system for providers who do business with both programs. We believe that this concept holds promise for enhancing the integrity of provider information, reducing costs for States, and minimizing burden on providers.

In the interim, States continue to collect information from providers as required in existing regulations. The Medicaid F&A Initiative will take responsibility to incorporate into the Regional Office Review Guide, a new focus on expanding State collection of information of

all required enrollment and credentialing information as specified in the State Medicaid Manual, Part II. The Regional Office Review Guide contains the procedures used to review program integrity efforts in States. This addition will become effective with the reviews conducted during FY 2001.

OIG Recommendation
Instruct States to independently verify the provider's exclusion status from all Federal programs.

HCFA Response
We concur that States should independently verify the provider's exclusion status from Federal programs. The Medicaid Fraud and Abuse Team released two State Medicaid Director letters in May 2000. The first letter reminded States to use the HCFA Pub. 69 monthly and OIG sanction web sites as tools for ascertaining and verifying whether a provider is excluded. HCFA Pub. 69 is available in both electronic format and hard copy. The second letter reminded States of their obligation to notify the OIG when an administrative sanction is imposed against a Medicaid program provider.

In addition, in response to concerns from some contractors and States having difficulty using the OIG exclusion data in enforcing sanctions, States will soon be given access to the Medicare Exclusion Database (MED). The MED contains provider information obtained from the OIG. We are working diligently so States can access the MED database online as soon as possible.

We have heard from States and other Federal programs that using General Services Administration's (GSA) "List of Parties Excluded from Federal Procurement and Nonprocurement Programs" is cumbersome and time consuming. This is a long-standing problem. Consequently, it is difficult to do a data match to compare all the names in the GSA supplier book to a monthly exclusion list.

OIG Recommendation
Require States to obtain provider information from other States and Federal entities.

HCFA Response
As discussed in our previous responses, we continue to explore ways to strengthen provider enrollment in a variety of different ways. Utilizing external information from States and Federal entities may assist States in validating key information suggested by providers or obtaining new information relevant to enrollment or disenrollment actions.

However, as we indicated previously, we lack sufficient basis to concur with the recommendation for new Federal requirements at this time. We believe continuing to work closely with States

to improve communication would better facilitate identifying past criminal, legal, licensing, and utilization issues of providers.

OIG Recommendation
Establish standards and processes for the deactivation and reactivation of provider identification numbers.

HCFA Response
The findings from the program integrity reviews indicated that many States are taking more aggressive steps to deactivate and reactivate provider identification numbers. However, we do not concur with the establishment of a national standard for States to follow for deactivation of inactive provider numbers after a 6-month period. More and more States are implementing deactivation standards, but the inactive billing period generally ranges from 12 months to 24 months. While a 6-month deactivation period may be beneficial in some States, it may not be in others. Nevertheless, the newly formed Federal/State Workgroup on Provider Enrollment will address this issue in their efforts to develop safeguards and strengthen the provider enrollment processes in both Medicare and Medicaid.