Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS GENERALLY ENSURED THAT MEDICARE PART C AND PART D SPONSORS DID NOT PAY INELIGIBLE PROVIDERS FOR SERVICES TO MEDICARE BENEFICIARIES

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Office of Inspector General

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Report in Brief
Date: October 2022
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

CMS Generally Ensured That Medicare Part C and Part D Sponsors Did Not Pay Ineligible Providers for Services to Medicare Beneficiaries

Why OIG Did This Audit

The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare Advantage (MA) organizations and private prescription drug plan sponsors (collectively known as "sponsors") to offer Part C and Part D managed care benefits to eligible Medicare beneficiaries. CMS relies on Part C and Part D sponsors to ensure that excluded, precluded, deactivated, and deceased providers (ineligible providers) do not receive payments for Medicare services.

We conducted a nationwide audit of Medicare Part C encounter data and Part D prescription drug event (PDE) data to identify ineligible providers associated with the data submitted to CMS by Part C and Part D sponsors. Our objective was to determine whether CMS oversight of Medicare Part C and Part D sponsors ensured compliance with Federal requirements for preventing payments for Medicare services to ineligible providers.

How OIG Did This Audit

We analyzed 1.46 billion encounters with $438 billion in total allowed charges submitted by 770 Part C plans and 3 billion PDEs with $234 billion in total drug plan payments submitted by 811 Part D plans for all services billed or rendered and prescriptions written for Medicare beneficiaries in calendar years 2018 and 2019.

What OIG Found

CMS generally ensured that sponsors complied with Federal requirements for preventing payments for Medicare services to ineligible providers. However, some sponsors submitted to CMS encounter and PDE data indicating that ineligible providers rendered services and wrote prescriptions for Medicare beneficiaries. We identified 136 Part C sponsors and 62 Part D sponsors that may have paid claims for health care services associated with ineligible providers. Specifically, these sponsors submitted data for 384,000 encounters with $51.8 million in allowed charges and 24,000 PDEs with $1.14 million in payments associated with ineligible providers.

The ineligible providers were able to submit these claims to plan sponsors because some sponsors may not have had effective compliance programs in place to prevent, detect, and correct noncompliance with CMS's program requirements. Also, CMS may not have adequately monitored the sponsors to ensure that their compliance programs were effective. In addition, although Part D regulations expressly require sponsors and their pharmacy benefit managers to reject pharmacy claims unless they contain active and valid provider identification numbers, CMS does not have similar requirements for claims submitted to Part C sponsors. Additionally, CMS system edits did not properly work to identify all ineligible providers after sponsors submitted their encounter and PDE data to CMS. As a result, CMS used data from services associated with ineligible providers in its risk adjustment of capitation payments to the sponsors.

What OIG Recommends and CMS Comments

We made a series of recommendations for CMS to direct Part C and Part D sponsors to ensure that only eligible providers receive payments for Medicare services. We also recommended that CMS strengthen its oversight of sponsors and provider identifiers to prevent deactivated and deceased providers from receiving payments for Medicare services. The detailed recommendations are listed in the body of the report.

In written comments on our draft report, CMS concurred with one of our recommendations and requested that we remove our remaining recommendations. After reviewing CMS's comments, we removed one recommendation and revised two recommendations to clarify their meaning. We maintain that our recommendations, as revised, are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region2/22001027.asp.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare Advantage (MA) organizations and private prescription drug plan sponsors (collectively known as "sponsors") to offer Part C and Part D managed care benefits to eligible Medicare beneficiaries. Federal law prohibits Medicare payments for services provided or prescriptions written by individuals or entities who are excluded from Federal health care programs (excluded providers) when the sponsor knows or has reason to know of the exclusion. CMS has controls to ensure that Part B payments are not made to excluded providers and providers whose billing privileges have been deactivated, denied, or revoked. However, CMS relies on Part C and Part D sponsors to ensure that excluded, precluded, deactivated, and deceased providers (ineligible providers) do not receive payments for Medicare services.

We conducted a nationwide audit of Medicare data for calendar years (CYs) 2018 and 2019 (audit period)[1] to identify ineligible providers associated with Part C encounter data and Part D prescription drug event (PDE) data submitted to CMS by sponsors.

OBJECTIVE

The objective of our audit was to determine whether CMS oversight of Medicare Part C and Part D sponsors ensured compliance with Federal requirements for preventing payments for Medicare services to ineligible providers.

BACKGROUND

Medicare Part C and Part D Sponsors

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. CMS contracts with sponsors to offer Part C and Part D managed care benefits to eligible Medicare beneficiaries. CMS pays each sponsor a monthly per-person amount (capitation payment) for each beneficiary enrolled in its plan. Capitation payments are risk-adjusted to account for differences in health status between enrolled beneficiaries. To determine the risk adjustment, sponsors must submit to CMS valid Part C encounter data and Part D PDE data for each item or service provided to a Medicare beneficiary.[2] When processing Part C and Part D data from sponsors, CMS performs system edits that identify data associated with ineligible providers and reject the submitted data or accept the data and inform sponsors of the ineligible providers.

[1] Our audit period was determined based on the most recent data available at the time we began the audit.

[2] 42 CFR §§ 422.310(b) and 423.329(b)(3).

CMS's National Plan and Provider Enumeration System (NPPES) assigns unique National Provider Identifiers (NPIs) to healthcare providers throughout the country. Providers must each obtain an NPI—a 10-digit number—to identify themselves on all Medicare transactions. Providers must also communicate any changes in registration data (e.g., change in contact person) associated with their NPIs within 30 days of the change. CMS collects and maintains information on NPIs and deactivates or reactivates NPIs upon receipt of appropriate information (e.g., provider deaths and dissolutions of provider organizations). Sponsors must include providers' NPIs on all transactions that require providers to be identified,[3] including encounter data and PDE data submitted to CMS.[4, 5] Also, sponsors must have effective compliance programs to prevent, detect, and correct noncompliance with CMS's program requirements.[6]

Providers Ineligible for Medicare Payments

Pursuant to section 1128 of the Social Security Act (the Act), the Office of Inspector General (OIG) may exclude individuals and entities from participation in Medicare and Medicaid (e.g., individuals convicted of Medicare fraud). OIG maintains a database of all excluded providers known as the List of Excluded Individuals/Entities (LEIE). Federal law prohibits payment under Medicare for services provided or prescriptions written by excluded providers when the sponsor knows or has reason to know of the exclusion (Section 1862(e) of the Act).[7]

CMS maintains a list known as the Preclusion List that includes providers and prescribers who have been or could have been revoked from the Medicare program for conduct that CMS determines is detrimental to the best interest of the Medicare program. Federal regulations prohibit sponsors from making payments for services provided or prescriptions written by providers on the Preclusion List.[8] Sponsors that do not comply with preclusion requirements

[3] 45 CFR §§ 162.410 and 162.412.

[4] 42 CFR §§ 422.310(c)(2), (d)(5) and 423.329(b)(3).

[5] CMS allows some provider fields to be optional for encounter data and PDE data submission (e.g., referring and rendering providers). We note that, in April 2021, OIG issued a study entitled *Medicare Advantage Organizations Are Missing Opportunities To Use Ordering Provider Identifiers to Protect Integrity* (OEI Report OEI-03-19-00432). The study found that almost half of the MA organizations that lack ordering NPIs on at least some MA encounter records raised concerns that this hinders their data analysis for program integrity. Further, when MA organizations collect ordering NPIs on MA encounter records, most do not validate these NPIs against CMS's NPI registry.

[6] 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

[7] OIG has the authority to waive a provider's exclusion from Medicare when the excluded provider is the sole community physician or the sole source of essential specialized services in a community and the exclusion would impose a hardship on Medicare beneficiaries. Each waiver is subject to the limitations described in the provider's waiver letter. 42 CFR § 1001.1801.

[8] 42 CFR §§ 422.222(a) and 423.120(c)(6).

may be subject to sanctions and termination.[9] CMS implemented the preclusion requirements on January 1, 2019, and required sponsors to begin rejecting claims on April 1, 2019, to ensure that they did not submit encounter data and PDE data associated with precluded providers.

The Social Security Administration (SSA) maintains the Death Master File (DMF), a dataset of information on deceased individuals, including first name, last name, Social Security number (SSN), date of birth, and date of death. CMS uses weekly DMF updates from SSA to deactivate NPIs and other records of deceased providers. CMS considers deactivated NPIs to be ineligible for Medicare payment and Part B regulations prohibit Medicare payment to deactivated NPIs.[10] However, although Part D regulations expressly require sponsors and their pharmacy benefit managers to reject pharmacy claims unless the claims contain active and valid NPIs, CMS does not have similar requirements regarding claims submitted to Part C sponsors that contain invalid NPIs.

HOW WE CONDUCTED THIS AUDIT

Our audit covered all Medicare Part C encounter data and Part D PDE data for services billed or rendered and prescriptions written for Medicare beneficiaries in CYs 2018 and 2019 that sponsors submitted to CMS. Our analysis covered data for 1.46 billion encounters with $438 billion in total allowed charges[11] submitted by 770 Part C plans and data for 3 billion PDEs with $234 billion in total drug plan payments submitted by 811 Part D plans.[12] We matched these data to the LEIE, the Preclusion List, the NPPES Deactivated NPI Report, and the DMF to identify claims for services billed or rendered by ineligible providers.[13]

[9] 42 CFR §§ 422.222(b), 423.120(c)(6), 423.509, and 423.752(b).

[10] 42 CFR §§ 424.555(b) and 424.5(a)(2).

[11] Allowed charges are maximum amounts allowed by the Part C plan sponsors for payment. Sponsors submitted allowed charges instead of payments in their encounter data. We were unable to determine if the claims for Part C services were actually paid because sponsors' payments to providers are considered proprietary information.

[12] Medicare does not directly reimburse sponsors for providers' claims. Rather, sponsors pay the providers. As noted in background, Medicare pays sponsors on a capitated basis. These capitated payments are meant to reflect the expected cost of providing Medicare coverage to beneficiaries and include the cost of services and prescriptions. Accordingly, the dollar amounts presented in this report relate to transactions between sponsors and providers—not direct Medicare payments to providers. Although the financial impact to Medicare is not directly reflected in these dollar amounts, we note that the payments could impact how future capitation payment rates are calculated. The payments could also affect the results of the Part D reconciliation process that, based on a comparison of payments a sponsor receives to its costs, determines whether any residual payments are required by Medicare to sponsors or by sponsors to Medicare.

[13] We did not match data submitted to CMS prior to April 1, 2019, to providers on the Preclusion List because that was the first day CMS required sponsors to reject claims associated with precluded providers, according to a CMS memo to sponsors issued on Nov. 2, 2018, available at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Downloads/Sample_Beneficiary_Letter.pdf.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

CMS generally ensured that sponsors complied with Federal requirements for preventing payments for Medicare services to ineligible providers. Our analysis indicated that more than 99.97 percent of Part C encounter data and more than 99.99 percent of Part D PDE data for the audit period reported health care services associated with eligible providers. However, some sponsors submitted encounter and PDE data to CMS indicating that ineligible providers rendered services and wrote prescriptions for Medicare beneficiaries. We identified 136 Part C sponsors and 62 Part D sponsors that may have paid claims for health care services associated with ineligible providers. Specifically, 32 Part C sponsors may have paid $431,882 in claims associated with excluded providers, 36 Part C sponsors may have paid $287,370 in claims associated with precluded providers, 124 Part C sponsors may have paid $50.6 million in claims associated with deactivated NPIs, and 71 Part C sponsors may have paid $561,592 in claims associated with deceased providers prior to CMS's deactivation of the NPIs.[14] In addition, 35 Part D sponsors paid $747,604 in pharmacy claims associated with excluded providers, 2 Part D sponsors paid $397 in pharmacy claims associated with precluded providers, 18 Part D sponsors paid $296,501 in pharmacy claims associated with deactivated NPIs, and 36 Part D sponsors paid $93,771 in pharmacy claims associated with deceased providers prior to CMS's deactivation of their NPIs.[15]

The ineligible providers were able to submit the claims to plan sponsors because some sponsors may not have had effective compliance programs in place to prevent, detect, and correct noncompliance with CMS's program requirements.[16] Also, CMS may not have adequately monitored the sponsors to ensure that their compliance programs were effective. In addition, although Part D regulations expressly require sponsors and their pharmacy benefit managers to reject pharmacy claims unless the claims contain active and valid NPIs, CMS does not have similar requirements regarding claims submitted to Part C sponsors that contain invalid NPIs.[17]

[14] Of the 136 Part C sponsors, we identified 72 sponsors that may have paid claims associated with providers who were ineligible for multiple reasons.

[15] Of the 62 Part D sponsors, we identified 18 sponsors that paid claims associated with providers who were ineligible for multiple reasons.

[16] We did not review sponsors' compliance programs.

[17] 42 CFR § 423.120(c)(5).

Additionally, CMS system edits did not properly work to identify all ineligible providers after sponsors submitted their encounter and PDE data to CMS.

As a result, CMS used data from as many as 383,753 encounters reporting Part C services with $51.8 million in allowed charges and 24,322 PDEs reporting Part D pharmacy claims with $1.14 million in payments associated with ineligible providers in its risk adjustment of capitation payments to the sponsors. Therefore, data for these encounters and PDEs could have led to increased capitation payments to the sponsors. Additionally, we note that the associated providers are excluded or precluded for misconduct that is detrimental to the best interest of the Medicare program (e.g., noncompliance, felonies, and providing false information).

SPONSORS MAY HAVE PAID CLAIMS ASSOCIATED WITH EXCLUDED PROVIDERS

Federal requirements prohibit payments for Medicare services provided or prescriptions written by an excluded provider when the person furnishing such item or service knows or has reason to know of the exclusion.[18] Additionally, Part C and Part D sponsors are required to ensure compliance with Federal regulations prohibiting them from contracting with excluded providers or any entity that employs or contracts with excluded providers.[19]

Some sponsors may have paid claims associated with excluded providers and submitted associated encounter data and PDE data to CMS. Specifically:

- 32 Part C sponsors submitted data for 4,583 encounters with $431,882 in allowed charges associated with services billed or rendered by 77 excluded providers and

- 35 Part D sponsors submitted data for 16,323 PDEs with $747,604 in pharmacy claim payments associated with 7,942 prescriptions written by 35 excluded prescribers and 331 prescriptions filled by 1 excluded pharmacy.

This occurred because sponsors' compliance programs may not have been effective for preventing, detecting, and correcting noncompliance with CMS program requirements.

[18] Sections 1128 and 1862(e)(1) of the Act; 42 CFR §§ 422.222, 422.224, and 423.120; and 42 CFR § 1001.1901(b)(1).

[19] Specifically, 42 CFR § 422.204(b)(4) states that a Part C sponsor must follow a documented process to ensure compliance with 42 CFR § 422.752(a)(8) that prohibit employment or contracts with excluded providers or any entity that employs or contracts with excluded providers. Also, 42 CFR § 423.752(a)(6) prohibits Part D sponsors from employing or contracting with excluded providers or any entity that employs or contracts with excluded providers. Sponsors must have effective compliance programs to prevent, detect, and correct noncompliance with CMS's program requirements (42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi)). Where applicable, sponsors are subject to appropriate enforcement tools, as determined by CMS (42 CFR §§ 422.752, 423.752(b), and 423.509).

Also, CMS system edits did not always reject data associated with excluded providers because CMS did not implement edits to identify excluded providers by SSN, process waiver limitations that restrict excluded providers by service location,[20] or process retroactive exclusion dates.

As a result, CMS may have used encounter and PDE data associated with excluded providers in its risk adjustment of capitation payments to the sponsors. Data for these encounters and PDEs could have led to increased capitation payments to the sponsors. Additionally, we note that the associated providers are excluded for misconduct that is detrimental to the best interest of the Medicare program (e.g., noncompliance, felonies, and providing false information).

SPONSORS MAY HAVE PAID CLAIMS ASSOCIATED WITH PRECLUDED PROVIDERS

Federal regulations prohibit sponsors from making payments for services provided or prescriptions written by providers on CMS's Preclusion List.[21] Sponsors must have effective compliance programs to prevent, detect, and correct noncompliance with CMS's program requirements.[22] Where applicable, sponsors are subject to appropriate enforcement actions as determined by CMS.[23]

Some sponsors may have paid claims associated with precluded providers and submitted associated encounter data and PDE data to CMS.[24] Specifically:

- 36 Part C sponsors submitted data for 1,771 encounters with $287,370 in allowed charges associated with services billed or rendered by 53 precluded providers and

- 2 Part D sponsors submitted data for 3 PDEs with $397 in pharmacy claim payments associated with 3 prescriptions written by 3 precluded prescribers.

This occurred because sponsors' compliance programs may not have been effective for preventing, detecting, and correcting noncompliance with CMS program requirements. Also, CMS did not implement system edits for encounter data associated with precluded Part C providers until after our audit period, in March 2020—more than 1 year after it began requiring sponsors to reject claims associated with precluded providers. CMS officials stated that CMS

[20] Each OIG waiver of a provider's exclusion is subject to the limitations described in the provider's waiver letter, which includes service location. We identified five excluded providers who violated their waiver limitations. Three of the five excluded providers billed services under Part C, and all five excluded providers wrote prescriptions for drugs paid under Part D.

[21] 42 CFR §§ 422.222, 422.224, and 423.120.

[22] 42 CFR §§ 422.503(b)(4)(vi) and 423.504(b)(4)(vi).

[23] 42 CFR §§ 422.752, 423.752, and 423.509.

[24] Although excluded providers are on the preclusion list, we separately reported on these providers.

relied on Part D sponsors to delete or adjust any PDE data associated with precluded providers, which the sponsors have corrected after our analysis of the PDE data.

As a result, CMS may have used encounter and PDE data associated with precluded providers in its risk adjustment of capitation payments to the sponsors. Data for these encounters and PDEs could have led to increased capitation payments to the sponsors. Additionally, we note that the associated providers are precluded for misconduct that is detrimental to the best interest of the Medicare program (e.g., noncompliance, felonies, and providing false information).

SPONSORS MAY HAVE PAID CLAIMS ASSOCIATED WITH DEACTIVATED PROVIDER NUMBERS AND DECEASED PROVIDERS

Providers must use their NPIs to identify themselves on Medicare claims.[25] Part C and Part D sponsors must include providers' NPIs on all transactions that require providers to be identified,[26] including encounter data and PDE data submitted to CMS.[27] CMS collects and maintains information on NPIs and deactivates NPIs upon receipt of appropriate information.[28] Generally, Part D sponsors and their pharmacy benefit managers must reject pharmacy claims that do not contain active and valid NPIs.[29]

Some sponsors may have paid claims associated with providers whose NPIs were deactivated and providers who were deceased as of the date of the claimed service and submitted data on these claims to CMS. Specifically:

- 124 Part C sponsors submitted data for 372,497 encounters with $50.6 million in allowed charges associated with 1,514 physicians whose NPIs were deactivated;[30]

- 71 Part C sponsors submitted data for 4,902 encounters with $561,592 in allowed charges associated with 306 deceased providers' NPIs prior to CMS's deactivation of the NPIs;[31]

[25] 45 CFR § 162.410.

[26] 45 CFR § 162.412.

[27] 42 CFR §§ 422.310(c)(2), (d)(5) and 423.329(b)(3), 423.120(c)(5).

[28] 45 CFR § 162.408.

[29] If the Part D sponsor communicates that the NPI is not active and valid, the sponsor must permit the pharmacy to confirm or correct the NPI (42 CFR § 423.120(c)(5)). We did not review whether Part D sponsors followed up with the pharmacy to confirm or correct the NPI.

[30] Of the 1,514 deactivated providers, 505 providers associated with 78,644 Part C encounters were deceased.

[31] As of Nov. 1, 2021, CMS had not yet deactivated NPIs for 4 of the 306 deceased providers.

- 18 Part D sponsors submitted data for 6,876 PDEs with $296,501 in pharmacy claim payments associated with prescriptions filled by 24 pharmacies/pharmacists whose NPIs were deactivated, including 1 pharmacist associated with 5,858 pharmacy claims who was deceased; and

- 36 Part D sponsors submitted data for 1,120 PDEs with $93,771 in pharmacy claim payments associated with 762 prescriptions written using the NPIs of 173 deceased prescribers and 1 prescription filled using the NPI of 1 deceased pharmacist prior to CMS's deactivation of the NPIs.[32]

Specific to the data for 6,876 PDEs associated with deactivated NPIs, this occurred because Part D sponsors did not reject pharmacy claims associated with deactivated NPIs. Additionally, although Part D regulations expressly require sponsors and their pharmacy benefit managers to reject pharmacy claims unless the claims contain active and valid NPIs, CMS does not have similar requirements regarding claims submitted to Part C sponsors that contain invalid NPIs. Also, CMS system edits did not properly work to identify the deactivated NPIs after Part C and Part D sponsors submitted their data to CMS. In addition, CMS did not timely deactivate the NPIs of some deceased providers,[33] thereby allowing claims associated with these providers to be processed.

As a result, CMS may have used data from 377,399[34] Part C encounters and 7,996[35] Part D PDEs associated with deactivated NPIs and deceased providers in its risk adjustment of capitation payments to the sponsors. Data for these encounters and PDEs could have led to increased capitation payments to the sponsors.[36]

[32] As of Nov. 1, 2021, CMS had not yet deactivated NPIs for 18 of the 173 deceased prescribers.

[33] After receiving a DMF update from SSA, CMS must verify the death by sending a letter to the primary contact person for the NPI. According to CMS, it deactivates the NPI if no response is received after 30 days. However, our audit identified the NPIs of some providers who died between 2009 and 2017 that were not deactivated until 2019 or 2020. We also identified NPIs for 4 deceased Part C providers and 18 deceased Part D prescribers that were not deactivated as of Nov. 1, 2021.

[34] The 377,399 Part C encounters include 372,497 services associated with deactivated providers and 4,902 services associated with deceased providers prior to CMS's deactivation of the NPIs.

[35] The 7,996 Part D PDEs include 6,876 prescriptions associated with deactivated providers and 1,120 prescriptions associated with deceased providers prior to CMS's deactivation of the NPIs.

[36] We note that some sponsors submitted to CMS Part C encounter data that reported services by deceased providers for which the sponsors did not actually pay the associated providers. The inclusion of these encounters in the sponsors' Part C encounter data may have also affected CMS's calculation of capitation payments to the sponsors.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct Part C and Part D sponsors to recoup any recoverable payments for Medicare services made to the excluded and precluded providers identified in our audit;

- direct Part C and Part D sponsors to recoup any recoverable payments for Medicare services made outside of our audit period to the excluded and precluded providers identified in our audit;

- direct Part C and Part D sponsors to review their lists of contracted providers and take action to ensure that only eligible providers receive payments for Medicare services in accordance with Medicare payment rules;

- determine whether any compliance actions, sanctions, or termination, are appropriate for any sponsors, if applicable; and

- strengthen its oversight of sponsors and provider NPIs to prevent deactivated NPIs and deceased providers from receiving payments for Medicare services.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS stated that it believes that the results of our audit demonstrate a good faith and successful effort by CMS to ensure that ineligible providers do not receive payments from MA organizations and Part D sponsors. CMS concurred with our third recommendation and requested that we remove our remaining recommendations.

After reviewing CMS's comments, we removed a recommendation[37] and revised our fourth and fifth recommendations to clarify their meaning.[38] We maintain that our recommendations, as revised, are valid for the reasons detailed.

CMS also provided technical comments, which we addressed as appropriate. CMS's comments, excluding the technical comments, are included in their entirety as Appendix B.

[37] We removed our recommendation that CMS strengthen its system edits for identifying and rejecting claims associated with excluded, deactivated, and deceased providers in the encounter and PDE data submitted by sponsors.

[38] We revised our fourth recommendation to clarify that CMS determines if any enforcement actions are applicable. Also, we revised our fifth recommendation to specify that deactivated NPIs and deceased providers should not receive payments for Medicare services.

CMS COMMENTS

CMS stated that it is strongly committed to program integrity efforts in Medicare and has extensive policies and procedures in place to ensure ineligible providers do not receive payments for Medicare services. CMS also stated that Part C and Part D sponsors are required to have effective compliance programs to prevent, detect, and correct noncompliance with CMS's program requirements. CMS further stated that Part C and Part D sponsors are required to ensure that a valid NPI is present prior to payment and that it considers deactivated NPIs to be ineligible for Medicare payment. Additionally, CMS stated that it has implemented several edits in the encounter data and PDE data systems to verify NPI validity on submitted records.

Regarding our first two recommendations, CMS stated that, to most efficiently use program integrity resources, it directs these resources to areas with highest rates of return. CMS noted that OIG's findings demonstrated that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were to potentially ineligible providers. CMS stated that it will continue to monitor the success of its efforts to ensure that MA organizations and Part D sponsors pay only eligible providers. Regarding our fourth recommendation, CMS stated that, given the extremely low rate of noncompliance identified by OIG, CMS believes that it is very unlikely that additional analysis would result in a compliance or enforcement action. Finally, regarding our fifth recommendation, CMS stated that, in order to conserve program integrity and administrative resources, it directs resources to the areas with highest rates of return. CMS stated that it is not clear that additional oversight could further improve these outcomes.

OFFICE OF INSPECTOR GENERAL RESPONSE

We acknowledge that CMS directs its resources to areas with highest rates of return. However, we note that our first two recommendations are related to recouping prohibited payments made by Part C and Part D sponsors to excluded and precluded providers identified by our audit. Using our audit results, CMS can direct the sponsors to take corrective actions and then determine whether any enforcement actions are appropriate based on the sponsors' compliance. Also, allowing excluded and precluded providers to keep any prohibited payments could send the message that providers and sponsors may violate exclusion and preclusion requirements without consequence. Therefore, we continue to recommend that CMS direct Part C and Part D sponsors to recoup any recoverable payments for Medicare services made to the excluded and precluded providers identified by our audit during and outside of our audit period. Also, we continue to recommend that CMS determine whether any compliance actions, sanctions, or terminations are appropriate for any sponsors, if applicable.

Even though CMS considers deactivated NPIs to be ineligible for Medicare payment, it has not issued any regulations or policy guidance requiring Part C sponsors to reject submitted claims unless they contain active and valid NPIs. As indicated in our report, 124 Part C sponsors submitted data for 372,497 Part C encounters with $50.6 million in allowed charges associated with 1,514 physicians whose NPIs were deactivated. To ensure that ineligible providers do not

receive payments from Part C sponsors, CMS should not allow anyone to use the deactivated NPIs of deceased or inactive providers to submit claims to Part C sponsors for Medicare services. Also, CMS should require that Part C sponsors reject submitted claims unless they contain active and valid NPIs. Therefore, we continue to recommend that CMS strengthen its oversight of sponsors and provider NPIs to prevent deactivated NPIs and deceased providers from receiving payments for Medicare services.

Finally, we commend CMS for implementing several edits in its encounter data and PDE data systems after our audit period to verify NPI validity on submitted records. We also acknowledge that additional oversight could increase plan and Government costs and operational burden beyond achievable cost savings. Therefore, we removed our recommendation that CMS strengthen its system edits for identifying and rejecting claims associated with excluded, deactivated, and deceased providers in the encounter and PDE data submitted by sponsors.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered all Medicare Part C encounter data and Part D PDE data for services billed or provided and prescriptions written for Medicare beneficiaries nationwide in CYs 2018 and 2019 (audit period) that sponsors submitted to CMS. We analyzed data for 1.46 billion encounters with $438 billion in total allowed charges submitted by 770 Part C plans and data for 3 billion PDEs with $234 billion in total drug plan payments submitted by 811 Part D plans.

We did not assess CMS's overall internal control structure. Rather, we limited our review of CMS's internal controls to those applicable to our audit objective. This included reviewing CMS's issued policies related to ineligible providers and CMS's processes for ensuring that sponsors complied with Federal requirements related to ineligible providers. Our audit did not include a review of sponsors' compliance programs to determine their effectiveness in preventing payments to ineligible providers.

We performed audit work from October 2020 to June 2022.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- met with CMS officials to gain an understanding of CMS's internal controls for preventing payments to ineligible providers;
- obtained and reviewed the LEIE, Preclusion List, NPPES Deactivated NPI Report, and DMF effective for CYs 2018 and 2019;
- matched encounter data and PDE data to:
    - the LEIE to identify excluded providers based on NPIs, SSNs, employer identification numbers (EINs), and individual names combined with dates of birth;
    - the Preclusion List to identify ineligible providers based on NPIs;
    - the NPPES Deactivated NPI Report to identify ineligible providers based on NPIs;
    - the DMF to identify deceased providers whose NPIs had not been deactivated; and
- discussed the results of our audit with CMS officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 22, 2022

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *CMS Did Not Ensure That Medicare Part C and Part D Sponsors Did Not Pay Ineligible Providers for Services to Medicare Beneficiaries* (A-02-20-01027)

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 notes that of the 1.46 billion encounters submitted during the OIG's audit period potential errors were found in only 0.02 percent of Medicare Advantage (MA) encounters and 0.0008 percent of Part D prescription drug events (PDEs). This represents a potential 0.01 percent of total allowed charges in MA and 0.0005 percent of total drug plan payments submitted as PDE data by Part D plans for all services billed or rendered, and prescriptions written for Medicare beneficiaries during the audit period. CMS believes that these results demonstrate a good faith and successful effort to ensure that ineligible providers do not receive payments from MA organizations and Part D sponsors. It is also important to note this is a contracting and payment issue, and beneficiaries were not prevented from accessing care.

CMS has extensive policies and procedures in place to ensure ineligible providers do not receive payments for Medicare services. In addition, MA organizations and Part D sponsors are required to have effective compliance programs to prevent, detect, and correct noncompliance with CMS's program requirements.

MA organizations and Part D sponsors are required to ensure that a valid National Provider Identifier (NPI) is present prior to payment. CMS collects and maintains information on NPIs and deactivates or reactivates NPIs upon receipt of appropriate information, such as death of a provider or dissolution of a provider organization. CMS considers deactivated NPIs to be ineligible for Medicare payment. CMS has implemented several edits in the encounter data and PDE data systems to verify NPI validity on submitted records. To further aid MA organizations and Part D sponsors, CMS established the Preclusion List to ensure patient protections and safety and to protect the Trust Funds from prescribers and providers identified as bad actors. The Preclusion List generally consists of individuals or entities who have been revoked from the Medicare program, could have been revoked had they been enrolled, or who have been convicted of a certain felony within the previous 10 years, and the conduct that led to the revocation or felony is considered detrimental to the Medicare program. MA organizations and Part D sponsors are required to use the CMS Preclusion List when paying or contracting with any provider. To assist MA organizations and Part D sponsors, CMS shares the Preclusion List with these entities every month for their review.

In addition, OIG maintains the List of Excluded Individuals and Entities (LEIE), a list of individuals and entities excluded from participation in Federally funded health care programs due to conviction for certain types of criminal offenses. While a state may request a waiver for an excluded provider who is the sole community physician or the sole source of essential specialized services in a community and the exclusion would impose a hardship on beneficiaries, each waiver is unique and must be read individually to determine what services the provider is permitted to provide. Therefore, CMS has in place PDE informational edits that flag when a prescriber or service provider is waived and prompt the plan sponsor to review the specific waiver to determine if the waiver is applicable for services associated with the PDE.

Federal regulations prohibit MA organizations from paying or contracting with providers on the LEIE or Preclusion List and prohibits Medicare payments for services provided or prescriptions written by individuals or entities on the LEIE when the sponsor knows or has reason to know of the exclusion. CMS has implemented several edits in the encounter data system to verify providers against the preclusion and LEIE lists. Further, federal regulations prohibit Part D sponsors from paying a pharmacy claim for a Part D drug prescribed by an individual on the Preclusion List. CMS enforces this Part D requirement through system edits and follow-up with individual Part D plan sponsors.

Lastly, the Social Security Administration (SSA) maintains the Death Master File (DMF), a dataset of information on deceased individuals. CMS uses weekly DMF updates from SSA to deactivate NPIs and other records of deceased providers. CMS considers deactivated NPIs to be ineligible for Medicare payment.

CMS appreciates OIG's work in this area, which highlights the success of these efforts by finding that two one-hundredths of a percent of claims, or fewer, were paid incorrectly. To most efficiently use program integrity resources, CMS directs resources to the areas with highest rates of return. CMS will continue to monitor the success of its efforts to ensure that MA organizations and Part D sponsors pay only eligible providers.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should direct Part C and Part D sponsors to recoup any recoverable payments for Medicare services made to the excluded and precluded providers identified in our audit.

CMS Response

CMS appreciates OIG's work in this area, and its findings that demonstrated that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were made to potentially ineligible providers. As stated above, to most efficiently use program integrity resources, CMS directs resources to the areas with highest rates of return. CMS will continue to monitor the success of its efforts to ensure that MA organizations and Part D sponsors pay only eligible providers. Therefore, CMS has requested that OIG remove this recommendation.

OIG Recommendation

CMS should direct Part C and Part D sponsors to recoup any recoverable payments for Medicare services made outside of our audit period to the excluded and precluded providers identified in our audit.

CMS Response
CMS appreciates OIG's work in this area, and its findings that demonstrated that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were to potentially ineligible providers. As OIG did not rely on a sampling, but examined each of the 1.46 billion MA encounter data records and 3 billion Part D PDEs, we believe that MA organization and Part D sponsor payments outside of the audit period would likely demonstrate the same level of compliance. As stated above, to most efficiently use program integrity resources, CMS directs resources to the areas with highest rates of return. CMS will continue to monitor the success of its efforts to ensure that MA organizations and Part D sponsors pay only eligible providers. Therefore, CMS has requested that OIG remove this recommendation.

OIG Recommendation
CMS should direct Part C and Part D sponsors to review their lists of contracted providers and take action to ensure that only eligible providers receive payments for Medicare services in accordance with Medicare payment rules.

CMS Response
CMS concurs with this recommendation. CMS will direct MA organizations and Part D sponsors to review their lists of contracted providers and/or pharmacies and take action to ensure that only those eligible receive payments for Medicare services in accordance with Medicare payment rules.

OIG Recommendation
CMS should determine whether any compliance actions, sanctions, or termination, are appropriate for any sponsors.

CMS Response
CMS appreciates OIG's work in this area, and its findings that demonstrated that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were to potentially ineligible providers. Given the extremely low rate of non-compliance identified by the OIG, it is very unlikely that additional analysis by CMS would result in a compliance or enforcement action. Therefore, CMS has requested that OIG remove this recommendation.

OIG Recommendation
CMS should strengthen its oversight of sponsors and provider NPIs to prevent ineligible providers from receiving payments for Medicare services.

CMS Response
In order to conserve program integrity and administrative resources, CMS directs resources to the areas with highest rates of return. Because this report demonstrated that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were to potentially ineligible providers, it is not clear that additional oversight could further improve these outcomes. Therefore, CMS has requested that OIG remove this recommendation.

OIG Recommendation
CMS should strengthen its system edits for identifying and rejecting claims associated with excluded, deactivated, and deceased providers in the encounter and PDE data submitted by sponsors.

CMS Response

In order to conserve program integrity and administrative resources, CMS directs resources to the areas with highest rates of return. This report demonstrated the success of the current system edits by finding that only 0.01 percent of total allowed charges in MA and 0.0005 percent of total payments in Part D during the audit period were to potentially ineligible providers, and it is not clear that additional oversight could further improve these outcomes without significantly increasing plan and government cost and operational burden to the extent that any savings achieved would be completely offset.

In addition, it is important to note that CMS uses diagnoses, not specific services, in calculating risk scores. Therefore, it may be possible that an encounter from an ineligible provider was submitted to CMS with a diagnosis that is also on an encounter from an eligible provider. In this scenario, CMS would still use the diagnosis in calculating risk scores. Therefore, CMS has requested that OIG remove this recommendation.

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