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STATEMENT OF

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HUMAN RESOURCES DIVISION

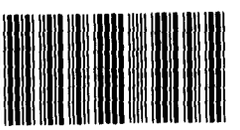
BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

ON S.837, S.1323, AND H.R. 1868



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to present our views on certain bills--S.837, S.1323, and H.R. 1868--that would give beneficiaries protection under the health care programs of the Social Security Act from unfit health care practitioners and entities. Basically, each bill consolidates the act's current legislative authorities for, and provides new authorities to, the Department of Health and Human Services (HHS) to exclude unfit and unethical health care practitioners and entities from participation in the act's health care programs.

In March we testified before the House Committees on Energy and Commerce and on Ways and Means in support of a similar bill, H.R. 1370. The provisions of H.R. 1370 were incorporated and

passed by the House as part of H.R. 1868. A number of these provisions (as well as many of those in the other bills) stem from the recommendations contained in 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). I would like to briefly summarize the report and then discuss the major differences between H.R. 1868 and S.1323. Our analysis of S.837 and H.R. 1868 showed that the two bills are virtually the same.

GAPS IN EXCLUSION AUTHORITIES NEED TO BE CLOSED

Our 1984 review was directed at identifying gaps in HHS' authority to exclude unfit and unethical practitioners from the Medicare and Medicaid programs. In that review, 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 state 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 illicitly trafficking in drugs, can continue to practice under both programs.

We believe that in the situations outlined above, where practitioners have been found to be unfit or unethical by either program or the criminal courts, HHS should be able to nationally exclude them from participation in both Medicare and Medicaid.

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 patients. In these instances federal beneficiaries would be treated by a practitioner who had been previously determined 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 in addition to the state taking action against them. Thirty-nine of these practitioners relocated to another state and enrolled in the Medicare and/or Medicaid programs. 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. In response to our recommendation, the HHS Inspector General's Office has worked with members of the Congress in developing the

bills that are the subject of today's hearings. We are pleased that the bills being considered 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.

FEATURES OF H.R. 1868 NOT IN S.1323

H.R. 1868 has several features not included in S.1323 that we believe are worthwhile. Section 2 of H.R. 1868 includes provisions authorizing HHS to exclude from Medicare and Medicaid Health Maintenance Organizations (HMOs), prepaid health plans, and entities operating under a Medicaid "freedom of choice" waiver if they fail substantially to provide medically necessary care required by law or their contract. Section 7 would require states to provide that they will exclude these same organizations if they are owned or controlled by, or have substantial contractual relationships with, individuals who have been convicted of certain crimes, have received a civil monetary penalty, or are excluded from Medicare or a state health program. We supported these provisions in H.R. 1868.

Our rationale was that the financial incentives of the fixed price contracts under which these types of health care entities usually operate, could lead to underprovision of services. Their contracts with the federal or state governments give them incentives to closely control the utilization of health care services. These incentives can help prevent the provision of unnecessary services and thereby assure that an

entity's costs stay within the payments it receives. With these incentives it is also possible that these entities could underprovide services in order to avoid a loss or to increase income.

We view the exclusion authority in section 2 of H.R. 1868 for HMOs, prepaid health plans, and entities operating under freedom of choice waivers who do not provide medically necessary services as providing a deterrent against letting the incentives of their contracts work to their patients' medical disadvantage. Also, the requirement in section 7 would extend current exclusion authority to provide a deterrent against unethical individuals gaining control over or advantage of these entities by means of contractual relationships. We believe that these deterrents are appropriate.

Another feature of H.R. 1868 that we believe is preferable to that of S.1323 relates to the programs covered by the provisions. The exclusion-related provisions of H.R. 1868 apply to all the programs of the Social Security Act under which health care services are provided--Medicare, Medicaid, the Maternal and Child Health programs of title V, and the Social Services programs of title XX. The provisions of S.1323 apply to Medicare and Medicaid, and in some cases title V programs, but not title XX.

We believe that the exclusion-related provisions should apply to all four programs. If a health care provider does something, or fails to do something, serious enough to be excluded from Medicare or Medicaid, we see no reason why that

provider should be permitted to continue to participate in title V or title XX. Conversely, if a health care provider is excluded from title V or title XX, the provider should not be permitted to participate in Medicare or Medicaid.

PROVISIONS IN S.1323 BUT NOT IN H.R. 1868

Sections 7 and 12 of S.1323 would amend Medicare and Medicaid law to prohibit payment for services furnished at the direction or on the prescription of an excluded physician. These provisions, which are not included in H.R. 1868, would provide a deterrent against an excluded physician continuing to participate in the programs "through the back door," that is, continued involvement with treatment of the programs' beneficiaries. We believe that providing such a deterrent is appropriate. In fact, we would support extending this provision to other types of practitioners who participate in the programs.

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