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United States General Accounting Office
Washington, DC 20548

November 2, 2000

The Honorable Pete Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Subject: Medicare: HCFA to Strengthen Medicare Provider Enrollment Significantly, but Implementation Behind Schedule

Dear Mr. Stark:

Medicare has long been the target of fraud and abuse. One of the first defenses against improper Medicare billings is the screening of applications from providers to participate in the program. All providers[1]—including physicians, hospitals, suppliers, and others who wish to provide goods or services to Medicare beneficiaries—must first enroll in the Medicare program. Denying enrollment to providers who are not qualified, or who might be suspected to bill the program improperly in the future, can reduce the risk of fraud and abuse.

The Health Care Financing Administration (HCFA), with the assistance of approximately 60 insurance companies, operates and manages the Medicare program. These insurance companies—or contractors—process claims and assist HCFA in ensuring the program's financial integrity. Their responsibilities include reviewing provider applications to determine whether providers meet Medicare requirements and if there is reason to suspect that providers' future Medicare billings would be improper.

Concerned that HCFA and its contractors should be doing more to identify dishonest providers before they are enrolled in Medicare, you asked that we (1) identify weaknesses in HCFA's current enrollment process, (2) assess HCFA's plans to strengthen this process, and (3) determine whether HCFA's enrollment of Medicare providers could be better performed by a smaller number of contractors.

To do this work, we interviewed HCFA officials and reviewed documentation related to provider enrollment requirements and practices. We interviewed representatives

[1]The Medicare program distinguishes between "providers," including hospitals, nursing facilities, and other institutions or agencies, and "suppliers," which include physicians, laboratories, and other sources of medical supplies and services. For simplicity, we will use the term "providers" to refer to both providers and suppliers of medical services and supplies.

from two of the largest Medicare contractors responsible for processing provider enrollment applications to discuss their processing methods. We also conducted telephone surveys with 10 additional Medicare contractors to determine the procedures and resources they used to verify provider enrollment data. Our work was performed between February and September 2000 in accordance with generally accepted government auditing standards.

In summary, we found that HCFA's current provider enrollment process does not completely ensure that dishonest and unqualified providers are prevented from obtaining Medicare billing privileges. In some instances, contractors do not independently verify critical information contained on enrollment applications or do not perform key verification tasks. Recognizing these weaknesses, HCFA has initiated improvements. It plans to revalidate provider enrollment information periodically and expand the criteria used to reject enrollment applications. It has also developed a new data system that will help ensure that only qualified providers enroll in Medicare. However, plans for the data system are behind schedule, and additional delays may slow implementation further. Finally, HCFA is considering reducing the number of contractors responsible for enrolling providers in Medicare. We believe that consolidating provider enrollment tasks with fewer contractors could strengthen HCFA's ability to oversee these contractors and enhance the efficiency of the enrollment process. HCFA is in general agreement with our assessment that more needs to be done to establish standards and improve the process for provider enrollment.

BACKGROUND

Medicare provides health insurance coverage to about 39 million elderly and disabled Americans. Before 1996, Medicare's provider enrollment process consisted of contractors' obtaining the names and billing addresses of applicant providers. In 1996, HCFA introduced its first standard provider enrollment applications and began collecting more detailed information such as medical education and practice location on its newly enrolled providers. However, with the exception of suppliers of durable medical equipment, prostheses, orthotics, and supplies (DMEPOS), HCFA did not solicit updated information from providers who had enrolled in the program before 1996. Consequently, HCFA and its contractors have only limited information for the estimated 85 percent of Medicare providers who enrolled in the program before the introduction of the standardized enrollment forms.

HCFA provides general guidance on processing provider enrollments to its contractors and requires them to review applications for completeness. To help assess whether applicants are qualified, HCFA requires applicants to submit certain documentation—such as copies of medical licenses—to its contractors, who also verify the accuracy of information presented on providers' applications. In addition, contractors must determine whether providers are ineligible to receive Medicare reimbursements. Providers may be excluded from participation in Medicare or other federal programs because of prior unethical or illegal activities. For example, contractors are required to compare provider names to those on the Department of Health and Human Services Office of Inspector General (OIG) list of excluded

providers[2] and the General Services Administration (GSA) debarment list.[3] Excluded providers cannot enroll in Medicare.

Contractors are also expected to perform additional verification tasks if providers indicate on their applications that they were previously enrolled in Medicare. In these instances, HCFA requires that the new contractor processing the enrollment application contact a provider's prior Medicare contractor to learn more about the provider's previous billing patterns. This gives HCFA the opportunity to have overpayments identified and recovered. If a provider has a history of questionable claims, the provider's enrollment application might not be denied. However, the provider's new claims may be subjected to intense scrutiny.

Medicare claims processing contractors, however, do not process the enrollment of DMEPOS suppliers. Instead, the National Supplier Clearinghouse (NSC) manages this process and maintains a national database of DMEPOS provider information. HCFA requires the NSC to contact these providers periodically to revalidate their enrollment information.

HCFA's CURRENT PROVIDER ENROLLMENT PROCESS DOES NOT ADEQUATELY SCREEN POTENTIAL PROVIDERS

HCFA and its contractors do not consistently and rigorously verify information on provider applications. HCFA cannot, therefore, completely ensure that the integrity of the Medicare program is adequately protected. A lack of clear guidance has weakened the enrollment process. For example, HCFA has instructed contractors to validate information on provider applications, such as practice locations and social security numbers, by using the "most reliable, readily available, and cost-effective means." We found that some contractors contact applicants by telephone and ask them to confirm verbally the information contained on their applications. While not costly, this approach does not provide an independent means of verification.

In addition, contractors do not always complete critical verification tasks. In 1999, HCFA identified deficiencies in the enrollment activities of 6 of the 15 contractors evaluated during its routine assessments of contractors' performance. Specifically, HCFA found that some contractors did not compare applicant names to the OIG exclusion list. Others had not obtained necessary documentation to verify that providers had fulfilled mandatory licensing and education requirements. HCFA also found that one contractor neglected to investigate the billing histories of providers whose applications indicated that they had previously enrolled in Medicare.

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[2]The Office of Inspector General's List of Excluded Individuals/Entities provides information on health care providers that are excluded from participation in Medicare, Medicaid, and other federal health care programs. These exclusions are based on criminal convictions related to Medicare or state health programs, patient abuse or neglect, felony convictions related to controlled substances, or other health care fraud. More than 15,000 individuals and entities are currently excluded from program participation.

[3]The U.S. General Services Administration provides information on those firms and individuals that have been suspended, debarred, or otherwise excluded from federal procurement and nonprocurement programs because of illegal or unethical behavior.

PROVIDER ENROLLMENT IMPROVEMENTS FACE SLOW IMPLEMENTATION

HCFA officials recognize the existence of shortcomings in the provider enrollment process and are taking steps to strengthen the process. However, HCFA's progress in implementing improvements has been slow, and its plans are not finalized. Given the uncertainty of these plans, additional delays are likely.

Delays Hinder Enrollment Revalidation and Data Systems Enhancements

To improve the enrollment process, on October 18, 2000, HCFA submitted to the Office of Management and Budget draft proposed regulations that would initiate several changes. The cornerstone of these improvements is the requirement that all Medicare providers periodically review and certify the accuracy of their enrollment information. This would enable HCFA to ensure that providers are still eligible to participate in Medicare and to collect important information on the 85 percent of providers who enrolled before 1996. At present, only DMEPOS suppliers go through periodic revalidation of their enrollment information. Enclosure I contains the problems and results of DMEPOS revalidation.

HCFA's revalidation of provider enrollment is behind schedule. Implementation was originally planned to have begun in 2001, but this will depend upon the issuance of the provider enrollment regulation and other actions. In addition, many decisions regarding implementation must be made. Although HCFA officials recently told us that they have made some preliminary decisions about conducting the revalidation, additional issues need to be addressed. For example, in late October 2000, HCFA advised us that it would use a specialized revalidation contractor to conduct the initial revalidation cycle, rather than having this work performed by current contractors. During this process, all currently enrolled providers that have not completed an enrollment form will be required to do so. However, the time frame for selecting this specialized contractor and beginning the revalidation process has not been determined.

HCFA officials told us they would not make final decisions about how to conduct the revalidation process until they have had an opportunity to consider anticipated comments on the draft proposed regulations, which may take until next year. HCFA officials anticipate that the initial revalidation cycle will be the most challenging because they will be collecting, reviewing, and verifying data on providers for whom they have little information on file. Subsequent revalidations will focus on verifying changes submitted by providers. Given the decisions to be made once the comments are received, the awarding of the initial revalidation contract, and the considerable work that will be involved in establishing the process, it is likely to be some time before the revalidation process is underway.

In addition to revalidating provider enrollments, HCFA's draft proposed regulations would also expand the criteria for rejecting enrollments. This provision would give

HCFA and its contractors expanded authority to deny enrollment to applicants with criminal records and to those who have submitted false information on their applications. It would impose penalties on providers, such as deactivation or revocation of Medicare billing privileges, if they do not advise HCFA of changes to their enrollment information within 30 days of such a change. The draft proposed regulations would also change the agency's policy regarding inactive providers and would require contractors to deactivate providers' billing numbers if they do not bill Medicare within 6 months. This should help prevent the billing numbers of inactive providers from being obtained and used by fraudulent entities. Moreover, the draft proposed regulation gives contractors the authority to deny or revoke enrollment if there are payment suspensions or overpayments that have not been recouped and no repayment plan is in place.

Although not part of HCFA's draft proposed regulations, another key component of its strategy includes development of a new centralized data storage and retrieval system to help ensure that only qualified providers enroll in Medicare. The Provider Enrollment, Chain and Ownership System (PECOS) will contain most of the information collected from provider enrollment forms[4] and will also facilitate HCFA's planned revalidation process. PECOS will enable contractors reviewing enrollment applications to determine if an applicant was previously enrolled in Medicare through another contractor and to identify all of the applicant's affiliations with other Medicare enrolled providers. The system will also aid contractor verification procedures by interfacing with the Social Security Administration's computer system to confirm the accuracy of numbers supplied. In addition, HCFA is working toward establishing an interface with the Internal Revenue Service's computer system as early as January 2002, which would enable Medicare contractors to verify providers' tax identification numbers.

Like provider revalidation, HCFA's introduction of PECOS is behind schedule. Originally, implementation of PECOS was planned to begin February 2000. HCFA now intends to phase in PECOS gradually between November 2000 and 2003. This delay may set back HCFA's revalidation plans even further because the revalidation of providers is dependent upon the implementation of PECOS.

Costly Background Checks Provide Limited Information

Given the threat that fraud and abuse poses to the Medicare program, one option would be to conduct criminal background checks on providers before their enrollment in Medicare. HCFA officials told us that these checks have not been required in the past because they are expensive and provide limited results. HCFA and contractor officials estimate that these checks could range from $10 to $100 per individual listed in the application. Because provider applications may include the names of numerous owners and managing directors, routinely requiring background checks could become prohibitively expensive.

[4]The National Supplier Clearinghouse has a similar database devoted solely to the enrollment data submitted by suppliers of durable medical equipment.

Despite their expense, background checks often generate information from public databases that may be inaccurate or incomplete. Although more extensive information is available to the law enforcement community, it is typically not accessible to the contractors who perform these checks for HCFA. Private companies may also perform background checks, and some may be able to obtain some criminal conviction records. However, these records must often be obtained at the county level and require a manual search of courthouse records.

The contractors we spoke with told us that they rarely, if ever, conduct background checks. Contractors told us that they could only deny enrollment if a provider's name appears on the OIG exclusion or GSA debarment lists. Until recently, HCFA has had limited authority to take action if a criminal history exists for an applicant.[5] However, the draft proposed regulations would give HCFA contractors expanded authority to deny enrollment to providers with criminal histories. HCFA is reconsidering the priority that Medicare contractors should give to performing background checks if they suspect a provider is not qualified or eligible to participate in the program.

CONSOLIDATING PROVIDER ENROLLMENT WITH FEWER CONTRACTORS COULD HOLD PROMISE

HCFA officials told us they are considering concentrating the provider enrollment function by using fewer contractors. We believe that this approach holds promise. Consolidation could result in more consistent application of HCFA's provider enrollment guidance and in more efficient enrollment processing.

HCFA officials also told us that contractors currently processing a relatively small number of applications may have only one or two staff who devote only part of their time to enrollment activities. Staff thus do not process enough applications to develop expertise in enrollment processing. They said that consolidation could result in provider enrollment contractors developing greater expertise in application review and data verification, as the process would be carried out at fewer sites by more specialized staff. It could also strengthen HCFA's oversight and simplify program administration because HCFA would be working with fewer contractors doing provider enrollment.

HCFA and contractor officials also cited potential drawbacks to consolidating provider enrollment activities from 60 contractors to a smaller number. Some noted that, under consolidation, provider enrollment staff serving a large multistate area might not have as clear an understanding of varying state education or licensing requirements for different provider types as current contractors typically serving only one or a small number of states. Other contractor officials told us that consolidation would require the few contractors processing enrollments to coordinate closely with the Medicare contractors that will continue to process claims.

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[5]The Balanced Budget Act of 1997 (P.L. 105-33), amended the Social Security Act, extended HCFA the authority to deny enrollment to providers convicted of felonies under federal or state law for offenses which the Secretary of HHS determines are detrimental to the best interests of the program or its beneficiaries.

If HCFA decides to move forward with consolidating provider enrollment activities with a smaller number of contractors, we believe that these problems can be managed. Provider enrollment staff could be trained in state requirements for an expanded geographic area. Additionally, the need for Medicare contractors to coordinate with other contractors is not new. HCFA already requires Medicare contractors to coordinate with its new program safeguard contractors, who perform various tasks supporting program integrity, including fraud detection and conducting site visits to certain types of providers.[6] Finally, the eventual implementation of PECOS should give both enrollment contractors and claims processing contractors access to national enrollment data, reducing the need for these contractors to coordinate data sharing.

CONCLUSIONS

Weaknesses in HCFA's current enrollment provider process have made Medicare more vulnerable to dishonest providers. To protect the integrity of Medicare, HCFA and its contractors must have effective practices for reviewing applicants to verify that they are eligible for enrollment in the program, as well as the authority to deny enrollment to those that are not.

HCFA is implementing a number of promising changes to its provider enrollment processes that may make it more difficult for dishonest providers to enroll in Medicare. However, delays in implementing these initiatives will also postpone their benefits. HCFA's draft proposed regulations should strengthen its guidance to contractors, while giving contractors more authority to deny enrollment to applicants with criminal histories. Periodic revalidation of provider enrollment data should be a valuable means of ensuring that HCFA has current, useful data on active providers and that providers no longer eligible to participate in Medicare are dropped from the program. Also, HCFA's plan for a new centralized database of provider enrollment information could considerably improve Medicare contractors' ability to screen out questionable applicants. The enrollment process may be further enhanced if HCFA decides to concentrate responsibility for this function with fewer contractors.

AGENCY COMMENTS AND OUR EVALUATION

We provided HCFA a draft of this letter. In written comments, HCFA emphasized that it is committed to preventing unscrupulous providers from participating in Medicare (see enclosure II). HCFA also agreed with our assessment that more needs to be done to improve the provider enrollment process. In addition, HCFA's comments addressed two other issues. First, HCFA highlighted its recent initiatives to improve the provider enrollment process. Second, HCFA pointed out that our evaluation did not show or measure the extent that unqualified or illegitimate providers were denied enrollment in Medicare.

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[6]The Health Insurance Portability and Accountability Act of 1996 authorized HCFA to contract with entities other than Medicare carriers and fiscal intermediaries to perform specific program safeguard functions. Under this authority, HCFA has awarded contracts to 12 prime contractors to perform this functions.

Concerning its recent initiatives, HCFA described a number of actions it has taken to enhance the provider enrollment process. HCFA noted that an important part of its strategy is the issuance of a rule to institute a process to revalidate provider enrollment. HCFA stated that the draft proposed rule was transmitted to OMB on October 18, 2000. HCFA said it is taking steps to ensure that, once its rule is promulgated, it will be able to implement the revalidation process immediately. However, HCFA officials have also told us that many decisions regarding this implementation have not yet been made because it wants to consider issues raised during the public comment period. In addition, ongoing delays in implementing PECOS, HCFA's new centralized data storage and retrieval system, may further hinder implementation of the revalidation process.

HCFA also noted several other steps it has taken to improve the provider enrollment process. For example, HCFA said it has strengthened its process for evaluating contractor performance, revised its provider enrollment manual, improved its communications with HCFA regional staff, contractors, and the provider community, designed a new set of provider enrollment forms, and intensified enrollment procedures for certain types of providers. We recognize that HCFA has been taking such steps and agree that they have the potential to strengthen the enrollment process. However, to date, these efforts have not been fully implemented. While HCFA has designed a new set of provider enrollment forms, these are not in use and are dependent upon implementation of the new provider enrollment regulation.

Concerning the issue that we did not measure the number of unqualified or unscrupulous providers that were denied enrollment, HCFA stated that its goal is to ensure that providers do not apply because they know they will be rejected. HCFA indicated that there have been few instances of providers that should have been denied enrollment in Medicare. We agree that we did not measure the percentage of providers who were denied enrollment in Medicare. Instead, we focused on identifying weaknesses in the current enrollment process, assessing HCFA's plans for improving this process, and evaluating whether the process could be successfully conducted by a smaller number of contractors.

HCFA also offered technical comments on the contents of this correspondence, which we have incorporated as appropriate.

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Please contact me at (312) 220-7600 if you or your staff have questions about this correspondence. Shaunessye D. Curry and Donald Kittler prepared this report under the direction of Geraldine Redican-Bigott.

Sincerely yours,

Leslie G. Aronovitz
Director, Health Care—
Program Administration and Integrity Issues

Enclosures – 2

REVALIDATION OF DMEPOS PROVIDER ENROLLMENT

Suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are enrolled in Medicare by the National Supplier Clearinghouse (NSC), which is administered by a single Medicare contractor. NSC also conducts a revalidation of DMEPOS suppliers' enrollment information. Every 3 years, these suppliers are required to review the information submitted on their original Medicare application and certify that it is still correct or submit updated information to NSC.

Revoking billing numbers of unqualified providers prevents them and others from potentially misusing the numbers to submit fraudulent claims. HCFA's recent revalidation of DMEPOS suppliers—the only group of providers currently required to review periodically and certify their Medicare enrollment information—showed that revalidation helps ensure that only active and viable providers participate in Medicare. NSC reported revoking the billing numbers of 1,300 DMEPOS suppliers, out of 21,700 suppliers subject to the revalidation process between October 1998 and March 2000. These billing numbers were revoked because the suppliers no longer met one or more of the requirements necessary to participate in Medicare as a DMEPOS supplier, such as maintaining a physical facility, complying with regulatory or local licensing requirements, or having proof of liability insurance.

In the first years that DMEPOS supplier revalidation was performed, NSC intended to randomly select one-third of the approximately 100,000 suppliers for revalidation in each year. However, NSC's initial selection process was flawed. Some suppliers that should have been included in the first year's revalidation process were inadvertently omitted. For fiscal year 1999, HCFA directed NSC to begin revalidating suppliers based on the year they originally enrolled in Medicare. However, for many suppliers, NSC did not possess accurate information and relied on the year 1993 as an artificial enrollment date, the year that the NSC's database was established. The result was the selection of more than 60,000 suppliers in 1 year, a number that overwhelmed NSC and created a backlog that is expected to be eliminated by the end of this year.

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: 10/26/00

TO: Leslie G. Aronovitz
Director
Health Care Program Administration and Integrity
General Accounting Office (GAO)

FROM: Michael M. Hash
Acting Administrator

SUBJECT: GAO Draft Report: "Medicare: HCFA to Strengthen Medicare Provider Enrollment Significantly But Implementation Behind Schedule" (GAO-01-114R)

Thank you for the opportunity to review and comment on this draft report concerning Medicare's provider enrollment process. The Health Care Financing Administration (HCFA) is committed to preventing unscrupulous providers from entering the Medicare program. Our efforts in this area have been greatly intensified over the past several years. We appreciate the GAO's insights into what is an important program integrity function for the Agency, and to your recognition of the significant improvements that have been and continue to be made in this area.

We agree with the GAO's assessment that more needs to be done to establish standards and improve the process for provider enrollment. However, we also believe that the Agency has made significant improvements in this area and would like the opportunity to highlight those improvements.

Like the GAO, we believe the proposed revalidation process will improve provider enrollment procedures, and we have taken strong steps to improve this process. In fact, we are moving forward with publishing the regulation that would begin the revalidation process. The proposed rule was transmitted to OMB on October 18, 2000. In addition, we have taken a number of steps to ensure that once the regulation is issued in final form it can be implemented immediately -- including performing a risk assessment of enrolled provider types to determine those that pose the greatest risk to the program and therefore would be a priority for revalidation.

Prior to 1996, each contractor had its own individual enrollment process for new providers and suppliers entering the Medicare program. Beginning in May 1996, HCFA implemented a national enrollment process that included the HCFA 855 Enrollment Application. Since 1996, along with making several improvements to the 855, we have taken a number of steps to strengthen the process within our current regulatory authority. These steps include:

- Strengthening contractor performance evaluation (CPE) criteria for provider enrollment and including this function in our latest round of national contractor performance reviews. In fact, the deficiencies mentioned by GAO were found by HCFA personnel as part of HCFA's

- CPE program. (Note: these contractors were placed on corrective action plans to address these problems).

- Revising and re-issuing the provider enrollment manual, recognizing, as noted in the GAO report, that the guidance prior to 1996 was not always clear or complete.

- Improving communications on enrollment issues with our regional staff, contractors and the provider community. For example, we have established a web site to provide contacts for providers and suppliers, answer commonly asked questions, and provide general information on how to obtain a Medicare billing number.

- Engaging in a year-long dialogue with the industry regarding process improvements that could be made in this area to heighten program integrity and decrease burden. One result of this process is a new set of provider enrollment forms, which will clarify information requirements for providers and make it easier for contractors to process and verify information. This dialogue also enabled us to refine our proposed regulatory requirements, in effect anticipating industry comments so that publishing a final regulation would take place more quickly than originally planned.

- Intensifying enrollment procedures for independent diagnostic testing facilities and community mental health centers and performing site visits.

The goal of any enrollment system is to ensure that only qualified and legitimate providers obtain Medicare billing privileges, and the best way to achieve such a goal is to ensure that unqualified or fraudulent individuals never apply, as they know they will be rejected. However, the GAO study does not measure the *outcome* of HCFA's enrollment procedures -- or the percentage of illegitimate or unqualified individuals who are actually denied enrollment in the program. Instead, GAO focused on the provider enrollment *process*, using evaluations of contractor performance, to determine whether contractors' process of verifying provider enrollment data is adequate.

Other data demonstrates that there are very few instances of providers inappropriately entering the program. Recent reports from the Office of Inspector General indicate that the risk to the program from billings by excluded providers, for example, are very low ($30,000 in 1997). Also, as part of the CFO error calculation, and for any of the years it has been calculated, there have been no payment errors related to excluded providers. Our own evidence also demonstrates that contractors are stringently reviewing applications. Between April 1999 and April 2000 fiscal intermediaries recommended 37 applications for denial and returned 4,803 for additional information and carriers denied 2,085 applications and returned 86,677 for additional information.

We appreciate the effort that went into this report and look forward to working with GAO on this and other issues in the future.

Enclosure

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