

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICAID ENHANCED
PROVIDER ENROLLMENT
SCREENINGS HAVE NOT
BEEN FULLY IMPLEMENTED**



Daniel R. Levinson
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EXECUTIVE SUMMARY: MEDICAID ENHANCED PROVIDER ENROLLMENT SCREENINGS HAVE NOT BEEN FULLY IMPLEMENTED

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WHY WE DID THIS STUDY

To bill for items and services provided to beneficiaries, providers must enroll, and periodically revalidate this enrollment, in Medicaid. Effective provider enrollment screening is an important tool in preventing Medicaid fraud. To protect Medicaid against ineligible and fraudulent providers, the Affordable Care Act requires States to screen Medicaid providers according to their risk for fraud, waste, and abuse using enhanced screening procedures. These can include fingerprint-based criminal background checks and site visits. To help States meet the demands of applying enhanced screening to all new and existing providers, the Centers for Medicare & Medicaid Services (CMS) allows States to substitute Medicare or other State Medicaid agency or Children's Health Insurance Program screening results for their own. Ensuring that States screen all providers in accordance with the new requirements is vital to protecting Medicaid, especially as it grows to serve more beneficiaries.

HOW WE DID THIS STUDY

To determine the extent to which States have screened high- and moderate-risk providers using risk-based screening, we surveyed States and requested data about their progress as of August 2014. We also asked States whether they used screening results from Medicare or other State Medicaid agencies as substitutes for their own activities. In addition, we asked States to provide data on the number of new and existing high- and moderate-risk providers requiring screening.

WHAT WE FOUND

State implementation of risk-based screening is incomplete. Most States reported not having fingerprint-based criminal background checks while waiting for the requirement to take effect. Although CMS did not initially require States to conduct these checks, pending additional guidance, CMS did issue this guidance in June 2015, albeit more than 4 years after the other enhanced screening activities went into effect. In addition, 11 States reported that they have not implemented site visits. Meanwhile, most States reported challenges and concerns regarding substitution of screening results from Medicare or other States for their own. These included difficulties accessing external screening data and ensuring the quality of other State and/or Medicare screening efforts. Some States that did not have all screening activities in place still enrolled and revalidated thousands of providers categorized as posing a high or moderate risk to Medicaid. Finally, 14 States reported that they would not finish revalidating existing high- and moderate-risk providers by the September 2016 deadline.

WHAT WE RECOMMEND

To ensure full implementation of Medicaid enhanced provider screening, we recommend that CMS (1) assist States in implementing fingerprint-based criminal background checks for all high-risk providers, and (2) assist States in overcoming challenges in conducting site visits. To facilitate substitution of screening results and minimize variation between Medicare and Medicaid, we recommend that CMS (3) enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data, (4) develop a central system where States can submit and access screening results from other States, and (5) strengthen minimum standards for fingerprint-based criminal background checks and site visits. Finally, to ensure that States conduct enhanced screening of existing Medicaid providers, we recommend that CMS (6) work with States to develop a plan to complete their revalidation screening in a timely way. CMS concurred with all six of our recommendations.

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OBJECTIVE

To determine the extent to which States have implemented risk-based screening activities for high- and moderate-risk providers.

BACKGROUND

Providers and suppliers, hereinafter referred to as “providers,” must enroll in Medicaid and periodically revalidate their enrollment to be eligible to bill Medicaid.¹ The Centers for Medicare & Medicaid Services (CMS) has stated that “provider enrollment is the gateway” to Medicaid.² If this gateway is not adequately safeguarded, Medicaid is at increased risk of enrolling ineligible providers or providers with intent to defraud the program. Effective enrollment screening is an important tool in preventing Medicaid fraud, waste, and abuse. Ensuring that States screen all providers in accordance with the new requirements is vital to protecting Medicaid, especially as it grows to serve more beneficiaries.

Beginning in 1997, the Office of Inspector General (OIG) has identified numerous vulnerabilities regarding provider enrollment and has made recommendations for improvement. In an effort to combat fraud, waste, and abuse resulting from vulnerabilities in the enrollment process, the Affordable Care Act (ACA) called for the establishment of risk-based provider enrollment screening procedures.^{3,4} To this end, the ACA gave CMS the authority to enhance provider enrollment screening with a set of new enrollment tools.⁵

In contrast to past screening standards, which varied by State, the ACA requires States to more uniformly screen providers according to the risk for fraud, waste, and abuse that they pose to Medicaid.⁶ The ACA also requires risk-based screening for all providers in Medicare and the Children’s Health Insurance Program (CHIP).⁷ In the ACA, Congress mandated that States use risk-based screening for all providers seeking

¹ 42 CFR § 455.410.

² Shantanu Agrawal, M.D., *Medicaid Program Integrity: Screening Out Errors, Fraud, and Abuse*, Testimony before the United States House Committee on Energy and Commerce, Subcommittee on Oversight and Investigations, June 2, 2015.

³ The Patient Protection and Affordable Care Act, P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), is known as the Affordable Care Act.

⁴ ACA, § 6401.

⁵ ACA § 6401.

⁶ ACA, § 6401(a)(3), (b)(1)(B).

⁷ ACA § 6401(a), (c).

enrollment as participating providers in Medicaid.⁸ However, the ACA granted CMS discretion to determine which screening activities, other than licensure checks, would be required and to establish screening procedures.⁹ CMS issued the risk-based screening requirements, effective March 25, 2011.¹⁰

Provider Screening

States must screen all providers using risk-based screening upon initial enrollment, re-enrollment, or revalidation of enrollment.¹¹ “Enrolling” providers are those either newly enrolling or re-enrolling in Medicaid. “Revalidating” providers are those enrolled in Medicaid as of March 25, 2011. Initially, in 2011, CMS directed States to complete the revalidation of existing providers under the risk-based screening by March 24, 2016.¹² Then, in January 2016, CMS issued additional subregulatory guidance that revised its earlier direction. At that time, CMS required States to (1) notify all affected providers of the revalidation requirement by March 24, 2016 and (2) complete all revalidations by September 25, 2016.¹³ CMS also required States to revalidate all providers’ enrollment at least every 5 years from the date of initial enrollment.¹⁴

Screening Activities by Risk Category

States must screen providers according to the risk category to which providers are assigned. States must assign providers to one of three risk categories: high, moderate, or limited.

The screening activities that States must use vary, depending on the risk category to which a provider is assigned. The screening activities become more extensive as the risk level increases. For example, States must conduct six screening activities for high-risk providers, while they need conduct only three screening activities for limited-risk providers. Newly enrolling providers and revalidating providers are subject to the same screening activities,

⁸ ACA, § 6401(b).

⁹ ACA, § 6401(a)(3), (b)(1)(B).

¹⁰ 76 Fed. Reg. 5862 (February 2, 2011).

¹¹ CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011, p. 2. Accessed at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf> on June 13, 2014.

¹² *Ibid.*

¹³ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Revalidation (2016-001)*. Accessed at <https://www.medicaid.gov/affordablecareact/provisions/downloads/revalidation-2016-001.pdf> on January 20, 2016.

¹⁴ 42 CFR § 455.414.

depending on their risk category. See Table 1 for the screening activities required by risk category.

Table 1: Screening Activities Required by Risk Category

Screening Activities	High	Moderate	Limited
Verification of any provider/supplier-specific requirements established by Medicaid/CHIP	X	X	X
Verification of licenses (may include licensure checks across State lines)	X	X	X
Database checks (to verify: SSN, NPI, the NPDB, licensure, HHS OIG exclusion, taxpayer identification, tax delinquency, death of individual practitioner, and persons with an ownership or control interest or who are agents or managing employees of the provider)*	X	X	X
Site visits	X	X	
Criminal background checks	X		
Fingerprinting	X		

Source: OIG analysis of 76 FR, p. 5896 and CMS guidance.

*SSN = Social Security Number, NPI = National Provider Identifier, NPDB = National Practitioner Data Bank, HHS OIG = U.S. Department of Health and Human Services, Office of Inspector General.

Initially, CMS did not require States to conduct the criminal background checks or fingerprinting (hereinafter referred to as fingerprint-based criminal background checks) for high-risk providers.¹⁵ In its Final Rule and its initial December 2011 guidance, CMS instructed States that fingerprint-based criminal background checks for high-risk providers were not required until CMS issued additional guidance.¹⁶ However, CMS indicated that States had discretion to implement fingerprint-based criminal background checks in the absence of guidance.¹⁷ Similarly, CMS did not require fingerprint-based criminal background checks for Medicare providers until August 2014, after it finalized an agreement with a contractor to conduct these checks for Medicare.¹⁸

¹⁵ In general usage among CMS and States, criminal background checks and fingerprinting are commonly referred to as “fingerprint-based criminal background checks.” CMS, State Medicaid Director Letter, June 1, 2015, (SMD# 15-002). Accessed at <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD060115.pdf> on June 4, 2015.

¹⁶ 76 Fed. Reg. 5862, 5902; CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 9. In the *CMCS Informational Bulletin*, CMS did not indicate when it planned to issue the additional guidance.

¹⁷ 76 Fed. Reg. 5862, 5902.

¹⁸ CMS, *The Basics of Internet-based Provider Enrollment Chain and Ownership System (PECOS) for Physicians and Non-Physician Practitioners*. Accessed at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1417.pdf> on November 20, 2015.

CMS issued the additional guidance requiring fingerprint-based criminal background checks in a letter to State Medicaid Directors on June 1, 2015.¹⁹ This guidance offered States some insight into how to conduct these checks and what to do with the results of these checks. For instance, CMS recommended that States conduct a Federal Bureau of Investigation (FBI) criminal history check and follow some elements of Medicare's process for fingerprint-based criminal background checks. CMS also suggested that States may leverage any existing protocols for obtaining fingerprint-based criminal background checks (such as in hiring employees or under CMS's National Background Check Program for Long-Term Care Facilities and Providers).^{20, 21} However, CMS did not require these activities and indicates that each State may decide the type and extent of its checks. CMS also left to States' discretion the form and manner for fingerprint submission. CMS also provided some instruction as to when States must terminate or deny enrollment, including if a provider fails to submit fingerprints within 30 days of request, fails to submit them in the form and manner requested by the State, or has a conviction related to his or her involvement with Medicare, Medicaid, or CHIP in the last 10 years.

Then, in January 2016, CMS issued further guidance providing States with two methods for complying with the fingerprint-based criminal background check requirement.²²

Risk Category Assignments

States are required to assign a provider to a risk category according to the types of health services the provider offers. State assignment of provider

¹⁹ CMS, State Medicaid Director Letter, June 1, 2015, (SMD# 15-002).

²⁰ CMS's National Background Check Program for Long-Term Care Facilities and Providers is a voluntary program. See ACA § 6201. A 2016 OIG report of this program found that 13 of 25 States participating at the time of our review had not obtained legislation that would enable them to conduct background checks and that 10 of 25 States did not yet have the ability to collect fingerprints. See OIG, *National Background Check Program for Long-Term-Care Employees: Interim Report*, OEI-07-10-00420, January 2016.

²¹ In a 2015 OIG report on background checks for home health employees, we recommended that CMS promote minimum standards for background checks by encouraging State participation in the National Background Check Program for Long-Term Care Facilities and Providers. See OIG, *Home Health Agencies Conducted Background Checks of Varying Types*, OEI-07-14-00130, May 2015.

²² CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Fingerprint-based criminal background checks (FCBC) (2016-002)*. Accessed at <https://www.medicaid.gov/affordablecareact/provisions/downloads/fcbc-2016-002.pdf> on January 20, 2016.

types to the various risk categories also depends on whether the provider type is recognized by both Medicare and Medicaid or by Medicaid only.²³

Medicare-recognized provider types. When Medicare recognizes a provider type, CMS requires States to use the risk category Medicare assigns.^{24, 25} The Medicare-recognized provider types and their assigned risk categories are:

- High risk: newly enrolling home health agencies (HHAs) and newly enrolling durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) providers;
- Moderate risk: ambulance service suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, physical therapists enrolling as individuals or group practices, portable x-ray suppliers, revalidating HHAs, and revalidating DMEPOS providers;
- Limited risk: all other Medicare provider types.²⁶

Medicaid-only provider types. When only Medicaid recognizes a provider type (e.g., personal care attendants), States must assess the provider type's risk for fraud, waste, and abuse and assign the appropriate risk category. In making these decisions, States must use criteria similar to those used to determine risk categories for the Medicare-recognized provider types.²⁷

Screening Substitution

CMS gives States the option of using the results of screening activities conducted by Medicare and other States' Medicaid or CHIP agencies as substitutes for conducting their own screening.²⁸ According to CMS, such substitutions could save States time and money. Previously, in its December 2011 bulletin, CMS indicated that States could substitute

²³ In States that administer CHIP separately from Medicaid, the regulations indicate that all screening provisions that apply to Medicaid apply to CHIP. See 76 Fed. Reg. 5862, 5895 (February 2, 2011).

²⁴ 76 Fed. Reg. 5862, 5895 (February 2, 2011).

²⁵ States may establish provider screening methods in addition to, or more stringent than, those required by 42 CFR 455, subpart E. See CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 2.

²⁶ 42 CFR § 424.518.

²⁷ 76 Fed. Reg. 5862, 5895 (February 2, 2011).

²⁸ 42 CFR § 455.410.

screening results only if Medicare or another State's Medicaid or CHIP agency has completed all applicable screening activities.²⁹

In its June 2015 letter to State Medicaid Directors and subsequent November 2015 subregulatory guidance, CMS modified its original instruction about what States can use to substitute a screening to avoid unnecessary cost and burden on States.^{30, 31} CMS indicated that States may rely on the results of Medicare's provider screening for approved providers without verifying each screening activity. States may rely on Medicare's screening up to and including a particular risk category, regardless of whether the Medicare record indicates that a particular screening activity was completed. This could mean that States do not have to conduct a fingerprint-based criminal background check if a provider is enrolled in Medicare, even if Medicare has not conducted such a check for that provider.

States obtain external screening information in different ways, depending on the entity that completed the screening. To obtain the results of screening activities conducted by Medicare, States may access screening information contained in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS).³² PECOS stores CMS's Medicare provider screening results. States can access PECOS information either through a Web-based portal or, as of October 2013, through an extract file that contains basic Medicare enrollment information. To obtain results of screening activities conducted by other States' Medicaid or CHIP agencies, States must contact other States individually. No national database exists to facilitate the sharing of Medicaid or CHIP screening results among States.

Related Reports

This evaluation builds on a body of OIG work related to provider enrollment in both Medicaid and Medicare that dates to 1997. Most recently, OIG reviewed the implementation of ACA's risk-based screening

²⁹ CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 9.

³⁰ CMS, State Medicaid Director Letter, June 1, 2015, (SMD# 15-002), Q&A 11.

³¹ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Instructions for relying on provider screening conducted by Medicare (42 CFR 455.410) or conducting additional screening when required*. Accessed at <http://www.medicaid.gov/affordablecareact/provisions/sub-reg-guidance.html> on December 3, 2015.

³² CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 3.

in Medicare and found vulnerabilities in the screening process.³³ We discuss the implications of these vulnerabilities for Medicaid's screening process in our findings.

In addition, an April 2016 Government Accountability Office (GAO) report examined the screening of Medicaid managed care providers.³⁴ GAO reviewed 10 States and 16 plans from those States. It found that States and Medicaid managed care plans faced significant challenges in screening managed care providers.

METHODOLOGY

This review evaluated the status of States' progress with enhanced provider screening as of August 31, 2014. See Appendix A for a detailed methodology.

Scope

This inspection was national in scope and focused on Medicaid's ACA risk-based screening. We included all 50 States and the District of Columbia in this review (hereinafter referred to as States).

We limited our review to high- and moderate-risk providers because they pose the most risk to Medicaid. In previous reports, OIG and GAO have raised concerns about many of the high- and moderate-risk provider types.

Data Collection and Analysis

Data Collection Instrument. We sent a data collection instrument to all 51 States in October 2014. We followed up with States twice by phone and twice by email. We obtained responses from 48 States. We counted as nonrespondents the three States that, despite our followup efforts, did not submit survey results.

The instrument had two sections—a survey and a data request.

Survey. The survey focused on States' progress in implementing the ACA screening requirements. We conducted most of our analysis on multiple-choice questions with response rates of 48. We counted the number of States per response item. A few questions had responses ranging from 43 to 47. Where appropriate in the text, we indicated when the number of States responding was fewer than 48. We also analyzed responses to open-ended questions primarily designed to develop themes concerning

³³ OIG, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results*, OEI-03-13-00050, April 2016.

³⁴ GAO, *Medicaid Program Integrity: Improved Guidance Needed to Better Support Efforts to Screen Managed Care Providers*, GAO-16-402, April 2016.

challenges States face with the risk-based screening activities. Forty-five of the 48 States responded to the question about challenges they face.

Data Request. We asked States for data on the number of high- and moderate-risk providers applying to enroll after March 25, 2011, and the number of high- and moderate-risk providers enrolled prior to March 25, 2011. We also asked States for data on the number of providers that were subject to all screening activities and the number of providers approved to enroll in Medicaid. Only 27 of the 48 responding States provided data sufficient for use in our analysis. Our work further summed across States the number of providers approved to enroll in Medicaid.

Limitations

Our analysis relied on self-reported data, which we did not independently verify. However, as part of our data collection, we asked States to identify their limitations and concerns with self-reported data.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

CMS issued the risk-based screening requirements in February 2011 with all but the fingerprint-based criminal background check requirement effective March 25, 2011.³⁵ CMS issued initial guidance related to these requirements in December 2011.³⁶ In both the Final Rule and initial guidance, CMS did not require States to conduct fingerprint-based criminal background checks until it issued additional guidance.³⁷ According to CMS, these checks pose unique operational and privacy concerns.³⁸ CMS issued this additional guidance in June 2015, more than 4 years after the effective date of the other screening requirements.³⁹ It issued further guidance in January 2016.⁴⁰

Most States reported not having fingerprint-based criminal background checks while waiting for the requirement to take effect

At the time of our review in August 2014, CMS did not require States to implement fingerprint-based criminal background checks. In total, 37 of 47 responding States reported that they had not implemented fingerprint-based criminal background checks for new and existing providers. This means that these States did not screen high-risk providers using fingerprint-based criminal background checks.

The delays in requiring fingerprint-based criminal background checks potentially exposed Medicaid to increased risks related to fraud, waste, and abuse. Of the 37 States without fingerprint-based criminal background checks in place, 27 reported allowing approximately 25,000 high-risk providers to enroll in Medicaid without completing fingerprint-based criminal background checks between March 2011 and August 2014. Of these 25,000 high-risk providers, nearly two-thirds were newly enrolling providers not known to State Medicaid agencies. The remaining 10 States could not provide information on the number of

³⁵ 76 Fed. Reg. 5862 (February 2, 2011).

³⁶ CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*.

³⁷ 76 Fed. Reg. 5862, 5902; CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 9.

³⁸ 76 Fed. Reg. 5871.

³⁹ CMS, State Medicaid Director Letter, June 1, 2015, (SMD# 15-002).

⁴⁰ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Fingerprint-based criminal background checks (FCBC) (2016-002)*. Accessed at <https://www.medicaid.gov/affordablecareact/provisions/downloads/fcbc-2016-002.pdf> on January 20, 2016.

high-risk providers enrolled or revalidated since the other risk-based screening activities went into effect.

States faced challenges with fingerprint-based criminal background checks, including the need for guidance

States faced challenges implementing fingerprint-based criminal checks. Most States reported the need for guidance, in general, and some States specifically noted as a challenge the need for guidance to implement this screening activity. States may also face additional challenges to timely implementation.

Need for CMS guidance. At the time of our review, most States without this screening activity in place reported that they needed guidance. Specifically, 29 of the 37 States without fingerprint-based criminal background checks reported needing guidance to resolve challenges with the ACA screening activities. Although most States did not specify the subject of the guidance needed, three States specifically offered that they did not implement fingerprint-based criminal background checks while waiting for guidance from CMS on this screening activity. One of the three States reported that it was uncertain how to comply with the fingerprinting and criminal background checks. The second State reported that it did not implement “so as to avoid incorrect implementation.” The third State indicated that waiting for CMS to issue guidance was a “barrier” to implementation.

Challenges to timely implementation. States may struggle to conduct fingerprint-based criminal background checks because of limited experience with these checks and the effort that this screening activity entails.

Implementing these checks requires States to collect and transmit fingerprints to the FBI or State law enforcement for processing in a secure manner. Overall, 34 of the 37 States without fingerprint-based criminal background checks indicated that they did not have experience conducting these checks for Medicaid enrollment.

In addition, the effort entailed in fingerprint-based criminal background checks may make implementation difficult. Because most States have not implemented these checks, we cannot determine how widespread implementation problems may be. However, five States identified specific challenges that other States may also face as they move forward. These include operational concerns—such as not having authority from their State to review results of fingerprint-based criminal background checks—and logistical concerns about integrating this check into their enrollment systems.

CMS no longer requires full implementation by June 2016

CMS issued guidance in June 2015 and January 2016 about fingerprint-based criminal background check implementation. Although CMS initially instructed States to comply with completing these checks, it later offered States an alternative path to compliance. This alternative path could mean that full implementation of these checks by States will not occur until after 2016. According to CMS, implementation means that the State has conducted a fingerprint-based criminal background check with respect to each provider designated as high risk, including those newly enrolling in Medicaid, those seeking re-enrollment in Medicaid, and those enrolled at the time of revalidation.⁴¹

June 2015 guidance. CMS did not provide States with guidance on fingerprint-based criminal background checks for more than 4 years. In June 2015, subsequent to our review, CMS provided its first guidance in a State Medicaid Director Letter.⁴² CMS instructed States that, from the date of the letter, they had (1) 60 days to begin implementing fingerprint-based criminal background checks and (2) 1 year to complete implementation of fingerprint-based criminal background checks.

January 2016 guidance. In January 2016, CMS issued additional guidance acknowledging the challenges that States may face but no longer requiring full implementation by June 2016. CMS acknowledged its June 2015 recommendation that States conduct FBI criminal history checks and stated that it continues to work with the FBI to facilitate State access to the infrastructure necessary to conduct such checks. Because of this continued work, CMS offered an alternate path to compliance and asked States when they anticipated fully implementing fingerprint-based criminal background checks.

This guidance provides States with two ways to comply with the fingerprint-based criminal background check requirement by June 1, 2016: (1) implement fingerprint-based criminal background checks as initially required in the June 2015 State Medicaid Director letter or (2) have a fingerprint-based criminal background check compliance plan approved by CMS by June 1, 2016.⁴³

States submitting compliance plans had to do so by April 15, 2016. As part of a compliance plan, CMS asked States to describe the barriers they face to full implementation. Submitting a compliance plan does not equal

⁴¹ CMS, State Medicaid Director Letter, June 1, 2015 (SMD# 15-002).

⁴² Ibid.

⁴³ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Fingerprint-based criminal background checks (FCBC) (2016-002)*.

compliance; only receipt of a CMS approval letter on or before June 1, 2016, will do so.

However, having an approved compliance plan does not ensure timely implementation, as CMS did not require a deadline for States. Instead, CMS asked States to indicate when they anticipate fully implementing the fingerprint-based criminal background check requirement.

Eleven States reported not conducting required site visits

Although most of the States indicated that they have implemented required site visits, 11 of 47 responding States reported, at the time of our review, that they did not have this screening activity in place for high- and moderate-risk providers. Six of these States indicated that the primary reason for not implementing site visits was insufficient resources, including too few staff and financial constraints. Further, one State noted that its large geographical size made site visits difficult to implement because staff would have to travel hundreds of miles to visit a provider in a small town. The remaining five States did not offer reasons why they did not have required site visits in place.

Between March 2011 and August 2014, 6 of these 11 States reported allowing approximately 21,000 high- and moderate-risk providers to enroll in Medicaid without site visits. The remaining five States could not provide the number of high- and moderate-risk providers enrolled or revalidated since risk-based screening went into effect. See Table 2 for a breakdown of the number of high- and moderate-risk providers allowed to enroll in Medicaid without site visits.

Table 2: High- and moderate-risk providers allowed to enroll in Medicaid without site visits

	Number of States	High-risk providers	Moderate-risk providers	Total
Newly enrolled providers	5	5,896	9,505	15,401
Revalidated providers	3	600	4,946	5,546

Source: OIG analysis of State survey responses, 2014.

Screening substitution is challenging for many States

Although CMS allows (but does not require) States to substitute screening results from Medicare and other State Medicaid agencies in place of conducting their own, many States do not do so.⁴⁴ In fact, 18 States reported that they do not substitute screening results from Medicare, and

⁴⁴ 42 CFR § 455.410(c).

an additional 13 States reported that they substitute few screening results from Medicare. Although the remaining 17 States reported that they substitute screening results from Medicare, most could not report the extent to which they did so. Similarly, 30 States reported that they do not substitute screening results from other State Medicaid agencies. An additional seven States reported that they substitute few screening results from other State Medicaid agencies. The remaining 11 States reported substituting screening results, yet 10 of these States could not determine the extent to which they did so.

States could benefit by using substituted screening results, but challenges associated with substitution exist. Use of substituted screening results could help States reduce the costs and burden associated with screening activities, especially as they work to meet the demands of screening all new and existing providers according to the ACA requirements. However, operational challenges, coupled with issues regarding the quality of Medicare and other State screening data, hinder States' ability to benefit from this option.

States face challenges substituting screening results from Medicare

States reported challenges to obtaining data from PECOS, the CMS data system that stores Medicare's provider screening results. Specifically, 11 of 45 States reported such challenges. The challenges included difficulty accessing PECOS, such as password problems, and/or difficulty navigating the system. Moreover, PECOS does not allow States to run an automated match of their providers against the system. Instead, States have to enter individual provider information into PECOS to retrieve screening results for that provider, which can be time intensive.

Even if States overcome the challenges to obtaining PECOS data, using Medicare screening results or enrollment data may open the door to other vulnerabilities for Medicaid and the States because Medicare screening data may not be complete or thorough.

States may not benefit from substituting Medicare screening results because PECOS may contain incomplete information. An April 2016 OIG report on the implementation of Medicare enhanced provider screening found that PECOS did not contain all the information needed for effective oversight.⁴⁵ PECOS was missing risk category designations in 10 percent

⁴⁵ OIG, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results*.

of cases and application submission reasons (e.g., new enrollment or change of information) in 12 percent of cases.

Further, GAO and OIG have raised concerns about the thoroughness of Medicare's screening process. In a June 2015 report, GAO identified weaknesses in CMS's procedure for verifying a provider's practice location and licensure status.⁴⁶ The April 2016 OIG report on Medicare enhanced provider screening raised similar concerns, finding that Medicare contractors did not verify key provider information, such as identification numbers and criminal convictions, during the enrollment process.⁴⁷ OIG also found that Medicare contractors were inconsistent in applying site visit procedures and using site visit results for enrollment decisions.

CMS's decision to allow States to substitute incomplete Medicare screening results may leave States vulnerable to fraud, waste, or abuse. CMS guidance indicates that States can skip a fingerprint-based criminal background check if a provider is enrolled in Medicare, even if Medicare has not conducted such a check for that provider.⁴⁸ Although this direction applies only to newly enrolling HHAs and DMEPOS providers, OIG and GAO have identified these provider types as problematic. As a result, if Medicare has not conducted fingerprint-based criminal background checks for these providers and States use proof of Medicare enrollment as a substitute for their own screening, States are vulnerable to fraud, waste, and abuse because these providers have not undergone a fingerprint-based criminal background check and may have no history with the State Medicaid agency.

Similarly, States face challenges substituting screening results from other States

States may not be able to substitute screening results from other States because of difficulties obtaining the results of other States' screening activities. Specifically, 9 of 45 States reported challenges obtaining screening results. Generally, these States reported that the lack of a single database for recording the results of screening activities means that States

⁴⁶ GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, GAO-15-448, June 2015.

⁴⁷ OIG, *Enhanced Enrollment Screening of Medicare Providers: Early Implementation Results*.

⁴⁸ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Instructions for relying on provider screening conducted by Medicare (42 CFR 455.410) or conducting additional screening when required*. Accessed at <http://www.medicaid.gov/affordablecareact/provisions/sub-reg-guidance.html> on December 3, 2015. See also CMS, State Medicaid Director Letter, June 1, 2015, (SMD# 15-002), Q&A 11.

must contact each other on a case-by-case basis. This requires significant resources and time. States reported that State-to-State substitution is further complicated because there is no consistent or easy means of State-to-State communication regarding substitution.

Even if States could readily obtain other States' screening data, those results may not meet a particular State's standards because screening practices may not be complete and are not consistent across States.

Similar to concerns about Medicare substitution, States may not be able to benefit from substituting other States' Medicaid or CHIP screening results because they may be incomplete. If a State is not conducting one or more of the required screening activities, such as site visits or fingerprint-based criminal background checks, others may not want to substitute the screening results. Two States reported that they do not substitute screening data from other States because they have found that States are at various stages of compliance with risk-based screening.

In addition, States may be reluctant to use each other's screening results because each State creates its own standards for screening providers, particularly for fingerprint-based criminal background checks and site visits. CMS allows States discretion on the type and extent of their criminal background checks.⁴⁹ While CMS recommends that States adopt elements of Medicare's screening process and conduct an FBI criminal history check, which provides national information, it does not require them to do so. CMS allows similar discretion for site visits, stating that States have the flexibility to determine the activities that constitute a site visit.⁵⁰ This means that States can create their own standards for conducting these screening activities. States that have stricter standards may be unwilling to use results from another State with less strict standards. In fact, two States cited this variation as a concern.

Fourteen States reported that they would not finish revalidating existing high- and moderate-risk providers by the September 2016 deadline

Although 34 States reported that they would finish revalidating all providers, 14 indicated they would not finish by the September 2016

⁴⁹ 76 Fed. Reg. 5862, 5902-03.

⁵⁰ CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 10.

deadline.⁵¹ These States expected to complete their revalidation screening between later in 2016 and 2019.⁵²

Some of the States reporting that they would not meet the revalidation deadline provided various reasons for this. For example, six States attributed the delay to their data management systems. These States variously indicated that they were updating their systems, that their systems needed to be updated, or that they had a paper-based, manual process. Four States cited resource issues, such as the number of providers to be revalidated, or having to hire more staff. Lastly, two States mentioned the delay in CMS guidance. One discussed the 10-month delay in initial guidance after the regulations became effective. The other cited the delayed guidance for fingerprint-based criminal background checks for high-risk providers.

The remaining 34 States reported that they were on schedule to meet the deadline. However, 26 of these States reported, at the time of our review, not having fingerprint-based criminal background checks, and 9 reported not conducting site visits. Thus, although these States reported that they were on schedule, our findings suggest that their revalidation screening may not include all required screening activities.⁵³

⁵¹ Initially, CMS directed States to complete risk-based screening for revalidating providers by March 24, 2016. However, CMS changed this date to September 25, 2016. See CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Revalidation (2016-001)*.

⁵² One of the States expecting to be finished in 2019 reported that it had an approved alternate compliance date with CMS.

⁵³ According to CMS, the screening requirements for revalidating existing high- and moderate-risk providers are the same as for new providers. To meet the deadline for screening existing high- and moderate-risk providers, States would need to complete all required screening activities, including site visits and the now-required fingerprint-based criminal background checks. See CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, p. 12.

CONCLUSION AND RECOMMENDATIONS

OIG's past work found vulnerabilities in the Medicaid provider enrollment process. To reduce enrollment vulnerabilities, the ACA required that States screen providers according to their risk for fraud, waste, and abuse to Medicaid. Implementing the ACA screening activities is critical to safeguarding Medicaid as it grows to serve more beneficiaries.

However, our findings indicate that State implementation of ACA screening activities is incomplete for high- and moderate-risk providers. Notably, CMS did not require fingerprint-based criminal background checks for high-risk providers for more than 4 years. States with incomplete screening activities enrolled thousands of providers categorized as posing a high- or moderate-risk to Medicaid. The option to substitute screening results from Medicare or other States could help States to meet the demands of screening all new and existing providers according to the ACA requirements. However, States reported challenges associated with substituting screening results from both Medicare and other States. Further, substituting screening results, especially incomplete or inconsistent screening results, from Medicare or other States may leave States open to fraud, waste, and abuse by risky providers.

Not implementing the required enhanced provider screening activities poses risks to Medicaid and its beneficiaries that the ACA intended to prevent. Regardless of the challenges that prevented States from implementing enhanced provider screening and CMS's decision not to enforce fingerprint-based criminal background checks, not implementing the screening activities leaves Medicaid vulnerable to providers who may be ineligible or intent on defrauding the program and harming patients in the process. Preventing fraudulent and abusive providers from enrolling in Medicaid is critical to ensuring the integrity of the program, especially as it grows to serve more beneficiaries. Therefore, to strengthen Medicaid's provider enrollment screening process, we recommend that CMS:

Assist States in implementing fingerprint-based criminal background checks for all high-risk providers

CMS should assist States in implementing fingerprint-based criminal background checks within a reasonable timeframe. CMS's assistance could include technical support to States or dissemination of best practices from States that are further along in the process. CMS should also consider the feasibility of making Medicare's fingerprint-based criminal background checks contractor available to States for these checks.

Assist States in overcoming challenges in conducting site visits

CMS should ensure that all States implement required site visits. CMS should work with the 11 States that have not implemented site visits to address the challenges that those States identified. CMS could provide technical assistance or share practices from other States that overcame similar challenges.

Separately, we referred to CMS for appropriate followup information for the 11 States that indicated that they did not have the required site visits in place. CMS should consider the number of high- and moderate-risk providers enrolled in each State when prioritizing its followup.

Enable States to substitute Medicare screening data by ensuring the accessibility and quality of Medicare data

States could save time and money by substituting Medicare screening results or enrollment for their own. However, many States reported that they did not take advantage of this option because of difficulties accessing and using Medicare data and concerns about the completeness and accuracy of that data. CMS should resolve these concerns and could do so in various ways. For instance, CMS could enhance PECOS, its national data repository for Medicare provider enrollment information, to resolve States' password problems and inability to obtain enrollment-screening results for multiple providers in a timely way. To ensure that PECOS data are complete and accurate, CMS should improve the completeness and accuracy of the Medicare enhanced provider screening, including ensuring implementation of complete fingerprint-based criminal background checks for high-risk providers, to protect Medicare and Medicaid.

Develop a central system where States can submit and access screening results from other States

CMS should develop a central system that allows States to submit and access provider enrollment screening results from other States to make it easier for States to substitute screening results from other States. Such a system should also allow States to search for multiple providers at once. As the Federal partner for all States, CMS is uniquely positioned to provide and oversee a central system to which all States can contribute their screening results. Toward that end, CMS could work with States to develop core, consistent submission requirements so States have common data elements across screening results. CMS could consider incorporating State information into PECOS.

Strengthen minimum standards for fingerprint-based criminal background checks and site visits

CMS's existing minimum standards for fingerprint-based criminal background checks and site visits could produce variations across States such that States do not want to substitute each other's screening results. While States can determine the type and extent of their criminal background checks and the activities that constitute their site visits, CMS could facilitate substitutions by working with States to strengthen minimum standards for these checks. Doing so could alleviate States' concerns about variation in screening standards. For fingerprint-based criminal background checks, CMS could consider requiring States to conduct national background checks. CMS could consider requiring a shared standard for site visits conducted by both Medicare and States that promotes consistency.

Work with States to develop a plan to complete their revalidation screening in a timely way

CMS should ensure that all States complete the necessary revalidation screening. CMS should work with the 14 States that reported they would not meet the September 2016 deadline and help them to develop plans to complete their revalidation screening. CMS should add to the list of 14 States any State that it identifies as unable to meet the deadline.

Separately, we referred to CMS for appropriate followup the 14 States that indicated they would not complete their revalidation screening by the September 2016 deadline. Again, CMS could consider the number of high- and moderate-risk providers enrolled in each State when prioritizing its followup.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all six of our recommendations. In its comments, CMS highlighted its most recent efforts to improve the Medicaid enhanced provider screening process. For example, CMS indicated that it has worked with the FBI to issue guidance in January 2016 to help States implement fingerprint-based criminal background checks.⁵⁴ CMS also indicated that, in March 2016, it published the *Medicaid Provider Enrollment Compendium*, a consolidated resource for guidance on Medicaid enhanced provider screenings.⁵⁵ With regard to screening substitution from Medicare, CMS indicated that it has provided States with direct access to Medicare's enrollment database, PECOS, as well as monthly PECOS data extracts that States can systematically compare to their enrollment records. Finally, with regard to States' revalidation efforts, CMS indicated that it has taken several steps to help States fulfill the requirement to revalidate Medicaid providers, including the assignment of CMS staff to work with States.

We look forward to receiving updates on CMS's progress but have concerns. We look forward to efforts by CMS to strengthen minimum standards for fingerprint-based criminal background checks and site visits and its efforts to assist States in sharing screening results with one another. However, we have concerns that CMS's January 2016 guidance on fingerprint-based criminal background checks could mean full implementation of these checks will not occur until after 2016. CMS has asked States submitting a compliance plan to indicate when they anticipated full implementation. Further, we have concerns about CMS's response to our recommendation on States' substituting screening results from Medicare. We encourage CMS to think broadly about this recommendation and to consider what steps are necessary to ensure that States have access to complete and accurate Medicare provider enrollment screening data. Implementing our related recommendations in OIG's report on Medicare enhanced provider screenings (OEI-03-13-00050) may assist States in substituting screening results from Medicare.

For the full text of CMS's comments, see Appendix B.

⁵⁴ CMS, *Sub Regulatory Guidance for State Medicaid Agencies (SMA): Fingerprint-based criminal background checks (FCBC) (2016-002)*.

⁵⁵ CMS, *Medicaid Provider Enrollment Compendium*, March 21 2016. Accessed at <https://www.medicaid.gov/affordablecareact/provisions/downloads/mpec-032116.pdf> on May 12, 2016.

APPENDIX A

Detailed Methodology

Data Collection and Analysis

Data Collection Instrument. Forty-eight of 51 States responded to the data collection instrument. Arkansas, Florida, and Rhode Island did not respond.

The instrument had two sections—a survey and a data request.

Survey. The survey had two types of questions, multiple-choice questions that required States to select from a set of responses and open-ended questions that allowed States to comment and provide additional information.

In general, the multiple-choice questions asked how States conduct their screening activities, whether States substitute screening results from other sources, and what the status of States' revalidation screening was. All 48 States responded to nearly all of the multiple-choice questions. For two questions, 43 and 47 States responded, respectively. Where appropriate in the text, we indicate when the number of States responding was fewer than 48.

The open-ended questions generally asked some States to elaborate on their responses to the multiple-choice questions, depending on their answers, and about any challenges States faced in implementing the ACA screening activities. For questions that asked States to elaborate on a response to a multiple-choice question, in all but one case, all of the States that had an opportunity to respond to the question did so. For the remaining question, only one State did not respond.

Data Request. We requested data on States' high- and moderate-risk providers. We relied on States' determination of risk for their providers.

We did not receive all of the requested data from all of the 48 responding States. Eight States did not provide any of the requested data. The remaining 40 States provided some or all of the requested data. However, only 27 States provided sufficient data for our analysis. To determine which States' data we could use in our analysis, we reviewed each States' data for internal consistency and verified that each State provided the specific data fields we planned to use.

Our analysis summed across States the number of providers that they approved to enroll in Medicaid. One State indicated that it

could not distinguish between newly enrolling providers and revalidating providers. In our analysis, we included this State in our count of revalidating providers because we deemed that category as less risky to Medicaid because revalidating providers already had been screened under States' previous enrollment standards. This State accounted for approximately 3,000 providers, which means that we could be undercounting the newly enrolling providers by up to 3,000 and overcounting the revalidating providers by up to 3,000.

CMS Documentation. We also reviewed CMS documents related to the ACA screening requirements, including subregulatory guidance, an informational bulletin, and a State Medicaid Director Letter.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: APR - 5 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt *Andrew M. Slavitt*
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Enhanced Provider Enrollment Screenings Have Not Been Fully Implemented" (OEI-05-13-00520)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to program integrity efforts in Medicaid.

As part of our continuing efforts to strengthen the Medicaid provider enrollment process, in February 2011, CMS issued regulations to implement categorical risk-based screening of newly enrolling and re-enrolling Medicaid providers and to revalidate all current Medicaid providers under the categorical risk-based screening requirements authorized by the Affordable Care Act. Categories of risk are determined based on factors such as the provider type and history of previous adverse actions. Providers in the limited risk category undergo verification of licensure, verification of compliance with federal regulations and state requirements for the provider type, and are checked against various databases. Providers in the moderate and high risk categories undergo additional screening, including unannounced site visits. Additionally, as a condition of enrollment, states must require providers in the high risk category or persons with 5 percent ownership interest in such providers to consent to criminal background checks including fingerprinting.

CMS has taken several steps to help states fulfill their requirement to revalidate Medicaid providers. CMS has provided states with direct access to Medicare's enrollment database—the Provider Enrollment, Chain, and Ownership System (PECOS)—as well as monthly PECOS data extracts that states can use to systematically compare state enrollment records against available PECOS information. CMS has also assigned staff to coordinate directly with each state and is providing extensive guidance and technical assistance to assist states on their revalidation efforts.

CMS has also taken several steps to help states conduct site visits and perform fingerprint-based criminal background checks for the relevant categories of providers. Recently, CMS issued guidance to allow states to rely on any site visits conducted by CMS for a provider that has an approved Medicare enrollment status. In March 2016, CMS published the Medicaid Provider Enrollment Compendium to help states in implementing various enrollment requirements including the site visit requirements. CMS has also worked with the Federal Bureau of

Investigation to publish guidance to help states implement fingerprint-based criminal background checks for providers in the high risk category.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Provide states assistance in implementing fingerprint-based criminal background checks for all high-risk providers.

HHS Response

CMS concurs with OIG's recommendation. CMS has worked with the Federal Bureau of Investigation to publish guidance to help states implement fingerprint-based criminal background checks for providers in the high risk category. This guidance was published in January 2016. CMS will continue to work with states to provide technical assistance on their risk-based screening efforts.

OIG Recommendation

Work with states to overcome challenges to conducting site visits.

HHS Response

CMS concurs with OIG's recommendation. CMS has taken several steps to help states fulfill their requirement to conduct site visits on providers in the moderate and high risk categories. Recently, CMS issued guidance to allow states to rely on any site visits conducted by CMS for a provider that has an approved Medicare enrollment status. In March 2016, CMS published the Medicaid Provider Enrollment Compendium which includes guidance to help states implement the site visit requirements. The Compendium is intended to provide states with a consolidated resource of guidance to improve compliance with Medicaid provider enrollment requirements, including site visits.

OIG Recommendation

Ensure that states can substitute Medicare screening data by ensuring the accessibility and quality of Medicare data.

HHS Response

CMS concurs with OIG's recommendation. CMS has been proactive about assisting states with provider enrollment and revalidation screening. CMS has provided states with direct access to Medicare's enrollment database—the Provider Enrollment, Chain, and Ownership System (PECOS)—as well as monthly PECOS data extracts that states can use to systematically compare state enrollment records against PECOS information. We have also provided states with training and technical assistance on using and accessing PECOS.

OIG Recommendation

Develop a central system where states can submit and access screening results from other states.

HHS Response

CMS concurs with OIG's recommendation. A centralized process for states to share screening results on providers with CMS could be beneficial once states have implemented their enhanced provider enrollment screening programs. CMS will work with states to explore this possibility.

OIG Recommendation

Strengthen minimum standards for fingerprint-based criminal background checks and site visits.

HHS Response

CMS concurs with OIG's recommendation. CMS will examine the current minimum standards for fingerprint-based criminal background checks and site visits and determine if there are enhancements that should be made. In addition, CMS will continue to work with states to provide guidance and technical assistance on these activities as necessary.

OIG Recommendation

Work with states to develop a plan to complete their revalidation screenings in a timely way.

HHS Response

CMS concurs with OIG's recommendation. CMS has taken several steps to help states fulfill their requirement to revalidate Medicaid providers. CMS has also assigned staff to coordinate directly with each state and is providing extensive guidance and technical assistance to assist states on their revalidation efforts.

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

ACKNOWLEDGMENTS

This report was prepared under the direction of Thomas F. Komaniecki, Regional Inspector General for Evaluation and Inspections in the Chicago regional office, and Laura T. Kordish, Deputy Regional Inspector General.

Nicole Hrycyk served as team leader for this study, and Jonathan Jones served as lead analyst. Other Office of Evaluation and Inspections staff from the Chicago regional office who conducted the study include Jane Ahn. Central office staff who provided support include Kevin Farber, Joanne Legomsky, and Kevin Manley.

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