Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE

Suzanne Murrin
Deputy Inspector General
for Evaluation and Inspections

September 2014
OEI-02-11-00320

EXECUTIVE SUMMARY: STATE STANDARDS FOR ACCESS TO CARE IN MEDICAID MANAGED CARE
OEI-02-11-00320

WHY WE DID THIS STUDY

Examining access to care takes on heightened importance as enrollment grows in Medicaid managed care programs. Under the Patient Protection and Affordable Care Act, States can opt to expand Medicaid eligibility, and even States that have not expanded eligibility have seen increases in enrollment. Most States provide some of their Medicaid services—if not all of them—through managed care. The Office of Inspector General received a congressional request to evaluate the adequacy of access to care for enrollees in Medicaid managed care. This report describes the standards that States establish for access to care in their Medicaid managed care programs and how States determine compliance with these standards. A companion report determines the extent to which providers offer appointments to enrollees and the timeliness of these appointments.

HOW WE DID THIS STUDY

We surveyed State Medicaid agency officials in the 33 States with comprehensive, "full risk" Medicaid managed care and collected documentation from each State on its standards for access to care. We also conducted structured interviews with external quality review organizations and the Centers for Medicare & Medicaid Services (CMS).

WHAT WE FOUND

State standards for access to care vary widely. For example, standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 enrollees. Additionally, standards are often not specific to certain types of providers or to areas of the State. States have different strategies to assess compliance with access standards, but they do not commonly use what are called "direct tests," such as making calls to providers. Further, most States did not identify any violations of their access standards over a 5-year period. The States that found the most violations were those that conducted direct tests of compliance. Among the States that identified violations, most relied on corrective action plans to address the violations; six imposed sanctions. Finally, our review found that CMS provides limited oversight of State access standards.

WHAT WE RECOMMEND

We recommend that CMS (1) strengthen its oversight of State standards and ensure that States develop standards for key providers, (2) strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards, (3) improve States' efforts to identify and address violations of access standards, and (4) provide technical assistance and share effective practices. CMS concurred with all four of our recommendations.

TABLE OF CONTENTS

Objectives 1

Background 1

Methodology 5

Findings 8

State standards for access to care vary widely and are often not specific to certain types of providers or areas of the State 8

States have different strategies to assess compliance with access standards, but do not commonly use direct tests 13

Most States did not identify any violations of access standards over a 5-year period; States that found the most violations conducted direct tests of compliance 15

Most States that identified violations relied on corrective action plans to address them; six States imposed sanctions 17

CMS provides limited oversight of State standards for access to care 17

Conclusion and Recommendations 19

Agency Comments and OIG Response 21

Appendices 22

Appendix A: State Access Standards: Maximum Distance or Time an Enrollee Should Have To Travel To See a Provider 22

Appendix B: State Access Standards: Maximum Number of Days an Enrollee Should Have To Wait for an Appointment 24

Appendix C: State Access Standards: Number of Enrollees per Provider 26

Appendix D: Agency Comments 28

Acknowledgments 30

OBJECTIVES

1. To describe State standards for access to care in Medicaid managed care.
2. To assess the methods that States use to determine compliance with their access standards.
3. To determine the extent to which States identify and address violations of their access standards.
4. To assess the Centers for Medicare & Medicaid Services' (CMS) oversight of States' access standards.

BACKGROUND

Medicaid is a jointly funded Federal and State health insurance program that finances the delivery of medical services to more than 69 million people.[1] In fiscal year (FY) 2013, the Federal Government and the States together spent almost $460 billion for the program.[2] Each State designs and administers its own Medicaid program within broad Federal guidelines. Most States provide some, if not all, Medicaid services through managed care, which covers nearly three-quarters of all Medicaid enrollees.[3]

Examining access to care takes on heightened importance as enrollment grows in Medicaid managed care programs. Under the Patient Protection and Affordable Care Act, States have the option to expand eligibility for their Medicaid programs.[4] In addition, many States that have not

[1] Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*. Accessed at http://www.cbo.gov/publication/45010 on August 26, 2014.

[2] The Medicaid and CHIP Payment and Access Commission (MACPAC), *Report to the Congress on Medicaid and CHIP*, March 2014. Accessed at http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0&d=1 on August 26, 2014.

[3] Centers for Medicare & Medicaid Services (CMS), *Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf on April 1, 2014.

[4] P.L. No. 111-148 § 2001 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively referred to as "the ACA."

expanded eligibility have also seen increases in enrollment.[5] As a result, Medicaid is expected to provide coverage for as many as 18 million more people by 2018.[6]

The Office of Inspector General (OIG) received a congressional request to evaluate the adequacy of access to care for enrollees in Medicaid managed care. This report describes the access standards States establish for their Medicaid managed care programs and how States determine compliance with these standards. A companion report determines the extent to which providers offer appointments to enrollees and the timeliness of these appointments.[7]

Medicaid Managed Care

States have the option to provide either all or some portion of their Medicaid services through Medicaid managed care.[8] The goal of managed care is to decrease Medicaid costs while providing high-quality care to enrollees. Additionally, managed care is intended to reduce the State's financial risk and allow for more predictable Medicaid costs.

States have different types of managed care arrangements, but the most common is full-risk managed care.[9] Under this arrangement, managed care organizations (MCOs) assume the full financial risk for delivering a comprehensive set of services. These services generally include all primary, specialty, and acute medical care. States pay MCOs a fixed monthly fee per enrollee (often referred to as capitation) and the MCO

---

[5] MACPAC, *Report to the Congress on Medicaid and CHIP*, March 2014. Accessed at: http://www.macpac.gov/reports/2014-03-14_Macpac_Report.pdf?attredirects=0&d=1 on September 8, 2014, and Kaiser Family Foundation, *Medicaid Enrollment: June 2013 Data Snapshot*. Accessed at http://kff.org/report-section/medicaid-enrollment-june-2013-data-snapshot-appendix-a-table-a-1-total-medicaid-enrollment-by-state/ on September 8, 2014.

[6] Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*. Accessed at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf on August 26, 2014.

[7] OIG, *Access to Care: Provider Availability in Medicaid Managed Care* (OEI-02-13-00670), forthcoming.

[8] States may provide Medicaid services through managed care under their State plans for medical assistance in accordance with Social Security Act § 1932(a) or under waivers to their State plans in accordance with Social Security Act §§ 1115, 1915(a), and 1915(b).

[9] Another arrangement is primary care case management, which pays providers a nominal fee for providing case management services to enrollees assigned to them. States may also contract with MCOs to provide a limited set of services under managed care, such as dental services.

delivers services through a network of participating providers.[10] MCOs maintain listings—typically in the form of a provider directory—of all participating providers in their networks who provide care to enrollees. This report focuses solely on MCOs providing full-risk managed care for a comprehensive set of services.

Federal Regulations Governing Medicaid Managed Care Access Standards

Federal regulations require States to have a written strategy for assessing and improving the quality of health care services offered by all MCOs.[11] That strategy must include standards for access to care that all MCOs must meet. These standards are intended to ensure that each MCO maintains a network of providers that is sufficient to provide adequate access to Medicaid services covered under the contract between the State and the MCO.[12] When establishing and maintaining its provider network, each MCO must consider (1) the anticipated Medicaid enrollment, (2) the expected utilization of services, (3) the numbers and types of providers needed, (4) the numbers of network providers who are not accepting new Medicaid patients, and (5) the geographic locations of providers and Medicaid enrollees. Regulations also require that each MCO provide timely access to care and services.[13]

Additionally, regulations require State contracts to ensure that if the MCO is unable to provide necessary services to a particular enrollee with providers in the managed care network, the MCO must cover these services using out-of-network providers at no additional cost to the enrollee.[14]

External Quality Reviews

Federal regulations also require States to ensure that external quality reviews are conducted annually to evaluate the quality of, timeliness of, and access to care furnished by MCOs to enrollees.[15] States may conduct these reviews themselves or contract with qualified independent entities,

---

[10] 42 CFR § 438.2. The MCO is responsible for paying for services delivered to enrollees by participating providers. In assuming the full financial risk, the MCO must cover the cost of services delivered to enrollees, even if the cost exceeds the amount of capitation payment from the State.

[11] 42 CFR § 438.202(a).

[12] 42 CFR § 438.206(b)(1)

[13] 42 CFR § 438.206(b)(1)(i)-(v). The regulations that we outline in this paragraph of our report are intended to ensure both the adequacy of MCO networks and timely access to care. State standards for access to care ensure that MCOs comply with both of these regulatory requirements.

[14] 42 CFR §§ 206(b)(4).

[15] 42 CFR §§ 438.310–370.

called external quality review organizations (EQROs). Among the requirements for these reviews is that the State or EQRO must determine at least once every 3 years whether each MCO is complying with the State's access standards. In addition, the State or EQRO may conduct up to five optional activities, such as conducting focused studies on specific aspects of quality.

After completing each review, the State or EQRO must produce a detailed technical report with conclusions about the quality of, timeliness of, and access to care that the MCO furnishes. It must also produce an assessment of the MCO's strengths and weaknesses related to quality, timeliness, and access to care, as well as recommendations for improving the quality of care that the MCO furnishes. Finally, it must also assess how effectively the MCO has addressed any recommendations made during the previous year's review.

Violations

States must have a plan for monitoring MCO compliance and identifying violations of access standards.[16] If a State finds—through onsite visits, reviews of complaints, or any other source—that an MCO is in violation of any regulation, including regulations related to access to care, the State may impose sanctions. These sanctions include imposing monetary penalties, appointing temporary management for the MCO, granting enrollees the right to terminate their enrollment without cause, suspending new enrollment, and suspending payment for enrollment. States also have the authority to impose additional sanctions under State statutes or regulations.

CMS Oversight

According to Federal regulations, CMS must review and approve all contracts that States enter into with MCOs, including contract provisions that incorporate standards for access to care.[17] In addition, each State must submit to CMS its quality strategy, which includes these standards, and must certify that its MCOs have complied with its requirements for availability of services.[18] Further, each State must submit to CMS regular reports describing the implementation and effectiveness of its quality strategy.[19]

---

[16] 42 CFR §§ 438.700–726.
[17] 42 CFR § 438.6(a).
[18] 42 CFR §§ 438.202 and 438.207(d).
[19] 42 CFR § 438.202(e)(2).

Related Work

In a 2008 report, OIG found that most States use the results of external quality reviews and require MCOs to make improvements to their standards, processes, and performance on the basis of these reviews.[20] However, more than half of States cited concerns about the external quality review process and the quality of reports produced by this process. Specifically, States were concerned that external quality review reports were missing required elements and information on mandatory activities. OIG recommended that CMS provide additional technical assistance and written guidance to States and that it work with States to ensure that the reports include complete information. CMS agreed with the recommendations and stated that it had implemented both of them.

METHODOLOGY

We based this study on data from four sources: (1) a survey of State Medicaid agency officials, (2) documentation and data from States that contract with Medicaid MCOs, (3) structured interviews with officials from EQROs, and (4) structured interviews with CMS officials.

Scope

We contacted all States to identify those that contract with Medicaid MCOs. We focused solely on MCOs providing full-risk managed care for a comprehensive set of services. We did not include other managed care arrangements, such as partial-risk plans, as these models typically offer a limited range of services under managed care.[21] We identified 33 States with 227 MCOs that were active from January 1, 2012, through January 1, 2013.[22] Further, we did not include in this study plans that served only specific populations, such as foster children, enrollees with long-term care needs, or enrollees who are eligible for both Medicaid and Medicare. Additionally, we focused our analysis on access standards for primary care providers and specialists.

---

[20] OIG, *External Quality Reviews in Medicaid Managed Care* (OEI-01-06-00510), June 2008.

[21] We excluded partial-risk managed care models, such as primary care case management programs, prepaid inpatient health plans, and prepaid ambulatory health plans, as these programs do not provide a full range of services under managed care. In addition, we excluded comprehensive Programs for All-Inclusive Care for the Elderly, as these programs provide services to both Medicaid and Medicare enrollees. Finally, we included Health Insuring Organizations, which are county-level MCOs in California.

[22] A given MCO may have more than one managed care plan. For the purposes of this report, we use the term "plans" to refer both to MCOs and to their plans. We also refer to the District of Columbia as a State.

Survey of State Medicaid Officials

We surveyed State Medicaid agency officials in the 33 States. Our questions focused on each State's standards for access to care as of January 1, 2013, as well as how each State determines compliance with its standards. In addition, we asked how often each State had identified plans that were not meeting State standards during a 5-year period (i.e., January 1, 2008, through January 1, 2013) and what actions, if any, the State took against those plans. We conducted this survey electronically in April and May 2013.

State Documentation and Data

We requested documentation and supporting data from the 33 States. Specifically, we asked each State for documentation of (1) its standards for access to care as of January 1, 2013; (2) the methods that it uses to assess plan compliance with standards; (3) any violations of standards that it identified over a 5-year period (January 1, 2008, through January 1, 2013); and (4) any actions that it took in response to these violations.

Structured Interviews with EQROs

In February 2014, we conducted structured interviews with officials from the three largest EQROs. In 2013, these three organizations contracted with 20 of the 33 States in this study to conduct all or part of their external quality reviews.[23] Our questions focused on how these organizations conduct external quality reviews and the methods they used to determine whether plans comply with State access standards.

Structured Interviews with CMS Officials

Throughout the course of the study, we conducted structured interviews with CMS officials responsible for Medicaid managed care. These interviews focused on CMS's role in developing State access standards, in monitoring compliance with standards, and in identifying and responding to violations of standards. We also asked about CMS's oversight of the external quality reviews.

Analysis

To determine each State's standards for access to care, we analyzed the survey responses and supporting documentation submitted by States. We focused our analysis on standards for access to primary care providers and specialists. Our analysis did not include standards for access to other

---

[23] CMS Center for Medicaid and Children's Health Insurance Program Services, *Findings from External Quality Review Technical Reports*. Accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/External-Quality-Review-Technical-Reports.html on August 25, 2014.

types of providers, such as behavioral health providers, dentists, hospitals, and pharmacies.

Next, we identified the various methods that States use to assess compliance with their access standards, either through their plans, through their EQROs, or on their own. Additionally, we determined the number of States that identified violations of their access standards over a 5-year period and analyzed each State's responses to these violations. As we did in our analysis of the access standards, we included only violations related to primary care providers and specialists; we did not include violations of standards for other types of providers. We also did not include violations that were unrelated to access, such as those involving billing issues. For each State that identified violations, we analyzed survey responses and State documentation to determine the action taken to address violations.

Finally, to assess CMS's oversight of State standards, we analyzed CMS officials' responses to interview questions.

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

State standards for access to care vary widely and are often not specific to certain types of providers or areas of the State

Medicaid regulations require that States establish access standards to ensure that each plan's provider network is adequate and meets the needs of its enrollees. However, States have considerable latitude in the standards they establish for their plans.

The three most common types of access standards are (1) standards that limit the distance or amount of time enrollees should have to travel to see a provider; (2) standards that require appointments to be provided within a certain timeframe; and (3) standards that require a minimum number of providers in relation to the number of enrollees.

Of the 33 States with risk-based managed care plans, 32 established standards regarding provider distance or time, 31 established standards regarding appointment availability, and 20 established standards regarding provider-to-enrollee ratios. All but one State has at least two of these types of standards. In addition, 22 States established other types of standards.

State standards vary widely and are often not specific to providers who are important to the Medicaid population, such as pediatricians, obstetricians and high-demand specialists. In addition, these standards often apply to *all* areas within a State and do not take into account differences between urban and rural areas. Without standards for specific provider types or areas, States may not be able to hold plans accountable for ensuring adequate access to care.

Thirty-two States limit the distance or time enrollees should have to travel to see a provider

Thirty-two States have standards that establish a maximum distance or time enrollees should have to travel to see a provider. These standards are intended to ensure that enrollees can access care with a network provider within a reasonable distance from their residence.

All of these 32 States have standards that apply to primary care providers. These standards vary from State to State. Standards for the maximum distance to a primary care provider range from 5 miles (as specified by

2 States) to 60 miles (as specified by 3 States).[24] The standards for maximum travel time to see a primary care provider range from a low of 30 minutes to a high of 60 minutes.

Fourteen of the thirty-two States do not have distance or time standards that apply to specialists. In the remaining 18 States, standards for specialists range from 15 miles in 1 State to as many as 100 miles in 2 States.

Additionally, 17 of the 32 States do not have standards that distinguish between urban and rural areas. In the remaining 15 States, the standards for rural areas are often two times greater than those for urban areas. (See Table 1.) For example, Hawaii requires that enrollees be able to find a provider within 30 minutes in urban areas and within 60 minutes in rural areas. See Appendix A for a description of States' standards regarding distance and travel time.

Table 1: Standards for Distance and Travel Time Among the States That Distinguish Between Urban and Rural Areas, 2013

		Shortest Distance/Time Among States	Longest Distance/Time Among States
Distance to Primary Care Provider	Urban Areas	6 Miles	30 Miles
	Rural Areas	15 Miles	60 Miles
Travel Time to Primary Care Provider	Urban Areas	30 Minutes	30 Minutes
	Rural Areas	30 Minutes	60 Minutes

Source: OIG analysis of State data, 2014.

Thirty-one States require that appointments be provided within a certain timeframe

Thirty-one States have standards that specify the maximum number of days an enrollee should have to wait for an appointment. These standards are intended to ensure that enrollees receive care with a network provider within a reasonable timeframe.

All of these 31 States have standards for primary care providers. However, these standards vary widely. As shown in Table 2, the standards for the maximum wait time for a routine-care appointment with a primary care provider range from a low of 10 days to a high of 45 days. All but 2 of these 31 States also have standards for urgent-care

[24] Eleven of the thirty-two States have standards that require at least two providers within the specified distance or travel time.

appointments; these standards range from 1 to 2 days for an appointment with a primary care provider.

Of the 31 States with appointment standards, 10 States do not specify the maximum number of days an enrollee should have to wait for a routine appointment with a specialist. In the remaining 21 States, the standards for maximum wait time for a routine appointment with a specialist range from 10 days to 60 days. See Appendix B for a description of States' standards for wait times for appointments.

Table 2: Standards for Wait Times for Appointments, 2013

		Shortest Wait Times Among States	Longest Wait Times Among States
Primary Care Providers	Routine Appointments	10 Days	45 Days
	Urgent Appointments	1 Day	2 Days
Specialists	Routine Appointments	10 Days	60 Days
	Urgent Appointments	1 Day	4 Days

Source: OIG analysis of State data, 2014.

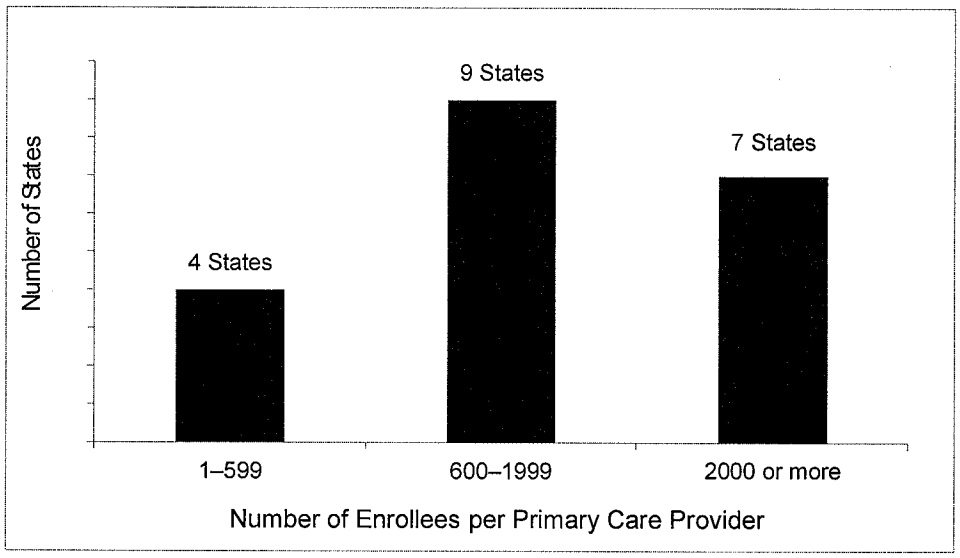
In addition, 15 States established specific standards for prenatal appointments. For example, Nebraska requires that an initial prenatal appointment be provided within 14 days if the enrollee is in her first trimester, 7 days for the second trimester, and 3 days for a high-risk pregnancy.

Twenty States require a minimum number of providers based on the number of enrollees

Twenty States have established standards that require a minimum number of providers in a plan's network in relation to the number of enrollees. These standards seek to ensure that plans' provider networks are sufficient in size to serve their enrollees.

All of these 20 States have standards for minimum numbers of primary care providers; however, as shown in Chart 1, these standards vary considerably—from 1 primary care provider for every 100 enrollees to 1 for every 2,500 enrollees.

Chart 1: Standards for Number of Enrollees per Primary Care Provider, by Number of States, 2013



Source: OIG analysis of State data, 2014.

Eight of these twenty States have different standards for minimum numbers of physician and nonphysician primary care providers. For example, New York requires 1 primary care physician per 1,500 enrollees and 1 certified nurse practitioner per 1,000 enrollees. In addition, five States have standards for specific types of primary care providers, such as obstetricians and pediatricians. For example, Illinois has standards for obstetricians (1 obstetrician per 300 pregnant enrollees) and women's health providers (1 women's health provider per 2,000 female enrollees). Massachusetts has a standard for pediatricians (1 pediatrician per 200 child enrollees).

Only 4 of the 20 States require plans to have a minimum number of specialists in relation to their number of enrollees. Two of these States have standards that apply to all specialists—Nevada requires 1 specialist for every 1,500 enrollees, and Colorado requires 1 specialist for every 2,000 enrollees. The remaining two States have standards for more than 15 different types of specialists. For example, Wisconsin's standards for minimum numbers of specialists range from 1 cardiologist per 1,000 enrollees to 1 urologist per 3,000 enrollees. Tennessee's standards for minimum numbers of specialists range from 1 orthopedic surgeon per 15,000 enrollees to 1 allergist/immunologist per 100,000 enrollees. See Appendix C for a description of States' standards for provider-to-enrollee ratios.

Twenty-two States have other standards for access to care

In addition to having the three most common types of standards, 22 States also have other types of standards for access to care. These standards vary and commonly include the following:

- *In-office wait time:* Eleven States have standards that limit the amount of time that an enrollee may wait in a provider's office before being seen by a provider. For example, New Jersey specifies that an enrollee must be seen by a primary care provider within 45 minutes of the scheduled appointment time. To minimize in-office wait time, two States have standards that limit the number of appointments a primary care provider can schedule in an hour. For example, Illinois allows no more than six scheduled appointments per hour for each primary care provider.
- *Access to multilingual care:* Six States have standards that require plans to provide enrollees with access to interpreter services or multilingual providers. For example, the District of Columbia requires its plans to provide non-English-speaking enrollees with access to free interpreters during appointments.
- *Twenty-four-hour telephone access to providers:* Six States have standards that require enrollees to have telephone access to providers 24 hours a day, 7 days a week. For example, Indiana requires that enrollees have 24-hour access to either their primary care provider or the provider's clinical staff through a tollfree telephone number.
- *Access-related performance measures:* Although a number of States provide incentive payments based on a plan's success in meeting key performance measures related to access, one State—Ohio—has incorporated these performance measures into its access standards.[25] For example, the State requires that 83 percent of enrollees 1 to 19 years old have had a primary care visit within the previous year.

---

[25] These measures are based on nationally recognized performance measures found in the Healthcare Effectiveness Data and Information Set (HEDIS), which was developed by the National Committee for Quality Assurance. HEDIS measures allow for assessment and comparison of health plans across many dimensions of care and service, including access. Many States use HEDIS measures to assess plan performance but do not include them as part of their State standards for access.

States have different strategies to assess compliance with access standards, but do not commonly use direct tests

All States have developed strategies for how they assess plan compliance with access standards. These strategies include reviews of reports from plans and external quality reviews. In some cases, States conduct their own tests of plan compliance.

While States use different strategies, they do not often use direct tests. Direct tests seek to reliably measure whether plans comply with access standards. These tests can also determine the accuracy of information maintained by plans. Such tests are important because States have established standards that rely heavily on provider information from plans and this information is often inaccurate or out of date.[26] Direct tests commonly include telephone calls to providers that either assess compliance with a specific standard, such as wait times for appointments, or assess the accuracy of provider information, such as whether a provider is participating in a plan.

All States rely on reports from managed care plans, but these reports vary widely

All States rely on managed care plans to help assess whether plans comply with State access standards. However, States differ widely in what they require their plans to report. Such reports range from an annual "self-attestation" that a plan is complying with standards to direct tests of plan compliance.

For example, several States rely on reports from plans that include numbers of network providers, but there was no evidence that the plan had validated the accuracy of those numbers. In some cases, these reports do not even include the network providers' names or contact information. In contrast, other States require their plans to conduct direct tests, including making calls to their own network providers.

States also use external quality reviews, but these reviews often do not include direct tests of compliance

Federal regulations require States with Medicaid managed care programs to provide for an external, independent review of their plans. These reviews must determine plan compliance with access standards at least once every 3 years. Most States contract with an EQRO to conduct all or

---

[26] OIG, *Access to Care: Provider Availability in Medicaid Managed Care* (OEI-02-13-00670), forthcoming.

part of these reviews. In these contracts, States specify the methods EQROs should use to determine plan compliance.

The methods that EQROs commonly use to assess plan compliance include reviewing plan policies and procedures and conducting onsite interviews of plan personnel. In addition, EQROs are often contracted by States to evaluate results from enrollee satisfaction surveys and to evaluate plans' performance on key health care measures, like how many children receive immunizations on a timely basis.[27] One EQRO official noted that these methods can provide a sense of how a plan performs with regard to access but do not directly measure compliance with access standards. EQROs also use information from plans—such as provider network lists—to assess compliance, but officials cited variation in the quality of such information as a concern.

EQROs less commonly use direct tests to determine plan compliance. EQRO officials explained that States often do not contract with them for such tests because they can be resource intensive. Officials noted, however, that such tests are particularly effective for assessing compliance. One State, for example, contracts with its EQRO to conduct data validation surveys to determine the accuracy of the provider data that each plan maintains.

Eight States report conducting their own direct tests of plan compliance

Only eight States report conducting their own direct tests to assess whether plans comply with access standards. For example, several States conduct "secret shopper" calls during which the caller pretends to be a patient. These calls are used to confirm specific information about providers, such as whether they are accepting new patients or how far in advance they can schedule appointments. States also report contacting providers to verify plan information. For example, one State conducts provider surveys to ensure that providers are listed correctly in the directory and are participating in the plan.

In addition to assessing compliance with the access standards, calls to providers can also help States identify other barriers to access. One State Medicaid official noted that there were barriers to access that would never have been discovered without conducting secret-shopper calls. For

---

[27] Enrollee satisfaction is commonly measured through a national survey instrument, the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Key health care measures are commonly collected through HEDIS. Although CAHPS and HEDIS are both standardized tools, the information collected through the two can vary across States or plans.

example, some providers request and review enrollees' medical records prior to making appointments.

Most States did not identify any violations of access standards over a 5-year period; States that found the most violations conducted direct tests of compliance

Only 11 of the 33 States with risk-based managed care plans identified at least one violation of their access standards between January 1, 2008, and January 1, 2013.[28] See Table 3 below. The remaining States found no violations. When States fail to identify violations of their access standards, they are unable to correct problems and improve access to care for enrollees.

Table 3: Number of Violations of Access Standards, 2008 to 2013*

State	Number of Violations Reported for 2008–2013	Percentage of All Violations Reported for 2008–2013
Ohio	76	32%
New York	63	27%
Georgia	41	18%
California	14	6%
Florida	11	5%
Texas	8	3%
West Virginia	7	3%
District of Columbia	5	2%
Maryland	5	2%
Massachusetts	2	1%
Washington	2	1%
Total	**234**	**100%**

*Includes violations related to primary care providers and specialists.

Source: OIG analysis of State data, 2014.

When violations were found, they most commonly involved problems with meeting standards for distance and time, for appointment availability, and for provider-to-enrollee ratios. Many of these violations also involved plans that had inaccurate provider information, such as wrong addresses or incorrect provider participation data. The accuracy of provider information is important because State standards rely heavily on this

[28] This analysis includes violations related to primary care providers and specialists. It does not include violations related to other types of providers, such as behavioral health providers, dentists, hospitals, and pharmacists.

information. For example, to assess compliance with a State's distance standard, a plan may submit information to the State about where its network providers are located in relation to its enrollees. If this provider information is inaccurate (e.g., because some providers are not at the reported addresses or do not participate in the plan), then States may fail to identify violations and correct problems regarding access to care.

Examples of Violations and Their Effects on Enrollees' Access to Care

One State found that in one of its plans, there were no participating urologists within 75 miles of an enrollee and that the plan did not provide appropriate referrals or an explanation of how the enrollee could receive care.

Another State found that for one of its plans, appointments for enrollees could not be made with 45 percent of the primary care providers listed as participating in a specific region.

Another State found significant deficiencies in the number of specialists participating in 1 of its plans, identifying 30 counties in which enrollees lacked access to certain types of specialists.

Source: OIG analysis of State data, 2014.

Just three States—Ohio, New York, and Georgia—identified more than three-quarters of all violations. In these three States, the State or its EQRO conducted direct tests of plan compliance, including making calls to providers. For example, Ohio contracted with its EQRO for the EQRO to call providers to validate plan provider information. In addition, the State made calls to each plan's enrollee-services department to assess whether plans were providing timely assistance to enrollees.

Similarly, New York contracted with its EQRO to conduct secret-shopper calls to providers to measure their access and availability as well as the accuracy of their information in provider directories. New York used the results from these surveys to determine the percentage of each plan's providers that were actually participating in the plan and accepting new enrollees. The State then cited each plan that had a provider-participation rate below 75 percent with a violation.

In Georgia, the State identified violations during quarterly secret-shopper calls to providers to determine appointment wait times and confirm the accuracy of information included in plan reports and directories.

Most States that identified violations relied on corrective action plans to address them; six States imposed sanctions

The 11 States that identified violations most commonly relied on corrective action plans (CAPs) to address them. States either issue CAPs to plans or approve CAPs developed by plans. These CAPs, which are used for both new and repeat violations of standards, outline the steps necessary to make plans compliant. To ensure that plans implement CAPs, States use (1) requirements in their contracts with plans, (2) conference calls with plan staff, and (3) site visits to plan offices. Some States contract with their EQROs to monitor completion of CAPs.

Six of the eleven States that identified violations reported imposing sanctions in response to violations—in some cases, in addition to CAPs. These sanctions include issuing monetary penalties and blocking new enrollees from signing up with plans. For example, after identifying one plan that failed to resolve access deficiencies, one State blocked new enrollment to that plan and transferred its existing enrollees to other plans in the State.

CMS provides limited oversight of State standards for access to care

Federal regulations require CMS to review and approve all State contracts with MCOs, including provisions that incorporate access standards. CMS uses a checklist to confirm that States have access standards, but officials reported that they do not assess whether these standards are adequate to ensure access to care. CMS officials further explained that setting the standards is primarily a State responsibility, but given how much these standards vary, there would be some utility in having more uniformity among State standards. One EQRO official also recommended that increased uniformity among State standards could improve access. Another EQRO official said that CMS could require States to have standards for certain types of providers, such as pediatricians, obstetricians, or high-demand specialists. This would enable States to maintain flexibility in setting their standards, but would help ensure access to key provider types that are essential to serving the Medicaid population.

CMS officials also reported that they generally do not assess the adequacy of States' methods for monitoring compliance with standards. However, CMS does play a role in the oversight of external quality reviews. For example, CMS has developed the protocols that States and EQROs use to conduct the reviews. These protocols do not require States or EQROs to use direct tests to assess plan compliance.

Lastly, CMS officials reported that until recently, they have not kept track of violations identified by States or EQROs, nor have they monitored State responses to such violations. Officials reported that in 2013 they began tracking violations identified in the technical reports that were prepared as part of the external quality reviews, and that they are in the process of hiring a contractor to evaluate the external quality review process and make recommendations for improvement.

CONCLUSION AND RECOMMENDATIONS

Access to health care services for enrollees in Medicaid managed care is essential. Without adequate access, enrollees would not receive the preventative care and treatment necessary to achieve positive health outcomes and improved quality of life. To ensure that Medicaid managed care enrollees have adequate access, States must have standards for access to care. They must also determine whether managed care plans comply with these standards.

Our review found that State access standards vary widely. For example, standards range from requiring 1 primary care provider for every 100 enrollees to 1 primary care provider for every 2,500 enrollees. Additionally, they are often not specific to certain types of providers or areas of the State. Without standards for specific providers or areas, States may not be able to hold plans accountable for ensuring adequate access to care. In addition, States have different strategies to assess compliance with standards, but do not commonly use direct tests, such as calls to providers. Further, most States did not identify any violations of their access standards over a 5-year period; States that found the most violations conducted direct tests. When States fail to identify violations of their access standards, they do not correct problems and improve access to care for enrollees. Among the States that identified violations, most relied on CAPs to address the violations; six imposed sanctions. Finally, our review found that CMS provides limited oversight of State standards for access to care.

These findings show that CMS and States need to do more to ensure that all States have adequate access standards and strategies for assessing compliance. This will help to ensure that enrollees in Medicaid managed care have access to the services they need. With Medicaid expanding and enrollment expected to reach as many as 87 million people by 2018, ensuring adequate access to care is increasingly important.

We recommend that CMS:

Strengthen its oversight of State standards and ensure that States develop standards for key providers

CMS should strengthen its oversight of State standards and work with States to ensure that they have adequate standards in place to meet the needs of their Medicaid managed care populations.

As a part of this effort, CMS should issue guidance to strengthen State standards. In addition, CMS should require States to develop standards for a core set of providers that are important to the Medicaid managed care

population, including primary care providers, pediatricians, obstetricians and other high-demand specialists. It should also work with States to ensure that standards are specific to urban and rural areas when appropriate.

Strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards

CMS should strengthen its oversight of States' methods to assess plan compliance with access standards. CMS should work with States to ensure that these methods accurately determine plan compliance.

As part of this effort, CMS should require that States or their EQROs conduct direct tests of their access standards. These tests could include calls to providers or other methods to determine compliance with standards or to validate the plan data used to determine compliance. CMS should revise its protocols for external quality reviews to instruct States or EQROs to conduct these tests.

Improve States' efforts to identify and address violations of access standards

Given how few States identified violations of access standards over a 5-year period, CMS should work with States to improve how States identify and address violations of access standards. Additionally, CMS should use the information it has started to collect to track violations and ensure that States are addressing them appropriately.

Provide technical assistance and share effective practices

CMS should provide technical assistance to States to ensure the adequacy of their access standards, their methods for testing them, and their methods for identifying and addressing violations. CMS should share effective practices with all States to improve access for Medicaid managed care enrollees.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations. Regarding our recommendation for it to strengthen its oversight of State standards, CMS concurred and stated that it is considering options to set forth expectations for network access standards through additional guidance to States. Regarding our recommendation for it to strengthen its oversight of States' methods to assess plan compliance and to ensure that States conduct direct tests of access standards, CMS concurred, noting that it will engage collaboratively with States to identify best practices for testing plan compliance rather than endorse a particular method.

Regarding our recommendation for it to improve States' efforts to identify and address violations of access standards, CMS concurred and stated that it believes that existing regulations provide an adequate array of remedies for States to pursue for plans' noncompliance with access standards. CMS added that it believes that flexibility should remain with the States to determine which compliance actions should be applied. CMS also stated that when it becomes aware of potential issues, it shares that information with the appropriate State and monitors—on an ongoing basis—the State's actions to remedy the situation. Regarding our recommendation for it to provide technical assistance and share effective practices, CMS concurred and noted that it has been providing technical assistance to States through existing contract resources. CMS added that it would continue such activities in the future as resources allow.

We support CMS' efforts to provide effective oversight of Medicaid managed care, and we encourage it to continue to work with States to ensure access to care for managed care enrollees. In its comments, CMS did not address whether it intends to issue guidance about requiring States to develop standards for core provider types and to conduct direct tests of their access standards. OIG requests that CMS provide in its Final Management Decision details on how it intends to address these issues.

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

APPENDIX A

State Access Standards: Maximum Distance or Time an Enrollee Should Have to Travel to See a Provider

Table A-1: Distance and Time Standards by State, 2013

State	Standards for Distance or Time Between Providers and Enrollees' Residences	
	Primary Care Providers	Specialists
Arizona	Within 5 miles for 95 percent of enrollees residing within boundary of metropolitan Phoenix or Tucson (There is no standard for enrollees outside of these two areas)	No standard
California	Within 30 minutes or 10 miles	No standard
Colorado	Within 30 minutes or 30 miles	Within 30 minutes or 30 miles
Delaware	Within 30 minutes or 30 miles	Within 100 miles
District of Columbia	Within 30 minutes' travel time via public transportation or within 5 miles	No standard
Florida	Within 30 minutes	Within 60 minutes
Georgia	**Urban:** Within 8 miles* **Rural:** Within 15 miles*	**Urban:** Within 30 minutes or 30 miles **Rural:** Within 45 minutes or 45 miles
Hawaii	**Urban:** Within 30 minutes **Rural:** Within 60 minutes	**Urban:** Within 30 minutes **Rural:** Within 60 minutes
Illinois	No standard	No standard
Indiana	Within 30 miles	Within 60 miles for selected specialists*; within 90 miles for other specialists
Kentucky	**Urban:** Within 30 minutes or 30 miles **Rural:** Within 45 minutes or 45 miles	No standard
Maryland	**Urban:** Within 30 minutes or 10 miles **Rural:** Within 30 minutes or 30 miles	No standard
Massachusetts	Within 30 minutes or 15 miles*	No standard
Michigan	Within 30 minutes or 30 miles	No standard
Minnesota	Within 30 minutes or 30 miles	Within 60 minutes or 60 miles
Mississippi	**Urban:** Within 30 minutes or 30 miles * **Rural:** Within 60 minutes or 60 miles*	No standard
Missouri	**Urban:** Within 10 miles† **Basic:** Within 20 miles† **Rural:** Within 30 miles†	**Urban:** Within 15 miles for general surgeons; within 25 miles for other selected specialists **Basic:** Within 30 miles for general surgeons; within 50 miles for other selected specialists **Rural:** Within 60 miles for general surgeons; within 100 miles for other selected specialists

* Denotes standards that require at least two providers within the specified distance or travel time.
† Denotes States that have additional standards for specific types of primary care providers, such as obstetricians.

continued on next page

Table A-1: Distance and Time Standards by State, 2013 (continued)

State	Standards for Distance or Time Between Providers and Enrollees' Residences	
	Primary Care Providers	Specialists
Nebraska	**Urban:** Within 30 miles*† **Rural:** Within 45 miles† **Frontier:** Within 60 miles†	Within 90 miles for high-demand specialists
Nevada	Within 25 miles	No standard
New Jersey	**Urban:** Within 6 miles for 90 percent of enrollees*† **Rural:** Within 15 miles for 85 percent of enrollees*†	Within 60 minutes or 45 miles for 90 percent of the enrollees in each county or approved subcounty service area
New Mexico	**Urban:** Within 30 miles for 90 percent of enrollees **Rural:** Within 45 miles for 90 percent of enrollees **Frontier:** Within 60 miles for 90 percent of enrollees	No standard
New York	**Urban:** Within 30 minutes **Rural:** Within 30 minutes or 30 miles	Within 30 minutes or 30 miles
Ohio	If medically necessary care is not within 30 miles, MCO must provide transportation	If medically necessary care is not within 30 miles, MCO must provide transportation
Pennsylvania	**Urban:** Within 30 minutes* **Rural:** Within 60 minutes*	**Urban:** Within 30 minutes for selected specialists* **Rural:** Within 60 minutes for selected specialists*
Rhode Island	Standard varies by plan*	Standard varies by plan*
South Carolina	Within 30 miles	No standard
Tennessee	**Urban:** Within 30 minutes or 20 miles **Rural:** Within 30 minutes or 30 miles	Within 60 miles for 75 percent of enrollees; within 90 miles for all enrollees
Texas	Within 30 miles	Within 75 miles
Utah	Within 40 minutes or 40 miles*	No standard
Virginia	**Urban:** Within 30 minutes or 15 miles*† **Rural:** Within 60 minutes or 30 miles*†	**Urban:** Within 30 miles **Rural:** Within 60 miles
Washington	**Urban:** Within 10 miles for 90 percent of enrollees in the service area* **Rural:** Within 25 miles for 90 percent of enrollees in the service area	No standard
West Virginia	Within 30 minutes*	Within 30 minutes for high-demand specialists*; within 60 minutes for other specialists
Wisconsin	**Urban:** Within 10 miles for enrollees residing in Milwaukee, Racine, or Kenosha **Rural:** Within 20 miles for enrollees residing in the remainder of the service areas	No standard

* Denotes standards that require at least two providers within the specified distance or travel time.
† Denotes States that have additional standards for specific types of primary care providers, such as obstetricians.

Source: OIG analysis of State data, 2014.

APPENDIX B

State Access Standards: Maximum Number of Days an Enrollee Should Have to Wait for an Appointment

Table B-1: Appointment Standards by State, 2013

State	Maximum Appointment Wait Times (Days)			
	Primary Care		Specialist	
	Routine Care	Urgent Care	Routine Care	Urgent Care
Arizona	21	2	45	3
California	10*	2	15*	4
Colorado	30	2	No standard	No standard
Delaware	21	2	21	2
District of Columbia	30	No standard	30	No standard
Florida	30	1	30	1
Georgia	14	1	30	No standard
Hawaii	21	1	28	1
Illinois	35	1	No standard	1
Indiana	No standard	No standard	No standard	No standard
Kentucky	30	2	30	2
Maryland	30	2	30	2
Massachusetts	45	2	60	2
Michigan	No standard	No standard	No standard	No standard
Minnesota	45	1	No standard	No standard
Mississippi	30	1	No standard	No standard
Missouri	30	1	30	1
Nebraska	14*	2	30*	3
Nevada	14	2	30	3
New Jersey	28	1	28	1
New Mexico	30	1	21	No standard
New York	28	1	42	1
Ohio	42	1	No standard	No standard
Pennsylvania	10*	1	15* for selected specialists; 10* for others	1

*Denotes business days

Continued on next page

Table B-1: Appointment Standards by State, 2013 (continued)

State	Appointment Wait Times (Days)			
	Primary Care		Specialist	
	Routine Care	Urgent Care	Routine Care	Urgent Care
Rhode Island	30	1	30	1
South Carolina	42	2	No standard	No standard
Tennessee	21	2	30	2
Texas	14	1	30	1
Utah	30	2	30	2
Virginia	30	1	No standard	1
Washington	30	2	No standard	No standard
West Virginia	21	2	No standard	2
Wisconsin	14	No standard	No standard	No standard

* Denotes business days.

Routine care includes nonurgent well-care visits; urgent care includes visits for conditions that require more immediate attention, but do not constitute an emergency.

Standards that do not specify which type(s) of provider(s) they apply to are counted as applying both to primary care providers and to specialists.

Source: OIG analysis of State data, 2014.

APPENDIX C

State Access Standards: Number of Enrollees per Provider

Table C-1: Provider-to-Enrollee Standards by State, 2013

State	Number of Enrollees per Primary Care Provider	Number of Enrollees per Specialist
Arizona	No standard	No standard
California	2,000 enrollees	No standard**
Colorado	2,000 enrollees	2,000 enrollees
Delaware	2,500 enrollees	No standard
District of Columbia	No standard	No standard
Florida	1,500 enrollees	No standard
Georgia	No standard	No standard
Hawaii	300 enrollees	No standard
Illinois	2,000 enrollees*	No standard**
Indiana	No standard	No standard
Kentucky	1,500 enrollees	No standard
Maryland	2,000 adult enrollees 1,500 enrollees under 21	No standard**
Massachusetts	200 enrollees*	No standard
Michigan	750 enrollees	No standard
Minnesota	No standard	No standard
Mississippi	No standard	No standard
Missouri	No standard	No standard
Nebraska	No standard	No standard
Nevada	1,500 enrollees	1,500 enrollees
New Jersey	2,000 enrollees*	No standard**
New Mexico	1,500 enrollees	No standard
New York	1,500 enrollees	No standard
Ohio	No standard	No standard
Pennsylvania	1,000 enrollees	No standard
Rhode Island	1,500 enrollees	No standard
South Carolina	No standard	No standard

* Denotes States that have additional standards for specific types of primary care providers, such as obstetricians and pediatricians.
** Denotes States that have additional standards that apply to all providers, but are not specific to specialists (i.e., 1 provider per 2,000 enrollees).

continued on next page

Table C-1: Provider-to-Enrollee Standards by State, 2013 (continued)

State	Number of Enrollees per Primary Care Provider	Number of Enrollees per Specialist
Tennessee	2,500 enrollees	Standard varies by specialty type
Texas	No standard	No standard
Utah	No standard	No standard
Virginia	1,500 enrollees*	No standard
Washington	No standard	No standard
West Virginia	500 enrollees*	No standard
Wisconsin	100 enrollees	Standard varies by specialty type

* Denotes States that have additional standards for specific types of primary care providers, such as obstetricians and pediatricians.
** Denotes States that have additional standards that apply to all providers, but are not specific to specialists (i.e., 1 provider per 2,000 enrollees).

Source: OIG analysis of State data, 2014.

APPENDIX D

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG 15 2014

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "State Standards for Access to Care in Medicaid Managed Care" (OEI-02-11-00320)

Thank you for the opportunity to review and comment on the above-referenced OIG draft report. The purpose of this report was to survey states with comprehensive, risk-based managed care to collect documentation and data on managed care program access standards.

Managed care has become an important delivery system in the Medicaid program. As many of our beneficiaries are enrolled in managed care plans, the Centers for Medicare & Medicaid Services (CMS) takes seriously our role in ensuring that states are providing effective oversight of these plans.

OIG Recommendation

The OIG recommends that CMS strengthen its oversight of State standards and ensure that States develop standards for key providers.

CMS Response

The CMS concurs generally that its oversight of state network access standards for managed care networks is important to the effective delivery of Medicaid services to enrollees. We are considering options to set forth CMS' expectations for network access standards and expect to address this issue through the development of additional guidance to states.

OIG Recommendation

The OIG recommends that CMS strengthen its oversight of States' methods to assess plan compliance and ensure that States conduct direct tests of access standards.

CMS Response

The CMS concurs generally that it is important for states to document ongoing oversight of health plan compliance with provider access standards. CMS will engage collaboratively with

states to identify best practices for testing health plan compliance with provider access standards, rather than endorse a particular method, as the assessment of provider access is best conducted through multi-pronged strategies.

OIG Recommendation

The OIG recommends that CMS improve States' efforts to identify and address violations of access standards.

CMS Response

The CMS concurs generally that states' ongoing oversight of health plan compliance with provider access standards and remediation of identified violations are key to the operation of an effective Medicaid managed care program. To that end, CMS believes that existing regulations in subpart I of 42 CFR part 438 provide an adequate array of remedies for states to pursue for health plan non-compliance with access standards and that flexibility should remain with the states to determine which compliance actions should be applied to its contractors. When CMS becomes aware of potential issues with a health plan's network, we share that information with the state and monitor the state's actions to remedy the situation on an ongoing basis. CMS will continue to track compliance information from external quality review organizations' reports and contract review to determine if expectations for oversight and compliance actions are appropriate.

OIG Recommendation

The OIG recommends that CMS provide technical assistance and share effective practices.

CMS Response

We concur. The CMS has been providing technical assistance to states that seek information on provider access standards through existing contract resources. As resources allow in the future, we would continue such activities.

The CMS thanks OIG for the work done on this issue and looks forward to working with OIG in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Vincent Greiber served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Marissa Baron, Marisa Beatley, and Hailey Davis. Office of Evaluation and Inspections staff who provided support include Janna Sayer from the Atlanta regional office and Deborah Cosimo from the Dallas regional office. Central office staff who provided support include Kevin Farber, Kevin Manley, and Christine Moritz.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.