

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE:
VULNERABILITIES RELATED
TO PROVIDER ENROLLMENT
AND OWNERSHIP
DISCLOSURE**



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EXECUTIVE SUMMARY – MEDICARE: VULNERABILITIES RELATED TO PROVIDER ENROLLMENT AND OWNERSHIP DISCLOSURE OEI-04-11-00591

WHY WE DID THIS STUDY

The Centers for Medicare & Medicaid Services (CMS) can prevent inappropriate payments, protect beneficiaries, and reduce time-consuming and expensive “pay and chase” activities by ensuring that providers that intend to engage in fraudulent or abusive activities are not allowed to enroll in Medicare. For CMS to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, providers must disclose accurate and timely information about their owners (i.e., individuals or corporations with a 5-percent or more ownership or controlling interest; agents; or managing employees).

HOW WE DID THIS STUDY

For selected providers, we compared three sets of owner names: (1) those on record with CMS for Medicare enrollment purposes, (2) those submitted by providers directly to the Office of Inspector General (OIG) for this evaluation, and (3) those on record with State Medicaid programs for Medicaid enrollment purposes. When we compared names, if we found owner names that were not identical but were reasonably similar, we considered the names to match. Additionally, we surveyed CMS’s Medicare Administrative Contractors regarding their checking of exclusions databases when they process Medicare enrollment applications.

WHAT WE FOUND

Over three-quarters of Medicare providers in our review had owner names on record with CMS that did not match those that providers submitted to OIG. Further, nearly all providers in our review had owner names on record with CMS that did not match those on record with State Medicaid programs. The prevalence of nonmatching owner names raises concern about the completeness and accuracy of information about Medicare providers’ ownership. It also demonstrates that providers may not be complying with the requirement to report ownership changes to CMS. Additionally, 2 of the 11 CMS contractors did not check all required exclusions databases, which could allow providers with excluded owners to enroll in the Medicare program. The two contractors reported that they checked only one of two exclusions databases, and this database does not always have the most current information on excluded individuals and entities. Taken together, these findings reveal vulnerabilities that could allow potentially fraudulent providers to enroll in the Medicare program and limit CMS’s ability to provide adequate oversight.

WHAT WE RECOMMEND

We recommend that CMS (1) review providers that submitted nonmatching owner names and take appropriate action, (2) educate providers on the requirement to report changes of ownership, (3) increase coordination with State Medicaid programs on the collection and verification of provider ownership information in Medicare and Medicaid, and (4) ensure that its contractors check exclusions databases as required. CMS concurred with all of our recommendations.

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OBJECTIVES

To determine the extent to which:

1. Owner names on record with the Centers for Medicare & Medicaid Services (CMS) matched the names submitted to the Office of Inspector General (OIG) for this evaluation and the names on record with State Medicaid programs.
2. CMS's contractors checked exclusions databases as part of the Medicare enrollment process.

RATIONALE

CMS can prevent inappropriate payments, protect beneficiaries, and reduce time-consuming and expensive “pay and chase” activities by ensuring that providers that intend to engage in fraudulent or abusive activities are not allowed to enroll in Medicare.¹ For CMS to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, providers must disclose information on owners and others with control interest in the business.

However, in some health care fraud schemes, individuals have concealed providers' true ownership from the Medicare program. For example, in October 2009, an individual in southern California was indicted for a scheme in which he allegedly recruited relatives and street gang members to pose as the “nominee owners”² of various companies selling durable medical equipment.³ The nominee owners then allegedly submitted fraudulent claims to Medicare, totaling more than \$11 million. This individual later pled guilty to one felony count of Medicare fraud and faced up to 10 years in prison.⁴ Additionally, in February 2013, an

¹ “Provider” means a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice, that has in effect an agreement to participate in Medicare; or a clinic, rehabilitation agency, or public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services; or a community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services. 42 CFR § 400.202.

² A “nominee owner” is a “straw owner”—someone who is an owner in name only.

³ Department of Justice (DOJ), *Justice News: Los Angeles Medicare Fraud Strike Force Charges 20 in Health Care Fraud Cases Involving Durable Medical Equipment*, October 21, 2009. Accessed at <http://www.justice.gov/opa/pr/los-angeles-medicare-fraud-strike-force-charges-20-health-care-fraud-cases-involving-durable> on December 9, 2015.

⁴ California Criminal Attorney Blog, *Santa Ana Man Pleads Guilty to \$26-million Medicare Fraud Scheme*, April 23, 2010. Accessed at http://www.californiacriminalattorneyblog.com/2010/04/santa_ana_man_pleads_guilty_to.html.

individual in Florida pled guilty for his role in using a holding company to purchase facilities that fraudulently billed Medicare \$28.3 million.⁵ This individual and his co-conspirators then sold the facilities to nominee owners in an attempt to disassociate from the facilities' fraudulent operations. This individual later pled guilty to conspiracy to commit health care fraud and faces up to 15 years in prison.⁶

There are also concerns about provider ownership information in Medicaid. In a companion report issued concurrently with this report, OIG found that few State Medicaid programs requested that providers disclose all required ownership information.⁷ In addition, 14 State Medicaid programs reported that they did not verify the completeness or accuracy of provider ownership information. OIG also found that 14 State Medicaid programs reported that they do not check all required exclusions databases. Additionally, when we compared the owner names on record with State Medicaid programs with the owner names that providers submitted to OIG for this review, most did not match.

BACKGROUND

Medicare Ownership Disclosure

When enrolling in Medicare, providers must disclose specific information to CMS, including the identity of any person who has an ownership or controlling interest of 5 percent or more, or is an agent or managing employee.⁸ (In this report, we refer to all four types as “owners.”) Providers enrolling in Medicare must also disclose whether any owners have been convicted of a criminal offense, subjected to any civil monetary penalties, or excluded from participating in federally funded health care programs.⁹

⁵ DOJ, *Justice News: Leader of \$28.3 Million Medicare Fraud Scheme Pleads Guilty*, February 3, 2014. Accessed at <http://www.justice.gov/opa/pr/leader-283-million-medicare-fraud-scheme-pleads-guilty> on December 9, 2015.

⁶ Herald-Tribune, *Florida man pleads guilty to Medicare fraud*, February 4, 2014. Accessed at <http://www.heraldtribune.com/article/20140204/ARTICLE/140209890> on December 11, 2015.

⁷ OIG, *Medicaid: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure* (OEI-04-11-00590), May 2016.

⁸ Social Security Act §§ 1124(a)(2)(B) and 1124A(a)(1)-(2); 42 CFR § 420.206(a)(1). In Medicaid, providers that are enrolling must also disclose the name and address of any person (individual or corporation) with an ownership or control interest or managing employee. 42 CFR §§ 455.104(b) and 420.206(a)(3).

⁹ 42 CFR § 420.204(a)(3). In Medicaid, providers that are enrolling must disclose whether any owners have been convicted of a criminal offense related to the provider's involvement in Medicaid or Medicare. 42 CFR § 455.106(a)(1)-(2).

Once enrolled in Medicare, providers must report changes of ownership or control to CMS within 30 days of the change.¹⁰ In addition, providers must revalidate (i.e., resubmit and recertify) enrollment information every 5 years and suppliers must revalidate every 3 years.¹¹

Regulations require CMS not to enroll providers that fail to disclose all required information, and to terminate any existing agreements or contracts with such providers.¹² Additionally, CMS may revoke providers from the Medicare program if any requirements, such as reporting changes of ownership or control within 30 days, are not met.¹³ Although CMS states that it generally does not take administrative action against providers for not updating their enrollment records, CMS will do so in certain situations where the failure to report the change would have caused the provider to be ineligible for enrollment in the Medicare program.¹⁴

Collection and Verification of Provider Ownership Information

CMS contracts with Medicare Administrative Contractors (MACs) to conduct several tasks, such as processing and verifying providers' ownership information. To enroll in Medicare or update existing enrollment information, providers enter information into the Internet-based Provider Enrollment, Chain, and Ownership System (PECOS) or use the paper enrollment application process (e.g., CMS's 855A Form), which MACs then process through PECOS.¹⁵

PECOS is an electronic Medicare enrollment system through which providers can submit and track the status of Medicare enrollment applications; view, print, and update enrollment information; complete the

¹⁰ 42 CFR § 424.516(e)(1). In Medicaid, enrolled providers must report changes of ownership to State Medicaid programs within 35 days of the change. 42 CFR § 455.104(c)(1)(iv).

¹¹ 42 CFR § 424.515. State Medicaid programs must revalidate provider enrollment information every 5 years. 42 CFR § 455.114.

¹² 42 CFR § 420.206(c).

¹³ Section 15 of Forms CMS-855A and CMS-855B. Accessed at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855a.pdf> and <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855b.pdf>, respectively, on July 16, 2015.

¹⁴ CMS, *Frequently Asked Questions: Will there be a penalty for not reporting the ownership change?* Accessed at <https://questions.cms.gov/faq.php?id=5005&faqId=9674> on November 12, 2014.

¹⁵ 42 CFR § 424.510. See also CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.1.3.B.

revalidation process; and voluntarily withdraw from the Medicare program.^{16, 17}

MACs are required to review providers' disclosed information, including ownership information, to determine its completeness and whether all required information and supporting documentation has been submitted.¹⁸ Specifically, MACs must ensure that the provider has completed all required data elements in PECOS or on the CMS-855 form, that all supporting documentation has been furnished, and that the application was completed in accordance with instructions.¹⁹ If an application is incomplete, MACs inform providers by letter and request that missing information be submitted within 30 days.²⁰

MACs are also required to verify all disclosed information using the most cost-effective methods available.²¹ The general purpose of the verification process is to ensure that all data furnished on applications are accurate.²² Examples of verification techniques include, but are not limited to, visiting provider Web sites; using third-party sources for data validation; checking Web sites for professional licensure and certification in the State (e.g., a medical board's Web site); checking State business Web sites²³; and checking the Yellow Pages.²⁴ If MACs cannot verify providers' information, they request additional information and, if necessary, conduct site visits.

¹⁶ CMS, *PECOS for Physicians and Non-Physician Practitioners*, July 2015. Accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MEDEnroll_PECOS_PhysNonPhys_FactSheet_ICN903764.pdf on December 9, 2015.

¹⁷ CMS has provided State Medicaid programs with limited access to PECOS to determine if a provider is currently enrolled, is enrolling, or has been denied enrollment in the Medicare program. CMS, *CMCS Informational Bulletin: Medicaid/CHIP Provider Screening and Enrollment*, December 23, 2011. Accessed at <http://www.medicare.gov/Federal-Policy-Guidance/downloads/CIB-12-23-11.pdf> on October 28, 2015.

¹⁸ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.1.3.C.

¹⁹ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, §§ 15.7 and 15.1.3.B.

²⁰ CMS, *Frequently Asked Questions: Will I be contacted if my application is found to be incomplete or missing information?* Accessed at <https://questions.cms.gov/faq.php?id=5005&faqId=9190> on November 12, 2014.

²¹ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.7.1.3.

²² Ibid.

²³ For example, the Web sites of the respective Secretaries of State.

²⁴ Ibid.

MACs approve, deny, or reject providers' enrollment applications based on their review.²⁵

Program Exclusions

As part of the process of enrolling providers in Medicare, MACs are required to confirm that providers' disclosed owners are not excluded by OIG or listed as excluded in the General Services Administration's Excluded Parties List System (EPLS).^{26,27} To do so, MACs must check providers against OIG's List of Excluded Individuals/Entities (LEIE) and the EPLS.²⁸ The LEIE is a database that contains all individuals and entities currently excluded by OIG from participating in federally funded health care programs.²⁹ The EPLS is a Governmentwide database with information on individuals and entities that have been suspended or excluded from receiving Federal financial assistance and benefits.³⁰ If the provider or any of its owners are excluded, then the MAC must deny the enrollment application.³¹

"Off-Cycle" Revalidation of Provider Enrollment Information

In addition to the regular once-every-5-years provider revalidation process, CMS has the authority to conduct "off-cycle" revalidations to assess and confirm the validity of enrollment information maintained in its systems.³² Factors that can trigger off-cycle revalidations include random checks, local problems with health care fraud, national initiatives, complaints, or other reasons that cause CMS to question providers' compliance with Medicare enrollment requirements.³³ As a result of the Patient Protection and Affordable Care Act, CMS must use the new

²⁵ 42 CFR §§ 424.502, 424.525, and 424.530. See also CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.1.1. A decision of "deny" means that the enrolling provider has been determined to be ineligible to receive Medicare billing privileges. "Reject" means that the provider's enrollment application was not processed due to incomplete information or that additional information or corrected information was not received from the provider in a timely manner.

²⁶ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.1.3.C.

²⁷ In July 2012, the EPLS was consolidated with other Federal procurement systems into the System for Award Management (SAM). Phase I consolidation included the Central Contractor Registration/Federal Agency Registration, the Online Representations and Certifications Application, and the EPLS. *What is SAM?* Accessed at <https://www.sam.gov/sam/announce1.htm> on September 1, 2015.

²⁸ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.1.3.C. 76 Fed. Reg. 5866, 5884 (Feb. 2, 2011).

²⁹ OIG, *List of Excluded Individuals and Entities Background Information*. Accessed at <http://oig.hhs.gov/exclusions/background.asp> on October 28, 2015.

³⁰ 71 Fed. Reg. 70515–70516 (Dec. 5, 2006).

³¹ 42 CFR § 424.530(a)(2)(i). See also CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 15, § 15.8.4.

³² 42 CFR § 424.515(d).

³³ *Ibid.*

enrollment criteria to complete an off-cycle revalidation for each provider that was enrolled in Medicare prior to March 25, 2011.³⁴

METHODOLOGY

We used multiple data collection activities and sources for this report. First, for selected providers, we collected and compared three sets of owner names: (1) those on record with CMS for Medicare enrollment purposes, (2) those submitted by providers to OIG for this evaluation, and (3) those on record with State Medicaid programs for Medicaid enrollment purposes.³⁵ We collected this information between December 2013 and April 2014. For 110 providers enrolled in Medicare, we compared the owner names on record with CMS to those that providers submitted to OIG. For the 58 of these providers that were enrolled in both Medicare and Medicaid, we also compared owner names on record with CMS to those on record with State Medicaid programs for Medicaid enrollment purposes.

We also completed an additional analysis on owner names submitted to OIG that were not on record with CMS. Specifically, we analyzed the effective dates for a given owner's ownership to determine whether the dates fell within the 30-day window during which providers are required to notify CMS of such changes. If dates fell within this window, providers still had time to notify CMS of the change. In January 2015, approximately 1 year after providers submitted owner names to us for this evaluation, we collected and reviewed the updated owner names for these providers in PECOS to determine whether the providers had notified CMS of their ownership changes.

Next, in August 2012, we sent an electronic questionnaire to 11 MACs.³⁶ The electronic questionnaire collected information on how each MAC collects and processes ownership information disclosed by providers. In particular, we asked whether each MAC compared ownership information that providers disclosed to the LEIE and EPLS.

See the Appendix for a detailed description of the methodology.

³⁴ The Patient Protection and Affordable Care Act, P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), § 6401(a). 76 Fed. Reg. 5866 (Feb. 2, 2011) outlines new enrollment screening criteria.

³⁵ Provider types in our review are ambulatory surgical centers, ambulance services, independent clinical laboratories, comprehensive outpatient rehabilitation facilities, home health agencies, hospices, and renal disease facilities.

³⁶ Eleven MACs were operational at the time of our data collection in August 2012.

Limitations

We did not attempt to collect information not reported or verify information that providers submitted to OIG. For example, providers did not always report the effective date for a given owner's ownership. We did not attempt to collect these dates if providers had not reported them, nor did we did not attempt to verify such dates if providers had reported them.

Additionally, the matching of owner names across two or more sources did not necessarily mean that ownership information was complete and accurate. Providers could have submitted information that was incomplete and/or inaccurate—but that matched—to CMS, OIG, and/or State Medicaid programs.

Finally, the results of comparisons are not projected and pertain only to the providers in our review included in each comparison.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

The prevalence of nonmatching owner names raises concern about the completeness and accuracy of information about Medicare providers' ownership

Overall, very few (4 of 58) providers in our review had owner names that matched across all 3 sources (i.e., CMS, OIG, and State Medicaid programs). The prevalence of nonmatching owner names raises concern about the completeness and accuracy of information about Medicare providers' ownership.

For over three-quarters of providers in our review, owner names on record with CMS did not match those submitted to OIG

When we compared the owner names on record with CMS for Medicare enrollment purposes to those that providers submitted to OIG for this evaluation, we found that 77 percent of providers in our review (85 of 110) had at least one nonmatching owner name. For 80 providers, some owner names matched and some did not match. For five providers, none of the owner names matched. Table 1 shows the extent to which owner names matched for the 110 providers in our review.

Table 1: Extent to Which Owner Names On Record With CMS Matched Those Submitted to OIG, 2013

Description	Number of Providers	Percentage of Providers
Not all owner names matched	85	77.3%
- Some—but not all—owner names matched	80	72.7%
- No owner names matched	5	4.5%
All owner names matched	25	22.7%
Total	110	100.0%

Source: OIG analysis of ownership information on record with CMS and ownership information submitted to OIG, 2015.

Additionally, it appears that some providers in our review did not notify CMS of changes in ownership within the required timeframe. Forty-eight providers in our review submitted 168 owner names to OIG that were not on record with CMS. Of these 48 providers, 39 reported the effective dates of ownership for 127 owners. For 91 percent of these owners (115 of 127), the effective dates fell outside the 30-day window during which providers are required to notify CMS of ownership changes. Approximately 1 year later, PECOS did not contain the information for

6 of the remaining 12 owners, indicating that CMS continued to be unaware of these ownership changes.

For nearly all providers in our review, owner names on record with CMS did not match those on record with State Medicaid programs

Although Medicare and Medicaid ownership information is collected and maintained separately, CMS and State Medicaid programs should have the same owner names for providers enrolled in both programs. However, when comparing owner names on record with CMS for Medicare enrollment purposes to those on record with State Medicaid programs for Medicaid enrollment purposes, we found that 90 percent of providers in our review (52 of 58) had at least one nonmatching owner name. For 44 providers, some owner names matched and some did not match. For eight providers, none of the owner names on record with CMS matched those on record with State Medicaid programs. Table 2 shows the extent to which owner names matched for the 58 providers in our review.

Table 2: Extent to Which Owner Names On Record With CMS Matched Those On Record With State Medicaid Programs, 2013

Description	Number of Providers	Percentage of Providers
Not all owner names matched	52	89.7%
- Some—but not all—owner names matched	44	75.9%
- No owner names matched	8	13.8%
All owner names matched	6	10.3%
Total	58	100.0%

Source: OIG analysis of ownership information on record with CMS and ownership information on record with State Medicaid programs, 2015.

Two of eleven CMS contractors reported that they did not check all required exclusions databases, which could allow providers with excluded owners to enroll in Medicare

MACs are required to check two databases—the LEIE and the EPLS—as part of the Medicare enrollment process to confirm that individuals or entities that providers disclosed as owners are not excluded. Nine of eleven MACs reported that they check both the LEIE and the EPLS to

confirm this. The remaining two MACs reported that they do not check the LEIE but do check the EPLS.³⁷

The two MACs that reported that they checked only the EPLS—not the LEIE—could inadvertently enroll providers with excluded owners. Although the EPLS includes information from the LEIE on excluded individuals and entities, there is a delay between when that information is posted to the LEIE and when it is uploaded to the EPLS. If a MAC searches the EPLS during that delay, the EPLS will be less current than the LEIE.

³⁷ CMS conducts automatic checks of providers in PECOS against its Medicare Exclusion Database (MED) on a monthly basis. The MED is similar to the LEIE, but the MED contains more personally identifiable information.

CONCLUSION AND RECOMMENDATIONS

CMS can prevent inappropriate payments, protect beneficiaries, and reduce time-consuming and expensive “pay and chase” activities by ensuring that providers that intend to engage in fraudulent or abusive activities are not allowed to enroll in Medicare. For CMS to identify potentially fraudulent providers, as well as those that may be associated with excluded individuals or entities, providers must disclose accurate and timely information about their owners.

However, very few providers in our review had owner names that matched across all three program sources—i.e., CMS, OIG, and State Medicaid programs. The prevalence of nonmatching owner names raises concerns about the completeness and accuracy of information about Medicare providers’ ownership. Further, the matching of owner names across two or more sources does not mean that ownership information is complete and accurate because providers could have submitted information that was incomplete and/or inaccurate—but that matched—to CMS, OIG, and State Medicaid programs. Additionally, we found that 2 of 11 MACs did not comply with the requirement to check both the LEIE and EPLS to confirm that individuals or entities that providers disclosed as owners were not excluded.

Taken together, these findings reveal vulnerabilities that could allow potentially fraudulent providers to enroll in the Medicare program and limit CMS’s ability to provide adequate oversight. Therefore, we recommend that CMS:

Review providers that submitted nonmatching owner names and take appropriate action

In a separate memorandum, we will refer to CMS the 85 providers that had owner names on record with CMS that did not match those submitted to OIG. CMS and/or its contractors should review these providers’ enrollment records in PECOS. After this review, CMS should determine and take an appropriate course of action.

Educate providers on the requirement to report changes of ownership

CMS should educate providers on the requirement to report changes of ownership to CMS within 30 days and the actions it may take if providers do not comply with this requirement. CMS could communicate this information to providers through the Medicare Learning Network or could instruct the MACs to conduct outreach and education on this issue.

Increase coordination with State Medicaid programs on the collection and verification of provider ownership information in Medicare and Medicaid

CMS should coordinate with State Medicaid programs on the collection and verification of ownership information for providers enrolling or enrolled in Medicare and Medicaid. For example, CMS could encourage State Medicaid programs to use their access to PECOS when verifying provider ownership information and to notify MACs when nonmatching information is identified. State Medicaid programs and MACs could then collaborate to determine why provider ownership information does not match and address the issue.

In the longer term, CMS should consider working toward consolidating into one centralized system the ownership information for providers enrolling or enrolled in Medicare and/or Medicaid. This would make processes more efficient by reducing the burden on providers and streamlining the enrollment process—providers would no longer have to separately disclose ownership information both to CMS and to their respective States' Medicaid programs.

Ensure that its contractors check exclusions databases as required

CMS should ensure that all MACs—as part of their respective Medicare provider enrollment processes—check the LEIE and EPLS, as required, to confirm that individuals and entities that providers disclosed as owners are not excluded. The checking of exclusions databases is an important safeguard that helps ensure that excluded individuals and entities are kept out of the Medicare program. CMS could ensure that MACs conduct these required checks as part of its performance evaluations of MACs and/or through some other process (e.g., by requiring MACs to attest that they conduct the exclusions checks).

In the aforementioned referral memorandum, we will refer to CMS the two contractors that reported not checking the LEIE.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all four of our recommendations. In its comments, CMS stated that it is strongly committed to Medicare program integrity efforts and is continuously working to enhance the process for provider enrollment and screening. CMS stated that since 2011, when it finalized regulations to require the revalidation of Medicare providers, it has taken several actions to address this requirement. For example, CMS deactivated billing privileges for more than 543,000 providers and suppliers as a result of revalidation and screening efforts.

CMS stated that it will implement a number of actions to address OIG's recommendations. For example, CMS will review the list of providers and suppliers that OIG identified as having owner names on record with CMS that did not match those submitted to OIG. CMS will develop educational materials for providers and suppliers and work with States and other relevant stakeholders to enhance processes for collecting and verifying provider ownership information. CMS also stated that it has already taken action to address our fourth recommendation. OIG provided preliminary information to CMS regarding the two contractors that reported checking one but not both of the required exclusions databases. CMS followed up with these two contractors, and the contractors attested to checking these exclusions databases. The two contractors stated that that they had mistakenly provided incorrect information to OIG.

The full text of CMS's comments is provided in Appendix B. We did not make changes to the report based on CMS's comments.

APPENDIX A

Detailed Methodology

Provider Selection

We selected a random sample of 170 providers that were enrolled in Medicare and/or Medicaid as of January 1, 2012, in specific provider types.³⁸ We designed the sample such that the results of our review would be projectable. However, as our data analysis progressed, it became clear that providers enrolled in two State Medicaid programs were overrepresented in the population because duplicate providers had not been removed before we selected our sample.³⁹

We selected the 170 providers using 2 population files in such a way that 30 providers were enrolled in Medicare, 30 providers were enrolled in Medicaid, and 110 providers were enrolled in Medicare and Medicaid.

- The first population file consisted of 34,984 records for providers enrolled in Medicare as of January 1, 2012, in our specified provider types. To create this file, we extracted identification and contact information from PECOS.⁴⁰ In particular, for each provider, we collected the name, provider type, address, phone number, national provider identifier (NPI), and tax identification number (TIN). We then selected from this file 30 records that were associated with 30 distinct providers enrolled in Medicare.
- The second population file consisted of 35,394 providers enrolled in Medicaid as of January 1, 2012, in our specified provider types. To create this file, we requested and received identification and contact information from each of the 52 State Medicaid programs on individual and nonindividual providers, including those in our specified provider types, enrolled as of January 1, 2012.⁴¹ In particular, for each provider, we requested the name, provider type,

³⁸ Provider types in our review are ambulatory surgical centers, ambulance services, independent clinical laboratories, comprehensive outpatient rehabilitation facilities, home health agencies, hospices, and renal disease facilities.

³⁹ To project the results of our analysis, we would have needed to remove duplicate providers from the population, sample providers again, and collect ownership information again. Because we did not identify this duplication until our data were collected, we did not do this because of the time and resources it would require. Therefore, we do not make projections in this report.

⁴⁰ We used a snapshot of PECOS to ensure that this population file consisted of providers enrolled in Medicare as of January 1, 2012.

⁴¹ The 52 State Medicaid programs consist of all 50 States, the District of Columbia, and Puerto Rico. We requested information on individual providers for separate OIG evaluations.

address, phone number, Medicaid provider identification number, NPI, TIN, Social Security number (SSN), and State license number. To compile this file, we combined information received from each Medicaid program and created a separate record for each unique combination—by Medicaid program—of Medicaid provider identification number, NPI, TIN, SSN, and State license number. Once we had compiled this information, we limited the file to our specified nonindividual provider types, thus reducing it from 2.86 million to 35,394 providers. From this subset, we selected 140 providers enrolled in Medicaid, of which at least 110 appeared to also be enrolled in Medicare.

Collection of Provider Ownership Information

We collected three sets of current (i.e., as of the date of our data collection) owner names and other information: (1) those on record with CMS for Medicare enrollment purposes, (2) those submitted by providers directly to OIG for this evaluation, and (3) those on record with State Medicaid programs for Medicaid enrollment purposes.

We first collected owner names directly from selected providers. From November 2013 to January 2014, we sent electronic questionnaires to the 170 selected providers and requested ownership information (e.g., owner names, dates each owner's ownership took effect, TINs, and SSNs) as of the date the provider received the questionnaire. We sent up to two written requests by mail and attempted to contact nonresponding providers by telephone and email, if this information was available. We received responses from 119 providers and did not receive responses from 29 providers. The remaining 22 providers were considered ineligible because they did not meet our selection criteria regarding provider type and/or enrollment timeframe.

As part of the questionnaire, we also asked providers whether they were enrolled in Medicare and/or Medicaid. If providers indicated that they were not enrolled in one or both programs, we no longer classified them as being enrolled in the program(s). Of the 119 responding providers, 113 indicated they were enrolled in Medicare. Further, 100 of the 113 providers also indicated that they were enrolled in Medicaid.

Next, we collected owner names on record with CMS for Medicare enrollment purposes. From December 2013 to April 2014, we extracted ownership information (e.g., owner names, ownership roles) from PECOS for selected providers.

Finally, we collected owner names on record with State Medicaid programs for Medicaid enrollment purposes. From December 2013 to February 2014, we collected ownership information for selected providers

from State Medicaid programs. State Medicaid programs provided electronic and hardcopy documents showing ownership disclosures, as well as extracts from ownership-disclosure databases. We received information from State Medicaid programs for 71 of the 100 providers enrolled in Medicare and Medicaid.

Analysis of Provider Ownership Information

We conducted two comparisons of the three sets of owner names—those on record with CMS, those submitted by providers to OIG, and those on record with State Medicaid programs. Each comparison involved (1) confirming that information being compared was for the same provider and (2) evaluating the similarity of owner names.

Comparison of Ownership Information on Record With CMS and Ownership Information Submitted to OIG. The first comparison determined the extent to which owner names on record with CMS for Medicare enrollment purposes matched those submitted to OIG for this evaluation.

We first manually compared each provider’s NPI, TIN, and/or name and address in the information on record with CMS to those submitted to OIG. We confirmed that 110 of the 113 providers were the same. We removed the remaining three providers from our analysis because we were unable to confirm that the CMS records and the OIG records were for the same provider.

Next, we compared owner names on record with CMS to those that the 110 providers submitted to OIG. We identified names that matched, meaning that the name was on record with CMS and submitted to OIG. We also identified names that did not match, meaning that the name was on record with CMS but not submitted to OIG or vice versa—and called these names “nonmatching.” When we compared names, if we found owner names that were not identical but were reasonably similar, we considered the names to match. For example, if owner names were not identical but were reasonably similar (e.g., “James Harris” and “Jim Harris”), we considered the names to match. See Figure 1 for an illustration of a provider that had two names that matched as well as both types of nonmatching names.

Figure 1: Illustration of Provider’s Owner Names That Did and Did Not Match

Name Submitted by Provider to CMS	Name Submitted by Provider to OIG	Match Versus Nonmatch
James Harris	Jim Harris	Match
Jane Smith	Jane Smith	Match
Business A		Nonmatch
	Company B	Nonmatch

Note: Blanks illustrate that the individual or entity’s name was not on record with CMS or not submitted to OIG.

Additionally, we completed two analyses on owner names submitted to OIG that were not on record with CMS. First, we analyzed the dates on which these owners’ ownership took effect to determine whether the dates fell within the 30-day window during which providers are required to notify CMS of such changes. If dates fell within this window, providers still had time to notify CMS of the change. In January 2015, approximately 1 year after providers submitted owner names to us for this evaluation, we collected and reviewed the updated owner names in PECOS for these providers to determine whether the providers had notified CMS of their ownership changes. Second, we searched the LEIE and EPLS for owner names submitted to OIG that had not been submitted to CMS to determine whether these individuals or entities were excluded. Because these names were not in CMS’s ownership information, CMS could not have previously searched for them in exclusions databases. We did not find any of these names in the LEIE or EPLS at the time of our review.

Comparison of Ownership Information on Record With CMS and Ownership Information on Record With State Medicaid Programs. The second comparison determined the extent to which owner names on record with CMS for Medicare enrollment purposes matched those on record with State Medicaid programs for Medicaid enrollment purposes.

We manually compared each provider’s NPI, TIN, and/or name and address in the information on record with CMS to those on record with State Medicaid programs. We confirmed that 58 of these 71 providers were the same. We removed the remaining 13 providers from our analysis because we were unable to confirm that the records from CMS and the records from the State Medicaid programs were for the same providers.

Next, we compared owner names on record with CMS and State Medicaid programs for each of the 58 providers. For our comparison of these owner

names, we used the same methodology as for our comparison of owner names on record with CMS and owner names submitted to OIG.

MAC Electronic Questionnaire

In August 2012, we sent an electronic questionnaire to the 11 MACs that were operational at the time of our data collection. The electronic questionnaire collected information on how each MAC collects and processes ownership information disclosed by providers. We received responses to all applicable questions from each MAC by October 2012. We reviewed and analyzed responses to determine whether each MAC compared ownership information that providers disclosed to the two exclusions databases—i.e., the LEIE and EPLS—that MACs are required to check as part of the Medicare enrollment process.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

DATE: MAY -6 2016

TO: Daniel R. Levinson
Inspector General

FROM: Andrew M. Slavitt *Andrew M. Slavitt*
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare: Vulnerabilities Related to Provider Enrollment and Ownership Disclosure" (OEI-04-11-00591)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is strongly committed to program integrity efforts in Medicare and is continuously working to enhance the provider enrollment and screening process.

In February 2011, CMS finalized regulations to implement categorical risk-based screening of newly enrolling Medicare providers and suppliers and to 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 checks against various databases. Moderate and high risk providers and suppliers undergo additional screening, including unannounced site visits. Additionally, 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. Since 2011, CMS has taken actions to deactivate billing privileges for more than 543,000 providers and suppliers as a result of revalidation and other screening efforts and more than 34,000 providers and supplier enrollments have been revoked. All existing Medicare providers and suppliers enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. In addition, CMS has performed nearly 250,000 site visits on Medicare providers and suppliers. CMS uses site visits to verify that a provider's or supplier's practice location meets Medicare requirements, which helps prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

Review providers that submitted nonmatching owner names and take appropriate action.

CMS Response

CMS concurs with OIG's recommendation. CMS will review the list of providers and suppliers that have owner names on record with CMS that did not match those submitted to OIG.

OIG Recommendation

Educate providers on the requirement to report changes of ownership.

CMS Response

CMS concurs with OIG's recommendation. CMS will develop the necessary educational materials for providers and suppliers.

OIG Recommendation

Increase coordination with state Medicaid programs on the collection and verification of provider ownership information in Medicare and Medicaid.

CMS Response

CMS concurs with OIG's recommendation. CMS will work with states and other relevant stakeholders to enhance state and federal processes for the collection and verification of provider ownership information.

OIG Recommendation

Ensure that its contractors check exclusions databases as required.

CMS Response

CMS concurs with OIG's recommendation. Upon receiving the draft report for this engagement, CMS reached out to the contractors identified by OIG as not checking exclusions databases as required. Those contractors attested that they do check these exclusions database and that they had mistakenly provided incorrect information to OIG.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Stewart, Deputy Regional Inspector General.

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Office of Inspector General

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