



**BEST PRACTICES
FOR MEDICAID PROGRAM INTEGRITY UNITS'
COLLECTION OF DISCLOSURES
IN PROVIDER ENROLLMENT**

Medicaid Integrity Group

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Introduction

The Centers for Medicare & Medicaid Services (CMS) and the Center for Program Integrity's Medicaid Integrity Group (MIG) are committed to providing effective support and assistance to States in their efforts to combat provider fraud and abuse. The MIG's State Program Integrity Reviews are a form of support and assistance to the States in which we: determine States' compliance with Federal program integrity laws and regulations; identify program vulnerabilities and effective practices; help the States improve overall program integrity efforts; and consider opportunities for future technical assistance to States.

We recognize that the States' first line of defense in program integrity is provider enrollment: preventing providers who should not be in the Medicaid program from becoming enrolled. Federal program integrity regulations require States to obtain certain disclosures from providers upon enrollment and periodically thereafter. When States obtain these disclosures and search exclusion and debarment lists and databases, States can take appropriate action on providers' participation in the Medicaid program. This Best Practices document is intended to further that objective. While these recommendations are not all-inclusive, we hope that the ideas contained herein will assist the States and result in the strengthening of program integrity efforts nationwide.

RECOMMENDATIONS:

Meet regularly and coordinate enrollment policy with the provider enrollment section.

Most States have indicated that program integrity and provider enrollment are separate operational functions. However, the two functions are dependent upon each other for front end program integrity operations. Regular meetings between the two sections promote the communication that is necessary for the success of both sections. The parties can use the meetings to hone policy and ensure that documents meet regulatory requirements. More importantly, open communication fosters a shared sense of responsibility for the success of the operation.

In addition, the program integrity unit and provider enrollment sections should develop provider enrollment policy in concert to ensure that their policies adequately address Medicaid agency goals. The two sections should establish management controls to ensure adherence to policies in both operational functions, both in front end and on-going provider enrollment and in program integrity investigations and enforcement.

Examples: Georgia's program integrity (PI) and provider enrollment (PE) units, though part of different divisions within the Department of Community Health (DCH), communicate and cooperate with each other to an unusual extent. For example, the PI and PE units jointly conduct onsite reviews of skilled nursing facilities at which they screen all employees against both

the List of Excluded Individuals/Entities (LEIE) and the Excluded Parties List System (EPLS). The PI unit also performs supplementary provider enrollment functions during fraud and abuse onsite reviews, which helps compensate for PE unit staff limitations. DCH's more general use of the EPLS to check for Federal debarments, in addition to searching the LEIE for exclusions, is also commendable.

The Louisiana PI Unit not only works closely with the provider enrollment contractor, but supervises and monitors the provider enrollment functions as well. This arrangement allows for the State and its contractor to be "joined at the hip" from the initial process of enrolling providers to performing pre-payment claims reviews and providing statistical services such as sampling and extrapolation. Since all processes and procedures used by the contractor must be approved by State staff, the PI Unit's oversight greatly speeds up communications between the entities and allows them to achieve increased efficiencies.

Review your provider enrollment forms to ensure that the forms request all required disclosures under 42 CFR sections 455.104 and 455.106.

In the course of conducting State Program Integrity Reviews, we have found that the highest incidence of regulatory non-compliance is in the deficient collection of disclosures. The parties about whom the State Medicaid agency must collect disclosures, as well as the timing of the disclosures, have been subject to findings in many States. Federal regulations require collection of disclosures regarding ownership and control interests from the provider applicant, as well as from other parties associated with that provider entity, and from the fiscal agent. For purposes of section 455.104, the provider applicant is the *disclosing entity*, or any Medicaid provider (other than an individual practitioner or group practice) or fiscal agent. For purposes of section 455.106, the provider applicant is the provider (including an individual practitioner or group practice), which must disclose its own criminal convictions and the criminal convictions of other parties associated with the provider.

State agencies that contract with fiscal agents frequently have failed to obtain disclosures from the agents at the time of execution and renewal of the contracts and when ownership changes. States also have failed to ensure that these disclosures are obtained by other State agencies that directly handle the procurement. A change of ownership is a circumstance when an updated disclosure under section 455.104(b)(3) would be appropriate. The Federal regulation requires collection of disclosures from the State's fiscal agent prior to contract execution and requires termination of the contract if the fiscal agent fails to comply with Federal disclosure mandates. *See* 42 CFR section 455.104(c).

Likewise, State Medicaid agencies should collect ownership and control disclosures under section 455.104 from managed care organizations (MCOs), prepaid inpatient health

plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case managers (PCCMs) at the time of contract execution, upon a change of ownership, and upon request. Federal law prohibits MCOs and PCCMs from having business relationships with excluded individuals and entities. *See* section 1932(d)(1) of the Social Security Act. The Federal regulation at 42 CFR section 438.610 extended this prohibition to PIHPs and PAHPs, as well as MCOs and PCCMs. Federal regulations prohibit payment for items or services furnished by excluded individuals or entities, regardless of whether the items or services were provided under fee-for-service or managed care delivery systems. In State Medicaid Director Letter # 08-003, issued June 12, 2008, CMS said that State Medicaid agencies must determine whether providers applying to participate in the Medicaid program, including MCOs and PCCMs, are excluded.

We have also noted confusion in some States over whether the mandates in section 455.104 apply equally to not-for-profit and for-profit organizations. The regulation requires disclosure of ownership and control information from persons, who may be individuals or corporations, with a direct or indirect interest of five percent or more. *See* 42 CFR section 455.104(a)(1). The definition of “person with an ownership or control interest” includes one who “is an officer or director of a disclosing entity that is organized as a corporation.” 42 CFR section 455.101. Thus, State Medicaid agencies must collect disclosures from all provider applicants regardless of for-profit status.

Finally, we have noted problems in State provider enrollment forms. Some States’ forms have referred to the requirements of the Federal regulations but have not made space available to supply the required disclosures in their provider enrollment applications or agreements. For example, a contract clause may require submission of disclosures, but the contract provides no form on which to supply the disclosures, and the clause contains no specific references to the parties about whom disclosures must be made. In addition, some States use forms from sister State agencies and from Federal agencies, assuming these forms are compliant, when, in fact, they are not always compliant. In short, States must independently check their provider enrollment forms for compliance with Federal Medicaid regulations.

Example: As the result of CMS’ fiscal year 2007 review, Delaware took corrective action to update its disclosure collection process. It developed an automated process for collection of providers’ disclosures under sections 455.104, 455.105, and 455.106. The new provider disclosure statement form meets all regulatory requirements for initial disclosure collection. However, for any State to be compliant with section 455.105, the State must also include appropriate language in its provider agreement, as indicated below.

Key Actions

We recommend that States add a clause to their provider agreement and standard contract template requiring providers and fiscal agents to submit updated ownership

and control disclosures upon a change of ownership and at any time within 35 days upon written request. States might monitor compliance through routine communication with managed care entities or by the addition of a question on change of ownership or control in regular reporting documents.

State Medicaid agencies should solicit ownership and control disclosures from all managed care entities, that is, from MCOs, PIHPs, PAHPs, and PCCMs, at the time of contract or provider agreement execution, upon a change of ownership, as applicable, and upon request.

To be compliant with Federal Medicaid regulations, a State Medicaid agency must ensure that its forms solicit disclosures from all persons and entities required under the regulations. For ease of compliance, we recommend that the State Medicaid agency ensure that there is adequate space available on the form in which to supply the solicited information.

- ***To comply with disclosure requirements under 42 CFR section 455.104***
 - The State Medicaid agency must solicit disclosures from disclosing entities including the State's fiscal agent. [42 CFR §455.104(c)]
 - The disclosures must be obtained from a disclosing entity either when the disclosing entity is surveyed (if surveyed periodically), or before entering into or renewing the provider agreement (if not surveyed periodically). [42 CFR §455.104(b)(1), (2)]
 - Updated disclosures must be supplied within 35 days upon request. [42 CFR §455.104(b)(3)]
 - Disclosures from fiscal agents are required prior to approving the contract with the fiscal agent. [42 CFR §455.104(c)]
 - Disclosures from managed care entities must be provided prior to approving the contract with the managed care entity.
 - The State Medicaid agency must require disclosure of the following information:
 - The name and address of any person (individual or corporation) with ownership and control interest:
 - in the disclosing entity, or
 - in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more. [42 CFR §455.104(a)(1)]
 - Whether the person (individual or corporation) with ownership and control interest in the disclosing entity, or in any subcontractor in which the disclosing entity has a direct or indirect ownership of five percent or more, is related to another as a spouse, parent, child, or sibling. [42 CFR §455.104(a)(2)]
 - The name of any other Medicaid disclosing entity in which an owner of the disclosing entity has an ownership or control interest; or any entity that does not participate in Medicaid but is required to disclose certain

ownership and control information because of participation in any program established under titles V, XVIII, or XX of the Act in which an owner of the disclosing entity has an ownership or control interest. [42 CFR §455.104(a)(3)]

- ***To comply with disclosure requirements under 42 CFR section 455.106***
 - The State Medicaid agency must solicit disclosures from providers. [42 CFR §455.106(a)]
 - The State Medicaid agency must also obtain these disclosures from managed care entities.
 - The disclosures must be obtained before the State Medicaid agency enters into or renews a provider agreement, managed care, or PACE contract, or at any time upon the State Medicaid agency's request. [42 CFR §455.106(a)]
 - The State Medicaid agency must require disclosure of the following information:
 - The identity of any person or entity having an ownership or control interest in the provider *and* who has been convicted of a crime related to Federal health care programs. [42 CFR §455.106(a)(1), (2)]
 - The identity of any person who is a managing employee of the provider *and* who has been convicted of a crime related to Federal health care programs. [42 CFR §455.106(a)(1), (2)]
 - The identity of any person who is an agent of the provider *and* who has been convicted of a crime related to Federal health care programs. [42 CFR §455.106(a)(1), (2)]

Solicit managing employee disclosures.

Federal program integrity regulations at 42 CFR section 455.104 require disclosure from applicants of the identity of:

- the disclosing entity;
- persons with five percent or more ownership interest in the disclosing entity;
- subcontractors of the disclosing entity where the disclosing entity has a five percent or more ownership interest;
- family members of persons with ownership or control interest in the disclosing entity; and
- any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

Federal regulations at 42 CFR section 455.106 require disclosure of the identity of:

- persons with an ownership or control interest in the provider (including managing employees) who have been convicted of a crime related to Federal health care programs; and
- persons who are agents of the provider who have been convicted of a crime related to Federal health care programs, an agent being “any person who has

been delegated the authority to obligate or act on behalf of a provider.” 42 CFR section 455.101.

A managing employee is a “general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency.” 42 CFR section 455.101. Managing employees are in a position to exert influence over the conduct of the provider’s operations.

Only section 455.106 requires disclosure of the identity of managing employees. Therefore, States learn only the names of managing employees who have been convicted of health care related crimes, and not the identity of all managing employees associated with the providers enrolled in the States’ Medicaid programs.

Key Actions

We recommend that States solicit disclosure of both the name and address of all managing employees at the time the State solicits section 455.104 disclosures for the purpose of checking those managing employees for exclusion, in addition to the required disclosures of criminal convictions of managing employees under section 455.106.

Review your provider agreement and standard contract template for language requiring provision of business transaction disclosures upon request, as required under 42 CFR section 455.105.

Unlike 42 CFR sections 455.104 and 455.106, the regulation at 42 CFR section 455.105 does not require collection of disclosures regarding business transactions prior to entering into a provider agreement. Rather, section 455.105 mandates that the State Medicaid agency’s provider agreement require disclosure within 35 days notice from the State Medicaid agency or the Secretary of the U.S. Department of Health and Human Services (HHS) of: ownership information about any subcontractor with which the provider has had more than \$25,000 in business during the 12 month period ending on the date of the request; and information about any significant business transaction between the provider and a wholly owned supplier or between the provider and any subcontractor during the five year period ending on the date of the request.

Key Actions

- ***To comply with disclosure requirements under 42 CFR section 455.105***
 - The State Medicaid agency must be clear in its provider agreement that the provider must supply the required disclosures within 35 days upon demand. [42 CFR §455.105(b)]

- While the provider agreement must include a clear, unambiguous reference to the regulatory requirement, the reference can take different forms, including anything from the pertinent text from section 455.105 to a regulatory citation and reference to the requirement.
- The State Medicaid agency must require managed care entities to comply with this section by including appropriate language in the provider agreement or managed care or PACE contract.

Search appropriate lists and databases for the names of provider applicants, owners, directors, managing employees, and agents.

CMS' State Medicaid Director Letter # 08-003 issued June 12, 2008, provides guidance to States on screening for excluded providers and searching lists and databases for those excluded providers' names. In that letter, we recommended that States search either the Medicare Exclusion Database (the MED) or the HHS Office of Inspector General's (HHS-OIG) List of Excluded Individuals/Entities (LEIE). Furthermore, we recommended that States check the MED or the LEIE upon enrolling a provider and each month thereafter to capture those exclusions and reinstatements that have occurred since the State conducted the last search.

CMS' State Medicaid Director Letter # 09-001 issued January 16, 2009, provided additional guidance to States on searching the LEIE for the excluded employees and contractors of providers enrolled in the Medicaid program. In that letter, CMS recommended that States require that providers search the LEIE each month for the names of the providers' employees and contractors.

Another resource available to States is the Excluded Parties List System (EPLS), maintained by the U.S. General Services Administration (GSA) under the authority of Executive Orders 12549 and 12689. The EPLS is a comprehensive list of debarred and suspended individuals and firms excluded from receiving Federal contracts or certain subcontracts. Under Federal regulations, States may not use Federal dollars to fund the contracts of these excluded individuals or firms. "States must not make any award or permit any award (subgrant or contract) at any tier to any party which is debarred or suspended or is otherwise excluded from or ineligible for participation in Federal assistance programs under Executive Order 12549, *Debarment and Suspension*." 45 CFR section 92.35. While States are not required under Federal regulations to search the EPLS, it is the only comprehensive source for government-wide exclusions.

Example: The Texas Medicaid Healthcare Partnership (TMHP) purchased an innovative software package that automates the verification of licenses of potential Medicaid providers and ensures that Medicaid does not allow payments to non-qualified health care providers. The software allows TMHP to match a provider's information against the TMHP Master File, the Federal Provider Exclusion List, the Texas State Provider exclusion list, the Texas Medicaid Do Not Enroll List, and the Open Investigations

list, so the user can easily determine if the provider is eligible to be enrolled; thereby significantly reducing the risk that Medicaid recipients are receiving health care from excluded or restricted providers.

Key Actions

State Medicaid agencies should check either the MED or the LEIE upon enrolling a provider and each month thereafter to check for exclusions. We recommend that State Medicaid agencies check the MED or the LEIE for the names of provider applicants, owners, directors, managing employees, and agents.

We also recommend that State Medicaid agencies routinely check the EPLS for the names of provider applicants, owners, directors, managing employees, and agents.

- **The MED:** Available to States by e-mail each month and through CMS' Application Portal.
- **LEIE:** http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp
- **EPLS:** <https://www.epls.gov/>

Report to the Regional HHS-OIG any adverse actions taken on providers' participation in the Medicaid program and providers' criminal convictions.

Federal regulations require State Medicaid agencies to report to the HHS-OIG actions the State has taken on a provider's application for participation in the Medicaid program and any action to limit a provider's participation in the Medicaid program, including "suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program to avoid a formal sanction." *See* 42 CFR section 1002.3(b)(2), (3). In addition, State Medicaid agencies must notify HHS-OIG of providers' criminal convictions related to the delivery of health care under the Medicaid program if the State's Medicaid Fraud Control Unit (MFCU) has not provided notice to HHS-OIG. *See* 42 CFR section 1002.230.

State Medicaid agencies should notify HHS-OIG whenever they deny a provider's application or limit a provider's participation based on fraud, integrity, or quality. States should require by contract that their managed care organizations (MCOs) report to the State whenever the MCOs decredential or terminate a provider's contract based on fraud, integrity, or quality, so that the State Medicaid agency, in turn, may report that information to HHS-OIG.

State Medicaid agencies should send all notifications to the Special Agent in Charge of the appropriate Regional Office of the HHS-OIG Office of Investigations.

Key Actions

- ***To comply with notification requirements under 42 CFR section 455.106(b)***
 - The State Medicaid agency must notify HHS-OIG of disclosures regarding criminal convictions within 20 working days. [42 CFR §455.106(b)(1)]
- ***To comply with notification requirements under 42 CFR section 1002.3(b)***
 - The State Medicaid agency must notify HHS-OIG promptly of any actions it takes on a provider's application for participation and any actions taken to limit the ability of an individual or entity to participate in the Medicaid program. [42 CFR §1002.3(b)(2), (3)]
- ***To comply with notification requirements under 42 CFR section 1002.230***
 - The State Medicaid agency must notify HHS-OIG within 15 calendar days of the conviction if the State Medicaid agency was involved in the prosecution, if the MFCU has not already notified HHS-OIG. [42 CFR §1002.230(b)]
 - The State Medicaid agency must notify HHS-OIG within 15 days of learning about the conviction if the State Medicaid agency was not involved in the prosecution, if the MFCU has not already notified HHS-OIG. [42 CFR §1002.230(c)]

Conclusion

CMS hopes that States find this information useful in their continued efforts to combat fraud and abuse. We also encourage States to offer to one another and the MIG other suggestions on identifying effective methods for collection and utilization of provider disclosures. Any comments or suggestions for future revisions of this best practices document should be directed to Claudia Simonson, Centers for Medicare & Medicaid Services, Center for Program Integrity, Medicaid Integrity Group, Division of Field Operations, 233 North Michigan Avenue, Suite 600, Chicago, IL 60601 or claudia.simonson@cms.hhs.gov.