S. HRG. 99-409

HEALTHCARE ANTI-FRAUD BILLS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

JULY 12, 1985

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CONTENTS

ADMINISTRATION WITNESS

PUBLIC WITNESSES

ADDITIONAL INFORMATION

COMMUNICATIONS

HEALTHCARE ANTI-FRAUD BILLS

FRIDAY, JULY 12, 1985

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:35 p.m. in room SD-215, Dirksen Senate Office Building, the Honorable David Durenberger (chairman) presiding.

Present: Senators Durenberger, Roth, and Heinz.

[The press release announcing the hearing, background information on the bills, and the statements of Senators Roth, Heinz, and Mitchell follow:]

[Press release No. 85-045—June 24, 1985]

FINANCE COMMITTEE SETS HEARING ON HEALTH CARE ANTIFRAUD BILLS

Senator Bob Packwood (R-Oregon), Chairman of the Senate Committee on Finance, announced today the scheduling of a hearing before the Health Subcommittee on three bills to provide protection against fraud and abuse in the nation's healthcare programs.

The hearing is set to begin at 2:30 p.m. on Friday, July 12, 1985, in Room SD-215 of the Senate Dirksen Office Building in Washington.

Senator Packwood said Senator Dave Durenberger (R-Minnesota), Chairman of the Subcommittee on Health, would preside at the hearing.

The hearing will review these bills:

S. 1323, the "Health Care Financing Fraud and Abuse Amendments of 1985," introduced by Senator William V. Roth, Jr., (R-Delaware).

S. 837, the "Patient and Program Protection Act for Medicare and Medicaid," intorduced by Senator John Heinz (R-Pennsylvania).

H.R. 1868, the "Medicare and Medicaid Patient and Program Protection Act of 1985," originally introduced by Congressman Henson Moore (R-Louisiana) and subsequently passed by the House of Representatives and referred to the Senate Committee on Finance.

Chairman Packwood said all three of the bills pending before the Committee have the same basic objectives: To protect beneficiaries of the Federal healthcare programs under the jurisdiction of the Committee from incompetent practitioners and to protect those programs from fraud and abuse.

Testimony is expected from the U.S. General Accounting Office and from the Department of Health and Human Services' Inspector General. The medical community also is expected to offer testimony on the bills.

The Chairman said the Committee is interested in testimony which addresses different approaches to achieving the stated objectives in each of the three bills. Testimony also is expected to examine the relative merits or drawbacks associated with those approaches to fulfilling the goals of the legislation.

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MEDICARE AND MEDICAID ANTI-FRAUD LEGISLATION

Background Paper

Prepared for the Use of the Members of
The Committee on Finance

July 10, 1985

MEDICARE AND MEDICAID ANTI-FRAUD LEGISLATION

I. OVERVIEW

In May 1984, the General Accounting Office (GAO) issued a report which concluded that there was a need to expand Federal authority to protect Medicare and Medicaid beneficiaries from health care practitioners who lose their licenses for failure to meet minimum professional standards. GAO found that practitioners whose licenses were revoked or suspended by one State's licensing board were able to relocate to another State where they had a license and therefore continue to practice. The Department of Health and Human Services (HHS) does not have authority to exclude these practitioners from Medicare and Medicaid based on State licensing board findings and actions.

In response to the GAO report and similar concerns expressed by others, including the Inspector General, the House recently passed the "Medicare and Medicaid Patient and Program Protection Act of 1985" (H.R. 1868). This legislation mandates exclusion from Medicare and Medicaid for persons convicted of program-related crimes or patient abuse and neglect. It broadens the grounds for discretionary exclusion of health care providers from Medicare and Medicaid and extends both the mandatory and discretionary exclusionary remedies to other State health care programs. The bill revises the current civil monetary penalty authorities. It adds as a grounds for imposing such penalties the submission of claims for payment by individuals who misrepresent that they are physicians or who obtained their licenses through misrepresentation; in addition such individuals would be subject to a criminal penalty. The legislation

requires States, as a condition of receiving Federal Medicaid matching funds, to provide information to the Secretary on actions taken against health care practitioners by State licensing authorities. Further, H.R. 1868 amends the Controlled Substance Act to permit the Attorney General to deny, revoke, or suspend the registration to manufacture, distribute or dispense a controlled substance for any individual or entity subject to mandatory exclusion from Medicare.

Two similar measures have been introduced in the Senate: the "Patient and Program Protection Act for Medicare and Medicaid" (S. 837, Heinz) and the Health Care Financing Fraud and Abuse Amendments of 1985" (S. 1323, Roth on behalf of the Administration). The majority of the provisions of S. 837 are similar to those included in H.R. 1868. S. 837 would however, subject a number of additional categories of offenses to mandatory rather than discretionary exclusion. Further, S. 837 does not specify criminal or civil monetary penalties for physician misrepresentation.

S. 1323 contains a number of provisions similar in intent to those contained in H.R. 1868 and S. 837. The measure would also broaden present authorities to impose sanctions short of terminations on Medicaid providers and Medicare providers and suppliers whose deficiencies, while serious, do not jeopardize patient health or safety.

II. BACKGROUND

A. State Licensing

Licensing of health practitioners is a State responsibility. In order to participate in Medicare or Medicaid a practitioner must hold a valid State license. When a State licensing board revokes a practitioner's license, such practitioner can no longer legally provide services in that State. However, a sanctioning action by one State does not automatically result in sanctioning by other States where the practitioner holds licenses.

B. Medicare/Medicaid Authority

Under current law, the Secretary of Health and Human Services (HHS) is authorized to exclude practitioners from participation in Medicare for the following reasons:

- o conviction of a criminal act against Medicare, Medicaid, or Title XX of the Social Security Act;
- o when a civil monetary penalty has been imposed for filing of fraudulent claims under Medicare or Medicaid;
- o submitting false claims to Medicare;
- o submitting Medicare claims with charges substantially in excess of the practitioner's customary charges;
- o furnishing services substantially in excess of the needs of individuals or of a quality which fails to meet professionally recognized standards of health care; or
- o repeatedly providing more services than necessary to Medicare beneficiaries.

The Secretary has the authority to require States to exclude practitioners from participating in Medicaid only when the practitioner is convicted of a criminal act against Medicare, Medicaid or Title XX or when the Department has imposed a civil monetary penalty for acts involving Medicare or Medicaid. If HHS excludes a practitioner from Medicare for another reason, it is required to notify the State Medicaid agency of the determination; however it cannot require the State to exclude the practitioner from Medicaid.

C. GAO Report

On May 1, 1984, the General Accounting Office (GAO) issued a report entitled "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses" (GAO/HRD-84-53). This report found that Medicare and Medicaid patients are being treated in some States by practitioners whose licenses had been revoked or suspended by another State's licensing board for failure to meet minimum professional standards. This occurred because practitioners are able to move to another State where they have a license and continue to practice.

GAO obtained information on three States (Michigan, Ohio, and Pennsylvania) which had revoked or suspended the licenses of 328 practitioners for one year or more. Reasons for sanctions included actions affecting the quality of care provided (58 percent); drug trafficking, drug sales, or violation of the controlled substance act (23 percent); criminal act or private insurance fraud (9 percent); submitting false Medicare or Medicaid claims (8 percent) and other reasons (2 percent). Of the 328 sanctioned practitioners, 122 held licenses in at least one State besides the State taking action against them. Of this group 39 relocated and enrolled in Medicare and/or Medicaid. Only 15 of the 328 practitioners sanctioned by the three States were also excluded by HHS.

GAO stated that a primary reason why sanctioned providers were able to go to other States to practice was that the other States never learned about the individuals previous offenses or did not learn about them in a timely fashion. In addition, State licensing laws may preclude a State from taking action based solely on another State's sanction.

GAO's review of the Department's exclusion authority under Medicare and Medicaid identified the following four potential gaps:

- o 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 both programs.
- o 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.
- o Practitioners who lose their license in one state can relocate to another state where they hold a license and practice under Medicare and Medicaid.
- o Practitioners convicted of crimes other than Medicare and Medicaid fraud can continue to practice under both programs.

GAO stated that if HHS obtained an expanded exclusion authority it could better insure that Federal beneficiaries receive services only from qualified practitioners.

D. Activities of the Office of the Inspector General

The Inspector General (IG) of HHS in his testimony before the House Energy and Commerce and Ways and Means Committees in March 1985 highlighted the activities of the Office in sanctioning and penalizing providers who attempt to defraud Medicare and Medicaid.

In 1983, the Secretary of HHS transferred to the IG's office the authority to suspend or terminate from program participation, health care providers who engage in fraudulent or abusive practices. During 1983, the provision governing

civil monetary penalties was formally implemented. Since receiving the sanction authority in 1983, the IG's office imposed 674 sanctions on various health care providers. Additionally, it collected more than $9 million in civil monetary penalties.

Despite these activities the IG reported that he is unable to bar from participation in Medicare or Medicaid individuals or entities who have been convicted of defrauding private health insurers; defrauding other Federal State, or local programs; patient abuse or neglect; or unlawful manufacture, distribution, or dispensing of controlled substances. The IG reported that during the preceding three months more than 100 serious cases had been reported to his Office which he had no authority to act on. Of these, 84 invqlved physicians who had lost their licenses due to drug violations, gross negligence or professional incompetence. Another 10 physicians were convicted of violating drug laws and four were convicted of defrauding private health care programs.

III. LEGISLATION IN THE 99th CONGRESS

A. House Action

On March 19, 1985, the Subcommittee on Health of the Committee on Ways and Means and the Subcommittee on Health and the Environment of the Committee on Energy and Commerce held a joint hearing on H.R. 1370, the "Medicare and Medicaid Patient and Program Protection Act of 1985" and H.R. 1091, the "Medical Imposters Act of 1985". Testimony was received from nine witnessess representing nine organizations including the General Accounting Office and the Office of the Inspector General.

On April 2, 1985 a clean bill, H.R. 1868, the "Medicare and Medicaid Patient and Program Protection Act of 1985" was introduced and jointly referred to the two committees. The bill was reported by the Committee on Ways and Means, as amended, on May 10, 1985 (Report No. 99-80, Part 1). The bill was reported by the Committee on Energy and Commerce, as amended, on May 23, 1985 (Report No. 99-80, Part II). The bill passed the House on June 4, 1985.

B. Summary of Major Bills

The attached chart compares the major provisions of H.R. 1868 as passed by the House and two related measures: S. 837 (Heinz), the "Patient and Program Protection Act for Medicare and Medicaid", and S. 1323 (Roth, on behalf of the Administration), the "Health Care Financing Fraud and Abuse Amendments of 1985."

COMPARISON OF "MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985" (H.R. 1868), "PATIENT AND PROGRAM PROTECTION ACT FOR MEDICARE AND MEDICAID" (S. 837) AND "HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985" (S. 1323)

Item	H.R. 1868	S. 837	S. 1323
I. General Concept			
	The measure is designed to protect Medicare and Medicaid beneficiaries from unfit health care practitioners and to recodify and strengthen the antifraud provisions of the Social Security Act.	Similar intent	Similar intent

Item	H.R. 1868	S. 837	S. 1323
II. Exclusion from Medicare and State Health Care Programs			
A. Mandatory Exclusions	The Secretary of Health and Human Services is required to exclude from participation in Medicare and required to direct States to exclude from State health care programs (i.e. Medicaid, Title V and Title XX of the Social Security Act) any individual or entity:	The Secretary of Health and Human Services is required to exclude from participation in Medicare and is required to direct States to exclude from State health care programs (i.e. Medicaid, Title V and XX of the Social Security Act) any individual or entity:	The Secretary of Health and Human Services is required to exclude from participation in Medicaid and required to direct States to exclude from participation in Medicaid any individual or entity:
	- convicted of a criminal offense relating to the delivery of services under Medicare or a State health care program;	- convicted of a criminal offense relating to the delivery of services under Medicare or a State health care program;	- convicted of a criminal offense relating to the Medicare, Medicaid or Title V.
	- convicted under Federal or State law, of a criminal offense related to neglect or abuse of patients in connection with the delivery of a health care item or service.	- convicted of fraud with respect to any Federal, State, or locally financed health care program or of an offense relating to neglect or abuse of patients.	

Item	H.R. 1868	S. 837	S. 1323
A. Mandatory Exclusions (continued)		- convicted of interfering with the investigation of health care fraud; - convicted of unlawfully manufacturing, distributing, prescribing or dispensing a controlled substance; - submitting false claims; - committing fraud, kick-backs, or other prohibited acts.	

Item	H.R. 1868	S. 837	S. 1323
B. Permissive Exclusions	The Secretary of HHS may exclude from participation in Medicare and may direct States to exclude from participation in a State health care program (i.e. Medicaid, Title V and Title XX of the Social Security Act) any individual or entity:	The Secretary of HHS may exclude from participation in Medicare and may direct States to exclude from participation in a State health care program (i.e. Medicaid, Title V and Title XX of the Social Security Act) any individual or entity:	The Secretary may exclude from participation in Medicare and may direct States to exclude from participation in Medicaid any individual or entity:
	- convicted of fraud with respect to any Federal, State, or locally financed health care program;	[See mandatory exclusions]	- convicted of fraud with with respect to any Federal, State, or locally financed health care program or any offense relating to neglect or abuse of patients;
	- convicted of interfering with the investigation of health care fraud;	[See mandatory exclusions]	No comparable provision
	- convicted of unlawfully manufacturing, distributing, prescribing or dispensing a controlled substance;	[See mandatory exclusions]	Similar provision
	- whose health care license has been suspended or revoked by any State licensing authority, or who otherwise lost such a license for reasons bearing on the individual's professional competence, professional conduct or financial integrity or whose license was surrendered while a formal hearing of a licensing authority was pending;	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
B. Permissive Exclusions (continued)	- suspended or excluded from participation in a Federal or State health care program;	Similar provision	Similar provision. Specifies that provision includes those suspended or excluded from Federally-assisted programs;
	- claiming excessive charges; furnishing items or services substantially in excess of the patients' needs or of a quality that fails to meet professionally recognized standards; or is a HMO or an entity operating under a waiver of Medicaid's freedom-of-choice requirement under Section 1915(b)(1) of the Act, which has failed to furnish medically necessary services as required by law or the contract with the Medicaid program if the failure has adversely affected (or has a substantial likelihood of adversely affecting) the patients;	Similar provision except that it does not specify that failure adversely affected patients;	Similar provision except does not include language relating to HMO's or entities operating under a waiver;
	- committing fraud, kickbacks or other prohibited acts;	[See mandatory exclusions]	Similar provision
	- owned or controlled by an individual convicted of cer - tain program-related offenses, or against whom a civil monetary penalty has been assessed or who has been excluded from participation in Medicare or a State health care program;	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
B. Permissive Exclusions (continued)	- failing to disclose required ownership information;	Similar provision	Similar provision
	- failing to supply requested information on subcontractors and suppliers;	Similar provision	Similar provision
	- failing to supply certain payment information	Similar provision	Similar provision
	- failing to grant immediate access to the Secretary, State agency, Inspector General, or State Medicaid fraud control unit for the purpose of performing their statutory functions;	Similar provision	Similar provision except does not include State Medicaid fraud control unit;
	- failing (in the case of a hospital) to take corrective action required by the Secretary (based on information supplied by a peer review organization) to prevent or correct inappropriate admissions or practice patterns;	No comparable provision	Similar provision
	No comparable provision	No comparable provision	- defaulting on repayment of scholarship obligations or loans in connection with health professions education, except that the Secretary may not exclude a sole community physician or sole source of essential specialized services, and must take into account access of beneficiaries to services.

Item	H.R. 1868	S. 837	S. 1323
C. Notice and Effective Date	Mandatory and permissive exclusions would be effective at such time and upon such reasonable notice to the public and to the individual or entity as may be specified in regulation. An exclusion would be effective on or after the effective date specified in the notice, except that an exclusion can not apply until 30 days after the effective date of the exclusion to payments made under the Medicare program or under a state health care program for: - inpatient institutional services furnished to an individual who was admitted to such institution before the date of the exclusion, or - home health services and hospice care furnished under a plan of care established before the date of the exclusion.	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
D. Period of Exclusion	The Secretary is required to specify in the notice of exclusion the minimum period of exclusion. The minimum period of the exclusion for persons convicted of program-related crimes may not be less than 5 years. The minimum period of the exclusion for failure to grant immediate access to the Secretary and other agencies is the sum of the length of the period in which the individual or entity failed to grant the immediate access and an additional period not to exceed 90 days.	Similar provision except that minimum period of exclusion is five years for all mandatory exclusions.	The Secretary is required to specify in the notice of exclusion the minimum period of exclusion. The minimum period of exclusion for persons convicted of program-related criminal offense can not be less that 5 years except that the Secretary has the authority to waive the exclusion where the individual or entity is the sole community provider or where the exclusion would adversely affect Medicare or Medicaid. The Secretary's decision to waive the exclusion would not be reviewable.
E. Notice to State Agencies and Exclusion Under State Health Care Programs	The Secretary is required to promptly notify each appropriate State agency administering or supervising the administration of each State health care program of the fact and circumstances of each exclusion effected against an individual or entity and the period for which the State agency is directed to exclude the individual or entity from participation in the State health care program.	Similar provision	Similar, except State health care programs includes Medicaid only.

Item	H.R. 1868	S. 837	S. 1323
E. Notice to State Agencies and Exclusion Under State Health Care Programs	The period of exclusion under a State health care program must be the same as any period of exclusion under Medicare unless the Secretary received and approved a waiver request from the State agency.	Similar provision	Similar provision
(continued)	The Secretary is also required to promptly notify State licensing authorities concerning exclusions, request that appropriate investigations be made and sanctions invoked in accordance with State law and policy and request that the agency keep the Secretary and Inspector General informed of actions taken.	Similar provision	Similar provision
F. Hearing, Judicial Review and Application for Termination of Exclusion	Current Medicare law provisions relating to opportunity for a hearing and judicial review of the Secretary's final decision would apply. Any individual or entity excluded from participation may apply to the Secretary (as specified in regulations) at the end of the initial period of exclusion and at such other times as the Secretary may provide, for reinstatement as a participant in these programs. The Secretary could	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
F. Hearing, Judicial Review and Application for Termination of Exclusion (continued)	reinstate the individual or entity if the Secretary determines there is no basis for continuation of the exclusion and there were reasonable assurances the actions which led to the exclusion would not recur. The Secretary must notify State agencies of termination of exclusion.		

Item	H.R. 1868	S. 837	S. 1323
III. Civil Monetary Penalties			
	The bill clarifies and consolidates authorities related to civil monetary penalties. It clarifies that the Secretary would be permitted to subject a person to civil monetary penalties for any claim the person knows is false or fraudulent.	Similar provision	Similar provision
	The Secretary would be permitted to subject a person to civil monetary penalties if the person submits a claim for a physician's service if the person is not licensed as a physician, had obtained a license by misrepresenting a material fact or falsely claimed to the patient to be board certified in a medical specialty.	No comparable provision	No comparable provision
	The Secretary would be permitted to exclude the person from participation in Medicare and to direct the State agency to exclude the person from any State health care program.	Similar provision	Similar provision except limited to Medicare and Medicaid.
	The Secretary would be permitted to use a single administrative and unified judicial review procedure for both the civil monetary penalty and the exclusion based on such penalty.	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
III. Civil Monetary Penalties (continued)	The Secretary would not be permitted to initiate an action under this section with respect to a claim later than 6 years after the claim was presented.	Similar provision	Similar provision
	The Secretary would be permitted to issue and enforce subpoenas with respect to civil monetary penalties to the same extent the Secretary has such authority in other areas of Medicare.	Similar provision	Similar provision
	The State's share of funds collected under the civil monetary penalty would be increased. The State would receive a portion of the total amount collected under the penalty in proportion to the State's share in the original claim.	Similar provision	Similar provision
	If it appears to the Secretary that any person has engaged, is engaging or is about to engage in any activity which would constitute a violation subject to civil monetary penalties, the Secretary would be permitted to enjoin such person from concealing or removing assets that could be required in order to pay a civil monetary penalty.	Similar provision	Similar provision except does not apply to cases where it appears individual is about to engage in such activities.

Item	H.R. 1868	S. 837	S. 1323
IV. Criminal Penalties			
	The measure consolidates the existing criminal penalty provisions for Medicare and Medicaid and broadens the scope to include titles V and XX.	Similar provision	The measure consolidates the existing criminal penalty provisions for Medicare and Medicaid.
	The measure provides criminal penalties for persons presenting a claim for a physician's service when the person was not a licensed physician or the license had been obtained through misrepresentation of material fact.	No comparable provision	No comparable provision

Item	H.R. 1868	S. 837	S. 1323
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners			
	As a condition of approval of a Medicaid plan, each State is required to have a system of reporting information with respect to formal proceedings concluded against a health care practitioner or entity by a State licensing authority.	Similar provision	Similar provision
	The State is required to maintain a reporting system on any adverse actions taken by a licensing authority, including any revocation or suspension of a license, reprimand, reason of the practioner or entity surrendering the license or leaving the State, also any other loss of license whether by operation of law, voluntary surrender, or otherwise.	Similar provision	Similar provision
	The State is required to provide the Secretary, or an entity designated by the Secretary, access to documents as may be necessary to determine the facts and circumstances of	Similar provision	Similar provision

Item	H.R. 1868	S. 837	S. 1323
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practitioners (continued)	such actions. The information must be supplied to the Secretary or, under other suitable arrangements made by the Secretary, to another entity in such a manner as determined by the Secretary.		
	Information would be required to be provided to State licensing authorities, State health care programs, peer review organizations and State fraud control units in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of beneficiaries and to protect the fiscal integrity of such programs.	Similar provision	The Secretary is authorized to share the information with Federal agencies administering Federal health care pregrams, peer review organizations and State health agencies.
	No comparable provision	No comparable provision	No information obtained by the Secretary or any other entity or agency under the measure can be subject to subpeona or proceedings in a civil action.
	The Secretary is required to provide suitable safeguards in order to ensure the confidentiality of such information as is not otherwise available to the public.	Similar provision	Information obtained by the Secretary is not available under the Freedom of Information Act except to the individual or entity that was the subject of the adverse determination. The Secretary and State agencies are required to provide safeguards to assure the

Item	H.R. 1868	S. 837	S. 1323
V. Information Concerning Sanctions Taken by State Licensing Authorities Against Health Care Practioners (continued)			confidentiality of the information and its use only for purposes directly connected with the performance of the legal duties of the Secretary or other entity receiving the information.

Item	H.R. 1868	S. 837	S. 1323
VI. Obligations of Health Care Practitioners and Providers	The bill extends the provisions relating to obligations of health care practitioners to provide medically necessary services of a quality meeting professionally recognized standards to all health care services paid for under the Social Security Act. It extends the exclusion authority to encompass violations occurring in and exclusions from any health care program for which payment could be made under the Act.	Similar provision.	Similar provision limited to Medicaid.
VII. Exclusion Under the Medicaid Program	The bill permits a State to exclude any individual or entity from participation in a State Medicaid plan for any reason which the Secretary could have excluded an individual from participation in Medicare. It requires a State, in order to receive Federal payments with respect to a health maintenance organization (HMO) or an entity operating under a waiver of Medicaid's freedom-of choice requirement under Section 1915(b)(1),	Similar provision.	The bill permits a State to exclude any individual or entity from participation in a State Medicaid plan for any reason which the Secretary could have excluded an individual from participation in Medicare.

Item	H.R. 1868	S. 837	S. 1323
VII. Exclusion Under the Medicaid Program (continued)	to exclude any such entity that: (1) could be excluded because of the conviction of the owners or managers of certain crimes; or (2) has a substantial contractural relationship with any individual or entity convicted of such crimes.		

Item	H.R. 1868	S. 837	S. 1323
VIII. Amendment to the Controlled Substances Act	The bill amends the Controlled Substances Act to add as a basis for the denial, revocation, or suspension of registration to manufacture, distribute or dispense a controlled substance by the Attorney General, any individual or entity that has been excluded, (or directed to be excluded) from Medicare.	Similar provision	No provision
IX. Medicaid Moratorium	The measure amends the provision added by DEFRA which established a moratorium on sanctions against States whose standards or methods of determining eligibility for non-cash Medicaid recipients are less restrictive than the standards or methods of the comparable cash assistance program. The measure specifies that the moratorium applies to any State Medicaid plan change submitted to the Secretary either before or after enactment of DEFRA whether or not approved, disapproved, acted on or not acted on.	No provision	The bill repeals the DEFRA moratorium provision except that it retains the provision requiring a report to Congress on the appropriateness and impact on States and recipients of applying eligibility standards and methodologies of cash assistance programs to noncash recipients of Medicaid.

Item	H.R. 1868	S. 837	S. 1323
X. Miscellaneous and Conforming Amendments			
	The bill clarifies that no payment could be made under Medicare or a State health program for any item or service furnished by an individual or entity excluded from participation in those programs.	Similar provision	Similar provision except payments may be made for an emergency item or service.
	The bill provides that an institution or agency would not be entitled to separate notice and an opportunity for a hearing under both the provision relating to exclusions and that relating to termination of provider agreements with respect to a determination or determinations based on the same underlying facts and issues.	Similar provision	Similar provision
	The bill makes other technical and conforming changes.	Similar provision	The bill makes additional technical and conforming changes.

51-772 O - 86 - 2

Item	H.R. 1868	S. 837	S. 1323
XI. Reporting Requirement for Financial Interests	No comparable provision	No comparable provision	The bill amends the definition of ownership or controlling interests to eliminate reporting requirements with respect to interests in obligations which amount to $25,000 or more, but which equal less than 5 percent of the assets of the entity.
XII. Alternative to Termination of Provider Agreement	No comparable provision	No comparble provision	The bill permits the Secretary to extend the provider agreement conditionally for up to 6 months (or in the case of skilled nursing facilities for up to a year) in cases where deficiencies would justify termination of a provider agreement under Medicare but did not jeopardize the health and safety of patients. The provider would not be entitled to a hearing before the sanction was imposed. Similar amendments are included for Medicaid.

Item	H.R. 1868	S. 837	S. 1323
XIII. Conditional Approval of Suppliers of Services			
	No comparable provision	No comparable provision	The bill authorizes the Secretary to give conditional approval to suppliers that fail to meet conditions of participation but whose deficiencies do not jeopardize patients' health or safety. (This is similar to the conditional provider status established above).
XIV. Modification of Secretary's "Look Behind" Authority			
	No comparable provision	No comparable provision	The bill gives the Secretary the same authority to impose alternative sanctions under Medicaid's "look-behind" authority. [This authority permits the Secretary to "look behind" a State's survey of a SNF or ICF and make an independent and binding decision with respect to a facility's participation.]

Item	H.R. 1868	S. 837	S. 1323
XV. Medigap Policies			
	No comparable provision	No comparable provision	The bill amends the provision establishing criminal sanctions for fraud and abuse relating to the sale of "Medigap" insurance, to provide that whoever "knowingly and willfully" (rather than knowingly or willfully) misrepresents a material fact is guilty of a felony.
XVI. Denial of Medicaid Payments Where Information Supporting Claims Not Furnished to Secretary			
	No comparable provision	No comparable provision	The bill authorizes the Secretary to deny Federal Medicaid payments for services furnished by an individual or entity which failed to furnish required information.
XVII. Medicaid Utilization Control			
	No comparable provision	No comparable provision	The bill provides that the length of patient stays on which the utilization control penalty is calculated include all consecutive stays, whether or not during the same fiscal year.

Opening Remarks
of
Senator Dave Durenberger
Health Subcommittee Hearing
on
Fraud and Abuse in Health Care
July 12, 1985

The jurisdiction of this Subcommittee covers Medicare, Medicaid, and the Maternal and Child Health Block Grant. In programs as broad as these, there is going to be some amount of fraud and abuse. In medicine as in other fields, there are unscrupulous and incompetent people who will try to take advantage of the system for personal gain. As we will learn today, the evidence is clear that the Secretary of Health and Human Services needs additional authority to go after those physicians and other providers of health services who are unfit and unethical.

This hearing will focus on three pending bills: HR 1868, S. 837 and S.1323. Each would give the Secretary the necessary authority to exclude from Medicare and Medicaid individuals convicted of program-related crimes or patient abuse and neglect. The bills broaden the grounds for discretionary exclusion of health care providers from Medicare and Medicaid and extends both the mandatory and discretionary exclusion of corrupt practitioners to other state health care programs. There are differences between the details of the measures, but they're primarily technical in nature.

I would like to commend my colleagues Congressman Henson Moore, Senator John Heinz, and Senator Bill Roth who introduced these important bills and have taken the leadership in this area. I would particularly like to highlight Henson Moore's work on shepherding HR 1868 through the House of Representatives. He has done a yeoman's job. It is quite rare that a minority member can achieve that kind of legislative success. But, he did it because he was right about the issue and had the tenacity and wisdom to see it through from beginning to end.

Today our hearing will focus on a problem requiring the immediate attention of the Senate. But, there are other issues of abusive practices concerning Medicare which deserve the attention of this Subcommittee. The manufacturers of pacemakers, intraocular lenses, and other prostheses have adopted a marketing practice of offering gifts as incentives to physicians to purchase a particular pacemaker or prosthetic product.

The law as it now stands permits a physician to accept a gift providing he "properly discloses and appropriately reflect the cost value by the provider." The Department of Health and Human Services is allowing these practices to continue.

Regardless, of the law and Department position, it is pretty clear that the extra "markup costs" of these gifts cost Medicare. For example, the price to Medicare of an intraoucular lens runs around $350. It is estimated that $100-$150 of this amount are costs incurred by the lens companies to underwrite incentives such as office equipment, cars, or vacations to encourage the physician to contract for a particular quantity of lenses.

The Subcommittee will explore this unethical marketing practice. We need to determine how widespread it is, how it is affecting the marketplace, and how much it is inflating the cost of these items to Medicare and its beneficiaries. But, most importantly, we need to examine the affect it is having on the quality of care. On its face, the issue raises questions of ethical practice as well as abuse. It deserves our attention.

I want to express the appreciation of the Subcommittee to the witnesses who have taken time to come here today. The issues we are considering are important. Your contribution will make a significant difference in furthering the legislative process on the three bills which we will discuss at this hearing.

OPENING STATEMENT

OF SENATOR DOLE

I WELCOME THOSE WITNESSES APPEARING BEFORE US TODAY AND ALSO WELCOME THE OPPORTUNITY TO WORK TOWARD CLOSING A SERIOUS GAP IN OUR EFFORT TO MAINTAIN QUALITY OF CARE TO BENEFICIARIES OF FEDERAL AND STATE HEALTH PROGRAMS. WE ALL KNOW THAT THE PROCESS OF SANCTIONS APPLIED TO HEALTH CARE PRACTITIONERS IS A SERIOUS ENDEAVOUR--NOT TO BE TAKEN LIGHTLY. ONCE THOSE SANCTIONS ARE IMPOSED, IT MAKES NO SENSE FOR US TO CONTINUE TO ALLOW THOSE PRACTITIONERS TO SIMPLY MOVE TO ANOTHER STATE OR CONTINUE TO PROVIDE SERVICES IN OTHER FEDERAL PROGRAMS. THESE ESCAPE ROUTES DEFEAT OUR EFFORTS. OUR CONCERN FOR THOSE WHO DEPEND ON THESE PROGRAMS MUST BE CONSISTENT.

FEDERAL BENEFICIARIES MUST BE ENTITLED TO RECEIVE SERVICES FROM QUALIFIED PRACTITIONERS. THOSE WHO ENGAGE IN FRAUDULENT OR ABUSIVE PRACTICES AND RECEIVE SANCTIONS FOR THEIR MISCONDUCT MUST BEAR THE BURDEN OF THAT SANCTION. I TRUST THIS HEARING WILL LEAD US TOWARD LEGISLATION THAT WILL ELIMINATE THIS LOOPHOLE.

OPENING STATEMENT OF

SENATOR WILLIAM V. ROTH, JR.

I WOULD LIKE TO TAKE THIS OPPORTUNITY TO COMMEND THE CHAIRMAN FOR HOLDING THESE IMPORTANT HEARINGS IN SUCH A TIMELY FASHION. THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985, WHICH I INTRODUCED ON JUNE 19 AND THE LEGISLATION OF MY ESTEEMED COLLEAGUES SENATOR HEINZ, S. 367, AS WELL AS H.R. 1868 INTRODUCED BY MY FRIEND HENSON MOORE WILL TAKE GREAT STRIDES IN ENABLING THE ADMINISTRATION TO PROTECT OUR ELDERLY AND POOR, AND OUR GOVERNMENT HEALTH PROGRAMS FROM UNSCRUPULOUS AND INCOMPETENT MEDICAL PRACTITIONERS.

MAKE NO MISTAKE, THESE DOCTORS ARE ENDANGERING THE HEALTH OF THE NATION'S POOR AND ELDERLY WHILE BILKING THE

FEDERAL GOVERNMENT OUT OF MILLIONS OF DOLLARS. I WANT TO EMPHASIZE THAT WE ARE ONLY TALKING ABOUT A FEW DOCTORS-WE ALL RECOGNIZE THAT THE MAJORITY OF PHYSICIANS PROVIDE EXCELLENT HEALTH CARE SERVICES. BUT, WE HAVE HEARD SHOCKING EXAMPLES OF PATIENT ABUSE BY SOME DOCTORS IN THIS COUNTRY. THEIR OFFENSES INCLUDE SEXUAL ABUSE, NEGLIGENCE, GROSS INCOMPETENCE, UNNECESSARY AND DANGEROUS MEDICAL PROCEDURES--THE LIST GOES ON. YET, WHEN THESE HEALTH CARE PROVIDERS ARE CAUGHT AND HAVE THEIR LICENSE REVOKED, THEY SIMPLY MOVE ON TO ANOTHER STATE. NOT ONLY DO THEY CONTINUE PRACTICING MEDICINE, THEY CONTINUE TO BE REIMBURSED FOR THEIR SERVICES THROUGH MEDICARE AND MEDICAID!

A STARTLING STUDY WAS CONDUCTED BY THE GENERAL ACCOUNTING OFFICE (GAO) ON THE EXTENT OF THIS PROBLEM. THE GAO REVEALED THAT OVER A SIX YEAR PERIOD, 328 DOCTORS, DENTISTS, PHARMACISTS, OSTEOPATHS, AND PODIATRISTS WERE IDENTIFIED OVER WHO HAD HAD THEIR LICENSES SUSPENDED OR

REVOKED FOR A YEAR OR MORE IN JUST THREE STATES AND WHO CONTINUE TO PRACTICE MEDICINE.

ONE DOCTOR IN MICHIGAN HAD HIS LICENSE REVOKED FOR INDISCRIMINATELY PRESCRIBING DRUGS AND FOR IMMORAL CONDUCT WITH BOTH A PATIENT AND AN EMPLOYEE. THAT DOCTOR MOVED TO FLORIDA WHERE HE BILLED MEDICARE ABOUT $15,000 FOR HIS SERVICES AND WAS PAID $9,236 OVER TWO YEARS. AN OSTEOPATHIC DOCTOR MOVED TO FLORIDA AFTER HAVING HIS LICENSE REVOKED IN ANOTHER STATE FOR MISREPRESENTING HIMSELF AS A MEDICAL DOCTOR AND FOR SELLING DRUGS. IN HIS NEW PRACTICE, HE RECEIVED MORE THAN $20,000 FOR MEDICARE CLAIMS AND $6,000 IN MEDICAID FUNDS.

IN ANOTHER CASE, AN OHIO DOCTOR MOVED TO PENNSYLVANIA AFTER LOSING HIS LICENSE FOR USING DRUGS AND FOR ILLEGAL POSSESSION OF DRUGS. HE CONTINUED TO RECEIVE MORE THAN $1,200 IN FEDERAL MEDICARE DOLLARS IN PENNSYLVANIA.

4

THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) HAS INSUFFICIENT AUTHORITY TO PREVENT THESE INCOMPETENTS FROM PARTICIPATING IN FEDERAL HEALTH PROGRAMS.

THE BILL I INTRODUCED WOULD ALLOW THE SECRETARY TO BAR HEALTH CARE PROVIDERS FROM FEDERAL AND STATE HEALTH PROGRAMS, IF THE PROVIDERS WERE CONVICTED OF SUCH THINGS AS CRIMINAL OFFENSES RELATED TO FEDERAL HEALTH PROGRAMS, FRAUD AND PATIENT ABUSE, DISTRIBUTION OF CONTROLLED SUBSTANCES, LICENSE REVOCATION OR SUSPENSION, BRIBES AND KICKBACKS. IN ADDITION, THE BILL GIVES THE SECRETARY ABILITY TO ACT AGAINST HEALTH CARE FACILITIES OWNED OR OPERATED BY INDIVIDUALS WHO HAVE BEEN BARRED OR WHO REFUSED TO ASSIST THE DEPARTMENT IN PROVIDING INFORMATION REQUESTED IN INVESTIGATING ABUSES.

THE BILL ALSO MAKES IT EASIER TO ASSESS CIVIL MONETARY PENALTIES FOR FRAUDULENT CLAIMS, AND EXPANDS THE

5

DEPARTMENT'S ABILITY TO TERMINATE PROVIDER AGREEMENTS WHEN ENTITIES ARE NOT LIVING UP TO THEIR CONTRACTUAL AND MORAL OBLIGATIONS. MY BILL, UNLIKE THE OTHERS, PROVIDES FOR ALTERNATIVE SANCTIONS AGAINST INSTITUTIONS WHO HAVE COMPLIANCE PROBLEMS BUT ONLY WHEN THOSE PROBLEMS DO NOT JEOPARDIZE THE HEALTH AND SAFETY OF PATIENTS.

I LOOK FORWARD TO EARLY ACTION ON THIS IMPORTANT TASK SO WE CAN MOVE THIS IMPORTANT LEGISLATION MOST EXPEDITIOUSLY.

STATEMENT OF SENATOR JOHN HEINZ

DRAFT OPENING REMARKS AT FINANCE HEALTH SUBCOMMITTEE HEARING ON MEDICARE AND MEDICAID ANTI-FRAUD AND ABUSE BILLS

Mr. Chairman, I commend you for holding this hearing on legislation to prevent fraudulent practices by physicians who receive Medicare and Medicaid payments. Medicare and Medicaid will spend an estimated $93 billion dollars in 1985 to provide health care to over 50 million of our nation's elderly and poor, yet the Department of Health and Human Services does not have the authority to ensure that public funds are spent only to provide quality care practiced by competent practitioners.

I won't review the existing authority possessed by the Secretary or the many loopholes that need addressing - we have expert witnesses from the GAO and the Department who will do that for us. What I would like to emphasize is the lengthy history on this issue, the ample record that has been compiled to date in support of this reform legislation, and the need for speedy action by the Senate.

The GAO report which first highlighted the Government's shocking inability to protect beneficiaries of federal health programs from unfit doctors was released at a hearing of the Senate Committee on Aging on May 1, 1984. At that hearing, we heard from several of the witnesses who will speak today, and from other experts on physician licensure and certification about

the serious problem associated with unfit and incompetent doctors who prey on the old, poor and sick. They urged us to act quickly to grant the Secretary of HHS the authority needed to prevent these unfit doctors from continuing to treat federal program beneficiaries.

The same pleas from expert witnesses were made before the House Energy & Commerce and Ways & Means Health Subcommittees in September of 1984 and again in March of 1985. Since that time, the House has passed Congressman Moore's bill, H.R. 1868, and the issue has returned to us in the Senate. There are three bills before us today. My bill, S. 837, is very similar to the Moore bill; both were drafted with substantial input from the Inspector General's office, and both are new and improved versions of the legislation that was developed after the original Aging Committee hearing more than a year ago.

S. 1323 differs from my bill, and Congressman Moore's, in that it has been used as a vehicle to re-introduce provisions creating "alternative or intermediate sanctions" into our consideration of this legislation. These provisions were included in my original 1984 version of this bill as well as the House's '84 version. At the beginning of the 99th Congress, the Department wanted more time to approve and propose these provisions, so I re-introduced my bill without them in order to keep up the momentum on this issue that we generated during the 98th Congress. I am pleased to see that the Department has

signed off on these provisions in time to offer them once again for inclusion in my bill.

I also feel that it is important to retain the provisions contained in both my bill and Congressman Moore's which amend the Controlled Substances Act, and the provisions of my bill which would require mandatory exclusion of practitioners who have engaged in certain criminal acts. I hope that the testimony provided today will clarify the importance of these issues.

Statement of Senator George J. Mitchell
Senate Subcommittee on Health
Healthcare Anti-Fraud Legislation
July 12, 1985

Mr. Chairman, I want to commend you and the Subcommittee for recognizing the need to strengthen federal legislation to protect against fraudulent health care practioners in the Medicare and Medicaid Programs.

A May 1984 General Accounting Office(GAO) report concluded that there was a need to expand Federal authority to protect Medicare and Medicaid beneficiaries from health care practioners who lose their licenses for failure to meet minimum professional standards.

GAO found that practioners whose licenses were revoked or suspended by one State's licensing board were able to relocate to another state where they had a license and continue to practice. Under current law the Department of Health and Human Services (HHS) does not have the authority to exclude these practioners from participation in Medicare and Medicaid based on State licensing board findings and actions.

GAO found that not only were practitioners who lose their right to participate in Medicare for such reasons as providing inappropriate care allowed to relocate and practice in another state, but practitioners who were convicted of crimes other than Medicare and Medicaid fraud, such as illicitly trafficking in drugs, can continue to practice under both programs.

Mr. President, this situation is not acceptable and does not represent the best quality care for the poor and elderly under the Medicare and Medicaid Programs.

The three bills before the Committee, S.837, S.1323, and H.R.1868, each provide new authority to HHS to prohibit health care practitioners who have been proven unfit to participate in the Medicare and Medicaid Programs from doing so.

I look forward to the testimony to be presented on the three bills before the Committee today which address the gaps in the current authority of HHS to protect Medicare and Medicaid beneficiaries from practioner fraud and abuse. I am confidant that the Senate will be able to agree upon an acceptable legislative vehicle to correct the problem in the near future.

Senator DURENBERGER. The hearing will come to order.

The jurisdiction of this subcommittee covers Medicare, Medicaid, and the maternal/child health block grant. In programs as broad as these there are going to be some amount of fraud and abuse, and in medicine as in other fields there are unscrupulous and incompetent people who will try to take advantage of the system for personal gain. As we will learn today, the evidence is clear that the Secretary of Health and Human Services needs additional authority to go after those physicians and other providers of health services who are either unfit or unethical.

This hearing will focus on three pending bills: H.R. 1868 and S. 837 and S. 1323.

Each would give the Secretary the necessary authority to exclude from Medicare and Medicaid individuals convicted of program-related crimes or patient abuse and neglect. The bills broaden the grounds for discretionary exclusion of health care providers for Medicare and Medicaid and extends both mandatory and discretionary exclusion of practitioners to other State health care programs. There are differences between the details of the measures, but the differences are primarily technical in nature.

I would like to commend my colleagues on this committee, Senator Bill Roth, who is here, from Delaware, Senator John Heinz, and particularly Congressman Henson Moore who will be testifying here today, all of whom introduced these important bills and have taken the leadership in this area.

In particular I would like to highlight Henson Moore's work on shepherding H.R. 1868 through the House of Representatives, which was a most difficult job, particularly for a Republican. He has done a yeoman's job, and it is certainly rare that a minority member can achieve that kind of legislative success. But he did it because he was right. He was right about the issue, and he had the tenacity and the wisdom to see it through from the beginning to end.

Today our hearing will focus on a problem requiring the immediate attention of the Senate. But there are other issues of abusive practices concerning Medicare which deserve the attention of the subcommittee: the manufacturers of pacemakers, inerocular lenses, and other prostheses have adopted marketing practices of offering gifts as incentives to physicians to purchase a particular pacemaker or prosthetic product. The law as it now stands permits the physician to accept the gift providing he "properly discloses and appropriately reflects the cost value by the provider." The Department of Health and Human Services is allowing these practices to continue. Regardless of the law and the Department position, it is pretty clear that the extra markup cost of these gifts are costing Medicare.

For example, the price to Medicare of an interocular lens runs around $350. It is estimated that $100 to $150 of this amount are costs incurred by the lens companies to underwite incentives such as office equipment, cars, or vacations to encourage the physician to contract for a particular quantity of lenses. This subcommittee will explore this kind of unethical marketing practice. We need to determine how widespread it is, how it is affecting the marketplace, and how much it is inflating the cost of the items to Medi-

care and especially to its beneficiaries. Most importantly, we need to examine the effect it is having on the quality of health care. On its face, the issue raises questions of ethical practice as well as questions of abuse. It deserves our attention.

I want to express the appreciation of the subcommittee to the witnesses who have taken the time to come here today; the issues we are considering are important. Your contributions will make a significant difference in furthering the legislative process on the three bills which we will discuss at this hearing.

I will yield now to my distinguished colleague from Delaware, Senator Roth.

Senator ROTH. Thank you, Mr. Chairman.

First, I want to thank you for holding these important hearings in such a timely fashion. The health care financing fraud and Abuse Amendments of 1985 which I introduced on June 19 and the legislation of my esteemed colleague, Senator Heinz, as well as that of my good friend, Henson Moore, will take great strides in enabling the administration to protect our elderly and poor and our Government health programs from unscrupulous, incompetent medical practitioners.

Now, make no mistake, these doctors are endangering the health of the Nation's poor and elderly while bilking the Federal Government out of millions of dollars. But I do want to emphasize at the beginning that we are talking only about a few, a few doctors. We all recognize that the majority of practitioners provide excellent health care services. Nevertheless, we have heard shocking examples of patient abuse by some doctors in this country. Their offenses include sexual abuse, negligence, gross incompetence, unnecessary and dangerous medical procedures, and the list goes on. Yet, when these health care providers are caught and have their licenses revoked, they simply move on to another State. Not only do they continue practicing medicine but they continue to be reimbursed for their services through Medicare and Medicaid.

A startling study was conducted by the General Accounting Office on the extent of this problem. The GAO revealed that in a 6-year period, 328 doctors, dentists, pharmacists, osteopaths, et cetera, who were identified, having had their licenses suspended or revoked for a year or more continued to practice medicine.

Mr. Chairman, I have a much longer statement, but in the interest of time I would ask that my full statement be included as if read.

Senator DURENBERGER. Without objection, the statement will be included in the record. I thank you.

Let me now yield to our distinguished colleague from Pennsylvania, the chairman of the Aging Committee, who has, over the years that I have been associated with him, contributed so much to our understanding of just a lot more than I alluded to in my opening statement, but our understanding of how those who are unscrupulous can take advantage of this system.

Senator Heinz.

Senator HEINZ. Thank you, Mr. Chairman.

Mr. Chairman, first I want to commend you and thank you for convening this hearing. We have several antifraud measures here before us; the one I have a particular interest in is S. 837, the pa-

tient and program protection bill for Medicare and Medicaid. My association with this problem and with the legislation goes back several years to hearings we held in the Aging Committee, where we were frankly shocked to learn that it is not only possible but apparently happens far more frequently than anyone would like to admit that a doctor will lose his right to practice in one State—maybe several States—go to another State, somehow continue to practice medicine, and will be reimbursed for treating Medicare patients even though the Department of Health and Human Services, if they knew about it, would not like to reimburse him. They are powerless right now to halt reimbursement.

It is my hope that we can end this outlandish game of Russian roulette—and in this we have been backed up consistently, I am thankful to say, by the inspector general of the Department of Health and Human Services. Where a doctor has illegally pushed drugs, as many have been convicted of doing, or has been literally convicted of killing people through malpractice, it is imperative that we have the means to shut these doctors down; they are a public health hazard. Worse, the public is paying to keep them in business.

I hope we are able here in the Finance Committee, when the time comes, to settle on the strongest possible legislation.

I want to commend, as you did, Mr. Chairman, Henson Moore for his indefatigable energy and enormous effectiveness as a member of the minority over there, where I used to serve with him, in getting a bill actually with his name on it. I am not even sure I have got a bill with my name on it through the Senate yet. When you get over here one of these days, Henson, you will learn that sometimes to pass legislation you have to put a lot of other people's names up front. [Laughter.]

Senator HEINZ. But anything in a good cause, you know.

One part of Congressman Moore's bill and mine that I want to single out is that provision which allow the revocation of the controlled substances permit that doctors are normally granted by the FDA to permit them to prescribe medications.

Many of the doctors that have been sanctioned have been prosecuted because they have illegally sold prescriptions in order to assist someone in illegal drug trafficking. It seems to me that it is ludicrous that we don't in addition, therefore, allow revocation, and indeed I would require the revocation of such a permit.

I know the Secretary of Health and Human Services is anxious to have good legislation. There is no doubt in my mind, Mr. Chairman, that we will act accordingly in that regard. I thank you for your initiative here today in moving this ahead.

Senator DURENBERGER. Thank you very much.

Our first witness is the Honorable Henson Moore of the U.S. House of Representatives.

I wonder what they expected after all the glowing introductions? Like, your average Congressman in a dark blue suit, a red, white, and blue tie? [Laughter.]

Mr. MOORE. Mr. Chairman, I don't get this kind of treatment over on the House side, I assure you.

Senator DURENBERGER. Well, when you get over here you won't get it either. [Laughter.]

Mr. MOORE. So, I had better enjoy it while I can.

STATEMENT BY HON. HENSON MOORE, U.S. REPRESENTATIVE FROM THE STATE OF LOUISIANA

Mr. MOORE. Mr. Chairman, I want to thank you and your committee for recognizing the importance of this legislation and the problem of fraudulent practices by having these hearings so quickly. I am especially pleased that H.R. 1868 is among the many bills upon which you are holding a hearing today. This is a bill that I authored in the House. The House passed it unanimously on June 4.

We are here today in a position to strengthen efforts to reduce fraud and abuse in Government health care programs in large part because of the Senate's leadership in this area. Were it not for this committee's foresight and leadership in 1977 when you initiated the anti fraud and abuse amendments of 1977, little progress would ever have been made in clamping down on fraudulent providers.

The bills you are considering today reflect efforts to improve the Department of Health and Human Services ability to identify and take action on fraudulent providers.

In 1984 I joined Senator Heinz in introducing a bill similar to those before the committee today. I want to thank the gentleman from Pennsylvania [Mr. Heinz] for his leadership in this area and working with us in the House as we have spent the last year and a half working with the Ways and Means and the Energy and Commerce Committees to refine the legislative language of H.R. 1868 before you today. These committees have held numerous hearings and drafting sessions. The language now reflects recommendations of the House legislative counsel, the Department of Health and Human Services' inspector general, the American Association of Retired Persons, the Federation of State Licensing Boards, physicians' groups, and hospital groups.

I especially appreciate the help of the physicians, some of whom will testify today, as they are just as frustrated, I am learning, with the abusing physicians as we are.

Recently there has been a great deal of press about doctors who lose their license in one State but continue to practice in another. This bill is intended to give the Secretary the necessary authority, authority he does not now have, to prevent those doctors from treating Medicare and Medicaid patients. Only a very small percentage of all physicians are abusing the system, but they must be stopped.

This bill represents a significant improvement toward protecting the integrity of the Medicare and Medicaid Programs—most importantly, their patients.

Since the Medicare and Medicaid Programs were established in 1965, Federal and State spending for direct health care services has grown from $5 billion to $112 billion annually. An unfortunate byproduct of that growth has been an increase in the problems relating to fraud and abuse. With the implementation of prospective payments legislation, there are now fewer opportunities for fraudulent billing. Hospitals are now being paid fixed amount for providing health care services. This legislation will work hand-in-hand

with the prospective payment systems to ensure that the Government is getting what the Government is paying for.

We are especially attempting to crack down on those providers who have shown a pattern of abuse and who have made no attempts to correct their misconduct. The Department of Health and Human Services has already a great deal of success in cracking down on fraudulent providers through the authority granted by the Congress in 1972 and then again in 1977. The Secretary's authority was delegated to the inspector general in 1983, and since that time more than 647 sanctions have been imposed, an amount more than two times the total imposed the previous entire 11 years. This increased activity to protect the patients as well as the fiscal integrity of the Medicare and Medicaid Programs is indeed heartening and is to be commended. However, even with this increased activity, there has come an awareness that serious loopholes still exist in these sanction statutes.

The GAO identified one such loophole, that the Department is currently powerless to bar certain practitioners from program participation based upon disciplinary actions imposed upon them by State licensing boards. This is the gap that allows a physician who loses his license in one State to continue to practice in another. This legislation will finally close that loophole.

In addition, H.R. 1868 would also stiffen the penalties from the existing civil monetary penalties, only, up to disbarment from participating in the Medicare and Medicaid Programs for a minimum of 5 years when a provider is convicted of a criminal offense related to their participation in Medicare and Medicaid.

Your prompt action in approving this legislation will ensure that the Department of Health and Human Services has the adequate authority to further curtail fraud and abuse in governmental health care services to our nation's elderly and poor. In passing this legislation, Congress will be sending a very clear signal to the American people that the fraudulent and abusive health care providers will not be allowed to destroy the integrity of these two important programs or jeopardize the health of the American people.

I thank you again, and I would be happy to answer any questions you may have.

[Congressman Moore's written testimony follows:]

TESTIMONY OF
THE HONORABLE W. HENSON MOORE
MEMBER OF CONGRESS

BEFORE THE SENATE FINANCE COMMITTEE'S HEALTH SUBCOMMITTEE

JULY 12, 1985

MR. CHAIRMAN, I WANT TO THANK YOU AND YOUR COMMITTEE FOR RECOGNIZING THE IMPORTANCE OF LEGISLATION TO STRENGTHEN DISCIPLINARY ACTIONS AGAINST OF FRAUDULENT AND UNSCRUPULOUS MEDICARE AND MEDICAID HEALTH CARE PROVIDERS. I AM ESPECIALLY PLEASED THAT H.R. 1868 IS AMONG THE BILLS YOU ARE HOLDING HEARINGS ON. THIS IS A BILL THAT I AUTHORED IN THE HOUSE OF REPRESENTATIVES THAT WAS PASSED UNANIMOUSLY ON JUNE 4.

WE ARE HERE TODAY, IN A POSITION TO STRENGTHEN EFFORTS TO REDUCE FRAUD AND ABUSE IN GOVERNMENT HEALTH CARE PROGRAMS, IN LARGE PART, BECAUSE OF THE SENATE'S LEADERSHIP IN THIS AREA. WERE IT NOT FOR THIS COMMITTEE'S FORESIGHT AND LEADERSHIP IN 1977 WHEN YOU INITIATED THE ANTI-FRAUD AND ABUSE AMENDMENTS OF 1977, LITTLE PROGRESS WOULD HAVE BEEN MADE IN CLAMPING DOWN ON FRAUDULENT PROVIDERS. THE BILLS YOU ARE CONSIDERING TODAY REFLECT EFFORTS TO IMPROVE THE DEPARTMENT OF HEALTH AND HUMAN SERVICE'S ABILITY TO IDENTIFY AND TAKE ACTION ON FRAUDULENT PROVIDERS.

IN 1984, I JOINED SENATOR HEINZ IN INTRODUCING A BILL SIMILAR TO THOSE BEFORE THE COMMITTEE TODAY. I WANT TO THANK THE GENTLEMAN FROM PENNSYLVANIA FOR HIS LEADERSHIP IN THIS AREA AND FOR WORKING WITH US IN THE HOUSE AS WE HAVE SPENT THE PAST YEAR AND ONE HALF WORKING WITH THE WAYS AND MEANS AND ENERGY AND COMMERCE COMMITTEES TO REFINE THE LEGISLATIVE LANGUAGE OF H.R. 1868. THESE COMMITTEES HAVE HELD NUMEROUS HEARINGS AND DRAFTING SESSIONS. THE LANGUAGE NOW REFLECTS THE

RECOMMENDATIONS OF THE HOUSE LEGISLATIVE COUNSEL, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE INSPECTOR GENERAL, THE AMERICAN ASSOCIATION OF RETIRED PERSONS, THE FEDERATION OF STATE MEDICAL LICENSING BOARDS, PHYSICIAN GROUPS AND HOSPITAL GROUPS.

RECENTLY, THERE HAS BEEN A GREAT DEAL OF PRESS ABOUT DOCTORS WHO LOSE THEIR LICENSE IN ONE STATE BUT CONTINUE TO PRACTICE IN OTHER STATES. THIS BILL IS INTENDED TO GIVE THE INSPECTOR GENERAL THE NECESSARY AUTHORITY TO PREVENT THOSE DOCTORS FROM TREATINNG MEDICARE AND MEDICAID PATIENTS. ONLY A VERY SMALL PERCENTAGE OF ALL PHYSICIANS ARE ABUSING THE SYSTEM BUT THEY MUST BE STOPPED. THIS BILL REPRESENTS A SIGNIFICANT IMPROVEMENT TOWARD PROTECTING THE INTEGRITY OF THE MEDICARE AND MEDICAID PROGRAMS.

SINCE THE MEDICARE AND MEDICAID PROGRAMS WERE ESTABLISHED IN 1965, FEDERAL AND STATE SPENDING FOR DIRECT HEALTH CARE SERVICES HAS GROWN FROM FIVE BILLION DOLLARS TO $112 BILLION DOLLARS. AN UNFORTUNATE BY-PRODUCT OF THAT GROWTH HAS BEEN AN INCREASE IN PROBLEMS RELATING TO FRAUD AND ABUSE.

WITH THE IMPLEMENTATION OF PROSPECTIVE PAYMENTS LEGISLATION THERE ARE FEWER OPPORTUNITIES FOR FRAUDULENT BILLING. HOSPITALS ARE BEING PAID A FIXED AMOUNT FOR PROVIDING HEALTH CARE SERVICES. AS LONG AS HOSPITALS ARE ACCURATELY REPORTING THE SERVICES THEY PROVIDE THEY WILL NOT BE AFFECTED BY THIS LEGISLATION. THIS LEGISLATION WILL WORK HAND IN HAND WITH THE PROSPECTIVE PAYMENTS SYSTEM AND ENSURE THAT THE GOVERNMENT IS GETTING WHAT THEY ARE PAYING FOR.

WE ARE ESPECIALLY ATTEMPTING TO CRACK DOWN ON THOSE PROVIDERS THAT HAVE SHOWN A PATTERN OF ABUSE AND HAVE MADE NO ATTEMPTS TO CORRECT THEIR MISCONDUCT. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ALREADY HAD A GREAT DEAL OF SUCCESS IN CRACKING DOWN ON FRAUDULENT PROVIDERS THROUGH THE AUTHORITY GRANTED BY CONGRESS IN 1972 AND THEN IN 1977 UNDER THE "MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE AMENDMENTS." THE SECRETARY'S AUTHORITY WAS DELEGATED TO THE INSPECTOR GENERAL IN 1983 AND SINCE THAT TIME MORE THAN 647 SANCTIONS HAVE BEEN IMPOSED, AN AMOUNT MORE THAN TWO TIMES THE TOTAL IMPOSED IN THE PREVIOUS 11 YEARS.

THIS INCREASED ACTIVITY TO PROTECT PATIENTS AS WELL AS THE FISCAL INTEGRITY OF THE MEDICARE AND MEDICAID PROGRAMS IS INDEED HEARTENING AND IS TO BE COMMENDED. HOWEVER, WITH THIS INCREASED ACTIVITY HAS COME AN AWARENESS THAT SERIOUS LOOPHOLES EXIST IN THESE SANCTION STATUTES. THE GAO IDENTIFIED ONE SUCH LOOPHOLE THAT THE DEPARTMENT IS CURRENTLY POWERLESS TO BAR CERTAIN PRACTITIONERS FROM PROGRAM PARTICIPATION BASED UPON DISCIPLINARY ACTIONS IMPOSED ON THEM BY STATE LICENSING BOARDS. THIS IS THE GAP THAT ALLOWS A PHYSICIAN WHO LOSES HIS LICENSE IN ONE STATE TO CONTINUE TO PRACTICE IN ANOTHER. THIS LEGISLATION WILL CLOSE THAT LOOPHOLE.

IN ADDITION, H.R. 1868 WOULD ALSO STIFFEN THE PENALTIES FROM EXISTING CIVIL MONETARY PENALTIES UP TO DISBARMENT FROM PARTICIPATING IN THE MEDICARE AND MEDICAID PROGRAMS FOR A MINIMUM OF FIVE YEARS WHEN A PROVIDER IS CONVICTED OF A CRIMINAL OFFENSE RELATED TO THEIR PARTICIPATION IN MEDICARE OR MEDICAID.

YOUR PROMPT ACTION IN APPROVING THIS LEGISLATION WILL ENSURE THAT THE DEPARTMENT OF HEALTH AND HUMAN SERVICE HAS THE ADEQUATE AUTHORITY TO FURTHER CURTAIL FRAUD AND ABUSE IN OUR GOVERNMENTAL HEALTH

PROGRAMS AND WILL ALSO ASSURE QUALITY HEALTH CARE SERVICES TO OUR NATION'S ELDERLY AND POOR. IN PASSING THIS LEGISLATION CONGRESS WILL BE SENDING A SIGNAL TO THE AMERICAN PEOPLE THAT FRAUDULENT AND ABUSIVE HEALTH CARE PROVIDERS WILL NOT BE ALLOWED TO DESTROY THE INTEGRITY OF THE MEDICARE AND MEDICAID PROGRAMS.

I WOULD BE HAPPY TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. Well, I thank you very much, Henson. I know that you have some connection you need to make this afternoon, but I will be glad to yield to the authors of the Senate legislation for their questions.

Bill?

Senator ROTH. Mr. Chairman, I know, too, that he has a tight schedule, so I will be happy to resist questioning of him.

Thank you very much for coming over here, Henson.

Mr. MOORE. Thank you, Senator.

Senator HEINZ. I don't want to detain Congressman Moore. I think there will be lots of other people we can ask questions of. I just want to commend him on a good job, and it is a pleasure working with you, Henson.

Mr. MOORE. Thank you. You have allotted a great deal of help to us in the past, and this idea very much germinated from you, I think, some years ago, and we thank you for it.

Senator DURENBERGER. Thank you very much.

Mr. MOORE. Thank you, Mr. Chairman.

Senator DURENBERGER. Our next witness is Michael Zimmerman, Associate Director, Human Resources Division of the U.S. General Accounting Office.

Senator HEINZ. Mr. Chairman, while our next witness is coming forward, I would like to ask unanimous consent that my full text of my prepared statement appear in the record.

Senator DURENBERGER. Without objection, it is so ordered.

Mike, thank you for being here again, and your full statement will be made part of the record. You don't have to stick to 5 minutes, but as close as you can come to it as possible in your testimony. We will appreciate it.

STATEMENT OF MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, WASHINGTON, DC, ACCOMPANIED BY THOMAS DOWDAL, GROUP DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE

Mr. ZIMMERMAN. Thank you, Mr. Chairman.

Let me begin first by introducing Mr. Tom Dowdal who is with me today. Mr. Dowdal is responsible for our work in the Medicare area.

We are pleased to be here today to present our views on three bills—S. 837, S. 1323, and H.R. 1868—that would give beneficiaries added protection under the health care programs of the Social Security Act.

Basically, each bill consolidates the act's current legislative authorities for and provides new authorities to HHS to exclude unfit and unethical health care practitioners and entities from participation in the act's health care programs. A number of provisions in the bills stem from the recommendations contained in our May 1, 1984, report entitled "Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients from Health Practitioners Who Lose Their Licenses." 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.

Our 1984 review was directed at identifying gaps in HHS's authority to exclude unfit and unethical practitioners from the Medicare and Medicaid programs. 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.

In addition, 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.

We also found that 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 these situations 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's 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 why 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 are pleased that the bills being considered today will close the gaps we identified as well as make other changes in the Social Security Act's antifraud and antiabuse provisions that the inspector general believes are needed.

Turning now to the differences in the bills. 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 HMO's, 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 re-

ceived a civil monetary penalty, or are excluded from Medicare or a State health program. We support these provisions in H.R. 1868.

Our rationale is 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 they provide. While these incentives can help prevent the provision of unnecessary services, it is also possible that these incentives could cause entities to underprovide services in order to avoid a loss or to increase income.

We view the exclusion authority in section 2 of H.R. 1868 as providing a deterrent against letting the incentives of these contracts work to the medical disadvantage of patients. 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 both 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 programs of the Social Security Act under which health care services are provided—Medicare, Medicaid, the health programs of title V and of title XX. The provisions of S. 1323 only apply to Medicare and Medicaid and in some cases to title V programs, but not title XX.

We believe that the 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.

On the final issue, 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 the treatment of the programs' beneficiaries. We believe that providing such a deterrent is appropriate. In fact, we would support extending this provisions to other types of practitioners who participate in the programs.

This concludes my statement, and we would be glad to answer any questions you may have.

[Mr. Zimmerman's written testimony follows:]

United States General Accounting Office

Washington, D.C. 20548

FOR RELEASE ON DELIVERY
EXPECTED AT 2 P.M. EDT
FRIDAY, JULY 12, 1985

STATEMENT OF

MICHAEL ZIMMERMAN, ASSOCIATE DIRECTOR

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.

Senator DURENBERGER. Thank you very much.

During your review of practitioners sanctioned by State licensing boards, did you find cases where the sanctioned was not, in GAO's opinion, related to the individual's professional competence, professional conduct, and financial integrity?

Mr. ZIMMERMAN. No, we did not, sir.

Senator DURENBERGER. Who do you believe should determine whether or not the revocation of a license is related to the individual's professional competence, conduct, or financial integrity?

Mr. ZIMMERMAN. Let me refer that question to Mr. Dowdal, if you don't mind.

Mr. DOWDAL. well, basically the State licensing boards make that determination in their findings in the case. And under the provisions of the bill, that information would be available to the Secretary of HHS for review, who would then make a determination again that they fell into an excludable category and that their actions were serious enough to warrant Medicare and Medicaid exclusion, along with exclusion from the other programs.

Senator DURENBERGER. So, the way I understand it, then, all of the findings were based on competence, conduct, or integrity—or lack of competence, professional conduct, or integrity. Is that right?

Mr. DOWDAL. Yes, every one that we discussed in our report, that we covered in our review.

Senator DURENBERGER. OK.

Now, when you switch over to the things that you like in section 2 of H.R. 1868, for example, bringing HMO's, prepaid health plans, and entities operating under freedom-of-choice waiver in, we are moving over to medical necessity. How is that going to get measured? How are you going to make the determination that an entity is not conforming with some standard of medical necessity?

Mr. DOWDAL. What that provision is directed at—my understanding of it is that if an organization in one of those categories did not provide needed services in a pattern, if we find a pattern of not providing needed services to beneficiaries the exclusion provision would apply.

Senator DURENBERGER. Well, is that a State licensing board function? Who is going to make that determination? I guess.

Mr. DOWDAL. It could be made by the Department of Health and Human Services; it could be made under licensure laws for those types of entities by the State. Many States have licensure laws for health maintenance organizations—prepaid health plans, for example, where thay have to meet certain requirements, one of which normally is the provision of needed services. If they are denying needed services, that is what this provision is directed against.

The Department of Health and Human Services through its quality-assurance programs could identify a pattern at a particular HMO or a freedom-of-choice waiver entity, and through those oversight monitoring procedures that the Department has, they could identify some of them.

Senator DURENBERGER. What are you going to do about large groups? Take something as large as the Oxner Clinic or the Mayo Clinic. Are they going to fall into this same category?

Mr. DOWDAL. I don't believe they are classified as one of those three types of organizations covered by that provision.

Senator DURENBERGER. But if they do sell prepaid plans, do they then become subject to this provision?

Mr. DOWDAL. If they had a contract with the Government in either Medicare or Medicaid as a prepaid organization, they would then become subject to that provision. Of course, if they did have a pattern of denial of medically-necessary services, I don't believe it would make any difference who they are. You know, that is something that they should not be doing under their contract.

Senator DURENBERGER. I am asking the question because I am not totally familiar with that particular section of 1868. Do you have an opinion as to whether or not that provision might discourage some contracting at the State level? Unless it is quite clear, how are you going to make that determination? Its presence might be discouraging to an HMO or prepaid health plan or some other entity that you want to get into this contracting business.

Mr. DOWDAL. I believe that it is why the provision directs it at a "pattern" and not one instance. Anybody could run into a particular instance where they had a problem like that without any fault of the overall organization. But I think that is why the provision is directed toward establishing a pattern of denying medically-necessary services to the beneficiaries under their contract.

Senator DURENBERGER. Senator Roth?

Senator ROTH. Thank you, Mr. Chairman.

I think this is an area in which Congress should set policy, but I do have a basic question I would like to ask you, Mr. Zimmerman. Don't the various agencies have inherent power to correct abuses?

The reason that I raise this question is that some time ago as chairman of Government Affairs we held some hearings—I think it was on FECA or one of the programs—and determined that in one particular case a New York doctor had wrongly charged I think something like 50 times in one year for doing certain work on a Federal employee's knee. I was told by the Department of Labor that they did not have authority to prevent that particular doctor from continuing to provide services. I wonder, would you agree with that conclusion? For example, does there have to be legislation to give him such authority, or is there inherent authority within an agency under a particular program to prevent a fraud from being perpetrated?

Mr. ZIMMERMAN. In the example you referred to, Senator, I would imagine it would be the responsibility of the State to get involved in the situation there. They are the ones who issue the licenses.

Senator ROTH. Well, it wouldn't be the State. Why would it be the State, any more than it would be the State's responsibility in the case of the Pentagon? What I am saying is, it was the Federal Government that was being charged 50 times for a particular service given a Federal employee. When the question came up of whether he could continue to provide services, wouldn't the Department of Labor say that that doctor could not continue to provide such services?

Mr. ZIMMERMAN. I would imagine they could probably preclude him or her from participating in the Federal program.

Senator ROTH. That is what I am talking about.

Mr. ZIMMERMAN. I would think so. As to whether they could prevent that provider from practicing medicine, that is——

Senator ROTH. No, no, no, I am not asking that. I agree with you. Obviously the State has that authority. What I am asking you is, doesn't the Federal agency that administers a program have inherent power to cut off any unqualified doctor, or in the case of the Pentagon, a contractor, or do you have to have some special legislation?

Mr. ZIMMERMAN. I don't know whether there is a contractual relationship between the Federal Government in this case and that doctor. It sounds to me like there is a relationship between the doctor and the patient.

Senator ROTH. Well, let me ask the question again. I am asking, can the Labor Department—which it was in this case—say to the doctor, "You are no longer qualified to provide services on the basis"—no contract, but they had provided services in the past for a particular Federal employee. It was sort of a "workman's compensation" case, because it was a Federal employee. Can they disqualify that doctor in the future, or does there have to be specific legislation for that?

Mr. ZIMMERMAN. I don't think they could disqualify that doctor. That's off the top of my head.

Senator ROTH. I would ask that GAO give me that after they have had a chance to study it.

Senator DURENBERGER. Mr. Dowdal is going to try it.

Are you going to embellish on that?

Mr. DOWDAL. Yes; I think it would depend on the law. There has to be something in the law that says who is eligible to participate in it, or in a contract written through an insurance program. As long as there is nothing that says that that particular offense makes him not eligible to participate, then that agency couldn't do anything about it. In the circumstance you have described, I would assume that somewhere in the law or the regulations or the contract provisions there would be something saying if he is a convicted felon—which sounded like the case there—that he would no longer be eligible.

But unless there is a law giving authority to do something, Departments can't do it on their own. There has to be some kind of authority. It can be a negative authority, like the guy has to meet a requirement—the physician has to meet a requirement—and then you can say because he did this he no longer meets that requirement. But there has to be something in the law to base it on.

Senator ROTH. Well, I appreciate your answer, and I realize you haven't had a chance to study that. But I would appreciate it if you would investigate the general authority in this area. Independently of this I will submit a letter for that purpose.

Mr. ZIMMERMAN. Thank you, Senator.

Senator ROTH. Thank you, Mr. Chairman.

Senator DURENBERGER. John.

Senator HEINZ. Mr. Chairman, thank you.

Mr. Zimmerman, I want to commend you and your organization for the excellent work you have done on this. You have testified on more than one occasion, in particular before our committee.

I want to direct your attention to the reasons or bases for exclusion from Medicare, Medicaid, title V, title XX. You have testified that, if someone is going to be excluded from one of those programs because of the conviction of a crime related to health care provided under one or the other, he should be excluded from all of them. That is a position, as you know, that I strongly report, and it is incorporated in our legislation S. 837. Congressman Moore's bill is the same in that regard.

But let me ask you: With respect to the conviction of crimes related to health care fraud in other programs such as defrauding a private health insurer—Blue Cross, Blue Shield—why shouldn't the same mandatory sanction be applied? Why should we be more lenient toward someone who commits fraud against the private sector or is convicted of fraud against the private sector than against the Federal Government?

Mr. ZIMMERMAN. I don't think it is an attempt to be more lenient; we are addressing the provisions that are contained in the proposed bills. That is not a provision, as I recall, that was in the bill.

Senator HEINZ. It is a provision in my bill. My bill would make it mandatory to exclude participation for Medicare and Medicaid if a doctor was convicted of a crime related to health care fraud in another program, such as defrauding Blue Cross, Blue Shield, something like that.

Mr. DOWDAL. Senator, I believe we wouldn't have any problem with including it as a mandatory one. It is included a discretionary authority in other bills.

Senator HEINZ. I know. But you have testified in favor of making it mandatory with respect to fraud in Federal programs; you have testified to that. I am saying, OK, some people say it should be discretionary, some people say it should be mandatory with respect to non-Federal programs. Why isn't what's good for the goose good for the gander in terms of mandatory?

Mr. ZIMMERMAN. I think, in terms of your proposal, I think it is mandatory with a judgment made by the Secretary as to what course of action, which I guess in essence is somewhat discretionary; it is still based on a judgment on the part of the Secretary as to what the appropriate course of action will be. So, from our sense, I think it, either one way or the other, doesn't really make that much of a difference. Both of them would require some discretionary action on the part of the Secretary.

Senator HEINZ. Well, what you are saying, I guess, is that if somebody is guilty of criminal activities, whether it is fraud, whether it is kickbacks, whether it is against Blue Cross, whether it is against Medicare, we ought to treat them all alike, and we should treat them fairly severely--correct?

Mr. ZIMMERMAN. That is correct.

Senator HEINZ. I would just point out on that that there are differences among our three bills on which items should be included. We all have some discretionary sanctions, but where crimes and fraud are committed S. 837 is the only one that requires mandatory action there.

In a second area, your report—which I remember very well from your testimony a year ago—revealed a shockingly high percentage

of sanctioned doctors that are convicted of drug-related offenses. Wouldn't you agree that amending the Controlled Substances Act as proposed by both Congressman Moore and myself would provide a desperately needed remedy for this problem?

Mr. ZIMMERMAN. Yes, sir; we certainly would. We would be supportive of that, definitely so.

Senator HEINZ. One last question. The Moore bill authorizes civil and criminal penalties against so-called doctors who bill Medicare yet are not licensed or who obtain their license through fraud. Is this something the Senate bills should include?

Mr. ZIMMERMAN. Yes, I believe so.

Senator HEINZ. Second, is this anything more than a clarification of current law? Or is it new ground?

Mr. ZIMMERMAN. Let me refer that question to Mr. Dowdal.

Mr. DOWDAL. It would be a clarification of law and a new law. Currently practitioners are not eligible providers without having a license. The new part of it would be holding oneself out to be a specialist when you are not a specialist.

Senator HEINZ. So on the one hand it is a clarification, and on the other hand it is an extension to a new area?

Mr. DOWDAL. Right. When we testified in the House, we did support that provision.

Senator HEINZ. You did support that?

Mr. DOWDAL. Yes.

Senator HEINZ. Mr. Chairman, I thank you very much.

Mr. CHAIRMAN. I would like to ask that questions that I have for HCFA, the Health Care Financing Administration, be submitted for the record to answer. Unfortunately I have a travel commitment, called an "airplane," that very inconveniently cancelled a later one, so I have to take an earlier one. I thank the Chair.

Senator DURENBERGER. All right. Thank you. They will be made part of our submission to HCFA to respond.

[The questions from Senator Heinz and answers from Thomas Morford follow:]

QUESTIONS FOR HCFA: from Senator John Heinz

Regarding a "technical amendment" in the Roth bill to the Medicaid utilization requirments contained in current law:

QUESTION #1: "The Administration's bill contains a provision (not contained in my bill or Congressman Moore's) which would change the way HHS calculates the length of patient stays in Medicaid facilities for the purpose of imposing over-utilization control penalties. This provision has been described as a technical amendment which would reduce paperwork for the states by eliminating the need to "recalculate stays annually for long term care patients who are essentially permanently institutionalized." I have also heard that some anticipated savings are associated with this provision.

"Can you explain exactly how this provision changes current law? Are the anticipated savings to be produced from lower administrative costs for the states or from lower federal matching funds?

"I am concerned that this change in the way length-of-stays are calculated may be more than technical. This provision doesn't seem to require any less from the states in terms of the frequency with which they must conduct utilization reviews in Medicaid facilities. Instead, wouldn't it result in many patients, who are now considered "short-term" patients, being considered "long-term" patients? Wouldn't the result of that be that those facilities with a higher proportion of newly defined "long-term" patients would be more likely to receive reduced federal matching funds for their Medicaid programs?"

A. Under current Medicaid law, States are required to institute utilization control programs. These programs are designed to ensure that long-stay patients are periodically evaluated to determine the best course of treatment. To ensure that States fulfill their responsibilities, the legislation include penalties to be assessed against States which do not institute effective programs. One of the factors used in computing the penalty is the number of "long-stay" patients in State institutions. A patient is defined as "long-stay" after residing in an intermediate care facility for 60 days, in a skilled nursing facility for 30 days, or in a mental disease hospital for 90 days. Because of an apparent drafting error, the law was written so that the long-stay status of every patient must be recalculated as though all stays began with the start of "any fiscal year." This means, for example, that a patient in a intermediate facility who has been there many years is not considered "long-stay" until 60 days after the start of every fiscal year.

The proposed technical change would establish a patient's long-stay status once for each stay after the initial 30, 60, or 90 day period. This in turn will result in the calculation of a utilization control penalty which more properly reflects the effect of a State's failure to implement effective utilization controls. There is no direct effect on the coverage of services or cost of services to beneficiaries. The savings estimated from the change to the penalty provision result from a more accurate calculation of the existing provision. Only $30 million have been collected from the inception of this penalty provision in FY 1979, so that overall savings impact from this change would be minimal over the next three years.

The civil money penalties (CMP) provisions of the Social Security Act are not available to act against HMOs or CMPs under risk contracts which fail to provide necessary services. The CMP provisions only apply to fraudulent activity and do not reach cases where services are not provided.

The only sanction available against errant HMOs is termination. HCFA monitors the execution of the HMO's contract through contract performance monitoring visits. HCFA visits each HMO at least once a year. Visits are more frequent if there are indications of problems.

Senator DURENBERGER. For the same reason I am going to call for our other author here. I am going to call Dr. Tikellis from the Board of Medical Practice and Regulation of Delaware, from Wilmington, Delaware to come up here.

Mike, thank you very much.

Mr. ZIMMERMAN. Thank you, Senator.

Senator DURENBERGER. Mr. Dowdal, thank you.

Senator ROTH. Mr. Chairman?

Senator DURENBERGER. Yes?

Senator ROTH. First of all, thank you for the courtesy extended me in calling forward Dr. Tikellis at this time. I would just like to point out that he is very well known and well respected member of our community. Dr. Tikellis is currently the president of the Board of Medical Practice of Delaware. He is a graduate of Harvard Medical School and Dartmouth. He has served with distinction as the past president of the New Castle County Medical Society as well as the Medical Society of Delaware. He is a practicing internist in the du Pont Co. as well as continuing his private practice.

I just want you to know, Dr. Tikellis, I appreciate your taking the time to be here today.

STATEMENT BY IGNATIOUS TIKELLIS, M.D., PRESIDENT, BOARD OF MEDICAL PRACTICE AND REGULATION OF DELAWARE, WILMINGTON, DE

Dr. TIKELLIS. Thank you very much, Senator Roth.

Mr. Chairman, I believe that the State of Delaware is a microcosm of what happens nationwide. Because we are small, we have an opportunity to accomplish things that could be more difficult to accomplish in a larger, more populous State.

In principle, the objectives of S. 1323 and the other bills are laudable and deserve support. A physician disciplined in one State by suspension or revocation of his or her license for any reason should not be able to go to another jurisdiction to subject those citizens to what he has already done to others elsewhere. State licensing and regulatory boards should be required to participate in a centralized computerized program where it would be a simple task for every State to receive a report that one of its licensees has been disciplined in another State. In addition, States which have not done so should be encouraged to change their medical practice acts to be able to act against a licensee on the basis of findings in other States.

It is important that the basic independence of the State licensing and regulatory boards be maintained and their authority in no way usurped by the Federal Government. The Federal Government should be only an adjunct to what States themselves should be doing. The strong arm of the Federal Government should be used to encourage State regulatory and licensing boards to participate in reporting disciplinary action to a national gathering entity such as the American Medical Association has.

I maintain that a physician should be able to continue his business contact with the Federal Government if the reason for the disciplinary action has nothing to do with fraud. If the reason for the disciplinary action is because of incompetency, for health reasons,

senility, a mental illness, I do not agree that such a physician should suffer financial hardship by being deprived of continued participation in legitimate entities that do business with the Federal Government in the health care field.

In Delaware, we have developed a program of active and inactive licenses. When an applicant applies for a license and he is declared eligible, a determination is then made as to whether there is a need for an active license. If no need is demonstrated, then that applicant is put on an inactive status. Physicians whose professional address changes to another State are also put in an inactive status at the time of biannual license renewal. What that accomplishes is that, if an inactive licensee wishes to establish or reestablish a practice in Delaware, he then must go through a process of review, and it gives our board an opportunity to look at the individual's history and to check with other States to determine if any disciplinary action has occurred or is pending. In this manner, we have been able to prevent undesirable physicians from practicing in Delaware.

In conclusion, I support S. 1323 but caution that the independence of each State licensing and regulatory board must be maintained so that each board is free to judge its own constituency, and that the Federal Government assist each board as much as possible so that it can accomplish its mission of protecting the public more easily and more effectively.

I would like to add one other concern before I close, and it is in regard to physicians who have scholarship loans and student loans. As we all know, there are graduates now who are graduating $50,000, $75,000, and $100,000 in debt. I think that to deny them the ability to bill Medicare and Medicaid for their services because they are in default without consideration of their individual status would be counterproductive. You want these physicians to be working, to be earning money legitimately, so that they can pay off their loans.

So, although I believe in agressiveness in the Federal Government collecting what is due, I think there should be some discretionary policy and leeway on the part of HCFA to determine the need for denying participation.

Senator DURENBERGER. I am glad you mentioned that, because I was just looking ahead to HCFA's testimony on that particular point. Now I see the opposite side, and I will ask them to respond when we get to that particular point.

[Dr. Tikellis' written testimony follows:]

TESTIMONY OF DR. IGNATIUS J. TIKELLIS
PRESIDENT
BOARD OF MEDICAL PRACTICE OF DELAWARE
JULY 12, 1985

MR. CHAIRMAN. BEFORE PROCEEDING WITH MY FORMAL STATEMENT RE SENATE BILL 1323, I WOULD LIKE TO THANK SENATOR ROTH FOR INVITING ME TO TESTIFY. I CONSIDER IT A GREAT PRIVILEGE TO REPRESENT THE STATE OF DELAWARE - THE NATION'S "SMALL WONDER".

I BELIEVE THAT THE STATE OF DELAWARE IS A MICROCOSM OF WHAT HAPPENS NATIONWIDE AND BECAUSE WE ARE SMALL WE HAVE AN OPPORTUNITY TO ACCOMPLISH THINGS THAT COULD BE MORE DIFFICULT TO ACCOMPLISH IN A LARGER MORE POPULOUS STATE.

IN PRINCIPLE, THE OBJECTIVES OF SENATE BILL 1323 ARE LAUDIBLE AND DESERVE SUPPORT. A PHYSICIAN DISCIPLINED IN ONE STATE BY SUSPENSION OR REVOCATION OF HIS OR HER LICENSE FOR ANY REASON SHOULD NOT BE ABLE TO GO TO ANOTHER JURISDICTION TO SUBJECT THOSE CITIZENS TO WHAT HE HAS ALREADY DONE TO OTHERS ELSEWHERE. STATE LICENSING AND REGULATORY BOARD SHOULD BE REQUIRED TO PARTICIPATE IN A CENTRAL COMPUTERIZED PROGRAM WHEREBY IT WOULD BE A SIMPLE TASK FOR EVERY STATE TO RECEIVE A REPORT THAT ONE OF ITS LICENSEES HAS BEEN DISCIPLINED IN ANOTHER STATE. IN ADDITION, STATES WHICH HAVE NOT DONE SO SHOULD BE ENCOURAGED TO CHANGE THEIR MEDICAL PRACTICE ACTS TO BE ABLE TO ACT AGAINST A LICENSEE ON THE BASIS OF FINDINGS IN ANOTHER STATE.

IT IS IMPORTANT THAT THE BASIC INDEPENDENCE OF THE STATE LICENSING AND REGULATORY BOARDS BE MAINTAINED AND THEIR AUTHORITY BE, IN NO WAY, USURPED BY THE FEDERAL GOVERNMENT. GOVERNMENT SHOULD BE ONLY AN ADJUNCT TO WHAT THE STATES THEMSELVES SHOULD BE DOING. THE 'RONG ARM OF THE FEDERAL GOVERNMENT SHOULD BE USED TO ENCOURAGE STA' REGULATORY AND LICENSING BOARDS TO PARTICIPATE IN REPORTING DISCIP' 'ARY ACTION TO A NATIONAL GATHERING ENTITY SUCH AS THE AMERICAN MEDICAL ASSOCIATION.

I MAINTAIN, THAT A PHYSICIAN SHOULD BE ABLE TO CONTINUE HIS BUSINESS CONTACT WITH THE FEDERAL GOVERNMENT, IF THE REASON FOR THE DISCIPLINARY ACTION HAS NOTHING TO DO WITH FRAUD. IF THE REASON FOR THE DISCIPLINARY ACTION IS BECAUSE OF INCOMPETENCY AS A PHYSICIAN, SENILITY, OR MENTAL ILLNESS, I DO NOT AGREE THAT SUCH A PHYSICIAN SHOULD SUFFER FINANCIAL HARDSHIP BY BEING DEPRIVED OF CONTINUED PARTICIPATION IN LEGITIMATE ENTITIES THAT DO BUSINESS WITH THE FEDERAL GOVERNMENT IN THE HEALTH CARE FIELD.

IN DELAWARE WE HAVE DEVELOPED A PROGRAM OF ACTIVE AND INACTIVE LICENSES. WHEN AN APPLICANT APPLIES FOR A LICENSE AND HE IS DECLARED ELIGIBLE, A DETERMINATION IS THEN MADE AS TO WHETHER THERE IS A NEED FOR AN ACTIVE LICENSE. IF NO NEED IS DEMONSTRATED FOR AN ACTIVE LICENSE, THEN THAT APPLICANT IS PUT ON AN INACTIVE STATUS. PHYSICIANS WHOSE PROFESSIONAL ADDRESS CHANGES TO ANOTHER STATE ARE ALSO PUT IN AN INACTIVE STATUS AT THE TIME OF BIANNUAL LICENSE RENEWAL. WHAT IS ACCOMPLISHED IS THAT IF AN INACTIVE LICENSEE WISHES TO ESTABLISH OR RE-ESTABLISH A PRACTICE IN DELAWARE, HE THEN MUST GO THROUGH A PROCESS OF REVIEW AND IT GIVES OUR BOARD AN OPPORTUNITY TO LOOK AT THE INDIVIDUAL'S HISTORY AND TO CHECK WITH OTHER STATES TO DETERMINE IF ANY DISCIPLINARY ACTION HAS OCCURRED OR IS PENDING. IN THIS MANNER WE HAVE BEEN ABLE TO PREVENT UNDESIRABLE PHYSICIANS FROM PRACTICING IN DELAWARE.

IN CONCLUSION, I SUPPORT SENATE BILL 1323 BUT CAUTION THAT THE INDEPENDENCE OF EACH STATE LICENSING AND REGULATORY BOARD MUST BE MAINTAINED SO THAT EACH BOARD IS FREE TO JUDGE ITS OWN CONSTITUENCY AND THAT THE FEDERAL GOVERNMENT ASSIST EACH BOARD AS MUCH AS POSSIBLE SO THAT IT CAN ACCOMPLISH ITS MISSION OF "PROTECTING THE PUBLIC" MORE EASILY AND MORE EFFECTIVELY.

AGAIN, THANK YOU VERY MUCH FOR INVITING ME TO TESTIFY.

IGNATIUS J. TIKELLIS, M.D.
STATE OF DELAWARE

Senator DURENBERGER. I don't have any questions.

Bill, do you?

Senator ROTH. Yes, let me ask a couple.

I think you raise two or three very interesting points. On this point just referred to by our chairman, if I understand what you are saying, it is that there ought to be sufficient discretionary authority that maybe some kind of an arrangement could be worked out where the individual, if he continues to serve and be paid, that part of that pay would be used to repay the debt owed the Government. Is that correct?

Dr. TIKELLIS. That is what I think would be desirable, yes.

Senator ROTH. I think on the surface—I haven't studied the matter carefully—it seems like it represents a commonsense point of view.

I would also like to get a little expansion on your thought that in some instances physicians whose licenses have been revoked should be able to continue to participate in Federal and State health programs. Could you maybe cite some examples of what you have in mind?

Dr. TIKELLIS. I do not mean that he should participate as a physician; but he may have had a legitimate investment and perhaps a controlling interest in some other entity that would be a provider. In that case, if the reasons for the revocation or suspension of his license is due to mental reasons, where there was no deliberate action on his part to defraud the Government or to abuse a patient, I think that he should be able to continue to participate through that entity in dealing with the Federal Government. I don't see the need to deny an individual who has had an investment in some other area the ability to continue with that investment.

Senator ROTH. If I understand what you are saying, if a man, for example, or a woman as the case may be, failed to provide inadequate medical services, maybe because of senility or mental problems or whatever it may be, that should not automatically disqualify him for other services, if he hasn't deliberately used fraud.

Dr. TIKELLIS. Yes.

Senator ROTH. Again, it is sort of a commonsense approach, I would say. I think you raised an interesting and valid point.

My final question. Let me ask you this to make sure I understand. We have a doctor who fails to provide adequate service. Now, how would that information, in your judgment, become disseminated to other States? Is it through the Federal Government? Or should it be just through the centralized computer? Would you give me an example of how you think it shoud work?

Dr. TIKELLIS. Senator Durenberger earlier asked an interesting question about what you do with physicians who perhaps have been found guilty and their license was revoked. I think part of the problem is that there is a lack of communication. For instance, the professional review organizations that we have in place in States or in districts of States, whose responsibility it is to monitor the Medicare and Medicaid Programs. Initially when they were formed it was for the purpose of quality; now it involves quality and cost. Physicians who are sanctioned under their review process—that information is withheld from the Board of Medical Practice of that State. That information should be made available to the State li-

censing board who is responsible for that physician. That board can then take action against individuals who Senator Durenberger was referring to. That licensing board can take action against that doctor who billed 50 times for the same procedure.

Therefore, I think it is important that we communicate this information and that we don't put barriers up that we have. I believe an entity such as the AMA, who already has in place a computerized program that includes a lot of information, could be expanded, and it could be made mandatory that every board report to a central collecting center. And that way, if California suspends a license of somebody who also is licensed in Delaware, we will know it, and we can take some action.

Senator ROTH. Well, thank you, Dr. Tikellis. In conclusion I would like to say that I agree with you. As we move to correct the problems the Federal Government faces, I also agree that we should not interfere with the independence of the State licensing group. I thank you for taking the time to be here.

Dr. TIKELLIS. Thank you very much.

Senator DURENBERGER. Dr. Tikellis, could you think of an example where a physician might lose a license for a reason other than competence, conduct, or financial integrity?

Dr. TIKELLIS. I can't think of any.

Senator DURENBERGER. All right. Thank you very much for your testimony.

Our next witness is Hon. Richard Kusserow, the Inspector General of the Department of Health and Human Services.

Dick, thank you very much for taking the time to be here, and thank you for 30 great months of working—well, longer than that, but some of this fraud stuff you have been at very intensively with some great, great results over the last 2½ years. Your full statement on this subject will be made part of the record, and you may proceed to do with it as you will.

STATEMENT BY HON. RICHARD KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY NANCY MILLER, GENERAL COUNSEL STAFF

Mr. KUSSEROW. Thank you, Mr. Chairman.

I brought with me today Nancy Miller from our General's staff, and we do indeed appreciate the opportunity to provide you with our comments on all three of the health care antifraud bills now before your subcommittee, H.R. 1868, S. 837, and S. 1323.

As you know, we testified last year on similar legislation introduced and sponsored by members of the Finance and Aging Committees, and it gives us really great pleasure to see the legislation reintroduced this year in a much advanced and improved form.

In addition, we have so far this year already provided testimony on the House side with regard to H.R. 1868. And I think that it goes without saying that the inspector general's office supports the concepts embodied in all three of these bills presently being considered by this subcommittee.

In our opinion, it is vitally important that we protect the beneficiaries of the federally financed health care programs from those

individuals who render inferior quality health care or who would defraud our health care programs. As stated in our enabling statute and as I have said on numerous occasions, the Office of the Inspector General is fully committed to stopping health care ripoffs and ensuring that our scarce health care resources reach the aged and infirmed and disadvantaged, in order for them to receive the benefits Congress intended.

We have found that these beneficiaries often do not have the ability to investigate a health care provider's professional and personal reputation and whether he or she is able to supply quality health care. In many cases, beneficiaries have no choice as to who will treat them. It is our responsibility and the responsibility of the professional organizations and State agencies to assure that quality health care for these beneficiaries is available. Passage of this kind of legislation will send a clear message that we will not permit Medicare and Medicaid beneficiaries to receive second-class health care.

In 1983, Secretary Heckler recommitted our Department to this goal by consolidating in the Office of the Inspector General—all of the sanctioning authorities, including the authority to deal with suspensions and terminations from participation in Medicare and Medicaid of those health care providers who engage in wrongful practices. Since then, we have worked actively to meet the responsibility of sanctioning health care providers who would defraud or abuse the system.

In addition, Congress, in the Deficit Reduction Act of 1984, further authorized us to impose sanctions against nonparticipating physicians who violate the freeze on their charges to program beneficiaries.

Under these sanction authorities, health care professionals engaging in various improper practices can be suspended from participation in the Medicare and Medicaid Programs and/or financially penalized. These authorities also provide for termination of agreements between the Department and hospitals, nursing homes, and other institutions engaging in similar acts.

Our emphasis on cracking down on incompetent or unscrupulous health care practitioners and providers has paid off. And as was pointed out by Congressman Moore, we have had significant increases in the number of sanctions that we have been able to successfully improve against wrongdoers. I would only point out that we have not just doubled the total number of all sanctions in the entire history of the program, but in the last 30 months, since the sanction authorities have been consolidated on our office, we have imposed over 800 exclusions against various health care providers for wrongful activities this is nearly three times the total number of sanctions imposed by the Department for the combined preceding 11 years. And we are operating at 10 times the level of sanctioning as in the year preceding the transfer of the authorities to our office.

The civil monetary penalties authority another sanctioning tool added another passed by the 97th Congress. The law was designed to deal with providers who submit bills for items or services not provided as claimed. It hit defrauders where it hurts, in the pocketbook. In addition to or in lieu of criminal action, the Department

now has the administrative authority to impose assessments and penalties to recover dollars lost to our health care programs as a result of the submission of false and fraudulent claims. The law permits an assessment of up twice the amount claimed against any person or organization who knows or has reason to know that items or services were not provided as claimed. In addition, up to $2,000 per item or service improperly claimed may also be levied as a civil penalty. This assures that there is no unjust enrichment of wrongdoers and that they may have to pay a substantial civil penalty for their improper claims.

Again, through an aggressive and accelerated implementation program, we have successfully demonstrated that this law can be used as Congress intended. In the last 2 years, our staff has collected approximately $15 million from those wrongdoers.

However, in pursuing our aggressive program of administrative sanctioning, we have identified major loopholes in our authorities which frustrate our attempts to rid the health care programs of corrupt or incompetent health care professionals. Presently, we are unable to bar individuals or health care entities who have been convicted of defrauding other Federal, State, or local programs; engaging in patient neglect or abuse not specifically involving the beneficiaries of our programs; or the unlawful manufacture, distribution, or dispensing of controlled substances.

An even greater threat to the health and safety of our beneficiaries is the fact that there are practitioners who lose or surrender their license in one State but are able to move to another and continue to practice in our programs unabated. A glimpse of the extent of this problem was provided earlier in the testimony by GAO in their report on this subject.

We are further inhibited by loopholes that exist for providers who are kicked out for criminal actions against our programs. They can often maintain their Medicaid and Medicare practices for long periods of time, using various subterfuges. We have found that convicted providers will expend inordinate efforts and resources in trying to litigate periods of exclusions downs so that they may maintain their practice in our programs. This bill sets up a minimum exclusion of 5 years for those convicted of crimes against the Medicare and Medicaid Programs, and that should end that problem.

We believe that the provisions of each of the bills before you—H.R. 1868, S. 1323, and S. 837—can be implemented within a reasonable period of time. Those provisions which affect the civil monetary penalties program are basically clarifying provisions. Immediate enactment of these provisions would greatly benefit the handling of all the CMPL cases. For example, the Secretary through the Attorney General will have the authority to seek an injunction against an alleged violator to prevent the concealment or removal of assets to avoid paying civil monetary penalties We have cases pending now where practitioners, in order to avoid money penalties and assessments, have sought to transfer their personal and business assets to strawmen or trusts where they would not be available to satisfy any judgment against them. Such blatant attempts to conceal assets strongly suggest the need for the type of injunction authority contained in the proposed bill.

We wholeheartedly support the basic concepts of each of these three bills, which for the most part are substantially the same but with minor differences. We will be happy to work with the committee in clarifying the effect of the differences on our programs. Mr. Chairman, we stand ready to answer any questions that you or any members may have at this time.

Senator DURENBERGER. Thank you very much. You got a lot in in a short period of time, and I appreciate it.

[Mr. Kusserow's written testimony follows:]

TESTIMONY

OF

RICHARD P. KUSSEROW

INSPECTOR GENERAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

HEALTH CARE ANTI-FRAUD LEGISLATION

BEFORE

THE SUBCOMMITTEE ON HEALTH

COMMITTEE ON FINANCE

UNITED STATES SENATE

JULY 12, 1985

GOOD AFTERNOON, MR. CHAIRMAN, MEMBERS OF THE COMMITTEE, I AM RICHARD P. KUSSEROW, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES. I APPRECIATE THE OPPORTUNITY TO PROVIDE YOU WITH OUR COMMENTS ON THE THREE HEALTH CARE ANTI-FRAUD BILLS NOW BEFORE YOUR SUBCOMMITTEE, H.R. 1868, S. 837, and S. 1323. AS YOU KNOW, I TESTIFIED LAST YEAR ON SIMILAR LEGISLATION INTRODUCED AND SPONSORED BY MEMBERS OF THE FINANCE AND AGING COMMITTEES AND IT GIVES ME GREAT PLEASURE TO SEE THE LEGISLATION REINTRODUCED THIS YEAR. IN ADDITION, I HAVE ALREADY TESTIFIED ON THE HOUSE SIDE ON H.R. 1868. NEEDLESS TO SAY, WE TOTALLY SUPPORT THE GENERAL CONCEPTS EMBODIED IN EACH OF THE BILLS PRESENTLY BEING CONSIDERED BY THIS SUBCOMMITTEE.

THIS AFTERNOON, WE WOULD LIKE TO SHARE SOME OF OUR EXPERIENCES IN EXERCISING EXISTING AUTHORITIES TO IMPOSE PENALTIES AND SANCTIONS AGAINST HEALTH CARE PROFESSIONALS WHO DEFRAUD OR ABUSE THE MEDICARE OR MEDICAID PROGRAMS. IN OUR OPINION, IT IS VITALLY IMPORTANT THAT WE PROTECT THE BENEFICIARIES OF OUR FEDERALLY FINANCED HEALTH CARE PROGRAMS FROM THOSE INDIVIDUALS WHO RENDER INFERIOR QUALITY HEALTH CARE OR WOULD ROB THE TRUST FUNDS THROUGH FRAUD. AS STATED IN OUR ENABLING STATUTE, AND AS I HAVE SAID ON NUMEROUS OCCASIONS, THE OFFICE OF INSPECTOR GENERAL IS FULLY COMMITTED TO STOPPING HEALTH CARE RIPOFFS AND INSURING THAT OUR SCARCE HEALTH CARE FUNDS REACH THE AGED, INFIRM AND DISADVANTAGED. WE HAVE FOUND THAT THESE BENEFICIARIES OFTEN DO NOT HAVE THE ABILITY TO INVESTIGATE A

HEALTH CARE PROVIDER'S PROFESSIONAL AND PERSONAL REPUTATION AND WHETHER HE OR SHE IS ABLE TO SUPPLY QUALITY HEALTH CARE. IN MANY CASES BENEFICIARIES HAVE LITTLE CHOICE AS TO WHO WILL TREAT THEM. IT IS THE RESPONSIBILITY OF PROFESSIONAL ORGANIZATIONS, STATE AGENCIES AND THIS DEPARTMENT,TO ASSURE QUALITY HEALTH CARE FOR THESE BENEFICIARIES. PASSAGE OF THIS KIND OF LEGISLATION WILL SEND A CLEAR MESSAGE THAT WE WILL NOT PERMIT MEDICARE AND MEDICAID BENEFICIARIES TO RECEIVE SECOND CLASS HEALTH CARE.

IN 1983, SECRETARY HECKLER RECOMMITTED OUR DEPARTMENT TO THIS GOAL BY TRANSFERRING TO THE INSPECTOR GENERAL'S OFFICE ALL THE DEPARTMENT'S EXISTING SANCTIONING AUTHORITIES TO SUSPEND OR TERMINATE FROM PARTICIPATION IN MEDICARE/MEDICAID, HEALTH CARE PROVIDERS WHO ENGAGE IN WRONGFUL PRACTICES. SINCE THEN, WE HAVE ACTIVELY WORKED TO MEET THE RESPONSIBILITY OF SANCTIONING HEALTH CARE PROVIDERS WHO WOULD DEFRAUD THE SYSTEM. DURING THE SAME TIME PERIOD, THE NEW CIVIL MONEY PENALTIES LAW (CMPL), WHICH PROVIDES FOR TOUGH ASSESSMENTS FOR FALSE CLAIMS, WAS FORMALLY IMPLEMENTED BY THE DEPARTMENT, FURTHER EMPOWERING THE INSPECTOR GENERAL TO TAKE ACTION AGAINST HEALTH PROVIDERS WHO ABUSE OR DEFRAUD THESE PROGRAMS. IN ADDITION, UNDER THE DEFICIT REDUCTION ACT OF 1984, WE HAVE BEEN AUTHORIZED TO IMPOSE SANCTIONS AGAINST NON-PARTICIPATING PHYSICIANS WHO VIOLATE THE

FREEZE ON THEIR CHARGES TO BENEFICIARIES.

UNDER THESE SANCTIONING AUTHORITIES, HEALTH CARE PROFESSIONALS ENGAGING IN VARIOUS IMPROPER PRACTICES CAN BE SUSPENDED FROM PARTICIPATION IN THE MEDICARE AND MEDICAID PROGRAMS AND/OR FINANCIALLY PENALIZED. THESE AUTHORITIES ALSO PROVIDE FOR TERMINATION OF AGREEMENTS BETWEEN THE DEPARTMENT AND HOSPITALS, NURSING HOMES, AND OTHER INSTITUTIONS ENGAGING IN SIMILAR ACTS.

OUR EXISTING ADMINISTRATIVE SANCTIONS MAY BE IMPOSED ON ANYONE WHO VIOLATES THE MEDICARE/MEDICARE PROGRAM BY:

(1) SUBMITTING FALSE STATEMENTS OR CLAIMS FOR PAYMENT;

(2) SUBMITTING, OR CAUSING TO BE SUBMITTED, BILLS OR REQUESTS FOR PAYMENT CONTAINING CHARGES SUBSTANTIALLY IN EXCESS OF CUSTOMARY CHARGES;

(3) FURNISHING SERVICES WHICH ARE DETERMINED TO BE SUBSTANTIALLY IN EXCESS OF THE NEEDS OF PATIENTS;

(4) FURNISHING SERVICES WHICH ARE DETERMINED TO BE OF QUALITY FAILING TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE; OR

(5) FAILING TO KEEP ADEQUATE MEDICAL RECORDS TO DEMONSTRATE THE NEED FOR SERVICES RENDERED.

IN ADDITION, CRIMINAL CONVICTIONS RELATING TO MEDICARE OR MEDICAID ARE GROUNDS FOR AUTOMATIC SUSPENSION FROM THOSE PROGRAMS.

A PROVIDER SANCTIONED UNDER ANY OF THE ABOVE AUTHORITIES IS EXCLUDED FOR A SPECIFIED PERIOD OF TIME. AT THE END OF THAT PERIOD, THE PROVIDER MAY APPLY FOR REINSTATEMENT BUT REINSTATEMENT TO THE PROGRAMS IS CONTINGENT ON A DETERMINATION THAT THE OFFENSE IS NOT LIKELY TO RECUR.

THE STATE AND LOCAL AGENCIES RESPONSIBLE FOR LICENSING OR CERTIFICATION ARE NOTIFIED OF THE SUSPENSION AND FREQUENTLY INVOKE A SANCTION IN ACCORDANCE WITH APPLICABLE STATE LAW OR POLICY.

OUR EMPHASIS ON CRACKING DOWN ON INCOMPETENT OR UNSCRUPULOUS HEALTH CARE PRACTIONERS AND PROVIDERS HAS REWARDED US MANY TIMES OVER. IN THE LAST 30 MONTHS, SINCE THE SANCTION AUTHORITIES HAVE BEEN WITH THE INSPECTOR GENERAL OFFICE, WE HAVE IMPOSED OVER 800 EXCLUSIONS ON VARIOUS HEALTH CARE PROVIDERS. THIS REPRESENTS NEARLY THREE TIMES THE TOTAL NUMBER OF SANCTIONS IMPOSED BY THE DEPARTMENT FOR THE COMBINED PRECEDING 11 YEARS.

THE CIVIL MONEY PENALTIES AUTHORITY ADDED ANOTHER SANCTIONING TOOL. THE LAW WAS DESIGNED TO DEAL WITH PROVIDERS WHO SUBMIT BILLS FOR ITEMS OR SERVICES NOT PROVIDED AS CLAIMED. IT HITS DEFRAUDERS WHERE IT HURTS -- IN THE POCKETBOOK. IN ADDITION TO OR IN LIEU OF PROSECUTORIAL ACTION, THE DEPARTMENT NOW HAS THE ADMINISTRATIVE AUTHORITY TO IMPOSE ASSESSMENTS AND PENALTIES TO RECOVER DOLLARS LOST TO OUR HEALTH CARE PROGRAMS AS A RESULT OF THE SUBMISSION OF FALSE AND FRAUDULENT CLAIMS. THE LAW PERMITS AN ASSESSMENT OF UP-TO-TWICE THE AMOUNT CLAIMED AGAINST ANY PERSON OR ORGANIZATION WHO KNOWS OR HAS REASON TO KNOW THAT ITEMS OR SERVICES WERE NOT PROVIDED AS CLAIMED. IN ADDITION, UP TO $2,000 PER ITEM OR SERVICE IMPROPERLY CLAIMED MAY ALSO BE LEVIED AS A CIVIL PENALTY. THIS INSURES THAT THERE IS NO UNJUST ENRICHMENT OF WRONGDOERS AND THAT THEY PAY A SUBSTANTIAL CIVIL PENALTY FOR THEIR IMPROPER CLAIMS.

AGAIN, THROUGH AN AGGRESSIVE AND ACCELERATED IMPLEMENTATION PROGRAM, WE HAVE SUCESSFULLY DEMONSTRATED THAT THE LAW CAN BE USED AS CONGRESS INTENDED. IN THE LAST TWO YEARS, OUR STAFF HAS COLLECTED APPROXIMATELY $15 MILLION FOR RECYCLING TO THE HEALTH CARE PROGRAMS.

UNQUESTIONABLY, THE CIVIL MONEY PENALTIES LAW AND THE SUSPENSION-EXCLUSION AUTHORITY ARE POTENT WEAPONS. COUPLED WITH THE FACT THAT HEALTH CARE PROVIDERS NOW FACE AN INCREASED RISK OF IMPRISONMENT, THESE SANCTIONS UNDERSCORE THE MESSAGE THAT THE TOTAL RESOURCES OF OUR OFFICE ARE MASSED IN AN ALL-OUT

EFFORT TO ROOT OUT THOSE FEW WHO WOULD TARNISH THEIR PROFESSIONS BY PREYING ON THE MEDICARE/MEDICAID PROGRAMS OR ON INNOCENT BENEFICIARIES AND RECIPIENTS OF THE SERVICES PROVIDED BY THOSE PROGRAMS.

HOWEVER, IN PURSUING OUR AGGRESSIVE PROGRAM OF ADMINISTRATIVE SANCTIONING WE HAVE IDENTIFIED MAJOR LOOPHOLES IN OUR AUTHORITIES WHICH FRUSTRATE OUR GOAL OF RIDDING THE HEALTH CARE PROGRAMS OF CORRUPT OR INCOMPETENT HEALTH CARE PROFESSIONALS. PRESENTLY, WE ARE UNABLE TO BAR INDIVIDUALS OR HEALTH CARE ENTITIES WHO HAVE BEEN CONVICTED OF:

1. DEFRAUDING OTHER FEDERAL, STATE, OR LOCAL PROGRAMS;
2. PATIENT NEGLECT OR ABUSE NOT SPECIFICALLY INVOLVING PROGRAM BENEFICIARIES; OR
3. UNLAWFUL MANUFACTURE, DISTRIBUTION, OR DISPENSING OF CONTROLLED SUBSTANCES.

AN EVEN GREATER THREAT TO THE HEALTH AND SAFETY OF OUR BENEFICIARIES, IS THE FACT THAT THERE ARE PRACTITIONERS WHO LOSE OR SURRENDER THEIR LICENSE IN ONE STATE BUT ARE ABLE TO MOVE TO ANOTHER AND CONTINUE TO PRACTICE IN OUR PROGRAMS, UNABATED. A GLIMPSE OF THE EXTENT OF THIS PROBLEM WAS PROVIDED BY GAO IN THEIR REPORT ON THIS SUBJECT. WE ARE FURTHER INHIBITED BY LOOPHOLES THAT EXIST FOR PROVIDERS WHO ARE KICKED OUT FOR CRIMINAL ACTIONS AGAINST OUR PROGRAMS. THEY CAN OFTEN MAINTAIN THEIR MEDICAID/MEDICARE PATIENTS FOR LONG PERIODS OF TIME, USING VARIOUS SUBTERFUGES. WE HAVE FOUND THAT CONVICTED PROVIDERS WILL EXPEND INORDINATE EFFORTS AND RESOURCES

IN TRYING TO LITIGATE PERIODS OF EXCLUSIONS DOWN SO THAT THEY MAY MAINTAIN THEIR PRACTICE IN OUR PROGRAMS. THIS BILL SETS UP MINIMUM EXCLUSIONS OF 5 YEARS OF THOSE CONVICTED OF CRIMES AGAINST OUR PROGRAM AND SHOULD END THAT PROBLEM.

OVER THE PAST TWO YEARS, NUMEROUS CASES HAVE BEEN REPORTED TO OUR OFFICES ILLUSTRATING THESE SHORTCOMINGS. FOR EXAMPLE, JUST IN THE PAST FEW MONTHS, MORE THAN 100 SERIOUS CASES HAVE BEEN REFERRED TO US UPON WHICH WE HAVE NO AUTHORITY TO ACT INVOLVING PHYSICIANS AND HEALTH CARE PROFESSIONALS WHO POSE A THREAT TO THE HEALTH AND SAFETY OF MEDICARE AND MEDICAID BENEFICIARIES OR TO THE FINANCIAL INTEGRITY OF THE PROGRAMS. IN REVIEWING THESE CASES, WE HAVE FOUND THAT 84 INVOLVE PHYSICIANS WHO HAVE LOST THEIR LICENSES DUE TO DRUG VIOLATIONS, GROSS NEGLIGENCE, OR PROFESSIONAL INCOMPETENCE. ANOTHER 10 PHYSICIANS WERE CONVICTED OF VIOLATING DRUG LAWS; FOUR OTHERS WERE CONVICTED OF DEFRAUDING PRIVATE HEALTH CARE PROGRAMS. THE FOLLOWING CASES ILLUSTRATE WHY IT IS URGENT THAT CONGRESS PASS THIS LEGISLATION TO EMPOWER US TO PROTECT THE HEALTH PROGRAMS AND ITS BENEFICIARIES AND TO CLOSE THE LOOPHOLES AVAILABLE TO THESE UNPRINCIPLED INDIVIDUALS:

- IN MASSACHUSETTS, A PHYSICIAN WAS CONVICTED FOR ASSAULT AND BATTERY ON A 14 YEAR-OLD PATIENT.

- IN LOUISIANA, A PHYSICIAN WAS CONVICTED OF 15 FELONY

COUNTS INCLUDING BANK FRAUD, WIRE FRAUD, FALSE ENTRIES IN BOOKS AND RECORDS, AND CONSPIRACY.

- IN PENNSYLVANIA, A PHYSICIAN WAS CONVICTED OF GRAND THEFT AND TRANSPORTATION OF STOLEN GOODS.

- IN INDIANA, A PHYSICIAN WAS FOUND GUILTY OF 27 COUNTS OF VIOLATING DRUG LAWS.

WE CURRENTLY HAVE NO AUTHORITY TO PROTECT BENEFICIARIES FROM THESE PERSONS; NOR, ARE WE ABLE IN MOST CASES TO SANCTION ENTITIES THAT SUCH INDIVIDUALS OWN OR CONTROL; NOR, ARE WE CURRENTLY ABLE TO TAKE ADMINISTRATIVE ACTION WHERE THERE HAVE BEEN KICKBACKS, OR TO EXCLUDE PERSONS WHO HAVE SURRENDERED OR LOST THEIR LICENSES TO PRACTICE IN ONE STATE FOR WRONGDOING OR INCOMPETENCE AND HAVE MOVED TO ANOTHER TO PRACTICE.

WE BELIEVE THAT THE PROVISIONS OF EACH OF THE BILLS BEFORE YOU, H.R. 1868, S.1323 and S.837, CAN BE IMPLEMENTED WITHIN A REASONABLE TIME. THOSE PROVISIONS WHICH AFFECT THE CIVIL MONEY PENALTIES PROGRAM ARE BASICALLY CLARIFYING PROVISIONS. IMMEDIATE ENACTMENT OF THESE PROVISIONS WOULD GREATLY BENEFIT THOSE HANDLING CMPL CASES. FOR EXAMPLE, THE SECRETARY, THROUGH THE ATTORNEY GENERAL, WILL HAVE THE AUTHORITY TO SEEK AN INJUNCTION AGAINST AN ALLEGED VIOLATOR TO PREVENT THE CONCEALMENT OR REMOVAL OF ASSETS TO AVOID PAYING THE CIVIL MONEY PENALTY. WE NOW HAVE CASES PENDING WHERE PRACTITIONERS,

IN ORDER TO AVOID MONEY PENALTIES AND ASSESSMENTS, HAVE SOUGHT TO TRANSFER THEIR PERSONAL AND BUSINESS ASSETS TO STRAWMEN OR IRREVOCABLE TRUSTS WHERE THEY WOULD NOT BE AVAILABLE TO SATISFY ANY JUDGEMENT AGAINST THEM. SUCH BLATANT ATTEMPTS TO CONCEAL ASSETS STRONGLY SUGGESTS THE NEED FOR THE TYPE OF INJUNCTION AUTHORITY CONTAINED IN THE PROPOSED BILL.

WE WHOLEHEARTEDLY SUPPORT THE BASIC CONCEPTS OF EACH OF THE THREE BILLS BEFORE YOU, WHICH ARE FOR THE MOST PART SUBSTANTIVELY THE SAME. WE WILL BE HAPPY TO WORK WITH YOU IN RESOLVING ANY INCONSISTENCIES BETWEEN THESE PROPOSALS.

THANK YOU FOR THE OPPORTUNITY TO TESTIFY THIS AFTERNOON. I AM AVAILABLE TO ANSWER ANY QUESTIONS YOU MAY HAVE.

Senator DURENBERGER. The AMA's testimony will raise concern about the exclusion of practitioners for situations that involve neither the professional fitness of the provider nor a serious threat to the Medicare Program. Let me ask you a couple of questions that I am sure they would like me to ask you.

Why would exclusions be the penalty for failing to provide immediate access to records, or failing to provide certain business information? An let me ask you why that authority is needed? Isn't the subpoena power granted to the Secretary sufficient to get at that sort of thing?

Mr. KUSSEROW. Well, I believe, Mr. Chairman, that this authority is necessary to reach several problems which we have encountered in our experience with various health providers.

First, we have found that when departmental inspectors go to nursing homes to inspect them for sanitation or health and safety code violations, they are often denied access to the facility while the unsanitary conditions are being cleaned up for subsequent inspections. And once they have remedied it and the inspectors come in, we have lost the benefit of knowing how the facility was actually operating on a day-to-day basis. The subpoena power is completely powerless to prevent this kind of subversion of the inspections process, since it allows a period of time for compliance, which would be the same thing as allowing them to rectify the premises for a subsequent inspection.

Second, we have found that in several instances providers have used the delay inherent in the subpoena process to destroy or alter existing records and then create new, false documents. The authority granted by this proposed legislation will help prevent this kind of obstruction of justice activities.

Senator DURENBERGER. All right.

A later testimony will argue that a minimum exclusion period of 5 years does not allow the Secretary to tailor the penalty to the offense. How do you feel about the argument? It might even apply to the examples you just used: Should a shorter minimum period of perhaps one year be considered?

Mr. KUSSEROW. The 5-year provision would apply only to those cases where there has been a criminal conviction in relationship to our program. Under H.R. 1868 and S. 1323 and S. 837, it would apply to certain other mandatory exclusions most of which are based on criminal convictions. My position on that, Mr. Chairman, is that whenever an individual commits a crime against the patients of our program or against the program itself, as far as I am concerned they should be barred from the program so long as the earth spins on its axis. [Laughter.]

Senator DURENBERGER. You're not even willing to settle for 5 years, right? [Laughter.]

Mr. KUSSEROW. However, there might be mitigating and extenuating circumstances wherein it might be reasonable to allow them to come in in a shorter period of time. The 5-year exclusion would prevent, though, the abuse that we are encountering now, where people who are convicted and who we have excluded from the program for a period of time, immediately seek to try to reduce the period of exclusion, and then are able to maintain, through strawmen and other subterfuges, their Medicare or Medicare practices,

knowing that if they can get the period of exclusion down to 18 months or 2 years they can continue their practice unabated. So the 5-year would at least knock that out.

But again, going back to it, I don't think they should be allowed back in the program unless there is really patent evidence that there are warranted extenuating and mitigating circumstances.

Senator DURENBERGER. The AMA testimony also will indicate that the false claims or unnecessary charges provisions contained in each of the three bills before us today should be deleted, because such authority is currently available under PRO law. As you know, the provisions of the three bills grant the Secretary authority to exclude from Medicare participation any individual or entity determined by The Secretary to have furnished items or services in excess of the patient's needs or to be of substandard quality. Do you agree that such authority is currently available—that is, under the PRO law? If not, why? And what additional authority is needed?

Mr. KUSSEROW. The provisions to which these people object, in S. 837, to section 1128(a)(3); and in S. 1323, section 1128(b)(10); and in H.R. 1868, section 1128(b)(6), are merely recodifications of the current law which has been on the books since 1972. This authority complements that of the Peer Review Organization, and its predecessor, the Professional Standard Review Organization. Existing law also provides for the exclusion based upon quality and medically unnecessary services. So it is simply recodification.

Historically, we have used this provision to which you refer in cases of substandard or excessive outpatient care discovered by the medical review personnel of our Medicare carriers. These types of cases often do not come to the attention of the PRO's due to their focus on inpatient hospital cases rather than outpatient cases. But in all cases, the allegations, of poor quality or excessive care are reviewed by peer medical reviewers, not be investigators or auditors but by peer medical reviewers retained by our carriers or fiscal intermediaries, and also by medical personnel staff that are on staff with the inspector general's office. I have physicians, I have nurses, hospital administrators, I have medical records administrators, and other health professionals that are actually on the staff of the inspector general to assist in the review process. But the primary review will be by professional peer review examiners.

Senator DURENBERGER. Do you recall a question I asked Dr. Tikellis, and I think I asked it of somebody else earlier on, about the argument for a physician losing his license, and the premise—competence, conduct, and integrity? Now, I wonder if the definition of 'competence, conduct, and integrity' doesn't vary somewhat from State to State. May be I will ask the witness from the AMA these questions, too, because it bothers me just a little bit to think that some State might be very, very lenient and some other State very tough, or whatever the case may be, on defining this.

That doesn't bother me half as one State may say, for example, that advertising is a violation of one of these, and 49 other States don't bother having that as a standard. I wish I could think of some other examples. Well, let me give you another example that is going to bother us one of these days: A State where you have a

terrible surplus of doctors in effect starts to use the licensing process as a way to move guys out of the State in one way or another. And yet, they would love to go to Wyoming or some other States where they desparately need practitioners. Are we going to say because in California, for example. They tightened up their requirements, their definitions of competence, conduct and integrity, so tight that maybe it might should be possible for this person to practice in Wyoming?

Mr. KUSSEROW. I think your concerns are valid under present law. It is not valid in any one of the three bills that you have before you. Under the three bills, it makes it perfectly clear the circumstances on which you can take sanctioning activities as a result of state medical board activities.

One of our concerns is that there has to be some way in which we review that to make sure the basis for loss of license is related to our concerns, and that is, we do not want people that are providing incompetent or substandard medicine participating in our programs; we do not want people who are violating their fiduciary responsibilities as physicians. And that is why the statutes or proposed statutes you have before you would limit our activities to those areas. We would not go into areas such as the fact that somebody may not have paid his State medical licensing dues moreover, the exclusion. authority would be discretionary which would allow us to weigh whether a sanction would be appropriate where a person may have violated some procedure that would be considered undesirable in one State whereas in another state that wouldn't even be under consideration.

So I think that all three bills have focused on that and have taken those concerns into consideration, and they have carefully crafted language to prevent that from happening.

Senator DURENBERGER. All right.

A final couple of questions that deal with related areas that I know you have been into but in one way or another involve practices.

I have seen contracts that interocular lens companies have prepared that offer a wide variety of incentives to physicians in hospitals to purchase certain quantities of lenses, and in checking with people they seem to range from anything from there. I got a copy of a contract here, a 3-year purchase agreement for interocular lenses, ophthalmic hardware, where the physician just gets to sort of fill in the blank, whetever he wants. And somebody told me someplace you can fill in as much as the rental of a $75,000 laser for 3 years—just put it in there. If you want a free automobile or you want a vacation, you sort of fill in the blank if your quantity is high enough. I could give you some other examples and just ask you if out there there is a concern, that you have developed a concern about what is going on? Company X will provide an all expense paid vacation for Dr. X and his family at the company's ski lodge or condominium, or whatever. Let's see—Company X asked Dr. Y to try its particular brand of IOL, and Dr. Y readily agrees because the company offers one of the following deals: and I mentioned two of them already. For each lens purchased from the company, Dr. Y receives $100 worth of supplies. He gets an invoice for $450 for the IOL and an invoice for $20 for the supplies. The other

$80 for the supplies is buried in the invoice for the lens. Medicare pays the inflated price for the lens.

I could go on and on. I got these from a hospital administrator who, one of these days, is going to swear they are all true. I don't have an oath attached to it, but he said I could use them. [Laughter.]

Senator DURENBERGER. Have you found this sort of thing going on out there?

Mr. KUSSEROW. Well, Mr. Chairman, if he won't swear it, I'll swear it.

Senator DURENBERGER. OK, go right ahead.

Mr. KUSSEROW. I swear that that is true.

Senator DURENBERGER. All right.

Mr. KUSSEROW. That indeed we have, as a byproduct of the miracles of modern medical technology, have encountered a lot of different problems, and interocular lenses is one of those areas. Previously we have seen—it was alluded to in passing—the pacemaker problem that Senate Aging, which Senator Heinz had brought forth earlier. We have found that there are problems associated with new technologies that are coming on the market.

There are prohibitions in the laws that would say that certain types of behavior is to be prohibited. The law also is changing and is being modified in such a way that we have some confusion. Certainly, the Medicare statute prohibts the offer of any kind of inducement, especially remunerations, to purchase items or services from a particular provider. But any determination of whether a particular situation is a kickback, such as the trip to the Third World someplace or a ski lodge in Vermont or Colorado——

Senator DURENBERGER. Or Minnesota.

Mr. KUSSEROW. Pardon?

Senator DURENBERGER. Or Minnesota.

Mr. KUSSEROW. There is especially good cross-country skiing out there. [Laughter.]

Senator DURENBERGER. I can see this guy skiing from Vermont to Colorado via Minnesota. [Laughter.]

Mr. KUSSEROW. It involves a myriad of facts and factors. For example, when we were looking into the kickbacks very closely in the pacemaker area, we had the concern that pacemaker salesmen seem to have an inordinate range from which they could make a profit and therefore share the profit on a sale with a cardiac surgeon who might want to implant their particular product. And of course, you have all the concerns that rise up about are surgical decisions made being based upon kickbacks, certainly as not only to the brand that is being chosen but perhaps as to whether there should be an implantation or not.

As a result of these kinds of concerns that we had 2 years ago when we explored that area, we also turned into the interocular area and have found that the pattern exists there, too. It is almost a replication of what we found in pacemakers. We indeed have determined that salesmen can receive very large commissions, large enough commissions to where they are in a position to offer special incentives to physician-clients to use their products.

So as a result of that, we are certainly examining along the same pattern as we did with the pacemaker situation. We are looking to

see whether or not there are inordinate profits being made. If so, maybe we should see to it that we cut back on the amount that we are willing to expend on those lenses and thereby reduce the range of profit to be made down to a reasonable level where they could not afford a kickback.

We certainly have found that there are problems in that inducing beneficiaries to come into one setting or another—whether it be inpatient or outpatient—is going to be governed by new policies that came about as the result of prospective payment.

We find that there is an anomaly developing wherein surgeries for the implementation of those lenses is probably going to be cheaper in an inpatient capacity than in an outpatient capacity. That seems to be inconsistent with the intent of Congress on that point. We think we need to look in that area, and we have some recommendations along that line.

We find that there are other abuses that are taking place in the program. Se we certainly would invite you to take a further and more detailed look in this area, and we would be more than happy to pledge our office to assist you in that effort.

Senator DURENBERGER. Great.

Let me ask you just finally about one other related area of concern, just so we aren't just talking about the doctors here or the lens folks. There are a number of hospitals around the country that seem to have found a great new deal under Medicare, and I am just wondering how legal this is. But here is the one called, don't let cataracts steal your joyous moments. You can have outpatient cataract surgery at Sutter General Hospital at no cost to you.

Here is, outpatient cataract surgery in a hospital setting at no cost to you. This is the Garland Community Hospital.

And here's Gramma—"I can see." [Laughter.]

Senator DURENBERGER. The Community Eye Center—for two eyes, cost cataract surgery.

Here is something the Methodist Hospital staff can do for you. At no additional cost, they will put in an IOL.

You can't afford cataracts; you can't afford to miss our gift of sight. That's the Winona Memorial Hospital in Indianapolis, Indiana. They do it for free.

The Priceless Sight Program of Senior Care—No out-of-pocket medical expenses. Ten most-asked questions about cataracts, from Senior Care—How can surgery be free? That's question number eight. [Laughter.]

Senator DURENBERGER. And then it goes on and on.

How do they do that?

Mr. KUSSEROW. Well, first of all, it is not free; 90 percent of all the surgical procedures are paid for by Medicare. Second, what makes it free to the beneficiary is that the facility is waiving the statutory 20-percent coinsurance. The problem that I would have with these offers of free are care would be greater with the services that are performed in an outpatient capacity than in an inpatient capacity. When it is performed in an inpatient capacity, you have two controls that are working to diminish the abuse in the area. One is the fact that no matter what they want to charge, they are going to get reimbursed the DRG rate, the diagnostic-related group rate that that particular type of surgical procedure would come

under. Therefore, if they want to waive the coinsurance, and they feel thay could do it profitably under those circumstances. I am less concerned in that environment, where we also have a peer review organization that is reviewing the decisions being made in connection with the billings of Medicare.

I think a far more vulnerable area is the outpatient area, where you do not have the peer review organizations reviewing the procedures and where we are paying on a reasonable charge basis, a retrospective payment basis rather than a prospective payment basis. But any determination whether the particular situation you have would in fact be a kickback—kicking back to the patient in order to encourage for them to have the procedure done and then raising the charges Medicare will pay—those kinds of things will have to be determined by the specific facts of the case. And each and every case must be presented to the Department of Justice for a final determination as to whether it constitutes a possible violation of Federal law.

Senator DURENBERGER. But if each one of these is done on an outpatient basis, that would be 80-20, wouldn't it? Wouldn't it be 80 percent Medicare and 20 percent——

Mr. KUSSEROW. Yes.

Senator DURENBERGER. How do they do it for free?

Mr. KUSSEROW. Because they jack up the price.

Senator DURENBERGER. And they can jack up the price because we still pay the lower percentages, right?

Mr. KUSSEROW. They jack it up 20 percent and give the 20 percent away, yes.

Senator DURENBERGER. That's right. We will pay them three times what it might cost someplace else, if that is the lower of costs or charges.

Mr. KUSSEROW. If they are doing it, that's wrong. If what they are doing, however, is not jacking up the price for Medicare beneficiaries but in fact the price to Medicare is the normal charge that they have, and it is usual and customary charges of the community for that, then of course what you might be able to do is make a case that they are trying to help the public good, they are trying to help the beneficiary who might otherwise not be able to afford that kind of a surgical procedure. That's what makes it so darned difficult to do. And that is, you have to get into specific facts of each and every circumstance to determine whether it is a de facto under-the-table discount which Medicare ends up paying for. Where is the detriment to the Government? The detriment would be if they raised the price.

Senator DURENBERGER. All right.

Dick, thank you very much for testifying. I appreciate it a lot.

Mr. KUSSEROW. Thank you, Mr. Chairman.

Senator DURENBERGER. Our next witness is Tom Morford, the Deputy Director of Health Standards and Quality Bureau, Health Care Financing Administration, Department of Health and Human Services.

Tom, we welcome you. We will make your statement in full part of the record, and you may proceed to summarize same.

STATEMENT OF THOMAS MORFORD, DEPUTY DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, DC; ACCOMPANIED BY JOYCE SOMSAK, DIRECTOR OF THE OFFICE OF QUALITY CONTROL PROGRAMS

Mr. MORFORD. Thank you Mr. Chairman.

First I would like to introduce Joyce Somsak who is accompanying me today. She is the Director of HCFA's Office of Quality Control Programs.

In general, we support the concept and indeed most of the details of the three bills before the committee. In particular, we do support Senator Roth's bill, S. 1323, which is also the administration's bill.

While current law gives the Secretary certain authorities to exclude from Medicare and Medicaid those who commit fraud or other program abuses, there are still significant areas where needed authority is lacking. For example, a provider convicted of fraud and abuse in the Medicaid Program may still continue to participate as a Medicare provider. Even though owners and staff of a facility have been convicted of defrauding Medicaid, the facility may continue to receive Medicare and Medicaid payment so long as the convicted individuals are not providing direct services to the patient.

Another example is that a physician who has lost his license for gross negligence can now move to another State and continue to serve Medicare and Medicaid patients.

All threee bills would close these loopholes and add a new range of authorities to sanction abusive acts.

What I would like to do is to comment on some of the specific differences between the various bills and mention what we are in favor of in particular.

In H.R. 1868, there is a requirement to exclude from Medicare and Medicaid those convicted of patient abuse. There is also a provision in that bill that allows exclusion for an HMO failing to provide medically necessary services. We are strongly in favor of both those provisions.

S. 837 mandates exclusion for certain areas beyond the other bills, including obstructing an investigation, abuse of a controlled substance, fraudulent claims, or violating the kickback provisions.

While in general we support sanctioning or excluding individuals or entities that do that, we are not in favor of the mandatory exclusion in those areas.

In addition, S. 1323 allows the exclusion for health care professionals who are defaulting on their PHS loans and scholarships, and we, of course, support that.

There are three other provisions I would like to mention in S. 1323 which support. The first has to do with the look-behind provisions which Congress gave us several years ago. Under these provisions, the Federal Government can go into a Medicaid-only facility and make certain determinations on its compliance with Federal health and safety standards. We can terminate a provider immediately if there is a serious threat to patient health and safety. However, if a facility is out of compliance, even substantially out of compliance, but yet there is no immediate threat, we cannot termi-

nate that facility until we allow it a hearing. And that has taken some of the teeth out of our enforcement efforts. We would like to have the hearing, as we do in the rest of the Medicare and Medicaid Program, after termination.

Another provision we support deals with the conditional approval of suppliers. This would strengthen our ability to move against health care suppliers that are providing substandard services, but again not immediately jeopardizing the health and safety of the patients.

A third provision has to do with intermediate sanctions. In 1980, Congress gave the Secretary the authority to ban new admissions from SNF's under Medicare, and gave the States authority to ban new admissions from SNF's and ICF under Medicaid. We strongly believe that we ought to expand those proposals to all providers, including psychiatric hospitals, home health agencies, hospices, and so forth. The bill's provisions will allow us to take appropriate action again where there is no immediate and serious threat to patient health and safety. It will allow us to penalize the facility first, still offering an opportunity to correct deficiencies without unnecessarily disrupting the patients who reside there.

Finally, S. 1323 would repeal the moratorium enacted in last year's Deficit Reduction Act on penalties against States using different methodologies for determining Medicaid eligibility for the medically needy other than the methodologies used for AFDC or SSI. We support the repeal of that moratorium.

In conclusion, we are in agreement philosophically and in most specifics with all three proposed bills. We are eager to work with the committee in an effort to deter and penalize those who would defraud our programs or harm our beneficiaries.

I am very happy to answer any questions you may have.

[Mr. Morford's written testimony follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D C 20201

STATEMENT OF

THOMAS G. MORFORD

DEPUTY DIRECTOR, HEALTH STANDARDS AND QUALITY BUREAU

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON HEALTH

FINANCE COMMITTEE

UNITED STATES SENATE

JULY 12, 1985

51-772 O - 86 - 5

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, I AM PLEASED TO BE HERE TODAY TO DISCUSS THREE SIMILAR BILLS WHICH ADDRESS THE INTEGRITY OF OUR LARGEST FEDERAL HEALTH CARE PROGRAMS: S. 1323, "THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985;" S. 837, "THE PATIENT AND PROGRAM PROTECTION ACT FOR MEDICARE AND MEDICAID;" AND H.R. 1868, "THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985." I AM ACCOMPANIED BY JOYCE SOMSAK, DIRECTOR OF THE OFFICE OF QUALITY CONTROL PROGRAMS.

WE SUPPORT THE CONCEPT AND MOST OF THE DETAILS OF ALL THREE BILLS. IN PARTICULAR WE ARE SUPPORTIVE OF THE PROVISIONS OF SENATOR ROTH'S BILL, S. 1323, WHICH IS THE ADMINISTRATION BILL. I WILL EXPLAIN THOSE ELEMENTS FOUND SOLELY IN S. 1323 AND COMMENT ON THE DIFFERENCES BETWEEN S. 1323 AND ITS COMPANION MEASURES IN THE COURSE OF MY TESTIMONY.

AS YOU KNOW THE MEDICARE AND MEDICAID PROGRAMS PROVIDE BASIC HEALTH CARE SERVICES FOR THE ELDERLY AND THE POOR. IN 1984, MEDICARE AND MEDICAID PAID OVER $80 BILLION FOR HEALTH CARE BENEFITS TO 48 MILLION BENEFICIARIES. IN ADDITION TO PROVIDING FINANCIAL ASSISTANCE, THE MEDICARE AND MEDICAID PROGRAMS ARE RESPONSIBLE FOR ASSURING THAT PAYMENT IS APPROPRIATE AND THAT HEALTH SERVICES MEET HIGH QUALITY STANDARDS.

THIS ADMINISTRATION IS COMMITTED, AS I KNOW THIS COMMITTEE IS, TO THE PROTECTION OF THE ELDERLY AND POOR FROM UNETHICAL AND INCOMPETENT MEDICAL PRACTITIONERS AND TO THE MAINTENANCE OF THE FISCAL INTEGRITY OF FEDERAL AND STATE HEALTH PROGRAMS. TO THIS END, THE ADMINISTRATION TRANSMITTED TO THE CONGRESS THE BILL SENATOR ROTH SUBSEQUENTLY INTRODUCED, S. 1323 - "THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985".

THIS BILL WOULD GIVE THE SECRETARY BROAD DISCRETIONARY AUTHORITY TO DETER AND SANCTION FRAUD AND ABUSE AFFECTING MEDICARE, MEDICAID AND THE MATERNAL AND CHILD HEALTH PROGRAM.

BACKGROUND

UNDER PRESENT LAW, THE SECRETARY MAY EXCLUDE FROM PARTICIPATION IN THE MEDICARE PROGRAM, PHYSICIANS AND OTHER HEALTH PROFESSIONALS WHO:

- KNOWINGLY SUBMIT FALSE CLAIMS;
- CHARGE SUBSTANTIALLY MORE THAN THEIR USUAL CHARGES TO OTHER PATIENTS;

- PROVIDE SERVICES SUBSTANTIALLY IN EXCESS OF PATIENTS' NEEDS OR SERVICES WHICH FAIL TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE; OR

- ARE FOUND BY A PEER REVIEW ORGANIZATION TO BE PROVIDING UNNECESSARY OR SUBSTANDARD CARE TO PROGRAM BENEFICIARIES.

FURTHER, THE SECRETARY IS REQUIRED TO EXCLUDE INDIVIDUALS FROM MEDICARE AND MEDICAID WHO HAVE BEEN CONVICTED OF CRIMINAL OFFENSES RELATED TO THEIR PARTICIPATION IN THE RESPECTIVE PROGRAMS.

IN ADDITION TO THESE EXCLUSION AUTHORITIES, THE SECRETARY HAS THE ADMINISTRATIVE AUTHORITY UNDER THE CIVIL MONETARY PENALTIES PROVISIONS OF THE SOCIAL SECURITY ACT TO ASSESS FINANCIAL PENALTIES ON HEALTH PROFESSIONALS AND OTHER INDIVIDUALS WHO FILE FALSE OR OTHERWISE IMPROPER CLAIMS FOR REIMBURSEMENT UNDER THE MEDICARE AND MEDICAID PROGRAMS.

THE OFFICE OF THE INSPECTOR GENERAL IS RESPONSIBLE FOR INVESTIGATING FRAUD AND ABUSE IN THE MEDICARE AND MEDICAID PROGRAMS, AND FOR SANCTIONING PHYSICIANS AND OTHER HEALTH

CARE PROVIDERS FOR FRAUDULENT AND ABUSIVE ACTIVITIES. USING EXISTING AUTHORITIES, THE INSPECTOR GENERAL HAS SIGNIFICANTLY INCREASED THE NUMBER OF SANCTIONED HEALTH PROVIDERS AND THE AMOUNT OF FINANCIAL RECOVERIES IN THE LAST TWO YEARS.

DESPITE THESE EFFORTS, HOWEVER, THE SECRETARY HAS BEEN UNABLE TO TAKE NEEDED ACTION AGAINST CERTAIN HEALTH CARE PRACTITIONERS AND PROVIDERS WHO CONTINUE TO SERVE MEDICARE AND MEDICAID BENEFICIARIES. FOR EXAMPLE:

- A PROVIDER EXCLUDED FROM THE MEDICAID PROGRAM MAY OFTEN CONTINUE TO PARTICIPATE AS A MEDICARE PROVIDER;

- EVEN THOUGH OWNERS AND STAFF OF A FACILITY HAVE BEEN CONVICTED OF DEFRAUDING MEDICAID, THE FACILITY MAY CONTINUE TO RECEIVE MEDICARE AND MEDICAID PAYMENT AS LONG AS THE CONVICTED PERSONNEL ARE NOT PROVIDING DIRECT SERVICES TO PATIENTS;

- A PHYSICIAN WHO HAS LOST A LICENSE IN ONE STATE FOR GROSS NEGLIGENCE CAN MOVE TO ANOTHER STATE AND CONTINUE TO SERVE MEDICARE AND MEDICAID PATIENTS;

ALL THREE BILLS BEFORE THE COMMITTEE TODAY CONTAIN PROVISIONS WHICH SEEK TO CLOSE THESE LOOPHOLES. I WOULD LIKE TO COMMENT ON HOW THE THREE BILLS APPROACH THESE LOOPHOLES. ALL CONTAIN PROVISIONS WHICH WOULD ADD VARIOUS NEW AUTHORITIES TO SANCTION ABUSIVE ACTS AFFECTING THE MEDICARE, MEDICAID AND MATERNAL AND CHILD HEALTH PROGRAMS.

- ALL THREE BILLS WOULD REQUIRE THE SECRETARY TO EXCLUDE FROM FEDERALLY-ASSISTED HEALTH CARE PROGRAMS, ENTITIES CONVICTED OF DEFRAUDING OR ABUSING THESE PROGRAMS.

- H.R. 1868 AND S. 837 WOULD ALSO REQUIRE THE EXCLUSION OF INDIVIDUALS OR ENTITIES CONVICTED OF PATIENT ABUSE. WE SUPPORT THIS BECAUSE OF THE CONVICTION'S CLOSE RELATIONSHIP TO A PROVIDER'S FITNESS AND INTEGRITY. S. 837 WOULD ALSO REQUIRE EXCLUSION OF ENTITIES CONVICTED OF OBSTRUCTION OF AN INVESTIGATION, RELATING TO A CONTROLLED SUBSTANCE, SUBMISSION OF FALSE CLAIMS, FRAUD OR KICKBACKS. WE OPPOSE MANDATORY EXCLUSION FOR THESE PROPOSALS BECAUSE CONVICTIONS ON THESE BASES DO NOT NECESSARILY HAVE A CLOSE RELATIONSHIP TO FITNESS AND INTEGRITY.

- Only S. 1323 would allow exclusion of health care professionals in default on Public Health Service Loans or scholarship obligations. We urge inclusion of this provision. It is inappropriate for individuals who owe one Federal program substantial sums of money to receive continued payments from another program.

- H.R. 1868 would allow exclusion of an HMO which has failed to provide medically necessary items and services. This provision offers beneficiary protection, and we support it.

In addition to these proposals and various other technical clarifying amendments, however, S. 1323 contains certain additional proposals that we feel are vital if we are to provide the maximum protection to Medicare and Medicaid patients. These proposals would add to the tools available to deal with deficient providers and suppliers. They are aimed at the protection of the most vulnerable of our beneficiary population, the institutionalized.

Terminations

Currently, if through the Federal "look-behind" authority, HCFA finds a long-term care facility out of compliance, the facility may undergo administrative review prior to

TERMINATION. THIS APPEALS PROCESS MAY TAKE AS MUCH AS TWO YEARS DURING WHICH TIME A FACILITY WITH SERIOUS DEFICIENCIES CONTINUES TO BE PAID UNDER MEDICAID. THIS BILL PROVIDES THAT UNDER THE LOOK-BEHIND AUTHORITY, THE SECRETARY MAY TERMINATE A LONG-TERM CARE FACILITY'S PROVIDER AGREEMENT OR IMPOSE AN ALTERNATIVE SANCTION PRIOR TO ADMINISTRATIVE REVIEW. THIS CONFORMS TO ALL OTHER SITUATIONS UNDER MEDICARE AND MEDICAID WITH RESPECT TO TERMINATIONS.

CONDITIONAL APPROVAL

CURRENTLY, THE SECRETARY CAN GIVE A ONE-YEAR CONDITIONAL PROVIDER AGREEMENT TO A SNF THAT IS EXPERIENCING COMPLIANCE DIFFICULTIES WITH CONDITIONS OF PARTICIPATION. THIS BILL WOULD PERMIT THE SECRETARY TO GIVE UP TO A 6-MONTH CONDITIONAL PROVIDER AGREEMENT TO OTHER MEDICARE AND MEDICAID PROVIDERS AND SUPPLIERS.

THIS CONDITIONAL AUTHORITY ENABLES US TO PUT PROVIDERS AND SUPPLIERS ON NOTICE THAT THEY MUST TAKE IMMEDIATE CORRECTIVE ACTION INSTEAD OF OUR HAVING TO MOVE IMMEDIATELY TO TERMINATION. THIS INTERMEDIATE STEP WOULD BE PERMITTED PRIOR TO A HEARING. THUS, WE WOULD BE TAKING STEPS FASTER TO MOVE PROVIDERS INTO COMPLIANCE.

Intermediate Sanctions

We propose building upon the provision enacted in 1980 which allowed the banning of new admissions to facilities where deficiencies pose no immediate jeopardy to health and safety. This would be an intermediate sanction, between allowing the facility to operate business as usual and terminating their Medicare or Medicaid provider agreement.

The Health Care Financing Administration (HCFA) is committed to assuring that Federal health care dollars buy an acceptable level of care for Medicare and Medicaid patients. To this end, facilities which participate in the Medicare and Medicaid programs are required to meet certain health and safety conditions of participation. Until recently, termination of the provider agreement was the only disciplinary measure available to the Secretary in cases where a facility had deficiencies in meeting those conditions of participation but they did not jeopardize the health and safety of patients.

But termination of a provider's agreement is not always the most satisfactory way to resolve facility problems. It may mean the disruptive relocating of patients to other facilities; the loss of needed money to make required corrections; and the termination process may take many months to complete. In addition, during the lengthy termination process, the facility may continue to admit new Medicare and Medicaid patients for whose care Federal payment is made.

THE SOCIAL SECURITY AMENDMENTS OF 1980 PROVIDED NEW AUTHORITY (SECTION 1866(F)) TO DEAL WITH DEFICIENT FACILITIES. FOR MEDICARE, IT GAVE THE SECRETARY THE ABILITY TO BAN PAYMENT FOR NEW ADMISSIONS TO SKILLED NURSING FACILITIES (SNFS) THAT DO NOT MEET CONDITIONS OF PARTICIPATION BUT DO NOT POSE IMMEDIATE JEOPARDY TO HEALTH AND SAFETY. FOR MEDICAID, IT GAVE THE STATES SIMILAR AUTHORITY FOR SNFS AND ICFS.

THE ADMINISTRATION'S BILL WOULD EXTEND THESE INTERMEDIATE SANCTIONS FOR MEDICARE TO ALL PROVIDERS, E.G., HOSPITALS, PSYCHIATRIC HOSPITALS, HOME HEALTH AGENCIES, HOSPICES, OUTPATIENT PHYSICAL THERAPY, AND COMPREHENSIVE REHABILITATION FACILITIES AND FOR ALL SUPPLIERS. AND FOR MEDICAID IT WOULD PROVIDE THE SECRETARY WITH THE SAME AUTHORITY THE STATES NOW HAVE TO IMPOSE INTERMEDIATE SANCTIONS ON SNFS AND ICFS.

INTERMEDIATE SANCTIONS:

- ALLOW PROVIDERS AND SUPPLIERS TIME TO MAKE NEEDED CORRECTIONS;

- DO NOT DISRUPT FACILITY PATIENTS UNNECESSARILY; AND

- CLEARLY PUT PROVIDERS AND SUPPLIERS ON NOTICE THAT WE WILL NO LONGER PAY FOR SUBSTANDARD CARE; AND THAT IF THEY DO NOT COME INTO COMPLIANCE, THEY WILL BE TERMINATED.

MORATORIUM ON PENALTIES

IN ADDITION TO THESE PROPOSED AMENDMENTS, SECTION 19 OF THE ADMINISTRATION'S BILL WOULD REPEAL THE MORATORIUM, ENACTED LAST YEAR IN THE DEFICIT REDUCTION ACT (DRA), ON FINANCIAL PENALTIES OR OTHER SANCTIONS AGAINST STATES WHO USE DIFFERENT METHODOLOGIES FOR DETERMINING "MEDICALLY NEEDY" MEDICAID ELIGIBILITY THAN METHODOLOGIES USED FOR DETERMINING ELIGIBILITY FOR THE CASH PROGRAMS, AFDC OR SSI.

THE OMNIBUS RECONCILIATION ACT (OBRA) OF 1981 PROVIDED STATES WITH FLEXIBILITY IN DESIGNING THEIR MEDICALLY NEEDY PROGRAMS. HCFA, THROUGH ITS OBRA REGULATIONS, PERMITTED STATES TO USE MEDICALLY NEEDY ELIGIBILITY POLICIES THAT WERE LESS RESTRICTIVE THAN FEDERAL POLICY. IN 1982, CONGRESS SOUGHT TO NARROW THIS FLEXIBILITY BY REQUIRING IN THE TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982 (TEFRA) THAT STATES USE SSI OR AFDC DEFINITIONS AND METHODOLOGIES FOR THEIR MEDICALLY NEEDY CASELOAD. TEFRA ALSO REQUIRED THAT ANY STATES WHICH IMPROPERLY DETERMINED

MEDICAID ELIGIBILITY WOULD BE FINANCIALLY LIABLE FOR ERRONEOUS PAYMENTS EXCEEDING 3% OF THE STATE'S MEDICAID PAYMENTS. AS A RESULT, A STATE WHOSE METHODOLOGIES DIFFERED FROM THOSE OF THE CASH PROGRAMS COULD BE LIABLE FOR A DISALLOWANCE. LAST YEAR, DRA IMPOSED A MORATORIUM ON SUCH PENALTIES. WE BELIEVE THAT THIS MORATORIUM TREATS STATES INEQUITABLY AND DISADVANTAGES STATES THAT COMPLIED WITH THE LAW.

H.R. 1868, IN ITS SECTION 9, WOULD ATTEMPT TO CLARIFY THE DRA MORATORIUM IN A WAY THAT WOULD ENCOURAGE STATES TO ATTEMPT TO SHIFT COSTS TO THE FEDERAL GOVERNMENT. IF THE COMMITTEE CHOOSES TO USE H.R. 1868 AS A VEHICLE FOR WASTE AND FRAUD LEGISLATION, WE URGE DELETION OF SECTION 9.

CONCLUSION

IN CONCLUSION, WE ARE PLEASED TO SEE CONGRESS MOVING TO STRENGTHEN THE PRESENT MEDICARE AND MEDICAID FRAUD AND ABUSE REQUIREMENTS AND TO PROVIDE NEEDED AUTHORITY FOR THE SECRETARY TO TAKE ACTION AGAINST PROVIDERS WHO ARE HARMING OUR BENEFICIARIES OR ARE DEFRAUDING OUR PROGRAMS. WE LOOK FOREWARD TO WORKING WITH THIS COMMITTEE IN THIS EFFORT. WE APPRECIATE THE OPPORTUNITY TO PRESENT THIS TESTIMONY TODAY AND I WILL BE PLEASED TO ANSWER ANY QUESTIONS.

Senator DURENBERGER. Tom, thank you.

According to the AMA's testimonny, the Secretary already has adequate remedies to gain access to records, documents, and information about subcontractors and about business transactions. In your opinion, is the subpoena power the Secretary now has inadequate when it comes to access to records?

Mr. MORFORD. I think it is generally inadequate. Again, a lot of these provisions simply strengthen the arsenal of weapons the Secretary has to act in particular cases. And I think as the Inspector General mentioned, we have run into cases where, if we are denied access, records can be doctored, surveyors can be prohibited from coming in to investigate health and safety conditions, and we have no threat to the facilty other than the lengthy subpoena process.

In addition, if we have a particular problem with one entity, we don't want to have to continually go through the subpoena process again and again every time we are denied access. We would like the authority to simply exclude. Certainly just the threat that we could use that authority would be extremely helpful.

Senator DURENBERGER. As part of the moratorium provision in DEFRA, the Secretary was required to submit a report to the Congress describing the impact of requiring that the budgeting methodologies of the AFDC and SSI Program be used in the Medicaid Program. Is that report being prepared? And when will it be available?

Mr. MORFORD. Well, Mr. Chairman, in answer to your first question, yes, the report is being prepared. In all candor, I have long ago given up projecting, especially with the Senate and Congressional committees, when regulations or congressional reports will actually be furnished. I can tell you the report, at least the first draft of that report, is completed. It is now under review in the Health Care Financing Administration. Of course, it will have to be cleared through the Administrator's office and then through the Secretary's office.

Senator DURENBERGER. As of today, to the best of your knowledge, it is still at HCFA?

Mr. MORFORD. Yes, sir.

Senator DURENBERGER. OK.

H.R. 1868 would allow exclusion of an HMO which has failed to provide medically necessary items and services. Mr. Morford. This provision offers beneficiary protection. We support it.

Senator DURENBERGER. I think you were here when I asked that question earlier. Can you respond to the question so that I don't have to rephrase it?

Mr. MORFORD. I will try to remember that.

Senator DURENBERGER. The question being who is going to determine it. How do we determine that?

Mr. MORFORD. Well, again, I think the important issue here is that it is a discretionary authority, No. 1; and No. 2, we think, again, it strengthens the arsenal that the Secretary has to act against individual providers, particularly HMO's. As you well know, the problem there is denying access any denying care, as opposed to, if you will, the usual problems of poor quality of care given. And I think the discretionary authority to take those kinds of actions will be extremely helpful. Hopefully there would be only

rare cases where an individual entity might even consider denying care to maximize revenue. Obviously some of the providers would disagree with me, but I think there is a lot to be said for having these weapons at the Secretary's discretion.

Senator DURENBERGER. Do you have anything in the current CMP authority that would permit you to do the same thing, at least with regard to Medicare?

Mr. MORFORD. I would really have to get all the details and supply those for the record. Obviously we can deal with with any kind of gross abuse with, but I am not aware of the specific authorities.

[The information follows:]

The civil money penalties [CMP] provisions of the Social Security Act are not available to act against HMOs or CMPs under risk contracts which fail to provide necessary services.

The only sanction available against errant HMOs is termination. HCFA monitors the execution of the HMO's contract through contract performance monitoring visits. HCFA visits each HMO at least once a year. Visits are more frequent if there are indications of problems.

Question. The Administration's bill contains a provision (not contained in my bill or Congressman Moore's) which would change the way HHS calculates the length of patient stays in Medicaid facilities for the purpose of imposing over-utilization control penalties. This provision has been described as a technical amendment which would reduce paperwork for the States by eliminating the need to "recalculate stays annually for long term care patients who are essentially permanently institutionalized." I have also heard that some anticipated savings are associated with this provision.

Can you explain how this provision changes current law? Are the anticipated savings to be produced from lower administrative costs for the states or from lower federal matching funds?

I am concerned that this change in the way length-of-stays are calculated may be more than technical. This provision doesn't seem to require any less from States in terms of the frequency with which they must conduct utilization reviews in Medicaid facilities. Instead, wouldn't it result in many patients, who are now considered "short-term" patients, being considered "long-term" patients? Wouldn't the result of that be that those facilities with a higher proportion of newly defined "long-term" patients would be more likely to receive reduced federal matching funds for their Medicaid programs?

Answer. Under current Medicaid law, States are required to institute utilization control programs. These programs are designed to ensure that long-stay patients are periodically evaluated to determine the best course of treatment. To ensure that States fulfill their responsibilities, the legislation include penalties to be assessed against States which do not institute effective programs. One of the factors used in computing the penalty is the number of "long-stay" patients in State institutions. A patient is defined as "long-stay" after residing in an intermediate care facility for 60 days, in a skilled nursing facility for 30 days, or in a mental disease hospital for 90 days. Because of an apparent drafting error, the law was written so that the long-stay status of every patient must be recalculated as though all stays began with the start of "any fiscal year." This means, for example, that a patient in a intermediate facility who has been there many years is not considered "long-stay" until 60 days after the start of every fiscal year.

The proposed technical change would establish a patient's long-stay status once for each stay after the initial 30, 60, or 90 day period. This in turn will result in the calculation of a utilization control penalty which more properly reflects the effect of a State's failure to implement effective utilization controls. There is no direct effect on the coverage of services or cost of services to beneficiaries.

The savings estimated from the change to the penalty provision result from a more accurate calculation of the existing provision. Only $30 million have been collected from the inception of this penalty provision in fiscal year 1979, so that overall savings impact from this change would be minimal over the next 3 years.

Senator DURENBERGER. Did HCFA draft the language that Senator Roth introduced on this subject?

Mr. MORFORD. Yes, we did.

Senator DURENBERGER. OK. Thank you very much for your testimony; I appreciate it a lot.

Mr. MORFORD. Thank you.

Senator DURENBERGER. Our last three witnesses we will call up together and make them a panel: Dr. Harrison L. Rogers, Jr., M.D., president of the American Medical Association, Washington, DC, Dr. Robert Rosenberg, executive director of Group Health Association, on behalf of the Group Health Association of Washington; and Russel Heeren, member of the National Legislative Council of the American Association of Retired Persons, Washington, DC.

We will begin with Dr. Rogers. Thank you, all of you, very much for your patience in sitting through the hearing so far. Dr. Rogers and Dr. Rosenberg and Mr. Heeren, your testimonies will be made part of the record, and you may proceed to summarize them. We will start with Dr. Rogers.

STATEMENT BY HARRISON L. ROGERS, JR., M.D., PRESIDENT, AMERICAN MEDICAL ASSOCIATION, CHICAGO, IL

Dr. ROGERS. Mr. Chairman, thank you very much.

I am Harrison Rogers president of the AMA. I am a practicing surgeon in Atlanta. With me is Mr. Ross Rubin.

I would like to reiterate what the chairman said at the beginning of this hearing. That is the numbers that we are talking about in the area of program fraud and abuse are quite small. As we talk more and more about the problems of fraud and abuse with physicians and other providers, it seems that the problem grows.

Senator DURENBERGER. The closer you get to Washington, the bigger the numbers get, right?

Dr. ROGERS. That's right, I'm sure.

But I would just like to remind the committee that the problem is a small number of individuals and that we are in general support of efforts to crackdown on violators. The American Medical Association strongly supports efforts to root out fraud and abuse in Medicare and Medicaid by whomever perpetrated, whether physicians, dentists, pharmacists, podiatrists, optometrists, chiropractors, hospitals, or any other provider. Reprehensible activity should not be tolerated under any circumstances. And at this time in particular, when program budgets are being cut, it is essential to deal with program fraud and abuse aggressively. A dollar fraudulently diverted means a dollar that is not available for covered services to beneficiaries. Fraud and abuse should be ferreted out of all government programs, whether they relate to health, food, housing, defense, or whatever. The taxpayers and beneficiaries deserve such accountability.

One of the central features of previous hearings has been on practitioners who have lost their license to practice in one State continuing to receive reimbursement through federally-funded programs by moving to another State. The AMA testified before the Senate Special Committee on Aging at the time of the release of a General Accounting Office report on this subject. At that time we stated, as we previously had discussed with GAO, that the AMA was gravely concerned that health care practitioners who had been

found unfit to practice in one jurisdiction could relocate and practice in another jurisdiction where they have a license. These practitioners discredit their profession and subvert procedurally the State licensing programs in our Nation. State licensure has been and continues to be a major factor in assuring the high quality of health care available to all citizens. Its integrity must not be diminished.

Through cooperative efforts with State authorities and the Federation of State Medical Boards, information on licensure actions and revocations is made available to the AMA on a monthly basis. The medical licensure boards in all States in which an individual has held or holds currently a license are alerted by the AMA when that individual has been sanctioned in a different jurisdiction. This effort allows States to act promptly against physicians who are the subject of State licensure actions and protects the entire patient population, not just the Federal Program beneficiaries.

Mr. Chairman, I am pleased to State that these activities are now being carried out with an average of 40 alerts per month. We are also using our data to alert licensure boards concerning information as to the date of a physician's death. This information is not always known by the State licensure boards, and there have been cases where individuals fraudulently renew and assume the credentials of deceased physicians. We have initiated the dissemination of this information to 13 State licensure boards with more soon to be added.

We are also reviewing the credentials of all the physicians involved in the VA, at the VA's request.

The AMA testified before several House committees last fall and spring, after introduction of the Medicare and Medicaid Patient Protection Act. That legislation was in many ways similar to H.R. 1868, S. 837, and S. 1323 which are now before this subcommittee. At that time the AMA voiced strong support for legislation to correct the situations identified by GAO where harm to patients or to the Medicare or Medicaid Programs could result. We, however, did raise several specific concerns regarding the exclusion of individuals from Federal health care programs where neither the professional fitness of the physician nor a serious threat to the program was involved, and where remedies currently existed. We were also concerned about provisions for a minimum period of exclusion contained in the bill. These and other concerns were expressed also by other witnesses at these hearings.

Mr. Chairman, our detailed comments are before you. I will not repeat them now. But let me make clear our strong support for efforts to end fraud and abuse in Federal and State health care programs in general. Those who intentionally set out to subvert these programs should be prosecuted to the full extent of the law.

As I earlier stated, when funds and resources are wasted on fraud and abuse, they become unavailable to provide covered services. We therefore urge that adequate efforts be expended for investigation and prosecution.

The AMA will continue its efforts to address the problems created when sanctioned practitioners move to other jurisdictions, and we encourage States to fund adequately their medical licensing programs. We support efforts to close the gaps in the Secretary's

authority, which are discussed by the GAO in its report on physicians whose licenses are revoked for cause.

We urge caution against using exclusion from programs where other administrative sanctions appropriately remedy any defaults and where patients are not at risk.

Finally, we stress the importance of procedural due process for the individuals involved. We support the major thrust of all three bills and would be pleased to work with the Congress to correct the problems with the bills that we have identified.

Mr. Chairman, we commend the subcommittee for its efforts. The medical profession has always supported efforts to deal with fraud and abuse related to medical practice. Since the enactment of Medicare and Medicaid, the AMA has supported efforts of the Federal and State governments to deal with fraud and abuse in these and other health programs.

Notwithstanding this strong support, we are compelled to make a cautionary comment: Congress must not so direct enforcement efforts that they become so punitive and harsh that unintentional errors or misunderstanding of program requirements which are now so complicated become traps for physicians who are trying to meet their obligations to serve patients. The Congress should strive to avoid an atmosphere of fear and instead foster an attitude of cooperation.

We will be pleased to answer any of your questions.

Senator DURENBERGER. One question, Dr. Rogers.

Dr. ROGERS. Yes, sir?

Senator DURENBERGER. Did you talk this fast before DRG's? [Laughter.]

Dr. ROGERS. No, that has really speeded me up a bit, but it was your committee's choice.

Senator DURENBERGER. If we had a DRG for testimony, you just made money. [Laughter.]

Senator DURENBERGER. Dr. Rosenberg?

[Dr. Rogers' written testimony follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Subcommittee on Health
Committee on Finance
U.S. Senate

Presented by

Harrison L. Rogers Jr., M.D.

RE: S. 837, Patient and Program Protection Act for Medicare and Medicaid

S. 1323, Health Care Financing Fraud and Abuse Amendments of 1985

H.R. 1868, Medicare and Medicaid Patient Program Protection Act

July 12, 1985

Mr. Chairman and Members of the Subcommittee:

I am Harrison L. Rogers Jr., M.D. I am a physician in the practice of general surgery in Atlanta, Georgia, and I am President of the American Medical Association. Accompanying me today is Ross N. Rubin, Director of AMA's Department of Federal Legislation.

INTRODUCTION

This is the fourth Congressional hearing in just over a year concerning fraud and abuse in the Medicare and Medicaid programs. Mr. Chairman, the AMA has appeared at the previous hearings and at this

time is again pleased to state our strong support for efforts to root out fraud and abuse in these important programs by whomever perpetrated--whether by physicians, dentists, pharmacists, podiatrists, optometrists, chiropractors, hospitals or other providers. Such reprehensible activities should not be tolerated under any circumstances, and at this time, in particular, when program budgets are being cut, it is essential to deal with program fraud and abuse aggressively. A dollar fraudulently diverted means a dollar not available for covered services to beneficiaries. Fraud and abuse should be ferreted out of all government programs whether they relate to health, food, housing, defense, or whatever. Taxpayers--and beneficiaries--deserve such accountability.

One of the central features of the various hearings has focused on practitioners who have lost a license to practice within one state and continue receiving reimbursement through federally-funded programs by moving to another state. AMA testified before the Senate Special Committee on Aging at the time of the release of a General Accounting Office report on this subject. At that time we stated--and as we previously had discussed with GAO--that the AMA was gravely concerned that health care practitioners who have been found unfit to practice in one jurisdiction could relocate and practice in another jurisdiction where they hold a license. These practitioners discredit their profession and subvert procedurally the state licensure programs in our nation. State licensure has been, and continues to be, a major factor in assuring the high quality of health care available to all citizens. Its integrity must not be diminished.

Through cooperative efforts with state authorities and the Federation of State Medical Boards of the U.S. information on licensure actions and revocations is made available to the AMA on a monthly basis. Using the AMA's unique database--the physician masterfile--medical licensure boards in all states in which an individual has held or holds a license are alerted when that individual has been sanctioned in a different jurisdiction. This effort allows states to act promptly against physicians who are the subject of state licensure actions. It protects the entire patient population, not just federal program beneficiaries. Mr. Chairman, I am pleased to state that these activities are now being carried out.

With information supplied by the Federation of State Medical Boards of the U.S., we have been issuing alerts on an average of 40 cases a month.

We have now recently increased our activities in this area by focusing on another unique aspect of our database--information as to the date of a physician's death. This information is not always known by the state licensure boards and there have been cases where individuals fraudulently renew and assume the credentials of a deceased physician. Our efforts to disseminate this information to states where our records show that a licensed physician is deceased allow states to purge the names of deceased physicians from state licensure lists and close this avenue of fraud. We have initiated the dissemination of this information to 13 state licensure boards, with more to be added soon.

I am also very pleased to announce that the nation's largest hospital system, the Veterans Administration, has asked the AMA to verify the credentials of as many as 94,000 physicians. Beginning June 28, the VA supplied the AMA with computer tapes containing the agency's records on 6,000 full-time and 11,000 part-time physicians. The VA also plans to supply records on 23,000 consulting physicians, 43,000 participating as CHAMPVA physicians, and 11,000 resident physicians. The total represents nearly a fifth of the U.S. physician population. The AMA Division of Survey and Data Resources will check the records against the AMA's comprehensive Physician Masterfile. The information provided by the AMA will permit the VA to determine that a physician's education, licensure and certification meets standards set by the VA for employment. It also will determine whether the physicians hold valid MD or DO degrees and valid licenses. VA physicians' educational training and board certification will be confirmed against the Masterfile. This is significant because the amount of residency training that physicians have completed as well as whether they are certified by one of the specialty boards is taken into account in determining VA salary levels. In a preliminary computer run, 20 VA physicians were identified as having credentials problems. Eight of these physicians have left the VA. The VA's Dept. of Medicine and Surgery has asked state examining boards to verify the licenses of the remaining 12.

The AMA testified before several House subcommittees last fall and spring, after introduction of the Medicare and Medicaid Patient Protection Act. That legislation was in many ways similar to H.R. 1868,

S. 837 and S. 1323 which are now before this Subcommittee. At that time, the AMA voiced strong support for legislation to correct the situations identified by the GAO, where harm to patients or to the Medicare or Medicaid programs could result. We, however, raised several specific concerns regarding the exclusion of individuals from federal health care programs where neither the professional fitness of the physician nor a serious threat to the program was involved and where remedies currently existed. We also were concerned about the adequacy of some procedural due process protections contained in the bill. These and other concerns were expressed also by other witnesses at these hearings.

Mr. Chairman, let me make clear our strong support for efforts to end fraud and abuse in federal and state health care programs. Those who intentionally set out to rip-off these programs should be prosecuted to the fullest extent of the law. As I earlier stated, when funds and resources are wasted on fraud and abuse, they become unavailable to provide for covered services. We therefore urge that adequate efforts should be expended for investigation and prosecution.

H.R. 1868 - MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT
S. 837 - PATIENT AND PROGRAM PROTECTION ACT FOR MEDICARE AND MEDICAID
S. 1325 - THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985

Loss of Licensure

Mr. Chairman, the AMA continues to support legislation to terminate participation in Medicare and Medicaid by physicians who lose their

license to practice medicine in any jurisdiction for cause related to professional competency. It is important to safeguard beneficiaries from unqualified practitioners.

H.R. 1868 and S. 837 contain improvements over last year's original bill, under which a physician could have been excluded from the programs if a license was suspended or revoked for any reason. We urged that exclusions be applied to those cases where the reasons for revocation or suspension were substantive. S. 837 now would allow exclusion of any individual or entity, "whose license to provide health care has been revoked or suspended by a state licensing authority or who otherwise lost such a license for reasons bearing on the individual's or entity's professional competence, professional conduct, or financial integrity...." This language creates an ambiguity which should be corrected by inserting commas before and after the phrase "or who otherwise lost such a license." This would clarify that exclusion from the programs would occur only when the revocation or suspension of a state license was for reasons bearing on professional competence, professional conduct or financial integrity. This change was contained in HR 1868, and S. 1323 already contains unambiguous language on this point which we believe achieves the purpose intended by all three bills.

Minimum Exclusion

S. 837 and H.R. 1868 contain provisions requiring a minimum five-year exclusion upon conviction of a criminal offense related to Medicare. We believe that such provisions should be deleted since discretionary authority to exclude such individuals would remain as part of the

legislation. With flexibility to fashion a penalty that fits the offense available, the mandatory five-year exclusion provision is unnecessary. A mandatory minimum five-year exclusion from health care programs fails to distinguish between various levels of culpability. We believe the Secretary should be allowed to determine the length of exclusion and entertain and be able to give consideration to meritorious requests for reinstatement in every case.

Therefore, we support the provisions of S. 1323 which provide for discretionary sanctions and allow the Secretary to take intermediate steps, short of mandatory exclusion, that appropriately reflect the degree of culpability.

Exclusions for Other Reasons

We also remain concerned that other situations which could result in exclusion under these bills involve neither the professional fitness of the practitioner nor a serious threat to the program involved. For example, the Secretary could exclude from federal health care programs:

- any entity for failing to grant immediate access to its records and documents;
- any entity managed by an individual against whom a civil monetary penalty under Section 1128A has been assessed;
- any individual or entity failing to supply information regarding certain subcontractors and business transactions.

Without diminishing the importance of complying with administrative requirements of federal health care programs, such infractions generally are relatively minor compared to substantive matters, such as loss of a license because of incompetence. We believe that the Secretary already has adequate remedies to address these other deficiencies.

Conflict with Peer Review

The proposed "False Claims" or "Unnecessary Charges" provisions in all three bills should be modified. These provisions grant the Secretary authority to exclude any individual or entity determined by the Secretary to have furnished items or services in excess of the patient's needs or to be of a substandard quality. Such authority is already available under the PRO law. It is important, we believe, that quality of care determinations remain a function of peer review. In light of the existing authority in this area, we recommend that these provisions be deleted from the bill as unnecessary.

Licensure Data Clearinghouse

The AMA concurs with testimony of other witnesses last September that HHS should not become a central clearinghouse for state licensure actions. Reporting of state licensure actions, such as suspensions and revocations, is a function already well performed by others. Any inadequacies in the collection and distribution of state licensure action data should be addressed within the existing system. As we discussed earlier, the AMA is actively involved in disseminating such information.

Injunctive Authority

The bills also contain a provision allowing the Secretary to seek injunctive relief and freeze assets when it appears a person "is about to" commit a violation subject to a civil monetary penalty. There is no requirement that the Secretary must even have "reason to believe" that assets would be removed or concealed before freezing them. This authority is overbroad and should be dropped.

Controlled Substances Registration

We must oppose provisions in H.R. 1868 and S. 837 which authorize the revocation or suspension of a practitioner's registration under the Controlled Substances Act because of certain exclusions from participation in Medicare. A penalty imposed by law should relate to the offense. Withdrawal of a practitioner's controlled substances registration for an offense totally unrelated to controlled substances practices is not appropriate and this provision should not be adopted.

Health Education Loan Defaults

The AMA strongly supports provisions in S. 1323 that would include within the bill's sanctions those who fail to repay health education loans or scholarship obligations. The AMA recognizes that it is not possible to lend significant sums of money without some delinquency and default problems. Nevertheless, individuals delinquent in or defaulting on their loans have both a moral and legal obligation to see that their educational debts are fully paid. It is our belief that financial aid programs, with reasonable payback provisions coupled with persistent collection action, can have the desired result of assisting individuals to attain a medical education. We urge the federal government and other leaders to take an aggressive posture in collecting past due obligations. Through such collections, coupled with funds paid back in the normal course of the loan programs, funds remain available to assist other deserving individuals.

Medical Impostors

We support provisions in H.R. 1868 which would authorize the Secretary to impose civil penalties and seek criminal sanctions against

an individual who misrepresents himself or herself as a licensed physician. The serious risk of harm to patients from individuals posing as physicians is obvious. It should be observed, however, that current federal statutes provide remedies for this misrepresentation. Indeed, such a misrepresentation is currently subject to sanctions under the statutes sought to be amended.

Another provision of H.R. 1868 applies civil and criminal penalties to an individual who has obtained a license through misrepresentation of material fact or cheating on a licensure examination. We recommend a modification so that such sanctions under Medicare occur only after the individual's license has been suspended or revoked by the state licensure authority for misrepresentation or cheating. This modification could be accomplished by changing the pertinent sections of the bill to read: "was licensed as a physician, but such license was suspended or revoked by state authority because the license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing)." This would allow for the proper review of credentials at the state level with the federal government taking action after the state has resolved the case. Such a technical modification in the bill would retain the appropriate state role and not interject an inappropriate federal administrative role in the state licensing process. This amendment would protect federal fiscal interests.

The third category of sanctioned individuals would be those who hold themselves out as board-certified medical specialists when, in fact, they are not so certified. It is not clear what the intent of this provision

is and who is intended to be covered. For example, there are 23 medical specialty boards, certifying in 29 areas, which are recognized by the American Board of Medical Specialties and the American Medical Association. Other "boards" do not have this recognition and many corporate entities use the words "American Board" as part of their names in the health care area. We are also concerned that there may be a general lack of understanding of the fact that a physician may limit a practice to a "specialty" without being "board certified" and that such a physician may have the same training and skills as a physician who is "certified." We therefore urge careful consideration of this provision in order that undesirable and unintended consequences do not occur. Major clarification in the language is needed.

CONCLUSION

The AMA will continue its efforts to address the problems created when sanctioned practitioners move to other jurisdictions, and we encourage states to fund adequately their medical licensing programs. We support efforts to close the gaps in the Secretary's authority which are discussed by the GAO in its report on physicians whose licenses are revoked for cause. We urge caution against using exclusion from programs where other administrative sanctions appropriately remedy any defaults and where patients are not at risk. Finally, we stress the importance of procedural due process for the individuals involved. We support the major thrusts of all three bills and we would be pleased to work with the Congress to correct the problems with the bills that we have identified.

Mr. Chairman, we commend the Subcommittee for its efforts in this area. The medical profession has always supported efforts to deal with fraud and abuse related to medical practice. Since the enactment of Medicare and Medicaid, the AMA has supported efforts of the federal and state governments to deal with fraud and abuse in these and other health programs. Notwithstanding this strong support, we are compelled to make a cautionary comment. Congress must not so direct enforcement efforts that they become so punitive and harsh that unintentional errors or misunderstanding of program requirements--which are now so complicated--become traps for providers who are trying to meet their obligations to serve patients. The Congress should strive to avoid an atmosphere of fear and instead foster an attitude of cooperation.

We would be pleased to answer any questions the members of the Subcommittee may have.

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STATEMENT BY ROBERT ROSENBERG, M.D., EXECUTIVE DIRECTOR, GROUP HEALTH ASSOCIATION, INC., WASHINGTON, DC, ON BEHALF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC., WASHINGTON, DC, ACCOMPANIED BY LESLIE ROSE, LEGISLATIVE REPRESENTATIVE

Dr. ROSENBERG. Mr. Chairman, I am Dr. Rosenberg, executive director of Group Health Association, Washington, a consumer co-op HMO of 140,000 members established in 1937. I also serve on the executive committee of Group Health Association of America, on whose behalf I am presenting this testimony.

GHAA is the national association of group and staff model HMO's whose member plans include nearly 75 percent of the national HMO enrollment.

Also pertinent to this testimony is my current position as president of the National Committee on Quality Assurance [NCQA], which was formed and established on the enactment of the HMO Act. That act requires HMO's to have formal peer-based quality assurance systems in place, focusing on the entire spectrum of health care services. NCQA is an independent organization of physician peers which provides review of HMO quality assurance systems to make sure that these systems are in accord with the intent of Congress and sound medical practice.

Mr. Chairman, I wish to state unequivocally that we support the intention of H.R. 1868, S. 837, and S. 1323 to protect Medicare and Medicaid Programs and their beneficiaries from fraud and abuse.

In the early 1970's, legitimate and sound HMO's in this country suffered as the result of scandals under the Prepaid Health Plan [PHP] Program for medical beneficiaries in California. We were not involved in these scandals, but nonetheless were subjected to undue attacks on our credibility as well as some fairly stringent regulatory enactments as a result. We therefore support efforts to ensure that unscrupulous providers are not allowed to take advantage of the often vulnerable Medicare and Medicaid population.

Mr. Chairman, I testified before the Health Subcommittees of the House Ways and Means and Energy and Commerce Committees on H.R. 18370, the predecessor of H.R. 1868. In that testimony, I pointed out the various safeguards against fraud and abuse already built into existing law and regulations. The HMO Act itself, as well as title 18 and title 19, place explicit requirements on HMO's with regard to financial solvency, grievance procedures, and quality assurance.

In addition, as you are aware, the HMO industry has been involved in discussions over the past several months with officials of the Health Standards and Quality Bureau [HSQB] of the Health Care Financing Administration in developing criteria for peer review of the quality of inpatient and outpatient services provided by HMO's and competitive medical plans under Medicare contracts. A final report has been recently presented to HSQB officials by an ad hoc committee representing GHAA, the American Medical Care and Review Association, and the American Medical Peer Review Association, recommending ways to implement a cost effective quality review process. One of the recommendations in the report is an automatic review of patient charts under 15 admission

diagnoses that have a significant potential for revealing possible inappropriate management of outpatient care, including underservice and poor access. We believe that this is the first organized wide-scale attempt to review the quality of ambulatory services for any patient population. The committee also recommends specific criteria directed toward evaluation of institutional patient management.

We expect that this peer review process which HCFA intends to implement by October 1, 1985, will result in an effective quality assurance program for HMO's and CMP's under the Medicare contracts. Nonetheless, it appears that there is strong support in Congress for further protection against possible underservice of Medicare and Medicaid patients. GHAA has been concerned about the broad implications of the language of the provisions pertaining to HMO's in H.R. 1868 and S. 837. We were concerned that the language of these bills might result in the imposition of sanctions based on single instances of underutilization. However, the report of the House Ways and Means, Energy, and Commerce Committees accompanying H.R. 1868 alleviates many of our concerns. The report notes the intention of these provisions is to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions. The report further states that the committee intends for the Secretary to examine whether there was a deliberate omission or pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved. These guidelines make the critical distinction between unintended omissions of care and a pattern of underservice or deliberate disregard for medical needs. In our opinion, this is the proper approach to achieving the stated goals of the legislation.

The report also provides that the practice standards upon which determinations about the necessity of medical services would be based would be those generally accceptable as HMO practice standards—in reference to something you mentioned earlier today. These standards would be developed by physicians involved with prepaid group practice, other HMO's and CMP's, or standards used by State agencies that have contracts with HMO's. We wholeheartedly agree that delivery of care by an HMO should be judged in the context of standards by which HMO's operate. As you know, for example, we emphasize preventive care and early access to treatment which results in fewer and shorter hospitalizations, with more procedures performed on an outpatient basis. Thus, it is necessary that utilization standards for HMO's be developed by those familiar with prepaid group practice.

GHAA supports the House Committee's intent as defined in the report language of H.R. 1868 and urges that the same concepts continue to be embodied in any comprehensive piece of legislation by this committee.

Mr. Chairman, GHAA appreciates the opportunity to comment on these legislative proposals. We commend their sponsors and the members of this subcommittee for their efforts to ensure that the elderly and needy receive appropriate and adequate medical care from competent and honest providers. We look forward to working with you.

Senator DURENBERGER. Thank you.
Mr. Heeren.
[Dr. Rosenberg's written testimony follows:]

STATEMENT
ON BEHALF OF
GROUP HEALTH ASSOCIATION OF AMERICA, INC.

ROBERT G. ROSENBERG, M.D.
EXECUTIVE DIRECTOR
GROUP HEALTH ASSOCIATION, INC.
WASHINGTON, D.C.

BEFORE THE
HEALTH SUBCOMMITTEE
OF THE
SENATE FINANCE COMMITTEE

ON
MEDICARE AND MEDICAID ANTI-FRAUD LEGISLATION
H.R. 1868, S. 837, S. 1323

JULY 12, 1985
WASHINGTON, D.C.

51-772 O - 86 - 6

SUMMARY OF TESTIMONY

BY

GROUP HEALTH ASSOCIATION OF AMERICA

ON

H.R. 1868, S. 837 and S. 1323

1. Group Health Association of America (GHAA) supports the fundamental purpose of this legislation to protect the Medicare and Medicaid programs and their beneficiaries against fraud and abuse.

2. As GHAA previously testified before House Subcommittees, there are a number of protections and safeguards already found in the HMO Act, Title 10 and Title 19. These include requirements for financial solvency, grievance procedures and quality assurance.

3. In addition, representatives of the HMO industry have been involved in discussions with officials of the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration (HCFA) in developing criteria for peer review of inpatient and outpatient care under Medicare risk contracts. A report has recently been presented to HSQB recommending specific ways to implement a cost effective quality review process.

4. However, there appears to be strong support in Congress for further protection against possible underservice of Medicare and Medicaid beneficiaries by HMOs, as evidenced by these legislative proposals.

5. GHAA has been concerned about the broad implications of statutory language in H.R. 1868 and S. 837 which would make HMOs subject to exclusion from Medicare or Medicaid programs for failure to provide medically necessary items or services.

6. The Committee Report accompanying H.R. 1868, however, alleviates our concerns. It clarifies that the intent of the Committee is to deal with serious failures to abide by acceptable standards of medical practice rather than isolated cases of

inadvertent omissions. The Committee also asks the Secretary to examine whether there was a deliberate omission or pattern of failure to provide services, as well as the seriousness of the effect on or risk to patients.

7. The Report also provides that the practice standards upon which the necessity of medical services would be based would be generally accepted HMO practice standards, which would be developed by those familiar with prepaid group practice.

8. GHAA believes that the above-mentioned guidelines in the Report on H.R. 1868 represent the proper approach toward achieving the goals of the legislation. We urge the Senate Finance Committee to include them in any comprehensive piece of legislation it develops.

9. We commend the efforts of those sponsoring and supporting these proposals and offer our help and cooperation in this legislative endeavor.

Mr. Chairman and members of the Subcommittee . I am Dr. Robert G. Rosenberg, Executive Director of Group Health Association, Inc. (GHA) of Washington, D.C. GHA is a consumer cooperative HMO of 140,000 members established in 1937 and is one of the nation's largest and most experienced group practice health plans. I also serve on the Executive Committee of Group Health Association of America (GHAA), on whose behalf I am presenting this testimony. GHAA is the national association of group and staff model HMOs whose member plans include nearly 75% of the national HMO enrollment.

Also pertinent to this testimony is my current position as President of the National Committee on Quality Assurance (NCQA). NCQA was formed and established following the enactment of the HMO Act (PL 93-222.) That act requires HMOs to have formal peer-based quality assurance systems in place, focusing on the entire spectrum of health care services. NCQA is an independent organization of physician peers which provides review of HMO quality assurance systems to make sure that these systems are in accord with the intent of Congress and sound medical practice.

Mr. Chairman, I wish to state unequivocally that we support the intent of H.R. 1868, S. 837 and S. 1323 to protect Medicare

and Medicaid programs and their beneficiaries from fraud and abuse. In the early 1970's, the legitimate and sound HMOs of this country suffered as a result of scandals under the prepaid health plan (PHP) program for MediCal beneficiaries in California. We were not involved in those scandals but nonetheless were subjected to undue attacks on our credibility, as well as some fairly stringent regulatory enactments as a result. We therefore support efforts to ensure that unscrupulous providers are not allowed to take advantage of the often vulnerable Medicare and Medicaid population.

My testimony today focuses on the sections of H.R. 1868 and S. 837 which specifically subject HMOs under certain circumstances to the sanctions and penalties provided by the legislation.

Mr. Chairman, I testified before the Health Subcommittees of the House Ways and Means and Energy and Commerce Committees on H.R. 1370, which was the predecessor of H.R. 1868. In that testimony, I pointed out the various safeguards against fraud and abuse already built into existing law and regulations. The HMO Act itself, as well as Title 18 and Title 19 place explicit requirements on HMOs with regard to financial solvency, grievance

procedures, and quality assurance.

In addition, as you are aware, the HMO industry has been involved in discussions over the past several months with officials of the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration (HCFA) in developing criteria for peer review of the quality of inpatient and outpatient services provided by HMOs and competitive medical plans (CMPs) under Medicare contracts. A final report has recently been presented to HQSB officials by an Ad Hoc Committee representing GHAA, the American Medical Care and Review Association (AMCRA), and the American Medical Peer Review Association (AMPRA) recommending ways to implement a cost effective quality review process. One of the recommendations in the report is an automatic review of patient charts under 15 admission diagnoses that have a significant potential for revealing possible inappropriate management of outpatient care, including underservice and poor access. We believe this is the first organized wide-scale attempt to review the quality of ambulatory services for any patient population. The Committee also recommends specific criteria directed toward evaluation of institutional patient management.

We expect that this peer review process which HCFA intends to implement by October 1, 1985, will result in an effective quality assurance system for HMOs and CMPs under Medicare contracts. It should go a long way toward allaying some of the fears underlying the legislation we are discussing here today.

Nonetheless, it appears that there is strong support in Congress for further protection against possible underservice of Medicare and Medicaid patients by HMOs. GHAA has been concerned about the broad implications of the language of the provision pertaining to HMOs in H.R. 1868 and S. 837. S. 837 states that an HMO is subject to the sanctions and penalties of the bill if it has "failed in a substantial number of cases" to provide medically necessary items and services. H.R. 1868 provides that if the entity has "failed substantially" to provide required services and "if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals," it may be subjected to exclusion from participation in Medicare and Medicaid programs.

We were concerned that the language of these bills might result in the imposition of sanctions based on single instances of underutilization. However, the Report of the House Ways and Means and Energy and Commerce Committees accompanying H.R. 1868 alleviates many of our concerns. The Report notes that the

intent of these provisions is "to deal with serious failures to abide by acceptable standards of medical practice, rather than isolated cases of inadvertent omissions." The Report further states that "the committee intends for the Secretary to examine whether there was a deliberate omission or pattern of failing to provide necessary items and services, the seriousness of the effect on or risk to patients, and the reasons or circumstances involved." These guidelines make the critical distinction between unintended omissions of care and a pattern of underservice or a deliberate disregard for medical needs. In our opinion, this is the proper approach to achieving the stated goals of the legislation.

The Report also provides that the practice standards upon which determinations about the necessity of medical services would be based would be those generally accepted as HMO practice standards. These standards would be developed by physicians involved with prepaid group practice, other HMOs and CMPs, or standards used by state agencies that have contracts with HMOs. We wholeheartedly agree that delivery of care by an HMO should be judged in the context of standards by which HMOs operate. As you know, Mr. Chairman, the prepaid group practice system differs in

many ways from the fee-for-service system. For example, we emphasize preventive care and early access to treatment which result in fewer and shorter hospitalizations, with more procedures performed on an outpatient basis. Thus, it is necessary that utilization standards for HMOs be developed by those familiar with prepaid group practice.

GHAA supports the House Committees' intent as defined in the Report language of H.R. 1868 and urge that the same concepts continue to be embodied in any comprehensive piece of legislation developed by this Committee.

Mr. Chairman, GHAA appreciates the opportunity to comment on these legislative proposals. We commend their sponsors and the members of this subcommittee for their efforts to ensure that the elderly and needy receive appropriate and adequate medical care from competent and honest providers. We look forward to working with you and your staff in this endeavor.

STATEMENT BY RUSSEL HEEREN, MEMBER, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, WASHINGTON, DC

Mr. HEEREN. Thank you, Mr. Chairman, for this opportunity to share with the subcommittee the American Association of Retired Persons [AARP] views on the Medicare and Medicaid Patient and Program Protection Act of 1985.

My name is Russel Heeren, and I am a member of the Association's National Legislative Council, which is responsible for AARP's Federal and State legislative policy. AARP is the Nation's largest organization of older citizens, representing more than 19 millions members over the age of 50

Senator DURENBERGER. Including me. Did you know that?

Mr. HEEREN. With me is Ms. Chris McEntee, a member of the AARP legislative staff.

I have five brief statements.

AARP supports the major thrust of H.R. 1868, S. 837, and S. 1323. By expanding the exclusion authority of the Secretary of Health and Human Services, particularly the authority to bar Medicare and Medicaid participation based upon disciplinary actions of State licensing boards, all three bills provide Medicare and Medicaid beneficiaries with improved protection against the delivery of substandard health care.

A critical element of today's so-called crisis in medical malpractice is the mitigation of actual occurrences of malpractice which result from the delivery of substandard care. By strengthening the ability of the Secretary to prevent the provision of care by incompetent and/or unlicensed practitioners, these three bills are important steps in mitigating actual occurrences of medical malpractice. In addition, AARP favors the provision in H.R. 1868, which imposes penalties on providers who submit Medicare and Medicaid claims by unlicensed or falsely-licensed physicians.

All three bills under discussion could be made more effective if the license revocation of a provider were a mandatory exclusion from Medicare and Medicaid participation rather than a permissive exclusion. AARP cannot envision a situation where a provider whose license has been revoked by a State licensing authority shoud be allowed to continue participation in either Medicare or Medicaid.

AARP urges a strong provision for public disclosure of providers excluded from participation in Medicare and Medicaid, and providers subject to adverse actions taken by State licensing authorities. The public has a right to know the competence of providers from whom they receive health care services. So that information on providers is located in one place and available to licensing boards and similar entities, Peer Review Organizations should be also be required to report to the Secretary their provider-specific information that bears on the issue of competence, fraud, and abuse.

AARP does believe that certain features of S. 837 and H.R. 1868 are preferable to those contained in S. 1323. These include the applicaton of the same sanctions and penalties to all federally funded health programs and the mandatory exclusion for conviction of crimes related to patient abuse and neglect.

Thank you very much
Senator DURENBERGER. Thank you very much
[Mr. Heeren's written testimony follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

before the

UNITED STATES SENATE

SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE

on

H.R. 1869 and S. 837, THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985

and

S. 1323, THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985

July 12, 1985

Presented by:
Russel Heeren
National Legislative Council

SUMMARY STATEMENT
on
H.R. 1868 and S. 837, THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985
and
S. 1323, THE HEALTH CARE FINANCING FRAUD AND ABUSE AMENDMENTS OF 1985
before the
UNITED STATES SENATE
SUBCOMMITTEE ON HEALTH, COMMITTEE ON FINANCE

July 12, 1985

1. AARP supports the major thrust of H.R. 1868, S. 837 and S. 1323. By expanding the exclusion authority of the Secretary of Health and Human Services, particularly the authority to bar Medicare and Medicaid participation based upon disciplinary actions of state licensing boards, all three bills provide Medicare and Medicaid beneficiaries with improved protection against the delivery of substandard health care.

2. A critical element of today's so-called "crisis" in medical malpractice is the mitigation of actual occurrences of malpractice which result from the delivery of substandard care. By strengthening the ability of the Secretary to prevent the provision of care by incompetent and/or unlicensed practitioners, these three bills are important steps in mitigating actual occurrences of medical malpractice. In addition, AARP favors the provision H.R. 1868 which imposes penalties on providers who submit Medicare and Medicaid claims by unlicensed or falsely licensed physicians.

3. All three bills under discussion could be made more effective if the license revocation of a provider were a mandatory exclusion from Medicare and Medicaid participation rather than a permissive exclusion. AARP cannot envision a situation where a provider whose license has been revoked by a state licensing authority should be allowed to continue participation in either Medicare or Medicaid.

4. AARP urges a strong provision for public disclosure of providers excluded from participation in Medicare and Medicaid and providers subject to alverse actions taken by state licensing authorities. The public has the right to know the competence of providers from whom they receive health care services. So that information on providers is located in one place and available to licensing boards and similar entities, Peer Review Organizations should also be required to report to the Secretary their provider specific information that bears on the issue of competence, fraud, and abuse.

5. AARP does believe that certain features of S. 837 and H.R. 1868 are preferable to those contained in S. 1323. These include: the application of the same sanctions and penalties to all federally-funded health programs and the mandatory exclusion for conviction of crimes related to patient abuse and neglect.

Thank you, Mr. Chairman, for this opportunity to share with the Subcommittee the American Association of Retired Persons' (AARP) views on The Medicare and Medicaid Patient and Program Protection Act of 1985, H.R. 1868 and S. 837, and The Health Care Financing Fraud and Abuse Amendments of 1985, S. 1323. My name is Russel Heeren and I am a member of the Association's National Legislative Council, which is responsible for AARP's federal and state legislative policy. AARP is the nation's largest organization of older citizens, representing more than 19 million members over the age of 50.

AARP supports the major thrust of all three bills under discussion today. All three bills expand the exclusion authority of the Secretary of Health and Human Services to bar providers from treating Medicare and Medicaid patients when these providers are convicted of certain criminal acts, engage in fraud and abuse, or provide incompetent care. In addition, the proposed pieces of legislation grant the Secretary the ability to bar practitioners from Medicare and Medicaid participation based upon the disciplinary action of state licensing boards. Thus, all three bills provide Medicare and Medicaid beneficiaries with improved protection against the delivery of substandard health care.

By strengthening the ability of the Secretary to prevent the provision of care by incompetent and/or unlicensed practitioners, these bills are important steps in mitigating actual occurrences of medical malpractice. There is much talk today of the so-called "crisis" in medical malpractice. AARP has long been concerned that the issue of medical malpractice litigation is eclipsing the critical element of the malpractice problem, i.e. the actual occurrences of

malpractice which result from the delivery of substandard care. AARP supports efforts by the government, and the medical profession to more agressively identify and deal with the incompetent practitioners that account for a disproportionate share of malpractice problems. Towards this end, AARP supports procedures for corrective action (sanctioning, license revocation, etc.) such as those contained in these bills in those instances where providers are responsible for incompetent and/or negligent care. In addition, AARP favors the provisions in H.R. 1868, but not included in S. 837 and S. 1323, which impose penalties on providers who submit claims for the care of Medicare and Medicaid patients by unlicensed or falsely licensed physicians.

AARP does believe that two additional steps would greatly enhance patient protections already incorporated into all three bills. First, AARP recommends that licnese revocation of a provider be a mandatory exclusion from Medicare and Medicaid participation rather than a discretionary exclusion. AARP cannot envision a situation where a provider whose license has been revoked by a state licensing authority should be allowed to continue participation in either Medicare or Medicaid.

Second, AARP urges a strong provision for public disclosure of providers excluded from participation in Medicare and Medicaid and providers subject to adverse actions taken by state licensing authorities. The public has the right to know the competence of providers from whom they receive health care services. A provision for public disclosure would be an important first step in assisting consumers in the choice of competent and licensed providers. Moreover, these bills should serve as the impetus for a clearinghouse of provider

specific information under the Secretary. In order to close the circle so that information on providers is located in one place and available to licensing boards and other similar entities, AARP urges that the Peer Review Organizations also be required to report to the Secretary their provider specific information that bears on the issues of competence, fraud, and abuse.

In addition to recommending the two provisions outlined above for inclusion in all three bills, AARP does believe that certain features of S. 837 and H.R. 1968 are preferable to those contained in S. 1323. Unlike S. 1323, S. 837 and H.R. 1968 apply the same sanctions and penalties to all federally-funded health programs -- Titles V, XVIII, XIX, and XX. AARP supports application of similar provisions against fraud, abuse, and incompetent care across all federally-funded health programs. Uniformity in application prevents fragmentation and improves data collection about potential abuses in federal health care programs. S. 837 and H.R. 1968 also include a mandatory exclusion for conviction of crimes related to patient abuse or neglect. AARP supports a mandatory exclusion for this purpose. This provision strengthens the ability of the Secretary to protect the beneficiaries of federal health programs against incompetent or substandard care, thereby expanding the patient protections included in the legislation.

Assuring high quality medicine requires constant attention to quality of care mechanisms so that quality is maintained before the fact, not after it. AARP believes that improvements contained in the three bills under discussion today would better assure that only qualified practitioners treat Medicare and Medicaid beneficiaries. AARP looks forward to working with the Congress on this and other measures to ensure that quality of care is not compromised as the costs of care are controlled.

Senator DURENBERGER. All of the statements will be made a part of the record.

Dr. Rogers, you testimony calls for deleting the minimum 5-year exclusion because the penalty should be tailored to fit the offense. To what extent do you believe a minimum period of exclusion should be retained for its deterrent effect.

Dr. ROGERS. Well, it is our position that this is a function of the Secretary's job, and that the Secretary should have the prerogative of deciding whether exclusion is going to be 1 year or 5 years, or as has been earlier testified, forever.

Senator DURENBERGER. What language would you suggest to clarify the provision to sanction individuals for holding themselves out as board-certified specialists?

Dr. ROGERS. Well, we think there are several problems associated with the consideration of board certification. I am sure the chairman is aware of the many, many board certification programs available to practitioners of health care throughout this country, varying from very minimal hip-pocket type operations to the best ones we have in the country. We feel that dependence on board certification per se, would be unwise and would be a disservice to the patients.

Senator DURENBERGER. I understand the AMA is currently using its physician master file to alert medical licensure boards in all States when a physician has had a license suspended or revoked for cause in another State. Is that true?

Dr. ROGERS. Yes, sir, that is true. And as I pointed out in my statement, we have about 40 alerts a month that are going out to the States, and we think this is a tremendous step forward in the making available information from one State to another regarding the sanctioning of a doctor—something that hasn't been possible in the past.

Senator DURENBERGER. What kind of information goes out with the alert? And do you make any request of the receiving State licensing body to make any investigation or take any action, or give you any particular feedback?

Dr. ROGERS. Yes. We will normally get feedback that same month from that State licensure board to whom we give information. But what we are doing is providing them with the information that the doctor's license has been lifted in other States. Say, if my license was lifted in Georgia and I went to South Carolina to practice, the AMA would notify South Carolina that my license had been lifted in Georgia. And there is no other direct way for that information to be communicated to South Carolina. The State licensure boards do, through their national organization, have that information available, but the State has got to go and dig it out. The AMA is making it available in every case where we know, by virtue of our master file, of where that doctor has licenses to practice in this country. And we let all those States know that he has had his license lifted in, say, Georgia.

Senator DURENBERGER. You heard my question earlier about what may be competence, conduct, or integrity in one State may not be in another State. Is it possible for a physician to lose his license in one State for some reason under one of those categories that wouldn't be adjudged the same reason in another State?

Dr. ROGERS. Well, the best example I can think of, Senator, would be the States that require continuing medical education [CME] for continued licensure. If, for instance, someone had his license lifted to meet the CME requirement and went to a State that did not have that as a requirement, he could in fact get a license in that State. And I do not believe that that would be reason to separate him from the Federal programs.

Senator DURENBERGER. Dr. Rosenberg, I take it the latter part of your testimony, which related to some of the questions I had earlier about the amendment to H.R. 1868 and also the provisions of the Roth bill on this side relative to HMO's, prepaid and so forth, the way I heard you, you said that report language was satisfactory to eliminate most if not all of your concerns. Is that a correct statament of your view?

Dr. ROSENBERG. Yes, sir.

Senator DURENBERGER. And then Tom Morford indicated, too, that I take it HCFA has the responsibility in many cases for trying to expand choice of a variety of plans both in Medicaid and Medicare, and if they think it is a good idea to work that in, then I just want to know if you have any concerns or not about the particular provision.

Dr. ROSENBERG. No, no other concerns. We would like to make sure that the report language is stressed when you mark up. No other concern.

Senator DURENBERGER. OK.

Mr. Heeren, your testimony calls for public disclosure of providers excluded from participation. Would you elaborate on how that might be done and why it is necessary?

Mr. HEEREN. Well, AARP not only represents seniors, but we represent all types of people from the kindergarten to the grave. And we want everyone to be aware of any practitioner who would not be able to practice in that State or transfer to another State. I think that could be done through the licensing board of each State quite easily.

Senator DURENBERGER. Your testimony urges that PRO's be required to—and I will quote your testimony—"report provider-specific information that bears on issues of competence, fraud, and abuse" to the Secretary. What kind of information do you have in mind, and how would you expect that it would be used after it has been reported?

Mr. HEEREN. Well, I imagine each State would have that material from the Peer Review Boards. And therefore, they could make the judgment on what material is received bears on whether the doctor is competent or not. I think that is part of what the Peer Review Boards are set up for, to make judgments about adequacy of care when they do the peer reviews, and then sending it on to the State person in charge at the top. That then could be reported throughout the State or to other States, as I understand it.

Senator DURENBERGER. Well, gentlemen and women, thank you very much for your testimony. I appreciate it a lot. The hearing is adjourned.

[Whereupon, at 4:26 p.m., the hearing was concluded.]

[By direction of the chairman the following communications were made a part of the hearing record:]

ahca
American Health Care Association 1200 15th Street, NW, Washington, DC 20005 (202) 833-2050

STATEMENT ON

MEDICARE-MEDICAID ANTI-FRAUD AND ABUSE BILLS

TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
U.S. SENATE

JULY 12, 1985

The American Health Care Association, representing approximately 8,500 nursing homes and allied long term health care providers, appreciates this opportunity to testify about the House-passed Medicare and Medicaid Patient and Program Protection Act (H.R. 1868), the Patient and Program Protection Act for Medicare and Medicaid (S. 837), and the Health Care Financing Fraud and Abuse Amendments (S. 1323).

To simplify analysis of the three bills, we used the House-passed bill, H.R. 1868, as the basis for our comparison and our recommendations.

AHCA supports efforts to deter, identify and sanction fraud and abuse of public funds; to protect beneficiaries from unfit providers and practitioners; and to clarify and integrate existing related provisions of the Social Security Act. However, we are concerned with several broad provisions of H.R. 1868 that give the HHS Secretary new discretionary powers to exclude providers from the Medicare and Medicaid programs without sufficient due process. Our concern is not with the intended exercise of the powers, but the opportunities for them to be used in unintended ways.

The presentation of our recommendations will first focus on some of the provisions of S. 1323 that would improve the less precise or objectionable provisions of H.R. 1868. The following provisions of H.R. 1868 would benefit from some S. 1323 language (**boldfaced** language is from S. 1323 for inclusion and underlined language is from H.R. 1868 for exclusion):

1. Section 2 -- Amendment of Section 1128(b)(5) Permissive exclusion; Exclusion from federal health care program

It would be excessive to penalize a provider more severely by Medicare and Medicaid exclusion for a lesser penalized situation in a federal or state health program. Would a health care provider

that is "sanctioned" under the Department of Health and Human Services "intermediate sanctions" regulations face possible exclusion? That would be ironic since the regulation was designed specifically to provide a lesser alternative to closing down a facility when there is a violation of federal conditions of Medicare and Medicaid participation. Further, some states impose "sanctions" or fines for minor violations related to licensure. In our view the definition of sanction is so unclear as to place individuals in jeopardy of exclusion when the penalty itself was designed to encourage improvement and continued program participation.

It is also important that the exclusion be related to professional competence, professional performance or financial integrity. Since providers can be excluded from many federal programs on unrelated grounds, such as not meeting statutory labor requirements (e.g., Veterans Administration contracts for community nursing home services having to comply with the Service Contract Act), it does not appear reasonable to exclude providers not meeting such requirements from Medicare and Medicaid, which have no such requirements.

We recommend the following modification from (b)(4) in Section 3 of S.1323:

> "Any individual or entity which has been suspended or excluded from participation, or otherwise sanctioned, for reasons bearing on professional competence, professional performance, or financial integrity, under any Federal program..."

2. Section 2 -- Amendment of Section 1128(b)(7) Permissive exclusion; Fraud, kickbacks, and other prohibited activities

We believe that these activities are already covered in in (b)(1). However, if this paragraph is retained, language from S. 1323 should be included which specifies a proceeding to determine culpability. A proceeding is particularly necessary for acts addressed in the new Section 1128B, since this section identifies criminal acts.

We recommend the following modification from (b)(5) in Section 3 of S.1323:

> "...that the Secretary determines (whether in a proceeding under this section or a proceeding combined with a proceeding under section 1128A) has committed an act which is described in subject to civil penalties under section..."

3. Section 3(f) -- Amendment of Section 1128A Civil monetary penalties: Application of subpoena power and injunctive powers

We do not believe this section is necessary. The federal government already has the power under existing law to seek to enjoin improper or illegal actions which could be subject to a civil monetary penalty.

If this section is to be retained, we have two objections to the H.R. 1868 provision.

First, we do not believe it is legally justifiable or sustainable "to enjoin such activity" by a person whom the Secretary "has reason to believe" is "about to engage in any activity which makes the person subject to a civil money penalty." Before requesting an injunction, the Secretary should have reason to believe that the individual has or is acting impermissibly. Situations in which it would be possible to prove that a person is "about to engage" in impermissible activity, existing law would already apply.

Second, the process of going to U.S. district court for such an injuction should be handled by the Attorney General, not the Secretary.

Therefore, we recommend the following modification from Section 3(f) of S.1323:

> "Whenever the Secretary has reason to believe that any person has engaged, or is engaging, or is about to engage in any activity which makes the person subject to a civil monetary penalty under this section, the Attorney General, at the request of the Secretary may bring an action in an appropriate district court..."

Our recommendations will now focus on modifications to H.R. 1868 that would correct remaining problems.

4. Section 2 -- Amendment of Section 1128(b) Permissive exclusion

We have a basic concern that final determination of wrongdoing should be required before the major penalty of exclusion from Medicare and Medicaid can be imposed. In some parts of 1128(b), the basis for exclusion is such that the final decision of an administrative or judicial body is required before the Secretary can exclude a provider from Medicare and Medicaid. For example, a conviction is required in paragraphs (1), (2), and (3).

However, in situatio s in which the Secretary's determination of wrongdoing would be the basis for exclusion, the requirement of a final decision is not always clear. Fairness and due process

considerations should require a final legally sustainable decision that a provider has acted improperly or failed to act properly. Notably, paragraphs (4), (6), (9), (10), and (11) raise questions of fact which should be resolved before the imposition of penalties. Actions described in these paragraphs are not so serious or dangerous to patients that exclusion, resulting in mandatory plans for patient transfer, is required prior to a final determination as to wrongdoing. We specifically recommend a final determination by the state authority for (4) "license revocation or suspension", and hearings for the other situations.

In addition, discretionary authority for the Secretary to excluded providers should be statutorily permitted only when reasonable analysis indicates that there is reliable and credible evidence to support a provider's suspension. The Secretary's extra-judicial powers should not permit less than judicial findings.

Other concerns about paragraphs of Section 1128(b) are the following:

- Paragraph (8): Entities controlled by a sanctioned individual

  We believe the entity should be given time to remove a sanctioned individual from office before imposing exclusion. It does not appear reasonable to exclude an entity, that may have, itself, been damaged by wrongdoing of the sanctioned individual.

- Paragraph (12): Failure to grant immediate access

  We are concerned that permitting the Secretary to exclude a provider who fails to provide "immediate access" to investigators could have a chilling effect upon providers' exercise of their rights, especially where possibility of criminal investigation exists (e.g., access by the HHS Inspector General or state Medicaid fraud units under subparagraphs (C) and (D)). "Immediate access, upon reasonable request" should be defined to mean access by a time specified upon sufficient and appropriate notice, allow reasonable opportunity to consult with counsel, and meet a probable cause standard.

5. Section 2 -- Amendment of Section 1128(f) Notice, hearing and judicial review

If Section 1128(b) is changed so as to require final decisions prior to suspension, as we suggested above, this hearing process is reasonable. If, however, it is contemplated that the hearing process under this section would also include making final determinations as to improper actions of providers, we believe that a hearing prior to suspension is required.

6. Section 5(b) -- Amendment of Section 1919(a)(1) Information reporting system

States should be required to have a system to prevent release of information other than as authorized in this section, in addition to the confidentiality provision applicable to the Secretary in Section 1919(c).

We appreciate the consideration of our recommendations.

3512.14

STATEMENT OF NEIL F. HARTIGAN

ATTORNEY GENERAL -- STATE OF ILLINOIS

IN SUPPORT OF S.837 AND H.R. 1868

"THE MEDICARE AND MEDICAID PATIENT AND PROGRAM PROTECTION ACT OF 1985"

I am pleased to have this opportunity to express my thoughts regarding Senate Bill 837 and House Bill 1868, **"The Medicare and Medicaid Patient and Program Protection Act of 1985."** This legislation is intended to reduce fraud and abuse in the Medicare and Medicaid programs as well as provide increased protection to patients from practitioners and providers who have a history of abuse and neglect in the rendering of medical services to the elderly and less fortunate of this country.

The Medicare and Medicaid programs have been in existence for twenty years. These programs were developed to meet the basic medical needs of the elderly and poor. It is incredulous that twenty years have elapsed and adequate safeguards have not been developed to assure taxpayers that swift retribution will be the result of financial abuse perpetrated by unscrupulous practitioners and institutional providers. If a physician or nursing home owner abuses requirements of the Medicaid program in Illinois, it is likely that this type of individual will continue this practice in another state, or if given the opportunity, will continue the practice in another government financed program.

What is more appalling is the lack of enforcement efforts in the area of patient abuse or neglect. The Illinois General Assembly passed legislation in 1984 which increased the penalties for nursing home patient abuse or neglect. (Illinois Senate Bill 1935 amended the 1979 Nursing Home Care Reform Act.) Your legislation would provide the capability of excluding these same individuals from the Medicare program if found guilty of abuse (class 3 felony) or gross neglect (class 4 felony). Physicians, hospitals and nursing homes have a professional responsibility to render acceptable care to all patients regardless of their payment source. If this does not occur, severe sanctions should be imposed upon these individuals. They should be barred from participation in any government financed health care program.

Much of the neglect of elderly patients in nursing homes emanates from physicians who have contracts with nursing homes but rarely visit Medicare or Medicaid patients. These individuals continue to bill the government for services never rendered. The physicians have profited immensely from Medicare and Medicaid payments. They have received little or no retribution for the lack of medical care rendered to the elderly.

All too often, state enforcement agencies do not adequately enforce this problem. I recommend that your committee consider additional provisions or supplemental legislation which would require states to vigorously pursue this type of negligence. A state's receipt of federal funds for government health financed programs should be contingent upon an acceptable level of performance of state licensing agencies. In order to implement this

recommendation, it may be necessary for additional appropriations to be earmarked to regional Health and Human Services offices. These offices are already mandated to conduct "look behind" surveys. However, over recent years, reductions in federal budget allocations have necessitated a curtailment in oversight activities. The net result has been an increase in neglect and abuse of elderly patients.

As Attorney General of the State of Illinois, I have organized a Nursing Home Strike Force unit to ferret out individuals who are suspected of abuse and neglect of nursing home patients as well as the physicians who fail to appropriately treat these elderly patients. These efforts present only a beginning to resolving this serious problem. Your legislation will contribute to this effort.

Specific recommendations regarding the **Medicare and Medicaid Program Protection Act** include the following:

Recommendation #1

H.R. 1868 Section 2, (c) (3) (B) and S. 837 Section 2 (c) (2) (A) should be revised to require a mandatory exclusion for five years for any individual or entity that has been convicted under Federal or State law of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service. As the legislation is currently drafted, only Section (a) (1), "Conviction of program-related crimes," would receive a minimum period of exclusion not less than five years. We recommend by adding the reference "(B) In the case of

an exclusion under subsection (a) (1), and (a) (2) this oversight can be corrected and the provision improved.

Recommendation #2.

H.R. 1868 Section 2 (c) (2) (B) (i) and S.837, Section 2 (c) (2) (A), should be amended to reflect the need to exclude institutional providers guilty of abuse or neglect of patients from receipt of Medicare or Medicaid funds for residents already residing in a facility after a reasonable time has been established for the orderly transfer of these individuals to a more qualified facility. H.R. 1868 allows for the Secretary to determine on a case by case basis whether or not the health and safety of the individuals is in jeopardy. It would appear that this method would be time consuming and less effective than a mandatory exclusion. It does not seem logical that an individual guilty of patient abuse or neglect should continue to receive government funds for patients already admitted to a facility. Barring physicians or providers from receiving future payments in the form of new admissions to a facility does not go far enough for a crime of abuse or neglect. Surely, our main priority should be the health and safety of all patients. The patient suffers from this oversight in the legislation. We recommend that language be included in this bill which would allow for the orderly transfer of these patients to nursing homes which are qualified to render care. Perhaps payment could be granted for sixty days prior to termination from program benefits.

Recommendation #3

There should be a central registry easily accessible for state licensing agencies or state law enforcement agencies to obtain information relating to individuals or corporate entities which have been barred participation in either the Medicare or Medicaid programs. This mechanism would ensure the availability of information for all interested parties.

I want to express my appreciation for this opportunity to offer input into this important legislation. I would like to offer the expertise of my prosecutors to your staff if additional information or assistance is needed in the development of more viable enforcement tools