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MEDICAID

HCFA and States Could Work Together to Better Ensure the Integrity of Providers

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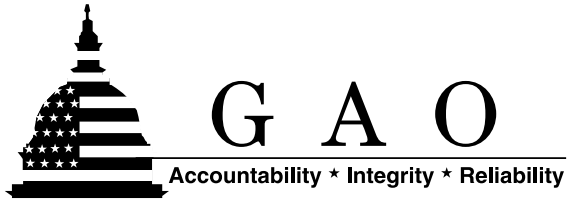

Medicaid: HCFA and States Could Work Together to Better Ensure the Integrity of Providers

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here as you discuss efforts to better ensure the integrity of providers who bill the Medicaid program. In the past, we have reported to the Congress that scrutinizing providers more rigorously before they begin billing the federal government's two major health care programs, Medicare and Medicaid, is an extremely important means of protecting program funds and beneficiaries.[1] In fiscal year 2001, federal funding of Medicare and Medicaid is projected to reach about $342 billion.

My remarks today will focus on (1) why it is important to take steps to ensure that only honest providers bill federal health care programs, (2) what Medicare is doing to strengthen its provider enrollment process, (3) what states are doing to ensure provider integrity in the Medicaid program, and (4) what additional opportunities exist to improve these efforts. My comments are based on our past work and work we are now conducting for the Commerce Committee on state fraud and abuse control efforts in the Medicaid program.

In brief, with hundreds of millions of claims to process each year, Medicare and Medicaid must rely in part on provider honesty in billing. As a result, it is critical to protect program funds by making efforts to ensure that only legitimate providers bill these programs. Recent incidents of Medicaid fraud perpetrated by dishonest medical equipment suppliers in California and other cases of Medicare and Medicaid fraud underscore these programs' vulnerability. Although the Health Care Financing Administration (HCFA) has made revamping its provider enrollment process a priority for Medicare, it has not sought similar efforts in state Medicaid programs. Medicaid state agencies report differing practices to ensure provider integrity, with only nine states reporting that they perform comprehensive provider enrollment activities. Because HCFA is redesigning its Medicare provider enrollment process, the HCFA Administrator has suggested that developing a joint Medicare/Medicaid provider enrollment process might be beneficial for both programs. Thus, HCFA and the states have an additional opportunity to work together to develop new procedures for Medicaid that could better ensure provider integrity for both programs while minimizing the administrative burden and cost.

[1] *Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers* (GAO/T-HEHS-96-7, Nov. 2, 1995); *Fraud and Abuse: Providers Excluded from Medicaid Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996); *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies* (GAO/HEHS-98-29, Dec. 16, 1997.)

Background

Medicare is a federal health insurance program for certain disabled persons and those 65 years and older. It is administered by HCFA, within the Department of Health and Human Services (HHS), through about 50 claims administration contractors. Medicaid is a jointly funded federal-state health insurance program for eligible low-income and medically needy people. HCFA oversees the Medicaid program at the federal level, but at the state level, the program actually consists of 56 separate state-operated programs (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Marianas—hereafter referred to collectively as "states"). The federal government matches state Medicaid spending according to a formula that is based on each state's per capita income. Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets its payment rates; and administers its program—including the enrollment of its providers.

Although Medicare and Medicaid have different structures and governance, and serve different populations, many providers bill both programs and must separately enroll in each. Enrollment refers to all of the application and verification activities that occur before a provider is issued a provider number and approved to bill a federal health care program.

My comments today are based on our past and on-going work for the Commerce Committee on controlling fraud and abuse in the Medicaid program. This statement focuses on enrollment processes for noninstitutional providers, because there are some specific requirements for institutions such as hospitals and nursing homes. Noninstitutional providers include durable medical equipment suppliers, physicians or physician groups, home health agencies, transportation companies, and laboratories—in effect, any providers who do not provide care in an institutional setting such as a hospital or nursing home. To gain more information on state efforts, we surveyed the 56 state Medicaid programs.[2] Several survey questions focused on states' provider enrollment activities. For this statement, we supplemented the states' self-reported survey data with on-site or telephone interviews of Medicaid officials from several states, including Connecticut, Florida, Georgia, New Jersey, and Texas, that reported taking actions to tighten their provider enrollment processes.

[2]Fifty-three of the 56 state Medicaid programs responded to the survey.

Problems With Fraudulent Providers Underscore the Value of Ensuring Provider Integrity

With hundreds of millions of claims being processed each year, federal health care programs need to rely to an extent on the integrity of their providers. Medicare and Medicaid receive claims for services, equipment, and supplies, and use automated computer edits as a check before payment to help ensure the claims are legitimate and billed by an enrolled provider. While some of the claims are also reviewed after payment is made, with such a massive number of claims, it is impossible to perform detailed checks on a significant share of them.

Most providers bill appropriately, reducing the risks from not being able to scrutinize claims more comprehensively. However, both programs have been victims of improper billing and outright fraud. For example, we recently reported on seven criminal health care fraud investigations, four of which involved both the Medicare and Medicaid programs.[3] In one of these cases, providers filed more than $120 million in fraudulent Medicare claims and $1.5 million in fraudulent Medicaid claims before being caught.

Recent fraud cases in California underscore Medicaid's vulnerability to providers who are eager to defraud the program. As you have heard from other witnesses today in more detail, since July 1999, a state-federal task force targeting questionable pharmaceutical and durable medical equipment providers has found large-scale fraud in California's Medicaid program—Medi-Cal. More than 100 Medicaid providers, wholesalers, and suppliers have been charged with more than $50 million in fraud since July 1999. At least 61 of these individuals have already been convicted and paid about $15 million in restitution. An additional 250 providers, wholesalers, and suppliers are being investigated for possible fraud that could exceed $250 million. In some cases, investigators found that providers set up shop for 4 or 5 months to bill Medi-Cal and collect payments for services not rendered and then closed down before the fraud was detected. These so-called "bump and run providers" often made off with hundreds of thousands of dollars before they disappeared.

These cases follow a pattern that has been seen in federal health care programs since at least the early 1990s. Investigations, some conducted as part of Operation Restore Trust,[4] pinpointed weaknesses in provider

[3] *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999).

[4] Operation Restore Trust was a 2-year demonstration to target Medicare and Medicaid fraud in five states conducted by HHS and federal law enforcement agencies.

enrollment procedures that have allowed questionable providers easy entry into the Medicare and Medicaid programs. Examples follow:

- A man convicted of health care fraud in 1989 and excluded from participating in Medicaid and Medicare was arrested in 2000 on new charges that he secretly ran several companies that received $40 million in Medicare reimbursements for fraudulent ambulance transportation claims. His involvement in the companies was hidden when these companies enrolled as Medicare providers. Employees of the companies routinely falsified paperwork for ambulance transports for patients who did not need this service. For example, patients, typically people being taken for radiation and dialysis treatment, would be described as "bed-confined," even though covert videotaping by federal investigators showed them walking to the ambulances.

- A provider opened two "storefront clinics" in New Jersey and began billing the Medicaid and Medicare programs for such invasive procedures as colonoscopies and upper gastrointestinal endoscopies. An investigation revealed that the clinic owner was not licensed to practice medicine in New Jersey and, in fact, did not have any medical license. Before the scheme was detected, the clinic owner had billed the Medicaid program for over $6 million and had defrauded the Medicare program of over $166,000.

- The owner of a medical supply company in New York pleaded guilty to billing Medicaid for more than $1.2 million for supplies that were never provided. The company, operated out of the owner's home, filed claims for medical items for several patients authorized by a physician who had been dead for more than 10 years.

Checking the credentials and qualifications of such providers more thoroughly might have raised questions about their integrity. Periodically requiring providers to reenroll would allow regular scrutiny and updating of their information. As a result, federal health programs could keep tighter control over the current validity of billing numbers. Failure to do so leaves federal health programs vulnerable to questionable providers who either may not be providing services to beneficiaries as billed or be providing poor quality services. For example, in 1996, HCFA reported that of 36 new applicants to provide durable medical equipment to Medicare beneficiaries in Miami, 32 were not bona fide businesses. Some of these entities did not have a physical address or an inventory of durable medical equipment. To determine whether this was only a problem in Florida, the HHS Office of Inspector General (OIG) conducted on-site inspections of 420 suppliers with Medicare billing numbers issued between January and

June 1996 and 35 applicants who had applied but had not yet been enrolled.[5] The OIG found that 31 of the 420 enrolled suppliers and 4 of the 35 new applicants did not have the required physical business address, or their addresses were suspect. Some had closed suddenly, leaving no forwarding address. Some operated out of homes, while others lacked inventory, making their suppliers' status suspect. Other enrolled suppliers did not provide the level of service expected, because they did not make repairs on items supplied to beneficiaries that were still under warranty or allow beneficiaries to return unsuitable items.[6]

As one convicted Medicaid fraud felon whose previous experience was owning a nightclub in Miami, Florida, remarked,

"I had no experience or training in health care services. . . Without this experience and with no knowledge of the Medicare program, I purchased a business and started billing Medicare. It was very easy for me to get approval from Medicare to become a provider. . . They gave me a provider number over the phone. No one from the government or anywhere else ever came to me or my place of business to check any information on the application. No one ever checked my credentials or asked if I was qualified to operate a medical supply business."

By the time this man was arrested in 1994, he owned seven medical supply companies, using the different billing numbers to hide the number of claims he was submitting. All of his businesses were at the same location, and he used the same staff and computers to bill under different numbers. He estimated that he billed about $32 million to Medicare in total, most for services not rendered.[7]

Some states and the federal government have realized that their programs do not have all the tools needed to address the problem of providers entering their programs intent on committing fraud. One state audit pointed out that the state's Medicaid program could not terminate a problem provider quickly and that providers could potentially sell their businesses, including their billing numbers, to others. In this state, once a

[5]These suppliers were located in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California.

[6]HHS OIG, *Medical Equipment Suppliers: Assuring Legitimacy*, OEI-04-96-00240 (Washington, D.C.: HHS, Dec. 1997).

[7]*Medicare Fraud Prevention: The Medicare Enrollment Process,* Appendix—Statement of Convicted Medicare Fraud Felon, hearings before the Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, 105th Congress, 2nd Sess. (Jan. 29, 1998).

provider was accepted into the program, there was no mechanism to ensure that Medicaid had up-to-date information about the provider, thus allowing billing numbers to be potentially misused by others. Furthermore, no efforts were made to verify information on the enrollment form. Because the state program accepted copies of out-of-state licenses rather than verifying them, a provider could produce a fraudulent out-of-state license and thereby be enrolled to treat Medicaid patients.

Efforts to Strengthen Medicare Provider Enrollment Under Way

As a result of repeated experiences with fraudulent and abusive providers, strengthening Medicare provider enrollment procedures became part of HCFA's Comprehensive Plan for Program Integrity issued in 1999.[8] Medicare had delegated provider enrollment to its claims administration contractors, which resulted in somewhat different processes at every contractor, with no clearly enunciated national enrollment requirements. HCFA is developing a standardized and strengthened provider enrollment process, which would hold providers to financial and performance standards before they could enroll in the Medicare program. HCFA has taken, or is planning, a number of other steps, including

- publishing a notice of proposed rulemaking to set standards for provider enrollment, specifying that HCFA can deny and revoke billing privileges and periodically require providers to reenroll;
- implementing a new centralized data system on enrolled providers—the Provider Enrollment, Chain and Ownership System (PECOS), which can be used to track ownership and relationships between providers;
- developing a new standard enrollment form that will ask for detailed information in many categories, such as ownership; and
- requiring provider Social Security numbers on the enrollment form, which then will be verified through the Social Security Administration.

In addition to our ongoing Medicaid work on this issue, we are now reviewing the Medicare provider enrollment process and will be reporting about it later this year. In that study, we are primarily focusing on the activities Medicare contractors perform to enroll new providers and HCFA's plans to require providers to periodically reenroll.

[8]The Comprehensive Plan, published in Feb. 1999, outlined HCFA's key program integrity initiatives for the next 6 to 18 months. It addresses five management areas, including provider integrity.

While HCFA has a number of actions planned or in process to help strengthen Medicare provider enrollment, its plan for program integrity does not include any actions to strengthen provider enrollment in Medicaid. Dealing with such issues at the federal level is more complex in Medicaid because of the differing program requirements and state approaches to ensuring program integrity. Because the Medicaid program is administered by the states under federal oversight, both federal requirements and state actions form a state's Medicaid provider enrollment program.

Federal Requirements Are Minimal, but a Few States Have Aggressive Provider Enrollment Programs

Because states design their own Medicaid provider enrollment processes, some are much more comprehensive than others. However, despite the importance of activities to ensure the integrity of Medicaid providers, HCFA does relatively little to oversee states' efforts. Responses to our survey revealed a handful of states that have developed aggressive actions through their enrollment processes to help ensure provider integrity. These efforts range from requiring and verifying comprehensive information on the enrollment form to performing site visits at potential providers' offices. We describe these practices later because we believe they can help other states that want to strengthen their provider enrollment processes.

Minimal Federal Requirements Exist to Ensure Medicaid Provider Integrity

There are few federal requirements for states to follow in enrolling Medicaid providers. All states must have an agreement between the state Medicaid agency and each provider or organization furnishing services to beneficiaries under the plan. However, there is no federal requirement that the provider certify the accuracy of information provided. Providers must also agree to minimum treatment record-keeping standards; give state and federal authorities access to treatment records; and disclose or supply upon request information concerning health care entity ownership and the identities of certain employees with criminal histories. In addition, the Balanced Budget Act of 1997 (BBA) established additional enrollment safeguards regarding home health agencies and durable medical equipment suppliers.

HCFA's guidance to states, incorporated in the State Medicaid Manual, indicates that states may only enroll providers that are qualified to provide the specified service and that have not been excluded from federal health

care programs.[9] A qualified provider is one that is licensed to practice in the state, if licensure is required, and that provides services within the scope of practice as defined by state law. States can impose additional qualifications on providers that they enroll in their Medicaid programs. Recently, the OIG found evidence that some state Medicaid programs have paid excluded providers for providing services to beneficiaries, and the OIG is thus concerned that some states may not be checking on whether a provider has been excluded.[10]

Finally, the federal government provides states matching funds for automated claims processing and information retrieval systems, called Medicaid Management Information Systems (MMIS), provided that the states' systems meet certain specifications. States that receive federal funding for their MMIS must collect and enter into their systems certain types of provider information to help ensure that their providers are eligible. This information includes a unique Medicaid provider identification number, the provider's Social Security number, and, if applicable, the provider's Medicare number. In addition, state information systems need to be able to support certain functions, such as enrolling providers only after they agree to abide by the state Medicaid program's rules and helping to screen applicants by verifying their state license or certification, if applicable.

Limited Federal Oversight of State Enrollment Processes

Although little attention has been given to state Medicaid provider enrollment processes,[11] HCFA is facilitating state Medicaid fraud and abuse control activities through the HCFA Medicaid Fraud and Abuse National Initiative. Of the 53 state Medicaid agencies that replied to our survey on efforts to control fraud and abuse, only 16 reported that HCFA staff visited their agency to review their fraud and abuse control activities

[9]The HHS OIG excludes individuals and entities from participating in federal health care programs under various provisions of the Social Security Act including sections 1128, 1128A, 1156, and 1892. When an exclusion is imposed, Medicare, Medicaid, and other federal health care program payments are prohibited for any items or services furnished, ordered, or prescribed by an excluded provider other than for emergency items or services not provided in a hospital emergency room. Reasons for the exclusion may bear on a provider's professional competence, professional performance, or financial integrity. Payment is also prohibited to any managed care organization that contracts with an excluded provider.

[10] We reviewed these processes, including the OIG's process to exclude providers, in 1996. See *Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996).

[11]Before the Systems Performance Review (SPR), a triennial standards-based review to reapprove/approve a state's MMIS as well as any reduction in federal financial participation levels, was repealed by the BBA, HCFA performed indirect oversight of provider enrollment via the SPR. Part of the review included an evaluation of the provider enrollment subsystem within the state MMIS.

during their most recent fiscal year. In interviews with HCFA and state Medicaid agency officials during our five state site visits, officials generally reported that HCFA was not overseeing their provider enrollment activities.

However, HCFA is working with state Medicaid programs on strengthening their fraud and abuse control activities through its Medicaid Fraud and Abuse National Initiative. The goal of this initiative is to facilitate, not oversee or direct, state efforts. The initiative is led from HCFA's Atlanta regional office and has coordinators in each of its 10 regional offices. Although the initiative's plan does not list provider enrollment as one of its strategic goals, its national work group has a goal to work with states to help them avoid providers who have been excluded, suspended, debarred, or sanctioned from other federal health care programs. Recently, HCFA teams consisting of regional office Medicaid fraud and abuse coordinators reviewed eight states' Medicaid program integrity procedures. In those states, they checked two processes relevant to provider enrollment—providers' disclosure of ownership, significant business transactions, and employee criminal history information; and states' processes to ensure that excluded providers do not participate or receive payment for services. HCFA has not yet reported its findings on this eight-state review.

Wide Variation in State Efforts to Check Provider Integrity

States have considerable latitude in how they structure their provider enrollment processes. While some states have begun to strengthen these processes, few have taken comprehensive measures to prevent problem providers from entering Medicaid. In our survey, while almost all states reported checking licensure and whether providers had been excluded from federal programs, less than half reported checking whether providers had criminal records or had a site to conduct business. About two-thirds of the states reported canceling inactive billing numbers, even though billing numbers are used to receive payment. Canceling billing numbers that have been inactive can help prevent unauthorized individuals from adopting and using those numbers. States were least likely to conduct checks of whether the provider is actually located at the address reported—21 states reported doing so. This may overstate the amount of checking that states are doing, because of the states that reported doing these checks, at least one had begun doing this within the last year, and one had done so on a trial basis in some parts of the state. Only nine states reported conducting all four of these checks—licensure, excluded provider, criminal record, and business location.

HCFA has found site visits to be useful in verifying whether applicants for enrollment in Medicare have bona fide businesses. In our survey, 19 states reported that they conducted site visits when a provider initially applies to become enrolled. Most states that conducted site visits reported visiting only certain providers that they feel have a greater likelihood of abusing the program—for example, the Kansas Medicaid program reported visiting only durable medical equipment suppliers. Because these site visits cost money, such targeting is seen by those states as the best approach. Only New Hampshire, which reported enrolling about 5,000 providers in the last 3 years, said that it checked the sites of all providers before enrollment.

Once enrolled, many states allow providers to stay indefinitely in the program without having to update information about their status. As a result, while some providers may be reporting changes to the Medicaid program, such as selling a business and its associated billing number, others may not. Twenty-six states reported allowing providers to continue to bill indefinitely once enrolled. Others had an enrollment time limit, which often varied by provider type. Eighteen states reported conducting visits to help determine whether providers should remain in the program. These states generally reported visiting only certain providers, with 11 reporting that they visited such providers at least once a year.

Because billing numbers allow claims to be processed, they are valuable and need to be guarded. Existing businesses may be sold to owners that intend to defraud Medicaid, and dead or retired providers' numbers can be used by unscrupulous individuals. Canceling inactive billing numbers can prevent questionable providers from deliberately obtaining multiple numbers to keep "in reserve" in the event that their practices result in suspension of claims under the primary number. Once again, a number of states reported doing nothing to control billing numbers. Only thirty-three states reported canceling inactive billing numbers. Of those, 16 reported canceling providers' numbers when they did not submit a bill for 2 years. Five states reported that they canceled a provider number if no bill had been submitted in more than 3 years.

States' Key Activities to Ensure the Integrity of Potential Providers

Some states, including Connecticut, Florida, Georgia, New Jersey, and Texas, are engaged in a number of activities that make it more difficult for questionable providers to enter and remain in their Medicaid programs. These include more stringent review of information on the provider enrollment application; developing provider agreements that give the state more flexibility to terminate without delays; reenrolling existing providers under new, stricter standards; increasing scrutiny of applications from certain provider types and continued scrutiny after enrollment; conducting

preenrollment site visits; and establishing better control over provider billing numbers. Examples follow.

More Stringent Review of Provider Enrollment Applications. In late 1998, Connecticut began using information from its fraud and abuse cases to help it determine what to require of new providers. Earlier audits had revealed that durable medical equipment providers operating in networks—many of which were family-based—were defrauding the program. As a result, representatives from Connecticut's Office of the Attorney General and Office of the Chief State's Attorney worked with Medicaid quality assurance and provider relations staff to revise the Medicaid enrollment process, starting with the provider enrollment application.

Connecticut's new application requires providers to disclose business or personal relationships with other Medicaid providers. In addition, applicants must now state whether they have any administrative sanctions, civil judgments, criminal convictions, or bankruptcies, and whether they are enrolled in federal or other states' health care programs. Further, the Connecticut Medicaid application requires submission of the names and Social Security numbers of all owners, officers, and directors of the provider's business. A critical step in the state's enrollment process is verification of the enrollment application information. Connecticut has a contractor that uses various on-line databases to check applicants' personal, financial and criminal backgrounds. Similar to Connecticut, beginning July 1, 2000, Georgia started using a revised provider enrollment application that requires the applicant to disclose criminal background, exclusions and sanctions, and ownership information on the application form.

As a result of problems with provider fraud in South Florida, in December 1995, Florida began to implement several changes in provider enrollment procedures. Florida now requires noninstitutional providers to undergo fingerprinting and criminal history background screenings. For group providers, all officers, directors, managers, and owners of 5 percent or more of the business must be screened. Applicants are required to submit fingerprints and to pay for the background checks. Fingerprints are checked with both state law enforcement authorities and the Federal Bureau of Investigation.

Strengthened Provider Agreements. Several states now include provisions in their provider agreements that allow either the provider or the Medicaid program to terminate the agreement without cause after giving the other party advance notice. While the details vary, such a clause

is now part of the Medicaid provider agreements required by Connecticut, Florida, Georgia, and Texas. New Jersey's provider agreement currently allows providers to terminate their agreement without cause after giving the program 30 days written notice. However, New Jersey Medicaid officials told us that a provision giving Medicaid the same termination rights is being developed. A Texas Medicaid official told us that the termination-without-cause provision was an important new tool to help protect the Texas Medicaid program by allowing officials to remove problem providers more expeditiously.

Reenrollment Under Stricter Standards. Several states that tightened standards for newly enrolling providers also required existing Medicaid providers to reenroll under the new standards. For example, after strengthening the Texas Medicaid program's provider enrollment process for new applicants, the Texas legislature directed Medicaid officials, beginning September 1, 1997, to initiate a 2-year period during which all current providers would be required to reenroll in the Medicaid program. Texas Medicaid providers—both new applicants and existing providers—must now sign a provider agreement that includes stricter terms of participation and new anti-fraud-and-abuse language. When Texas providers were slow to reenroll, the legislature extended the deadline by a year to September 1, 2000, and reduced some requirements, such as filling out a provider information form, but not the requirement that providers sign the new agreement. Texas Medicaid officials reported that as of May 31, 2000, 68 percent of the providers had reenrolled. Similarly, starting in 1996, Florida required all noninstitutional Medicaid providers to reenroll on a staggered basis under stricter standards. When Florida began the reenrollment, there were approximately 80,000 Medicaid providers; when it ended, there were about 20,000 less. State program officials report that access to health care was not affected by the reduction in Medicaid providers.

Special Scrutiny of Certain Provider Types. As several other states have done, New Jersey's Division of Medical Assistance and Health Services has instituted special Medicaid enrollment procedures for certain types of providers. The New Jersey Medicaid program's fiscal agent handles all aspects of the Medicaid provider enrollment process for most provider types. However, enrollment applications from pharmacies, independent laboratories, transportation companies, and durable medical equipment providers receive extra attention. Both the Medicaid Program

Integrity staff and Medicaid Fraud Control Unit (MFCU)[12] staff review pharmacy and independent laboratory enrollment applications. The review includes a criminal background check. Other New Jersey Medicaid program personnel review applications from durable medical equipment and transportation providers.[13] Program consultants conduct preenrollment site visits to pharmacy and durable medical equipment applicants. In addition, physician group practices are visited on-site after they are enrolled. This type of approach can root out those individuals who set up a physical location only long enough to enroll in the program. For example, in an Illinois Medicaid fraud case involving a laboratory, an individual paid 1 month's rent on office space and state-of-the-art medical testing equipment to obtain the certification needed to bill Medicaid for complex laboratory tests. But after receiving certification, no patients were actually tested, although Medicaid was billed for laboratory services.

Florida requires certain types of Medicaid providers, including home health agencies, durable medical equipment suppliers, nonemergency transportation providers, physician groups with more than 50 percent nonphysician ownership, and independent laboratories to obtain surety bonds. On May 25, 2000, legislation was enacted that increases the maximum surety bond the Medicaid agency can require a prospective or participating provider to obtain. Under the new law, Medicaid can require the current $50,000 flat rate or, if greater, the total amount billed by the provider during the current or most recent calendar year. Florida officials indicated that a primary reason for the surety bond requirement is that in underwriting a bond, surety companies check the capacity and financial ability of the providers to operate as a valid business. Florida officials consider such a review an effective screening tool to help keep less qualified providers out of the program. However, obtaining a surety bond does not reflect how well an applicant will perform as a health care provider, just that they are a business. In a previous report, we pointed out that these requirements may negatively affect the ability of small providers

[12]Under the Social Security Act, Sec. 1902 (a)(61), states are required to have an MFCU or a waiver of this requirement from the Secretary of Health and Human Services. These units are to be separate from a state's Medicaid agency and are responsible for investigating and prosecuting Medicaid provider fraud, patient abuse, and program administration fraud. Forty-eight states have MFCUs.

[13]Since November 1998, a moratorium has been in effect on the enrollment of "invalid coach" providers by New Jersey's Medicaid program. Invalid coaches provide transportation services to beneficiaries who require assistance.

to serve beneficiaries. In addition, individuals with no history of criminal action but an intent to defraud the program could still obtain bonds.[14]

Preenrollment Site Visits. In 1999, after receiving new budget authority from the state, the recently reestablished Georgia Medicaid program's Provider Enrollment Unit began conducting site audits on all new noninstitutional provider applicants. Georgia's site audit requirements include verification of the provider's business location, a check of the provider's compliance with the Americans With Disabilities Act, and a check of the provider's business license. The audit also checks compliance with any additional criteria that are required for that category of provider as stipulated in the state's Medicaid provider manual. Georgia Medicaid officials reported that when they began the site audits they detected numerous applicants with nonexistent addresses or mailbox-only operations; now such a finding is rare.

According to Texas Medicaid officials, that state had a less successful experiment with preenrollment site visits. In 1997, in part because of the experience of the Florida Medicaid program, the Texas legislature directed its Medicaid program to establish a pilot project aimed at reducing fraud by conducting random on-site reviews of prospective Medicaid providers in targeted counties. For the pilot, program officials selected the three urban counties that had the largest concentration of providers in the specialties designated by the legislation—durable medical equipment providers, home health care providers, therapists, and laboratories. At a minimum, Texas Medicaid investigators were required to inspect the providers' sites; review appropriate licenses or other authorities; interview the providers' representatives, staff, and patients; and review medical and business records. Only nine provider applications were received during this time period. The nine applicants reviewed during the 5-month pilot were found to be capable of delivering the specific services proposed in their applications and to have fully operational businesses. Program officials calculated that the reviews cost an average of $4,200 per provider—too high to be cost-effective—and they recommended against extending the pilot or implementing the preenrollment reviews statewide.

Site visits are done before enrollment in the Florida Medicaid program for certain types of provider applicants, including pharmacies, durable medical equipment suppliers, physicians' group practices that are at least 50 percent owned by nonphysicians, independent laboratories, home

[14] *Medicare Home Health Agencies: Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments* (GAO/HEHS-99-23, Jan. 29, 1999.)

health agencies, and some transportation companies. Florida officials plan to begin conducting checks on 100 percent of the pharmacies in two counties that historically have had a problem with fraud. In addition, the state or its contractor may conduct site visits on any existing providers if they are considered to be high risk, have exhibited aberrant billing practices, or are the subject of a complaint made to the Medicaid state agency.

Better Control of Medicaid Billing Numbers. Because control of Medicaid billing numbers has been lax in some states, Medicaid has been billed by individuals using information from deceased or retired providers—either directly or as referring physicians. In an effort to better control Medicaid billing numbers, Texas Medicaid officials developed the Texas Provider Identification System, which they planned to institute in conjunction with their provider enrollment changes. At present, Texas providers can legitimately have and use several Medicaid provider numbers simultaneously. Under the new system, each provider would have one seven-digit base number to which locator code numbers could be added to indicate where a service was performed. Texas has had to delay implementing the new identification system because the start-up of the state's new MMIS is behind schedule. The Georgia Medicaid program uses a billing number system similar to the one envisioned by Texas Medicaid officials. Medicaid providers in Georgia have a base number to which letters are added that indicate the location where the service was provided.

As previously mentioned, many states now cancel the billing numbers of providers who have not submitted a bill to the Medicaid program during a certain period of time. Of the states whose Medicaid officials we interviewed, Florida, Georgia, and Texas currently cancel the billing numbers of inactive providers, while Connecticut and New Jersey do not.

The state Medicaid officials reported that the strengthened provider enrollment measures they have adopted have given them important new tools to help ensure the integrity of their Medicaid programs. Despite the obstacles encountered in recent efforts to better ensure the integrity of their Medicaid providers, Texas Medicaid officials reported that they have sent a strong message to providers about the program's intolerance for fraudulent and abusive practices. Connecticut Medicaid officials said that while it is difficult to quantify the deterrent effect of their provider enrollment measures, preventing fraudulent providers from entering the Medicaid program is inherently more cost-effective than trying to recover inappropriately expended funds.

Improving Medicare Provider Enrollment Creates Additional Opportunities to Strengthen Medicaid

The current revamping of Medicare's provider enrollment process may provide an opportunity for HCFA to help states strengthen the provider enrollment process in their Medicaid programs. Because many of the same providers bill both programs, we were interested in finding out whether the programs' working together could more efficiently screen out problematic providers. Sharing a standard enrollment form with Medicare and checking providers using the new database, PECOS might help Medicaid programs more effectively operate their provider enrollment processes.

The HCFA Administrator has suggested that developing a joint Medicare/Medicaid provider enrollment process might be beneficial for both programs. A HCFA official with responsibility for program integrity activities advised us that HCFA plans to solicit state Medicaid officials' comments in the next month concerning the use of HCFA's provider enrollment form for enrollment of both Medicare and Medicaid providers.

Combining Medicare and state Medicaid efforts would not necessarily mean that states with particularly aggressive or more comprehensive provider enrollment programs would not continue them. HCFA and the states would need to agree on the minimum requirements of a provider enrollment process in Medicaid and to what extent enrollment through the Medicare process satisfied those requirements. For example, it might be reasonable to have states verify provider business addresses and readiness to provide services through state-controlled site visits. Either Medicare or Medicaid could be responsible for verifying provider credentials and qualifications. The Medicare program could be responsible for verifying Social Security numbers and other information available in national databases, as well as for entering provider information into the PECOS system. This would allow the states to put more effort into activities that are best done at the local and state levels.

One other recent development will affect both programs' enrollment processes. As contemplated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HHS is developing the National Provider Identifier, a single, unique identifier for each provider to be used in transactions with all health payers. This number could help eliminate the multiple identification numbers for the same provider present in today's environment that unscrupulous providers can use to obscure their billing practices. This system would more easily track all the activities of a provider by his or her unique identifier. Currently, the draft of the final regulation is awaiting approval by HCFA, HHS, and the Office of Management and Budget.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the Subcommittee Members may have.

GAO Contact And Acknowledgments

For future contacts regarding this testimony, please call Sheila K. Avruch, Assistant Director, on (202) 512-7277. Key contributors to this testimony include Barrett W. Bader and Bonnie L. Brown.

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Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

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