

S. HRG. 114-859

THE DOCTOR IS NOT IN: COMBATING MEDICARE PROVIDER ENROLLMENT FRAUD

HEARING BEFORE THE SPECIAL COMMITTEE ON AGING UNITED STATES SENATE ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

WASHINGTON, DC

JULY 22, 2015

Serial No. 114-10

Printed for the use of the Special Committee on Aging



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

48-875 PDF

WASHINGTON : 2022

SPECIAL COMMITTEE ON AGING

SUSAN M. COLLINS, Maine, *Chairman*

ORRIN G. HATCH, Utah
MARK KIRK, Illinois
JEFF FLAKE, Arizona
TIM SCOTT, South Carolina
BOB CORKER, Tennessee
DEAN HELLER, Nevada
TOM COTTON, Arkansas
DAVID PERDUE, Georgia
THOM TILLIS, North Carolina
BEN SASSE, Nebraska

CLAIRE McCASKILL, Missouri
BILL NELSON, Florida
ROBERT P. CASEY, JR., Pennsylvania
SHELDON WHITEHOUSE, Rhode Island
KIRSTEN E. GILLIBRAND, New York
RICHARD BLUMENTHAL, Connecticut
JOE DONNELLY, Indiana
ELIZABETH WARREN, Massachusetts
TIM KAINE, Virginia

PRISCILLA HANLEY, *Majority Staff Director*
DERRON PARKS, *Minority Staff Director*

C O N T E N T S

	Page
Opening Statement of Senator Susan M. Collins, Chairman	1
Opening Statement of Senator Claire McCaskill, Ranking Member	2
PANEL OF WITNESSES	
Seto J. Bagdoyan, Director, Audit Services, Government Accountability Office, Washington, D.C.	5
Shantanu Agrawal, M.D., Deputy Administrator, Centers for Medicare and Medicaid Services (CMS), and Director, Center for Program Integrity (CPI), Washington, D.C.	6
Katherine M. Leff, R.N., Director, Special Investigations Unit, Care Source Management Group, Dayton, Ohio	8
APPENDIX	
PREPARED WITNESS STATEMENTS	
Seto J. Bagdoyan, Director, Audit Services, Government Accountability Office, Washington, D.C.	41
Shantanu Agrawal, M.D., Deputy Administrator, Centers for Medicare and Medicaid Services (CMS), and Director, Center for Program Integrity (CPI), Washington, D.C.	57
Katherine M. Leff, R.N., Director, Special Investigations Unit, Care Source Management Group, Dayton, Ohio	67
QUESTIONS FOR THE RECORD	
Seto J. Bagdoyan, Director, Audit Services, Government Accountability Office, Washington, D.C.	73
Shantanu Agrawal, M.D., Deputy Administrator, Centers for Medicare and Medicaid Services (CMS), and Director, Center for Program Integrity (CPI), Washington, D.C.	75
STATEMENTS FOR THE RECORD	
GAO Report - Medicare Program	79

THE DOCTOR IS NOT IN: COMBATING MEDICARE PROVIDER ENROLLMENT FRAUD

WEDNESDAY, JULY 22, 2015

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 2:17 p.m., Room 562, Dirksen Senate Office Building, Hon. Susan M. Collins, Chairman of the Committee, presiding.

Present: Senators Collins, Cotton, Tillis, Sasse, McCaskill, Casey, Whitehouse, Donnelly, Warren, Kaine.

Also present: Senator Carper.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS, CHAIRMAN

The CHAIRMAN. The Committee will come to order. Good afternoon. Before I begin my remarks, let me thank our Ranking Member, Senator Claire McCaskill, for proposing this hearing on improper payments in the Medicare program. This is an incredibly important topic to which Senator McCaskill has supplied her formidable investigative skills.

Today we will examine the GAO's latest assessment of efforts to prevent these improper payments which are now estimated at an astonishing \$60 billion, or nearly 11 percent of Medicare's total spending. This problem calls to mind the old adage, the more things change, the more they remain the same, for it was in 1998 when I was Chairman of the Permanent Subcommittee on Investigations that I held a series of hearings to examine fraud in the Medicare program.

Those hearings uncovered dramatic examples such as the payments of \$117,000 to two so-called physicians whose address was actually a laundromat in Brooklyn. We also found \$6 million paid to durable medical equipment companies that supposedly were headquartered in the middle of a runway at the Miami International Airport.

We were able to cull PSI's archives to find photos of these provider locations which you can see on the monitors. Seventeen years later, after I chaired these hearings, I am dismayed to learn that improper payments are still flowing to con artists who billed the system from fictitious locations.

Take a look at the provider locations highlighted by the GAO in the report that is released today. One turns out to be a burger joint. Another, a vacant lot. They say a picture is worth a thousand words. These pictures, side-by-side, illustrate the ongoing risk of

improper payments in the Medicare system and the billions of taxpayer dollars that are already lost.

Since 1990, the GAO has identified Medicare as being at high risk for improper payments and fraud. The central question for us to ask today is why, after so many years, does Medicare remain unable to distinguish between legitimate healthcare providers seeking payment for services rendered and con artists looking to scam the system.

In part, the answer is that the task of ferreting out wasteful and fraudulent spending is made all that much more difficult by the ingenuity of scam artists, but it is also true that Medicare has dismally failed to take the comprehensive actions needed to seal its systems against vulnerabilities.

For example, the software used by Medicare to check provider addresses does not flag invalid locations such as UPS stores, mailboxes, or vacant lots, or burger joints, for that matter. Just checking these addresses using websites like Google Maps or 411.com would be an easy way to spot invalid addresses. Yet, inexplicably, CMS issued guidance in March of last year discouraging this simple practice.

Likewise, the procedures used by Medicare to screen providers remain inadequate. While they are an improvement over past practice, they ought to be strengthened. It is clear that we must do more to shift from a pay-and-chase strategy to combat Medicare fraud to one that prevents the harm from ever occurring in the first place.

Our witnesses have a wealth of knowledge about Medicare's fraud prevention mechanisms and what can be learned from private insurers and other stakeholders to reduce improper payments. I look forward to their testimony and hope that 17 years from now we are not complaining about the failure of Medicare to implement simple fraud protection procedures. It is now my pleasure to turn the hearing over to Senator McCaskill for her opening statement, introductions of witnesses, and the first round of questions.

OPENING STATEMENT OF SENATOR CLAIRE McCASKILL, RANKING MEMBER

Senator McCASKILL. Thank you so much, Chairman Collins. Before I get started, I do want to acknowledge on the record our colleague, Senator Carper, for his dedication to this issue. The GAO report was requested jointly by a number of us including him and we have worked together a long time on improper payments and improving and safeguarding the Medicare program. I know that Senator Collins has also worked with him when she previously served on the Homeland Security and Government Affairs Committee.

The Medicare program is an essential commitment that we as a society have made to Americans in their golden years. Through Medicare, our Government provides high quality medical care to seniors at an affordable cost for as long as they need it. We owe it to seniors and taxpayers to do our best to eliminate any potential fraud in the program so seniors can receive the best care and taxpayer dollars are not wasted.

Unfortunately, it appears that the Centers for Medicare and Medicaid Services, known as CMS, is falling down on some key aspects of ensuring that it is successfully implementing the very first step in eliminating fraud, preventing illegitimate providers from enrolling in the program. Before a provider can be reimbursed for taking care of beneficiaries, he or she must be enrolled in the program. CMS relies on contractors to handle and verify these enrollments.

The enrollment process is intended to ensure that the healthcare providers and suppliers in Medicare are licensed and legitimate providers of healthcare services. This is a relatively straightforward process that has four main steps. First, verifying an actual practice location for the provider; second, verifying that the licensure information listed in the application is accurate; third, verifying that the providers are not deceased; and fourth, verifying that providers had not previously been excluded from doing business with the Federal Government.

We asked GAO to review whether CMS was accomplishing these four steps. Although GAO found no major problems in CMS's process for ensuring the providers it enrolls in Medicare are alive and not excluded from working with the Federal Government, it found that CMS had some pretty big blind spots on the other two verification points.

First, as the illustrations today clearly show, CMS is doing a poor job of flagging potentially ineligible practice locations. This includes enrolling providers who list their practice addresses as rented mailboxes from companies like UPS and Mailboxes, Etc., and enrolling those who list their practice addresses at fast food restaurants or even vacant lots.

Although GAO did not have access to detailed enough claims information to be able to figure out exactly how much CMS paid out to ineligible providers, the total amount is in the hundreds of millions, perhaps as big as \$1 billion. I understand that CMS does not have the resources to require its contractors to conduct in-person visits to all 1.8 million Medicare providers and suppliers, but it is inexcusable for CMS, especially in light of today's technology, to not have the built-in ability to flag potentially invalid, vacant, or rented mailbox addresses when the United States Postal Service flags such addresses and provides that information to CMS. This should be easy, and yet, CMS has potentially misspent billions of dollars throughout the years because it failed to use this readily available information. During today's hearing, I plan to examine exactly why this has been the case for so long and how the Government can better contract for services that actually utilize the information it needs to prevent fraud.

GAO also found that CMS's process for checking adverse actions on physicians' licenses before enrolling them in Medicare is woefully lacking. CMS currently relies on physicians to self-report any adverse action on licenses that he or she may have in states other than where he or she is enrolling in Medicare.

Now, if a physician is enrolling to be a Medicare provider in Missouri with a clean Missouri medical license and a revoked Illinois medical license, that revoked Illinois medical license is something that CMS should know about. It is certainly something I would

want to know about, and although CMS may have felt confident in relying on such a physician to self-report that revoked license, I believe that both seniors and taxpayers deserve much more protection and vigilance from CMS against unscrupulous physicians. Relying on self-reporting cannot provide the necessary protection.

I have questions today about why CMS has structured its licensure check to rely on self-reporting and I plan to dig deep into CMS's current plans for fixing this problem. Next week is the 50th anniversary of the Medicare program. For 50 years, it has protected the health and well-being of millions of seniors including the 50 million or so currently enrolled in Medicare. This is a stunning achievement by our Government. I want to acknowledge and applaud that achievement.

Today's hearing is not about tearing the program down. It is about how we can all work together to make it better and ensure that it continues to provide quality care for our seniors, living up to the commitment our Government has made to them in their golden years. I thank the witnesses for being here today. First, we have Dr. Shantanu Agrawal—close?

Dr. AGRAWAL. Close. It is Shantanu.

Senator MCCASKILL. Shantanu?

Dr. AGRAWAL. Yep.

Senator MCCASKILL. Agrawal.

Dr. AGRAWAL. Agarwal.

Senator MCCASKILL. Agarwal?

Dr. AGRAWAL. I am good with that.

Senator MCCASKILL. Okay. I am sorry. I am sure you have this every day, right? You are used to it.

Dr. AGRAWAL. More often than not, yes.

Senator MCCASKILL. More often than not. He is the Deputy Administrator of the Centers for Medicare and Medicaid and the Director of the Center for Program Integrity. He comes to this position having served as chief medical officer of CPI. He is a board-certified emergency medicine physician and fellow of the American Academy of Emergency Medicine.

Mr. Seto Bagdoyan—you guys are killing me today—is the Director of Audit Services at the Government Accountability Office. During his GAO career, Mr. Bagdoyan has served in a variety of positions including as legislative advisor in the Office of congressional Relations and as an Assistant Director for Homeland Security and Justice. He has also served on congressional details with the Senate Finance Committee and the House Committee on Homeland Security.

Finally, Katherine M. Leff—this is very nice—who is a registered nurse, is the Director of the Special Investigations Unit for CareSource Management Group. CareSource is a non-profit managed healthcare plan headquartered in Dayton, Ohio. It offers managed healthcare plans including Medicaid plans, in Ohio, Kentucky, and Indiana. Ms. Leff is also the current Chair of the National Healthcare Anti-Fraud Association.

We would ask that your oral testimony be no more than five minutes. Your written testimony will be printed in the record in its entirety. Thank you all and I look forward to hearing from you. Mr. Bagdoyan, we will begin with you.

**STATEMENT OF SETO J. BAGDOYAN,
DIRECTOR, AUDIT SERVICES, GOVERNMENT
ACCOUNTABILITY OFFICE, WASHINGTON, D.C.**

Mr. BAGDOYAN. Thank you. Chairman Collins, Ranking Member McCaskill, Senator Carper who has joined us, and members of the Committee, I am pleased to be here today to discuss the results of GAO's recent report on the Medicare eligibility verification process for providers and suppliers.

As Chairman Collins mentioned earlier, Medicare is a significant expenditure for the Federal Government. In Fiscal Year 2014, Medicare paid \$554 billion for healthcare and related services, of which CMS estimates that about \$60 billion, or 11 percent, were improper payments. This is an increase from the Fiscal Year 2013 level of about \$49.9 billion.

Earlier this year we reported that Medicare remains on GAO's high-risk list partly because of continuing concerns about the adequacy of fiscal oversight of the program including improper payments. My remarks today highlight key findings from our review of four enrollment screening controls CMS uses to prevent and detect enrollment fraud involving its provider, enrollment chain, and ownership system, also known as PECOS.

Based on our review, we found that controls used to screen for providers and suppliers listed as deceased or excluded from participating in Federal or healthcare related programs appear to be generally working. However, we identified weaknesses in two other controls. First, we identified weaknesses in CMS's verification of practice locations.

Medicare providers must submit the address of the practice location from which they offer services. The software CMS uses to validate addresses does not flag potentially ineligible addresses such as rental mailboxes, and it also does not flag vacant or invalid addresses which are those where providers or suppliers no longer reside or those not recognized by the U.S. Postal Service.

Of the 980,000 addresses in PECOS, we examined using Postal Service software. About 105,000 initially appeared as a CMRA, that is essentially a rental mailbox, a vacant address, or an invalid address. Based on subsequent analyses of a projectable sample of 496 addresses, we estimated that about 22 percent of the 105,000 addresses, or 23,400, are potentially ineligible.

Separately, CMS's March 2014 guidance reduced address verification steps conducted by its contractors. CMS's 2013 guidance encouraged contractors to conduct additional verification steps such as using Google Maps and conducting site visits. However, CMS's latest guidance does not reference such a steps beyond contacting the provider. By reducing verification steps, CMS has increased its vulnerability to potential fraud.

We recommended CMS incorporate flags into its software to help identify questionable addresses and revise its 2014 guidance to enhance verification of practice locations. CMS agreed with the first recommendation and disagreed with the second. We believe additional address verification steps to be an essential control and stand behind our recommendation.

Second, we identified weaknesses in the verification of medical licenses. Medicare physicians are required to hold an active license

in the State they practice in and report any final adverse actions to CMS. Final adverse actions include license suspensions or revocations by any State licensing authority.

We found 147 out of the approximately 1.3 million physicians listed as eligible in PECOS had received a final adverse action and were either not revoked from PECOS or revoked at a much later time.

In March 2014, CMS began providing a report to its contractors to improve licensure reviews. While a good first step, this report only includes current licensure status for the State in which providers enroll. It does not include the full adverse action history of these licenses or their licenses in other states, creating the opportunity for ineligible physicians to enroll into PECOS. We recommended CMS collect additional licensure information to ensure providers are self-reporting all final adverse actions and CMS agreed with this recommendation.

In closing, our findings highlight that CMS needs to maximize its efforts to promote program integrity to ensure ineligible or fraudulent providers and suppliers do not enroll into PECOS. Our recommendations in this regard are designed to enhance CMS's toolbox and help narrow the window of opportunity for potential improper payments and fraud. Madam Chairman, this concludes my statement. I look forward to the Committee's questions.

Senator McCASKILL. Thank you.

Dr. Agrawal.

**STATEMENT OF SHANTANU AGRAWAL, M.D., DEPUTY
ADMINISTRATOR, CENTERS FOR MEDICARE AND
MEDICAID SERVICES (CMS), AND DIRECTOR, CENTER
FOR PROGRAM INTEGRITY (CPI), WASHINGTON, D.C.**

Dr. AGRAWAL. Thank you. Chairman Collins, Ranking Member McCaskill, Senator Carper and members of the Committee, thank you for the invitation to discuss CMS's work to improve provider and supplier enrollment systems. Enhancing program integrity is a top priority for the Administration and an agency-wide effort at CMS.

Thanks in part to the authorities provided by the Affordable Care Act, CMS has improved the provider and supplier enrollment and screening process. We are seeing real results from our efforts and have generated over \$927 million in savings from just our enrollment and screening work in the last four years.

These actions are part of a larger set of provider enrollment activities which have saved the program \$2.4 billion in avoided costs. These savings reflect the actions CMS has taken to deactivate billing privileges for more than 540,000 providers and suppliers that do not meet Medicare requirements and to revoke the enrollment and billing privileges of an additional 34,000 providers and suppliers.

As required by the ACA, and in line with broader changes in program integrity, CMS has implemented risk-based screening of providers and suppliers who want to participate in Medicare and Medicaid which require certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation.

Providers in the limited risk category undergo verification of licensure and compliance with Federal regulations and State requirements, frequently in an automated manner. Providers and suppliers in the moderate and high risk categories undergo additional screening including fingerprint-based background checks, criminal record searches, and unannounced site visits.

CMS uses site visits to verify that a provider or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from enrolling in the Medicare program. Since 2011, CMS has completed 220,000 site visits which have resulted in nearly 1,300 revocations. Importantly, these activities have also stopped nearly 5,000 initial enrollments in the last 12 months which means the provider was not able to enroll or enter the Medicare program.

Today's GAO report confirms that our risk-based approach to enrollment is effective, particularly in addressing higher risk providers. It also shows that we could do more to scrutinize certain limited risk providers like physician practices. We appreciate the GAO's recommendations and will take several steps to address these recommendations.

To better target limited risk providers, CMS has begun conducting ad hoc site visits to these providers to further ensure that every provider entering the Medicare program meets program requirements and are valid and operational. CMS already uses USPS data in our address verification system, and to strengthen the enrollment screening process, CMS will enhance the address verification software to better detect potentially ineligible addresses in line with GAO's recommendation.

We are working toward configuring the provider and supplier address verification system in PECOS to flag commercial mail receiving agencies, vacancies, invalid addresses, and other potentially questionable practice locations. We expect this enhancement to be complete by early next year.

In their report, GAO sampled 496 Medicare locations as a sample of the enrollment data. GAO referred 92 locations with the most concerning questionable addresses to CMS for further investigation and appropriate action, as this figure shows. The vast majority of these locations were found to be operational, contained clerical keying errors, and otherwise legitimate providers, or were already previously revoked or deactivated through our ongoing efforts.

Importantly, not a single high risk provider in the GAO sample had fallen through the cracks. Some addresses were locations of legitimate, limited risk providers with other addresses on file, the provider moved without closing out a previous address in our system.

In fact, I would point out that the two examples brought up by Chairman Collins were both examples of locations of limited risk physicians practices that in fact had moved and had not billed the program in over a decade. In all, this accounted for 80 of the locations out of 92 and only 12 of the locations referred by the GAO required CMS to take an administrative action.

Even among this set, eight of these twelve locations did not bill the Medicare program during the time period studied by GAO. Based on GAO's own methodology, this administrative action rate

is only .3 percent of all addresses in PECOS. It is important to note that these twelve locations were all of limited risk providers, suggesting that our risk-based approach to targeting our program integrity efforts to higher risk, high dollar providers has been effective.

GAO's report has helped us to better understand where our efforts are succeeding and where we have further work to do. Their work will help inform our efforts going forward to focus on certain limited risk providers which will be driven by data analysis and other lead generation approaches. As I stated earlier, CMS is committed to strengthening provider and supplier enrollment and screening processes to make sure that Medicare beneficiaries receive items and services from appropriate providers and taxpayer dollars are protected, but the importance of program integrity efforts extends beyond dollars in healthcare costs alone. It is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care. We are committed to working with GAO as we continue to strengthen program integrity. We look forward to working with this Committee and Congress on these efforts. Thank you.

Senator McCASKILL. Thank you, Doctor.

Ms. Leff.

**STATEMENT OF KATHERINE M. LEFF, R.N., DIRECTOR,
SPECIAL INVESTIGATIONS UNIT, CARE SOURCE
MANAGEMENT GROUP, DAYTON, OHIO**

Ms. LEFF. I want to thank Chairman Collins, Ranking Member McCaskill, and Senator Carper and the distinguished members of the Special Committee on Aging for the opportunity to speak to you today about the GAO report calling for improved eligibility verification of providers and suppliers.

CareSource agrees with the GAO report recommendations. However, we also recognize the challenges CMS faces in identifying fraudulent providers in the enrollment process due to CMS's enormous size and any willing provider requirement. Private plans are much smaller, have more control over providers entering into and staying in our network.

The GAO report identified two weaknesses in Medicare provider enrollment screening, the verification of provider practice locations and physicians' licensure status. In my testimony, I offer CareSource's process as a means of comparison for the Committee. At CareSource, we do the following to verify practice locations and licensure status.

First, we require a Council on Affordable Healthcare Quality Healthcare credentialing application. We obtain then a report from the National Practitioner Data Bank which provides licensure, practice address, malpractice cases, and any adverse actions. We conduct secret shopper calls to provider offices. We utilize a USPS address verification software to identify invalid addresses.

However, it is important to note here that providers have multiple addresses. One of those addresses may be a P.O. box at a UPS store that is used to secure payment, provide access for mailing for payment by the provider or the providers' billing company. We also do periodic onsite visits at providers' offices. We obtain the pro-

viders' malpractice insurance certificate. We pull providers' AMA physician profile. We check license boards in all states.

We also enter the providers into a software program that checks the providers against State licensing boards, the specially designated nationals list, Social Security Death Index, excluded parties list system, HHS OIG exclusions, and State provider sanctions list.

It is important to note here that while this process is automated, mitigating the findings are not. Naming conventions in all these data bases are frequently different and there is not enough information to confirm matches. Matches must be validated manually, which is a very resource intensive process.

While we cannot always identify fraud in the enrollment process, many plans have methods in place to identify aberrant provider billing behavior. At CareSource, our Special Investigations Unit uses a rules-based post-payment fraud detection software to identify known fraud schemes. We are right now in the process of implementing a new fraud detection software that uses mathematically based predictive analytics. This new software also provides the opportunity to identify fraud prior to payment.

We share identified fraud schemes and providers under investigations at fraud information sharing meetings, with law enforcement, Government agencies, and other plans. We report new fraud schemes in provider investigations to SIRIS, which is a national fraud data base through the National Healthcare Antifraud Association. We review grievance data looking for trends.

We compare our providers' recredentialing to our investigative case tracking system to identify providers with issues. We send explanation of benefit forms to members to identify services not provided. CareSource's Special Investigation Unit works closely with internal CareSource departments and Federal and State agencies to proactively and cooperatively prevent and detect fraud, waste and abuse.

Each year we enhance our prevention detection and investigative efforts by adding staff, software, and process, resulting in increased savings and member safety. Already in 2015, we have taken significant actions on DME and allergy—allergy cases, genetic labs, optical cases that have saved considerable taxpayer dollars. In addition, we have identified complicated issues in the home healthcare arena and are working collaboratively with State agencies and other plans to address these issues.

Finally, in 2015, we saw the end results of a multiyear provider investigation by witnessing the provider being sentenced to six and a half years in prison for behavior that involved excessive CT scans, excessive knee and perciformis injections out of the country, drug purchases, et cetera.

Thank you again for the opportunity to appear before you today to discuss the ways to prevent healthcare fraud. I would be pleased to address any questions you have.

Senator MCCASKILL. Thank you. Thank you all for your testimony. Dr. Agrawal, let us start with an acknowledgment that the main way we have gone after fraud in the Medicare program is to pay and Chase, correct?

Dr. AGRAWAL. I think that has been historically true, but in the last five years, we have changed significantly to a much more preventive footing.

Senator MCCASKILL. Okay. The contractor that you use now, Finalist, is only able to standardize addresses, which I understand is like correcting misspellings and making sure they are correct. It is currently unable to flag rented mailboxes, vacant addresses, and invalid addresses, correct?

Dr. AGRAWAL. The finalist software is used by our contractor. It has a couple of different data inputs including a USPS data base. It does have shortcomings compared to the data base that GAO has described, which is why we are also incorporating that level of data.

Senator MCCASKILL. Okay. If it does not have the correct data that it needed, I assume that the employees, the contractor employees, could have gone to USPS and checked their website, right, for this data? I mean, what I am trying to figure out is, why in the world would we ever hire a contractor that was not doing a basic check that is available for free?

Dr. AGRAWAL. I think we should maybe differentiate a little bit, Senator. We have Medicare administrative contractors that actually do the enrollment work.

Senator MCCASKILL. Right.

Dr. AGRAWAL. We have program integrity contractors that supply them with tools, resources, technologies, data bases to do that.

Senator MCCASKILL. Well, but do we really need somebody to supply them with a basic that you can check USPS for free to see if it is a valid address? We need another layer to do that?

Dr. AGRAWAL. Well, what we have been moving toward in order to really have that position toward prevention is automated approaches through these kinds of checks. We have been implementing over several years now and working to improve, the automated provider screening system. One of the things that that system does is look at address verification. It also looks for licensure, and now, most recently, we have been working to incorporate criminal background history into that system. Our approach is to try to give our enrollment contractors as much consistent automated, timely, actionable data that we possibly can.

Senator MCCASKILL. How much are we paying to Finalist for address checks that we can do for free through USPS—through the Postal Service?

Dr. AGRAWAL. Again, we pay—so I do not have a specific number in front of me, Senator. I am happy to get that for you.

Senator MCCASKILL. Should you not know that coming to this hearing, what we pay them?

Dr. AGRAWAL. Well, what we do is we bring on board various data bases, so we have over 100 data bases that perform the kind of enrollment checks that we need. All of that is filtered through the automated provider screening system utilizing physician identifiers, other information like that, and made available, so what we have is, we have costs associated with rolling on those data bases and relatively few, we hope, for individual manual checks. I mean, the whole purpose is to move away from manual checks that might be inconsistent to totally consistent automated checks.

Senator McCASKILL. I know you understand the point I am making.

Dr. AGRAWAL. Sure.

Senator McCASKILL. That this information, and I think the point was made very clearly in this audit, it is a good audit, and it points out that the basic address checks that can be done through technology very simply and for free were not being done by the paid contractor that was supposed to be doing address checks, correct?

Dr. AGRAWAL. Senator, I agree that this report is useful.

Senator McCASKILL. That is good.

Dr. AGRAWAL. It definitely has highlighted areas of improvement for us. I think what the report also highlights is that there is no such thing as a perfect single data base. What we saw in the sample, as I discussed in my opening remarks, and the sample provided to us by GAO, is that several addresses were actually legitimate, several were truly operational at the address identified for us by GAO, and indeed some really did need administrative action.

Senator McCASKILL. Well, I am a little troubled, honestly, with the chart.

Dr. AGRAWAL. Okay.

Senator McCASKILL. Let me tell you why. There are two ways to take an audit. One way is to say, you know, this is a good point. We can do better. This is basic information that is available with a few clicks, free from the United States Postal Service, and we have got to get this integrated as quickly as possible, and by the way—and I will save these questions for later because I will not have time on this round—about this contractor. Why in the world we have a contractor that did not integrate this into their software check is beyond me since this is a fairly important part of a—it is a four-step process and this is one of the steps, so your chart, GAO referred you a list of 92 providers, correct?

Dr. AGRAWAL. Correct.

Senator McCASKILL. That list of 92 providers was determined from a generalized sample of 496 providers, correct?

Dr. AGRAWAL. Correct.

Senator McCASKILL. That generalized sample of 496 represents .47 percent of the potentially ineligible addresses, correct?

Dr. AGRAWAL. The number I will take as given from you.

Senator McCASKILL. Well, Mr. Bagdoyan will check my math, but I believe my math is correct, so your chart shows that four of these addresses required administrative action, had billing activity. How much did you indicate was paid to those four providers, how much money?

Dr. AGRAWAL. I will have to check on that again.

Senator McCASKILL. I know. It was \$1.2 million from 2005 to 2013. You should know. Since GAO used a generalized sample, we can statistically assume that roughly what applies to those 496 will apply to the whole group of 105,000, correct?

Dr. AGRAWAL. I would have to defer on methodology to the GAO.

Senator McCASKILL. Correct, Mr. Bagdoyan?

Mr. BAGDOYAN. That is correct, Senator.

Senator McCASKILL. Okay, so relying on that statistical projection, if we were able to say that for each group of 496 ineligible,

there would be about \$1.2 million paid out fraudulently and we apply it to the entire group, we come up with \$254 million.

Now, you coming in here and showing us a chart that there is only four I think is completely misleading and worries me that you are not saying, you know, we had a problem and we are going to get after it and fix it. What you have done instead is created a chart that we got a half hour before the hearing that skews the data and makes it look like you only had four addresses out of the hundreds of thousands that were identified by GAO, which is completely misleading.

Dr. AGRAWAL. Senator, the GAO was most concerned and asked us to investigate, look into the 92 cases that they had presented to us. They presented that data, you know, with the expectation that most of those addresses would be concerning. We tracked them down with diligence performing the necessary subsequent investigative actions that included site visits, other kinds of data analytics.

We wanted to be forthcoming with both the GAO that has asked the data from us, and this Committee, about our findings. Now, none of that suggests that the GAO's recommendations are not legitimate or that there are not improvements that we ought to make. In fact, I believe I stated that up front in my remarks and I am happy to state it again.

I believe that they have found a tool that will enhance our efforts. We are working to incorporate that tool into our screening systems. I did not want to leave you with the impression that somehow all 92 of these locations were truly fraudulent billers because I think that does not reflect the reality on the ground.

Senator McCASKILL. Well, I appreciate that. I think you can also appreciate that it looks a little bit like circling the wagons and gosh, this really is not that big a problem, and I think we do have a problem when something as simple as checking addresses is not being done by the contractor. Thank you. I have gone two minutes over and my colleagues have been very patient. Madam Chairman.

The CHAIRMAN. Thank you very much. I am glad that you went over it because I share your concern and outrage over this issue. I want to switch to a different issue and that is the physicians with active provider numbers were collecting money and yet, have an adverse action from a State Medical Board that resulted in a suspension or revocation of their license.

First I will start with you, Mr. Bagdoyan. GAO's review found that 321 physicians with active provider numbers had received an adverse action from their State Medical Board, and we are talking about serious adverse actions. I am going to have the chart put up so that everyone sees. It is a little hard to read, at least for my eyes, but I think this will make the point.

Can you tell me how the GAO determined that these physicians' licenses had been revoked or suspended and why CMS, by contrast, still considered them to be active providers eligible for Medicare payments?

Mr. BAGDOYAN. Thank you for your question. What we did was we used the Federation of State Medical Boards' data base of licensure which has the most complete history of licensure as well as adverse actions for all licenses for a particular physician. We also

researched the individual State data bases as well as referred to the PECOS data base as well.

The CHAIRMAN. Is there any reason why CMS could not refer to those same data bases?

Mr. BAGDOYAN. I would have to refer that question to Dr. Agarwal for a response.

The CHAIRMAN. I spent five years in State government and part of my job was reviewing licensing and I know our State board of medicine always did a check of other states before granting a license in Maine. That was just due diligence on their part, so this is of great concern to me. Doctor, on April 29th, the GAO referred 147 providers to CMS whom GAO had identified as having had an adverse action resulting in suspension or revocation of one of their medical licenses, and yet, they have not been removed from the Medicare program or they remained an eligible biller for months after that adverse action against their license.

Now, just so everyone understands in case not everybody can read this chart, I want to emphasize how egregious the referred cases are. For example, out of the 78 adverse license actions GAO identified for sexual misconduct, 48 of those providers, or 61 percent, were either not revoked from the Medicare program until months after the adverse action or never removed. How can this happen? Why does not CMS use the same data bases that GAO did?

Dr. AGRAWAL. Why do I not start there, Senator. What we have done in order to get licensure information is try to go back to the source, so as I mentioned just a few minutes ago, we have rolled in over 100 data bases specifically on licensure, not relying on a single source of that data, by trying to get actually back to states and try to get that data, you know, from as much of the source as possible so that it is timely and accurate, because licensure information can actually change quite a bit even for, you know, valid physicians.

I think to your broader point, Senator, there is absolutely no way that I defend the presence of a criminal or a convict, a felon in the Medicare program. I think it is clearly our job, when those cases are identified either proactively by us or even in responses to report by GAO or others, to react swiftly.

Now, GAO did give us, to your point, 147 leads to investigate which were concerning from their perspective for licensure issues. I am happy to share the results with them. I want to be careful when I do that, I am not sending the message that we have not taken their recommendations seriously. We still do, but I am happy to share the results on the ground in terms of what we found with these 147 cases.

The CHAIRMAN. Well, GAO asked for a response from you by June 29th. Has that response occurred?

Dr. AGRAWAL. I do not believe we have formally sent it to them in writing yet. We will obviously be doing that. We have been working diligently on looking at each and every one of these cases, trying to get underneath the potential licensure issues. What we have generally found is there were 19 revocations for licensure issues that we were able to take out of the 147, so we are grateful to the GAO for those leads.

The remainder of the cases, which we will obviously be sharing, were cases where we had already taken an action like a revocation or deactivation, or where we could not corroborate the licensure issue, or the licensure issue would not have been a disqualifying event in Medicare.

The CHAIRMAN. Well, Doctor, I can tell you that I know from talking to GAO that CMS has not responded, and so you are overdue with your response.

Dr. AGRAWAL. Correct.

The CHAIRMAN. To me, if I were in your position and GAO, which has done all this work for you, gave you this list, I would be really concerned that you have individuals with revocation of their license who are still receiving Medicare payments or at least are eligible for those payments, especially when GAO was able to identify them from just going to a consolidated data base. Thank you.

Senator McCASKILL. Thank you.

Senator Kaine.

Senator Kaine. Thank you to Madam Chair and Ranking Member and to our witnesses. Dr. Agarwal, you are getting the attention today, so I think I am going to stick with you for a second. Here is a fraud and abuse issue that I am very concerned about.

Not this GAO study, but other recent reports have really focused upon the number of opioid prescriptions and fraud and abuse in the Medicare Part D program. A lot of challenges with opioids. We are seeing them all across the Nation. We are seeing them in the VA system. We are seeing them in the private pay. We are seeing them in Medicare. The studies have shown that the opioid prescriptions within Medicare Part D have increased dramatically higher than other drug prescriptions and there are some geographical hot spots in that.

I hear about this all the time. In Virginia, it does not respect class or geography. It is a serious problem. Talk to us about CMS's efforts to try to control the fraud and abuse and especially with respect to opioid prescriptions in Medicare Part D.

Dr. AGRAWAL. Senator, thank you. That is obviously a very important area and as a physician who has seen the ravages of substance abuse and other related issues, I completely agree that it is a priority. We have been doing more work in the Part D program to address beneficiary issues as well as provider issues, and then the various intermediaries, Part D plan sponsors as well as pharmacies.

On the provider side, one of the biggest actions that we are working to implement over the next year is full enrollment of Part D prescribers. This hearing so far has focused on enrollment on the Medicare A-B side. We are implementing similar authorities and controls in Part D so that every prescription written in Part D is by a Medicare approved provider.

That is a radically new stance in Medicare than has been adopted historically. That will allow non-qualified providers, really for Part D plan sponsors, to place edits in their system so that prescriptions from those providers simply cannot be filled. I think that will help really make sure that providers, again, are licensed to have DEA licensure and other things that are more germane to—

Senator KAINE. This is not opioid-specific. This is general system-wide improvement to try to track, right?

Dr. AGRAWAL. Correct. On the beneficiary side, we look at—we have an over-utilization monitoring system that focuses on particular beneficiaries that are above what we would consider and what the CDC considers safe thresholds of opioid utilization.

We share that information about specific beneficiaries with Part D plan sponsors and then they are able to take, you know, elevated steps like case management and other utilization-related steps to address these over-utilizing beneficiaries.

We have noted through that kind of data sharing that there is a 28 percent reduction in those high-utilizer beneficiaries, that they are brought back down under safer thresholds. There are other kinds of data sharing that we do with Part D plan sponsors. We provide them, on a quarterly basis, information about aberrant pharmacies, aberrant prescribers so that they are able to take their own investigative actions and administrative actions as relevant.

We have a healthcare fraud prevention partnership which Ms. Leff is a part of that encourages exactly that kind of data exchange and encourages exactly that kind of administrative action since a number of elements of the Part D program are actually directly administered by the plan sponsors not CMS, so it is very important to work with them and through them.

Senator KAINE. Just to put on the record some statistics, between 2006 and 2014, Medicare spending on opioids went up from \$1.5 billion to \$3.9 billion in that eight year period, and in some regions of the country, Alabama, Tennessee, Oklahoma, and Alaska, more than 40 percent of Medicare beneficiaries file at least one prescription that includes a narcotic. That is really staggering, so these anti-fraud measures in that particular area in Medicare Part D are appreciated.

Let me ask you just one more question for any of the witnesses. This is a panel that does significant oversight. We are not a legislative panel. We do not initiate legislation, but we are very interested in it. You have oversight tools and we will stay on you about them. Are there legislative improvements that could be made, in any of your opinion, that would advance an anti-fraud agenda so that we could better deal with this problem? Are there other things that we ought to be doing?

Ms. LEFF. One thing that I would suggest, Senator Kaine, is that in the Medicaid side, we have lock-in programs for members, and so what happens is when we find them abusing controlled substances, doctor shopping to get those substances, we lock them into one pharmacy, one provider. That is very effective.

Then we have case managers working with them to get them into the right level of care. If they need psych care and that sort of thing, we get them into those type of areas, making sure that they are compliant with the program. It seems to be very effective in the Medicaid side, but it is not something that is permitted under Medicare. That would certainly be an opportunity.

Senator KAINE. Do you know if that is a regulatory matter or a legislative matter?

Ms. LEFF. I am not certain.

Senator KAINE. Dr. Agarwal, do you know?

Dr. AGRAWAL. It is a legislative matter. We agree that lock-in programs can be beneficial. They are utilized in Medicaid by the private sector. We do not currently have this. In fact, we are statutorily not permitted to do and it is part of the President's budget that we would be happy to work with this Committee around to get that kind of authority.

Senator KAINE. Great. Thank you very much. Thank you, Madam Chair.

Senator McCASKILL. Senator Warren.

Senator WARREN. Thank you, Madam Chair. You know, when the little guys, doctors' offices or pharmacies are caught breaking the law, they sometimes get kicked out of the Medicare program, but the consequences for giant corporations are very different. Instead of kicking these big time bad actors out of the Medicare program or putting CEOs in jail, the Government settles with a fine and the company enters a corporate integrity agreement, basically a promise not to break the law again.

I want to consider one for-profit hospital chain, Tenet Health. It is a \$5.8 billion corporation. Now, back in 1994, Tenet paid a \$379 million fine, suggesting some pretty serious activity here, for illegal kickbacks to doctors, and it signed one of these corporate integrity agreements.

Then in 2006, Tenet got caught fraudulently billing Medicare and giving illegal kickbacks to doctors for which they paid a \$900 million fine, suggesting some pretty significant activity here, and signed a new corporate integrity agreement. Then in 2012, Tenet admitted to breaking the law again, while under the 2006 corporate integrity agreement, and it paid a \$42 million fine, and then just a year later, Tenet got another \$4 million slap on the wrist for misconduct that occurred while they were under the corporate integrity agreement.

If a big company can commit major fraud again and again and again, and each time they just pay a fine and promise to be good and move on, I am not sure what incentive there is for them to stop breaking the law. Dr. Agrawal, why is it that a company like Tenet—we know about lots of other examples—are allowed to settle allegations of fraud over and over with just a fine and a promise not to break the law again? When is it that you say enough is enough?

Dr. AGRAWAL. Senator, thank you for the question. We are an administrative agency, as you know. We have a variety of authorities that allow us to review medical records, recover overpayments, deny enrollment, revoke enrollment. From our perspective, there is no such thing as too big to fail. There is no provider that we cannot medically review. In fact, some of the providers that you cited we have conducted medical reviews of and secured overpayments.

We perform the same screening activities for those providers and we have revoked or kicked out of the program institutional providers, larger institutional providers. With respect to settlements and CIAs in particular, those are activities that we as an administrative agency do not engage in. Those are conducted by the DOJ and Office of Inspector General. I could not really address for you what their thresholds are for taking action beyond those.

Senator WARREN. Well, so fair enough that you do not speak for them, but you testified here last year and when you did, I asked you about how CMS, the HHS Inspector General, and the DOJ do not coordinate their actions to deter these bad corporate actors.

As the Director of the Center for Program Integrity, have you worked with HHS IG and the DOJ to implement any shared policies or guidelines among the agencies that will help assure that the actions taken by one agency, like imposing a fine and putting in place this corporate integrity agreement, will be strong enough to defer future corporate bad acts? What have you done since we met last time?

Dr. AGRAWAL. Yes, I completely remember that line of questioning.

Senator WARREN. Good.

Dr. AGRAWAL. So we—

Senator WARREN. I thought you might.

Dr. AGRAWAL. We work very closely with the Office of Inspector General on a daily basis. We coordinate with them on investigations. We make referrals to them on a routine basis. We have referred thousands of cases in the last year to the OIG for further investigation and their actions.

They have full access to all of our data analytics and other systems so that they know what we are working on. They have real-time access to the same data that we do. Indeed, we coordinate on cases where if it looks like we want to take a revocation action, we coordinate with them and make sure that they are aware of that action. There are certain authorities—

Senator WARREN. Well, this sounds good. It sounds like you are working together.

Dr. AGRAWAL. It is promising. There is more.

Senator WARREN. All right.

Dr. AGRAWAL. There are certain authorities that they have such as exclusion authority, that I think is very useful and obviously they leverage whenever they can. That exclusion authority goes beyond kicking somebody out of Medicare. It keeps that person or that entity from getting any healthcare dollars, so we do make referrals of cases to leverage that exclusion authority, and another area of collaboration, there is a legislative proposal in the President's budget around expanding that exclusion authority. We are very supportive of that because it is another place where we can work together.

Senator WARREN. Okay, but let me just track this down just to make sure—I realize I am running out of time, but I just want to see if I can finish this point, so you are working together. You are making referrals. Do you know if DOJ and HHS IG have official policies or informal practices with regard to whether or not they are really deterring future wrongdoing? I do not understand how Tenet can keep showing up like this in the records, promising not to break the law and breaking the law over and over.

Dr. AGRAWAL. In my day to day interactions with the IG and DOJ, it is very clear to me that they are committed to stemming as much healthcare fraud as possible, either by kicking entities out of Medicare or the healthcare system or getting them into compliance. I think the specific policies they would have to reference, but

I have seen nothing in my daily interactions with them that would suggest otherwise.

Senator WARREN. Well, let me tell you the part I see and that is the part where we are watching the same actors appear again and again and again, which suggests to me that whatever it is you are doing or they are doing is not getting us where we need to be, and the consequence of that is we are seeing repeating bad acts and the American taxpayers are losing a lot of money over this.

Companies should not be allowed to get away with fines and a promise that they will do better in the future and a wrist slap. Until we get serious about holding these big bad actors accountable when they defraud Medicare and Medicaid, the big guys who cheat the system are not going to have a reason to stop. Thank you, Madam Chair.

Senator MCCASKILL. Thank you. I want to turn it to Senator Carper who is visiting our Committee today, but he is welcome because this audit, he was one of the primary requesters of this audit. He is a one-man vigilante when it comes to improper payments. This is somebody who has been on this for as long as I have been in the Senate. He has been working on improper payments. We are happy to have you today and welcome your questions.

Senator Carper.

Senator CARPER. Thank you. Thank you so much. My thanks to you, to our Chair, for giving me the opportunity to come by. I used to serve on this Committee and I said to Senator Casey one day, Senator Reid said to me, would you like to be on the Finance Committee? I said yes. He said would you be willing to give up Banking? I said yes. Would you be willing to give up the Commerce Committee? I said yes. He said would you be willing to give up Aging? I said no. I ultimately gave it up and now I no longer serve on any of those Committees, but I am glad to be where I am on the others. Thanks for giving me a chance. You can come home again and so I thank you for the opportunity to come back.

I may have been a vigilante, but I am not a one-man and you have been part of the posse, and God knows Senator Collins has been along with Tom Coburn, all of us who have served at one time or another on Homeland Security and Governmental Affairs.

When they asked Willie Sutton, why do you rob banks, he says, that is where the money is. There is a lot of money at stake in Medicare and Medicaid, and it is a lot to say grace over and we acknowledge that and applaud CMS and those who are trying to be vigilant in making sure they are good stewards with all of those dollars.

Having said that, I watched with dismay as we learned at the beginning of this year that improper payments for last year, 2014, did not go down despite all of our collective efforts, including all of what we put in the Affordable Care Act to kind of strength the hand of CMS to go after improper payments, to actually see them go up, and not by a little bit, by 20 percent, by \$10 billion from roughly \$50 billion the year before to last year at \$60 billion.

Let me just start off by saying to the representative from GAO, Mr. Bagdoyan, why did it go up? Why so much? I was astounded.

Mr. BAGDOYAN. Well, thank you for your question, Senator Carper. That bit of insight was beyond the scope of our work. There

may be a range of reasons for that, but I cannot really comment on specifics.

Senator CARPER. Okay. Same question, if I could, Dr. Agrawal. Why did it go but, just very briefly?

Dr. AGRAWAL. Sure, thank you.

Senator CARPER. \$10 billion, 20 percent after all this effort that we put into it. We have, you have.

Dr. AGRAWAL. The improper payment rate is definitely an area that we are continuing to focus on and appreciate your leadership on. We have seen a few major drivers of the improper payment rate. One thing that we have seen is as our program integrity efforts increase, as we get more vigilant, providers can sometimes have a hard time keeping up, which can drive up the improper payment rate for a while until they learn our new rules.

One example of that is the home health face-to-face requirement which I think is obviously a very sensible policy. It makes a lot of common sense, but it has led to now over 50 percent of home health claims being improperly paid. In other words, where the medical record documentation of the face-to-face requirement is not there, is not sufficient to meet the standards of the requirement.

As you know, certainly, Senator, the improper payment rate is not a fraud rate, it is not overlapping with fraud. I think these are usually vigilant providers that are trying to keep up with the rules that we can do a better job to educate. We can also do a better job to move our reviews to a prepayment world through efforts like prior authorization, as we are doing, to help drive down the improper payment rate.

Senator CARPER. I thank you. Mr. Bagdoyan, has anyone ever mispronounced your name?

Mr. BAGDOYAN. Always.

Senator CARPER. Okay. Well, good.

Mr. BAGDOYAN. You are not the first one, Senator.

Senator CARPER. I will try not to do that that as well. In his testimony, Dr. Agrawal said that he recognizes the importance of the problem that we are talking about here today, and he is just trying to take steps to address those problems. Could you just comment on CMS's plan for addressing the vulnerabilities that GAO has identified? Do you think this plan is adequate?

Mr. BAGDOYAN. Sure. Thank you for your question and I appreciate Dr. Agarwal stating that CMS has agreed with the recommendations, that they have already initiated some steps to respond to them, including providing us with responses to the referrals we have made.

I think the absolute key here is sustained execution and attentiveness to a strong internal control regime, front, middle, and end to help address some of the issues that we identified.

Senator CARPER. All right. Dr. Agarwal, your testimony demonstrates, I think, fairly clearly that you and your colleagues take seriously what GAO, the findings of GAO, and you stated your commitment to addressing the identified vulnerabilities. Could you just give us a little more detail as to when you will have implemented these steps and what is your timeline for closing the vulnerabilities described by GAO?

I will just say, for me, one of my frustrations here is we have all heard the term low hanging fruit. This is not low hanging fruit we are talking about. This is a fruit that is laying on the ground. I just want to hear a sense of urgency that we are going to seize this day, we are going to seize this day. Go ahead.

Dr. AGRAWAL. Absolutely, Senator, and we do have a sense of urgency. We have staff that are focused on provider enrollment every day as their main job and they want to get all of these bad actors out of the program as well. For example, when it comes to ineligible addresses, the GAO has recommended on-boarding a new data base through the USPS to essentially replicate the work that they did. We agreed with that recommendation.

The time for—we need a certain amount of time to get access to the data base, verify it, get it incorporated into our systems, and so we are targeting doing that by early next year. However, in the intervening timeframe, we are also going to do other work as we on-board the final fix.

One is we are going to be doing more ad hoc site visits of these limited risk providers since again, those were the ones that kind of fell through the cracks in our screening process. We are going to do several thousand site visits right away and then work to ramp that up in the coming months.

When it comes to mailboxes, we are also going to immediately start comparing lists of the CMRAs, these commercial mailbox agencies, bump that list up against PECOS. We are going to do that on a routine monthly basis and then, you know, visit, investigate, whatever comes out of that in this intervening phase until we get this data base incorporated.

Senator CARPER. All right. If I could, Madam Chair, you and I worked for a lot of years on postal reform and one of the things we have tried to do is to help the Postal Service figure out how to take a 200-plus-year-old legacy distribution network and find new ways to make money out of it, to monetize it in a digital age.

It occurs to me that in a time when we have thousands of so-called Medicare providers that are operating out of a mailbox or that may be operating, if you will, out of an empty building or a vacant building, a vacant lot, you have got the Postal Service over here that literally knows what is there, what is there in each of these delivery sites.

There has got to be some way that the Postal Service is looking for a way to make money. They have this information. There ought to be a way to provide a great partnership, which enables the folks at CMS to save a ton of money in Medicare and provide, frankly, a revenue stream that the Postal Service could use.

I am going to pursue that and my hope would be that the two of you would join me in that pursuit. Thank you so much for letting me come by. Thank you.

Senator MCCASKILL. Thank you, Senator Carper. We are thrilled to have you here today.

Senator CASEY.

Senator CASEY. I want to thank Senator McCaskill for this hearing today. Madam Chairman, I thank you as well. I thank both of you for this opportunity and for your work a lot of years working

hard to make sure we are doing everything possible to root out waste and fraud.

Look, I am a believer that when you have any program, especially one as consequential and significant in the lives of Americans as Medicare whenever you have waste, fraud or abuse, that is a taking. It is like stealing resources from people that need it, and apparently people that are both vulnerable and their families have a reasonable and legitimate expectation that the program will be secure, that will be efficient, and that the services will be delivered, and services means quality care.

This is serious business and we cannot do enough to make sure that we are insisting on much greater strides than we have made to date on rooting out waste, fraud and abuse, so it is both a taking, but I think it is also an issue that arises in the context of our own responsibilities. If we say we support a program, we must be willing to support strategies to root out waste and fraud.

We are grateful for the efforts so far, but we have got a long way to go. Every minute of every day that there is waste and fraud in a program like this, it gives legitimacy or momentum to those who would like to slash a program. You cannot just be for a program and be for funding if you are not going to be for the integrity of the program.

I wanted to start with Dr. Agarwal and I may not get to our other two witnesses, but I wanted to ask him at least two questions. First, was on Senior Medicare Patrol, which, as you know, is legislation that was—I should say the program itself is part of our law for a number of years now.

We had an extension added to the Older Americans Act and we know the basics of what that Medicare patrol does. It helps to educate Medicare beneficiaries and their families about how to spot and report waste, fraud and abuse. We know that through the year 2013, the program saved Medicare 120 million bucks and that is not bad.

I was noticing the error rate in Medicare, that is a lot more than \$120 million, but it is a contributor. This program is a contributor to that goal of rooting out waste and fraud, so using that as kind of a point of departure, Doctor, that program, is that something we can build on? Is that something we can replicate or enlarge?

Dr. AGRAWAL. Yes. I am a big fan of the Senior Medicare Patrol. We do work closely with that program. I speak routinely with that organization. In fact, next week we have another meeting. One of the biggest things that we have focused on from a beneficiary standpoint is the use of the Medicare summary notice or the EOB to make sure that beneficiaries are aware of and educated about their health care utilization patterns and making sure that they give us leads if they see something on the MSN that is not accurate.

We get 40,000 complaints from beneficiaries related to program integrity alone and use that information in our automated practices. We have it as part of our predictive analytics system. We use it in investigations. Many of those complaints have led to significant investigations and outcomes for us, so I think that is certainly a foundation we build on. The agency conducts an annual sort of educational campaign for beneficiaries, particularly around the

open enrollment periods, to make sure that they are aware of program integrity efforts, how to protect their private information and things like that.

Senator CASEY. Are there other resources or tools that you would need to accomplish that or you think you have the resources you need right now?

Dr. AGRAWAL. You know, I appreciate the question. I think we are building on the foundations that we have. I think there is lots that we could do with beneficiaries. That relationship clearly matters a lot. There are potentially 50 million investigators on the ground for us, so I would not make a particular ask at this point. That might be unusual, but no, I really appreciate the support around this kind of program and the support of the beneficiaries that we have.

Senator CASEY. I appreciate that. Second, before I wrap up, I will put it on the record. It might be a brief answer and you could amplify it in writing, but the provider screening process. We, of course, want to get the balance right between being thorough and vigorous and making sure that the process is strict and thorough, but at the same time make it fair and navigable. I guess the basic question I would ask you is, do you think you are getting that balance right or do you think we have got a ways to go on that?

Dr. AGRAWAL. I think you are absolutely right about the need for balance. I think we think about that balance on a daily basis in our work. I think as long as we have one, you know, illegitimate provider in the program, we need to continue to be vigilant. I think that balance is something that we need to continue to work to achieve, but we are not there yet on the numbers, and like I said, if there is one, we need to get them out of the program.

Senator CASEY. Thanks very much.

Senator MCCASKILL. Senator Cotton.

Senator COTTON. Thank you. Thank you all for attending today. Mr. Bagdoyan, thank you in particular for the good work that you and the GAO have done on this issue. In your years of doing this, but especially over the last year since the CMS changed the steps that are necessary for verifying information of Medicare providers, do MACS tend to take steps over and above what CMS requires of them?

Mr. BAGDOYAN. Thank you for your question, Senator Cotton, first of all. I think based on what we have encountered during this work, the MACS seem to be following the guidance that originated in March 2014. In fact, we encountered a couple of instances where the MACS, pretty much acting on that guidance, actually verified providers that should have been flagged for potential action.

Senator COTTON. What were some of the main reasons why they verified those providers that should have been flagged? What was omitted? What did they not check that they might have checked if the CMS steps were slightly different?

Mr. BAGDOYAN. From my recollection, basically what they did is they made calls to a single location and asked over the phone to see whether the address that they had on record was the actual address for providing services.

Senator COTTON. Some of the examples are pretty arresting, you know, of addresses that are open fields or fast food restaurants or

so forth. Would it be possible to verify or at least provide a more complete picture needed for verification by, say, using Google Maps?

Mr. BAGDOYAN. Sure. That is part of our analytical approach to our work. What we did was we started with the USPS address data base and then we employed the Google Maps, we did Internet research.

Senator COTTON. When you are saying we, you are saying the GAO?

Mr. BAGDOYAN. This is my colleagues and I on the team, yes. We looked at the providers' purported websites and then on 30 occasions we had a site visits including taking photographs, some of which were displayed earlier today.

Senator COTTON. Do you think that is an onerous process?

Mr. BAGDOYAN. Well, I think we did it with a fairly small team. It is work, but as you see from the results of our report, it is solid work. We certainly stand by it. I am very proud of my colleagues for doing a great job, and these are things that are available to be done, the commercially available USPS software, for example, and the Internet, site visits. Those are all things within one's purview.

Senator COTTON. Certainly the Internet and Google Maps.

Mr. BAGDOYAN. Sure.

Senator COTTON. Or MapQuest, to be agnostic about one's preferred choice.

Mr. BAGDOYAN. Whichever works best for the circumstance, yes.

Senator COTTON. Dr. Agarwal, do you think it is too much to ask MACS to say, use Google Maps or MapQuest, at least to see that providers are not using addresses that are fast food chains or UPS stores or empty lots?

Dr. AGRAWAL. We perform similar tests as what the GAO had utilized in the generation of this report. Again, as I stated earlier, we do appreciate the work of the GAO and these findings. We conducted 220,000 site visits since new enrollment and screening standards were implemented. We have revoked 1,300 providers for being non-operational due to those site visits. We conducted similar work related to the leads that the GAO gave us.

Overall, we are moving toward an approach that is more automated, so one thing that we will be doing as a result is folding in the data base identified by the GAO which will augment existing data bases that we have that do licensure checks, address checks.

If there is a way to enhance those things, we are absolutely looking forward to doing that, but what we want to move away from are lots of potentially inconsistent manual checks, rather, a system that is highly automated with very timely data and MACS are free to elevate their levels of concern and trigger even non-required site visits if there is anything potentially concerning about an enrollment.

Senator COTTON. Well, automation is great and centralized data bases are great, but we have seen the Government does not have the best track record with those. Using something as simple as Google Maps or MapQuest would seem to be a reasonable step to ask MACS to take, would it not?

Dr. AGRAWAL. Well, we have geospatial software in our system. Again, you know, I think with the risk of potential variability in

how different operators, different contractors do the work, we have opted toward a system that is much more consistent, much more automated, and yet, still gives the contractors all the tools they need to do the work. I think GAO has identified a good tool that we will be incorporating into those, rather than making a significant strategic change and moving back toward manual processing.

Senator COTTON. How are these MACS held accountable whenever they make an inaccurate verification, in particular, when it could be so easily confirmed as visiting the site or even using an Internet search engine like Google Maps or MapQuest?

Dr. AGRAWAL. Sure. We hold MACS like other contractors accountable in a similar manner, so we assess their performance on a routine basis. We conduct our own site visits of the contractors to make sure that they have the right tools, processes, operations in place to do the work.

We look at the performance metrics and where necessary, we take actions like expressing letters of concern reflecting our findings in their performance reviews, and then, you know, increasing scrutiny from there as necessary, putting them on corrective action plans, for example.

Senator COTTON. Well, thank you. My time has expired, but I do think some more work is probably needed.

Senator MCCASKILL. Thank you, Senator Cotton.

Senator Donnelly.

Senator DONNELLY. Thank you, Madam Chair. You know, one of the areas that is growing very fast is data analytics, big data, data mining. The Chair's—St. Louis Cardinals use all kinds of data analytics, can tell you exactly where the ball is going, how many times it rotates on the way in is a curveball.

Senator MCCASKILL. The best record in baseball.

Senator DONNELLY. For now.

As you look at this, there are markers that will indicate to you, when they do data mining, they can tell exactly what that 59-year-old male who happens to like Coca-Cola and this particular ball club and this matter and this matter and tell you from all of those exactly what they are going to do next. This is all predictive. This is all easily determined.

You can put about 20 markers together and find out very, very quickly who your top suspects are and where you can go to find them, use the Google Maps that Senator Cotton talks about, and go locate them, but an extensive use of data analytics can completely change this. I am wondering what your plans are in that area, and have any of the biggest data analytics firms in the country taken a look at the processes you are using and said, hey, this is up to snuff or not?

Dr. AGRAWAL. Yes, I absolutely agree that data analytics is vital to program integrity work, especially in a system with the volume of Medicare. For that reason, three years ago, we began implementation of the fraud prevention system which is exactly the kind of system that you are describing. It is the claims analytics system that looks at all 4.5 million claims that come into Medicare every single day.

That was, again, a sizable change from the historic approach to processing claims which was just to pay them. We now have eyes

on our—automated eyes on every single claim looking for outlier claims and outlier providers. That system allows us to implement predictive models that are exactly as you describe, multi-variant models that are trying to identify outlier behavior that is highly indicative of waste, abuse or fraud. We base those models on historical patterns, on other data analytics, on conversations and discussions with law enforcement.

Senator DONNELLY. Then the next question is, with all of those, how did we go up 20 percent last year?

Dr. AGRAWAL. Well, I think the improper payment rate is different from the fraud rate, so you asked if we had had anybody come in and assess the system. The answer is yes. The OIG came in and did an assessment of our fraud prevention system.

Senator DONNELLY. Anybody outside of government, anybody who are the very, very best in the data analytic field?

Dr. AGRAWAL. Well, I will remind you that our contractors are private-sector contractors and the scrutiny that the system has faced has been higher than any predictive analytics system in program integrity, and what the OIG has found and certified as a ten to one ROI for the system, that is still different from the 20 percent rise in the improper payment rate, and that is because improper payments are not the same as fraud.

Most of the time, improper payments are lack of appropriate documentation or the ability of the provider to substantiate in the medical record what they actually billed to the agency. We do not see medical records at the time of claims payment or actually very, very few of them, so 60 percent of the improper payment rate is just from that documentation issue.

Senator DONNELLY. As you look at the data analytics and the opportunity to do data mining and you have private-sector companies that are providing this to you, what do you do continue to make sure that you have best practice modeling going on with this?

Dr. AGRAWAL. I think that is a great question, so one thing that we are required to do by law is to re-procure the system periodically. We are actually in the process of doing that, which allows us to compete again the system, what our needs are, to make sure that if there is a company that is now doing better at it than the ones that we have, we will get the appropriate company in the door.

We continue to work on refining models. We implement new models on an annual basis, really on quarterly cycles, as well as refine models that are already existing in the system to help improve their accuracy and the impact that they deliver.

We are also moving the system into other arrays now that we have proven its worth and the positive ROI to the taxpayer, focusing mainly on the worst cases like fraud. We are going to apply the system against other patterns that are concerning like waste and abuse, implementing things like system edits and other models so that we can really start to tackle some of the biggest areas of losses in the program.

Senator DONNELLY. Ms. Leff, when you look at the fraud prevention activities that CareSource and other private companies use, do you have any suggestions that CMS should adopt that could help them to do a better job?

Ms. LEFF. CMS—we have worked very closely with CMS on many, many programs. For example, the Health Fraud Prevention Partnership, which I think is a phenomenal collaborative effort that pulling data together from all the plans and putting it together running algorithms trying to identify fraud from a bigger perspective, I think that is going to be a phenomenal thing going forward.

I certainly encourage, you know, that process to continue. The prepay system, predictive analytics are certainly another area that I think is very important in the fraud space. We in the past have always depended on post-payment fraud detection systems that had known fraud schemes built in, so it was only looking for certain things.

These new predictive systems, and they can be morphing every day, every week, have phenomenal capability to find aberrancies that most of us could not find on our own, so using those new technologies are just very crucial.

Senator McCASKILL. Thank you. Thank you, Madam Chair.

Senator Whitehouse.

Senator WHITEHOUSE. Thank you very much. Let me first thank Mr. Bagdoyan and GAO for their work that led to this hearing. I was one of the signators of the original letter requesting this report, and I know that the Chairman and the Co-Chairmen—are you Chairman and Ranking Member?

Senator McCASKILL. I am the Ranking Member. She is the Chairman.

Senator WHITEHOUSE. Chairman and ranking member have been very energetic in pursuing this and making sure that we had this hearing. I express my appreciation to Senator Collins and Senator McCaskill as well, but job well done. I am glad we have this report.

There is another report that was done by the Office of Inspector General for the U.S. Department of Health and Human Services about questionable billing in geographic hot spots, and I am wondering, Mr. Agarwal, what you think the geographic hot spot effect is for Medicare fraud? My layman's impression is that there are places where this is an industry, like Florida, and there are places where people rent a place, set up shop, send out millions of dollars in bills.

As soon as they get a big pile, close the doors and they are gone and they move on. Hard to pull that off in Rhode Island because everybody kind of knows each other. We are a small State, but I do have the impression that there are serious geographic hot spot issues here and I wonder if you would comment on whether that is the case and what you are doing to look into that question.

Dr. AGRAWAL. Sure, and let me just start by confirming Rhode Island is not a huge hot spot for us, so there are. I think what you see when you look at almost any healthcare system, including Medicare utilization, is that there are significant geographic variability. A lot of internal and external folks have commented on that. In the particular area of fraud—

Senator WHITEHOUSE. Geographic variability consistent through time, i.e., it is the same places?

Dr. AGRAWAL. Correct.

Senator WHITEHOUSE. Okay.

Dr. AGRAWAL. Specifically in fraud, there are certain hot spot areas that do always, it seems, tend to originate schemes and kind of spread them from there. South Florida, obviously, is an example, Detroit, Southern California around Los Angeles, the Brooklyn area in New York. These are areas that come up all the time.

Senator WHITEHOUSE. What have you done to focus on those areas?

Dr. AGRAWAL. We take an approach that obviously is looking at the entire country. We have regionalization, to some degree, through our contractors, but our strategic focus has been to create national resources that can still focus on these areas as needed.

One thing that I just discussed was the fraud prevention system, this predictive analytics system. Our contractors that are regionally based can actually tell us about specific schemes that they are encountering in their area, so it might be geographically very specific, but we can get those in as models into the FPS. That will be then primarily for those contractors, so these models can be both national in scope, but also be designed to address particular pockets of issues.

Senator WHITEHOUSE. Where there are geographic pockets, let me suggest that you try to establish working relationships with local investigative authorities. We have a Medicaid fraud control unit in Rhode Island that is part of the Attorney General's office. Every State has one. If folks are cheating Medicare, they may well also be cheating Medicaid, and so, you have kind of a natural group of allies there.

I noticed that your hot spot areas you mentioned were all in very big states, Florida, Michigan, California, so it may be that the Medicaid fraud control unit has so much span there that they cannot really focus, in which case you would have to look at district attorneys.

I would encourage you to follow Senator Cotton's suggestion that there are people who would be willing to take a drive by, if you had the relationship with them, to say, look, we just got billed a million dollars out of this address in the last month and nobody has ever billed us from that address before. Would you mind just go checking it out? If it looks like it is an abandoned garage, boom, you have learned something. I would encourage you to do that.

The other thing I would suggest, and I would ask you to comment on this, is that there are prescription drug monitoring programs out there. They are kind of an under-utilized thing. It is not quite clear who owns them. It is not quite clear, you know, where they—there is a lot of variability State to State.

The HHS IG report was heavily about the problem of opioids. I wonder what your thoughts are and how you are working with the prescription drug monitoring programs in the states and trying to develop them to the point where they are a valuable asset for your anti-fraud as well as anti-opioid abuse efforts.

Dr. AGRAWAL. Sure. Let me just say on the first point, we totally agree. I totally agree that a relationship with local entities is extremely important. Our contractors are indeed required to work with local law enforcement entities, including regional OIG offices. We also have Federal staff located in many of these hot spot areas so that we can address the hot spots directly.

To your second point about opioid utilization, there is a variety of programs in place at CMS, primarily through the Part D program and Medicaid, to address opioid over-utilization. We look at prescribers of these medications as well as the beneficiaries who utilize them. We have controls, utilization management protocols, case management approaches to the beneficiaries, and then we have the same oversight approaches to the prescribers that we do in the rest of the program, including enrollment and screening, claims analytics or prescription analytics, and investigations, so you know, we are doing more and more to incorporate Part D into this overall work. In the Medicaid work, of course, we have to work very closely with states in their monitoring approaches so that we are addressing providers that might be particular to the Medicaid program.

Senator WHITEHOUSE. If I could, with the Chairman's permission, make a query for the record, I would like to ask Dr. Agrawal to have the opportunity to respond in writing to where they see themselves going with the PDMPs, prescription drug monitoring programs, as an enforcement and public safety device. That way I do not have to use any more of my time since I am over it.

Senator McCASKILL. Certainly.

Senator WHITEHOUSE. Thank you.

Senator McCASKILL. Thank you. Thank you, Senator. Senator Collins.

The CHAIRMAN. Thank you very much. Mr. Bagdoyan, I want to go back to a comment that the doctor made in his opening statement. He said that both the hamburger joint and the vacant lot had not received any payments in 10 years, and in the interest of time, I am going to focus on the vacant lot.

That comment bothered me greatly because it was so dismissive of the concern that brings us here today. According to the GAO report, and I am looking at page 21, GAO made a site visit and found that the lot was vacant in December 2014. Is that accurate?

Mr. BAGDOYAN. That is accurate, Senator.

The CHAIRMAN. Then according to GAO, the provider went through a re-validation process using this vacant lot as the address and was approved by the MAC the very next month, in January 2015. Is that accurate?

Mr. BAGDOYAN. Looks to be, yes.

The CHAIRMAN. Does that not mean that the provider remained eligible to bill Medicare in the future from that lot as long as you are in the provider system, the PECOS system. Is that accurate?

Mr. BAGDOYAN. That is the risk, Madam Chair.

The CHAIRMAN. Is that not the problem? Even if someone has not billed from an address in some time, if they remain in the system and eligible to bill, then the potential for fraud is still there.

Mr. BAGDOYAN. That is correct, yes.

The CHAIRMAN. Doctor, I want to turn to another issue that we did not complete on providers that have had their licenses either revoked or suspended and yet are still eligible for Medicare. Is it correct that CMS primarily relies on self-reporting by physicians?

Dr. AGRAWAL. Providers are required in their enrollment application to self-report license information. However, we have, in recent years, implemented the automated provider screening system

which then does continuous monitoring of licensure, which is what has allowed us in these—since the APS was created, to revoke 11,000 providers for licensure issues, so no, we do not rely entirely on self-reported data, but of course that is part of the enrollment application.

The CHAIRMAN. Sure. Someone who is determined to keep drawing money out of the system and is not ethical and has had his or her license revoked is not likely to report honestly, are they?

Dr. AGRAWAL. Well, correct. That is why we have implemented other data checks around exactly those issues, and where a provider has falsely reported information, we can take action against them. The reporting is actually useful as a lever for that purpose, because that, in and of itself, if they have inaccurately reported data to the agency, we can kick them out of the program for that reason, so getting the reports is actually useful for us from an investigative standpoint.

The CHAIRMAN. Do you use the Federation of State Medical Boards data, the FSMB data, as a check automatically?

Dr. AGRAWAL. We go upstream of the FSMB, actually going back to the states themselves. Since the FSMB is an umbrella organization for the states, they get information from the states, so what we have done to try to get more accurate, more timely information, is to go back to the states themselves, which is why we have to use so many different data bases to get license information.

The CHAIRMAN. Well, do you use this consolidated data base at all?

Dr. AGRAWAL. We do. Again, we do and we perform continuous monitoring on licenses, which is why we have been able to revoke 11,000 providers for license issues.

The CHAIRMAN. Okay. If you are doing continuous monitoring, how is it that GAO was able, in a relatively short time, and not doing—and not that it took years and years—to come up with hundreds of providers that had had their licenses either revoked or suspended, and yet, under your system, were still eligible?

Dr. AGRAWAL. Yes. I think it is important to keep in mind that there were 19 providers on the list that we ultimately took an action on against—you know, with GAO's input and recommendations. I think where the GAO has clearly added a lot of value—

The CHAIRMAN. Well—

Dr. AGRAWAL. Just permit me to answer the question because I think it is important.

The CHAIRMAN. Sure, certainly.

Dr. AGRAWAL. Thank you. Where the GAO has clearly added a lot of value is they said to us, we should be monitoring more than just the licenses of active enrollments, the licenses for states in which a provider is actively enrolled, but looking at the provider's entire set of licenses. That is an enhancement of the program and enhancement of the use of our continuous monitoring system. We agreed with that approach and we are implementing that change so that additional licenses are being monitored in the system.

The CHAIRMAN. Mr. Bagdoyan, do you agree that there were only 19 physicians on that list? It was my understanding that you had not gotten a report back from CMS despite it being overdue.

Mr. BAGDOYAN. That is right, Madam Chairman. We would be happy to look at what CMS provides us in response to our referrals, which is a matter of routine for my mission team. We do that, work closely with the agencies to make referrals for action on their part and a response to us in terms of what they have done, so once I have had a chance to look at the details, we would be happy to consider any additional actions.

The CHAIRMAN. I would officially ask you on behalf of the Committee to undertake the review that you did of the referrals to CMS, compare it with the response we have received today, that there were only 19 physicians on that list who warranted being kicked out of the Medicare program, and help us better understand the discrepancy. It is my understanding that part of it is that you referred the names of physicians that were not removed until many months after adverse action.

Mr. BAGDOYAN. That is right.

The CHAIRMAN. That obviously puts the system at risk. Is that accurate?

Mr. BAGDOYAN. It is. Even though the numbers may be relatively small, obviously these are potentially bad actors, to use a term of art, so it is important to flag each and every one of them to the extent possible. What we are looking for here is reasonable assurance, not absolute assurance, that everybody is going to be flagged. I had that as an action item for followup.

The CHAIRMAN. Thank you, and in fact, I think that one of the providers had billed something like \$600,000. I mean, there can be a lot of money at issue here.

Mr. BAGDOYAN. That is right.

The CHAIRMAN. Ms. Leff, just one final quick question for you. If you were to compare your system to that used by CMS, what one improvement would you suggest that CMS use?

Ms. LEFF. I think CMS is working on the same issues that CareSource is working on. We are looking at new analytic systems, predictive analytics. Prepay, I do not know how possible that is, but you are doing some of that, I believe, in the CMS area.

I think those are the things right now that seem to be the focus in the fraud program integrity area, really trying to get ahead of the game, preventing the dollars from going out the door, and instead of trying to pay it and chase it and trying to get it back.

The CHAIRMAN. Thank you. Thank you.

Senator MCCASKILL. Thank you. Mr. Bagdoyan, do you know what the amount of fraud is? Dr. Agrawal pointed out that improper payments does not mean all fraud. Do we have any estimates of what percentage of the improper payments represent fraud?

Mr. BAGDOYAN. We do not. It is inherently difficult to estimate, so the big top line number is improper payments, some of which may be fraud, but it is very difficult to ascertain the exact extent.

Senator MCCASKILL. Has there ever been an attempt at CMS to determine what the level of fraud is on an annual basis out of the \$554 billion that we are spending on this program?

Dr. AGRAWAL. Nothing on the scale of the improper payment rate measurement that is done. We have been working on a project to essentially pilot some kind of fraud rate calculation. I totally agree

with Mr. Bagdoyan. That is actually very complicated, to try to generate a fraud rate since, of course, once you have identified a potential issue, you have got to investigate it, you know, take appropriate actions, and if it truly is fraud, remove it from the system, which inherently alters the rate itself.

We have started—we have been working on a pilot in the home health area. We will actually be piloting that methodology very soon working with law enforcement, with other entities, to see if we can generate an initial sample in home health of what a fraud rate might look like. That will be the first time the agency has done such a thing.

Senator MCCASKILL. Well, is anybody compiling the cases around the country of Medicare fraud that are brought and the dollar amounts they represent? I know with some regularity, our attorney general trumpets a multimillion dollar settlement on Medicare fraud. I am sure every attorney general in the country does that. Are you all making any attempt to compile that so that we can begin to get some kind of—it is unsettling to me that we so easily do improper payments, but we are not doing fraud.

I do not really—I mean, I understand there has to be a determination legally that it was fraud, but at least we could be identifying potential fraud, just like you are identifying potential improper payments. The improper payment figure, there is some money included in there that turns out not to be improper payment.

Dr. AGRAWAL. Well, that is exactly the approach that we are trying to take in this home health example that I provided, is to look at potential fraud. When you look at improper payments, that is a statistical sample of claims that we then compared to medical records. It is on the order of, I believe, 100,000 claims, if I remember correctly, and then it is extrapolated since it is a statistically valid random sample.

That is the improper payment rate in Medicare and it is corroborated with medical records. The challenge of determining a fraud rate is that you cannot just go to the medical record.

Senator MCCASKILL. I understand.

Dr. AGRAWAL. You have to conduct a site visit. You have to try to get at the intentionality of the provider.

Senator MCCASKILL. Could you compile the amount of Medicare fraud that has been determined through DOJ and attorney generals across the country. Do you do that?

Dr. AGRAWAL. Well, that is a good point. DOJ and OIG do compile their own casework. They compile, obviously, settlements, other actions that are taken, and that we do publish on a routine basis.

Senator MCCASKILL. What is that number?

Dr. AGRAWAL. Well, in our HCFAC report, I believe we have reported between seven to eight to one ROI last year in terms of dollars recovered in all of these civil—

Senator MCCASKILL. I do not want to hear ROI because sometimes that justifies a lot of contracts. What I want to know is, what is the cumulative amount of Medicare fraud that was determined by various agencies, whether it is OIG or DOJ or State law enforce-

ment or Agencies, what was the total amount of Medicare fraud identified last year?

Dr. AGRAWAL. Right. Clearly that is on the law enforcement side of the house. We do not keep those kinds of figures. I am happy to——

Senator MCCASKILL. Well, should you not? Should you not know what it is?

Dr. AGRAWAL. Well, you know, again, I think fraud is determined through very extensive legal process.

Senator MCCASKILL. I know that.

Dr. AGRAWAL. Our goal——

Senator MCCASKILL. That is not my point. My point is, if you are sitting there doing your job, the reason we have GAO is because they allow us to go in and see how agencies are doing. Your job is, in fact, to provide integrity to the program, correct?

Dr. AGRAWAL. Yes.

Senator MCCASKILL. That would be not just improper payments, but fraud. Now, if I had your job, one of the first things I would want to figure out is, are we getting after fraud and are we doing it well? One of the first things I would want to ask is, how much do we recover in fraud, how much fraud has been identified over the last 10 years? Are we doing better or worse? I am puzzled why this is not something you are curious about.

Dr. AGRAWAL. It is absolutely something that we are working to know. However, you know—so what we do is we look at a variety of indicators. Where are the cases that we are spending most of our time on geographically? What kind of cases are they? You know, different utilization areas. We look at overall cost to health care or to Medicare and actually see if there are changes in that as we press our activities in certain areas. There are a variety of indirect indicators that we use to substantiate that we are focused in the right areas, including, obviously, talking to law enforcement, that we are spending our resources wisely.

I think a basic practical question is, how much time, effort, energy, and resources we should spend to determining a fraud rate, which at some point becomes an academic exercise, as opposed to doing the work and trying to get these bad actors out of the program.

Senator MCCASKILL. Well, you know, it was interesting. I had the same experience when I asked the people at Immigration, Customs Enforcement, how many employers they had prosecuted for hiring—knowingly hiring illegal immigrants when I first came to the Senate, and I actually got an answer that they did not know.

I was stunned that they would not know that, and then they said they could not really get me that because it would take too much time, too much energy, too many people, so we had our interns Google, you know, a few phrases, illegal immigrants arrested, employer charged, and we were able to, in a fairly short period of time, begin coming up with some significant numbers, and when confronted with that, there was some embarrassment at ICE about it.

I guess what I am telling you is, when these prosecutors announce it, it is really common knowledge. This is not hard to compile. All you would have to do is write a letter to all the attorney

generals saying, would you send us all the Medicare fraud cases that you successfully identified last year and the dollar amount. I mean, at least having that—what I am worried about is that we are not keeping track if we are doing better or worse, so let me go on to the next question. What does Finalist do?

Dr. AGRAWAL. Finalist is a piece of software. What it does is it does similar address verification, although again, we agree not to the enhanced level that GAO had undertaken, but it does similar address verification activity for CMS in the enrollment and re-validation process.

Senator McCASKILL. Was it written for CMS?

Dr. AGRAWAL. You know, honestly I am not totally aware. I think this was a product that we purchased.

Senator McCASKILL. Do you know, Mr. Bagdoyan? Was this written—was this software designed for CMS or was it off-the-shelf?

Mr. BAGDOYAN. I do not know off the top of my head, Senator McCaskill, but I would be happy to get back to you.

Senator McCASKILL. That would be great. I would love that for the record, because one of the things we are trying to get at is that sometimes Government has a tendency, people come in the door and say, we can do this for you, and you get so focused on somebody who can do it for you that you do not realize there is a product sitting on the shelf like Google Maps or like USPS or like other places that you could do the same thing, so you said earlier you do not know what it costs. Do you know when your contract with Finalist is expiring?

Dr. AGRAWAL. I do not.

Senator McCASKILL. I believe you do know, Mr. Bagdoyan, right?

Mr. BAGDOYAN. My colleagues can correct me, but I believe it is toward the end of this year.

Senator McCASKILL. That is correct, the end of this year, so the question is, are there any plans to replace Finalist?

Dr. AGRAWAL. Well, I think what is less important to us is the specific name of the product or, you know, what a particular company has. I think what we want to do is we have actually taken the approach that you are describing, which is to try to use as many off-the-shelf tools as possible.

That is why we have rolled into our enrollment systems things like the GSA debarment list, the law enforcement exclusions data base, other existing data bases that allow us to do our work and that do not have to be customized a lot so that there is—

Senator McCASKILL. I think that is great.

Dr. AGRAWAL. That is definitely the approach that we have taken. That is the approach that we will take to roll in the USPS system that GAO has identified.

Senator McCASKILL. What I am anxious to know is, when it gets near the end of the year, is there someone somewhere in CMS that is going to renew the contract with Finalist when perhaps it is not even necessary, when perhaps it is much more expensive than the products you can get off-the-shelf that could easily be programmed together?

I think the people at GAO could help you with this. They are very good at it. They do it for living. There seems to be this kind of default in Government. We do not want to do anything dif-

ferently because if we do anything differently, you know, it might not work in PECOS and people are going to have to learn different software, and then we get these legacy customized systems that go on and cost our Government a fortune. I will be anxious to hear how much Finalist costs, and what I really want to know for the record, I not only want to know what Finalist costs, I want to know how long it has been used. I want to know whether it was designed and scoped by the Government or whether it was off-the-shelf.

I want to know how much time they have been spending adjusting the program, and what, if any, plans are already in place to compete it for the end of this year, because I believe with what you are trying to do with all the data analytics that are out there and all the off-the-shelf programs that are out there, I believe you could compete this program, and I am willing to bet you are going to be able to save some money, but you know, we need to know all this information.

Dr. AGRAWAL. Sure. We are—I am happy to get that to you. I will just say, Senator, that we definitely do not have the mentality that systems that are in place need to stay in place, or that off-the-shelf products are not useful to us. We have specifically made strategic decisions to try to take advantage of existing high-value products, and in fact, do competitions between products to make sure that we are on-boarding the ones that are most useful.

Senator McCASKILL. Okay. Let me move on to something else. If I am fraudulently registering as a Medicare provider and somebody calls me and I lie about the address, or if someone calls me or I failed to report that I have lost my medical license in New Hampshire and I am currently in Mississippi, what happens to them? How many of them have been referred for prosecution?

Dr. AGRAWAL. Maybe those are two different questions.

Senator McCASKILL. Same question. Somebody lying to you, you know, whether it is a failure to self-report, adverse action, in another jurisdiction, or lying about the address.

Dr. AGRAWAL. All right. If it is very clear, we have done the investigative work, we found out that they operated in a non-operational setting or they clearly lied, we can work with law enforcement and consider, in all of those cases, whether to make a referral to law enforcement. Then obviously law enforcement makes a determination about whether they will accept that referral and continue to move it along the process.

Senator McCASKILL. Obviously.

Dr. AGRAWAL. We—I mean, I think you know this, but we do not engage in the direct prosecution itself.

Senator McCASKILL. Correct. I am asking how many you have referred.

Dr. AGRAWAL. I can get you a formal number, but I know that it is in the thousands just from last year alone.

Senator McCASKILL. Whatever delineation you have, I mean, these are all performance measures.

Dr. AGRAWAL. Sure.

Senator McCASKILL. We did not ask GAO to do a performance audit, but they do a lot of good ones, and these are performance measures. It is very hard to judge your performance if we have no

baseline. If we do not know what fraud was at any point in the last 10 years, we have no idea if we are doing better or worse.

The same thing with criminal referrals. There a lot of things that we can, if we get a baseline, then if you are doing great work, Doctor, then you are going to get acknowledged for it. The only thing we have got now is that improper payments have gone up by billions of dollars and that does not look good for you.

I am trying to give you some other tools. It looks like to me you are trying to get after it. I do not think anybody is trying to pick on you here. I think we are just trying to do basic oversight. If we could get some basic baseline on fraud referrals and those kinds of things, then I think it helps us measure your progress in a way that taxpayers really expect of us.

Dr. AGRAWAL. Sure. We will send you that data.

Senator MCCASKILL. Okay, great. Finally, my last question is just about the prescription meds. When you were talking about that, as you know, it is a huge, huge problem and I think it is one that is going to become part of the everyday national discourse in this country since so many of our children are now dying of heroin overdose as opposed—more in my State dying of heroin overdose than in car accidents.

I think it is true in many, many states in our country, that young people are turning to heroin because it is so cheap, much cheaper than oxy, much cheaper than Vicodin and Percocet that they get on the street, so when you see a pattern of over-prescription for someone, are you contacting the prescribing doctors?

Dr. AGRAWAL. Yes, so this is an area of focus for us. One of the basic tools that we need is to get these prescribers enrolled in the program, because once they are enrolled, we would then have the same administrative authorities to oversee them, to audit them, ultimately kick them out of the program if that is what is required.

Senator MCCASKILL. Put them in jail maybe?

Dr. AGRAWAL. Again, we would refer them to law enforcement to do that, and because our main—you know, our main tool has not been in place, you know, we promulgated a rulemaking last year, we are working to get 400,000 prescribers enrolled this year so that we have that direct oversight with them.

We have definitely been focusing on referrals to law enforcement in the interim because that is a major tool that we, you know, of course can access.

Senator MCCASKILL. Okay, great. Anything else, Senator?

The CHAIRMAN. No.

Senator MCCASKILL. We appreciate all of you being here very much, appreciate your work. Please give my best to what I consider a home away from home for me in Washington and that is that gorgeous building down off of 4th and Mass. where all of you hang out at GAO. I appreciate so much the work you do and the audits you produce. This was a good one and I think we have made some progress today.

I want to thank you, Doctor, and thank you, Ms. Leff, for your contributions, also. I particularly want to thank the Chairman because every once in a while she throws me a bone and lets me believe that I have some semblance of control over what is going on here, which I very much appreciate. I think it was a terrific hear-

ing and it would not have happened without her agreement and her corporation, and obviously her willingness to let us focus on this issue. Thank you.

The CHAIRMAN. Thank you very much and thank you for your leadership in pulling this hearing together. Committee members will have until Friday, July 31st to submit additional questions for the record. I want to note that there were two members who were here, Senator Sasse and Senator Tillis, who did not get an opportunity to question you even though they were here for testimony, and they may be submitting some additional questions for the record.

I want to join Senator McCaskill in thanking all of our witnesses today and this concludes the hearing.

[Whereupon, at 4:10 p.m., the hearing was adjourned.]

APPENDIX

Prepared Witness Statements



United States Government Accountability Office

Testimony
Before the Special Committee on Aging,
U.S. Senate

For Release on Delivery
Expected at 2:15 p.m. ET
Wednesday, July 22, 2015

MEDICARE PROGRAM

Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers

Statement of Seto J. Bagdoyan, Director, Forensic Audits
and Investigative Service

Chairman Collins, Ranking Member McCaskill, and Members of the Committee:

I am pleased to appear before you today to discuss our June 2015 report on the controls used to verify the eligibility of Medicare providers and suppliers.¹ Medicare is the federally financed health-insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.² In fiscal year 2014, Medicare paid \$554.2 billion for health care and health care–related services. According to the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—an estimated \$59.9 billion (10.8 percent) of that total was paid improperly, which is an increase over the 2013 level of about \$49.9 billion.³ Due to the program's large estimated improper payments, the Office of Management and Budget has placed Medicare on its list of high-error programs in 2014.⁴ Further, because of its size, complexity, and susceptibility to mismanagement and improper payments, we have long designated Medicare as a high-risk program.⁵

¹GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, [GAO-15-448](#) (Washington, D.C.: June 25, 2015).

²Medicare consists of four parts. Medicare Part A covers items such as inpatient hospital care. Part B services include physician and outpatient hospital services. Medicare Part C or Medicare Advantage is a Medicare private plan, while Medicare Part D is an outpatient prescription drug benefit.

³An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, § 3(a)(1), 126 Stat 2390 (codified at 31 U.S.C. § 3321 note). For more information about improper payments, see [GAO-15-448](#).

⁴The Office of Management and Budget designates a program as "high-error" based on improper-payment information in agencies' annual Performance and Accountability Reports and Agency Financial Reports. Specifically, a program is considered high-error if it has improper payments greater than \$10 million and over 2.5 percent of all payments made under that program, or if the program has more than \$100 million in estimated improper payments.

⁵GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: February 2015).

To enroll in Medicare and bill for services provided to Medicare beneficiaries, CMS requires prospective providers and suppliers to be listed in the Provider Enrollment, Chain and Ownership System (PECOS). PECOS is a centralized database designed to contain providers' and suppliers' enrollment information. According to CMS, there were about 1.8 million health-care providers and suppliers enrolled in PECOS as of December 31, 2014.

My remarks today highlight the key findings of our June 2015 report on CMS's Medicare provider and supplier enrollment-screening procedures. Accordingly, this testimony discusses the extent to which CMS's enrollment-screening procedures are designed and implemented to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) into PECOS.

To conduct this work, we reviewed CMS procedural manuals and directives, including the Medicare manual that outlines the procedures that CMS's contractors—Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC)—should use to determine provider and supplier enrollment eligibility.⁶ We also interviewed CMS officials about provider and supplier enrollment-screening procedures, including procedures that were developed and implemented as a result of the Patient Protection and Affordable Care Act's (PPACA) provisions. In addition, we conducted interviews with MACs and NSC officials about enrollment-screening procedures. We matched the list of providers and suppliers present in PECOS, as of March 29, 2013, and the DMEPOS suppliers, as of April 6, 2013 (the most-current data available at the time of our review) to the following databases: (1) the United States Postal Service (USPS) Address Matching System Application Program Interface;⁷ (2) Federation of State Medical Boards (FSMB) licensure data;

⁶MACs are responsible for verifying provider and supplier application information in PECOS before the providers and suppliers may enroll into Medicare. CMS currently contracts with 12 MACs, each of which is responsible for its own geographic region. The NSC is responsible for verifying information regarding DMEPOS suppliers.

⁷In this statement, we refer to the USPS Address Management System Application Program Interface as the USPS address-management tool.

(3) the Social Security Administration's (SSA) full death file;⁸ and (4) the HHS Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) to determine whether ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers were in PECOS. We also contacted those MACs and the NSC responsible for enrolling the specific individuals or entities that appeared in our four sets of matches to gather more updated information during the months of September 2014 through October 2014. For the USPS address-management tool, we selected a generalizable stratified random sample from the addresses that the USPS address-management tool identified as being a Commercial Mail Receiving Agency (CMRA), vacant, or invalid and took additional steps to confirm whether the practice location address was an eligible address, such as searching Google Maps and providers' websites, and conducting physical site visits. Based on our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes. More details on our scope and methodology can be found in the issued report.⁹ We conducted the work on which this statement is based in accordance with generally accepted government auditing standards.

In summary, our audit work identified weaknesses in two of four enrollment-screening procedures that CMS implemented to detect ineligible or potentially fraudulent providers and suppliers from enrolling into PECOS. While the procedures used to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care-related programs appear to be working; we identified weaknesses in procedures used to verify provider practice locations and those used to verify the licensure status of physicians. These weaknesses may have resulted in CMS making improper payments to thousands of potentially ineligible providers and suppliers. In our June 2015 report we recommended that CMS incorporate flags into its software to help identify potentially questionable addresses, revise its guidance for verifying practice locations, and collect additional license information. The agency concurred with two of our recommendations, but

⁸SSA maintains death data including names, Social Security numbers, dates of birth, and dates of death. SSA shares a comprehensive file of this death information, which includes state death data, with certain eligible entities, including CMS, according to SSA. We used this comprehensive file, which we call the "full death master file," for our analysis. A subset of the full death master file that does not include state death data is available to the public.

⁹GAO-15-448.

did not agree with the recommendation to revise its guidance. We continue to believe the recommendation is valid, as I will discuss later in this statement.

Limitations Exist in CMS Screening Procedures for Verifying Applicants' Practice Locations

We found thousands of questionable practice location addresses for providers and suppliers listed in PECOS, as of March 2013, and DMEPOS suppliers, listed as of April 2013.¹⁰ Under federal regulations, providers and suppliers must be "operational" to furnish Medicare covered items or services, meaning that they have a qualified physical practice location that is open to the public for the purpose of providing health care-related services. The location must be properly staffed, equipped, and stocked to furnish these items or services. Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of CMRA, such as a United Parcel Services (UPS) store.¹¹ We checked PECOS practice location addresses for all records that contained an address using the USPS address-management tool, a commercially available software package that standardizes addresses and provides specific flags on the address such as a CMRA, vacant, and invalid address.¹² As illustrated in figure 1, based on our analysis of a generalizable stratified random sample of 496 addresses, we estimate that about 23,400 (22 percent) of the 105,234 addresses we initially identified as a CMRA, vacant, or invalid address are potentially ineligible addresses.¹³ About 300 of the

¹⁰GAO-15-448. All providers and suppliers must list a physical practice location address in their application, regardless of provider or supplier type.

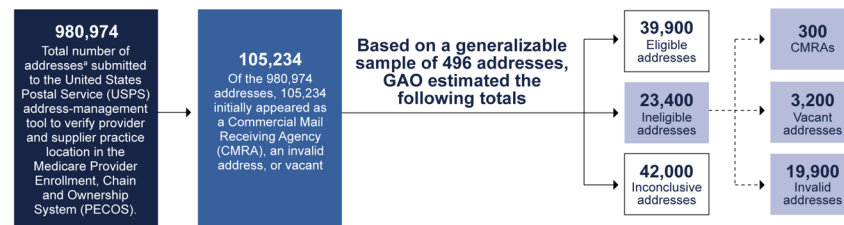
¹¹Based on USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. Not all CMRAs would disqualify an applicant from PECOS enrollment. For example, a hospital may be legitimately designated as a CMRA and could be considered an eligible practice location. Post office boxes and drop boxes are not acceptable except in some cases where the provider is located in rural areas.

¹²The USPS address-management tool includes addresses as of December 15, 2013. This software is not currently being used by CMS. Instead, CMS uses the software—called Finalist—to standardize practice location addresses. A vacancy refers to a provider or supplier that is no longer at the location provided on the application form. USPS would flag a location as vacant if it used to deliver mail there and has not delivered mail there in more than 90 days. An invalid address is when an address is not recognized by USPS, was incorrectly entered in PECOS, or was missing a street number.

¹³As part of our initial analysis using the USPS address-management tool, we identified 105,234 (about 11 percent) of the 980,974 address listed in PECOS that appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address. For more information on our estimates and methodology, see GAO-15-448.

addresses were CMRAs, 3,200 were vacant properties, and 19,900 were invalid.

Figure 1: GAO Sample Estimates of Provider and Supplier Practice Location Addresses in PECOS Using the USPS Address-Management Tool



Source: GAO. | GAO-15-762T

Note: Estimated numbers do not add to totals due to rounding. All estimates in this figure have a margin of error, at the 95 percent confidence level, of plus or minus 10 percentage points or fewer. These data are from March 2013 (Medicare providers and suppliers) and April 2013 (suppliers of durable medical equipment, prosthetics, orthotics, and supplies).

*We did not submit addresses of providers in PECOS that reassigned their benefits to a group. These providers did not have a practice location address listed in PECOS and were not included in our work.

Of the 23,400 potentially ineligible addresses submitted as practice locations, we estimate that, from 2005 to 2013, about 17,900 had no claims associated with the address, 2,900 were associated with providers that had claims that were less than \$500,000 per address, and 2,600 were associated with providers that had claims that were \$500,000 or more per address. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. Due to how we compiled claims by the National Provider Identifier, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

We found limitations with CMS's Finalist software used to validate practice location addresses. The Finalist software is one technique used by the MACs and the NSC to validate a practice location. According to CMS, Finalist is integrated into PECOS to standardize addresses and does so by comparing the address listed on the application to USPS records and correcting any misspellings in street and city names, standardizing directional markers (such as NE or West) and suffixes

(such as Ave. or Lane), and correcting errors in the zip code. However, the Finalist software does not indicate whether the address is a CMRA, vacant, or invalid address—in other words, whether the location is potentially ineligible to qualify as a legitimate practice location. CMS does not have these flags in Finalist because the agency added coding in PECOS that prevents post office box addresses from being entered, and believed that this step would prevent these types of ineligible practice locations from being accepted.

However, some CMRA addresses are not listed as post office boxes. For example, we identified 46 out of the 496 sample addresses that were allowed to enroll in Medicare with a practice location that was inside a mailing store similar to a UPS store. These providers' addresses did not appear in PECOS as a post office box, but instead were listed as a suite or other number, along with a street address. Figure 2 shows an example of one provider we identified through our search and site visits as using a mailbox-rental store as its practice location and where services are not actually rendered. This provider's address appears as having a suite number in PECOS and remained in the system as of January 2015. According to our analysis of CMS records, this provider was paid approximately \$592,000 by Medicare from the date it enrolled in PECOS with this address to December 2013, which is the latest date for which CMS had claims data.

Figure 2: Mailbox Rental Store with a Suite Number Address Used as a Provider Practice Location



Source: GAO. | GAO-15-762T

Our review also found locations that were vacant or addresses that belonged to an unrelated establishment. For example, we visited a provider's stated practice location in December 2014 and instead found a fast-food franchise there (see fig. 3—the name of the franchise has been blurred). We found a Google Maps image dated September 2011 that shows this specific location as vacant. Although the provider was not paid by Medicare from the date this practice location address was flagged as vacant, by remaining actively enrolled into PECOS, the provider may be eligible to bill Medicare in the future.

Figure 3: Fast-Food Franchise Listed as Provider's Practice Location



Source: GAO. | GAO-15-762T

In March 2014, CMS issued guidance to the MACs that revised the practice location verification methods by requiring MACs to only contact the person listed in the application to verify the practice location address and use the Finalist software that is integrated in PECOS to standardize the practice location address. Additional verification, such as using 411.com and USPS.com, which was required under the previous guidance, is only needed if Finalist cannot standardize the actual address.¹⁴ Our findings suggest that the revised screening procedure of contacting the person listed in the application to verify all of the practice location addresses may not be sufficient to verify such practice locations. For example, two providers in our sample of 496 addresses that the USPS address-management tool flagged as CMRA, invalid, or vacant that successfully underwent a MAC revalidation process in 2014. The MAC used the new procedure of calling the contact person to verify the

¹⁴411.com is an online directory of contact information for people and businesses. USPS.com offers the ZIP Code Lookup tool, which standardizes addresses using USPS address records.

practice location. Each of these two providers had a UPS or similar store as its practice location.

To help further improve CMS's enrollment screening procedures to verify applicants' practice location, we made two recommendations to CMS in our June 2015 report. First, we recommended that CMS modify the CMS software integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as a CMRA. The agency concurred with this recommendation. Second, we recommended that the agency revise the CMS guidance for verifying practice locations to include, at a minimum, the requirements contained in the guidance in place prior to March 2014 so that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a CMRA, vacant, or invalid address to better ensure that the address meets CMS's practice location criteria. The agency did not concur with this recommendation, stating that the March 2014 guidance was sufficient to verify practice locations. However, our audit work shows that additional checks on addresses flagged by the address-matching software as a CMRA, vacant, or invalid can help verify whether the addresses are ineligible. As our report highlighted, we identified providers with potentially ineligible addresses that were approved by MACs using the process outlined in the existing guidance. Therefore, we continue to believe that the agency should update its guidance for verifying potentially ineligible practice locations. We described the methodology that we used to identify these cases to CMS and referred these cases to CMS for further review.

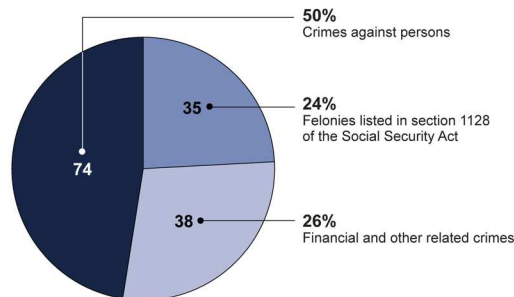
Limitations Exist in Verifying Applicants' Licensure Information

We found 147 out of about 1.3 million physicians with active PECOS profiles had received a final adverse action from a state medical board, as of March 2013. Adverse actions include crimes against persons, financial crimes, and other types of health-care related felonies. These individuals were either not revoked from the Medicare program until months after the adverse action or never removed (see fig. 4).¹⁵ All physicians applying to participate in the Medicare program must hold an active license in the state they plan to practice in and also to self-report final adverse actions, which include a license suspension or revocation by any state licensing authority. CMS requires MACs to verify final adverse actions that the applicant self-reported on the application directly with state medical board

¹⁵GAO-15-448.

websites. We found that because physicians are required to self-report adverse actions, the MACs did not always identify unreported actions when enrolling, revalidating, or performing monthly reviews of the provider.¹⁶ As a result, 47 physicians out of the 147 physicians we identified as having adverse actions have been paid approximately \$2.6 million by the Medicare program during the time CMS could have potentially barred them from the Medicare program between March 29, 2003, and March 29, 2013.

Figure 4: Summary of the Adverse License Actions Related to 147 Physicians Who Were Not Revoked for Months or Never Removed from Medicare, as of March 2013



Source: GAO. | GAO-15-762T

To identify the 147 physicians with adverse actions, we used data from FSMB to examine physician license information and disciplinary actions. FSMB data differ from the database that CMS uses in that the FSMB database includes a provider's entire history of license revocations and suspensions, for all medical licenses in all states. Some of the adverse actions that were unreported by physicians occurred within the state

¹⁶According to CMS guidance, when an applicant first enrolls into Medicare, MACs must corroborate adverse legal actions and licensure information directly with state medical board website. MAC's must research all enrolled providers each month using multiple state medical board websites in their respective jurisdictions. Medicare providers must go through the revalidation process every 5 years.

where the provider enrolled in PECOS, while others occurred in different states. For example, we identified a physician who initially enrolled into Medicare in 1985 and was suspended for about 5 months in 2009 by the Rhode Island medical board. In 2011, his information was revalidated by the MAC. This provider did not self-report the adverse action, and the MAC did not identify it during its monthly reviews or when revalidating the provider's information. CMS bars providers that are already enrolled in Medicare who do not self-report adverse actions for 1 year. This individual billed Medicare for about \$348,000 during the period in which he should have been deemed ineligible. CMS officials highlighted that delays in removing physicians from Medicare may occur due to MAC backlogs, delays in receipt of data from primary sources, or delays in the data-verification process.

In March 2014, CMS began efforts to improve the oversight of physician license reviews by providing the MACs with a License Continuous Monitoring report, which was a good first step. However, the report only provides MACs with the current status of the license that the provider used to enroll in the Medicare program. Without collecting license information on all medical licenses, regardless of the state the provider enrolled in, we concluded that CMS may be missing an opportunity to identify potentially ineligible providers who have license revocations or suspensions in other states, which can put Medicare beneficiaries at risk.

To help improve the Medicare provider enrollment-screening procedures, in our June 2015 report we recommended that CMS require applicants to report all license information including that obtained from other states and expand the License Continuous Monitoring report to include all licenses, and at least annually review databases, such as that of FSMB, to check for disciplinary actions. The agency concurred with the recommendation, but stated it does not have the authority to require providers to report licenses for states in which they are not enrolled. While providers are not currently required to list out-of-state license information in the enrollment application, CMS can independently collect this information by using other resources, just like we did. Therefore, we clarified our recommendation to state that CMS should collect information on all licenses held by providers that enroll in PECOS by using data sources that contain this information, which is similar to the steps that we took in our own analyses.

Some Instances of Providers and Suppliers in PECOS Listed as Deceased or Excluded from Participating in Federal or Health Care–Related Programs

We found that about .03 percent (460) out of the 1.7 million unique providers and suppliers in PECOS as of March 2013 and DMEPOS suppliers as of April 2013 were identified as deceased at the time of the data we reviewed.¹⁷ The MAC or CMS identified 409 of the 460 providers and suppliers as deceased from March 2013 to February 2015. Additionally, 38 out of the 460 providers and suppliers we found to be deceased were paid a total of about \$80,700 by Medicare for services performed after their date of death until December 2013, which is the most-recent date CMS had Medicare claims data available. Not identifying a provider or supplier as deceased in a timely manner exposes the Medicare program to potential fraud. It is unclear what caused the delay or omission by CMS and the MACs in identifying these individuals as deceased or how many overpayments they are in the process of recouping. We referred these cases to CMS for further review.

We found that about .002 percent (40) out of the 1.7 million unique providers and suppliers enrolled in PECOS were listed in the List of Excluded Individuals and Entities (LEIE), as of March 2013.¹⁸ These individuals were excluded from participating in health care–related programs. Of those 40 excluded providers and suppliers, 16 were paid approximately \$8.5 million by Medicare for services rendered after their exclusion date until the MAC or the NSC found them to be excluded.¹⁹ When we followed up with the MACs in September and October 2014, we found that the MACs had removed 38 of the 40 providers and suppliers from PECOS from March 2013 to October 2014. However, for two matches that we identified, the MACs had not taken any action.²⁰ Given

¹⁷GAO-15-448. To help ensure that Medicare maintains current enrollment information and to prevent others from utilizing the enrollment data of deceased providers and suppliers, MACs are required to check that providers and suppliers in PECOS are not deceased.

¹⁸GAO-15-448.

¹⁹We calculated the Medicare claims data paid from 2005 to 2013 to the excluded providers and suppliers by considering only claims paid for services rendered after the exclusion date through the date CMS or MACs found the providers or suppliers to be excluded, since providers' and suppliers' exclusion periods could have expired after March 2013.

²⁰One MAC conducted additional research on one of the two providers and found that the provider was listed in the HHS OIG list; however, it was not in the Medicare Exclusion Database. It is unknown why the provider was not listed in the Medicare Exclusion Database. The other MAC searched the other provider and did not identify this provider in the System for Award Management or LEIE.

the small number of cases identified (40) and the MACs removal of 38 out of these 40 providers during our review, we did not make a recommendation to CMS. However, we referred the two providers that the MACs did not remove as well as the 16 providers that were paid \$8.5 million by Medicare for services rendered after their exclusion date, to CMS for further review and action.

Chairman Collins, Ranking Member McCaskill, and Members of the Committee, this concludes my prepared remarks. I look forward to answering any questions that you may have at this time.

For questions about this statement, please contact me at (202) 512-6722 or BagdoyanS@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

GAO Contact and Staff Acknowledgments

GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or BagdoyanS@gao.gov

Staff Acknowledgments

Individuals making key contributions to this testimony were Latesha Love, Assistant Director; Gloria Proa; Ariel Vega; and Kelsey Carpenter. Additionally, Marcus Corbin; Colin Fallon; and Danny Royer provided technical support; Shana Wallace and James Ashley provided methodological guidance; and Brynn Rovito and Barbara Lewis provided legal counsel.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#). Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#). Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800, U.S. Government Accountability Office, 441 G Street NW, Room 7149, Washington, DC 20548



Please Print on Recycled Paper.

STATEMENT OF

SHANTANU AGRAWAL, M.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

“THE DOCTOR’S NOT IN: COMBATting MEDICARE PROVIDER ENROLLMENT
FRAUD”

BEFORE THE
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING

JULY 22, 2015

U.S. Senate Special Committee on Aging
Hearing on
“The Doctor’s Not In: Combatting Medicare Provider Enrollment Fraud”
July 22, 2015

Chairman Collins, Ranking Member McCaskill, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services’ (CMS) program integrity efforts. Enhancing program integrity is a top priority for the Administration and an agency-wide effort at CMS. We have made important progress in strengthening our provider and supplier enrollment and screening processes, and I appreciate the opportunity to discuss CMS’ efforts to prevent ineligible providers and suppliers from entering the Medicare program.

Provider and supplier enrollment is the gateway to the Medicare program, and a cornerstone of our program-integrity strategy. Beneficiaries are at risk when fraudulent providers and suppliers perform medically-unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations and/or medical necessity. By preventing fraudulent or unqualified providers or suppliers from enrolling in the program and removing existing unqualified providers and suppliers, CMS ensures that fewer beneficiaries are exposed to risks and harm, and taxpayer dollars are spent only on services provided by legitimate providers and suppliers.

Thanks in part to the authorities provided by the Affordable Care Act, CMS has improved the provider and supplier enrollment and screening process. We are seeing real results from our efforts, and have generated over \$927 million in savings from revocations since March 2011, protecting both beneficiaries and the Medicare Trust Funds. These actions are part of a larger set of provider enrollment and screening activities which have saved the Medicare program \$2.4 billion in avoided costs.¹ These savings reflect the actions CMS has taken to deactivate billing privileges for more than 543,163 providers and suppliers that do not meet Medicare

¹ These savings estimates use the same methodology as the identified “costs avoided by revoking billing privileges” savings measure that was certified by the OIG in the 2nd and 3rd Year FPS Reports to Congress. Please see CMS’ Report to Congress: Fraud Prevention System Third Implementation Year, for more information (available at: <http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html>). While these particular estimates have not been certified by the OIG, they reflect comparable calculations applied to actions taken under authorities provided in both the Affordable Care Act and CMS’ previously existing authorities.

requirements, and to revoke the enrollment and billing privileges of an additional 34,888 providers and suppliers since 2011.²

Perhaps most importantly, increased screening efforts have allowed CMS to deny 4,949 applications in the last 12 months based on improved enrollment screening, preventing these providers or suppliers from ever submitting a claim. This is the clearest signal of how CMS is prioritizing prevention.

Strengthening and Modernizing Provider and Supplier Enrollment

CMS has made a number of significant improvements to the Medicare provider and supplier enrollment process. We have implemented improved user workflows for initial enrollment, changes of information submissions, and user revalidation. In order to reduce errors in reporting, CMS increased transparency so that providers and suppliers can see all their enrollment information that is currently on file. CMS has made the enrollment process electronic, providing modern tools such as e-signatures and the capability for providers and suppliers to upload supporting documents online. All of these changes have resulted in a marked increase in all forms of electronic applications, rising from ten percent in 2011 to over 45 percent in 2015.

To enroll in the Medicare program, a provider or supplier may submit its enrollment application online using the Provider Enrollment, Chain and Ownership System (PECOS) or by paper by sending a CMS-855 to its Medicare Administrative Contractor (MAC). PECOS is a centralized database that contains providers' and suppliers' enrollment information. CMS contracts with MACs, which are responsible for verifying provider application information before the providers are permitted to enroll into Medicare. The National Supplier Clearinghouse is responsible for verifying information for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). If approved, enrollment information must be resubmitted and recertified every three years for DMEPOS and every five years for all other providers and suppliers.

² Deactivated providers and suppliers have their Medicare billing privileges stopped; however, their billing privileges can be restored upon the submission and approval of an updated enrollment application. Revoked providers and suppliers have their Medicare billing privileges terminated and are barred from re-entering the Medicare program for a period of one to three years, depending on the severity of the revocation.

CMS is seeking to improve and redesign PECOS to better match CMS' and the provider and supplier community's needs, providing the capacity for changes occurring across CMS. We are also seeking to improve the data quality in the National Plan and Provider Enumeration System (NPPES), the system that assigns National Provider Identifiers (NPI) to providers and suppliers enrolled in the Medicare program. When the system was first launched, its purpose was to produce a single identifier number for providers and suppliers. Today, the needs of the industry have changed and NPPES is seen as a source for the both provider and supplier identifier and serves as a centralized reference for other purposes, such as for external, commercial claims processing. In addition, other payers leverage National Provider Identifier data to understand the potential universe of health care providers and to vet providers participating in their programs.

Risk-based screening of providers and suppliers

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare and Medicaid, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare, Medicaid, and CHIP providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare.

All Medicare providers and suppliers undergo a baseline screening, including confirmation of the provider's or supplier's Social Security Number through the Social Security Administration and license and certification through the state licensing boards; and searches in the General Services Administration's (GSA) System for Award Management for Government contracting exclusion (suspension and debarments) and the Department of Health and Human Services (HHS) Office of Inspector General's (OIG's) exclusion list for all individuals listed on the application.

Providers and suppliers in the "limited risk" category undergo this verification of licensure and verification of compliance with Federal regulations and state requirements. Providers and suppliers in the "moderate and high risk" category undergo additional screening, including unannounced site visits. CMS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from

enrolling in the Medicare program. Since 2011, CMS contractors have completed 222,566 site visits, which have resulted in 1,279 revocations.

Additionally, individuals with a five percent or greater direct or indirect ownership interest in a designated high risk provider or supplier must undergo fingerprint-based criminal background checks. On an individual basis, a provider or supplier may be elevated to high-risk, and therefore subject to the additional screening, if it has had a payment suspension or had billing privileges revoked in the last 10 years, or if it previously had been excluded from Medicare.

Provider and Supplier Revocations and Terminations

CMS routinely revokes billing privileges from enrolled providers and suppliers based on information contained in the Social Security Administration's complete death master file and CMS' repository of information contained in OIG's exclusion list, the Medicare Exclusion Database (MED). Under section 1128 of the Social Security Act, the Secretary, through HHS OIG, must exclude individuals and entities from Federal health care programs based on felony or misdemeanor convictions related to the Medicare or Medicaid programs, or related to the abuse or neglect of patients, and has discretionary authority to exclude individuals on a number of grounds, including misdemeanor convictions related to health care fraud. Revocations are retroactive to the date of a provider's respective plea or conviction, and if the provider or supplier submitted claims after that date, CMS demands those payments be repaid.

CMS has historically relied on the MED and the GSA System for Award Management list to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony convictions of Medicare providers and suppliers. CMS is currently working on a process to match enrollment data against public and private databases to receive timely felony conviction data.³

State Medicaid agencies are required to terminate the enrollment of any provider that has been terminated by Medicare or another state Medicaid program for cause. Additionally, CMS has the

³ OIG has the authority to exclude individuals and entities from Federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently-excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). If a provider or supplier is on the LEIE, CMS has the authority to deactivate or revoke their billing privileges.

discretionary authority to revoke Medicare billing privileges where a state has terminated or revoked a provider's or supplier's Medicaid billing privileges. CMS established a process for states to report and share information about Medicaid termination. States have been instructed to report all "for cause" Medicaid terminations, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. This prevents bad actors from jumping from program to program.

In addition to traditional provider-enrollment activities, CMS' sophisticated predictive analytics technology, the Fraud Prevention System (FPS), identifies investigative leads to further protect the Medicare program from inappropriate billing practices and provide oversight on provider-enrollment actions. In its first three years of implementation, CMS has identified approximately \$242 million in cost-avoidance savings from revoking provider billing privileges as a result of FPS leads.⁴

Revalidation of existing Medicare providers and suppliers

CMS must also revalidate all existing Medicare providers and suppliers under new requirements established by the Affordable Care Act. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. CMS has requested the revalidation of all 1.6 million existing Medicare providers to ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Thus far, the revalidation initiative has mailed 1,652,895 revalidation notices and resulted in 888,060 approvals. These revalidation efforts alone resulted in the deactivation of over 307,388 provider and supplier practice locations as well as the revocation of 17,655 providers' and suppliers' billing privileges.

Further Improvements to Strengthen Medicare Program Integrity

CMS is proud of the results we have seen from provider and supplier enrollment and screening efforts, which have removed hundreds of thousands of questionable providers and supplies from the Medicare program, saving taxpayers billions of dollars. As you know, GAO reviewed the

⁴ Report to Congress: Fraud Prevention System Third Implementation Year. Available at: <http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html>

implementation of four enrollment screening procedures that CMS uses to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling in the Medicare program. In the report entitled “Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers,” GAO concluded that, as part of an overall effort to enhance program integrity and reduce fraud risk, effective enrollment and screening procedures are essential to ensure that ineligible or potentially fraudulent providers and suppliers do not enroll in the program and that CMS has taken steps to develop and implement such procedures.⁵ GAO analysis identified areas for improvement in our PECOS system, including verification of provider practice locations and physician licensure statuses. We appreciate GAO’s work in this area and are working to address its recommendations, as discussed further below.

CMS has made significant progress in reducing the number of questionable providers and suppliers enrolling in Medicare. GAO noted in the report that only 2.3 percent of provider and supplier practice locations are potentially ineligible for Medicare participation as providers and suppliers. This small percentage of provider or supplier locations that could not be confirmed as eligible or ineligible by GAO could result from data-entry issues. For example, information (such as a missing suite number) may be missing, while the address itself could be an eligible practice location.

CMS routinely advises the provider and supplier community of the importance of maintaining accurate, up-to-date provider enrollment practice location information. CMS also has initiated several actions to improve Medicare enrollment screening and to reduce provider burden. In March 2014, CMS updated its guidance on verification of practice locations to remove redundant practices, such as the use of 411.com and USPS.com, to verify practice locations because the provider and supplier address verification system in PECOS performed the same checks. If the MAC is unable to validate the practice location using the software incorporated in PECOS, they are permitted to request clarifying information (*i.e.*, letterhead showing the appropriate address, phone/power bill, or other documentation containing the provider/supplier’s legal business name and address) from the provider or supplier or request an unannounced site visit. To strengthen

⁵ GAO Report GAO-15-448, “Medicare Program: Additional Actions Needed to Improve Eligibility of Verification of Providers and Suppliers”

the enrollment screening process, CMS will enhance the address verification software to better detect potentially ineligible addresses. CMS is working towards configuring the provider and supplier address verification system in PECOS to flag Commercial Mail Receiving Agencies, vacancies, invalid addresses, and other potentially questionable practice locations. We expect this enhancement to be complete by early next year. Removing the redundant requirements allowed CMS to reduce provider and supplier burden and eliminate duplication of effort without reducing the effectiveness of our program integrity efforts.

As noted in the GAO report, CMS provides monthly data to the MACs, which process provider-enrollment applications in a document called the License Continuous Monitoring Report. This provides consistency in terms of State Medical Board licensure data, as MACs may need to review data from States across the country. In our response to the GAO, CMS noted that while we concur with the recommendation on the reporting of licensure data, CMS does not currently have the authority to require providers and suppliers to report licenses for states in which they are not enrolled. However, CMS will take steps to make certain that all applicants' licensure information is evaluated as part of the screening process by MACs and the License Continuous Monitoring report as appropriate. CMS will also regularly review other databases for disciplinary actions against enrolled providers and suppliers.

Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the Attorney General announced a ground-breaking partnership with the private sector to fight fraud, waste, and abuse across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover fraud, waste, and abuse that could not otherwise be identified. The HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop improper payments from going out the door.

As one part of our initiative, CMS partnered with eight major private plans to share facts and information to locate possible fraudulent store fronts. Currently, over 4,300 questionable store

front locations have been identified and, as a result, participating partners are now conducting investigations to further verify if the identified locations are enrolled in their systems and are valid and operational.

Empowering Beneficiaries: A Key Tool in Preventing Fraud

Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to providers and suppliers for inappropriate services or items, and prevent further abuses in the Medicare program. We also want to recognize this Committee for the creation of The United States Special Committee on Aging Fraud Hotline and commend its efforts in educating seniors and others about the dangers of fraud.

CMS is making it easier for seniors to help us fight fraud, waste, and abuse. In June 2013, CMS began sending redesigned Medicare Summary Notices (MSNs),⁶ the explanation of benefits for people with Medicare fee-for-service, to make it easier for beneficiaries to spot fraud or errors. The new MSNs include clearer language, as well as descriptions and definitions. The MSNs have a dedicated section that tells beneficiaries how to spot potential fraud, waste, and abuse and encourages beneficiaries to report suspected fraud, waste, and abuse to 1-800-MEDICARE. CMS has an incentive reward program that offers a reward of 10 percent of the amount recovered, up to \$1,000, to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds.

CMS also partnered with the Administration for Community Living (ACL) to lend support to the Senior Medicare Patrol (SMP) program, a volunteer-based national program that educates Medicare beneficiaries, their families, and caregivers on how to prevent, detect, and report Medicare fraud, waste, and abuse. During 2013, SMP program grantees' staff and 5,406 volunteers reached over 1.5 million people.⁷ In that same time, SMP projects held 10,545 community outreach education events reaching more than 1,048,000 people, and were

⁶ <http://blog.medicare.gov/2013/06/06/redesigned-with-you-in-mind-your-medicare-summary-notice/>

⁷ <https://oig.hhs.gov/oci/reports/oci-02-14-00140.pdf>

responsible for over 181,143 media airings to increase beneficiary awareness about issues related to Medicare fraud. In addition, over 501,400 beneficiaries were educated through 14,924 group educational sessions conducted by SMP programs in local communities. Volunteers are essential to the success of this program, contributing 105,235 hours and conducting over 148,000 one-on-one counseling sessions to educate beneficiaries about how to prevent and detect Medicare fraud within local communities.

The SMP program also works to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control and consumer protection entities, including MACs, State Medicaid fraud control units, State attorneys general, CMS, HHS OIG, and the Federal Trade Commission.

Moving Forward

CMS is committed to strengthening provider and supplier enrollment and screening processes to make sure that Medicare beneficiaries receive items and services from appropriate providers and suppliers and taxpayer dollars are protected. This effort is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care. Although we have made significant progress in improving our provider screening and enrollment, more work remains to be done. We are committed to working with GAO as we continue to strengthen program integrity. We look forward to working with this Committee and the Congress on these efforts.

CareSource Management Group
 230 N. Main St.
 Dayton, OH 45402
 937-531-3451
 Testimony of Katherine Leff
 In Support of GAO Report "Medicare Programs: Additional
 Actions Needed to Improve Eligibility Verification of
 Providers and Suppliers"
 Before the Senate Special Committee on Aging
 July 22, 2015

Good afternoon, my name is Katherine Leff. I am the Director of Special Investigations for CareSource Management Group and the current Board Chair of the National Healthcare Anti-Fraud Association. CareSource is a nonprofit Ohio-based health plan and one of the largest Medicaid managed health care plans in the country. We serve more than 1.4 million Medicaid, MyCare and Exchange members in Ohio, Kentucky and Indiana.

I want to thank Chairman Collins, Ranking Member McCaskill and the distinguished members of the Special Committee on Aging for the opportunity to speak to you today about the GAO Report on "Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers".

The GAO Report identified two weaknesses in Medicare provider enrollment screening to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling in PECOS: 1) verification of provider practice locations and 2) verification of physician licensure status.

CareSource agrees with the GAO Report but also recognizes the challenges identifying a fraudulent provider in the provider enrollment process. We offer CareSource's process as a means of comparison for the Committee.

Verification of Provider Practice Location

CareSource verifies provider practice locations in many ways:

- **Council on Affordable Quality Healthcare (CAQH) Credentialing Application** – This application requires the provider's address.
- **Provider Office Calls** – For any missing information or any questions on the provider address, the provider or the provider's billing office is contacted for provider address questions.
- **National Practitioner Data Base (NPDB)** - The NPDB is a federal information repository dedicated to improving health care quality, promoting patient safety, and preventing fraud and abuse. CareSource contacts the NPDB to identify provider malpractice, licensure information and if any adverse reports against the provider has been filed.
- **Secret Shopper Calls** – CareSource conducts Secret Shopper calls once a year on a statistically valid sample of providers. These calls verify basic information regarding the provider practice.

- **USPS Address Verification** – Prior to loading a provider in our claim payment system, we check the provider’s address using the USPS Address Verification System. Invalid addresses are researched and corrected. If the address is a vacant lot or a PO Box, the file is sent to the Special Investigations Unit for investigation.
- **Periodic On-site Visits** – Plan Representatives periodically visit provider offices at the address loaded in our claim system.
- **Malpractice Insurance Certificate** – A copy of the provider’s current Malpractice Insurance certificate must be provided in the Credentialing process. This allows us to not only check the provider’s address but ensure that the provider is currently paying for active Malpractice Insurance indicating a valid business.
- **CMS or State Certification/Review** – CareSource relies on both Medicare and Medicaid certification as part of the credentialing process. The accuracy of this process is important to our review.
- **Member Grievances** – CareSource lists all credentialed providers in our Provider Directory with the address provided to us. If the address is not valid, it is likely that members would file a grievance against the provider.
- **PO Box Addresses** – A PO Box address is not accepted during the credentialing process as our Provider Directory must show a valid office location for member access. A provider that would list a street address and suite number for a UPS Office are identified in the USPS address verification process.
- **AMA Physicians Profile Service** - The AMA Physician Profile Service provides key information to verify physician credentials including mailing address.

Physician Licensure Verification

CareSource verifies physician licensure status in the following ways:

- **License Boards** - CareSource checks the license board in the state of application for current license and any adverse actions.
- **Yost (Yeihealthcare.com)** – All providers are checked using Yost’s software at initial credentialing, upon recredentialing (every 3 years), and once per month, if paid. The following sources are checked:
 - Application state and surrounding states license boards (Medical, Nursing, Physical Therapy, Chiropractic, Social Worker, etc.)
 - Specially Designated Nationals List
 - Social Security Death Index
 - SAM EPLS (Excluded Parties List System)
 - HHS-OIG
 - State provider sanctions lists
- **National Practitioner Data Base (NPDB)** - The NPDB is a federal information repository dedicated to improving health care quality, promoting patient safety, and preventing fraud and

abuse. CareSource contacts the NPDB to identify provider malpractice, licensure information and if any adverse reports against the provider has been filed.

- **AMA Physician Profile Service** - The AMA Physician Profile Service verifies physician credentials including state license(s) issued and issue date(s), expiration date(s), status (as of date), and type of license (temporary, limited, or unlimited).

Other Methods of Fraud Detection

CareSource's Special Investigation Unit (SIU) utilizes the following methods to identify and investigate fraud:

- **Post-Payment Fraud Detection Software** – We utilize a rules-based post-payment fraud detection software to identify provider billing aberrancies for known fraud schemes.
- **Pre- and Post-Payment Fraud Detection Software** - We are in the process of implementing a predictive analytic pre-and post-payment software. This software offers several advantages including the use of predictive analytics that scores both providers and claim lines from 1-1000. It is anticipated we will identify more fraud with the use of this software. The pre-pay software will allow us to stop fraudulent billing before payment is made thus avoiding pay and chase.
- **Preliminary and Full Investigations** – Allegations from any source and data analytic findings will initiate a preliminary investigation to attempt to validate the allegation/finding. Once validated, a full investigation is initiated. Full investigations involve data analytics, medical record reviews, provider/staff interviews, on-site investigations, interviews, research, background checks, social media checks, etc.
- **Information Sharing Meetings** – CareSource attends both state and national information sharing groups to discuss fraud schemes and providers under investigation.
- **Special Investigation Resource and Intelligence System (SIRIS)** –We use SIRIS to identify and report schemes and cases. SIRIS is a software program available to National Healthcare Anti-Fraud Association (NHCAA) member companies and law enforcement.
- **Review Grievance Data** - Member grievances are reviewed to trend for any fraud, waste and abuse concerns. Grievances relevant to individual cases under investigation are reviewed as part of the investigative process.
- **Re-credentialing SIU Review** - All providers going through re-credentialing are compared against CareSource's SIU Investigative Case Tracking System to identify any prior or current investigations.
- **Data Analysis of UPS Office Addresses** – SIU runs data looking for inappropriate addresses.
- **Explanation of Benefits Forms** – These forms are sent to members asking them to call the Fraud hotline if they did not receive the services indicated.

The GAO Report identified issues with CMS' eligibility verification of providers and suppliers and we agree with their findings. Since we agree, we shared many of the steps CareSource takes to safeguard program integrity and prevent provider and supplier fraud.

CareSource's Special Investigations Unit works closely with internal CareSource departments and federal/ state agencies to proactively and cooperatively prevent and detect fraud, waste and abuse. Each year we enhance our prevention, detection and investigative efforts by adding staff, software and process. Between 2013 and 2014 we experienced a 74% increase in saved benefit dollars. We anticipate a similar or greater increase between 2014 and 2015 with the addition of our new predictive analytic pre- and post-payment fraud detection software this fall.

Already in 2015, we have taken significant actions on excessive and inappropriate allergy testing, DME suppliers billing without documentation to support the quantity and type of supplies provided, and optical providers that backdated eligibility and provided services not rendered. For these cases alone we have saved over \$5 million. We are also working with the State of Ohio and other managed care plans on a Home Health Care initiative to address significant fraud in this space. Finally, in 2015 we witnessed a very concerning provider be criminally prosecuted and sentenced to six and a half years in prison. Our investigation uncovered excessive use of CT Scans, drug purchases from outside the county and medically unnecessary injections.

Thank you again for the opportunity to appear before you today to discuss the above ways to prevent health care fraud. I would be pleased to address any questions you have at this time.

Questions for the Record

U.S. Senate Special Committee on Aging
“The Doctor Is Not In: Combating Medicare Provider Enrollment Fraud”
July 30, 2015
Questions for the Record
Mr. Seto Bagdoyan

Senator Claire McCaskill

Question:

Please provide a detailed breakdown of the cost to GAO for its work verifying practice addresses listed in PECOS, as described in GAO-15-448. Please include the cost of applicable subscriptions and FTEs.

Response:

To determine the validity of the providers’ or suppliers’ practice location addresses, we obtained a commercially available United States Postal Service (USPS) software package known as the Address Matching System Application Program Interface. This package standardizes addresses and provides specific flags to determine the eligibility of the providers’ or suppliers’ practice location address.¹ The subscription and initial set up cost for us to use the software package for a year was approximately \$8,700. In addition, we used an estimated 2 FTEs per month for approximately 4 months to download monthly software updates and to conduct additional verification of the addresses—such as through internet searches, Google Maps searches, and site visits, when possible—on the sampled 496 addresses.

¹ USPS standardizes an address by converting an address to a standard format through correcting the address, including adding missing information such as directional or zip code information, to provide a complete address. The software includes specific flags such as a Commercial Mail Receiving Agency (CMRA), vacant, and invalid. Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of CMRA, such as a United Parcel Service (UPS) store. Based on USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. USPS would flag a location as vacant if it used to deliver mail there and has not delivered mail there in more than 90 days. An invalid address is an address that is not recognized by USPS, was incorrectly entered in PECOS, or was missing a street number. Not all addresses flagged by the USPS software are ineligible addresses. However, the software provides an initial indicator that an address warrants a closer review.

Question:

Please provide a detailed breakdown of the cost to GAO for its work verifying the licenses of physicians in PECOS, as described in GAO-15-448. Please include the cost of applicable subscriptions and FTEs.

Response:

To examine physician license information and to determine whether providers or suppliers in PECOS had disciplinary action that might make them ineligible for Medicare enrollment, we obtained data from the Federation of State Medical Boards (FSMB). FSMB is a nonprofit organization that serves state medical boards in all U.S. states, Puerto Rico, Guam, and the Northern Mariana Islands; and 14 state boards of osteopathic medicine. The cost to obtain FSMB data for 1 year, which includes two downloads, was \$15,000.¹ In addition, we used an estimated 1 FTE per month for 1 month to upload the data and validate the FSMB licensure information against individual state medical licensing boards.

¹ GAO obtained the FSMB data at a discounted, one-time flat fee.

U.S. Special Senate Committee on Aging
“The Doctor Is Not In: Combating Medicare Provider Enrollment Fraud”
 July 30, 2015
 Questions for the Record
 Dr. Shantanu Agrawal

Senator Claire McCaskill

Question:

Please provide a copy of the list of 542 providers and suppliers that GAO referred to CMS for further review. For the providers on the list that CMS has already reviewed, please provide a detailed description of each of the actions taken by CMS on each provider or supplier, including, but not limited to:

1. Actions taken to verify the validity of the provider/supplier,
2. The length of time it took to verify the validity of the provider/supplier,
3. The length of time it took to take final action on the provider/supplier, and
4. The amount of all payments associated with any provider/supplier that was ultimately terminated from the Medicare program.

Question:

Please provide the average length of time it takes CMS to remove a provider once CMS verifies that he or she is not a valid provider.

Question:

Please provide a detailed explanation of CMS’ process for verifying and removing a provider that CMS suspects may not be a valid provider, including any procedures for holding payments during review of the provider’s validity.

Question:

Please provide CMS’ best estimate as to how much it pays in claims each year to invalid providers.

Question:

Please provide the cost to CMS of using Finalist (on either an annual or multi-year basis, whichever more accurately aligns with the terms of the Finalist contract).

Question:

Please provide a detailed description (including a monthly timeline) of CMS' plans to update Finalist to incorporate additional address verification capability.

Question:

Please provide a detailed description (including a monthly timeline) of CMS' plans to use the Automated Provider Screening system to review the status of a provider's license.

Question:

Please provide the number of providers that CMS has referred to DOJ for fraud in the last five years.

“At this time, responses are not available for printing. Please contact the U.S. Special Committee on Aging for further updates and to perhaps obtain a hard copy, if available.”

Statements for the Record



United States Government Accountability Office

Report to Congressional Requesters

June 2015

MEDICARE PROGRAM

Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers

GAO-15-448

GAO Highlights

Highlights of [GAO-15-448](#), a report to congressional requesters

Why GAO Did This Study

In fiscal year 2014, Medicare paid \$554 billion for health care and related services. CMS estimates that \$60 billion (about 10 percent) of that total was paid improperly. To establish and maintain Medicare billing privileges, providers and suppliers must be enrolled in a CMS database known as PECOS. About 1.8 million providers and suppliers were in PECOS as of December 2014, according to CMS.

GAO was asked to assess Medicare's provider and supplier enrollment-screening procedures to determine whether PECOS was vulnerable to fraud. This report examines the extent to which CMS's enrollment-screening procedures are designed and implemented to prevent enrollment of ineligible or potentially fraudulent Medicare providers. GAO reviewed relevant documentation, interviewed CMS officials, and contacted the 12 CMS contractors that evaluate provider applications. GAO matched providers and suppliers in PECOS, as of March 2013, to several databases to identify potentially ineligible providers and suppliers, and used 2005–2013 Medicare claims data to verify whether they were paid during this period.

What GAO Recommends

GAO recommends that CMS incorporate flags into its software to help identify potentially questionable addresses, revise its 2014 guidance for verifying practice locations, and collect additional license information. The Department of Health and Human Services concurred with two of the three recommendations, but did not agree with the recommendation to revise its guidance. GAO continues to believe the recommendation is valid, as discussed in the report.

View [GAO-15-448](#). For more information, contact Seto J. Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

June 2015

MEDICARE PROGRAM

Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers

What GAO Found

GAO examined the implementation of four enrollment screening procedures that the Centers for Medicare & Medicaid Services (CMS) uses to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling into its Provider Enrollment, Chain and Ownership System (PECOS). Two of CMS's procedures appear to be working to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care-related programs. However, GAO identified the following weaknesses in the other two procedures: CMS's verification of provider practice location and physician licensure status.

First, Medicare providers are required to submit the address of the actual practice location from which they offer services. GAO's examination of 2013 data found that about 23,400 of 105,234 (22 percent) of practice location addresses are potentially ineligible. The computer software CMS uses as a method to validate applicants' addresses does not flag potentially ineligible addresses, such as those that are of a Commercial Mail Receiving Agency (such as a UPS store mailbox), vacant, or invalid addresses. In addition, CMS's March 2014 guidance has reduced the amount of independent verification conducted by contractors, thereby increasing the program's vulnerability to potential fraud. For example, the figure below shows a mailbox located within a UPS store that an applicant reported as a practice location, which CMS contractors inaccurately verified as an authentic practice location under CMS's new guidance, which allows contractors to use phone calls as the primary means for verifying provider addresses.

Reported Practice Location Verified Using New CMS Guidance



Source: GAO. | GAO-15-448

Second, physicians applying to participate in the Medicare program must hold an active license in the state they plan to practice and self-report final adverse actions, such as a suspension or revocation by any state licensing authority. CMS requires its contractors to verify final adverse actions that the applicant self-reported on the application directly with state medical board websites. In March 2014, CMS began providing a report to its Medicare contractors to improve their oversight of physician license reviews. However, the report only includes the medical license numbers providers use to enroll into the Medicare program, but not adverse-action history or other medical licenses a provider may have in other states that were not used to enroll into Medicare. GAO found 147 out of about 1.3 million physicians listed as eligible to bill Medicare who, as of March 2013, had received a final adverse action from a state medical board for crimes against persons, financial crimes, and other types of felonies but were either not revoked from the Medicare program until months after the adverse action or never removed.

United States Government Accountability Office

Contents

Letter		1
	Background	7
	Limitations in Implementation of CMS Enrollment-Screening Procedures Allowed Potentially Ineligible Providers and Suppliers to Enroll in Medicare	13
	Conclusions	35
	Recommendations for Executive Action	36
	Agency and Third-Party Comments and Our Evaluation	37
Appendix I	Objectives, Scope, and Methodology	41
Appendix II	Processes within Each Provider and Supplier Enrollment-Screening Procedure to Determine Medicare Program Eligibility	47
Appendix III	Practice Locations Allowed Based on the Type of Services the Provider or Supplier Renders	49
Appendix IV	Breakdown of the Sample of 496 Addresses	50
Appendix V	Actions Resulting in Revocations and Suspensions	52
Appendix VI	Comments from the Department of Health and Human Services	54
Appendix VII	GAO Contact and Staff Acknowledgments	58
Tables		
	Table 1: Categories of Medicare Providers and Suppliers Designated by Risk Level for Enrollment Screening	10

Table 2: Processes within Each Provider and Supplier Enrollment-Screening Procedures	47
Table 3: Practice Locations Allowed Based on the Type of Services Rendered by Medicare Provider or Supplier	49
Table 4: Summary of the Adverse Actions Resulting in Revocations and Suspensions	52

Figures	
Figure 1: Twelve Medicare Administrative Contractors (MAC) and Their Jurisdictions	8
Figure 2: Four Key Provider and Supplier Enrollment-Process and Verification Checks Used in Determining Medicare Eligibility	12
Figure 3: GAO Sample Estimates of Provider and Supplier Practice Location Addresses in PECOS Using the USPS Address-Management Tool	18
Figure 4: Mailbox Rental Store with a Suite Number Address Used as a Provider Practice Location	20
Figure 5: Demolished Site Listed as Provider's Practice Location	21
Figure 6: Fast-Food Franchise Listed as Provider's Practice Location	22
Figure 7: No Real Working Offices Operating in Provider's Practice Location Address	25
Figure 8: Reported Practice Location Verified by Using the Phone Verification Method	27
Figure 9: Summary of the Adverse License Actions Related to 147 Physicians Who Were Not Revoked for Months or Never Removed from Medicare, as of March 2013	31

Abbreviations

CMRA	Commercial Mail Receiving Agency
CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
FSMB	Federation of State Medical Boards
HHS	Department of Health and Human Services
LCM	License Continuous Monitoring
LEIE	List of Excluded Individuals and Entities
MAC	Medicare Administrative Contractor
NSC	National Supplier Clearinghouse
OIG	Office of Inspector General
PECOS	Provider Enrollment, Chain and Ownership System
PPACA	Patient Protection and Affordable Care Act
SSA	Social Security Administration
UPS	United Parcel Service
USPS	United States Postal Service

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

June 25, 2015

Congressional Requesters

Medicare is the federally financed health-insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.¹ In fiscal year 2014, Medicare paid \$554.2 billion for health care and health care–related services. According to the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—an estimated \$59.9 billion (10.8 percent) of that total was paid improperly, which is an increase over the 2013 level.² Due to the large dollar amount involved in improper payments, the Office of Management and Budget has placed Medicare on its list of high-error programs.³ Further, because of its size, complexity, and susceptibility to

¹Medicare consists of four parts. Medicare Part A covers inpatient hospital care, skilled nursing-facility care, some home health-care services, and hospice care. Part B services include physician and outpatient hospital services, diagnostic tests, mental-health services, outpatient physical and occupational therapy, ambulance services, prosthetics, orthotics, and supplies. Medicare Parts A and B are known as original Medicare or Medicare Fee-for-Service. The Centers for Medicare & Medicaid Services (CMS) also contracts with private health plans to administer a Medicare private plan, known as Medicare Part C or Medicare Advantage, and with drug-plan sponsors to administer the Medicare outpatient prescription drug benefit known as Medicare Part D.

²These payments are any that should not have been made or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

³The Office of Management and Budget designates a program as “high-error” based on improper-payment information in agencies’ annual Performance and Accountability Reports and Agency Financial Reports. Specifically, a program is considered high-error if it has improper payments greater than \$10 million and over 2.5 percent of all payments made under that program, or if the program has more than \$100 million in estimated improper payments. There are three Medicare components that are considered high-error programs by the Office of Management and Budget. The Fee-for-Service, Medicare Advantage Part C, and Medicare prescription drug benefit Part D are ranked first, fourth, and ninth, respectively, based on the dollar amount, as high-error programs.

mismanagement and improper payments, for more than 20 years we have designated Medicare as a high-risk program.⁴

CMS requires prospective providers and suppliers to be listed in the Provider Enrollment, Chain and Ownership System (PECOS) to enroll in Medicare and bill for services provided to Medicare beneficiaries.⁵ PECOS is a centralized database designed to contain providers' and suppliers' enrollment information. According to CMS, there were about 1.8 million health-care providers and suppliers enrolled in PECOS as of December 31, 2014.

CMS is responsible for developing provider and supplier enrollment procedures to help safeguard the program from fraud, waste, and abuse.⁶ CMS contracts with Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC) to manage the enrollment process. MACs are responsible for verifying provider and supplier application information in PECOS before the providers and suppliers are permitted to enroll into Medicare. The NSC is responsible for verifying information regarding suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). CMS requires providers and suppliers to resubmit and recertify the accuracy of their enrollment information every 5 years in order to maintain billing privileges. DMEPOS suppliers must revalidate information with the NSC every 3 years.

In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which included provisions that provide CMS with increased authority to combat potential fraud, waste, and abuse in Medicare. Some

⁴GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: February 2015).

⁵The term "provider" refers collectively to institutional providers such as hospitals and health-care facilities, as well as physicians and nonphysician practitioners who provide health-care services to Medicare beneficiaries. Providers also include organ-procurement organizations, skilled-nursing facilities, hospice, and end-stage renal disease centers. The term "supplier" refers to certain Part B entities such as ambulance-service providers, mammography centers, and portable X-ray facilities. Suppliers also include entities that supply Medicare beneficiaries with Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs. This report will specify DMEPOS suppliers when applicable.

⁶Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

of these provisions allowed CMS to evaluate providers and suppliers previously enrolled in the Medicare program under new enrollment criteria designed to strengthen Medicare's provider-enrollment standards and procedures.⁷

We have previously reported that CMS should strengthen Medicare enrollment standards and procedures as a key strategy for reducing fraud, waste, abuse, and improper payments. For example, from July 2008 to September 2010 we issued three reports identifying persistent weaknesses in CMS's Medicare enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the Medicare program.⁸ As a result, in September 2010, we recommended, among other things, that CMS monitor more closely the MACs' provider and supplier enrollment activities to help ensure the accuracy and completeness of PECOS data. CMS agreed to implement our recommendations. Since 2012, CMS has taken several actions to improve its oversight of the enrollment process, such as conducting an in-depth review of nursing-home chains and reviewing sample applications once a year rather than every 5 years.

In May 2013, the HHS Office of Inspector General (OIG) reported improvements were needed to ensure that health-care provider information in the National Plan and Provider Enumeration System—a database in which providers apply to obtain a National Provider Identifier—and Medicare enrollment data in PECOS are accurate,

⁷PPACA requires all existing provider and supplier information to be revalidated by 2015. PPACA, § 6401, 124 Stat. 119, 749, amended by § 10603, 124 Stat. 119, 1006 (codified at 42 U.S.C. § 1395cc(j)). After the revalidation of all providers and suppliers required by PPACA, CMS's current cycle for revalidation—3 years for DMEPOS suppliers and 5 years for all other providers and suppliers—will apply. CMS retains the authority to require a provider or supplier to revalidate off-cycle when certain compliance-related concerns arise. PECOS data must also be updated when there is a change of address or other change to provider or supplier status.

⁸See GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, [GAO-08-955](#) (Washington, D.C.: July 3, 2008); *Medicare: Improvements Needed to Address Improper Payments in Home Health*, [GAO-09-185](#) (Washington, D.C.: Feb. 27, 2009); and *Nursing Homes: Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data*, [GAO-10-710](#) (Washington, D.C.: Sept. 30, 2010).

complete, and consistent.⁹ According to the OIG report, addresses are essential for identifying trends in fraud, waste, and abuse because they were the source of the most inaccuracies and inconsistencies. The report found that CMS did not verify most provider information in PECOS or the National Plan and Provider Enumeration System. The HHS OIG recommended that CMS require MACs to implement program-integrity safeguards for Medicare provider enrollment as established in the CMS Program Integrity Manual.¹⁰ In addition, the OIG found that CMS should detect and correct inaccurate and incomplete provider enumeration and PECOS enrollment data for new and established records, among other things. CMS agreed with the recommendations and as of March 2015 was revalidating 1.5 million enrolled providers and suppliers, which includes verifying the information contained on the applications. According to CMS, it sent all revalidation notices by March 23, 2015.

You asked that we assess Medicare's provider and supplier enrollment-screening procedures to determine whether PECOS was vulnerable to fraud. This report examines the extent to which CMS's enrollment-screening procedures are designed and implemented to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers into PECOS.

To assess the extent to which CMS's enrollment-screening procedures are designed to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers into PECOS, we reviewed CMS procedural manuals and directives including the Medicare manual that outlines the procedures that MACs and the NSC should use to determine provider and supplier enrollment eligibility.¹¹ We also interviewed CMS officials about provider and supplier enrollment-screening procedures, including procedures that

⁹Before enrolling in Medicare, a health-care provider must first apply to the National Plan and Provider Enumeration System to obtain a National Provider Identifier. See Department of Health and Human Services, Office of Inspector General, *Improvements Needed to Ensure Provider Enumeration and Medicare Enrollment Data are Accurate, Complete, and Consistent*, OEI-07-09-00440 (Washington, D.C.: May 2013).

¹⁰In this report, we will refer to the Program Integrity Manual as CMS's manual.

¹¹According to CMS, Program Integrity Manual chapter 15 provides overall CMS guidance used by the MACs and NSC for establishing and maintaining provider and supplier enrollment in the Medicare program and has been continuously updated through change requests or technical direction letters.

were developed and implemented as a result of the Patient Protection and Affordable Care Act's (PPACA) provisions. In addition, we conducted interviews with 5 of the 12 MACs about enrollment-screening procedures.¹² We selected the five MACs to include some with larger numbers of physicians serviced, some that met and some that did not meet the accuracy threshold in CMS's provider enrollment performance evaluation, some that participated in the automated screening process and some that did not (to capture additional possible checks that some MACs performed on providers' enrollment information through this process), and some that served more than one jurisdiction to maximize the number of states included in our review. We also interviewed NSC officials responsible for enrolling DMEPOS suppliers to learn about the DMEPOS supplier enrollment-screening procedures. We contacted by e-mail the remaining 7 MACs to obtain additional information on the provider enrollment-screening procedures to verify applicants' practice location addresses and validate applicants' applicable licensure information.

To assess the extent to which CMS implemented enrollment-screening procedures to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers into PECOS, we matched the list of providers and suppliers present in PECOS, as of March 29, 2013, and the DMEPOS suppliers, as of April 6, 2013 (the most-current data available at the time of our review) to the following databases: (1) the United States Postal Service (USPS) Address Matching System Application Program Interface,¹³ which is a commercially available USPS software package that standardizes addresses and provides specific flags, to determine the validity of the providers' or suppliers' practice location address; (2) Federation of State Medical Boards (FSMB) licensure data, to determine whether enrolled providers or suppliers had disciplinary actions that might make them ineligible for Medicare enrollment; (3) the Social Security Administration's (SSA) full death file, to determine whether enrolled providers or suppliers

¹²CMS contracts with 12 MACs that enroll providers and suppliers, except for DMEPOS suppliers, and are responsible for their own geographic regions, known as jurisdictions.

¹³In this report, we will refer to the USPS Address Management System Application Program Interface as the USPS address-management tool.

were deceased;¹⁴ and (4) the HHS OIG List of Excluded Individuals and Entities (LEIE), an information source that shows names of providers and suppliers who have been excluded from doing business with the federal government, to determine whether enrolled providers or suppliers had been previously excluded from doing business with the federal government or health care–related programs.

We also contacted those MACs and the NSC responsible for enrolling the specific individuals or entities that appeared in our four sets of matches. Since our PECOS data were as of March 29, 2013, for providers and suppliers and April 6, 2013, for DMEPOS suppliers, we requested updated information during the months of September 2014 to October 2014. This information included whether the provider or supplier was revalidated or changed its PECOS profile information. We also requested providers' and suppliers' application files, including site-visit reports from the MACs when appropriate to corroborate MACs' responses. In addition, we obtained Medicare claims data from CMS for all of our matches to determine how much the providers and suppliers were paid with Medicare funds, if at all, while they may have been ineligible.¹⁵

We assessed the reliability of the PECOS data, USPS address-management tool, FSMB licensure data, SSA's full death file, LEIE, and Medicare claims data by reviewing relevant documentation, interviewing knowledgeable agency officials, and performing electronic testing to determine the validity of specific data elements in the databases and determined that these databases were sufficiently reliable for the purpose of our work. Specifically, for the USPS address-management tool, we selected a generalizable stratified random sample from the addresses

¹⁴SSA maintains death data including names, Social Security numbers, date of birth, and date of death. SSA shares a comprehensive file of this death information, which includes state death data, with certain eligible entities, including CMS, according to SSA. We used this comprehensive file, which we will call the "full death master file" for our analysis. A subset of the full death master file that does not include state death data is available to the public. SSA advises recipients of the file not to take any adverse action against any individual without verification of the information.

¹⁵We were not able to calculate the claims data associated with each practice location because the data we obtained compiled claims by the National Provider Identifier. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. As a result, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

that the USPS address-management tool identified as being a Commercial Mail Receiving Agency (CMRA), vacant, or invalid and took additional steps to confirm whether the practice location address was an eligible address, such as searching Google Maps and providers' websites, and conducting physical site visits. For the FSMB licensure data, we selected a random, nongeneralizable sample of 153 licenses and traced the license information, including disciplinary actions when applicable, to the appropriate state licensing medical board for confirmation. Appendix I contains additional details regarding our scope and methodology.

We conducted this performance audit from January 2014 to June 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

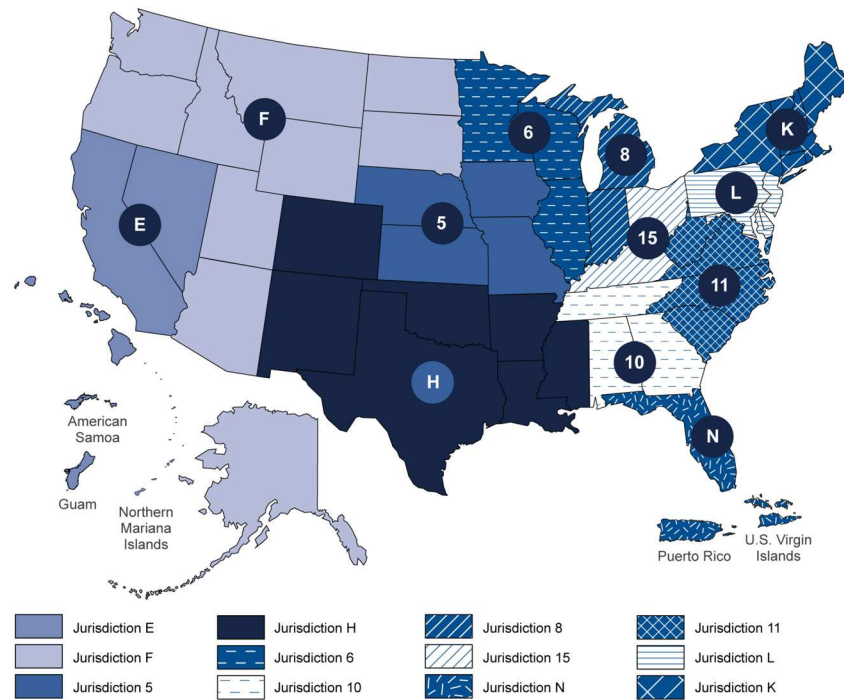
Background

Medicare Contractors' Duties and Responsibilities

Since the Medicare program was created in 1965, it has been administered largely by private contractors under federal oversight. These contractors enroll and pay providers and suppliers while also maintaining the responsibility to help ensure Medicare program integrity.¹⁶ CMS currently contracts with 12 MACs, each of which is responsible for its own geographic region, known as a "jurisdiction." Figure 1 shows the MACs' jurisdiction areas.

¹⁶Some of the other required enrollment information includes but is not limited to: an agreement for electronic funds transfer and a Social Security or tax identification number.

Figure 1: Twelve Medicare Administrative Contractors (MAC) and Their Jurisdictions



The NSC manages the DMEPOS suppliers' enrollment, performs site visits for DMEPOS suppliers, and interacts with the durable medical equipment MACs, which pay claims for durable medical equipment items.

MACs and the NSC are instructed by CMS to adhere to the processing guidelines of CMS's manual to enroll providers, suppliers, and DMEPOS suppliers into PECOS. PECOS is CMS's centralized database for Medicare provider and supplier enrollment information. Entities enrolled in PECOS are granted Medicare billing privileges and can be reimbursed for services rendered to Medicare beneficiaries.¹⁷ CMS provides additional guidance to the MACs and the NSC using directives such as technical direction letters and, in some cases, has monthly calls with the MACs to discuss new guidance or process changes. MACs and the NSC are responsible for updating PECOS after they have approved or revalidated enrollment for providers and suppliers. CMS requires all enrolled providers or suppliers to report changes to existing profile information within a certain period.¹⁸ For example, if a provider needs to update its practice location address, the provider must notify the MAC or the NSC of this change and the MAC or the NSC is responsible for verifying the new address information, and updating the provider's profile in PECOS to reflect the current practice location address.

**PPACA Provisions for
Medicare Providers and
Suppliers**

PPACA requires all providers and suppliers to be subject to licensure checks. Applicants must provide copies of all applicable federal and state licenses and certifications. A licensure check consists of a MAC checking the provider's license information with a state licensing board within its jurisdiction to determine whether the provider has an active license and any board disciplinary actions. PPACA also gives CMS the authority to require additional screening procedures beyond those each provider and supplier must undergo, such as criminal-background checks, depending on the type of risk presented by the provider or supplier type.

¹⁷DMEPOS suppliers were not included in PECOS until 2010. Applicants submit identifying information such as their names, address, specialty area, and information about applicable licensure and accreditation. As previously noted, there 1.8 million health-care providers and suppliers enrolled in PECOS as of December 31, 2014. CMS estimates around 28,000 to 44,000 new enrollments per month in 2015 based on linear projections on the 2012 to 2014 trend in initial enrollments. This estimate takes into account the estimates of new Part D prescribers. Given the 2012 and 2014 trend in deactivations and revocations, linear projections estimate around 16,000 revocations and deactivations per month in 2015.

¹⁸Physicians and clinical nurse specialists, among others, must report a change of ownership, final adverse action, and change of practice location within 30 days. All other changes in enrollment must be reported within 90 days. DMEPOS suppliers must report any changes to the information supplied on the application within 30 days.

Further, PPACA required new screening procedures based on risk of fraud, waste, and abuse. As a result of PPACA, CMS now assigns categories of providers and suppliers to limited-, moderate-, and high-risk levels; those in the highest level are subject to the most-rigorous screening. For example, whereas providers and suppliers in all three risk levels must undergo licensure checks, those in moderate- and high-risk levels are also subject to unannounced site visits. In addition, the NSC is required to conduct site visits to all of the DMEPOS suppliers (which are categorized as moderate or high risk).¹⁹ Table 1 shows the categories of Medicare providers and suppliers and their associated risk level.

Table 1: Categories of Medicare Providers and Suppliers Designated by Risk Level for Enrollment Screening

Risk level	Categories of Medicare providers and suppliers ^a
Limited	Physician or nonphysician practitioners and medical groups or clinics, excepting physical therapists and physical-therapy groups and including ambulatory surgical centers, end-stage renal disease facilities, federally qualified health centers, hospitals, Indian Health Service facilities, and mammography screening centers.
Moderate	Ambulance suppliers, community mental-health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, physical therapists including physical-therapy groups, portable X-ray suppliers, currently enrolled (revalidating) home health agencies, and currently enrolled (revalidating) suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).
High	Prospective (newly enrolling) home health agencies and prospective (newly enrolling) DMEPOS suppliers.

Source: Centers for Medicare & Medicaid Services (CMS). I GAO-15-448

^aThe Centers for Medicare & Medicaid Services (CMS) can elevate the risk level of the provider or supplier based on certain factors, such as whether the provider was previously excluded from Medicare by the Department of Health and Human Services (HHS) Office of Inspector General (OIG).

According to CMS, as of January 2015, there were 2,506 high-risk providers and suppliers, 105,558 moderate-risk providers and suppliers, and 1,649,779 limited-risk providers in PECOS. In addition, there were 15,885 high-risk DMEPOS suppliers and 74,372 moderate-risk DMEPOS suppliers.

In 2011, CMS awarded two contracts to assist the MACs with performing aspects of the provider and supplier enrollment-screening process. The first was issued to an automated screening contractor that collects and

¹⁹The NSC is required to request a revalidation of all DMEPOS suppliers by March 2015, which will result in a site visit. According to CMS, there are about 15,885 high-risk DMEPOS suppliers and about 74,000 moderate-risk DMEPOS suppliers. Some DMEPOS suppliers can receive more than one site visit based on fraud indicators or a change of practice location.

analyzes license information and then provides the information to CMS for review. The data are then reviewed by a MAC for further determination. The second was issued to a site-visit contractor, who is in charge of performing site visits to all providers and suppliers, except DMEPOS suppliers.²⁰ Prior to these awards, MACs were responsible for conducting all site visits and required to manually review individual state medical-licensing boards within their respective jurisdictions.

Four Screening Procedures to Enroll in the Medicare Program

CMS requires MACs and the NSC to implement four screening procedures it developed to prevent and detect the enrollment of ineligible or potentially fraudulent providers and suppliers in PECOS.²¹ The CMS manual outlines the procedures the MACs and the NSC must follow during enrollment screening to verify provider or supplier eligibility for the Medicare program. The eligibility-screening process includes but is not limited to verifying: (1) the authenticity of the applicant's practice location address, (2) the validity of the licensure information that applicants provide,²² (3) that applicants are not listed as deceased in SSA's full death master file, and (4) that applicants are not listed on federal excluded-parties lists. Figure 2 outlines the enrollment procedures for providers and suppliers, including these four enrollment-screening procedures. The interactive graphic features additional information regarding the enrollment-screening procedures (see app. II for a printer-friendly version of the processes within each step of the enrollment-screening procedures).

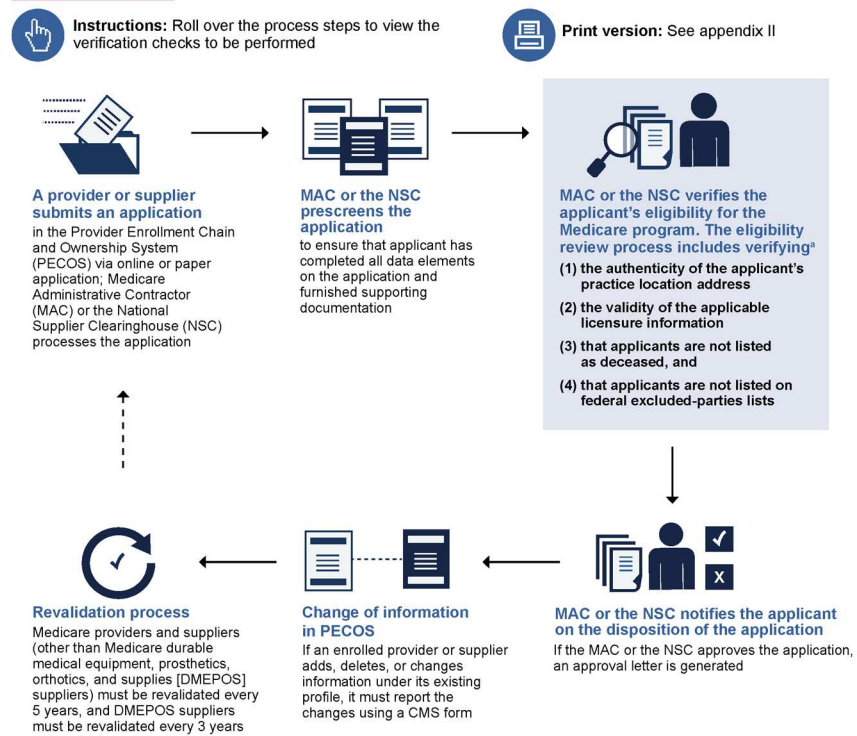
²⁰The NSC continues to conduct site visits related to enrollment of DMEPOS suppliers. Neither of the contracts that CMS awarded were to MACs.

²¹Medicare provider and supplier enrollment entails other screening procedures based on the type of providers and suppliers. For example, MACs and the NSC need to validate the identity of individual providers, owners, and authorized/delegated officials using SSA validation; validate and verify the legal business names for organizations; and validate and verify the provider's National Provider Identifier, among other things. For the purposes of our review, we will focus on the four specific screening procedures outlined in our report.

²²Licensure is a mandatory process by which a state government grants permission to an individual practitioner or health-care organization to engage in an occupation or profession.

Figure 2: Four Key Provider and Supplier Enrollment-Process and Verification Checks Used in Determining Medicare Eligibility

Interactive Graphic



Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. | GAO-15-448

*Medicare provider and supplier enrollment entails other screening procedures based on the type of providers and suppliers.

Limitations in Implementation of CMS Enrollment-Screening Procedures Allowed Potentially Ineligible Providers and Suppliers to Enroll in Medicare

We identified weaknesses in two of the four screening procedures CMS implemented to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling in PECOS: the verification of practice location and of licensure status. CMS's procedures to screen for providers and suppliers listed as deceased or excluded from participating in federal programs or health care-related programs appear to be working, but we identified a few instances of ineligible or potentially fraudulent providers and suppliers that we referred to CMS for further review.

Limitations Exist in CMS Screening Procedures for Verifying Applicants' Practice Locations

Our examination of practice location addresses of providers and suppliers listed in PECOS as of March 2013 and DMEPOS as of April 2013 revealed thousands of questionable practice location addresses. We found limitations with CMS's Finalist software used to validate practice location addresses. For example, Finalist does not provide flags to indicate whether the practice location is potentially ineligible to qualify as a legitimate location. Additional checks, such as checking for these addresses in Internet searches of sites such as 411.com, USPS.com, or Google Maps, or conducting site visits, are at times required to determine whether a practice location is legitimate. However, the revised screening procedures that CMS issued in March 2014 require MACs to do less verification of providers' practice locations than before.

Our Examination of Practice Locations Revealed Thousands of Questionable Addresses

Federal regulations stipulate the type of physical practice location that applicants must have. Specifically, providers and suppliers must be "operational" to furnish Medicare covered items or services.²³ Federal regulations define "operational" as having a qualified physical practice location, being open to the public for the purpose of providing health care-related services, being prepared to submit valid Medicare claims, and being properly staffed, equipped, and stocked to furnish these items or services.²⁴ All providers and suppliers are required to list a physical practice location address in their application, regardless of provider or

²³42 C.F.R. § 424.510.

²⁴42 C.F.R. § 424.502.

supplier type.²⁵ For example, a provider who renders in-home services would be required to supply his or her own home address in the application.

Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of Commercial Mail Receiving Agency (CMRA), such as a United Parcel Service (UPS) store. Based on USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client.²⁶ Additionally, addresses that can be traced to a virtual office—that is, a company advertising mailboxes, telephone answering services, and dedicated workspaces—raise questions about whether the provider or supplier meets the CMS practice location requirements under CMS regulations. Vacant or invalid addresses are also ineligible for PECOS enrollment. A vacancy refers to a provider or supplier that is no longer at the location provided on the application form. USPS would flag a location as vacant if it used to deliver mail there and has not delivered mail there in more than 90 days. An invalid address is when an address is not recognized by USPS, was incorrectly entered in PECOS, or was missing a street number. Once enrolled in PECOS, providers and suppliers have the responsibility to self-report changes to their practice locations. CMS requires providers, suppliers, and DMEPOS suppliers to report a change in practice location within 30 days.

Prior to March 2014, CMS required MACs to verify a practice location address using various techniques, such as searching the Internet using

²⁵The practice location requirement is based on the type of facility, provider, or service being rendered. For example, providers who render services in retirement or assisted-living communities must supply the names and addresses of those communities as the practice location; and mobile facilities and portable units such as independent diagnostic testing facilities, portable X-ray suppliers, and mobile clinics must provide the address where the vehicles are housed when not in use as their practice location. DMEPOS suppliers must provide the practice location address where they furnish services or supplies. See app. III for the practice locations allowed by the type of services provided by the provider or supplier.

²⁶Not all CMRAs would disqualify an applicant from the PECOS enrollment. For example, a hospital may be legitimately designated as a CMRA if it uses or acts as a third party that collects and distributes mail to its employees and would be considered an eligible practice location. Post office boxes and drop boxes are not acceptable except in some cases where the provider is located in rural areas.

sites like 411.com and USPS.com,²⁷ calling the official business telephone number listed on the application, and using software called Finalist to validate the practice location address.²⁸ In March 2014, CMS issued additional guidance to MACs that requires fewer verification techniques to verify a practice location. This new guidance is discussed later in the report.

Our examination of practice location addresses of the providers and suppliers listed in PECOS as of March 2013 and DMEPOS as of April 2013 (the most-current data available at the time of our review) revealed thousands of questionable addresses. Specifically, we checked PECOS practice location addresses for all records that contained an address using the USPS address-management tool, a commercially available software package that standardizes addresses and provides specific flags on the address such as CMRA, vacant, and invalid.²⁹ The USPS address-management tool includes addresses as of December 15, 2013. This software is not currently being used by CMS. Instead, CMS uses the Finalist software to standardize practice location addresses.

As part of our initial analysis using the USPS address-management tool, we identified 105,234 (about 11 percent) of the 980,974 addresses listed in PECOS appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address.

We took further steps to determine the number of these questionable addresses that could be determined to be ineligible for Medicare

²⁷411.com is an online directory of contact information for people and businesses. USPS.com offers the ZIP Code Lookup tool, which standardizes addresses using USPS address records.

²⁸We reviewed the techniques MACs used to verify the practice location address before CMS provided MACs with additional guidance in March 2014 for verifying applicants' practice locations. We did so because we analyzed the practice location addresses listed in PECOS as of March 2013. At that time, the providers and suppliers in PECOS would have been enrolled in PECOS based on instructions from CMS's manual, which requires MACs to verify the practice location address using several techniques, such as by searching Internet pages.

²⁹USPS standardizes an address by converting an address to a standard format through correcting the address, including adding missing information such as directional or zip code information, to provide a complete address. Not all addresses flagged by the USPS address-management tool are ineligible addresses. However, the tool provides an initial indicator that an address warrants a closer review.

providers and suppliers. Specifically, we selected a generalizable stratified random sample of 496 addresses from the population of 105,234 that appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address.³⁰ For each selected address, we used Google Maps, Internet searches,³¹ or physical site visits to confirm whether the practice location address was an eligible address.

On the basis of our additional analysis of the generalizable sample of 496 addresses, we estimate the following:³²

- About 23,400 (22 percent) of the 105,234 addresses that we initially identified as a CMRA, vacant, or invalid address are potentially ineligible for Medicare providers and suppliers.³³ About 300 of the addresses were CMRAs, 3,200 were vacant properties, and 19,900 were invalid. Of the 23,400 potentially ineligible addresses, we estimate that, from 2005 to 2013, about 17,900 had no claims associated with the address, 2,900 were associated with providers that had claims that were less than \$500,000, and 2,600 were associated with providers that had claims that were \$500,000 or more per address.³⁴
- About 39,900 (38 percent) of the 105,234 addresses that we initially identified as a CMRA, vacant, or invalid address are potentially valid

³⁰As noted previously, post office boxes and drop boxes may be acceptable practice locations in some rural locations. However, there were none of these types of rural practice location addresses in our sample of 496 addresses.

³¹Internet searches include searching for the company website.

³²The numbers presented do not total due to rounding. These estimates are based on our generalizable stratified random sample of 496 addresses and have a margin of error at the 95 percent confidence level of plus or minus 10 percentage points or fewer. See app. I for more details on our generalizable sample. See app. IV for additional details on the breakdown of the 496 addresses.

³³This estimate represents about 22 percent of the 105,234 addresses we sampled from and is about 2.3 percent of the entire population of 980,974 addresses.

³⁴The claims amount was calculated based on all claims associated with the National Provider Identifier that was listed on the matched address. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. Due to how we obtained compiled claims by the National Provider Identifier, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

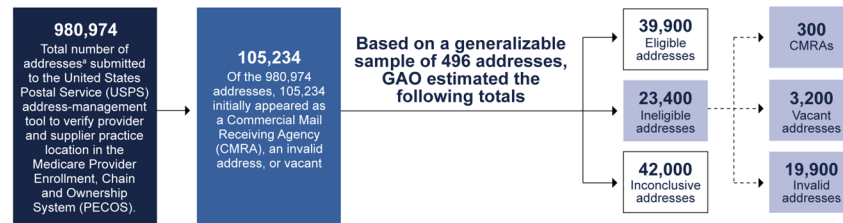
addresses and thus eligible for Medicare providers and suppliers.³⁵ For example, in some instances, the USPS address-management tool flagged an address as a CMRA that we subsequently identified as a hospital, based on our Google Maps or related searches. A hospital may be considered a CMRA if it acts as a third party distributing mail to its staff. Although the hospital was correctly flagged as a CMRA, for the purposes of our review we considered these addresses to be valid, since they are likely practice locations.

- About 42,000 (40 percent) of the 105,234 addresses could not be identified as either eligible or ineligible using the methods described above, and may warrant further review to make an eligibility determination.³⁶ Among those for whom we could not verify an address, we estimate that about 25,500 had no claims associated with the address, 9,500 were associated with providers that had claims that were less than \$500,000, and 7,000 were associated with providers that had claims that were \$500,000 or more per address, from 2005 to 2013. Some of these claims could be at risk of being ineligible Medicare payments. See figure 3 below for a breakdown of the identified addresses and our estimates of the number of ineligible addresses.

³⁵This estimate represents about 38 percent of the 105,234 addresses we sampled from and is about 4 percent of the entire population of 980,974 addresses.

³⁶For these cases, we were not able to determine whether providers and suppliers were located in the building that they listed as their address. For example, when searching the address in Google Maps we were able to identify the building. However, we were not able to visually confirm whether the suite number that the provider or supplier listed existed in the location. We performed additional Internet searches, such as reviewing the building-management website to confirm whether the provider was located in a suite. However, in some cases we were not able to find this information. For additional information about the methodology we used to research and confirm the addresses, see app. I. This estimate represents about 40 percent of the 105,234 addresses we sampled from and is about 4.3 percent of the entire population of 980,974 addresses.

Figure 3: GAO Sample Estimates of Provider and Supplier Practice Location Addresses in PECOS Using the USPS Address-Management Tool



Source: GAO. | GAO-15-448

Note: Estimated numbers do not add to totals due to rounding. All estimates in this figure have a margin of error at the 95 percent confidence level of plus or minus 10 percentage points or fewer. These data are from March 2013 (Medicare providers and suppliers) and April 2013 (durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers).

*We did not submit addresses of providers in PECOS that reassigned their benefits to a group. These providers did not have a practice location address listed in PECOS and were not included in our work.

During our review of the CMS internal controls intended to prevent and detect these potentially ineligible providers from enrolling or remaining in PECOS, we found limitations with the Finalist software being used to validate the addresses. As previously noted, the Finalist software is one of the techniques used by the MACs and the NSC to validate a practice location. According to CMS, Finalist is integrated into PECOS to standardize addresses and does so by comparing the address listed on the application to USPS records and correcting any misspellings in street and city names, standardizing directional markers (NE, West, etc.) and suffixes (Ave, Lane, etc.), and correcting errors in the zip code.³⁷ However, the Finalist software does not indicate whether the address is a CMRA, vacant, or invalid—in other words, whether the location is potentially ineligible to qualify as a legitimate practice location.³⁸ CMS

³⁷The Finalist output gives MACs and the NSC the option to select the standardized address or to use the address as originally entered and does not show whether the address is valid or invalid.

³⁸As noted previously, a CMRA is a third-party agency that receives and handles mail for a client, such as a UPS store. Not all CMRAs would disqualify an applicant. For example, a hospital may be legitimately designated as a CMRA if it uses or acts as a third party that collects and distributes mail to its employees.

does not have these flags in Finalist because the agency added coding in PECOS that prevents post office box addresses from being entered, and believed that this step would prevent these types of ineligible practice locations from being accepted. CMS officials agreed, however, that adding flags to the Finalist software to identify any potential issues that might make the practice location address ineligible, such as a CMRA, could be of value.

Some CMRA addresses are not listed as post office boxes. For example, during our review of the practice location addresses in PECOS, we identified 46 out of the 496 sample addresses that were allowed to enroll in Medicare with a practice location that was inside a mailing store similar to a UPS store. These providers' addresses did not appear in PECOS as a post office box, but instead were listed as a suite or other number, along with a street address. Businesses can purchase a post office box that is listed to the public as a suite number in a business district from some commercial mailing businesses. By doing so, businesses can mask the identity of the address as a post office box. Figure 4 shows an example of one of the providers that we identified through our search and site visits as using a mailbox-rental store as its practice location and where services are not actually rendered. This provider's address appears as having a suite number in PECOS and was continuing to be used in the system as of January 2015. According to our analysis of CMS records, this provider was paid approximately \$592,000 by Medicare from the date it enrolled in PECOS with this address to December 2013, which is the latest date for which CMS has claims data.³⁹

³⁹The claims amount was calculated based on all claims associated with the National Provider Identifier that was listed on the matched address. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. Due to how we obtained compiled claims by the National Provider Identifier, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

Figure 4: Mailbox Rental Store with a Suite Number Address Used as a Provider Practice Location



Source: GAO. | GAO-15-448

Our review also found locations that were vacant addresses. For example, we identified a provider who used a hospital's address as its practice location, but the hospital no longer exists. The USPS address-management tool flagged this address as vacant as of September 2013. When we conducted a site visit to this address in December 2014, we found that the hospital had been demolished (see fig. 5). According to the MAC, however, the provider went through the revalidation process using the demolished hospital address and was approved in January 2015. As of January 2015, therefore, this provider continued to use the vacant address as one of its practice locations. If the provider moved to another location, it was required to report the change of its practice location to the MAC within 30 days. This provider was not paid by Medicare from September 2013 through December 2013 data. However, by remaining in PECOS, this provider may be eligible to bill Medicare in the future.

Figure 5: Demolished Site Listed as Provider's Practice Location



Source: GAO. | GAO-15-448

Provider listed this
demolished site as
its practice location

In another example in which we identified an address as vacant, we visited a provider's stated practice location in December 2014 and found a fast-food franchise there (see fig. 6). Workers from the fast-food franchise said that they have been in the location for about 3 years. In addition, we found a Google Maps image dated September 2011 that shows this specific location as vacant. According to the MAC in charge of enrolling this provider, the provider was enrolled in PECOS in March 2010. As of January 2015, this provider had not updated its address in PECOS and continued to use the fast-food franchise as its practice location. As previously noted, CMS requires providers to report changes in practice locations within 30 days. Currently, this provider is enrolled in Medicare with an ineligible practice location because services can no longer be rendered at this address. This provider was not paid by Medicare from the date this practice location address was flagged as vacant in the USPS address-management tool to December 2013. However, by being enrolled in PECOS, this provider may be eligible to bill Medicare in the future.

Figure 6: Fast-Food Franchise Listed as Provider's Practice Location



Source: GAO. | GAO-15-448

Providers' submission of addresses that do not appear to be actual practice locations are an indicator of potential fraud. Without having flags in Finalist to better indicate the validity of the providers or suppliers' practice locations, CMS misses an opportunity to focus on addresses that may be potentially illegitimate practice locations at enrollment or after enrollment.

Additional Checks Can Help to Verify Addresses

Using software that flags potentially ineligible addresses can help to identify potentially ineligible practice locations, but conducting additional research on addresses, including site visits, may be additionally helpful to determine whether the provider or supplier is located at the address provided at enrollment. As mentioned previously, MACs are only required to conduct a site visit to providers and suppliers that are listed as moderate or high risk, which is a cost-effective and practical option. However, there are more than 1.6 million limited-risk providers—which make up the vast majority of providers in PECOS—that will likely never

receive a site visit to confirm the practice location unless their risk status changes.⁴⁰ Of the 496 addresses in our sample that were flagged as potentially ineligible, 252 were categorized as limited risk. In specific instances where a limited-risk provider's address is flagged as a CMRA, vacant, or invalid address, additional checks on these particular providers may be warranted.

For example, when searching addresses in Google Maps, we could sometimes identify the building of the practice location, but not always visually confirm whether the suite number that the provider or supplier listed existed in the location. We visited 30 practice locations that the USPS address-management tool flagged as vacant or located at a CMRA.⁴¹ Of these 30, we were able to confirm that 2 housed a legitimate provider or supplier. According to our physical observation, 11 of the 30 locations appeared to be vacant; 6 appeared to be ineligible CMRAs; and 11 locations were inconclusive because we were not able to find the providers or suppliers at the address.

We also identified 25 applicants out of our generalizable sample of 496 addresses that the USPS address-management tool flagged as a CMRA and that our additional research found to be located in places advertised as "virtual offices."⁴² The companies offering virtual offices advertise mailboxes, telephone-answering services, and a dedicated workspace to clients who are not physically located on the premises.⁴³ While, according to CMS, a virtual office may be appropriate for some suppliers, it may not be appropriate for other types of providers and suppliers, since CMS requires the practice location to be open to the public for purposes of providing health care-related services and properly staffed, equipped, and stocked to furnish services or items.

⁴⁰Although limited-risk providers will likely never receive a site visit, CMS has the authority to conduct a site visit at any time. In addition, if the provider's risk level is elevated to a higher risk level, a site visit will be conducted, according to CMS.

⁴¹The 30 locations were selected based on the geographic proximity to the three MACs and the NSC we visited, and to GAO offices. These locations were selected independently of our generalizable sample of 496 addresses, and this selection is not generalizable to any set of addresses.

⁴²These addresses were flagged as CMRA because they serve as a third party that handles their customers' mail.

⁴³Virtual offices can have many companies hosted in one suite number since virtual offices can be rented for a short period and can serve more than one company at a time.

We visited 5 of the 25 providers and suppliers in Maryland, Texas, and California that our research indicated were located in places advertised as virtual offices. Based on our observational visits, the 5 providers and suppliers were located in places that were advertised as virtual offices.⁴⁴ In one instance, we took pictures of an office space in Texas that a provider had listed as its practice location. As previously noted, CMS requires the practice location to be open to the public for purposes of providing health care–related services and properly staffed, equipped, and stocked to furnish services or items. As shown in figure 7, at the time of our visit there was no actual office operating at the practice location address provided to CMS. As of May 2015, this provider had not updated its practice location address in PECOS or received a site visit because the provider falls into the limited-risk category. Without conducting additional reviews or a site visit, the MAC or CMS will not be able to confirm whether this provider is located at the practice location address listed in PECOS or whether this virtual office meets CMS’s eligibility requirements.

⁴⁴The NSC, CMS’s contractor that screens DMEPOS suppliers, conducted a total of seven observational and full site visits from initial enrollment to April 2015 at a DMEPOS supplier we identified at this same virtual office location. An observational site visit is intended to determine whether the supplier is operational and consists of taking photographs of the facility and inventory. According to the NSC, a full site visit consists of a detailed interview with the DMEPOS supplier, review of the supplier’s policies and procedures, review of a sample of patient files, and photographs of the facility, inventory, signage, and access, among other things. In response to our findings, in April 2015, the NSC conducted a full site visit to the DMEPOS supplier. Based on the site visit, it found that the DMEPOS supplier was located in a different suite number than what was listed in PECOS. Based on NSC’s review of documentation and physical site visit, it determined that the DMEPOS supplier is eligible to participate in the Medicare program.

Figure 7: No Real Working Offices Operating in Provider's Practice Location Address



Suite address provided to Centers for Medicare & Medicaid Services (CMS) as the provider's practice location, which was advertised as a virtual office

Source: GAO. | GAO-15-448

In light of the advertised characteristics of many virtual office spaces, which may not meet practice location requirements, and what we observed about these addresses, virtual office practice locations may warrant a site visit or other detailed address check. However, 17 of the 25 provider or supplier applicants our research indicated were located in places advertised as virtual offices had not received site visits, primarily because most of these providers or suppliers were not classified as high or moderate risk. We referred the 25 cases of providers and suppliers with virtual office locations that we identified to CMS for further review.

Revised Screening Procedures Issued in March 2014 Require Less Verification of Practice Locations

As previously noted, for the practice location addresses found in the PECOS data we obtained as of March 2013, CMS required MACs to verify practice location addresses using various techniques to obtain information about the practice location, such as searching the Internet using sites like 411.com and USPS.com, calling the official business telephone number listed on the application, and using Finalist to standardize the practice location address. In March 2014, however, CMS issued guidance to the MACs that revised the practice location verification

methods.⁴⁵ Specifically, under the March 2014 guidance, MACs are required to contact the person listed in the application to verify the practice location address and use the Finalist software that is integrated in PECOS to standardize the practice location address. Additional verification, such as using 411.com and USPS.com, which was required under the previous guidance, is only needed if Finalist cannot standardize the actual address. According to CMS officials, they revised the screening procedures to verify the practice location to reduce application processing time frames.

Our findings suggest that the revised screening procedure of contacting the person listed in the application to verify all of the practice location addresses may not be sufficient to verify such practice locations. For example, we found two providers in our sample of 496 addresses that the USPS address-management tool flagged as CMRA, invalid, or vacant that underwent the revalidation process in 2014. The MAC used the new procedure of calling the contact person to verify the practice location. We found that each of these two providers had a UPS or similar store as its practice location.⁴⁶ Figure 8 shows the mailbox that was used as a practice location by one of the providers that the MAC verified by contacting the provider by telephone. As we stated earlier in this report, conducting additional address-verification steps may be helpful to identify ineligible practice locations. Federal internal-control standards require management to identify risks that could impede an agency's ability to achieve its objectives and then take appropriate steps to manage those risks.⁴⁷ By using the new procedure of only calling the contact person listed in the application to verify the practice location, CMS has weakened its internal controls in this process and has increased the likelihood that it could miss identifying some potentially ineligible practice locations and could allow potentially ineligible providers and suppliers to enroll in Medicare.

⁴⁵In contrast, CMS did not reduce the requirements for the NSC. The NSC verifies the DMEPOS supplier's practice location by conducting an unannounced site visit.

⁴⁶We identified these two providers by conducting Internet searches and also conducting a site visit to one of the two providers.

⁴⁷GAO, *Internal Control: Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

Figure 8: Reported Practice Location Verified by Using the Phone Verification Method



Source: GAO | GAO-15-448

Limitations Exist in Verifying Applicants' Licensure Information

All physicians applying to enroll in the Medicare program must hold an active license in the state in which they plan to practice.⁴⁸ They must include that licensing information on their applications; however, CMS does not require that physicians also report licenses they might hold in other states.⁴⁹ They must also self-report any final adverse actions they have received by any state licensing authority regardless of the state in which they plan to practice. Under federal law, a final adverse action can be

- a suspension or revocation of a license to provide health care by any state licensing authority due to a conviction for a federal or state

⁴⁸As discussed earlier, the term "provider" refers collectively to institutional providers such as hospitals and health-care facilities, as well as physicians and nonphysician practitioners who provide health-care services to Medicare beneficiaries. For the purposes of this section, we focus on physicians.

⁴⁹Providers who plan on practicing in multiple states within the contractor's jurisdiction are required to submit a license for each state where they plan on maintaining a practice location.

felony offense that CMS has determined to be detrimental to the best interest of the program⁵⁰ or

- revocation or suspension by an accreditation organization, among other actions.

Applicants with an active license and a final adverse-action history may still enroll into the Medicare program depending on the severity of the actions and whether the applicant self-reported the action on his or her application. According to CMS guidance, when an applicant first enrolls into Medicare, MACs must corroborate adverse legal actions and licensure information directly with state medical boards using information located on the respective state medical board website and conduct follow-up research to ensure that the applicant retains an active license, as applicable, before allowing applicants to enroll in Medicare.⁵¹

CMS does not require MACs to independently identify and verify an applicant's license status in areas other than the state where the applicant is enrolling. Further, CMS only requires MACs to verify final adverse actions that the applicant self-reported on the application.

To improve oversight of the provider-license review process, in March 2014 CMS began providing the License Continuous Monitoring (LCM) report to MACs. CMS officials explained that because MACs must research all enrolled providers each month using multiple state medical board websites in their respective jurisdictions, CMS established the LCM report to provide consistency over the review process. It is designed to be used in a monitoring capacity to evaluate changes in current license information, according to CMS.⁵² The LCM report is generated from an external vendor that obtains license information directly from individual state medical boards. Each report is compiled monthly into an Excel spreadsheet and provides a nationwide snapshot of PECOS provider licensure status such as "suspended," "surrendered," "probation," or "deceased." The report does not change the overall review process;

⁵⁰42 C.F.R. § 424.535(a)(3)(i).

⁵¹Centers for Medicare & Medicaid Services, *Medicare Program Integrity Manual*, "Medicare Enrollment, Final Adverse Actions," ch. 15.5.3, p. 98-101 (revised 2012).

⁵²According to CMS, the LCM report was not intended to be used as a tool for validation of adverse actions; however, it is looking to expand this capability in the future.

MACs are still required to access the state medical board website of each provider to verify licensure status.

The LCM report that CMS provides to MACs includes the current provider license status but not the adverse-action history. MACs therefore cannot use the report to review a provider's adverse-action history, but can use the report to research current changes in the provider's license status on state medical websites and determine whether an adverse action was the cause.

Further, the LCM report is limited to only those license numbers used to enroll into the Medicare program. Some licenses of providers with multiple medical licenses would not appear in the LCM report because they were not used to enroll into Medicare. A provider may be associated with various license numbers because of licenses in different states.

We found instances in which providers could have been denied enrollment, based on our analysis of providers' adverse-action histories. We used data from the Federation of State Medical Boards (FSMB) to examine physician license information and disciplinary actions.⁵³ FSMB is a nonprofit organization that serves state medical boards in all U.S. states, Puerto Rico, Guam, and the Northern Mariana Islands; and 14 state boards of osteopathic medicine. FSMB data differ from the database that CMS uses in that the FSMB database includes a provider's entire history of license revocations and suspensions, for all medical licenses, while the LCM report only includes the current license status of the licenses reported by providers in PECOS. We found that 321 out of about 1.3 million physicians with active PECOS profiles as of March 29, 2013 (the most-current data available at the time of our review) had received an adverse action from a state medical board related to conduct such as crimes against persons (e.g., battery, rape, or assault), financial or related crimes (e.g., extortion, embezzlement, income-tax evasion, or insurance

⁵³According to CMS, it does not use the FSMB data because FSMB only updates the total number of licenses included in its master license file every 2 years. According to FSMB, it compiles this list of licensed physicians every 2 years and receives an update on these specific medical licenses on a weekly, monthly, or quarterly basis from 65 state and territorial medical boards in the United States. The vendor that CMS currently uses updates the total number of licenses included in its master list of licenses continuously. However, we found the LCM report provided by this vendor only provides the current license status and not the history of the license, while FSMB provides the license history as well as disciplinary actions.

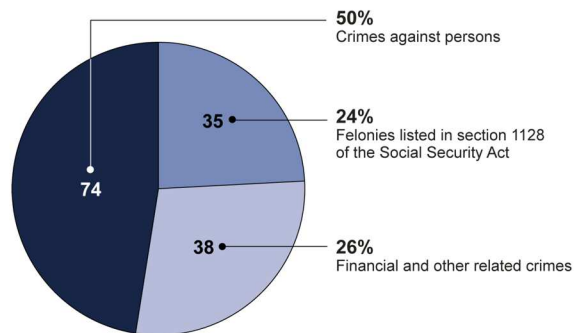
fraud), and felony crimes outlined in section 1128 of the Social Security Act (e.g., substance abuse, health-care fraud, or patient abuse) that resulted in a revocation or suspension of their licenses sometime between March 29, 2003, and March 29, 2013.⁵⁴ See appendix V for a breakdown of adverse actions identified in our review.

We followed up with the MACs to determine whether these physicians self-reported final adverse actions or whether MACs had identified any actions and revoked these physicians from the Medicare program. For 174 of the 321 physicians we identified as having adverse actions, MACs either revoked and later reinstated the physician into the Medicare program after meeting eligibility requirements or determined that the adverse action did not affect the physician's enrollment and allowed the physician to remain in the Medicare program. The remaining 147 physicians were either not revoked from the Medicare program until months after the adverse action or never removed.⁵⁵ CMS officials highlighted that delays in removing physicians from Medicare may occur due to MAC backlogs, delays in receipt of data from primary sources, or delays in the data-verification process. Figure 9 provides a breakdown of adverse actions related to the 147 physicians.

⁵⁴Adverse actions include suspensions or revocations related to federal or state felony offenses as defined in federal regulations. The adverse actions we identified occurred between March 29, 2003, and March 29, 2013. We focused our review on crimes against persons, financial crimes, and felonies outlined in section 1128 of the Social Security Act, because in addition to denying enrollment based on actions taken by a state licensing authority, CMS is also permitted to deny a provider or supplier enrollment into Medicare based on felony offenses; specifically, if the provider or supplier has been convicted of a federal or state felony offense that CMS has determined is detrimental to the best interests of the program. The categories we used are outlined in 42 C.F.R. § 424.530(a)(3). CMS noted that it does not have sufficient tools to identify felony data because there is not a single source of such information of which they are aware. CMS is working to identify a data source through the automated screening contractor. However, we were able to identify adverse action history through FSMB. As a result of PPACA, on August 2014, CMS implemented fingerprint-based background checks, which are required for all individuals with a 5 percent or greater ownership interest in a provider in the high-risk level category.

⁵⁵We referred the 147 physicians to CMS for further review and action.

Figure 9: Summary of the Adverse License Actions Related to 147 Physicians Who Were Not Revoked for Months or Never Removed from Medicare, as of March 2013



Source: GAO. | GAO-15-448

Because physicians are required to self-report adverse actions, the MACs did not always identify unreported actions when enrolling, revalidating, or performing monthly reviews of the provider. As a result, 47 physicians out of the 147 physicians we identified as having adverse actions have been paid approximately \$2.6 million by the Medicare program during the time CMS could have potentially barred them from the Medicare program between March 29, 2003, and March 29, 2013.

Some of the adverse actions that were unreported by physicians occurred within the state where the provider enrolled in PECOS, while others occurred in different states.

- We identified a physician who initially enrolled into Medicare in 1985 and was suspended for about 5 months in 2009 by the Rhode Island medical board. In 2011, his information was revalidated by the MAC. This provider did not self-report the adverse action, and the MAC did not identify it during its monthly reviews or when revalidating the provider's information. CMS bars providers that are already enrolled in

Medicare who do not self-report adverse actions for 1 year.⁵⁶ This individual billed Medicare for about \$348,000 during the period in which he should have been deemed ineligible.

- We also identified a physician whose California license was suspended in 2008 due to sexual misconduct. The physician then applied for a Missouri state medical license and was granted a license and enrolled into the Medicare program in 2010. The MAC responsible for Missouri explained to us that the physician did not report any adverse action and that the Missouri medical board has never taken action against the physician. According to CMS, if a provider does not list or include prior adverse actions on his or her initial application, but if the MAC discovers an adverse action during the verification process, the application is denied. However, this did not occur because the MAC was unaware of the adverse action since that took place in California, and, because the provider did not report it, the action was not subsequently discovered during the verification process. During this physician's first year in the program, he billed Medicare approximately \$113,000.

By focusing on the license numbers used to enroll in PECOS and relying on applicants to self-report final adverse actions on the application, CMS and MACs could be missing an opportunity to develop a more-complete picture of individual providers. By identifying all license numbers associated with the individual providers including outside the states for which they seek Medicare privileges, and monitoring providers' adverse actions, CMS and MACs might obtain better assurance that they are preventing potentially ineligible physicians from enrolling in PECOS.

**Few Instances of
Providers and Suppliers in
PECOS Listed as
Deceased**

To help ensure that Medicare maintains current enrollment information and to prevent others from utilizing the enrollment data of deceased providers and suppliers, MACs are required to check that providers and suppliers in PECOS are not deceased. Since January 2009, CMS sends the MACs a file containing a list of individuals who have been reported as deceased to the SSA, and MACs review the file monthly. For individual providers, CMS automatically applies the date of death to the PECOS enrollment record and deactivates the enrollment. For owners, authorized

⁵⁶A 1–3 year enrollment bar applies to individuals who have already had their billing privileges revoked. That period can span from 1 to 3 years depending on severity.

officials, and managing employees, MACs are required to manually update the enrollment record, according to CMS.

We compared the list of about 1.7 million unique providers and suppliers in PECOS as of March 2013 and DMEPOS suppliers as of April 2013 with SSA's full death file and found 460 (about 0.03 percent) who were identified as deceased.⁵⁷ In September and October 2014, we followed up with the MACs to obtain additional information on these providers and suppliers. Of the 460 providers and suppliers our analysis had identified as deceased, CMS or the MACs found 409 (89 percent) to be deceased between March 2013 to February 2015.⁵⁸ According to the MACs' responses, the remaining 51 of the 460 deceased providers and suppliers were not identified as deceased by the MACs or CMS. Some MACs noted that due to our work they confirmed that the provider or supplier was deceased and will take further action. Even though the MAC or CMS identified 409 of the 460 providers and suppliers that were deceased from March 2013 to February 2015, there were some instances when much more time elapsed before the MAC or CMS identified the provider as deceased. For example, we found that a provider died in April 2008, but the MAC identified the provider as deceased and duly updated the PECOS record in July 2014. Further, we found that for 162 of the 409 providers, CMS or the MAC took a year or more to identify the provider as deceased. According to CMS, some of the delays in identifying the

⁵⁷We obtained the list of active providers and suppliers in PECOS as of March 2013. However, we reached out to the MACs in September and October 2014 to request a status update of the providers and suppliers in PECOS.

⁵⁸According to CMS, if a provider was already deactivated or revoked in PECOS for other reasons and later determined to be deceased, the date of death will be added to the PECOS profile, but it will not be deactivated again. CMS noted that there is generally a minimum of a 30-day delay in deactivation of a provider due to secondary validations that are performed on the SSA death master file because that file has previously been found to have errors. However, the date of death is the effective date of the provider's termination. According to SSA, the SSA death data is highly accurate for its program purposes; however, SSA cannot guarantee the accuracy of the data for other agencies' use. SSA advises recipients of the data not to take any adverse action against any individual without verifying the information.

deceased providers occurred because SSA may take a long time to report an individual as deceased.⁵⁹

Not identifying a provider or supplier as deceased exposes the Medicare program to fraud. A provider or supplier can be paid after the date of death for services performed before the date of death. Therefore, CMS is required to check that no claims are paid for services provided after the date of death. We found that the 38 out of the 460 providers and suppliers we found to be deceased were paid about \$80,700 by Medicare for services performed after their date of death until December 2013, which is the date CMS had Medicare claims data available. It is unclear what caused the delay or omission by CMS and the MACs in identifying these individuals as deceased or how many overpayments they are in the process of recouping. We referred these cases to CMS for further review.

Few Instances of Providers and Suppliers in PECOS Excluded from Participating in Federal Programs or Health Care–Related Programs

MACs are required to check the Medicare Exclusion Database and the General Services Administration debarment list known as System for Award Management to ensure that the applicant and other individuals listed in an application have not been suspended or debarred from participating in a federal contract or a Medicare or Medicaid program. If a MAC identifies the applicant as debarred or suspended, it is required to document the finding and confirm whether it is an accurate match. Applicants found on the System for Award Management website are not automatically excluded; the MAC needs to contact the agency that issued the exclusion or suspension action and confirm that the applicant is the same person. In addition, the applicants can be excluded or suspended for a certain period, but once the suspension period expires, the applicant can apply to enroll in Medicare. According to CMS, in April 2010, it began providing the MACs a report each month on any providers and suppliers that have been sanctioned on the Medicare Exclusion Database.

On the basis of our analysis of relevant data, we found about 0.002 percent (40) of providers and suppliers listed in the HHS OIG List of Excluded Individuals and Entities (LEIE), which feeds into the Medicare Exclusion Database and PECOS, as of March 2013. These individuals

⁵⁹According to SSA, it does not generate death data, but rather collects the data from a variety of sources in order to administer SSA programs. SSA relies on third parties, including CMS, to provide this information, so for some instances there may be delays in reporting the deaths due to SSA's death-verification process. In addition, SSA may not receive reports of all deaths.

were excluded from participating in health care–related programs. We found that 16 of the 40 excluded providers and suppliers were paid approximately \$8.5 million by Medicare for services rendered after their exclusion date until the MAC or the NSC found them to be excluded.⁶⁰ In September and October 2014, we followed up with the MACs to determine the status of these providers and suppliers in PECOS. Of the 40 providers we found, MACs had removed 38 providers and suppliers from PECOS from March 2013 to October 2014. However, for two matches that we identified, the MACs did not take any action.⁶¹ According to CMS, one of two providers was not found in the Medicare Exclusion Database or LEIE using specific identifiers such as National Provider Identifier, last name, and Social Security number. This provider is currently approved in PECOS. According to CMS, the other provider was found in LEIE using the specific identifiers, but the middle initial did not match. Because the MAC could not determine an exact match to the excluded provider, it did not take any action. Since May 2014, this provider was deactivated due to requesting to be withdrawn from the Medicare program. However, this provider billed Medicare about \$22,000 during the period for which she should have been ineligible to participate in the Medicare program. We referred these two providers to CMS for further review and action.

Conclusions

As part of an overall effort to enhance program integrity and reduce fraud risk, effective enrollment-screening procedures are essential to ensure that ineligible or potentially fraudulent providers or suppliers do not enroll in the Medicare program. CMS has taken steps to develop and implement such procedures, but our analysis found limitations in two key areas that have allowed potentially ineligible providers and suppliers to enroll in Medicare. First, CMS software to validate the applicant's practice location address does not contain specific flags that can help identify questionable practice locations. Without those flags, CMS misses an opportunity to

⁶⁰We calculated the Medicare claims data paid from 2005 to 2013 to the excluded providers and suppliers by considering only claims paid for services rendered after the exclusion date through the date CMS or MACs found the providers or suppliers to be excluded, since providers' and suppliers' exclusion periods could have expired after March 2013.

⁶¹One MAC conducted additional research on one of the two providers and found that the provider was listed in the HHS OIG list; however, it was not in the Medicare Exclusion Database. It is unknown why the provider was not listed in the Medicare Exclusion Database. The other MAC searched the other provider and did not identify this provider in the System for Award Management or LEIE.

identify questionable practices that might warrant further review. In addition, the absence of those flags along with CMS's recently revised guidance—in which the MACs contact the person listed in a provider's or supplier's application to verify an address—call into question the overall effectiveness of CMS's procedures to ensure that applicants have a legitimate practice address.

Similarly, CMS's efforts to improve the oversight of physician license reviews by providing the MACs with the License Continuous Monitoring (LCM) report are a good first step. However, the report only provides MACs with the current status of the license that the provider used to enroll in the Medicare program. Without collecting license information on all medical licenses, regardless of the state the provider enrolled in, CMS may be missing an opportunity to identify potentially ineligible providers who have license revocations or suspensions in other states, which can put Medicare beneficiaries at risk. Utilizing additional resources, such as the Federation of State Medical Boards (FSMB), could help CMS identify whether providers or suppliers have additional licenses in other states that have ever been revoked or suspended. These resources would enable CMS and the MACs to access a provider's entire adverse-action history and could provide the MACs with a more-complete picture when enrolling or revalidating a Medicare provider.

Recommendations for Executive Action

To help improve the Medicare provider and supplier enrollment-screening procedures, we recommend that the Acting Administrator of CMS take the following three actions:

1. modify the CMS software integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as Commercial Mail Receiving Agency (CMRA), vacant, and invalid addresses;
2. revise CMS guidance for verifying practice locations to include, at a minimum, the requirements contained in CMS's guidance in place prior to March 2014 so that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a CMRA, vacant, or invalid to better ensure that the address meets CMS's practice location criteria; and
3. collect information on all licenses held by providers that enroll in PECOS by using data sources that contain this information, including licenses obtained from other states, and expand the License Continuous Monitoring (LCM) report to include all licenses, and at

least annually review databases, such as that of the Federation of State Medical Boards (FSMB), to check for disciplinary actions.

Agency and Third-Party Comments and Our Evaluation

We provided a draft of this report for review to HHS and received written comments that are summarized below and reprinted in appendix VI. HHS also provided technical comments, which we incorporated as appropriate. In addition, we provided excerpts of this draft report to the 12 MACs, NSC, SSA, USPS, and FSMB to help ensure the accuracy of our report. We received technical comments from these parties, which we have incorporated, as appropriate.

In its comments, HHS concurred with two of our three recommendations, but disagreed with the recommendation to revise its guidance. We continue to believe this action is needed, as discussed below.

Specifically, HHS concurred with our recommendation to modify CMS's software already integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as CMRA, vacant, and invalid addresses. HHS stated that it will configure the provider and supplier address-verification system in PECOS to flag CMRAs, vacancies, invalid addresses, and other potentially questionable practice locations.

HHS did not agree with the recommendation to revise its guidance for verifying practice locations to include, at a minimum, the requirement contained in CMS's guidance in place prior to March 2014 so that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a CMRA, vacant, or invalid. In its written comments, HHS stated that the March 2014 guidance was updated to remove redundant practices, such as the use of 411.com and USPS.com to verify practice locations because the provider and supplier address-verification system in PECOS performed the same checks. Further, HHS noted that removing these requirements allowed HHS to reduce provider and supplier burden and eliminate duplication of effort without reducing the effectiveness of its program-integrity efforts. The agency noted that, if a MAC is unable to validate the practice location using the software incorporated in PECOS, it is permitted to request clarifying information from the provider/supplier or request an unannounced site visit.

However, our audit work shows that additional checks on addresses flagged by the address matching software as a CMRA, vacant, or invalid

address can help to verify whether the addresses are ineligible. For example, when the USPS address-management tool flagged a practice location address as a CMRA, we took further steps, such as conducting Google Maps searches or physical site visits, to determine whether the address was ineligible. On the basis of these steps, we were able to confirm that the addresses were legitimate in some cases, while in other cases the practice locations in PECOS were ineligible addresses, such as a UPS store or similar establishments. We continue to believe that our recommendation will help ensure that HHS conducts this type of additional research on practice location addresses, when necessary. This additional research can include Google Map searches, Internet searches, site visits, or the additional steps HHS highlighted in its response. We are concerned that HHS's 2014 guidance does not describe any of these specific types of additional methods or techniques, beyond contacting the person listed in the application, and some of the MACs that we contacted were no longer taking the types of additional steps outlined above after issuance of HHS's 2014 guidance. Further, as our report highlighted, we identified providers with potentially ineligible addresses that were approved by MACs using the process outlined in that guidance. Therefore, we continue to believe that the agency should update its 2014 guidance to reflect the need to conduct the types of additional address research that we cite in our report and that the agency cites in its response, on addresses that are flagged as potentially ineligible practice locations.

HHS also concurred with our draft recommendation to require applicants to report all license information including those obtained from other states and expand the LCM report to include all licenses, and at least annually review databases, such as that of FSMB, to check for disciplinary actions. HHS noted that it will take steps to make certain that all applicants' licensure information is evaluated as part of the screening process by MACs and the LCM report as appropriate and will regularly review other databases for disciplinary actions against enrolled providers.

HHS further stated, however, that it does not have the authority to require providers to report licenses for states in which they are not enrolled. As shown in our report, having a provider's complete licensing history is a way to determine whether a provider has a history of final adverse actions. Without obtaining all licenses from a provider, as we did, CMS does not have the ability to verify whether all final adverse actions were reported. Without collecting license information on all medical licenses, regardless of the state the provider enrolled in, it is unclear how HHS will obtain the information it needs to identify past disciplinary actions, as the

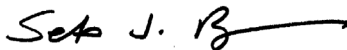
agency indicated it will do in its response to our report. Instead, HHS may continue to miss an opportunity to identify potentially ineligible providers who have license revocations or suspension in other states, which can put Medicare beneficiaries at risk.

While providers are not currently required to list out-of-state license information in the enrollment application, CMS can independently collect this information by using other resources. For example, CMS can compare the provider's information to license databases, such as FSMB's, that identify all licenses associated with an individual. For the purposes of our work, we compared the provider's SSN and name with FSMB's data to determine whether enrolled providers had disciplinary actions that might make them ineligible for Medicare enrollment and found instances in which providers could have been denied enrollment.

Therefore, we clarified our recommendation to state that CMS should collect information on all licenses held by providers that enroll in PECOS by using data sources that contain this information. Doing so will help HHS to develop a more-complete picture of individual providers.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the appropriate congressional committees, the Acting Administrator of CMS, and other interested parties. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VII.



Seto J. Bagdoyan
Director, Forensic Audits and Investigative Service

List of Requesters

The Honorable Ron Johnson
Chairman
The Honorable Thomas R. Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Susan M. Collins
Chairman
The Honorable Claire McCaskill
Ranking Member
Special Committee on Aging
United States Senate

The Honorable Orrin G. Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Sheldon Whitehouse
United States Senate

Appendix I: Objectives, Scope, and Methodology

GAO was asked to assess Medicare's provider and supplier enrollment-screening procedures to determine whether the Provider Enrollment, Chain and Ownership System (PECOS) was vulnerable to fraud. This report examines the extent to which Centers for Medicare & Medicaid Services (CMS) enrollment-screening procedures are designed and implemented to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers; suppliers; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers into PECOS.

To assess the extent to which CMS's enrollment-screening procedures are designed to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers into PECOS, we reviewed CMS procedural manuals and directives including the Program Integrity Manual that outlines the procedures that Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC) should use to determine provider and supplier enrollment eligibility. We also interviewed CMS officials about provider and supplier enrollment-screening procedures, including procedures that were developed and implemented as a result of the Patient Protection and Affordable Care Act's (PPACA) provisions.¹ In addition, we conducted interviews with five MACs,² to learn about the enrollment-screening procedures. We selected the five MACs to include some with larger numbers of physicians serviced, some that met and some that did not meet the accuracy threshold in CMS's provider enrollment performance evaluation, some that participated in the automated screening process and some that did not (to capture additional possible checks that some MACs performed on providers' enrollment information through this process), and some that served more than one jurisdiction to maximize the number of states included in our review. We

¹In 2010, Congress passed PPACA, which included provisions that provide CMS with increased authority to combat potential fraud, waste, and abuse in Medicare. Some of these provisions allowed CMS to evaluate providers and suppliers previously enrolled in the Medicare program under new enrollment criteria designed to strengthen Medicare's provider enrollment standards and procedures. At a minimum, PPACA requires all providers and suppliers to be subject to licensure checks, which may include checks in multiple states. It also gives CMS the authority to require additional screening procedures, such as criminal-background checks, depending on the type of risk presented by the provider or supplier type.

²CMS contracts with 12 MACs that enroll providers and suppliers, except for DMEPOS suppliers, and are responsible for their own geographic regions, known as jurisdictions.

also interviewed NSC officials responsible for enrolling DMEPOS suppliers to learn about the DMEPOS supplier enrollment-screening procedures. We contacted by e-mail the remaining seven MACs to obtain additional information on the provider enrollment-screening procedures to verify applicants' practice location addresses and validate applicants' licensure and accreditation information.

To assess the extent to which CMS implemented enrollment-screening procedures to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers into PECOS, we matched the list of providers and suppliers present in PECOS on March 29, 2013, and DMEPOS suppliers on April 6, 2013—the most-current data available at the time of our review—to four specific databases listed below.

1. **The United States Postal Service (USPS) Address Matching System Application Program Interface,**³ which is a commercially available USPS software package that standardizes addresses and provides specific flags such as Commercial Mail Receiving Agency (CMRA), vacant, or invalid addresses to determine the validity of the providers' or suppliers' practice location addresses. Specifically, we submitted 980,974 PECOS practice location addresses to the USPS address-management tool.⁴ The USPS address-management tool contained valid addresses as of December 15, 2013. Of the 980,974 addresses, 105,234 (about 11 percent) appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address. For those addresses that the tool flagged as a CMRA, vacant, or invalid, we selected a generalizable stratified random sample. Specifically, we sampled 496 addresses from the population of 105,234. We stratified the population addresses by the type of match (CMRA, vacant, or invalid) and by the type of provider (individual practitioner, organization, or DMEPOS supplier). This resulted in nine mutually exclusive strata. We computed sample sizes to achieve a precision of plus or minus 10 percentage points or fewer, at the 95 percent confidence level for each of the three types of

³We will refer to the USPS Address Matching System Application Program Interface as the USPS address-management tool.

⁴We did not submit addresses of providers in PECOS that reassigned their benefits to a group. These providers did not have a practice location address listed in PECOS and were not included in our work.

matches. Because we followed a probability procedure based on random selections, our sample is only one of a large number of samples that we might have drawn. Since each sample could have provided different estimates, we express our confidence in the precision of our particular sample's results as a 95 percent confidence interval (e.g., plus or minus 10 percentage points). This is the interval that would contain the actual population value for 95 percent of the samples we could have drawn. To confirm whether each of the 496 sampled practice location addresses was an eligible address, we used Google Maps, Internet searches including searching the provider's website, or physical site visits. On the basis of the results of our work on the sample, we produced estimates of how many addresses were likely to be ineligible, potentially valid, or inconclusive. The estimates are based on our generalizable stratified random sample of 496 addresses and have a margin of error at the 95 percent confidence level of plus or minus 10 percentage points or fewer. To calculate the amount of Medicare claims paid to providers and suppliers we confirmed to have an ineligible practice location, we ran the provider and supplier National Provider Identifier⁵ against the claims paid from 2005 to 2013, the period for which CMS has claims data.⁶ For addresses that were located at an ineligible CMRA, we calculated the claims data from the date the provider or supplier enrolled into PECOS using the address to December 2013.⁷ For addresses flagged as vacant by the USPS address-management tool, we calculated the claims data from September 2013 to December 2013.⁸ According to USPS guidance, an address must be vacant for at least 90 days to be flagged as vacant in the USPS address-management tool. For the invalid addresses, we calculated the claims

⁵We were not able to calculate the claims data associated with each practice location because the data we obtained compiled claims by the National Provider Identifier. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location. As a result, we were unable to determine how much, if any, of the claim amount may be associated with a different, valid address.

⁶For instances where the provider or supplier updated its practice location address after March 2013, we used the date the provider updated the address and not the date when the provider started providing services at the practice location.

⁷If the provider or supplier updated its practice location address prior to December 31, 2013, we used the date the provider updated its address as the end date.

⁸If the provider or supplier updated its practice location address prior to September 2013, we did not calculate claims data for these providers or suppliers.

data from the date the provider or supplier enrolled into PECOS using the address to December 2013.⁹ The Medicare claims paid to providers and suppliers with ineligible addresses may be understated because some of the providers and suppliers enrolled in PECOS with a potential ineligible address prior to 2005.

2. **The Federation of State Medical Boards (FSMB) licensure data** from March 31, 2014, to determine whether enrolled providers or suppliers had disciplinary actions that might make them ineligible for Medicare enrollment. We matched the providers and suppliers in PECOS with the FSMB licensure data by Social Security number and provider name. We then validated the FSMB licensure information against individual state medical licensing boards. We then calculated Medicare claims for those physicians that received a suspension or revocation of their medical license while enrolled in PECOS. This included the time the physician was actively suspended or revoked and in some cases the time when the provider could have been barred from the Medicare program for not reporting an adverse action. We calculated the Medicare claims data paid from 2005 to 2013, which are the years CMS had the claims data available.
3. **The Social Security Administration's (SSA) full death file** containing updates through April 2013, to determine whether enrolled providers or suppliers were deceased.¹⁰ We matched the providers and suppliers with the SSA full death file by Social Security number and provider's last name. We also matched the providers and suppliers we identified as deceased with the Medicare claims by National Provider Identifier. We calculated the Medicare claims data paid from 2005 to 2013, which are the years CMS had the claims data available, to the deceased providers by considering only claims paid for services rendered after the date of death.

⁹If the provider or supplier updated its practice location address prior to December 31, 2013, we used the date the provider updated its address as the end date.

¹⁰SSA maintains death data including names, Social Security numbers, date of birth, and date of death. SSA shares a comprehensive file of this death information, which includes state death data, with certain eligible entities, including CMS, according to SSA. We used this comprehensive file, which we will call the "full death master file" for our analysis. A subset of the full death master file that does not include state death data is available to the public. SSA advises recipients of the file not to take any adverse action against any individual without verification of the information.

-
4. **The Department of Health and Human Services (HHS) Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)** as of September 17, 2012, to determine whether providers or suppliers were excluded from doing business with the federal government or health care–related programs.¹¹ We conducted this match by comparing the provider’s Social Security number and provider’s last name. We also matched the providers and suppliers we identified as being excluded with the Medicare claims data by using the provider and supplier National Provider Identifier. We calculated the Medicare claims data paid from 2005 to 2013, which are the years CMS had the claims data available, to the excluded providers and suppliers by considering only claims paid for services rendered after the exclusion date through the date the MAC or CMS found the provider to be excluded. The Medicare claims paid to excluded providers and suppliers may be understated in cases where these providers and suppliers were excluded prior to 2005.

We also contacted the NSC and those MACs responsible for enrolling any of the individuals and entities that appeared in our four sets of matches. Since our PECOS data were as of March 29, 2013, for providers and suppliers and April 6, 2013, for DMEPOS suppliers, we requested updated information during the months of September 2014 to October 2014. This information included whether the providers or suppliers were revalidated or changed their PECOS profile information. We also requested providers’ and suppliers’ application files including site-visit reports from the MACs when appropriate to corroborate MACs’ responses. We also selected 30 locations for a physical site visit to confirm whether the practice location address was an eligible address. The 30 locations were selected based on the geographic proximity to the five MACs and the NSC we visited, and to GAO offices. These locations were selected independently of our generalizable sample of 496 addresses and this selection is not generalizable to any set of addresses.

¹¹Federal exclusions include individuals or entities excluded by the HHS OIG from participating in the Medicare program. Specifically, the HHS OIG has the authority to exclude individuals and entities from federally funded health-care programs and maintains the LEIE. The General Services Administration also maintained a similar program that excludes individuals and entities from receiving federal contracts or assistance, formerly called the Excluded Parties List System. The Excluded Parties List System has been consolidated into a system called System for Award Management.

We assessed the reliability of the PECOS data, USPS address-management tool, FSMB licensure data, SSA full death file, HHS LEIE, and Medicare claims data by reviewing relevant documentation, interviewing knowledgeable agency officials, and performing electronic testing to determine the validity of specific data elements in the data. Specifically, for the USPS address-management tool, we selected a generalizable stratified random sample of 496 addresses that the tool flagged as a CMRA, vacant, or invalid and used Google Maps, Internet searches, or physical site visits to confirm the address. For the FSMB licensure data, we selected a random, nongeneralizable sample of 153 licenses and traced the license information, including disciplinary actions when applicable, to the appropriate state licensing medical board for confirmation. We determined that these databases were sufficiently reliable for the purpose of our work.

We conducted this performance audit from January 2014 to June 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Processes within Each Provider and Supplier Enrollment-Screening Procedure to Determine Medicare Program Eligibility

The following table outlines the steps in the enrollment-screening process depicted in figure 2.

Table 2: Processes within Each Provider and Supplier Enrollment-Screening Procedures

Step 1: A provider or supplier submits an application in the Provider Enrollment, Chain and Ownership System (PECOS) via online or paper application; Medicare Administrative Contractor (MAC) or the National Supplier Clearinghouse (NSC) processes the application.

MACs manage Medicare provider and supplier enrollment. The NSC manages enrollment for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The contractors review and verify the applicant's information and determine eligibility for the Medicare program.

Step 2: MAC or the NSC prescreens the application to ensure that applicant has completed all data elements on the application and furnished supporting documentation. Supporting documentation includes but is not limited to:

- medical or professional licenses
- certifications or registrations required for applicable specialty supplier types
- businesses licenses
- employer identification number

Step 3: MAC or the NSC verifies applicant's eligibility for the Medicare program. The eligibility review process includes verifying⁴:

- (1) the authenticity of the applicant's practice location address,
- (2) the validity of the applicable licensure information,
- (3) that applicants are not listed as deceased, and
- (4) that applicants are not listed on federal excluded parties' lists.

The MAC and the NSC validation checks are part of Centers for Medicare & Medicaid Services (CMS) prevention and detection controls to identify any potential ineligible or fraudulent providers. Some of the checks are performed during initial enrollment and then periodically to ensure the applicant remains eligible for the Medicare program. Validation checks performed include, but are not limited to

- provider's practice location address
- adverse legal actions
- status on the Social Security Administration's (SSA) death master file, and
- exclusions or debarment from participating in federal or state health care programs or other federal programs.

If a discrepancy is found between the application information and data found during the verification process, the contractor is to contact the provider for clarification.

Step 4: MAC or the NSC notifies the applicant on the disposition of the application.

- Approval—If the MAC or the NSC approves the application, an approval letter is generated.
- Denial—The MAC or the NSC must deny the applicant if any of the following situations are present:
 - the application does not comply with the Medicare enrollment requirements
 - the applicant or other individuals in the application are excluded from Medicare, Medicaid, or any other federal health-care program or debarred, suspended, or otherwise excluded from participating in any other federal procurement or nonprocurement activity
 - the applicant was, within the 10 years preceding enrollment or revalidation of enrollment, convicted of a federal or state felony offense that CMS has determined to be detrimental to the best interest of the program and its beneficiaries
 - the applicant submitted false or misleading information
 - on-site review or other reliable evidence shows that the applicant is not operational to furnish Medicare covered items or services

Appendix II: Processes within Each Provider
and Supplier Enrollment-Screening Procedure
to Determine Medicare Program Eligibility

Step 5: Change of Information in PECOS—If an enrolled provider or supplier adds, deletes, or changes information under its existing profile, it must report the changes using a CMS form:

Physicians and clinical nurse specialists, among others, must report the following changes within 30 days:

- change of ownership
- final adverse action
- change in practice location

All other information changes must be reported within 90 days.

For DMEPOS suppliers, any changes must be reported within 30 days.

Step 6: Revalidation Process Medicare providers and suppliers (other than DMEPOS suppliers) must be revalidated every 5 years, and DMEPOS suppliers must be revalidated every 3 years. As part of the revalidation process, the MAC or the NSC should verify all data furnished on the application—just as it would with an initial enrollment—using the procedures above (back to step 1).

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) data. I. GAO-15-448

*Medicare provider and supplier enrollment entails other screening procedures based on the type of providers and suppliers.

Appendix III: Practice Locations Allowed Based on the Type of Services the Provider or Supplier Renders

Federal regulations require that applicants have a physical practice location that is open to the public for providing health care–related services that is properly staffed, equipped, and stocked to furnish the services for which they will be receiving Medicare funds. Providers and suppliers are required to list a physical practice location address in the enrollment application regardless of their provider or supplier type.¹ The practice location address provided in the application depends on the type of services the provider or supplier renders. Table 3 describes the type of practice locations allowed based on the services the provider or supplier renders.

Table 3: Practice Locations Allowed Based on the Type of Services Rendered by Medicare Provider or Supplier

Type of services provider or supplier renders	Practice location address allowed ^a
Practitioners rendering services only in patients' homes	Home address if no office is available
Practitioners rendering services only in retirement or assisted-living communities	Address of the communities where services are rendered
Mobile facilities and portable units (e.g., independent diagnostic testing facilities, portable X-ray suppliers, and mobile clinics)	Address where personnel are dispatched, where mobile or portable equipment is stored, and, when applicable, vehicles are parked when not in use
Medicare durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers	Address where suppliers furnish services or supplies

Source: GAO. | GAO-15-448

^aPost office boxes and drop boxes are not acceptable except where providers are located in rural areas.

¹To enroll in the Medicare program, the provider or supplier must be operational. 42 C.F.R. § 424.510. Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care–related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped, and stocked (as applicable, based on the type of facility or organization, provider or supplier specialty, or the services or items being rendered) to furnish these items or services. 42 C.F.R. § 424.502.

Appendix IV: Breakdown of the Sample of 496 Addresses

We selected a generalizable stratified random sample of 496 addresses from the population of 105,234 that appeared in the United States Postal Service (USPS) address-management tool as a Commercial Mail Receiving Agency (CMRA), a vacant address, or invalid address.¹ For each selected address, we used Google Maps, Internet searches,² or physical site visits to confirm whether the practice location address was an eligible address.³ For the 496 addresses we reviewed, we confirmed the following:⁴

- 120 of the 496 addresses had an ineligible address, of which 46 addresses were determined to be CMRAs, 29 were vacant properties, and 45 were invalid.
- We contacted the Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC) to determine whether the 120 addresses were updated, because providers and suppliers can submit changes to their addresses or update them during the revalidation process, since the time we obtained the list of providers and suppliers in the Provider Enrollment, Chain and Ownership System (PECOS).⁵
- The MACs and the NSC noted that 92 of the 120 addresses we found to be ineligible have not been updated in PECOS from

¹The sample of 496 addresses is a combination of different types of providers, suppliers, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Specifically, 24 of the 496 addresses are institutional providers such as hospitals and home health agencies. Of the 496 addresses, 181 include portable X-ray facilities, independent diagnostic testing facilities, or group practice, among others; 72 providers are physicians and nonphysicians such as nurse practitioner or physical therapist, among others; 219 of the 496 addresses are DMEPOS suppliers.

²Internet searches include searching for the company website.

³An ineligible address can be a CMRA, a vacant property, or an invalid address.

⁴Note that percentages computed based on the sample counts presented here may not match the estimated percentages presented in this report. The estimated percentages are based on methods appropriate for sample data selected from a stratified random sample.

⁵The Centers for Medicare & Medicaid Services' (CMS) current cycle for revalidation is 3 years for DMEPOS suppliers and 5 years for all other providers and suppliers. 42 C.F.R. § 424.515.

**Appendix IV: Breakdown of the Sample of 496
Addresses**

March 30, 2013, to October 2014.⁶ We found that from the time a provider enrolled in PECOS with the ineligible practice location through December 2013 or the date the provider updated the address, the Medicare program has paid providers associated with these 120 addresses approximately \$122.4 million.⁷

- 162 of the 496 addresses were determined to be valid addresses and thus eligible for Medicare.
- 214 of the 496 addresses cannot be determined as either eligible or ineligible using these methods.

The numbers of addresses presented in this appendix are unweighted counts of results obtained from the stratified random sample of 496 cases. These numbers do not represent estimates of the population. The estimated percentages included in the body of the report were computed using methods appropriate for a stratified random sample and have been weighted to account for the sample design. As a result, percentages computed from the numbers presented in this appendix are not expected to match the estimated percentages included in the body of the report.

⁶CMS noted that institutional providers such as skilled nursing facilities, home health agencies, hospices, and hospitals, among others, are affected by longer screening reviews that can take up to 9 months. Six of the 120 providers we identified as ineligible were institutional providers, of which 1 updated its address in 2013 and 5 did not update their addresses as of October 2014. We referred the 92 cases to CMS for further review.

⁷We were not able to calculate the claims data associated with each practice location because the data we obtained compiled claims by the National Provider Identifier. Because some providers are associated with more than one address, it is possible that some of the claim amounts reported may be associated with a different, valid practice location.

Appendix V: Actions Resulting in Revocations and Suspensions

During our review, we found that 321 physicians in the Provider Enrollment, Chain and Ownership System (PECOS) have received some type of revocation or suspension from March 29, 2003, to March 29, 2013. Of the 321 physicians, 147 were either not revoked from the Medicare program until months after the adverse action or never removed. Below in table 4 is a breakdown of the adverse actions identified in our review.

Table 4: Summary of the Adverse Actions Resulting in Revocations and Suspensions

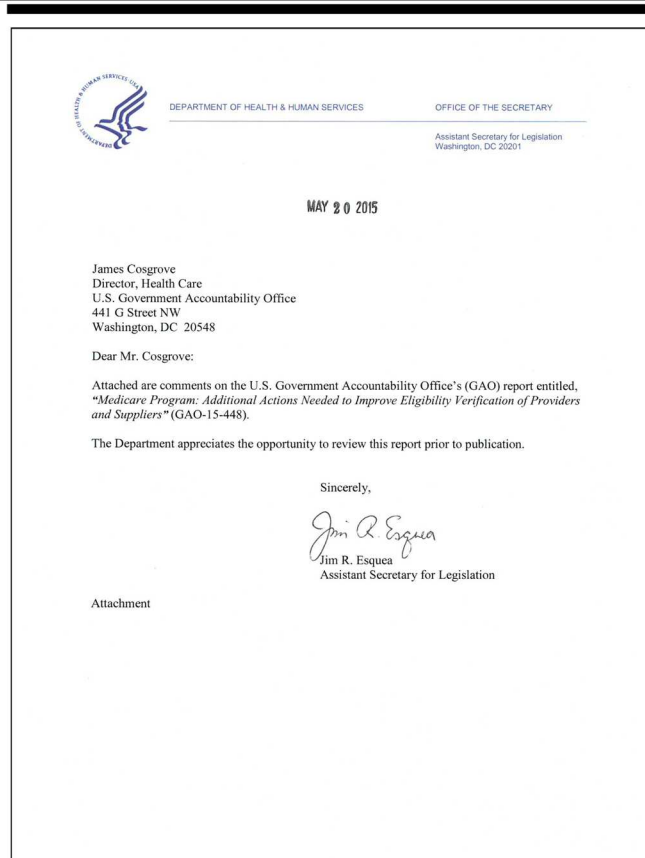
Basis description	Actions resulting in revocations and suspensions	Physicians that remained or were not revoked for months from Medicare
Crimes against persons		
Convicted of a Felony	50	23
Convicted of Assault	1	1
Convicted of Battery	2	
Convicted of Criminal Sexual Conduct	1	
Convicted of Rape	1	
Sexual Misconduct	78	48
Willfully Harassing, Abusing, or Intimidating a Patient Either Physically or Verbally	2	2
Total	135	74
Financial and other related		
Alteration/Falsification of Medical Record(s)	15	10
Attempting to Obtain a License by Misrepresentation	10	3
Falsification of Licensure Application	15	2
Felony Conviction Relating to Health-Care Fraud	4	1
Fraud	2	1
Income-Tax Evasion	1	
Insurance Fraud	2	1
Making a False/Fraudulent/Misleading Statement	27	10
Making or Using a False and/or Misleading Statement	1	1
Medicaid Fraud	1	
Medicare Fraud	2	1
Medicare/Medicaid Fraud	1	
Obtaining License by Fraudulent Misrepresentation	19	4
Practicing the Profession Fraudulently	10	4
Total	110	38

Appendix V: Actions Resulting in Revocations
and Suspensions

Basis description	Actions resulting in revocations and suspensions	Physicians that remained or were not revoked for months from Medicare
1128 Social Security Act		
Controlled Substance Abuse	21	7
Controlled Substance Violations	35	18
Conviction Relating to Controlled Substances	6	4
Conviction Relating to Fraud	1	
Conviction Relating to Health-Care Fraud	1	
Felony Conviction Relating to Controlled Substance Violations	9	3
Patient Abuse	1	1
Prescribing/Dispensing/Selling to Addicts	2	2
Total	76	35
Grand total	321	147

Source: GAO. | GAO-15-448

Appendix VI: Comments from the Department of Health and Human Services



Appendix VI: Comments from the Department
of Health and Human Services

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED: MEDICARE PROGRAM: ADDITIONAL ACTIONS
NEEDED TO IMPROVE ELIGIBILITY VERIFICATION OF PROVIDERS AND
SUPPLIERS (GAO-15-448)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity efforts in Medicare. HHS has a number of ongoing activities to enhance the provider enrollment and revalidation process in addition to the improvements that have been implemented as a result of our increased authority provided by the Affordable Care Act to strengthen provider enrollment and screening.

In February 2011, HHS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare providers and suppliers and revalidate all current Medicare providers and suppliers under new requirements established by the Affordable Care Act. Limited risk providers and suppliers undergo verification of licensure, verification of compliance with federal regulations and state requirements, and perform various database checks. Moderate and high risk providers and suppliers undergo additional screening, including unannounced site visits. Additionally, high individuals with a five percent or greater direct or indirect ownership interest in a high risk provider or supplier must consent to criminal background checks including fingerprinting.

Since these regulations were issued, more than one million providers and suppliers have been subject to the new screening requirements. Over 470,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and almost 28,000 provider and supplier enrollments were revoked. In addition, HHS has performed nearly 250,000 site visits on Medicare providers and suppliers. HHS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from enrolling in the Medicare program. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015.

HHS has made significant progress in reducing the number of questionable providers and suppliers enrolling in Medicare. GAO noted in the report, that only 2.3 percent of provider and supplier practice locations are potentially ineligible for Medicare providers and suppliers. This small percentage of provider or supplier locations that could not be confirmed as eligible or ineligible by GAO could be as a result of a data entry issue such as a missing suite number; however, the address itself could be an eligible practice location.

Based on HHS experience in conducting site visits nationally, less than one percent of the visits actually result in a finding of ineligible or non-operational addresses. In addition, GAO obtained claims compiled by National Provider Identifier (NPI). Because some NPIs are associated with more than one practice location, these providers may be billing Medicare from eligible practice locations despite never having updated their practice locations in PECOS.

HHS enhanced screening methods such as site visits, fingerprinting, and revalidation efforts are working effectively in identifying and eliminating invalid and ineligible providers from Medicare. As part of our ongoing Program Integrity Outreach and Education efforts, HHS routinely advises the provider and supplier community of the importance of maintaining

Appendix VI: Comments from the Department
of Health and Human Services

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED: MEDICARE PROGRAM: ADDITIONAL ACTIONS NEEDED TO IMPROVE ELIGIBILITY VERIFICATION OF PROVIDERS AND SUPPLIERS (GAO-15-448)

accurate, up-to-date provider enrollment practice location information. To strengthen the enrollment screening process, HHS will enhance the address verification software to better detect potentially ineligible addresses.

HHS has also initiated several actions to improve Medicare enrollment screening and to reduce provider burden. In March of 2014, HHS updated its guidance on verification of practice locations to remove redundant practices, such as the use of 411.com and USPS.com, to verify practice locations because the provider and supplier address verification system in PECOS performed the same checks. If the Medicare Administrative Contractor (MAC) is unable to validate the practice location using the software incorporated in PECOS, they are permitted to request clarifying information from the provider or supplier or request an unannounced site visit. Removing the redundant requirements allowed HHS to reduce provider and supplier burden and eliminate duplication of effort without reducing the effectiveness of our program integrity efforts.

HHS has started evaluating the supporting practice location identification data submitted by the GAO and will thoroughly review it and take any appropriate actions.

GAO's recommendations and HHS' responses are below.

GAO Recommendation

The Acting Administrator of CMS should modify the Finalist software already integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as Commercial Mailing Receiving Agency, vacancies, and invalid addresses.

HHS Response

HHS concurs with this recommendation. We will configure the provider and supplier address verification system in PECOS to flag Commercial Mail Receiving Agencies, vacancies, invalid addresses, and other potentially questionable practice locations.

GAO Recommendation

The Acting Administrator of CMS should revise CMS guidance for verifying practice locations to include, at a minimum, the requirements contained in CMS's guidance in place prior to March 2014 so that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a Commercial Mailing Receiving Agency, vacant, or invalid to better ensure that the address meets CMS's practice location criteria.

HHS Response

HHS does not concur with this recommendation. In March of 2014, HHS updated its guidance on verification of practice locations to remove redundant practices, such as the use of 411.com and USPS.com, to verify practice locations because the provider and supplier address verification system in PECOS performed the same checks. Removing these requirements allowed HHS to reduce provider and supplier burden and eliminate duplication of effort without reducing the effectiveness of our program integrity efforts. If the MAC is unable to validate the practice location using the software incorporated in PECOS, they are permitted to request

Appendix VI: Comments from the Department
of Health and Human Services

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN
SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO)
DRAFT REPORT ENTITLED: MEDICARE PROGRAM: ADDITIONAL ACTIONS
NEEDED TO IMPROVE ELIGIBILITY VERIFICATION OF PROVIDERS AND
SUPPLIERS (GAO-15-448)**

clarifying information from the provider/supplier (i.e., letter head showing the appropriate address, phone/power bill, or other documentation containing the provider/supplier's legal business name and address) or request an unannounced site visit.

In addition, implementation of the first recommendation in this report will further enhance MACs' ability to identify ineligible practice locations.

GAO Recommendation

The Acting Administrator of CMS should require applicants to report all license information, including those obtained from other states and expand the License Continuous Monitoring report to include all licenses, and at least annually review databases, such as Federation of State Medical Boards, to check for disciplinary actions.

HHS Response

HHS concurs with this recommendation. HHS does not currently have authority to require providers and suppliers to report licenses for states in which they are not enrolled. However, we will take steps to make certain that all applicants' licensure information is evaluated as part of the screening process by MACs and License Continuous Monitoring report as appropriate. We will also regularly review other databases for disciplinary actions against enrolled providers and suppliers.

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

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or bagdoyans@gao.gov.

Staff Acknowledgments

In addition to those mentioned above, the following staff members made significant contributions to this report: Latesha Love, Assistant Director; Gloria Proa, Analyst-in-Charge; Ariel Vega; and Georgette Hagans. Additionally, Colin Fallon, Maria McMullen, and Marcus Corbin provided technical support; Shana Wallace and James Ashley provided methodological guidance; and Brynn Rovito and Barbara Lewis provided legal counsel.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://www.gao.gov> and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#). Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#). Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@gao.gov, (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548



Please Print on Recycled Paper.