MAY 19 2010

**TO:** Marilyn Tavenner
Acting Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

**FROM:** Stuart Wright /S/
Deputy Inspector General
for Evaluation and Inspections

**SUBJECT:** Memorandum Report: *Excluded Medicaid Providers: Analysis of Enrollment*, OEI-09-08-00330

This memorandum report provides information on the enrollment of selected Medicaid providers that the Office of Inspector General (OIG) later excluded from participation in Federal health care programs. Our review included 188 Medicaid providers from 26 States that OIG excluded between January 1, 2007, and June 30, 2008. Specifically, we examined the providers' backgrounds before and after they enrolled to gather information related to potential weaknesses in States' provider enrollment procedures. For example, we reviewed the providers' backgrounds to determine whether providers with questionable financial and criminal histories gained entry into Medicaid. Twenty-four out of 188 excluded providers had a history of tax debt, criminal convictions, or false disclosures before they enrolled.

States must comply with Federal regulations at 42 CFR § 455.104 and 42 CFR § 455.106, which require States to collect specific information from providers. States require providers to disclose information on ownership and control of an entity and criminal convictions related to Federal health care programs. The regulations do not require States to verify this information, although States may impose additional enrollment requirements. According to the Centers for Medicare & Medicaid Services' (CMS) Medicaid Integrity Group (MIG), 18 out of the 19 States it reviewed in fiscal years 2007 and 2008 did not collect the required information related to ownership, and 17 out of 19 States did not comply with the Federal disclosure requirement for criminal convictions.

Based on our review of 188 excluded providers and the policies and procedures of the 26 States that enrolled them, we found:

- Eight providers disclosed false information about ownership at the time of enrollment,
- States impose few enrollment requirements beyond those mandated by Federal regulations, and
- Current regulations do not require disclosure of nonprogram-related convictions or tax liens.

## BACKGROUND

Medicaid is an entitlement program for eligible low-income and medically needy people. In fiscal year 2009, Medicaid covered 59 million people nationally at a cost of $372 billion (Federal and State expenditures).[1] States spent $20 billion,[2] or 5 percent of this amount, on program administration, which includes provider enrollment. The Federal Government paid for 50 percent of States' administrative costs.[3]

### Medicaid Provider Enrollment

The Federal Government prescribes requirements for provider enrollment. Providers must disclose (1) all persons with an ownership interest of 5 percent or more in a disclosing entity and (2) criminal convictions related to Federal health care programs.[4] (Appendix A contains additional information on these Federal disclosure requirements.) States must collect specific information from providers, but are not required to verify the accuracy of providers' disclosures when entering into or renewing a provider agreement. However, States may impose additional requirements to improve the screening of potential providers.

Although States must collect information about ownership and program-related convictions, they vary in the other information that they collect from providers and the procedures that providers must follow to enroll in the Medicaid program. These procedures may include criminal background checks, site visits, probationary enrollment, and reenrollment.[5] Criminal background checks range from checks of State databases to a national check by the Federal Bureau of Investigation (FBI). Site visits are inspections, typically for certain high-risk provider types, such as durable medical equipment (DME) and transportation providers. Probationary enrollment is time-limited enrollment for

[1] CMS, *CMS Financial Report, Fiscal Year 2009*. Accessed at http://www.cms.hhs.gov/CFOReport/Downloads/2009_CMS_Financial_Report.pdf on February 3, 2010.
[2] Ibid.
[3] 42 CFR § 433.15(b)(7).
[4] 42 CFR §§ 455.104 and 455.106.
[5] U.S. Government Accountability Office (GAO), *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments* (GAO-04-707), July 2004, pp. 8–11.

certain providers, such as nonemergency transportation providers. Reenrollment is a process in which providers reapply to Medicaid at specific intervals.

**Medicaid Integrity Group**

Since 2006, MIG has assessed States' compliance with Federal requirements for provider enrollment. MIG performs this function by conducting onsite reviews of States' program integrity operations once every 3 years. In addition to assessing compliance with Federal laws and regulations, the reviews (1) identify vulnerabilities and effective practices, (2) help States improve program integrity, and (3) identify opportunities for CMS to provide technical assistance to States.[6] After each review, MIG issues a report to the State. According to MIG, 18 out of the 19 States it reviewed in fiscal years 2007 and 2008 did not comply with the Federal disclosure requirement for ownership (42 CFR § 455.104), and 17 out of 19 did not comply with the Federal disclosure requirement for criminal convictions (42 CFR § 455.106).[7]

MIG's comprehensive plan for fiscal years 2009 to 2013 proposes to strengthen provider enrollment by developing a joint enrollment system with Medicare, known as the Uniform Provider Enrollment Project (UPEP).[8] The objective of the UPEP is to develop and implement a secure, centralized provider enrollment system that would meet both Medicare and Medicaid requirements. This system would include a Web-based application for providers and a national provider file that would include information about ownership, disciplinary actions by licensing boards, and terminations.

**Exclusion From Federal Health Care Programs**

Since 1977, the Secretary of Health & Human Services has had the authority to exclude certain individuals and entities from Medicare and Medicaid.[9] Pursuant to this authority, between January 1, 2007, and June 30, 2008, OIG excluded a total of 4,991 individuals and entities. Exclusions can be mandatory or permissive. Mandatory exclusions are required by law, and permissive exclusions are imposed at the discretion of OIG. For example, a provider convicted of a program-related crime must be excluded; a provider whose license was revoked or suspended may be excluded.

An excluded provider cannot bill or cause bills to be submitted to any Federal health care program for direct or indirect services or for any administrative or management services.[10] In addition, an excluded provider may be debarred from all Federal grants and

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[6] CMS, *Medicaid Integrity Program, Program Integrity Review Annual Summary*, May 2009. Accessed at http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2009pireviewannualsummaryreport.pdf on July 15, 2009.

[7] Ibid.

[8] CMS, Center for Medicaid and State Operations, MIG, *Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program, FYs 2009–2013*, July 2009, p. 10.

[9] Social Security Act, § 1128, 42 U.S.C. § 1320a-7.

[10] OIG Special Advisory Bulletin: *The Effect of Exclusion from Participation in Federal Health Care Programs*. September 1999.

contracts.[11] However, an excluded provider may bill and receive payment for certain emergency services. The current bases for mandatory exclusion include convictions related to program-related fraud, patient abuse and neglect, nonprogram-related health care fraud, and controlled substances. Bases for permissive exclusions include licensing board actions and defaults on Health Education Assistance Loans (HEAL).[12] Exclusion has national effect and applies even if the provider obtains another license or moves to another State. OIG maintains a List of Excluded Individuals/Entities (LEIE) on its public Web site. OIG's exclusions also are listed on the General Services Administration's publicly searchable Web site of all individuals and entities debarred by any Federal agency, known as the Excluded Parties List System. Information about excluded providers also is included in the Healthcare Integrity and Protection Data Bank (HIPDB).

**Federal Tax Debt and the Link to Fraud**

Research suggests a correlation between tax debt and fraud. For example, in 2007, GAO reported that over 30,000 Medicaid providers, about 5 percent of those paid in fiscal year 2006, owed a total of over $1 billion in unpaid Federal taxes. GAO selected 25 providers for more in-depth investigation and found abusive and criminal activity, including fraud.[13]

In 2003, the Los Angeles County Office of the District Attorney established the Fraud Interdiction Program. When the District Attorney's Office identifies a health care fraud suspect, it collects reimbursement data from a variety of public and private payers, such as insurance companies, and sends the information to the State of California Franchise Tax Board. If the suspect failed to file or pay State income taxes, the Tax Board reports the information to the District Attorney's Office, which files felony tax charges. Since the program began, it has identified more than 200 suspects who were responsible for more than $300 million in fraudulent health care claims.[14] The program has resulted in convictions and prison sentences for the defendants.

**Related Work**

Both OIG and GAO have identified vulnerabilities in Medicaid provider enrollment. In a 2006 report, OIG reviewed Medicaid enrollment standards for DME providers and found that most of the 15 States it reviewed did not verify whether providers met the standards.[15] In a 2001 report, OIG examined credentialing and enrollment policies among States and identified systemic weaknesses, including the lack of verification of

[11] Federal Acquisition Streamlining Act of 1994, P.L. 103-355, § 2455; 31 U.S.C. § 6101; 45 CFR 76.115.
[12] From fiscal year 1978 through 1998 the Federal HEAL Program insured loans made by participating lenders to eligible graduate students in schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, public health, pharmacy, chiropractic, and clinical psychology; or in programs in health administration.
[13] GAO, *Thousands of Medicaid Providers Abuse the Federal Tax System*, November 2007, cover page.
[14] The Bureau of National Affairs, *Health Care Fraud Report*, Vol. 12, No. 17, August 13, 2008.
[15] OIG, *Medicaid Provider Enrollment Standards: Medical Equipment Providers*, October 2006 (OEI-04-05-00180).

providers' disclosures.[16] In 2004, GAO issued a report that identified successes and limitations of State and Federal efforts to control Medicaid fraud and abuse. GAO described States' measures to tighten enrollment.[17] In 2000 testimony, GAO detailed how weak provider enrollment procedures allowed questionable providers easy entry into both Medicaid and Medicare.[18] According to GAO, both programs rely heavily on providers' honesty rather than verification.[19]

## METHODOLOGY

### Scope

We reviewed individuals and entities that had enrolled in Medicaid and that OIG subsequently excluded from Federal health care programs, including Medicare, Medicaid, and all other plans and programs that provide health benefits funded directly or indirectly by the United States (other than the Federal Employees Health Benefits Plan), between January 1, 2007, and June 30, 2008. We used national databases to review the providers' criminal and financial histories before and after Medicaid enrollment. Based on the potential correlation between tax debt and health care fraud, we analyzed the providers' tax debt. We reviewed the providers' enrollment files, including their applications, and assessed States' procedures to enroll providers as of September 2008.

### Data Sources

We used OIG's LEIE database to identify the number of Medicaid providers out of the 4,991 individuals and entities excluded between January 1, 2007, and June 30, 2008.[20] From these, we identified 232 individuals and entities with a Medicaid billing number and contacted States based on the address in the LEIE. Because the remaining 4,759 cases had no Medicaid billing number, we could not determine the exact number of Medicaid providers that had been excluded.

We dropped a total of 38 providers from our group of 232. We dropped 34 providers because States had no record of the provider or the provider had no billing number and worked for a facility such as a home health agency that billed the program (the LEIE showed the billing number for the facility and not the individual). We dropped an additional four providers because the State disclosed that they were still active. Finally, we consolidated 12 related individuals and entities into six unique providers. We used

[16] OIG, *Credentialing of Medicaid Providers: Fee for Service*, February 2001 (OEI-07-99-00680).
[17] GAO, *Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments* (GAO-04-707), July 2004, p. 21.
[18] GAO, *Medicaid: HCFA and States Could Work Together to Better Ensure the Integrity of Providers*, testimony before the Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives, July 18, 2000, pp. 3–4. HCFA was the predecessor to CMS.
[19] Ibid., p. 1.
[20] We used the LEIE because it is the only national database that identifies excluded Medicaid providers.

the resulting group of 188 providers as the basis for our analysis (Appendix B lists the exclusion authorities that OIG used for the providers we reviewed).

We contacted each of the 26 States in which our group of 188 providers were located to request the enrollment files for the providers. (Appendix C lists the number of excluded providers by State and provider type.) The dates of enrollment for the providers we reviewed ranged from 1976 to 2007, and half the providers enrolled before 1998. We were unable to obtain complete enrollment files containing the original enrollment applications for 30 providers because the States had purged the records.

We conducted background checks of the 188 excluded providers with LexisNexis (SmartLinx) to identify their criminal and financial histories as well as the accuracy of the information that they reported on their applications.[21] SmartLinx scans all LexisNexis databases of public records. Public records include, but are not limited to, current mailing addresses, real property deeds and mortgages, records of civil and criminal actions, professional licenses, and liens for nearly all States. In addition, we queried the HIPDB[22] for each provider to identify any licensing actions against them and obtained additional information from State medical boards.

We surveyed the 26 States that enrolled the 188 providers to determine whether they had used the following procedures at the time the providers in our review enrolled in Medicaid: criminal background checks, probationary enrollment, reenrollment, and site visits. In addition, we asked the States to complete a survey about the process they used to enroll providers as of September 2008.

We obtained Medicaid claims data from the Medicaid Statistical Information System (MSIS) maintained by CMS to assess the providers' billing patterns. We identified claims for New York, California, and Ohio providers. The claims data covered 2001 to 2006. Sixty-five percent of the excluded providers under review came from these three States. We found no claims data for the excluded providers under review from the other 23 States. We reviewed MSIS data for these States, but the Medicaid provider numbers in the LEIE did not match any claims.[23]

**Data Analysis**

We used SAS statistical software to record and quantify the information that we gathered about the providers' backgrounds as well as States' enrollment policies.

[21] We did not obtain or review court dockets to verify the criminal and civil histories in LexisNexis. The information in LexisNexis may not reflect the complete criminal and civil history of a provider.

[22] The HIPDB is a national database that the Health Resources and Services Administration manages. It contains information on actions against providers, including licensing and certification actions, civil judgments, and criminal convictions.

[23] A 2009 OIG report highlighted the limits of MSIS and noted that it does not capture many of the data elements that can assist in fraud, waste, and abuse detection. See *MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse* (OEI-04-07-00240).

**Limitations**
We based our analysis on a selected group of 188 providers that OIG excluded between January 2007 and June 2008. We were unable to obtain complete enrollment files for 30 of these providers and could not analyze their disclosures about ownership. We cannot project our results to excluded Medicaid providers as a whole, because the LEIE contained Medicaid numbers for only 232 out of 4,991 excluded individuals and entities, and we were unable to identify the universe of excluded Medicaid providers. We collected information about current enrollment policy from the 26 States that enrolled the excluded providers we reviewed, not from all States.

**Standards**
We conducted this review in accordance with the *Quality Standards for Inspections* approved by the Council of the Inspectors General on Integrity and Efficiency.

## RESULTS

### Eight out of the 188 excluded providers disclosed false ownership information at the time of enrollment

Providers must disclose information about ownership. Federal regulations require States to collect information from providers about ownership and control.[24] The States that enrolled these eight providers complied with Federal regulations, which require States to collect information about ownership from providers when they apply to Medicaid, but the States did not verify the accuracy of ownership information. For example, a Texas provider failed to disclose the identity of the coowner when the provider applied to Medicaid. Because the State collected the ownership information but did not verify it, it did not detect that the information was false.

### States impose few enrollment requirements beyond those mandated by Federal regulations

Over half of the excluded providers (132 out of 188) were subject to no State enrollment requirements beyond the Federal regulations when they enrolled in Medicaid. The other 56 providers were subject to enrollment requirements in addition to the Federal regulations. Specifically, States conducted limited background checks, involving checks of State databases only, for 51 providers; conducted site visits for two providers; and required reenrollment for six providers (we counted one provider twice that was subject to two enrollment requirements and one provider three times that was subject to three enrollment requirements).

Criminal background checks are the most common additional enrollment requirement among the States we reviewed, but their use varies widely. Although 15 out of the

[24] 42 CFR § 455.104.

26 States we surveyed reported that they conduct background checks, the checks are typically limited to State databases rather than national sources, such as FBI, and to certain types of providers, such as transportation and personal care assistants.

Several States reported that they conduct site visits (11 out of 26), reenroll providers (9 out of 26), or subject new providers to probationary enrollment (4 out of 26). Among States that reenroll providers, the intervals between reenrollment may be several years, and States vary as to whether they verify providers' information or conduct a new background check with each reenrollment. Florida, which ranks fourth in terms of Medicaid spending, reenrolls providers every 5 years and conducts new FBI background checks at that time. Iowa reenrolls all providers every 6 years. Oklahoma conducts State criminal background checks for personal care and community service workers when they enroll but not when they reenroll at 3-year intervals.

*Three States restrict the enrollment of certain provider types.* One alternative to heightened review of applicants is to limit their entry into Medicaid. New York, California, and New Jersey use this approach.

New York uses density criteria to limit the entry of certain provider types. For example, New York imposes density criteria on nonemergency transportation services in New York City. The State compares the ratio of the number of claims to the number of recipients in New York City to the ratio in the rest of the State. If the ratio is greater than 5 percent, the State deems the area "dense" and does not enroll new providers. The State also applies density criteria to pharmacies, suppliers of orthopedic shoes, and laboratories.

California has moratoria in place for the following four provider types: adult day health care centers (since 2004); Los Angeles County nonchain, nonpharmacist-owned pharmacies (since 2002); clinical laboratories (since 2001); and DME providers located outside of California and operating in Los Angeles, Orange, Riverside, and San Bernardino Counties (since 1999). According to the Department of Health Care Services, the moratoria are "necessary to safeguard public funds and to maintain the fiscal integrity of the Medi-Cal program."[25]

In July 2006, New Jersey imposed moratoria on the enrollment of new partial care services providers (outpatient mental health services), chiropractors, DME providers, and podiatrists unless the State granted an exception. As of April 2009, the State has not approved any new applications from chiropractors (26 applications received) or podiatrists (35 applications received). New partial care providers did not apply to Medicaid during this period. The State reviewed 93 applications from DME providers, denied 84, and approved 9 because the providers met a special need.

[25] California Department of Health Care Services, Orders for Moratoria, August 2008, November 2008, and February 2009.

**Current rules do not require disclosure of nonprogram-related convictions or tax liens**

Federal regulations at 42 CFR § 455.104 and 42 CFR § 455.106 require States to collect information from providers about ownership and program-related convictions. States are not obligated to collect information about criminal convictions unrelated to Federal health care programs or tax liens.

*Eight of the 188 excluded providers had criminal convictions before they enrolled in Medicaid and committed health care-related crimes after they enrolled.* Upon enrollment in Medicaid, providers are required to disclose only program-related convictions.[26] Eight providers in our review had convictions unrelated to Federal health care programs, which they did not have to disclose. Examples include the following:

- An Iowa aide had a felony conviction for forgery before she enrolled in 2004. She was convicted of theft, a program-related crime, after she enrolled.
- The owner of an Ohio DME company was convicted of receiving stolen property 6 months before enrollment. After he enrolled, he was convicted of Medicaid fraud.
- A New York dentist was convicted of insurance fraud in 2003 for filing a claim for a dental machine that he had removed from his office. The State did not know about the conviction and enrolled him in 2004. He was subsequently convicted of Medicaid fraud.
- In 1989, an Indiana physician was convicted of illegal dispensing of narcotics, a nonprogram-related felony. The State did not know about the conviction, and he enrolled in Medicaid in 1996. He operated a drug and alcohol rehabilitation clinic and was later convicted of health care fraud and insurance fraud.

*Forty-eight of the 188 excluded providers had Federal or State tax liens before or after they enrolled in Medicaid.* Nine of the 188 excluded providers collectively had 15 Federal and State tax liens totaling $443,100 before they enrolled in Medicaid. Additionally, 43 of the 188 excluded providers had a total of 147 Federal and State tax liens for a total of $4.2 million while they were active providers (four providers had tax liens both before and after they enrolled).

Ten of the 34 excluded providers in California, New York, and Ohio that had liens received reimbursement from their State Medicaid programs after imposition of the liens. Medicaid reimbursed these providers a total of $3.8 million between the date of the first tax lien and the date of termination. These providers include the following:

- A New York dentist had Federal tax liens of $9,495 and State tax liens of $10,280 during the period when he was an active provider. Medicaid paid him $709,549. OIG excluded this provider for insurance fraud.

[26] 42 CFR § 455.106.

- An Ohio pediatrician had $114,591 in Federal tax liens before enrollment and received $582,421 from the Medicaid program. OIG excluded this provider for a program-related conviction.

## CONCLUSION

We recognize that CMS is taking steps to address provider enrollment. In addition, Congress passed legislation in 2010 to strengthen provider enrollment and program integrity. The Patient Protection and Affordable Care Act imposed new provider screening requirements on providers in Medicare, Medicaid, and the Children's Health Insurance Program. This memorandum provides information that CMS may find useful regarding Medicaid provider enrollment. We cannot project our results to excluded Medicaid providers as a whole. Twenty-four out of 188 excluded providers had a history of tax debt, criminal convictions, or false disclosures before they enrolled (one provider had both a tax lien and a conviction). Federal regulations only require providers to disclose program-related convictions, and States are not required to verify the information that providers submit on their enrollment applications. We believe that additional reviews and oversight in this area are warranted to ensure that Medicaid enrollment standards are sufficient to protect the program from fraud and abuse.

This review is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-09-08-00330 in all correspondence.

**APPENDIX A**

**Federal Provider Disclosure Requirements**

**42 CFR § 455.104 Disclosure by providers and fiscal agents: Information on ownership and control.**

(a) Information that must be disclosed. The Medicaid agency must require each disclosing entity to disclose the following information in accordance with paragraph (b) of this section:

(1) The name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

(2) Whether any of the persons named, in compliance with paragraph (a)(1) of this section, is related to another as spouse, parent, child, or sibling.

(3) The name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must--

(i) Keep copies of all these requests and the responses to them;

(ii) Make them available to the Secretary or the Medicaid agency upon request; and

(iii) Advise the Medicaid agency when there is no response to a request.

(b) Time and manner of disclosure. (1) Any disclosing entity that is subject to periodic survey and certification of its compliance with Medicaid standards must supply the information specified in paragraph (a) of this section to the State survey agency at the time it is surveyed. The survey agency must promptly furnish the information to the Secretary and the Medicaid agency (2) Any disclosing entity that is not subject to periodic survey and certification and has not supplied the information specified in

paragraph (a) of this section to the Secretary within the prior 12-month period, must submit the information to the Medicaid agency before entering into a contract or agreement to participate in the program. The Medicaid agency must promptly furnish the information to the Secretary.

(3) Updated information must be furnished to the Secretary or the State survey or Medicaid agency at intervals between recertification or contract renewals, within 35 days of a written request.

(c) Provider agreements and fiscal agent contracts. A Medicaid agency shall not approve a provider agreement or a contract with a fiscal agent, and must terminate an existing agreement or contract, if the provider or fiscal agent fails to disclose ownership or control information as required by this section.

(d) Denial of Federal financial participation (FFP). FFP is not available in payments made to a provider or fiscal agent that fails to disclose ownership or control information as required by this section.

**42 CFR § 455.106 Disclosure by providers: Information on persons convicted of crimes.**

(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX Services Program since the inception of those programs.

(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any

disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.

(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

## APPENDIX B Office of Inspector General Exclusion Authorities for Providers We Reviewed, January 2007 to June 2008[27]

| Exclusion Authorities | | | |
|---|---|---|---|
| **Mandatory Exclusions** | | | |
| **Authority** | **Description** | **Number of Providers** | **Percentage** |
| 1128(A)(1) | Program-related conviction | 121 | 64.0 |
| 1128(A)(2) | Conviction for patient abuse/neglect | 6 | 3.2 |
| 1128(A)(3) | Felony conviction for health care fraud | 10 | 5.3 |
| 1128(A)(4) | Felony conviction for controlled substances | 6 | 3.2 |
| | Subtotal | 143 | 75.7 |
| **Permissive Exclusions** | | | |
| **Authority** | **Description** | **Number of Providers** | **Percentage** |
| 1128(B)(2) | Conviction for obstruction of an investigation | 1 | 0.5 |
| 1128(B)(4) | License revocation or suspension | 30 | 15.9 |
| 1128(B)(5) | Suspension from government health care program | 1 | 0.5 |
| 1128(B)(7) | Fraud, kickbacks, and other prohibited activities | 3 | 1.6 |
| 1128(B)(8) | Entity owned/controlled by excluded individual | 10 | 5.3 |
| 1128(B)(15) | Individual owning/controlling excluded entity | 1 | 0.5 |
| | Subtotal | 46 | 24.3 |
| | **Total** | **189*** | **100** |

Source: Office of Inspector General analysis, 2009.

*We counted one provider twice because she owned two entities excluded under different authorities.

[27] We listed only the authorities that applied to the group of excluded providers. The authorities cited refer to sections of the Social Security Act.

## APPENDIX C Excluded Providers We Reviewed by State and Provider Type, January 2007 to June 2008

| Number of Excluded Providers by State | | |
|---|---|---|
| **State** | **Number of Providers** | **Percentage** |
| Ohio | 54 | 28.7 |
| California | 37 | 19.7 |
| New York | 32 | 17.0 |
| Texas | 13 | 6.9 |
| Oregon | 6 | 3.2 |
| Wisconsin | 6 | 3.2 |
| Arkansas | 3 | 1.6 |
| Illinois | 3 | 1.6 |
| Indiana | 3 | 1.6 |
| Louisiana | 3 | 1.6 |
| Minnesota | 3 | 1.6 |
| New Jersey | 3 | 1.6 |
| Arizona | 2 | 1.1 |
| Connecticut | 2 | 1.1 |
| Iowa | 2 | 1.1 |
| Michigan | 2 | 1.1 |
| Nevada | 2 | 1.1 |
| Oklahoma | 2 | 1.1 |
| Wyoming | 2 | 1.1 |
| Kansas | 2 | 1.1 |
| Colorado | 1 | 0.5 |
| Florida | 1 | 0.5 |
| Kentucky | 1 | 0.5 |
| Missouri | 1 | 0.5 |
| Washington | 1 | 0.5 |
| West Virginia | 1 | 0.5 |
| **Total** | **188** | **100*** |

Source: Office of Inspector General analysis, 2009.

*Total may not add to 100 because of rounding.

**Number of Excluded Providers by Type**

| Provider Type | Number of Providers | Percentage |
|---|---|---|
| Physician | 51 | 27.1 |
| Aide | 43 | 22.9 |
| Dentist | 19 | 10.1 |
| Nurse | 14 | 7.5 |
| Durable medical equipment company | 12 | 6.4 |
| Nonemergency transportation company | 10 | 5.3 |
| Pharmacist | 7 | 3.7 |
| Home health agency | 6 | 3.2 |
| Psychologist | 4 | 2.1 |
| Clinic | 3 | 1.6 |
| Counselor | 3 | 1.6 |
| Licensed clinical social worker | 2 | 1.1 |
| Chiropractor | 2 | 1.1 |
| Pharmacy | 2 | 1.1 |
| Physician assistant | 2 | 1.1 |
| Social worker | 2 | 1.1 |
| Therapist | 1 | 0.5 |
| Acupuncturist | 1 | 0.5 |
| Ambulance company | 1 | 0.5 |
| Counseling center | 1 | 0.5 |
| Mental health facility | 1 | 0.5 |
| Optometrist | 1 | 0.5 |
| **Total** | **188** | **100** |

Source: Office of Inspector General analysis, 2009.