



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

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# MEDICARE PROGRAM

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

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

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

I am pleased to appear before you today to discuss our June 2015 report on the controls used to verify the eligibility of Medicare providers and suppliers.<sup>1</sup> 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>2</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 of about \$49.9 billion.<sup>3</sup> Due to the program’s large estimated improper payments, the Office of Management and Budget has placed Medicare on its list of high-error programs in 2014.<sup>4</sup> Further, because of its size, complexity, and susceptibility to mismanagement and improper payments, we have long designated Medicare as a high-risk program.<sup>5</sup>

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

<sup>2</sup>Medicare 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.

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

<sup>4</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.

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

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

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

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

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

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



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

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

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<sup>8</sup>SSA 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.

<sup>9</sup>GAO-15-448.



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

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

We found thousands of questionable practice location addresses for providers and suppliers listed in PECOS, as of March 2013, and DMEPOS suppliers, listed as of April 2013.<sup>10</sup> Under federal regulations, providers and suppliers must be “operational” to furnish Medicare covered items or services, meaning that they have a qualified physical practice location that is open to the public for the purpose of providing health care-related services. The location must be properly staffed, equipped, and stocked to furnish these items or services. Addresses that generally would not be considered a valid practice location include post office boxes, and those associated with a certain type of CMRA, such as a United Parcel Services (UPS) store.<sup>11</sup> We checked PECOS practice location addresses for all records that contained an address using the USPS address-management tool, a commercially available software package that standardizes addresses and provides specific flags on the address such as a CMRA, vacant, and invalid address.<sup>12</sup> As illustrated in figure 1, based on our analysis of a generalizable stratified random sample of 496 addresses, we estimate that about 23,400 (22 percent) of the 105,234 addresses we initially identified as a CMRA, vacant, or invalid address are potentially ineligible addresses.<sup>13</sup> About 300 of the

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

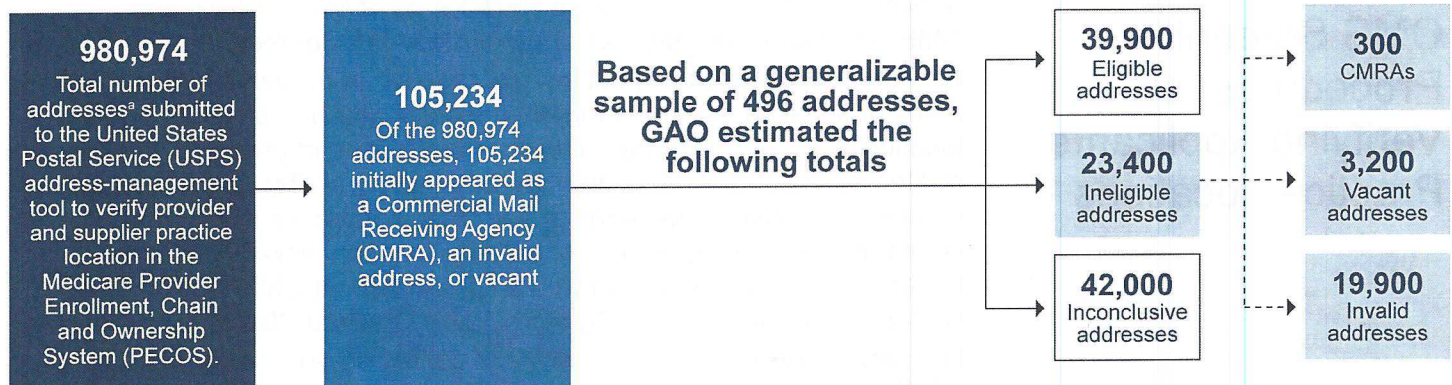
<sup>11</sup>Based on USPS guidance, a CMRA is a third-party agency that receives and handles mail for a client. Not all CMRAs would disqualify an applicant from PECOS enrollment. For example, a hospital may be legitimately designated as a CMRA and could be considered an eligible practice location. Post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

<sup>12</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 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.

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

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

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



Source: GAO. | GAO-15-762T

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

<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.

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

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



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

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



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



Provider listed this mailbox-rental store as its practice location

Source: GAO. | GAO-15-762T

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

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



Source: GAO. | GAO-15-762T

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

<sup>14</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.



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

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

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## Limitations Exist in Verifying Applicants' Licensure Information

We found 147 out of about 1.3 million physicians with active PECOS profiles had received a final adverse action from a state medical board, as of March 2013. Adverse actions include crimes against persons, financial crimes, and other types of health-care related felonies. These individuals were either not revoked from the Medicare program until months after the adverse action or never removed (see fig. 4).<sup>15</sup> 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

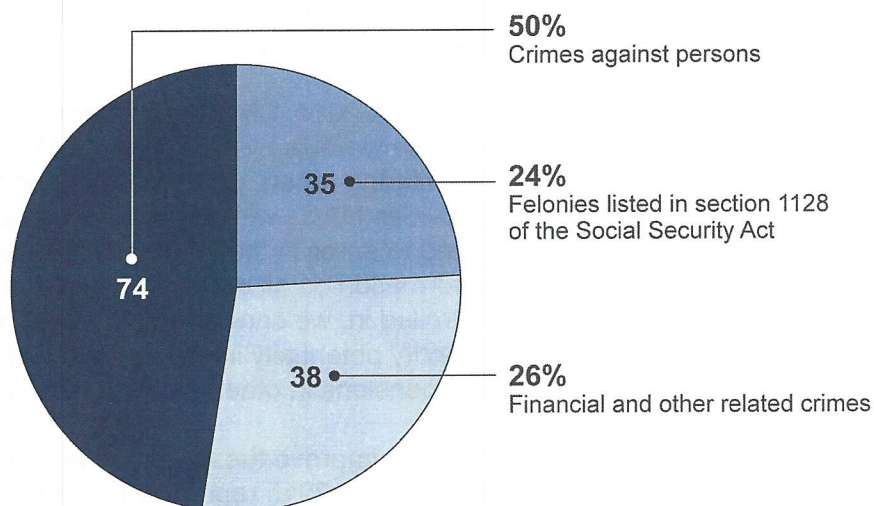
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<sup>15</sup>GAO-15-448.



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

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



Source: GAO. | GAO-15-762T

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

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

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

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

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



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

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

We found that about .002 percent (40) out of the 1.7 million unique providers and suppliers enrolled in PECOS were listed in the List of Excluded Individuals and Entities (LEIE), as of March 2013.<sup>18</sup> These individuals were excluded from participating in health care–related programs. Of those 40 excluded providers and suppliers, 16 were paid approximately \$8.5 million by Medicare for services rendered after their exclusion date until the MAC or the NSC found them to be excluded.<sup>19</sup> 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.<sup>20</sup> Given

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<sup>17</sup>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.

<sup>18</sup>GAO-15-448.

<sup>19</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>20</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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the small number of cases identified (40) and the MACs removal of 38 out of these 40 providers during our review, we did not make a recommendation to CMS. However, we referred the two providers that the MACs did not remove as well as the 16 providers that were paid \$8.5 million by Medicare for services rendered after their exclusion date, to CMS for further review and action.

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

For questions about this statement, please contact me at (202) 512-6722 or [BagdoyanS@gao.gov](mailto: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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# GAO Contact and Staff Acknowledgments

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## Staff Acknowledgments

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