DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

JAN 15 2002

CIN: A-04-01-01004

Mr. Gary Redding, Commissioner
Georgia Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W., 40th Floor
Atlanta, Georgia 30303-3159

Dear Mr. Redding:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, ***Audit of the Office of Inspector General Excluded Providers in Georgia.***

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by Public Law 104-231, OIG, OAS reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 Code of Federal Regulations Part 5.) As such, within 10 business days after this final report is issued, it will be posted on the World Wide Web at http://www.hhs.gov/progorg/oig.

To facilitate identification, please refer to Common Identification Number (CIN) A-04-01-01004 in all correspondence relating to this report. If you have any questions, please call me or Andrew Funtal of my staff, at (404) 562-7800.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:
Mr. Eugene Grasser
Associate Regional Administrator – Region IV
Centers for Medicare & Medicaid Services
61 Forsyth Street, S.W., Suite 4T20
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF OFFICE OF INSPECTOR GENERAL EXCLUDED PROVIDERS IN GEORGIA

JANET REHNQUIST
Inspector General

JANUARY 2002
A-04-01-01004

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Mr. Gary Redding, Commissioner
Georgia Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W., 40th Floor
Atlanta, Georgia 30303-3159

Dear Mr. Redding:

This final report provides you with the results of our ***Audit of the Office of Inspector General Excluded Providers in Georgia***.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of the audit was to determine whether the Georgia Medicaid Program is appropriately preventing providers that have been excluded from the Medicare and Medicaid programs by the Office of Inspector General (OIG) from being enrolled and paid by the Medicaid program.

FINDINGS

Our review indicated that the Georgia Medicaid Program made $41,245.40 ($23,132.57 Federal share) in payments during Calendar Year (CY) 1999 to providers that had been excluded by the OIG during that same period. These improper Medicaid payments occurred because the Georgia Department of Community Health does not have an adequate mechanism in place to prevent excluded providers from participating in the Medicaid program.

RECOMMENDATIONS

We recommend that these payments be rebooked on the State of Georgia's HCFA64 Quarterly Expenditure Report as recoveries.

We also recommend that the State take additional steps to prevent excluded providers from participating in the Georgia Medicaid program, and to terminate payments to those providers who are already enrolled and who are excluded in the future by the OIG. Specifically,

- full background checks should be run on all providers seeking enrollment in the Medicaid program;

- Medicaid providers should be required to reenroll every 2-3 years. This would ensure background checks are performed on all providers; and

- periodic post-enrollment site visits should be conducted to determine the validity of the provider and his billing number(s).

A copy of this report will also be provided to the OIG's Office of Investigations (OI) for use at their discretion in enforcing the excluded provider regulations.

We believe the issues identified in this report may also be occurring in other States' Medicaid programs. Therefore, we are initiating other reviews to determine if further recommendations are necessary to address a nationwide systemic problem.

The Georgia Department of Community Health (DCH) has concurred with the findings and recommendations of this report. Additionally, DCH has made some suggestions for improvement of the facilitation of the OIG excluded providers database. A synopsis of their comments is contained in the section titled *Results of Review – Recommendations and Auditee Response.* The complete text of DCH's response is attached to this report as Appendix A.

BACKGROUND

Georgia Medicaid Program

Medicaid (Title XIX of the Social Security Act) is a jointly funded Federal-State health program for eligible low-income and needy individuals. It covers approximately 41 million individuals, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. In Fiscal Year (FY) 1999, the Federal and State Governments jointly expended $180.9 billion to provide for medical care to Medicaid beneficiaries. These expenditures are projected to increase to $285 billion by FY 2005. The Centers for Medicare & Medicaid Services (CMS - formerly the Health Care Financing Administration) provides Federal oversight for the Medicaid program.

States are allowed, within Federal laws, regulations, and program policies, to exercise discretion in the methods used to administer, operate, and reimburse services for their Medicaid programs. Nonetheless, the Federal Government retains an obligation to ensure that Medicaid beneficiaries

receive services only from qualified providers and that excluded providers do not receive reimbursement from the Medicaid program.

The Georgia Medical Assistance Program (Medicaid) became effective in October 1967, under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act. The State of Georgia created the Department of Medical Assistance (DMA) on July 1, 1977 to administer the State's Medicaid program. Medicaid is jointly funded by the State of Georgia and the Federal Government. The primary purpose of the Georgia Medicaid program is to furnish medical assistance to low income families with dependent children and aged, ailing, or disabled individuals who are unable to afford the cost of medical services. This is accomplished by enlisting health care professionals as Medicaid providers and reimbursing them after they perform authorized services to individuals who qualify for medical assistance under DMA guidelines. A provider of medical care services interested in eligibility for reimbursement of covered Title XIX benefits must be enrolled with the DMA for the appropriate category of service.

As of September 15, 1993, the Provider Enrollment Unit of the Electronic Data Systems, the company contracted in Georgia to maintain the provider database, is responsible for the clerical functions of provider enrollment. In October 1998, the DMA, through the Provider Enrollment Unit, became responsible for processing provider enrollment requests to ensure that only qualified providers, who agree to comply with Title XIX rules and regulations, are duly enrolled.

The current structure of the DCH was created by law in July 1999. The DCH was formed to serve as the lead agency for the coordination of health care purchasing decisions on behalf of the State of Georgia. A nine-member board appointed by the Governor sets the general policy for DCH. The DCH has the responsibility for:

- insuring the health care of nearly 2 million individuals – 25 percent of Georgia's population;
- maximizing the State's health care purchasing power;
- planning for health care coverage of an estimated 1.3 million uninsured Georgians;
- administering funds from the tobacco suit settlement; and
- coordinating health planning for State agencies.

The OIG Excluded Provider List

The Secretary of the Department of Health and Human Services (HHS) has delegated to the OIG the authority, under sections 1128 and 1156 of the Social Security Act, to exclude certain health care providers from most Federal health care programs. Under the law, the OIG, which acts through its OI, must exclude, nationwide, providers that have been convicted of a criminal offense related to Medicare or any State health care program, a criminal offense related to patient abuse or neglect, or a felony related to other health care fraud or controlled substances.

The OIG exclusions apply to Medicare (Title XVIII of the Social Security Act) and State health care programs defined as Medicaid (Title XIX), Maternal and Child Health Services Block grant (Title V), and block Grants to States for Social Services (Title XX).

When an individual or entity is excluded, notification is sent to the appropriate licensing boards and the exclusion is posted on the OIG's web site (http://www.dhhs.gov/progorg/oig). On a monthly basis, reports of all exclusions being implemented are released to all payer agencies in the United States. Specific notice is provided to CMS for its use in notifying all Medicare and Medicaid agencies of the exclusion action. The exclusion is also published in the Federal Register and in the Federal debarment listing. A cumulative report of all exclusions in effect is published twice a year and is available on the Internet. Cumulative reports are routinely sent by the OIG to recipients of the monthly reports and, on a request-specific basis, to other interested parties. The excluded parties are only removed from the cumulative list if and when they are reinstated – they are shown on the list regardless of whether eligible for reinstatement or not.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine whether the Georgia Medicaid Program is appropriately preventing providers that have been excluded from the Medicare and Medicaid programs by the OIG from being enrolled and paid by the Medicaid program.

Scope

As part of our review, we obtained an understanding of the internal control structure of those controls relating to the enrollment of providers into the Medicaid program in Georgia; however, we did not perform an assessment of these controls. With respect to the payments to providers that were downloaded by the State of Georgia and used to calculate the error amounts, we restricted our time frame to only those payments occurring in CY 1999.

Methodology

To accomplish the objective of this audit, we:

- performed an initial review of the internal controls associated with Medicaid provider enrollment in Georgia through interviews and publications provided by DCH. This provided us with a working knowledge of the process of enrollment as well as the history and background of the State of Georgia Medicaid program.

- obtained the OIG Excluded Provider database and matched it to the database of Georgia Medicaid providers used by the State of Georgia, Department of Audits and Accounts. The match was performed based on the social security number in the OIG Database, and the tax ID number in the Georgia database. This match was then further refined through software and manual sorts.

- based on this list of provider matches, a spreadsheet of payments made during CY 1999 was provided by the State of Georgia Department of Audits and Accounts. The payment list was then compared to the individual exclusion date(s) of each of the associated providers. Those payments made during a provider's exclusion period were counted as errors and calculated. Those payments made outside a provider's exclusion period were considered a non-error. A list of nine provider identification numbers and their associated error amounts was compiled.

- the error list was reviewed to determine if any of the excluded providers had been granted waivers of their exclusion. Because one provider had been granted a waiver due to his service area being "medically underserved," the list of errors was reduced to eight provider identification numbers and their associated error amounts.

We conducted our audit in accordance with generally accepted government auditing standards. Fieldwork was performed at the offices of Georgia Department of Community Health, Atlanta, Georgia, and the HHS/OIG/Office of Audit Services offices in Atlanta, Georgia and Tallahassee, Florida from December 2000 through September 2001.

RESULTS OF REVIEW

Our review indicated that the Georgia Medicaid Program made $41,245.40 ($23,132.57 Federal share) in payments during CY 1999 to providers that had been excluded by the OIG during that same period.

CRITERIA

The Code of Federal Regulations (CFR), Title 42, Section 1001.2, defines exclusion as:

> *"Items and services furnished, ordered or prescribed by a specified individual or entity will not be reimbursed under Medicare, Medicaid and all other Federal health care programs until the individual or entity is reinstated by the OIG. A Federal health care program is any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program."*

With respect to these reimbursements, or payments, CFR, Title 42, Section 1002.211 states:

> *"No payment may be made by the State agency for any item or service furnished on or after the effective date specified in the notice by an excluded individual or entity, or at the medical direction or on the*

> *prescription of a physician who is excluded when a person furnishing such item or service knew, or had reason to know, of the exclusion."*

Clarification of this issue is also provided by the Balanced Budget Act of 1997 (BBA 1997) which emphasizes that "no agency which funds a Federal health care program may reimburse excluded individuals for items or services they provide, nor may any such agency pay the salaries or expenses of such persons using Federal dollars." The exclusion applies to any individual or entity that provides or supplies items or services, directly or indirectly.

CONDITION

We determined that the Georgia Medicaid program made improper payments to nine different provider numbers that had been previously excluded by the OIG. Of these nine provider numbers, only one (Provider G) had been granted a waiver of his exclusion. The remaining eight provider identification numbers accounted for $41,245.40 ($23,132.57 Federal share) in erroneous payments.

Provider Number	Summary of Total Amount Paid	Total # of Claims Paid	*Amount of Error*
A	6,138.33	644	$6,138.33
B	11,895.82	184	$4,109.44
C	1,048.78	2	$1,048.78
D	21,715.04	192	$21,715.04
E	74,607.10	920	$1,926.07
F	21,533.54	264	$1,002.23
G	***30,667.87***	***306***	***$30,667.87***
H	23.24	1	$23.24
I	5,282.27	29	$5,282.27
	Total Error Amt:		**$71,913.27**
	Less: Waiver of Provider G		**($30,667.87)**
	TOTAL ERROR:		**$41,245.40**

Of the above nine providers, all but Provider G were listed as effective in the Georgia Medicaid program prior to their exclusion by the OIG. Provider G's exclusion preceded the effective date by 3 years. However, the waiver on Provider G allows Georgia to make Medicaid payments for covered services during 1999.

The existence of these payments illustrates that the Georgia Medicaid program has weaknesses in detecting excluded providers during the enrollment process, as well as providers that are currently enrolled.

CAUSE

These overpayments occurred because the Georgia DCH does not have an adequate mechanism in place to prevent excluded providers from participating in the Medicaid program. In other States, we have found that internal controls to prevent the above improper payments from occurring have included: (1) full background checks on all providers seeking enrollment in the Medicaid program, (2) reenrollment of Medicaid providers every 2-3 years, and (3) periodic post-enrollment site visits to determine the validity of the provider. The Georgia Medicaid program has not incorporated any of these controls.

EFFECT

Providers in the State of Georgia who should be excluded from receiving payments from any federally funded health program received $41,245.40 ($23,132.57 Federal share) in improper Medicaid payments during CY 1999.

RECOMMENDATIONS AND AUDITEE RESPONSE

The DCH has concurred with the findings and recommendations of this report. Our specific recommendations and a summary of DCH's response are listed below. The complete text of DCH's response is enclosed to this report as Appendix A.

Recommendation

We recommend that these payments be rebooked on the State of Georgia's HCFA64 Quarterly Expenditure Report as recoveries.

DCH Response

The DCH concurs, and will rebook the $41,245.50 on the State of Georgia's HCFA 64 Quarterly Expenditure Reports as recoveries. The DCH will pursue recovery of the amount as needed.

Recommendation

We also recommend that the State take additional steps to prevent excluded providers from enrolling in the Georgia Medicaid program, and to terminate payments to those providers who are already enrolled and who are excluded in the future by the OIG. Specifically,

- full background checks should be run on all providers seeking enrollment in the Medicaid program;

- Medicaid providers should be required to reenroll every 2-3 years. This would ensure background checks are performed on all providers; and

- periodic post-enrollment site visits should be conducted to determine the validity of the provider and his billing number(s).

DCH Response

The DCH concurs. With the implementation of the new Medicaid Management Information System (MMIS), DCH will verify an applicant provider's background information before allowing a provider to enroll, and overall enrollment procedures will be improved. In addition, DCH will require Medicaid providers to be re-credentialed every 2 to 3 years as a requirement of continued participation. The DCH has in the past and is now conducting periodic post-enrollment site visits to validate providers and provider numbers.

A copy of this report will also be provided to the OIG's OI for use at their discretion in enforcing the excluded provider regulations.

We believe the issues identified in this report may also be occurring in other States' Medicaid programs. Therefore, we are initiating other reviews to determine if further recommendations are necessary to address a nationwide systemic problem.

APPENDIX

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

Roy E. Barnes, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.communityhealth.state.ga.us

Gary B. Redding
Commissioner
404.656.4507
404.651.6880 fax

December 27, 2001

Mr. Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Re: CIN: A-04-01-01004

Dear Mr. Curtis:

We have reviewed your letter dated December 3, 2001, and the accompanying draft report titled "*Audit of the Office of Inspector General ("OIG") Excluded Providers in Georgia.*" This letter addresses the draft report's recommendations in the sequence presented on page seven (7) of the report. We have added notes of corrective actions planned or taken and some suggestions for improvement in the access to information.

First Recommendation, Page 7

We concur. The Georgia Department of Community Health (DCH) will rebook the **$41,245.40** on the State of Georgia's HCFA 64 Quarterly Expenditure Report as recoveries. DCH will pursue recovery of the amount as needed.

Second Recommendation, Page 7

We concur. With the implementation of the new Medicaid Management Information System (MMIS), DCH will verify an applicant provider's background information before allowing a provider to enroll, and overall enrollment procedures will be improved. In addition, DCH will require Medicaid providers to be re-credentialed every two (2) to three (3) years as a requirement of continued participation. DCH has in the past and is now conducting periodic post-enrollment site visits to validate providers and provider numbers.

DCH has utilized the cross-reference system referred to in the last paragraph on page three (3) of the draft to identify excluded providers. As discussed in the exit conference with your staff, we think improvements can be made in the notification process.

Our suggestions for improvements are:

(1) The OIG should include the Federal Employer's Identification Number in its database to cross-reference providers and businesses with similar names;

(2) Many of the providers on the OIG's list were not listed on its web site. The OIG web site should be updated frequently.

(3) The OIG should provide an electronic database of excluded providers to Medicaid agencies annually or more frequently for data match analysis by the agencies.

We appreciate the opportunity to comment on this draft report. If additional information is needed, please contact Alan Sacks, Audit Coordinator for DCH, at (404) 657-7113.

Sincerely,

Gary B. Redding

cc: Clyde Reese
Ruth Carr
Jacqueline Koffi
Alan Sacks
Byron Bohannon