



June 2015

# MEDICARE PROGRAM

## Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers

# 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](mailto: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.

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## 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

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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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup> Further, because of its size, complexity, and susceptibility to

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<sup>1</sup>Medicare 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.

<sup>2</sup>These 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).

<sup>3</sup>The 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.

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

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.<sup>5</sup> 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.<sup>6</sup> 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

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<sup>4</sup>GAO, *High-Risk Series: An Update*, [GAO-15-290](#) (Washington, D.C.: February 2015).

<sup>5</sup>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. 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.

<sup>6</sup>Fraud 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.

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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.<sup>7</sup>

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.<sup>8</sup> 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,

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<sup>7</sup>PPACA 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.

<sup>8</sup>See 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).

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complete, and consistent.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> We also interviewed CMS officials about provider and supplier enrollment-screening procedures, including procedures that

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<sup>9</sup>Before 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).

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

<sup>11</sup>According 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.

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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.<sup>12</sup> 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,<sup>13</sup> 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

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

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

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were deceased;<sup>14</sup> 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.<sup>15</sup>

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

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<sup>14</sup>SSA 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.

<sup>15</sup>We 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.

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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.

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## Background

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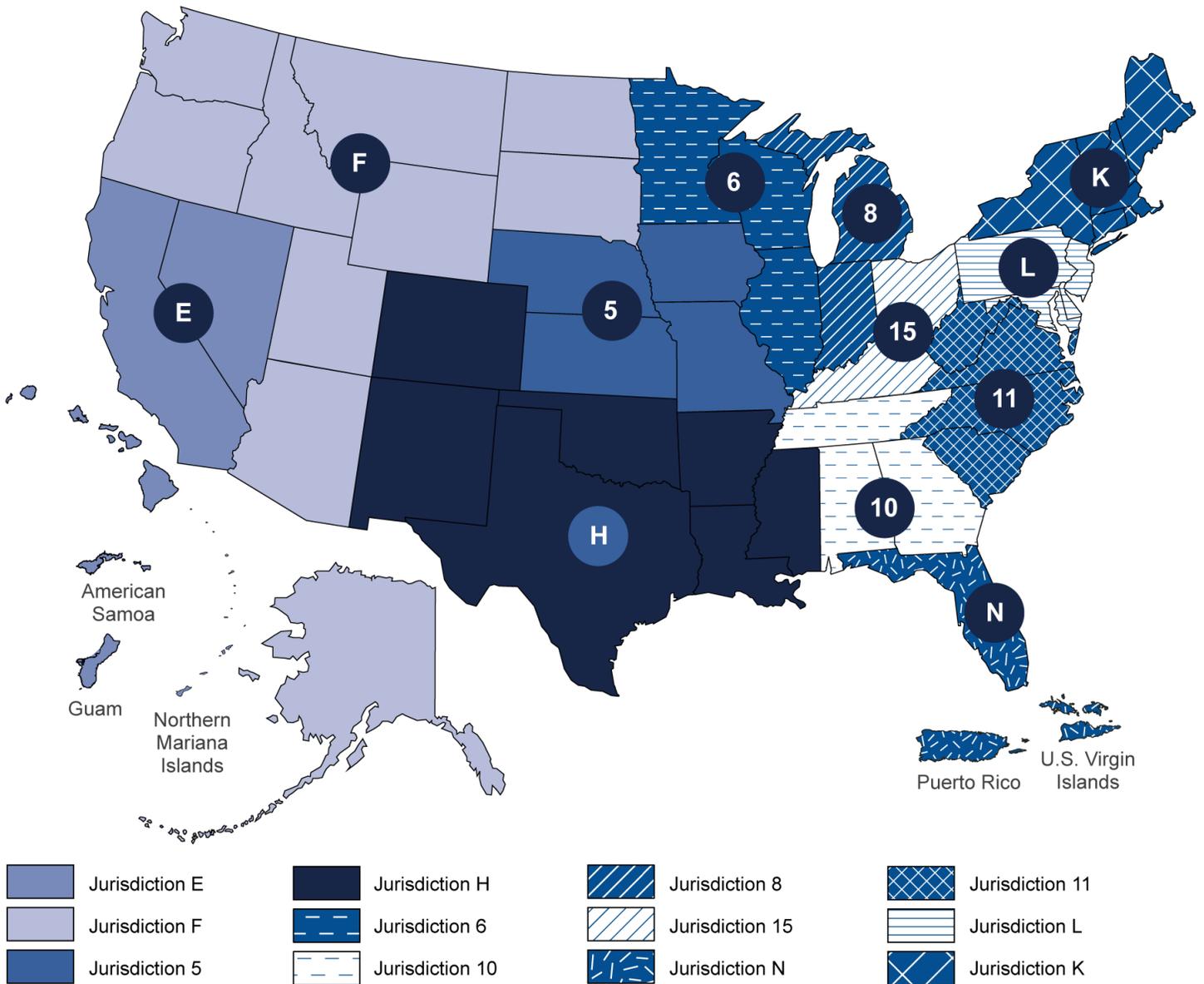
### Medicare Contractors' Duties and Responsibilities

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.<sup>16</sup> 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.

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<sup>16</sup>Some 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**



Source: Centers for Medicare & Medicaid Services (CMS) (data); Map Resources (map). | GAO-15-448

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.

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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.<sup>17</sup> 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.<sup>18</sup> 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.

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## 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.

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<sup>17</sup>DMEPOS 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 29,000 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.

<sup>18</sup>Physicians 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).<sup>19</sup> 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 <sup>a</sup>
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

<sup>a</sup>The 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

<sup>19</sup>The 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.

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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.<sup>20</sup> 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.

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## 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.<sup>21</sup> 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,<sup>22</sup> (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).

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

<sup>21</sup>Medicare 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 identify 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.

<sup>22</sup>Licensure 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**



**Instructions:** Roll over the process steps to view the verification checks to be performed



**Print version:** See appendix II

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

to ensure that applicant has completed all data elements on the application and furnished supporting documentation

- (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**

Medicare providers and suppliers (other than Medicare durable medical equipment, prosthetics, orthotics, and supplies [DMEPOS] suppliers) must be revalidated every 5 years, and DMEPOS suppliers must be revalidated every 3 years

If an enrolled provider or supplier adds, deletes, or changes information under its existing profile, it must report the changes using a CMS form

If the MAC or the NSC approves the application, an approval letter is generated

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.

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## 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.

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## 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.<sup>23</sup> 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.<sup>24</sup> All providers and suppliers are required to list a physical practice location address in their application, regardless of provider or

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<sup>23</sup>42 C.F.R. § 424.510.

<sup>24</sup>42 C.F.R. § 424.502.

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supplier type.<sup>25</sup> 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.<sup>26</sup> 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

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<sup>25</sup>The 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.

<sup>26</sup>Not 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.

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sites like 411.com and USPS.com,<sup>27</sup> calling the official business telephone number listed on the application, and using software called Finalist to validate the practice location address.<sup>28</sup> 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.<sup>29</sup> 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

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<sup>27</sup>411.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.

<sup>28</sup>We 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.

<sup>29</sup>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. 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.

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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.<sup>30</sup> For each selected address, we used Google Maps, Internet searches,<sup>31</sup> 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:<sup>32</sup>

- 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.<sup>33</sup> 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.<sup>34</sup>
- About 39,900 (38 percent) of the 105,234 addresses that we initially identified as a CMRA, vacant, or invalid address are potentially valid

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<sup>30</sup>As 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.

<sup>31</sup>Internet searches include searching for the company website.

<sup>32</sup>The 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.

<sup>33</sup>This 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.

<sup>34</sup>The 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.

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addresses and thus eligible for Medicare providers and suppliers.<sup>35</sup> 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.

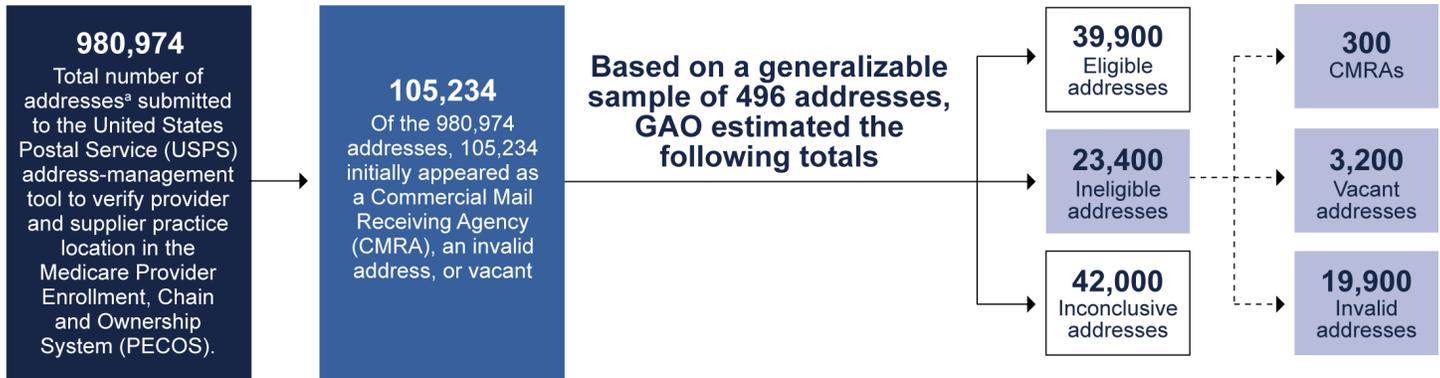
- About 42,000 (40 percent) of the 105,234 addresses could not be identified as either eligible or ineligible using the methods described above, and may warrant further review to make an eligibility determination.<sup>36</sup> Among those for whom we could not verify an address, we estimate that about 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.

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<sup>35</sup>This 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.

<sup>36</sup>For 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).

<sup>a</sup>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.<sup>37</sup> 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.<sup>38</sup> CMS

<sup>37</sup>The 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.

<sup>38</sup>As 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.

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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.<sup>39</sup>

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<sup>39</sup>The 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**



Provider listed this mailbox-rental store as its 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**



Provider listed this demolished site as its practice location

Source: GAO. | GAO-15-448

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

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receive a site visit to confirm the practice location unless their risk status changes.<sup>40</sup> 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.<sup>41</sup> 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."<sup>42</sup> The companies offering virtual offices advertise mailboxes, telephone-answering services, and a dedicated workspace to clients who are not physically located on the premises.<sup>43</sup> 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.

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<sup>40</sup>Although 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.

<sup>41</sup>The 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.

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

<sup>43</sup>Virtual 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.

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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.<sup>44</sup> 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.

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<sup>44</sup>The 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

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methods.<sup>45</sup> 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.<sup>46</sup> 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.<sup>47</sup> 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.

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<sup>45</sup>In 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.

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

<sup>47</sup>GAO, *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



Provider listed this mailbox within a UPS store as a suite number for a practice location

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.<sup>48</sup> 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.<sup>49</sup> 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

<sup>48</sup>As 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.

<sup>49</sup>Providers 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.

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felony offense that CMS has determined to be detrimental to the best interest of the program<sup>50</sup> 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.<sup>51</sup>

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.<sup>52</sup> 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;

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<sup>50</sup>42 C.F.R. § 424.535(a)(3)(i).

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

<sup>52</sup>According 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.

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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.<sup>53</sup> 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

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<sup>53</sup>According 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.

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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.<sup>54</sup> See appendix V for a breakdown of adverse actions identified in our review.

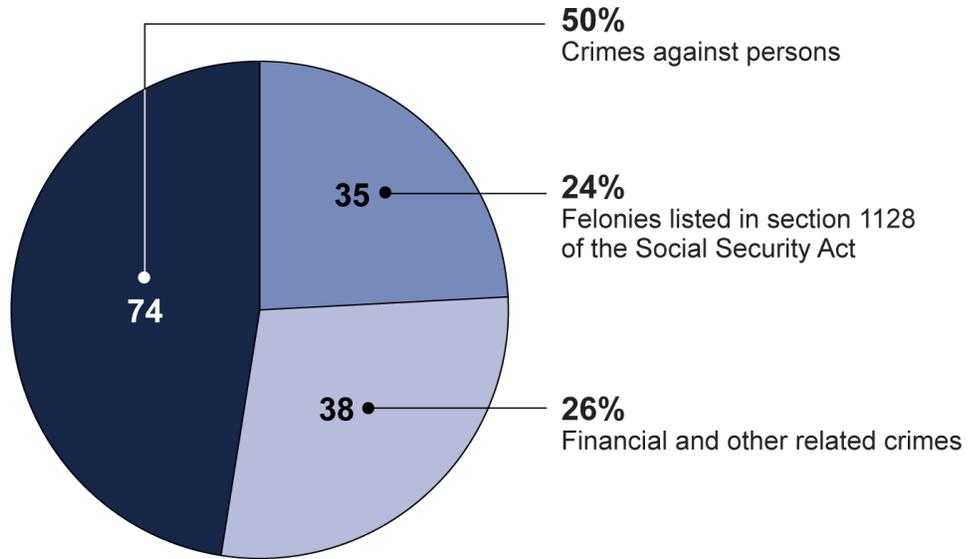
We followed up with the MACs to determine whether these physicians self-reported final adverse actions or whether MACs had identified any actions and revoked these physicians from the Medicare program. For 174 of the 321 physicians we identified as having adverse actions, MACs either revoked and later 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.<sup>55</sup> 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.

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<sup>54</sup> Adverse 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.

<sup>55</sup> We 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

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Medicare who do not self-report adverse actions for 1 year.<sup>56</sup> 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.

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### 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

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<sup>56</sup>A 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.

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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.<sup>57</sup> 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.<sup>58</sup> 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

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<sup>57</sup>We 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.

<sup>58</sup>According 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.

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

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.

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### 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

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<sup>59</sup>According 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.

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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.<sup>60</sup> 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.<sup>61</sup> 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.

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## 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

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<sup>60</sup>We 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.

<sup>61</sup>One 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.

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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.

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## 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

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

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## 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

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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

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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.

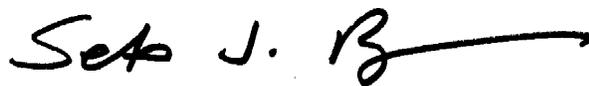
While providers are not currently required to list out-of-state license information in the enrollment application, CMS can independently collect this information by using other resources. For example, CMS can compare the provider's information to license databases, such as FSMB's, that identify all licenses 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.

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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](mailto: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

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*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

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# Appendix I: Objectives, Scope, and Methodology

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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.<sup>1</sup> In addition, we conducted interviews with five MACs,<sup>2</sup> 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

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<sup>1</sup>In 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.

<sup>2</sup>CMS contracts with 12 MACs that enroll providers and suppliers, except for DMPEPOS 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**,<sup>3</sup> 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.<sup>4</sup> 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

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<sup>3</sup>We will refer the USPS Address Matching System Application Program Interface as the USPS address-management tool.

<sup>4</sup>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.

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 Identifier<sup>5</sup> against the claims paid from 2005 to 2013, the period for which CMS has claims data.<sup>6</sup> 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.<sup>7</sup> For addresses flagged as vacant by the USPS address-management tool, we calculated the claims data from September 2013 to December 2013.<sup>8</sup> 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

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<sup>5</sup>We 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.

<sup>6</sup>For 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.

<sup>7</sup>If 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.

<sup>8</sup>If 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.<sup>9</sup> 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.<sup>10</sup> 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.

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<sup>9</sup>If 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.

<sup>10</sup>SSA 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.<sup>11</sup> 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.

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<sup>11</sup>Federal 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.

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

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

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

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**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 verifying<sup>a</sup>:

- (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 be 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

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

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**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.

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**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).

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

<sup>a</sup>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.<sup>1</sup> 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 <sup>a</sup>
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

<sup>a</sup>Post office boxes and drop boxes are not acceptable except where providers are located in rural areas.

<sup>1</sup>To 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.

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# Appendix IV: Breakdown of the Sample of 496 Addresses

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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.<sup>1</sup> For each selected address, we used Google Maps, Internet searches,<sup>2</sup> or physical site visits to confirm whether the practice location address was an eligible address.<sup>3</sup> For the 496 addresses we reviewed, we confirmed the following:<sup>4</sup>

- 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).<sup>5</sup>
  - The MACs and the NSC noted that 92 of the 120 addresses we found to be ineligible have not been updated in PECOS from

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<sup>1</sup>The 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.

<sup>2</sup>Internet searches include searching for the company website.

<sup>3</sup>An ineligible address can be a CMRA, a vacant property, or an invalid address.

<sup>4</sup>Note 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.

<sup>5</sup>The 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.

March 30, 2013, to October 2014.<sup>6</sup> 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.<sup>7</sup>

- 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.

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<sup>6</sup>CMS 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.

<sup>7</sup>We 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**

<b>Basis description</b>	<b>Actions resulting in revocations and suspensions</b>	<b>Physicians that remained or were not revoked for months from Medicare</b>
<b>Crimes against persons</b>		
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
<b>Total</b>	<b>135</b>	<b>74</b>
<b>Financial and other related</b>		
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
<b>Total</b>	<b>110</b>	<b>38</b>

**Appendix V: Actions Resulting in Revocations  
and Suspensions**

<b>Basis description</b>	<b>Actions resulting in revocations and suspensions</b>	<b>Physicians that remained or were not revoked for months from Medicare</b>
<b>1128 Social Security Act</b>		
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
<b>Total</b>	<b>76</b>	<b>35</b>
<b>Grand total</b>	<b>321</b>	<b>147</b>

Source: GAO. | GAO-15-448

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

MAY 20 2015

James Cosgrove  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mr. Cosgrove:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*" (GAO-15-448).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script that reads "Jim R. Esquea".

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**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

**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

**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.

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# Appendix VII: GAO Contact and Staff Acknowledgments

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## GAO Contact

Seto J. Bagdoyan, (202) 512-6722 or [bagdoyans@gao.gov](mailto:bagdoyans@gao.gov).

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## 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.

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