DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

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/S/

FROM: Stuart Wright
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SUBJECT: Memorandum Report: *Excluded Individuals Employed by Service Providers in Medicaid Managed Care Networks*, OEI-07-09-00632

This memorandum report provides information about Office of Inspector General (OIG)–excluded individuals who were employed by service providers participating in 12 Medicaid managed care entities' (MCE) provider networks in 2011. In addition, it provides information on the safeguards in place to prevent excluded individuals from being employed by providers in those networks.

SUMMARY

OIG is authorized to exclude certain individuals and entities (providers) from participating in federally funded health care programs, including Medicaid. Federal programs are prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider. Managed care plans and their network providers may not employ or contract with an excluded individual to provide items or services paid for by Medicaid. Nationally, approximately 70 percent of Medicaid beneficiaries receive some or all of their Medicaid services through managed care.

To determine whether excluded providers are present in Medicaid managed care provider networks, OIG has conducted two evaluations; this is the second of the two evaluations. In the prior study, entitled *Excluded Providers in Medicaid Managed Care Entities* (OEI-07-09-00630),[1] we identified 11 excluded providers out of approximately

[1] We use the term "managed care entity" to refer to managed care organizations (MCOs), prepaid inpatient health plans, and prepaid ambulatory health plans. Readers should not confuse this abbreviated term with the statutory definition of managed care entity which only refers to MCOs and primary care case management

277,000 providers checked.[2] In the current study, we identified 16 excluded individuals out of approximately 249,000 individuals employed by 500 sampled providers. Nine of these excluded individuals were in occupations that provided direct patient care. Contributing to the employment of these excluded individuals were gaps in information available on excluded individuals and failure of contracted staffing agencies and background check vendors to follow procedures. Most providers reported using a variety of safeguards to ensure that they do not employ excluded individuals, but identified costs and resource burdens as challenges in executing those safeguards. Seven percent of providers enrolled in the selected Medicaid MCEs reported that they do not check the exclusion status of their employees.

BACKGROUND

Office of Inspector General Exclusions

To protect patients and Federal health care programs, OIG has been delegated authority from the Secretary of Health and Human Services (the Secretary) to exclude certain providers (e.g., doctors, physician group practices, transportation companies, hospitals, and home health agencies) from participating in Medicaid and other federally funded health care programs.[3] These Federal programs are generally prohibited from paying for any items or services furnished, ordered, or prescribed by an excluded provider. Managed care plans and their network providers may not employ or contract with an excluded individual to provide items or services paid for by Medicaid. OIG excludes providers from participation in these programs through legal authorities contained in sections 1128, 1128A, 1156, and 1867 of the SSA. Some common reasons for exclusion include convictions for program-related fraud and patient abuse, and licensing board actions, such as the suspension or revocation of a medical license due to concerns about the licensed individual's professional competence or performance.

In addition to prohibiting Federal payment, the SSA authorizes the imposition of civil monetary penalties against health care providers and entities, including MCEs, that arrange or contract with an individual or entity to provide federally reimbursed items or services that they know or should know were excluded from participation in Federal health care programs.[4] Under these authorities, MCEs, hospitals, nursing homes, hospices, group medical practices, and other health care providers may face civil monetary penalties if they employ or contract with an excluded individual to provide, directly or indirectly, items or services paid for with Federal funds.

Types and Duration of Exclusions. Exclusions are either mandatory or permissive. Although mandatory exclusions are required by law, permissive exclusions are imposed

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programs. See section 1932(a)(1)(B) of the Social Security Act (SSA). CMS has included prepaid partial-risk entities under managed care regulations at 42 CFR part 438.

[2] OIG, *Excluded Providers in Medicaid Managed Care Entities* (OEI-07-09-00630), February 2012. The evaluation examined a variety of provider types including businesses and individual providers.

[3] Federally funded health care programs include Medicare 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) or any State health care program, including Medicaid. SSA § 1128B(f); 42 CFR § 1001.2.

[4] SSA § 1128A(a)(6).

at OIG's discretion.[5] For example, a provider convicted of a program-related crime must be excluded; a provider who failed to disclose required information may be excluded, as determined by OIG.

The minimum duration of an exclusion may be fixed by law or at the discretion of OIG. Exclusions can be time-limited or permanent. If an excluded provider whose minimum period of exclusion has expired wishes to participate in Federal health care programs, the provider must apply for reinstatement and OIG must approve the applicant.[6]

Exceptions to the payment prohibition. Limited exceptions exist that allow excluded providers to be paid for certain services (e.g., emergency services).[7] Additionally, States can request that the Secretary approve waivers allowing excluded providers, such as providers in medically underserved areas, to be paid.[8]

Sources of Exclusion Information. OIG maintains a list of all currently excluded parties called the List of Excluded Individuals/Entities (LEIE), which is publically available on the OIG Web site for search or download.[9] OIG updates the LEIE on a monthly basis to add new exclusions and reinstatements. OIG recommends that providers rely primarily on the LEIE for the most accurate and timely information on Federal exclusions. OIG sends monthly updates of exclusions information to the Centers for Medicare & Medicaid Services (CMS). CMS then uses the updates to populate the Medicare Exclusions Database, which is available to State Medicaid agencies and other stakeholders. OIG also sends monthly updates of the LEIE to the General Services Administration, which maintains the Excluded Parties List System.[10] The Excluded Parties List System includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. Another source of exclusions information is State sanctions and licensure databases. States have authority to exclude

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[5] SSA §§ 1128(a) and (b); 42 U.S.C. 1320a-7(a) and (b).

[6] SSA § 1128(g); 42 U.S.C. 1320a-7(g); 42 CFR § 1001.3001.

[7] 42 CFR § 1001.1901(c) establishes limited exceptions allowing payment of certain services provided by excluded providers. Payments may be made for up to 30 days after the effective date of an exclusion for: inpatient institutional services furnished to an individual who was admitted to an excluded institution before the date of the exclusion; home health services and hospice care under a plan of care established before the effective date of the exclusion; and any health care items that are ordered from an excluded manufacturer before the effective date of the exclusion. Claims for items or services ordered or prescribed by an excluded individual can be paid for dates of service up to 15 days after the notice of the exclusion was mailed to the supplier. Finally, claims for certain emergency items or services furnished by an excluded provider, or at the medical direction or on the prescription of an excluded physician or other authorized individual during the period of exclusion can be paid. To be payable, such a claim must be accompanied by a sworn statement of the person furnishing the items or services specifying the nature of the emergency and why the items or services could not have been furnished by an eligible provider.

[8] Section 1128(d)(3)(B)(i) of the Act; 42 U.S.C. 1320a-7(d)(3)(B)(i) allows States to request waivers for certain excluded providers.

[9] When searching the LEIE online, users can enter only five names at a time. For larger entities such as hospitals that may need to check many names at a time, OIG provides a downloadable LEIE database that can reduce administrative time by checking multiple names against the full LEIE data base. See http://www.oig.hhs.gov/exclusions/exclusions_list.asp.

[10] In late July 2012, the Excluded Parties List System was migrated to the System for Award Management, which combines several Federal procurement systems.

providers from their Medicaid programs.[11] Many States maintain a database—often called a State sanctions list—of providers that they have excluded. State sanctions lists may also include OIG-excluded providers. Many States also maintain databases of providers to whom they have issued licenses; if a provider loses his or her license because of exclusion, either by OIG or by a State, the licensure database reflects that status.

State Medicaid Programs

Medicaid is financed jointly by the Federal and State governments. Although each State Medicaid program must operate within the parameters of broad Federal requirements, each State program is unique in structure and administration. States use two primary delivery systems to provide Medicaid-covered services: managed care and fee-for-service. Approximately 70 percent of Medicaid recipients receive some or all of their Medicaid services through managed care.[12]

MCEs are responsible for contracting with and paying individual providers and/or provider entities for the services they render to Medicaid recipients enrolled in a managed care plan. Under a risk contract with the State, the MCE assumes the financial risk for the cost of the services covered under the contract and incurs loss if the cost of the services exceeds the payments under the contract.[13]

CMS Guidance to State Medicaid Agencies Regarding Screening Employees

A State Medicaid Director letter dated January 16, 2009, advised States of their obligation to direct providers to screen their employees and contractors for excluded persons to prevent Medicaid payments for items or services furnished or ordered by excluded individuals and entities. It further advised States to require that providers search OIG's LEIE database monthly to capture new exclusions or reinstatements that have occurred since the last search.

Previous OIG Work

In a 2011 evaluation regarding 12 selected MCEs in 10 States, we found that 4 MCEs reviewed had 11 excluded providers enrolled in their provider networks in 2009.[14] Four of these providers were paid a total of $40,306 in 2009; the remaining seven providers received no payments during the review period. All 12 MCEs and all 10 States reviewed had safeguards to identify excluded providers; however, gaps in provider credentialing processes and LEIE information contributed to the enrollment of excluded providers. Eleven of the twelve selected MCEs reported that they checked the

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[11] Under § 1902(p)(1) of the SSA (42 U.S.C. 1396a(p)(1)), a State may exclude a provider from the State Medicaid program for any reason that OIG could exclude a provider from Federal health care programs.

[12] Beginning in 1981, Federal law allowed States to seek a waiver of Federal requirements to permit a State to require that Medicaid recipients enroll in managed care, usually under § 1915(b) or the demonstration authority at § 1115 of the Social Security Act. In 1997, Congress amended the Medicaid statute to permit States to require enrollment in MCEs for most recipients as a State plan option without seeking a waiver. SSA § 1932; see 67 Fed. Reg. 40989 (June 14, 2002) for an overview of Medicaid managed care laws.

[13] 42 CFR § 438.2.

[14] OIG, *Excluded Providers in Medicaid Managed Care Entities* (OEI-07-09-00630), February 2012.

LEIE to identify excluded providers. All MCEs checked providers' exclusion status at initial enrollment and rechecked them at varying frequencies ranging from monthly to every 3 years.

METHODOLOGY

In the first evaluation, entitled *Excluded Providers in Medicaid Managed Care Entities* (OEI-07-09-00630), we compared the provider networks of 12 selected Medicaid MCEs to the LEIE to identify whether excluded providers (i.e., individuals and entities, such as physicians, nurse practitioners, physician groups, community mental health centers) were present. There were approximately 675 MCEs participating in Medicaid in 2009; the beneficiaries enrolled in the 12 selected MCEs represented 16 percent of national Medicaid managed care enrollment in 2009. Overall, 277,835 providers were enrolled in the provider networks of the 12 MCEs.

For this evaluation, we limited the provider population of the 12 MCEs to only hospitals, nursing facilities, home health agencies, and pharmacies. A total of 63,606 providers of these four types were enrolled in the provider networks of the 12 MCEs. We then stratified the population by these provider types, and selected a stratified random sample of 500 providers. Table 1 shows the total providers of each type in the population and sample, and the employees of the sampled providers.

Table 1: Population and Sampled Providers and Employees by Strata

	Population	Sample	
Stratum	**Number of Providers**	**Number of Providers**	**Number of Employees**
Hospitals	971	125	178,489
Nursing Facilities	272	125	38,883
Home Health Agencies	507	125	27,986
Pharmacies	61,856	125	3,511
Total in Strata	**63,606**	**500**	**248,869**

Source: OIG analysis of MCE provider network data and employee rosters from sampled providers, 2012.

We requested from each sampled provider a roster of all of its employees in calendar year 2011, including any contracted employees.[15] A total of 248,869 employees were listed on the rosters we received. We compared the contents of the rosters to the LEIE to identify any excluded individuals among the sampled providers' employees.[16] We also asked each sampled provider to complete a survey on the safeguards that it used to ensure that excluded individuals are not employed.

[15] Some providers in our sample had contracts with outside companies to provide staff for their businesses; the individuals we call "contracted employees" were employed by the outside companies, but performed services for the providers in our sample.

[16] Our comparison did not include providers excluded by States or listed on the Excluded Parties List System that are not included on the LEIE.

During data collection, 19 of the 500 sampled providers were determined to be ineligible for inclusion in our evaluation, either because they went out of business prior to January 1, 2011, or because they were not actually enrolled in one of the selected Medicaid MCEs during our review period. As a result, the potential number of responses we expected to receive from providers was 481. We received 472 rosters, a roster response rate of 98 percent, and 467 surveys, a survey response rate of 97 percent.

Due to the low number of excluded individuals identified in the sample, our findings about excluded individuals present sample counts and are not projected to the population. Except where noted, our findings regarding the survey of providers present projections to the population of 63,606 hospitals, nursing facilities, home health agencies, and pharmacies enrolled in the networks of the 12 MCEs. The findings regarding the provider survey are based on self-reported information; we did not independently verify responses.

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

Sixteen Excluded Individuals Were Employed By Sampled Providers Enrolled in the 12 Selected Medicaid MCEs

Of the 248,869 individuals listed on the employee rosters requested from sampled providers, we identified 16 excluded individuals among the employees of 14 sampled providers. Of the 16 excluded individuals we identified, 9 were employed in occupations that provided direct patient care. The remaining seven excluded individuals were employed in occupations that did not involve providing direct patient care. See Table 2 for details on the occupations of the 16 excluded individuals.

Our evaluation included only providers enrolled in 12 of the approximately 675 Medicaid MCEs in operation in 2009;[17] additional excluded individuals may be employed by providers enrolled in the 663 MCEs not included in this study.

[17] The beneficiaries enrolled in the 12 selected MCEs represented 16 percent of national Medicaid managed care enrollment in 2009.

Table 2: Occupations of 16 Excluded Individuals Identified

Occupation	Employer Provider Type	Number of Excluded Individuals	Patient Contact Level*
Registered Nurse/Licensed Practical Nurse	Nursing Facility	4	Direct patient care
	Hospital	1	Direct patient care
Personal Care Attendant/Certified Nurse Aide	Home Health Agency	3**	Direct patient care
Nurse Supervisor	Nursing Facility	3	No direct patient care
Chaplain	Hospital	1	No direct patient care
Clinical Technician	Hospital	1	No direct patient care
Collector (Business Office)	Hospital	1	No direct patient care
Instrument Technician	Hospital	1	No direct patient care

*We defined "direct patient care" to mean that the individual's primary function is to provide medical or personal care to patients.

**There were 4 excluded individuals identified as personal care attendants among the 16 excluded individuals. However, the provider for which one personal care attendant worked told us that the excluded individual did not actually provide any services during the period of her employment; although her occupation was one in which she would normally provide direct patient care, she did not serve any clients.

Source: OIG analysis of employee rosters and LEIE, 2012.

We determined the authorities under which each of the 16 excluded individuals were excluded.

- Seven individuals were excluded because their licenses had been revoked (Section 1128(b)(4) of the Act).
- Five individuals were excluded because of program-related convictions (e.g., fraud against a Federally funded healthcare program, typically Medicare or Medicaid) (Section 1128(a)(1) of the Act).
- Three individuals were excluded because of convictions for patient abuse and/or neglect (Section 1128(a)(2) of the Act).
- One individual was excluded because of a felony conviction of health care fraud (fraud against privately funded health insurance) (Section 1128(a)(3) of the Act).

See Appendix A for information on the occupations of the individuals excluded under each authority.

Fourteen of the excluded individuals identified were directly employed by providers in our sample; two of the excluded individuals were contracted employees. The employment of 13 of the 16 excluded individuals was terminated by the conclusion of our data collection. The termination of 6 of these 13 individuals was a direct result of our review.[18] Of the three remaining excluded individuals, one was suspended pending the result of her application to OIG to be reinstated, one was on administrative leave while the provider for which she worked investigated her situation, and one we were unable to

[18] The employment of the other seven excluded individuals was terminated prior to our review for various reasons; only one of those seven was terminated because of her exclusion status.

determine the status of because the provider did not specify whether her employment had been terminated.

Incorrect names and failure of contractors to follow procedures contributed to the employment of excluded individuals by sampled providers enrolled in Medicaid MCEs

The sampled providers who employed the 16 excluded individuals gave the following explanations about how those individuals became employed despite the safeguards they had in place.

Incorrect names. The sampled providers that employed 9 of the 16 excluded individuals explained that the excluded individuals gave names on their employment applications and/or other documents that were different from the names listed on the LEIE.[19] For example, one excluded individual was listed on the LEIE under her maiden name, but gave her married name on her employment documents. In another example, an excluded individual gave a different first name than she is listed with on the LEIE. OIG provides tips on the OIG Web site to improve accuracy and increase name verification.[20]

We also identified misspellings of two employees' names as an issue. For example, one provider entered the excluded individual's last name incorrectly, including an extra letter, when searching the LEIE. Because of the misspelling, there was no match.

Contracted staffing agencies not identifying employees' exclusion status correctly. Two sampled providers had excluded individuals who were contracted employees. These providers explained that they required the contracted companies to check the exclusion status of the employees they provide. However, the contracted companies either did not check the employees' exclusion status as required, or did not inform the providers of the employees' exclusion status.

Contracted background check vendors not identifying employees' exclusion status correctly. Two sampled providers contracted with outside vendors to conduct background checks on their employees; these background checks were supposed to include identifying the employees' exclusion status. However, the contracted vendors failed to identify the exclusion status of two excluded individuals. No further reason or explanation for the failures was given.

Other reasons why excluded individuals were employed. One sampled provider searched the excluded individual's name on LEIE and a match was identified, but the LEIE listed a different birth date than the individual provided on her application. Therefore, the provider concluded that the match was a false positive. A second sampled provider hired the excluded individual prior to her exclusion date; the individual's exclusion status was identified in a later routine periodic check, and her employment was terminated. Finally,

[19] We were able to identify these individuals despite their names on the rosters being different from the names listed in the LEIE, because we searched the LEIE for their SSNs first and then looked for similar names.
[20] See http://oig.hhs.gov/exclusions/tips.asp.

one sampled provider explained that the human resources director at the time of the excluded individual's hiring simply did not follow company policy to conduct exclusion status screenings. That human resources director has since been terminated.

Most providers reported using a variety of safeguards to ensure they do not employ excluded individuals, but identified costs and resource burdens as challenges in executing those safeguards

Seventy-eight percent of providers indicated that they used the LEIE to check the exclusion status of their employees. See Table 3 for the databases used and percentages of providers that used them to check their employees' exclusion status. See Appendix B for 95-percent confidence intervals and sample sizes for all estimates presented in this report.

Table 3: Databases Used To Check Exclusion Status and Percentages of Providers

Database	Percentage of Providers*
LEIE	78.1%
Excluded Parties List System	51.2%
State sanctions and licensure databases	44.4%
Medicare Exclusions Database	32.4%
National Practitioner Data Bank/ Healthcare Integrity and Protection Data Bank	2.2%

*Many providers used more than one database to check their employees' exclusion statues; therefore, the percentages sum to more than 100 percent.

Source: OIG analysis of provider survey responses, 2012

Seventy-eight percent of providers indicated that they check the exclusion status of their employees at hire and that they also conduct a periodic check (i.e., monthly, quarterly, annually). Nine percent of providers reported checking employees' exclusion status only at hire; 7 percent of providers reported checking only periodically with no check at hire. See Table 4 for the percentages of providers that checked their employees' exclusion status at different frequencies.

Table 4: Frequency of Checks of Employees' Exclusion Status

Frequency	Percentage of Providers
At hire with periodic checks	77.8%*
Monthly	41.1%
Quarterly	6.0%
Annually	18.1%
Other	15.4%
At hire only	8.6%
Periodic checks only	6.8%
Monthly	0.9%
Quarterly	1.7%
Annually	3.3%
Other	0.9%
No checks	6.8%

*Some providers conducted multiple periodic checks in addition to checking at hire. For example, a provider could check an employee's exclusion status at hire, monthly, and annually thereafter. In this example, the provider would be represented in the percentages of providers conducting both the monthly and annual periodic check. Thus, the sum of the percentages of providers conducting each periodic check exceeds the percentage of providers conducting any periodic check.

Source: OIG analysis of provider surveys, 2012

We asked providers what safeguards other than checking the databases listed in Table 3 they used to check their employees' exclusion status. Forty-two percent of providers required prospective employees to sign an affidavit or attestation regarding their exclusion status. Only four sampled providers indicated having a policy requiring contracted companies (such as staffing agencies) to check the exclusion status of the employees they supplied to the providers. We did not identify any relationships among the databases used, the frequency with which the checks are conducted, or the other safeguards used and the presence of excluded individuals.

Fifty-five percent of providers identified the costs and resource burdens of conducting exclusion checks as challenges. One sampled provider stated, "It take[s] about 16 hours to look up every employee in 2 different databases . . . It is very difficult to only be able to process 1 to 5 employees at a time depending on the database."[21]

[21] This provider was referring to the LEIE and the Excluded Parties List System. The online LEIE allows users to search up to five names at a time; however, the downloadable version of the LEIE allows users to search multiple names against the full exclusions list. The Excluded Parties List System allows users to search only one name at a time.

Seven Percent of Providers Enrolled in the 12 Selected Medicaid MCEs Do Not Check the Exclusion Status of Their Employees; Most of These Providers Lacked Knowledge Regarding Exclusions

Seven percent of providers do not check the exclusion status of their employees. Despite the vulnerability created by the lack of screening, we found that of the providers in the sample that did not check their employees' exclusion status, none employed excluded individuals. Four percent of providers do not check their employees' exclusion status because they lack knowledge about exclusions—they were either unaware that it is possible to be excluded from participation in federally funded health care programs, or that employers participating in federally funded health care programs are obligated to check the exclusion status of their employees. One percent of providers do not check their employees' exclusion status because they lack both knowledge about exclusions and the resources to conduct the checks.[22]

CONCLUSION

Sixteen excluded individuals were employed by sampled providers that participate in the networks of 12 Medicaid MCEs. Of the 16 excluded individuals, 7 were excluded because their licenses had been revoked; 5 were excluded because of convictions of fraud against a Federally funded healthcare program; typically Medicare or Medicaid; 3 were excluded because of convictions for patient abuse and/or neglect; and 1 was excluded because of a felony conviction of fraud against privately funded health insurance. Because of issues with matching names on the LEIE, 9 of these 16 excluded individuals became employed despite the safeguards the providers had in place. Providers used a variety of safeguards to ensure that they do not employ excluded individuals, but identified costs and resource burdens as challenges in executing those safeguards. However, 7 percent of the providers enrolled in Medicaid MCEs did not check the exclusion status of their employees; 4 percent of providers said they do not check their employees' exclusion status because they lack knowledge about exclusions.

Our prior study identified 11 excluded network providers out of approximately 277,000 providers checked; this study found 16 excluded individuals out of approximately 249,000 individuals checked. In both studies, the network providers and individuals we checked represent only the provider networks of 12 selected Medicaid MCEs; additional excluded individuals may be employed by providers enrolled in the other 650 Medicaid MCEs. Given the number of excluded providers identified in the small number of MCEs examined, CMS may want to reinforce its guidance to MCEs on their obligation to check—and to require their network providers to check—OIG's LEIE on a monthly basis to identify exclusions and reinstatements. Finally, CMS may want to reiterate that providers are obligated to prevent use of Federal funds for payments to excluded persons and entities, regardless of whether those persons are located by contract staffing agencies or checked by other vendors.

[22] Two percent of providers did not indicate why they do not check the exclusion status of their employees.

This report 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-07-09-00632 in all correspondence.

Appendix A: Social Security Act Authorities Under Which the 16 Individuals Employed by Sampled Providers Were Excluded

Occupation	Social Security Act Authority	Number of Excluded Individuals
Registered Nurse/Licensed Practical Nurse	1128(b)(4) License Revocation/Suspension/Surrender	3
	1128(a)(2) Patient Abuse/Neglect Convictions	1
	1128(a)(1) Program-Related Convictions	1
Personal Care Attendant/Certified Nurse Aide	1128(b)(4) License Revocation/Suspension/Surrender	3
	1128(a)(1) Program-Related Convictions	1
Nurse Supervisor	1128(b)(4) License Revocation/Suspension/Surrender	1
	1128(a)(2) Patient Abuse/Neglect Convictions	1
	1128(a)(1) Program-Related Convictions	1
Chaplain	1128(a)(1) Program-Related Convictions	1
Clinical Technician	1128(a)(1) Program-Related Convictions	1
Collector (Business Office)	1128(a)(3) Felony Conviction for Health Care Fraud	1
Instrument Technician	1128(a)(2) Patient Abuse/Neglect Convictions	1

Source: Office of Inspector General analysis of employee rosters, List of Excluded Individuals and Entities data, and legal authorities, 2012.

Appendix B: Point Estimates, Sample Sizes, and Confidence Intervals

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that indicated they used the List of Excluded Individuals and Entities to check employees' exclusion status	467	78.1%	69.7%–85.1%
Percentage of providers that indicated they used the Excluded Parties List System to check employees' exclusion status	467	51.2%	42.0%–60.4%
Percentage of providers that indicated they used the State sanctions and licensure databases to check employees' exclusion status	467	44.4%	35.4%–53.7%
Percentage of providers that indicated they used the Medicare Exclusions Database to check employees' exclusion status	467	32.4%	24.2%–41.5%
Percentage of providers that indicated they used the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank to check employees' exclusion status	467	2.2%	0.6%–5.9%
Percentage of providers that check employees' exclusion status at hire plus doing any periodic check	467	77.8%	69.4%–84.8%
Percentage of providers that check employees' exclusion status at hire plus doing monthly check	467	41.1%	32.3%–50.4%
Percentage of providers that check employees' exclusion status at hire plus doing a quarterly check	467	6.0%	2.5%–11.8%
Percentage of providers that check employees' exclusion status at hire plus doing an annual check	467	18.1%	11.8%–26.1%
Percentage of providers that check employees' exclusion status at hire plus checking at a frequency other than monthly, quarterly, or yearly	467	15.4%	9.5%–23.0%
Percentage of providers that check employees' exclusion status at hire only	467	8.6%	4.3%–15.0%
Percentage of providers that check employees' exclusion status periodically only	467	6.8%	3.0%–12.8%
Percentage of providers that check employees' exclusion status monthly only	467	0.9%	0.04%–4.4%
Percentage of providers that check employees' exclusion status quarterly only	467	1.7%	0.2%–5.9%
Percentage of providers that check employees' exclusion status annually only	467	3.3%	0.9%–8.4%
Percentage of providers that check employees' exclusion status only at a frequency other than monthly, quarterly, or yearly	467	0.9%	0.03%–4.5%
Percentage of providers that do not check the exclusion status of their employees	467	6.8%	3.0%–12.8%
Percentage of providers that require employees to sign an affidavit or attestation regarding their exclusion status	467	41.7%	32.8%–50.9%
Percentage of providers that identified the costs and resource burdens of conducting exclusions checks as challenges	467	54.9%	45.6%–63.9%
Percentage of providers that identified lack of knowledge as the reason they do not check employees' exclusion status	467	4.2%	1.4%–9.5%

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Appendix B: Point Estimates, Sample Sizes, and Confidence Intervals (Continued)

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of providers that identified lack of knowledge and lack of resources as the reason they do not check employees' exclusion status	467	0.8%	0.02%–4.6%
Percentage of providers that did not identify a reason why they do not check employees' exclusion status	467	1.7%	0.2%–5.9%

Source: Office of Inspector General analysis of provider surveys, 2012.