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Testimony of CareSource  
In Support of GAO Report “Medicare Programs: Additional  
Actions Needed to Improve Eligibility Verification of  
Providers and Suppliers”  
Before the Senate Special Committee on Aging  
July 22, 2015

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

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

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

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

### **Verification of Provider Practice Location**

CareSource verifies provider practice locations in many ways:

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

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

## Physician Licensure Verification

CareSource verifies physician licensure status in the following ways:

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

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

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

## Other Methods of Fraud Detection

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

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

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

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

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

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