UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected at 2:00 p.m. EDT
Tuesday, September 18, 1984

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Before the

Subcommittee on Health and the

Environment

Committee on Energy and Commerce

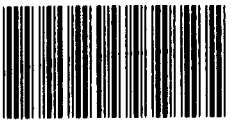
and

Subcommittee on Health

Committee on Ways and Means

United States House of Representatives

On the Need for Expanded Federal Exclusion Authority



Mr. Chairmen and members of the Committees we are pleased to be here today to discuss the need for expanded federal exclusion authority for practitioners to help ensure that Medicare and Medicaid recipients receive quality care. While reviewing how the Medicare and Medicaid programs operate, we noted that it was possible for medical practitioners--medical doctors, osteopathic doctors, podiatrists, chiropractors, dentists and pharmacists--who held licenses in more than one state, to have one of these licenses suspended or revoked by a state licensing board but relocate and continue to treat Medicare and Medicaid patients.

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Our review showed that Medicare and Medicaid patients are in fact being treated in some states by health practitioners whose licenses were revoked or suspended in other states. These practitioners were able to continue practicing under Medicare and Medicaid because existing federal exclusion authority does not permit a national exclusion of practitioners who are found by state licensing boards to have failed to meet minimum professional standards. Accordingly, the federal government's assurance that Medicare and Medicaid recipients receive quality care is diminished.

House bill H.R. 5989 was introduced on June 29, 1984. This bill, if enacted, would expand existing Federal authority to excluded practitioners from participating in the Medicare and Medicaid programs. A similar bill, S. 2744, was introduced in the Senate. We believe that additional exclusion authority is needed in four areas to sanction practitioners nationally from participation in Medicare and Medicaid when they are (1) excluded by any state Medicaid program, (2) excluded by Medicare, (3) convicted of crimes such as violations of the controlled substances laws and convictions for defrauding private insurance firms, or (4) sanctioned by any state licensing board. Mr. Chairmen, H.R. 5989 provides for the needed expansion of federal exclusion authority in the four areas I just mentioned and we support those provisions in the bill.

The first part of my statement will focus on the need for expanded federal exclusion authority. Next, I will briefly discuss the need to include all exclusions and sanctions in the

Department of Health and Human Service's (HHS's) planned information system on sanctioned providers and practitoners. Both of these issues are discussed in our report Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Heatlh Practitioners Who Lose Their Licenses (GAO/HRD-84-53), which was issued May 1, 1984.

BACKGROUND

Licensing of health care professionals is a responsibility of the states, and practitioners can hold licenses in more than one state. HHS administers Medicare and Medicaid at the Federal level. To participate in these programs a practitioner must hold a valid state license. Medicare and Medicaid administrators are responsible for determining that practitioners are licensed before paying claims for services they provide, normally by contacting the various state licensing boards. When a state licensing board revokes or suspends a practitioner's license, he or she can no longer legally provide services in that state and the state licensing board makes Medicare and Medicaid aware of this. However, sanctioning action by one state does not automatically result in sanctioning by other states where the same practitioner holds licenses.

Although the specific procedures vary somewhat from state to state, the sanctioning process generally proceeds as follows. The state licensing board becomes aware of a possible problem with a practitioner. The board conducts an investigation and notifies the practitioner of the findings. The practitioner is informed of potential actions and of his or her right to a

hearing. If the board decides to suspend or revoke the practitioner's license, he or she has the right to appeal the decision administratively and/or through the courts.

SANCTIONED PRACTITIONERS MOVE TO OTHER STATES AND TREAT MEDICARE AND MEDICAID PATIENTS

Nationwide relatively few disciplinary actions are imposed by individual states to protect their citizens from being treated by incompetent, unethical, and/or unqualified health care practitioners. In our review of licensing boards' disciplinary actions in Michigan, Ohio, and Pennsylvania we identified 328 health care practitioners from six professions who had their licenses revoked or suspended for 1 year or more, or surrendered them for disciplinary reasons, during the period January 1, 1977, through December 31, 1982. These sanctions were imposed when the practitioners did not meet minimum professional standards because they had problems--such as alcohol and drug abuse--or committed acts--such as malpractice, sexual offenses, or drug trafficking. State licensing boards sanction many more practitioners than HHS excludes from participation in Medicare and Medicaid. The boards, which are responsible for assuring that practitioners are qualified to treat patients, can sanction practitioners for their actions related to any patient. However, HHS is responsible only for practitioners' participation in Medicare and Medicaid and can exclude practitioners only for acts committed against these programs and their beneficiaries. Because of these differences, HHS excludes relatively few of those practitioners sanctioned by state boards. For example, while the licensing boards in

Michigan, Ohio, and Pennsylvania sanctioned 328 practitioners in 1977-82, HHS nationwide excluded 335 practitioners from September 1975 through December 1982. Also, only 15 of the 328 practitioners sanctioned by the three states were also excluded by HHS.

There are also differences in the reasons for state sanctions and HHS exclusions although the reasons for both types of action are serious. Over 70 percent of the HHS exclusion actions were for criminal violations against the programs. However, 58 percent of the 328 licensing board sanctions in the three states were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care. We found that 189 state sanctions (58 percent) were taken because of such problems as malpractice, alcohol or drug abuse, and immoral conduct which affect quality of care. Seventy-five (23 percent) were due to drug trafficking, drug sales, or violation of the controlled substance act; 29 (9 percent) of the practitioners were sanctioned for criminal acts or private insurance fraud; and 28 cases (8 percent) occurred because of the practitioners submitting false Medicare and Medicaid claims. Seven sanctions (2 percent) were for other reasons.

Reasons for state sanctions nationwide are similar to those in the three states. Information reported nationally by state licensing boards to the Federation of State Medical Boards for 1979-82 on 1,388 practitioners showed that the reasons for actions taken in Michigan, Ohio, and Pennsylvania are similar to

the reasons for actions taken by licensing boards throughout the nation. For example, 61 percent of the actions reported by the Federation involved problems that affected quality of care as compared to the 58 percent we found in the three states in our review.

The problems that caused the physicians to lose their licenses are serious. However, it is important to note that the problems involved only a small percentage of the nation's physicians. For example, in 1982 only about 1 in every 1,000 physicians lost their licenses for disciplinary reasons.

Of the 328 practitioners sanctioned by the three states we identified, 122 held licenses in at least one other state at the time of the sanction. Having licenses in other states permits sanctioned practitioners to move to another state and continue practicing. Of these 122 practitioners, 30 corrected their problems, retired, or died. The other 92 had to relocate if they wanted to practice. We were able to trace 49 of these practitioners to other states and found that 39 obtained provider numbers to directly bill the Medicare and/or Medicaid programs. The other 10 relocated, but did not obtain a provider number. They could be serving Medicare and Medicaid patients in a hospital, clinic, or other institution where the institution and not the practitioner bills the two programs for services provided. We could not determine the whereabouts of the other 43.

When practitioners sanctioned by state licensing boards relocate, we believe serious questions arise concerning the quality of care provided by them to Medicare and Medicaid

patients becasue there are no assurances that the problems that led to their sanctioning in one state were corrected before they began treating Medicare and Medicaid patients in other states.

Practitioners who have problems practice in other states

Of the 39 practitioners who moved to other states and enrolled in the Medicare and/or Medicad programs, 28 originally lost their licenses because they committed acts or had problems which, according to the state licensing boards, showed that they did not meet minimum professional standards. The other 11 practitioners were sanctioned by the states for various criminal activities. Only three of these practitioners were excluded by HHS from participation in Medicare and Medicaid. This permitted the others to participate in the two programs in other states and, in some instances, commit the same or similar acts. For example:

--A medical doctor was found to be mentally impaired and unfit to practice medicine by the Michigan Medical Board in June 1978. He surrendered his Ohio license in the same year but moved to New York and received Medicare and Medicaid payments. In April 1982, New York revoked his license for gross incompetence based on another state's action.

--An Ohio dentist moved to Pennsylvania after he surrendered his license in Ohio because of drug usage and illegal possession of drugs. He participated in the Medicare program in Pennsylvania. He also enrolled in the Pennsylvania Medicaid program, but received no payments.

In August 1983, the Pennsylvania Medicaid agency took action to deny all future payments to him based on information received concerning a guilty plea in Pittsburgh to a federal criminal charge of illegal prescribing practices.

--An osteopathic doctor was licensed in Michigan in 1949 and also obtained licenses in 13 other states. In March 1951 he was convicted of unlawfully selling drugs in Michigan and did not renew his Michigan license but continued to practice elsewhere. In 1964 he was convicted of illegal drug sales in Texas, and many states began taking sanction actions against him. He again obtained a Michigan license in January 1972. In 1982, he was convicted of illegal drug sales for the third time and sentenced to 10 years in prison. Over the years, he worked under a Public Health Service grant, at the Veterans Administration, and as part of a group practice in Michigan serving Medicaid patients.

In summary, practitioners sanctioned by State licensing boards because they fail to meet minimum professional standards are moving to other states and treating Medicare and Medicaid patients. The continued participation of these practitoners in these programs raises serious questions about the quality of care some Medicare and Medicaid patients are receiving. There is no assurance that the practitioners corrected the problem that caused them to lose their licenses. They can continue to move and practice without correcting their problem until each state where they hold a license individually takes a sanction action against them.

ADDITIONAL AUTHORITY NEEDED AT THE FEDERAL LEVEL TO PROTECT MEDICARE AND MEDICAID BENEFICIARIES

A primary reason why sanctioned practitioners were able to go to other states to practice was that the other states never learned about the practitioners' previous offenses or, by the time they did, many months or years had passed. When states are informed, it takes up to 3 years to sanction practitioners because of the procedures that must be followed and the shortage of personnel to carry out these procedures. Specifically, for the 39 practitoners that we identified as relocating and practicing under Medicare and/or Medicaid after a state licensing board had revoked or suspended their licenses, as of October 1983, 18 had their licenses suspended or revoked in the other states where they held licenses and 21 still held licenses. The time elapsed between the initial sanctioning action and action by the other states averaged about 2.6 years, ranging from 6 months to 5.2 years. On the average, 3.5 years had elapsed since the 21 practitioners still holding licenses had been sanctioned by the initial state. The range was from 10 months to 8.7 years.

State licensing officials said the main reason for allowing practitioners to remain active in their states was that they did not know about disciplinary actions in other states. In cases where they were informed and considered the offenses serious enough to remove the practitioners' licenses, they usually were not informed of the other states' actions in a timely manner. In addition, state licensing laws may preclude a state from taking action based solely on another state's sanction.

Under current law, HHS can exclude practitioners from participation in Medicare for a number of reasons:

--Conviction of a criminal act against Medicare, Medicaid, or title XX of the Social Security Act, (section 1128).

--When HHS imposes a civil monetary penalty for acts against Medicare or Medicaid (section 1128A).

--Submitting false claims to Medicare (section 1128).

--Habitually providing more services than necessary to Medicare beneficiaries (section 1862(d)).

--Submitting Medicare claims with charges that substantially exceed the practitioner's customary charges (section 1862(d)).

--Providing services to Medicare beneficiaries that are of a quality which fails to meet professionally recognized standards of care (section 1862(d)).

HHS has authority to require all States to exclude practitioners from participating in Medicaid only when the practitioner is convicted of a criminal act against Medicare, Medicaid, or title XX (section 1128) or when HHS has imposed a civil monetary penalty on the practitioner for acts against Medicare or Medicaid (section 1128A). If HHS excludes a practitioner from Medicare for one of the other allowed reasons, it is required to notify state Medicaid agencies of this but cannot require the states to exclude the practitioner from Medicaid.

We believe that the current practitioner exclusion authority HHS has is insufficient in several respects. Our review of HHS'

exclusion authority under Medicare and Medicaid showed four potential gaps:

--Practitioners who lose their right to participate in Medicaid in one state for such reasons as habitual overutilization can continue to practice under Medicare in that state or relocate to another where they hold a license and practice under Medicare and Medicaid.

--Practitioners who lose their right to participate in Medicare for such reasons as providing inappropriate care can continue to participate in Medicaid in any state where they hold a license.

--Practitioners who lose their license in one state can relocate to another state where they hold a license and practice under Medicare and Medicaid.

--Practitioners convicted of crimes other than Medicare and Medicaid fraud can continue to practice under Medicare and Medicaid.

The kinds of situations when HHS cannot nationally exclude practitioners discussed above involve serious problems. Practitioners have been found unfit to participate in Medicare or Medicaid in a particular state, or have been found unfit to practice in one state. We believe that to protect all Medicare and Medicaid patients from practitioners found unfit, HHS needs the authority to nationally exclude them from participation in these programs after reviewing the findings that caused action to be taken against the practitioners. Also, if HHS could sanction nationally a practitoner sanctioned by a state licensing board,

it would help eliminate the lag in time between action in one state and action in other states where a practitioner holds licenses.

H.R. 5989 would close the gaps in HHS's exclusion authority that we identified in our May 1 report and we support enactment of those provisions.

HHS INFORMATION SYSTEM ON SANCTIONED PROVIDERS SHOULD BE EXPANDED

Through its Office of Inspector General, HHS is establishing an information reporting system which will include public information on practitioners who have been excluded from federal health care programs and from other public and private health care payment programs that choose to participate in the information system. However, HHS was not planning to include initially in this system practitioners sanctioned by state licensing boards. We believe that to be effective the system should include public information on all practitioners sanctioned by states because they committed acts or have problems that resulted in state licensing boards determining that these practitioners did not meet minimum professional standards.

We recommended that the information system include all practitioners sanctioned by state licensing boards. H.R. 5989 includes provisions that would provide a legal basis to assure that HHS receives from the states the necessary data to implement the provision enabling exclusion of practitioners sanctioned by their state licensing boards.

Mr. Chairmen, this concludes my statement. We would be pleased to respond to questions.