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STATEMENT OF MICHAEL ZIMMERMAN

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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 H.R. 1370

Mr. Chairmen and Members of the Subcommittees:

We are pleased to be here today to present our views on H.R. 1370, a bill to give beneficiaries protection under the health care programs of the Social Security Act from unfit health care practitioners and entities. Basically, the bill consolidates the act's current legislative authorities for, and provides new authorities to, the Department of Health and Human Services (HHS) related to excluding unfit and unethical health care practitioners and entities from participation in the act's health care programs.

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Last year we testified before your Subcommittees in support of a similar bill, H.R. 5989. At that hearing we presented details on our May 1, 1984, report Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses (GAO/HRD-84-53). Today I would like to briefly summarize that report and discuss provisions in H.R. 1370 that were not covered by our testimony on H.R. 5989.

GAPS IN EXCLUSION AUTHORITIES NEED TO BE CLOSED

To prepare our 1984 report, we analyzed the Social Security Act provisions authorizing HHS to exclude unfit and unethical practitioners from the Medicare and Medicaid programs. Our analysis was directed at identifying gaps in these authorities, and we found that:

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

--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 convicted of crimes other than Medicare and Medicaid fraud, such as defrauding private insurance or illicitly trafficking in drugs, can continue to practice under both programs.

We believe that in the situations outlined above, HHS should be able to nationally exclude practitioners from both Medicare and Medicaid because in each case the practitioner had been found to be unfit or unethical by one of the programs or the criminal court system.

We also identified a fourth major gap in HHS' exclusion authority. We noted that a practitioner licensed in more than one state could have one of these licenses suspended or revoked by a state licensing board but relocate to another state and continue to treat Medicare and Medicaid patients. In these instances, therefore, federal beneficiaries would be treated by a practitioner who had been determined by a licensing board in another state to be unfit to provide care.

We reviewed 328 practitioners who had been sanctioned by state licensing boards in Michigan, Ohio, and Pennsylvania and found that 122 of them held licenses in at least one state besides the state taking action against them. In total, these practitioners held licenses in 39 states and the District of Columbia. Of these 122 practitioners, 39 relocated and enrolled in the Medicare and/or Medicaid programs, 10 relocated but we identified no Medicare or Medicaid participation, and 43 could

have relocated because they still held licenses in other states but we could not determine their whereabouts. The report presents a number of examples of why practitioners lost their licenses and how they continued to see Medicare and Medicaid patients. The reasons the practitioners lost their licenses involved serious matters ranging from drug addiction and sexual abuse of patients to mental incompetence and the unnecessary provision of dangerous medical procedures.

To better protect federal beneficiaries from unfit and unethical practitioners, we recommended that HHS request legislation to close these four gaps in its exclusion authorities. We understand that in response to our recommendation, the HHS Inspector General's Office has worked with the sponsors of H.R. 1370 in developing that bill. We are pleased that the bill, if enacted, will close the gaps we identified as well as make other changes in the Social Security Act's antifraud and abuse provisions that the Inspector General believes are needed.

NEW PROVISIONS IN H.R. 1370

The major difference between H.R. 5989 and H.R. 1370 is the inclusion of (1) health maintenance organizations (HMOs) and similar types of prepaid health plans under contract with Medicare or Medicaid and (2) entities operating under a waiver of Medicaid's "freedom of choice" requirement granted to the state by HHS under section 1915(b)(1) of the Social Security Act.

H.R. 1370 (section 2, which would add section 1128(b)(6)(D) and (E) to the Social Security Act) would authorize the Secretary of HHS to exclude from Medicare and Medicaid HMOs, prepaid health plans, and entities operating under the cited Medicaid waiver if they fail in a substantial number of cases to provide medically necessary items or services as required by law or their contracts with the programs. H.R. 1370 (section 7) would also require states to provide that they will exclude HMOs, prepaid health plans, and entities operating under the waiver if they are owned or controlled by, or have substantial contractual relationships with, individuals who have been convicted of certain crimes or who received a civil monetary penalty or are excluded from Medicare or a state health care program.

All of the entities covered by these provisions operate under contracts with the federal or state governments; these contracts give the entities incentives to closely control the utilization of health care services. This results because the entities are normally paid a fixed rate to furnish all of the services covered by the contract that the program beneficiaries need. Thus, preventing the provision of unnecessary services helps the entity assure that its costs stay within the fixed payments it receives. Under the incentives of these agreements, it is also possible that entities could underprovide services in order to avoid a loss or to increase income.

We view the exclusion authority for denial of medically necessary services by HMOs, prepaid health plans, and entities operating under freedom of choice waivers as providing a deterrent to them against letting the incentives of their contracts work to their patients' medical disadvantage. We believe that providing such a deterrent is appropriate. The requirement in section 7 for states to provide for exclusion of HMOs, prepaid plans, and entities operating under the waiver basically calls for states to have available the same exclusion authority for entities as HHS would have under H.R. 1370. It would also extend the authority to provide a deterrent against unethical individuals gaining control over or advantage of these entities by means of contractual relationships. Again, we believe that such a deterrent is appropriate.

This concludes my prepared statement. We will be happy to answer any questions you may have.