



MEDICAID PROGRAM INTEGRITY

Toolkits to Address Frequent Findings: 42 CFR 455.436

Federal Database Checks

The following information addresses frequent findings from CMS's comprehensive program integrity reviews of State Medicaid Agencies' operations. This information helps address common issues for states when conducting required federal database checks on providers who seek to enroll and continue to participate in the Medicaid program.

455.436 Federal database checks.

The State Medicaid agency must do all of the following:

- (a) Confirm the identity and determine the exclusion status of providers and any person with an ownership or control interest or who is an agent or managing employee of the provider through routine checks of Federal databases.**
- (b) Check the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the Excluded Parties List System (EPLS), and any such other databases as the Secretary may prescribe.**
- (c) (1) Consult appropriate databases to confirm identity upon enrollment and reenrollment; and
(2) Check the LEIE and EPLS no less frequently than monthly.**

The regulation at 42 CFR 455.436 is part of the new provider screening and enrollment requirements under Section 6401 of the Affordable Care Act. This regulation specifies who must have their identity confirmed and be screened for exclusion status, which databases must be checked, and when screening must be performed and/or repeated. The regulation at 42 CFR 455.450 outlines the categorical screening levels for Medicaid providers, and specifies which screening tools must be applied to providers in each risk level. Pursuant to this regulation, database checks under 455.436 must be performed with respect to providers in all three risk levels. The first line of defense against Medicaid provider fraud and abuse is to screen persons or entities during the provider enrollment and contracting process and continue screening on a routine basis. Conducting proper database searches can prevent inappropriate Medicaid payments to excluded providers and reduce time-consuming and expensive "pay and chase" activities.

Although managed care entities (MCEs) are not mandated by this regulation to conduct exclusion searches of the network providers they enroll, CMS considers the requirements under this regulation to be program safeguards that would be prudent in managed care settings. States may delegate these requirements to their MCEs through their contracts with their MCEs.

Below are some **Common Issues** we have observed in our reviews, followed by **Solutions** that states can implement to ensure compliance with the regulation.

Common Issues:

- 1) States fail to obtain complete information on all persons with an ownership or control interest, agents, and managing employees of providers when they apply to enter the Medicaid program. This information is necessary for states to check the exclusion status of the individuals prior to enrolling the provider as required by 42 CFR 455.436(a).
- 2) [Further information on common problems and helpful hints for collecting information related to persons with an ownership or control interest in a disclosing entity may be found under **Solutions** in the toolkit on *Disclosures of Ownership and Control* (42 CFR 455.104). It should be noted that since individual practitioners and groups of practitioners do not complete ownership and control interest disclosures, states often fail to gather information on agents and managing employees of these providers.]
- 3) States have not established procedures for checking all required databases listed at 42 CFR 455.436(b). Virtually all states have procedures for checking the LEIE or the Medicare Exclusion Database (MED), but not all are not checking the Social Security Administration's Death Master File (SSADM), the NPES, or the EPLS¹. Some issues have been related to technical problems in accessing the databases.
- 4) States fail to check all parties against the LEIE and EPLS monthly after enrollment/re-enrollment as required at 42 CFR 455.436(c)(2). Common issues here deal with some states' Medicaid Management Information Systems (MMIS) having insufficient fields to allow multiple entries for all persons with ownership or control, agents, and managing employees. By not being able to store all information in their MMIS or an alternative searchable database, states cannot automatically compare their list of providers, persons with ownership and control, managing employees, and agents against the LEIE and EPLS on a monthly basis to ensure that the individuals or entities have not been excluded or debarred since their enrollment.
- 5) States fail to communicate to their providers and MCEs the importance of checking their employees for exclusion prior to hire as outlined in earlier guidance from CMS. See State Medicaid Director's Letter #09-001 for further information:
<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf>

¹ The EPLS was merged with the System for Award Management (SAM) in June 2012.

- 6) Where states have Medicaid services provided by sister agencies, and providers for these services are not enrolled directly through the State Medicaid Agency, the sister agency is not conducting appropriate database checks. This is often due to the sister agency not being familiar with the requirements for screening providers prior to enrollment.

Solutions:

- a) Collect the necessary information to identify parties that must be searched. This information will include name, address, date of birth, and social security number for individuals. Where information on corporations is collected, the information will include the corporations' tax identification numbers along with business addresses, address for corporate headquarters (if different), and all P.O. Box addresses for correspondence or mailing of payment. What information is collected and how it is collected will be different for providers who are "disclosing entities" as defined in 42 CFR 455.101 as compared to individual practitioners and groups of practitioners.

For those providers classified as a disclosing entity², the federal regulation at 42 CFR 455.104 requires states to obtain specific identifying information on individuals and corporations with an ownership or control interest in the provider and those who are managing employees of the provider. Therefore, the majority of the information necessary to conduct database searches will be collected on the enrollment application for disclosures of ownership or control interest. However, 42 CFR 455.436 also requires checking agents of the provider, so application forms will need to request that the provider include this information.

For individual practitioners and groups of practitioners, 42 CFR 455.104 is not applicable, so these provider types may not be completing the disclosure form that asks for information on managing employees and agents. Therefore, if the state has separate enrollment application forms for individual practitioners and group practitioners, it will need to ensure that its enrollment forms for these provider types request that applicants supply information on managing employees and agents so that the names can be checked against the federal databases.

- b) Develop quality controls to check the completeness of the disclosures in the provider enrollment or contracting package. Look critically at the persons disclosed on application forms and whether the applicant has provided all relevant individuals and/or corporations. Exercise due diligence to confirm the identity of the persons listed. State websites for corporations can provide information for key individuals such as officers and board members. In addition, provider websites will often list their key staff and/or organizational charts indicating staff positions/titles.

² A disclosing entity is defined as a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent. This will often include, but is not limited to, corporations or other large organizations such as hospitals, nursing homes, clinics, or partnerships.

- c) Maintain the information in a searchable format so that appropriate database checks can be performed prior to enrollment, at the time of reenrollment, and on a monthly basis thereafter. If a state's MMIS is not capable of storing all relevant names and identifying information, another database application may be used. CMS does not limit what types of software states use, and allows states to work with their fiscal agent or internal Information Technology staff to develop a system that is efficient and fiscally sound for the state.
- d) The LEIE has both an online searchable database and a downloadable format. Both databases may be accessed directly on the HHS-OIG website at:
<http://oig.hhs.gov/exclusions/index.asp>.
- e) CMS has also processed the LEIE into an equivalent database - the MED - which some states have found easier to search. Currently, states are allowed up to two licenses for accessing the MED – one for the State Medicaid Agency (SMA) and one for its fiscal agent. States can request access to the MED through the CMS website for gaining individual access to CMS systems. This website is located at:
<https://am.cms.hhs.gov/amserver> .
- f) In addition to conducting their own ongoing exclusion searches, states should instruct all enrolled Medicaid providers to check their own employees and contractors for exclusions against the LEIE at the time of hiring and on a monthly basis. See State Medicaid Director Letter #09-001, dated Jan. 16, 2009, at:
<http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD011609.pdf>.
- g) The EPLS is a database of individuals and entities currently debarred from federal contracting. The EPLS was merged with the System for Award Management (SAM) in June 2012. Further guidance on its use was issued in CMS's Information Bulletin published August 1, 2012, which can be found at: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-08-01-12.pdf>. However, we have found that the link to the SAM website within the informational bulletin is no longer usable. The current link to the SAM website is: <https://www.sam.gov/portal/public/SAM/#1> .
- h) The Social Security Administration's Death Master File (SSADMf) must be searched at the time of enrollment to ensure that Medicaid is not being billed in the name of a deceased provider. The database can be accessed at:
<http://www.ntis.gov/products/ssa-dmf.aspx>. It should be noted that the SSADMf requires a subscription to access its information. States may want to consider obtaining access not only for provider enrollment staff, but also surveillance and utilization review staff in order to run reports on providers and beneficiaries to ensure that no services are paid after death.
- i) The NPDES must also be searched at the time of enrollment to ensure that providers and other health professionals have received National Provider Identifiers (NPIs), where applicable, prior to participating in the Medicaid program. Note: Not all

providers may be required to obtain an NPI, e.g. personal care attendants, although some states are now beginning to require they do so in order to better track these services. The NPPES website for confirming providers' NPI numbers can be found at: <https://npiregistry.cms.hhs.gov/NPPESRegistry/NPIRegistryHome.do>.

- j) States should be aware that the regulation at 42 CFR 455.410, implemented pursuant to section 6401 of the Affordable Care Act now requires all ordering or referring physicians or other professionals providing services under the State plan or waiver of the plan to be enrolled as participating providers. States should be prepared to conduct all required database searches on these individuals as part of the enrollment and screening process. States may establish a streamlined enrollment process for providers whose only relationship with the Medicaid program is ordering and/or referring services.
- k) Where State Medicaid Agencies make use of alternate delivery systems, they should be performing all required database searches on their contracted managed care entities, non-emergency medical transportation brokers, and other contractors.
- l) Where ancillary services may be provided by a sister agency, the State Medicaid Agency should communicate to the sister agency all requirements for provider screening. This can be done through an Interagency Agreement or similar document.

We hope this information on conducting federally-mandated database checks on providers entering or participating in the Medicaid program has been helpful to states. Please direct any suggestions or feedback to: Medicaid_Integrity_Program@cms.hhs.gov.