



Testimony
Before the Subcommittee on Oversight
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Representatives

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MEDICARE PROGRAM

Continued Action Required to Address Weaknesses in Provider and Supplier Enrollment Controls

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Chairman Murphy, Ranking Member DeGette, and Members of the Subcommittee:

I am pleased to appear before you today to discuss our previous work on the controls used to verify the eligibility of Medicare providers and suppliers and potential opportunities to recover overpayments to providers with criminal backgrounds.¹ Medicare is the federally financed health-insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.² In fiscal year 2015, Medicare paid \$568.9 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 \$59.6 billion (10.5 percent) of that total was paid improperly.³ 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.⁴ Further, because of its size, complexity, and susceptibility to

¹GAO, *Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers*, [GAO-15-448](#) (Washington, D.C.: June 25, 2015); *Medicare: Opportunities Exist to Recover Potential Overpayments to Providers with Criminal Backgrounds*, [GAO-16-365R](#) (Washington, D.C.: Apr. 13, 2016).

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

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

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

mismanagement and improper payments, we have designated Medicare as a high-risk program.⁵

To enroll in Medicare and bill for services provided to Medicare beneficiaries, CMS requires prospective providers and suppliers to be listed in the Provider Enrollment, Chain and Ownership System (PECOS). PECOS is a centralized database designed to contain providers' and suppliers' enrollment information. According to CMS, there were about 1.9 million health-care providers and suppliers enrolled in PECOS as of December 31, 2015.

My remarks today highlight the key findings of our June 2015 report on CMS's Medicare provider and supplier enrollment-screening procedures and our April 2016 report on potential overpayments to providers with criminal backgrounds. Accordingly, this testimony discusses the extent to which selected enrollment-screening procedures are designed and implemented to prevent and detect the enrollment of ineligible or potentially fraudulent Medicare providers and suppliers into PECOS.

In June 2015, we reported on the implementation of four enrollment-screening procedures that CMS uses to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling into PECOS, including verifying provider practice locations and physician licensure status, and screening for providers and suppliers listed as deceased or excluded from participating in federal programs or health care-related programs. To assess the extent to which CMS had controls to verify the eligibility of Medicare providers and suppliers, we reviewed CMS procedural manuals and directives, and interviewed CMS officials about provider and supplier enrollment-screening procedures. We matched the list of providers and suppliers present in PECOS, as of March 29, 2013, and durable medical equipment, prosthetics, orthotics, and supplies (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;⁶ (2) Federation of State Medical Boards (FSMB) licensure data;

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

⁶In this statement, we refer to the USPS Address Management System Application Program Interface as the USPS address-management tool.

(3) the Social Security Administration's (SSA) full death file;⁷ and (4) the HHS Office of Inspector General's (OIG) List of Excluded Individuals and Entities (LEIE) to determine whether ineligible or potentially fraudulent Medicare providers, suppliers, and DMEPOS suppliers were in PECOS. For the USPS address-management tool, we selected a generalizable sample from the addresses that the USPS address-management tool identified as being a Commercial Mail Receiving Agency (CMRA), vacant, or invalid and took additional steps to confirm whether the practice location address was an eligible address. In addition, we obtained Medicare claims data from 2005 through 2013 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. On the basis of our discussions with agency officials and our own testing, we concluded that the data elements used for this report were sufficiently reliable for our purposes. In November 2015, February 2016, and May 2016, CMS officials provided us with updates on actions taken to address our three recommendations made in the June 2015 report. From August 2015 through May 2016, CMS officials also provided updates on the actions taken on the cases we referred.

In April 2016, we reported on a fifth enrollment-screening process CMS used to conduct criminal-background checks on Medicare providers and suppliers. To assess the extent to which CMS had controls in place to verify criminal-background information for providers and suppliers in PECOS, we matched the PECOS data of approximately 1.2 million unique physicians and nonphysicians as of March 2013 to data from the Federal Bureau of Prisons and the National Sex Offender Registry as of February 2014, by Social Security number, name, and date of birth, to identify potentially ineligible providers.⁸ We also reviewed CMS supporting documentation and interviewed agency officials. We also

⁷SSA maintains death data including names, Social Security numbers, dates of birth, and dates of death. SSA shares a comprehensive file of this death information, which includes state death data, with certain eligible entities, including CMS, according to SSA. We used this comprehensive file, which we call the "full death master file," for our analysis. A subset of the full death master file that does not include state death data is available to the public.

⁸Our findings are based on data from 2013, the most-current data available to us at the time of our review. CMS implemented new procedures in April 2014 to update its criminal-background check process. Although CMS has new procedures in place, the results of our review of the 2013 data provide an opportunity for CMS to recover potential overpayments that were made prior to putting the revised procedures in place.

calculated Medicare claims that were paid to providers while they were potentially ineligible. We assessed the reliability of data and determined that these databases were sufficiently reliable for the purpose of our review. More details on our scope and methodology can be found in the issued reports.⁹ In May 2016, CMS officials provided us with an update on the 66 providers we referred to CMS for further review. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards.¹⁰

Limitations Exist in Certain CMS Screening Procedures for Preventing and Detecting Enrollment of Ineligible or Potentially Fraudulent Medicare Providers and Suppliers

In our June 2015 and April 2016 reports examining CMS screening procedures, we found weaknesses in CMS's verification of provider practice location, physician licensure status, providers listed as deceased or excluded from participating in federal programs or health care-related programs, and criminal-background histories. These weaknesses may have resulted in CMS improperly paying thousands of potentially ineligible providers and suppliers. We made recommendations to address these weaknesses, which CMS has indicated it has implemented or is taking steps to address. Additionally, as a result of our work, we referred 597 unique providers and suppliers to CMS. According to CMS officials, they have taken some actions to remove or recover overpayments from the potentially ineligible providers and suppliers we referred to them in April 2015 and April 2016, but CMS's review and response to the referrals are ongoing.

Practice Location Verification Procedures

In our June 2015 report, we found thousands of questionable practice location addresses for providers and suppliers listed in PECOS, as of March 2013, and DMEPOS suppliers, listed as of April 2013.¹¹ Under federal regulations, providers and suppliers must be "operational" to

⁹[GAO-15-448](#) and [GAO-16-365R](#).

¹⁰Those 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.

¹¹[GAO-15-448](#). All providers and suppliers must list a physical practice location address in their application, regardless of provider or supplier type.

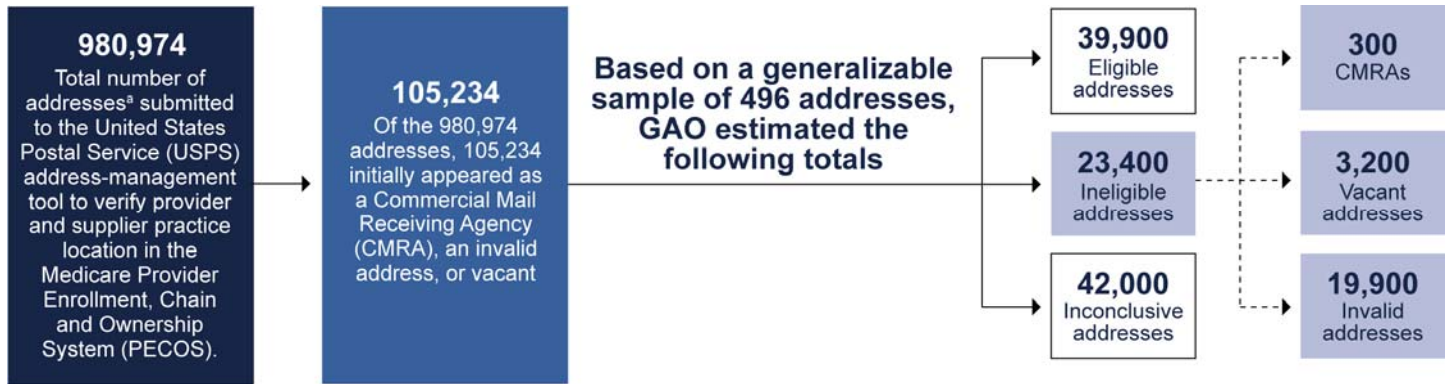
furnish Medicare covered items or services, meaning that they have a qualified physical practice location that is open to the public for the purpose of providing health care–related services. The location must be properly staffed, equipped, and stocked to furnish these items or services. Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of CMRA, such as a United Parcel Service (UPS) store.¹² We checked PECOS practice location addresses for all records that contained an address using the USPS address-management tool, a commercially available software package that standardizes addresses and provides specific flags on the address such as a CMRA, vacant, or invalid address.¹³ As illustrated in figure 1, on the basis of our analysis of a generalizable stratified random sample of 496 addresses, we estimate that about 23,400 (22 percent) of the 105,234 addresses we initially identified as a CMRA, vacant, or invalid address are potentially ineligible addresses.¹⁴ About 300 of the addresses were CMRAs, 3,200 were vacant properties, and 19,900 were invalid.

¹²On the basis of USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. Not all CMRAs would disqualify an applicant from PECOS enrollment. For example, a hospital may be legitimately designated as a CMRA and could be considered an eligible practice location. Post office boxes and drop boxes are not acceptable except in some cases where the provider is located in rural areas.

¹³The USPS address-management tool includes addresses as of December 15, 2013. This software is not currently being used by CMS. Instead, CMS uses the other software—called Finalist—to standardize practice location addresses. A vacancy refers to a provider or supplier that is no longer at the location provided on the application form. USPS would flag a location as vacant if it used to deliver mail there and has not delivered mail there in more than 90 days. An invalid address is when an address is not recognized by USPS, was incorrectly entered in PECOS, or was missing a street number.

¹⁴As part of our initial analysis using the USPS address-management tool, we identified 105,234 (about 11 percent) of the 980,974 address listed in PECOS that appeared in the USPS address-management tool as a CMRA, a vacant address, or an invalid address. For more information on our estimates and methodology, see [GAO-15-448](#).

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



Source: GAO. | GAO-16-703T

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

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

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

In our June 2015 report, we found limitations with CMS’s Finalist software used to validate practice location addresses. The Finalist software is one technique used by the Medicare Administrative Contractors (MAC) and the National Supplier Clearinghouse (NSC) to validate a practice

location.¹⁵ According to CMS, Finalist is integrated into PECOS to standardize addresses and does so by comparing the address listed on the application to USPS records and correcting any misspellings in street and city names, standardizing directional markers (such as NE or West) and suffixes (such as Ave. or Lane), and correcting errors in the zip code. However, the Finalist software does not indicate whether the address is a CMRA, vacant, or invalid address—in other words, whether the location is potentially ineligible to qualify as a legitimate practice location. CMS does not have these flags in Finalist because the agency added coding in PECOS that prevents post office box addresses from being entered, and believed that this step would prevent these types of ineligible practice locations from being accepted.

Further, some CMRA addresses are not listed as post office boxes. For example, in our June 2015 report we identified 46 out of the 496 sample addresses that were allowed to enroll in Medicare with a practice location that was inside a mailing store similar to a UPS store. These providers' addresses did not appear in PECOS as a post office box, but instead were listed as a suite or other number, along with a street address. Figure 2 shows an example of one provider we identified through our search and site visits as using a mailbox-rental store as its practice location and where services are not actually rendered. This provider's address appears as having a suite number in PECOS and remained in the system as of January 2015. According to our analysis of CMS records, this provider was paid approximately \$592,000 by Medicare from the date it enrolled in PECOS with this address to December 2013, which was the latest date for which CMS had claims data at the time of our review.¹⁶

¹⁵CMS contracts with the MACs and the 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 DMEPOS suppliers.

¹⁶The 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 2: 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-16-703T

Our June 2015 report also found locations that were vacant or addresses that belonged to an unrelated establishment. For example, we visited a provider's stated practice location in December 2014 and instead found a fast-food franchise there (see fig. 3—the name of the franchise has been blurred). In addition, we found a Google Maps image dated September 2011 that shows this specific location as vacant. Although the provider was not paid by Medicare from the date this practice location address was flagged as vacant, by remaining actively enrolled into PECOS, the provider may be eligible to bill Medicare in the future.

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



Source: GAO. | GAO-16-703T

In March 2014, CMS issued guidance to the MACs that revised the practice location verification methods by requiring MACs to only contact the person listed in the application to verify the practice location address and use the Finalist software that is integrated in PECOS to standardize the practice location address. Additional verification, such as using 411.com and USPS.com, which was required under the previous guidance, is only needed if Finalist cannot standardize the actual address.¹⁷ In our June 2015 report, we noted that our findings suggest that the revised screening procedure of contacting the person listed in the application to verify all of the practice location addresses may not be sufficient to verify such practice locations. For example, two providers in our sample of 496 addresses that the USPS address-management tool flagged as CMRA, invalid, or vacant successfully underwent a MAC revalidation process in 2014. The MAC used the new procedure of calling

¹⁷411.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.

the contact person to verify the practice location. Each of these two providers had a UPS or similar store as its practice location.

To help further improve CMS's enrollment-screening procedures to verify applicants' practice location, we made two recommendations to CMS in our June 2015 report. First, we recommended that CMS modify the CMS software integrated into PECOS to include specific flags to help identify potentially questionable practice location addresses, such as CMRA, vacant, and invalid addresses. The agency concurred with this recommendation. On May 16, 2016, CMS provided us with supporting documentation that shows that the agency replaced its current PECOS address verification software to include Delivery Point Verification (DPV)—which is similar to the software we used when conducting the work in the June 2015 report—as an addition to the existing functionality. According to CMS officials, this new DPV functionality flags addresses that may be CMRA, vacant, or invalid. By updating the address verification software, CMS can ensure that providers with ineligible practice location are not listed in PECOS.

Second, we recommended in our June 2015 report that CMS revise its guidance for verifying practice locations to include, at a minimum, the requirements contained in the guidance in place prior to March 2014. Such a revision would require that MACs conduct additional research, beyond phone calls to applicants, on the practice location addresses that are flagged as a CMRA, vacant, or invalid address to better ensure that the address meets CMS's practice location criteria. The agency did not concur with this recommendation, stating that the March 2014 guidance was sufficient to verify practice locations. However, our audit work shows that additional checks on addresses flagged by the address-matching software as a CMRA, vacant, or invalid can help verify whether the addresses are ineligible. As our report highlighted, we identified providers with potentially ineligible addresses that were approved by MACs using the process outlined in the existing guidance. Therefore, we continue to believe that the agency should update its guidance for verifying potentially ineligible practice locations. In February 2016, CMS officials told us that, as part of configuring the PECOS address verification software to include the DPV functionality and flag CMRAs, vacancies, invalid addresses, and other potentially questionable practice locations, the agency plans to validate the DPV through site visits and follow its current process to take administrative action if the results are confirmed. CMS officials told us that they believe that by implementing the first recommendation by incorporating software flags and revising its guidance for verifying potentially ineligible practice location, if necessary, the second

recommendation will be addressed. As of May 17, 2016, CMS had not provided us with details and supporting documentation of how it will revise its guidance. Accordingly, it is too early for us to determine whether the agency's actions would fully address the intent of the recommendation. We plan to continue to monitor the agency's efforts in this area.

CMS has taken some actions to remove or recover overpayments from potentially ineligible providers and suppliers that we referred to it, based on our June 2015 report. On April 29, 2015, we referred 286 unique providers to CMS for further review and action as a result of our identification of providers with potentially ineligible practice location address. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS has taken the following actions:

- taken administrative action to remove the provider or collect funds for 29 of the providers,¹⁸
- corrected the invalid addresses for 70,
- determined that the questionable location was actually valid for 84, and
- determined that the provider had already been removed from the program for 102.

However, CMS did not take action on 1 provider because it was unable to find the practice location for this provider.

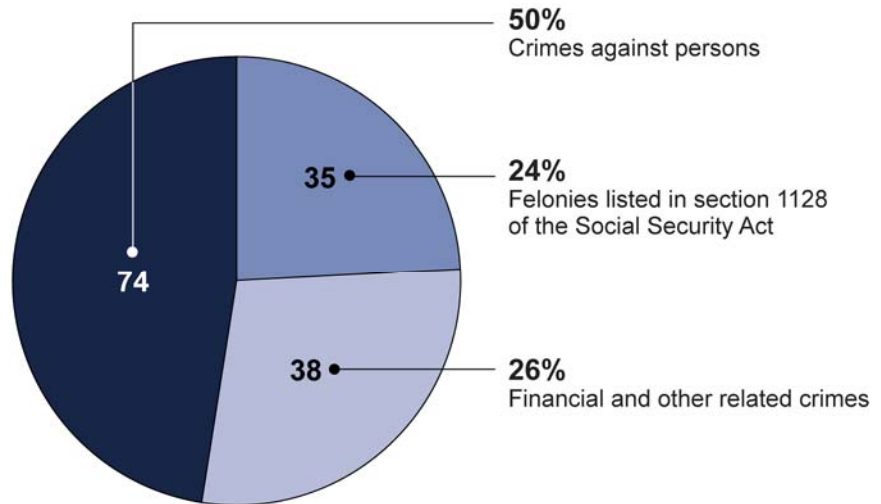
Applicants' Licensure Information Verification

In our June 2015 report, we found 147 out of about 1.3 million physicians with active PECOS profiles had received a final adverse action from a state medical board, as of March 2013. Adverse actions include crimes against persons, financial crimes, and other types of health care-related felonies. These individuals were either not revoked from the Medicare program until months after the adverse action or never removed (see fig. 4).¹⁹

¹⁸According to CMS, it plans to collect about \$7,900 from 2 of the 29 providers.

¹⁹[GAO-15-448](#).

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



Source: GAO. | GAO-16-703T

All physicians applying to participate in the Medicare program must hold an active license in the state they plan to practice in and also to self-report final adverse actions, which include a license suspension or revocation by any state licensing authority. CMS requires MACs to verify final adverse actions that the applicant self-reported on the application directly with state medical board websites. We found that because physicians are required to self-report adverse actions, the MACs did not always identify unreported actions when enrolling, revalidating, or performing monthly reviews of the provider.²⁰ 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.

²⁰According to CMS guidance, when an applicant first enrolls into Medicare, MACs must corroborate adverse legal actions and licensure information directly with state medical board websites. MACs must research all enrolled providers each month using multiple state medical board websites in their respective jurisdictions. Medicare providers must go through the revalidation process every 5 years.

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

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

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

In February 2016, CMS officials told us that CMS will take steps to ensure that all applicants' licensure information is evaluated as part of the screening process by MACs and the License Continuous Monitoring

report, as appropriate, and will also regularly review other databases for disciplinary actions against enrolled providers and suppliers. In May 2016, CMS officials stated that CMS has established a process to annually review databases and has incorporated the FSMB database into its screening process. On May 19, 2016, CMS officials provided us with supporting documentation that shows that the FSMB database was incorporated into its automatic screening process. By incorporating the FSMB database into its automatic screening process, CMS will be able to regularly check this database for licensure updates and disciplinary actions against enrolled providers and suppliers, as well as to collect all license information held by providers that apply to enroll in PECOS.

On April 29, 2015, we referred the 147 unique providers to CMS for further review and action as a result of our identification of revoked licenses. On the basis of our analysis of CMS's updates as of May 2016, CMS has taken the following actions:

- taken administrative action to remove the provider or collect funds for 21 providers,²¹
- determined that the provider had already been removed from the program for 48,
- determined that the adverse actions were disclosed or partially disclosed for 71, and
- has ongoing reviews of 6.

CMS did not take action on 1 provider because it was unable to find the adverse action for this provider.

Deceased and Exclusion Verification Procedures

In our June 2015 report, we found that about 460 (0.03 percent) out of the 1.7 million unique providers and suppliers in PECOS as of March 2013 and DMEPOS suppliers as of April 2013 were identified as deceased at the time of the data we reviewed.²² The MAC or CMS identified 409 of the

²¹ According to CMS, it plans to collect \$40,300 from 2 of the 21 providers.

²² [GAO-15-448](#). To help ensure that Medicare maintains current enrollment information and to prevent others from utilizing the enrollment data of deceased providers and suppliers, MACs are required to check that providers and suppliers in PECOS are not deceased.

460 providers and suppliers as deceased from March 2013 to February 2015. Additionally, 38 out of the 460 providers and suppliers we found to be deceased were paid a total of about \$80,700 by Medicare for services performed after their date of death until December 2013, which was the most-recent date CMS had Medicare claims data available at the time of our review. Not identifying a provider or supplier as deceased in a timely manner exposes the Medicare program to potential fraud. It is unclear what caused the delay or omission by CMS and the MACs in identifying these individuals as deceased or how many overpayments they are in the process of recouping.

On April 29, 2015, we referred 82 unique providers to CMS for further review and action as a result of our identification of providers whose status was deceased. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS has taken the following actions:

- taken administrative action to remove the provider for 4 of the providers,²³
- determined that the provider had already been removed from the program for 25,
- determined that the provider had already been removed from the program but updated the provider's PECOS profile to reflect the date of death for 22, and
- started but not completed the review on 31 providers that were reported to be deceased and had submitted claims for payments.²⁴

We found in our June 2015 report that about 40 (0.002 percent) out of the 1.7 million unique providers and suppliers enrolled in PECOS were listed in LEIE, as of March 2013.²⁵ These individuals were excluded from participating in health care–related programs. Of those 40 excluded providers and suppliers, 16 were paid approximately \$8.5 million by

²³According to CMS, it will not collect any claims on any of the 4 providers.

²⁴The remaining 31 cases were provided to CMS in April 2015. In October 2015, the agency confirmed that it will review these cases. As of May 2016, CMS has not provided supporting documentation that it has completed the review of these providers.

²⁵[GAO-15-448](#).

Medicare for services rendered after their exclusion date until the MAC or the NSC found them to be excluded.²⁶ When we followed up with the MACs in September and October 2014, we found that the MACs had removed 38 of the 40 providers and suppliers from PECOS from March 2013 to October 2014. However, for two matches that we identified, the MACs had not taken any action.²⁷ Given the small number of cases identified (40) and the MACs' removal of 38 out of these 40 providers during our review, we did not make a recommendation to CMS. On April 29, 2015, we referred the two providers that the MACs did not remove, as well as the 16 providers that were paid \$8.5 million by Medicare for services rendered after their exclusion date, to CMS for further review and action. From August 2015 to May 2016, CMS has provided updates on these referrals. On the basis of our analysis of CMS's updates, CMS did not take action on 2 providers because CMS deemed the providers eligible. Further, CMS has not completed the review on 14 providers that were reported to be excluded and had submitted claims for payments.²⁸

Criminal-Background Screening Procedures

As part of CMS's enrollment-screening process, CMS has controls in place to verify criminal-background information for providers and suppliers in PECOS. CMS may deny or revoke a provider's or supplier's enrollment in the Medicare program if, within the 10 years before enrollment or revalidation of enrollment, the provider, supplier, or any owner or managing employee of the provider or supplier was convicted of a federal or state felony offense, including certain felony crimes against persons, that CMS has determined to be detrimental to the best interests

²⁶We 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.

²⁷One 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.

²⁸The remaining 14 cases were provided to CMS in April 2015. As of May 2016, CMS has not provided supporting documentation that it has completed the review of these providers.

of the program and its beneficiaries.²⁹ In our April 2016 report, we found that 16 out of 66 potentially ineligible providers we identified with criminal backgrounds received \$1.3 million in potential overpayments. These providers were convicted of drug and controlled substance, health-care, mail and wire fraud, or sex-related offenses and were enrolled in Medicare before CMS had implemented more-extensive background check processes in April 2014.

Before CMS revised procedures for reviewing the criminal backgrounds of existing and prospective Medicare providers and suppliers in April 2014, the agency relied on verifying applicants' self-reported adverse legal actions by checking whether providers and suppliers had previously lost their licenses because of a conviction such as a crime against a person. CMS also checked whether the HHS OIG had excluded providers and suppliers from participating in federal health-care programs. According to CMS, it also relied on Zone Program Integrity Contractors (ZPIC) to identify providers and suppliers with a conviction history. However, CMS did not always have access to federal or state offense information that identified the cause of a provider's or supplier's license suspension or exclusion from participating in federal health-care programs, which could have led to an earlier ineligibility date.

In our April 2016 report, we found 52 providers whose offenses occurred before the removal effective date that was provided to us by the MACs and 14 additional providers that CMS did not remove. As mentioned earlier, out of these 66 providers, 16 were paid about \$1.3 million by Medicare through the fee-for-service program. Specifically, 10 providers were paid about \$1.1 million between the time they were initially convicted of a crime and the time that they were officially removed from the program, and six other providers that were not removed were paid about \$195,000 during the year after their conviction. We referred all 66 cases to CMS for further review and requested an initial status update on these providers by June 20, 2016. On May 16, 2016, CMS stated that it determined that 52 of the providers had already been deactivated or revoked; however, our report indicates that these providers were deactivated and revoked and the effective removal date needed review. Further, CMS indicated that it will continue to review these providers to

²⁹42 C.F.R. § 424.535 and 42 C.F.R. § 424.530.

determine whether additional updates or actions are needed since we found that these providers had offenses that occurred before the removal effective date that was provided by the MACs. Further, CMS informed us that it will continue to review the remaining 14 providers.

Additionally, in April 2016, we reported that in April 2014 CMS implemented steps that provide more information on the criminal backgrounds of existing and prospective Medicare providers and suppliers than it obtained previously. Specifically, CMS supplemented its criminal-background controls by screening provider and supplier criminal backgrounds through an automated screening process. Under this revised process, MACs are to review an applicant's self-reported license information and whether the applicant has been excluded from participating in federal health-care programs. In addition, CMS receives information from ZPICs, which provide a conviction history on providers and suppliers they investigate. The automated-screening contractor is to supplement these controls by conducting criminal-background checks on providers, suppliers, and organization principals (i.e., individuals with 5 percent or more ownership in the business). The contractor uses third-party vendor applications available to the public to conduct the criminal-background checks. As a result, CMS and its contractors obtain greater access to data about federal and state offenses and the ability to conduct a more-comprehensive review of provider and supplier criminal backgrounds than in the past.

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

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact me at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

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