BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Secretary Of Health And Human Services

Expanded Federal Authority Needed To Protect Medicare And Medicaid Patients From Health Practitioners Who Lose Their Licenses

Medicare and Medicaid patients are being treated in some states by health practitioners whose licenses were revoked or suspended by another state's licensing board because they did not meet minimum professional standards. This occurs because practitioners move to another state where they have a license and continue to practice. Such practitioners are able to treat Medicare and Medicaid patients because HHS does not have the authority to exclude them from these programs based on state licensing board findings and actions. This raises questions about the quality of care provided to patients using these programs.

Overall, GAO identified several gaps in HHS' exclusion authority which can result in, among other things, practitioners who are excluded from either Medicare or Medicaid continuing to participate in the other program or practitioners who lose their licenses to practice in one state relocating to another state and participating in the programs. HHS plans to seek legislation to close some of the gaps, but HHS still would not have authority to exclude practitioners nationwide when they lose their license because of a state board's actions. GAO believes that HHS could better ensure that federal beneficiaries receive services only from qualified practitioners if it obtains the expanded exclusion authority.

GAO/HRD-84-53
MAY 1, 1984

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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-214207

The Honorable Margaret M. Heckler
The Secretary of Health and
Human Services

Dear Madam Secretary:

The Social Security Act gives you the authority to exclude from participation in Medicare and Medicaid practitioners who submit false claims, provide excessive services, or are convicted of fraud against the programs. This report discusses practitioners who have their licenses revoked or suspended by one state licensing board but relocate to another state where they hold a license and participate in Medicare and Medicaid.

You currently do not have authority to exclude nationally from participation in Medicare or Medicaid practitioners based solely on the fact they lose their licenses in a state. HHS plans to submit a legislative proposal to close gaps (which are also discussed in this report) in your authority to exclude practitioners from participation in Medicare and Medicaid. We are recommending that you expand the proposed legislation to cover practitioners who have their licenses revoked or suspended by state licensing boards. We are also recommending that the information system on sanctioned practitioners that you are developing include information on practitioners sanctioned by state licensing boards.

As you know, 31 U.S.C. 720 requires the head of a federal agency to submit a written statement on actions taken on our recommendations to the Senate Committee on Governmental Affairs and the House Committee on Government Operations not later than 60 days after the date of the report. A statement is also to be submitted to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

Copies of this report are being sent to the above-mentioned Committees, the Senate Committee on Finance, the House Committee on Ways and Means, and the House Committee on Energy and Commerce; the Director, Office of Management and Budget; your Inspector General; the Administrator, Health Care Financing Administration; and other interested parties.

Sincerely yours,

Richard L. Fogel
Director

GENERAL ACCOUNTING OFFICE
REPORT TO THE SECRETARY OF
HEALTH AND HUMAN SERVICES

EXPANDED FEDERAL AUTHORITY NEEDED TO PROTECT MEDICARE AND MEDICAID PATIENTS FROM HEALTH PRACTITIONERS WHO LOSE THEIR LICENSES

D I G E S T

While reviewing how the Medicare and Medicaid programs operate, GAO noted that it was possible for a health practitioner, who held licenses in more than one state, to have one of these licenses suspended or revoked by a state licensing board but relocate and continue to treat Medicare and Medicaid patients. Thus, in these instances, federal beneficiaries would not be protected against practitioners determined by a state licensing board to be unfit to provide care.

To determine whether practitioners did relocate to another state and practice after having their licenses suspended or revoked, GAO reviewed practitioners who surrendered their licenses or had them suspended or revoked in Michigan, Ohio, or Pennsylvania. These practitioners held licenses in a total of 40 jurisdictions. Licensing boards in all these jurisdictions were contacted to obtain information for this report.

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

Although the specific procedures vary somewhat from state to state, the sanctioning process generally proceeds as follows. The state licensing board becomes aware of a possible problem with a practitioner. The board conducts an investigation and notifies the practitioner of the findings. The practitioner is informed of potential actions and of his or her right to a hearing. If the board decides to suspend or revoke the practitioner's license, he or she has the right to appeal the decision administratively and/or through the courts. (See pp. 2 and 3.)

REASONS WHY PRACTITIONERS WERE SANCTIONED BY STATES

GAO obtained information for the period January 1977 through December 1982 on six types of practitioners--medical doctors, osteopathic doctors, dentists, chiropractors, podiatrists, and pharmacists--who had their licenses revoked or suspended for a year or more by Michigan, Ohio, or Pennsylvania. (See p. 4.) GAO identified 328 practitioners in these categories--144 medical doctors, 37 osteopathic doctors, 33 dentists, 10 chiropractors, 5 podiatrists, and 99 pharmacists. (See p. 22.) The following table summarizes the reasons they were sanctioned.

Categories	Number	Percent
Actions affecting the quality of care provided, such as malpractice, alcohol and drug abuse, and immoral conduct	189	58
Drug trafficking, drug sales, or violation of the controlled substance act	75	23
Criminal act or private insurance fraud	29	9
Submitting false Medicare or Medicaid claims	28	8
Other	7	2
Total	328	100

The problems that caused these practitioners to be sanctioned are serious and must be dealt with to protect patients. The reasons for sanctioning in the three states reviewed by GAO are similar to those for all states. For example, information for 1979-82 reported by state boards to the Federation of State Medical Boards showed that 1,388 doctors were sanctioned and that the reasons for action were similar to those shown in the table for Michigan, Ohio, and Pennsylvania. It is important to note, however, that these doctors represent only a very small percentage of the nation's physicians. For example, only about 1 of every 1,000 physicians lost their license for disciplinary reasons in 1982. (See pp. 7 and 8.)

SANCTIONED PRACTITIONERS RELOCATED AND PARTICIPATED IN MEDICARE AND MEDICAID

Of the 328 sanctioned practitioners GAO reviewed, 122 held licenses in at least one state besides the state taking action against them. In total, these practitioners held licenses in 39 states and the District of Columbia. Of these 122 practitioners, 39 relocated and enrolled in the Medicare and/or Medicaid programs, 10 relocated but GAO identified no Medicare or Medicaid participation, and 43 could have relocated because they still held licenses in other states but GAO could not determine their whereabouts. (See pp. 8 and 9.) A few examples of sanctioned providers who relocated and participated in Medicare and/or Medicaid follow.

An osteopathic doctor was licensed in Michigan in 1949 and also obtained licenses in 13 other states. In March 1951 he was convicted of unlawfully selling drugs in Michigan and did not renew his Michigan license but continued to practice elsewhere. In 1964 he was convicted of illegal drug sales in Texas, and many states began taking sanction actions against him. He again obtained a Michigan license in January 1972. In 1982, he was convicted of illegal drug sales for the third time and sentenced to 10 years in prison. Over the years, he worked under a Public Health Service grant, at the Veterans Administration, and as part of a group practice in Michigan serving Medicaid patients. (See pp. 12 and 13.)

In another case, a medical doctor was found to be mentally impaired and unfit to practice medicine by the Michigan Medical Board in June 1978. He surrendered his Ohio license in the same year but moved to New York and received Medicare and Medicaid payments. In April 1982, New York revoked his license for gross incompetence based on another state's action. (See pp. 9 and 10.)

GAO asked the state licensing boards in 40 jurisdictions why they did not sanction practitioners sanctioned by other states or why it took so long to act. The replies can be summarized as follows:

--The state licensing board was not informed or was not informed in a timely manner of the other state's action.

--The state licensing board did not have sufficient staff to handle the number of cases involved.

--State licensing law did not permit taking sanctioning action based on another state's action.

--Due process requirements stretched out the sanctioning process.

--A combination of two or more of the above reasons resulted in the lack of or delay in action. (See pp. 14 to 16.)

GAPS IN HHS' CURRENT MEDICARE AND MEDICAID EXCLUSION AUTHORITY

Under Medicare and Medicaid law, HHS can exclude practitioners from participation in these programs only for acts committed against the programs or their beneficiaries. GAO's review of HHS' exclusion authority under Medicare and Medicaid showed four potential gaps:

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

private health care payment programs that choose to participate in the information system. However, HHS is not planning to include initially in this system practitioners sanctioned by state licensing boards. GAO believes that to be effective the system should include public information on all practitioners sanctioned by states because they committed acts or have problems that resulted in state licensing boards determining that these practitioners did not meet minimum professional standards. (See pp. 16 to 18.)

RECOMMENDATIONS

GAO recommends that the Secretary of HHS

--expand HHS' legislative proposal regarding exclusion of practitioners to fill the gaps in authority listed above and

--direct the HHS Inspector General to include in the information system on excluded providers all practitioners sanctioned by state licensing boards. (See pp. 20 and 21.)

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

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

--Practitioners convicted of crimes other than Medicare and Medicaid fraud can continue to practice under both programs. (See pp. 18 and 19.)

HHS' Office of Inspector General, which is responsible for carrying out the criminal and civil enforcement aspects of the Medicare and Medicaid programs at the federal level, agrees that these gaps exist. That Office plans to submit a legislative proposal during the spring of 1984 which would expand the current exclusion authority. As drafted on April 2, 1984, the proposal would not provide authority to exclude practitioners from the programs for being sanctioned by state licensing boards. Thus, this proposal is too limited to cover all of the situations discussed above. (See pp. 19 and 20.)

GAO believes that HHS could better protect Medicare and Medicaid beneficiaries from unqualified practitioners if it had authority to exclude practitioners in the situations noted above. If HHS could exclude nationally for an appropriate period of time a practitioner sanctioned by a state licensing board after reviewing that board's records, it would better assure that only qualified practitioners treat Medicare and Medicaid beneficiaries. (See p. 20.)

PROPOSED INFORMATION SYSTEM ON SANCTIONED AND EXCLUDED PRACTITIONERS TOO LIMITED

Through its Office of Inspector General, HHS is establishing an information reporting system which will include public information on practitioners who have been excluded from federal health care programs and from other public and

ABBREVIATIONS

GAO General Accounting Office

HHS Department of Health and Human Services

Contents

CHAPTER 1

INTRODUCTION

As part of our ongoing reviews of the Medicare and Medicaid programs, we reviewed whether practitioners who lose their licenses in one state relocate to another state and continue to practice under these two programs. We also analyzed the various authorities available to the Department of Health and Human Services (HHS) to exclude practitioners from Medicare and Medicaid. The programs were established by titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 and 1396), enacted on July 30, 1965, to help beneficiaries pay for health care services. Medicare is a federal program under which most people over age 65, and some of the disabled, are eligible to receive a wide range of health care services. Under Medicaid, the federal government shares with the states the costs of providing medical services to persons whose incomes and resources are insufficient to pay for health care.

During fiscal year 1983, Medicare covered about 29 million people and paid about $56 billion for services. State and federal Medicaid payments were about $35.3 billion on behalf of about 22 million recipients. The federal share amounted to about $19.5 billion.

MEDICARE AND MEDICAID PROGRAM ADMINISTRATION

HHS has responsibility at the federal level for administering Medicare and Medicaid. Within HHS, the Health Care Financing Administration is responsible for developing program policies, setting standards, and assuring compliance with federal legislation and regulations. The HHS Office of the Inspector General is responsible for carrying out the criminal and civil enforcement aspects of the Social Security Act as they relate to the Medicare and Medicaid programs.

Since the beginning of Medicare in 1965, section 1862(d) of the act has allowed the federal government to exclude practitioners from program participation for certain acts, as long as certain due process requirements are met. Practitioners can be excluded if HHS determines that they have (1) submitted fraudulent claims, (2) habitually overutilized or abused the Medicare program, or (3) failed to provide care of a quality meeting professionally recognized standards of health care. Other authority to exclude practitioners from Medicare and Medicaid has been granted to HHS over the years. Specifically, if a practitioner is convicted of fraud against Medicare or Medicaid, he or she must be

excluded from both programs, and if a civil monetary penalty is imposed on a practitioner for filing false claims against Medicare or Medicaid, he or she may be excluded from both programs.

Currently practitioners can be excluded as follows:

--A practitioner is convicted of a Medicare- or Medicaid-related crime, such as fraud. The practitioner must be excluded from both programs.

--A practitioner is not convicted of a program-related crime but is excluded from Medicare for other reasons, such as habitual overprovision of services. In this case he or she is excluded from participating in Medicare nationwide but can continue to participate in Medicaid.

--A practitioner is not convicted of a program-related crime but is excluded from Medicaid by a state for other reasons, such as filing false claims. In this case, the practitioner can continue participating in Medicaid in other states where he or she holds a license and can continue participating in Medicare in any state.

--A practitioner has his or her license revoked or suspended by the state licensing board. In this case the practitioner is precluded from practicing medicine or participating in Medicare or Medicaid in the state which took the sanction action. The practitioner, however, can practice medicine in any other state where he or she is licensed and can participate in both programs in those states.

Before excluding a practitioner for reasons other than conviction of a crime against Medicare or Medicaid, HHS investigates the practitioner, presents its findings and proposed action to the practitioner, and informs the practitioner of his or her right to a hearing. If HHS decides to exclude the practitioner, he or she can appeal the decision to the courts. Exclusion from Medicare and Medicaid is usually for a specified time period. Before a practitioner can be reinstated in Medicare, the act requires HHS to determine that there is reasonable certainty that program violation will not recur.

Role of state licensing boards

Each state has licensing boards to serve as its licensing authority. Because these boards determine who is qualified to practice in a state, they play an important role in the Medicare and Medicaid programs. Medicare's claims paying agents (called carriers) and state Medicaid agencies rely on the boards to let them know whether practitioners are licensed. The carriers and

state agencies rely on the boards to let them know when practitioners have their licenses revoked or suspended, so that their participation in the programs can be terminated.

Each board issues licenses to applicants who meet its educational requirements and pass an examination. Licenses in certain instances are also issued if an applicant has met the requirements of another state and is licensed there. This permits practitioners to obtain licenses in other states once they meet one state's requirements.

State laws also give the licensing boards the authority to suspend or revoke practitioners' licenses if they fail to meet minimum professional standards. Although the specific procedures vary somewhat from state to state, the sanction process generally proceeds as follows. The state licensing board becomes aware of a possible problem with a practitioner. The board conducts an investigation and notifies the practitioner of the findings. The practitioner is informed of potential actions against him or her and of his or her right to a hearing. If the board decides to suspend or revoke the practitioner's license, he or she has the right to appeal the decision administratively and/or through the courts.

If a state licensing board suspends or revokes a practitioner's license, it does not affect the practitioner's licenses in other states. Each state must take a separate action to prevent the practitioner from practicing in that state. The Federation of State Medical Boards provides a formal mechanism for communicating suspension and revocation actions to other states. The individual state boards for doctors report actions taken to the Federation, which disseminates them to other states. However, no formal communication mechanisms exist for the other types of practitioners we reviewed.

Role of Medicare carriers

The Health Care Financing Administration contracts with private and commercial insurance companies to act as "carriers" in the administration of benefits provided by practitioners under part B[1] of the Medicare program. The carriers' responsibilities include

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[1]Part B, or the Supplemental Medical Insurance Program, covers noninstitutional health services provided by physicians and other practitioners. Eligible individuals who enroll in this voluntary program pay monthly premiums that cover about 25 percent of the program's costs. The federal government provides the rest of the funding.

--determining through state licensing boards whether practitioners have a current license to practice in that state,

--determining that practitioners who have been excluded or suspended from the Medicare program by the HHS Office of Inspector General are not being paid for services provided after their exclusion or suspension date,

--forwarding cases of habitual overutilization or other abuse to the Office of Inspector General for exclusion from participation or other administrative action, and

--forwarding cases to the Office of Inspector General where practitioner fraud is suspected.

Role of state Medicaid agencies

The states are responsible for initiating and administering their Medicaid programs. The nature and scope of a state's Medicaid program are contained in a state plan which, after approval by HHS, provides the basis for federal grants to the state. States administer the program through a state agency or under contract with private organizations. They perform functions similar to those of the Medicare carriers. However, the state Medicaid agencies refer suspected fraud cases to the State Medicaid Fraud Control Unit or other prosecuting authorities and take action on their own against those who provide excessive or medically unnecessary services.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if practitioners whose licenses were revoked or suspended by one state, and thereby removed from the Medicare and Medicaid programs in that state, moved to other states and practiced in these two programs. We reviewed state licensing boards' records for medical doctors, osteopathic doctors, podiatrists, chiropractors, dentists, and pharmacists in Michigan, Ohio, and Pennsylvania. We determined how many practitioners from these professions had their licenses revoked or suspended for 1 year or more, or who surrendered their licenses for disciplinary reasons, during January 1, 1977, through December 31, 1982. We also determined in what other states these practitioners held licenses. We identified 39 states and the District of Columbia as places where additional licenses were held.

We asked licensing boards in these 40 jurisdictions the current status of those who surrendered their licenses or had them revoked or suspended in Michigan, Ohio, and Pennsylvania. We contacted the state Medicaid agencies and the Medicare carriers

in each jurisdiction to determine if these practitioners practiced under the Medicare and Medicaid programs after the initial sanctioning action against them. We also contacted the Railroad Retirement Board's carrier (Travelers Insurance) to determine if it made any Medicare payments to these practitioners. We asked the Veterans Administration, the armed services, and the Public Health Service if they had employed or currently employ any of these practitioners.

We discussed the process for providing information on sanctioned practitioners to state licensing boards with officials of the Federation of State Medical Boards, the Council of State Governments, various state licensing boards, and the HHS Office of Inspector General. We also reviewed legislation and implementing regulations for excluding practitioners from Medicare and Medicaid and supplying information to concerned parties. We discussed the impact of the legislation and implementing regulations on the exclusion process and the need for changes with Office of Inspector General and state officials. Our work was done in accordance with generally accepted government audit standards.

CHAPTER 2

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

Nationwide a relatively small number of disciplinary actions are imposed by individual states to protect their citizens from being treated by incompetent, unethical, and/or unqualified health care practitioners. In a review of licensing boards' disciplinary actions in Michigan, Ohio, and Pennsylvania, we identified 328 health care practitioners from six professions who were sanctioned over a 6-year period. The sanctions were suspensions, revocations, or surrenders of the practitioners' license to practice in the states. These sanctions were imposed when the practitioners could not meet minimum professional standards because they had problems--such as alcohol and drug abuse--or committed acts--such as malpractice, sexual offenses, or drug trafficking.

Of the 328 sanctioned practitioners, 122 had valid and current licenses in at least one other state at the time of their sanction. We found that of these 122 practitioners:

--39 relocated to other states shortly before or after their sanctions and enrolled to participate under the Medicare and/or Medicaid programs. Most (34) received funds for treating Medicare and/or Medicaid patients in these states. Eighteen of the 34 later had their licenses suspended in the states they moved to.

--10 relocated and could be treating Medicare and/or Medicaid patients in a hospital, clinic, or other institution but we could not determine where they were practicing.

--43 may have relocated but we could not determine their whereabouts.

--30 corrected their problems, retired, or died.

Given these situations, we believe serious questions arise concerning the quality of care provided by such practitioners to Medicare and Medicaid patients because there are no assurances that the problems that led to their sanction in one state were corrected before they began treating Medicare and Medicaid patients in other states.

STATE BOARDS SANCTION MORE PRACTITIONERS THAN HHS

State licensing boards, which are responsible for assuring that practitioners are qualified to treat patients, can sanction practitioners for their actions related to any patient. However, HHS is responsible only for practitioners' participation in Medicare and Medicaid and can exclude practitioners only for acts committed against these programs and their beneficiaries. Because of these differences, HHS excludes relatively few of those practitioners sanctioned by state boards. For example, while the licensing boards in Michigan, Ohio, and Pennsylvania sanctioned 328 practitioners in 1977-82, HHS nationwide excluded 335 practitioners from September 1975 through December 1982. Also, only 15 of the 328 practitioners sanctioned by the three states were also excluded by HHS.

Over 70 percent of the HHS actions were for criminal violations against the programs, as shown in the following table.

Categories	Number	Percent
Exclusions from November 1977 through December 1982 for conviction for program-related crimes	239	71
Exclusions from September 1975 through December 1982 for submitting fraudulent or false claims, charging excessive amounts for services, or furnishing excessive services	96	29
Total	335	100

However, 58 percent of the 328 licensing board sanctions taken during the period January 1977 through December 1982 in the three states were for problems that affected the practitioners' ability to meet minimum professional standards or to provide quality care, as shown in the following table.

Categories	Number	Percent
Actions affecting the quality of care provided, such as malpractice, alcohol and drug abuse, and immoral conduct	189	58
Drug trafficking, drug sales, or violation of the controlled substance act	75	23
Criminal act or private insurance fraud	29	9
Submitting false Medicare or Medicaid claims	28	8
Other	7	2
Total	328	100

A more detailed breakdown by specific category is provided in appendix II.

Reasons for sanctions nationwide are similar to those in the three states. Information reported nationally by state medical and osteopathic boards to the Federation of State Medical Boards for 1979-82 on 1,388 medical and osteopathic physicians showed that the reasons for actions taken in Michigan, Ohio, and Pennsylvania are similar to the reasons for actions taken by licensing boards throughout the nation. For example, 61 percent of the actions reported by the Federation involved problems that affected quality of care as compared to the 58 percent we found in the three states in our review.

The problems that caused the physicians to lose their licenses are serious. However, it is important to note that the problems involved only a small percentage of the nation's physicians. For example, in 1979, 257 of the 390,353 physicians lost their licenses for disciplinary reasons. The total rose to 401 in 1982, but this is only about 1 in every 1,000 physicians.

SANCTIONED PRACTITIONERS MOVE TO OTHER STATES TO PRACTICE

Of the 328 practitioners sanctioned by the three states, we identified 122 (or 37 percent) who had a license in at least one other state at the time of the sanction. This situation permits sanctioned practitioners to move to another state and continue practicing. Of these 122 practitioners, 30 corrected their problems, retired, or died. The other 92 had to relocate if they wanted to practice. We were able to trace 49 of these practitioners to other states and found that 39 obtained provider numbers to directly bill the Medicare and/or Medicaid programs. The other 10 relocated, but did not obtain a provider number. They

could be serving Medicare and Medicaid patients in a hospital, clinic, or other institution; in this case, the institution and not the practitioner could bill the two programs for services provided. We could not determine the whereabouts of the other 43. (See app. III.)

The continued participation of these practitioners in the Medicare and Medicaid programs raises questions about the quality of care some Medicare and Medicaid patients are receiving. The 39 practitioners who we found participating in Medicare and/or Medicaid in other states originally lost their license because they had problems that rendered them unfit to practice.

Practitioners who have problems practice in other states

Of the 39 practitioners who moved to other states and enrolled in the Medicare and/or Medicaid programs, 28 originally lost their licenses because they committed acts or had problems which, according to the state licensing boards, showed that they did not meet minimum professional standards. These acts and problems, as highlighted by the examples below, included drug usage, mental impairment, indiscriminate drug prescribing practices, malpractice, lack of reasonable skills and safety, misrepresentation, and sexual offenses. Federal exclusions were not issued against these practitioners. This permitted them to participate in the two programs in other states and, in some instances, commit the same or similar acts.

Failure to conform to minimum standards

The license of a Michigan medical doctor was revoked in June 1980 for failing to use reasonable care and indiscriminately prescribing drugs, not conforming to minimum standards of acceptable and prevailing medical practices, and lacking good moral character because he requested a patient to engage in sexual acts in payment of an outstanding fee. In addition, he sexually harassed and assaulted an employee when seeking sexual relations.

His license was revoked in Michigan, and he no longer participated there in the Medicare and Medicaid programs. However, he had a Florida license, so he moved there and participated in the Medicare program. He billed Medicare about $15,000 and was paid $9,236 in 1982 and 1983 for services provided to Medicare patients. He also obtained a West Virginia license in January 1981 after the Michigan revocation.

Mental impairment

A Michigan doctor's license to practice medicine and surgery was revoked in June 1978 because the state medical board found

him mentally impaired, rendering him unfit to practice medicine or surgery. He participated in the Michigan Medicaid and Medicare programs and received payments of $10,011 and $665, respectively, during 1975 through 1978. In October 1978, he voluntarily surrendered his Ohio license at the request of the Ohio Medical Board because of the Michigan findings. He then moved to New York, where he participated in the Medicare and Medicaid programs. In 1979 through 1982, while practicing in New York, he billed Medicare $3,944 and was paid $1,631. He also received $167 from Medicaid in 1981 and 1982. In April 1982, his license was revoked in New York for gross incompetence based on another state's action.

Drug usage

An Ohio dentist moved to Pennsylvania after he surrendered his license in Ohio because of drug usage and illegal possession of drugs. He participated in the Medicare program in Pennsylvania and billed Medicare $2,457. He was paid over $1,200. He also enrolled in the Pennsylvania Medicaid program, but received no payments. In August 1983, the Pennsylvania Medicaid agency took action to deny all future payments to him based on information received concerning a guilty plea in Pittsburgh to a federal criminal charge of illegal prescribing practices.

Lack of reasonable skills and safety

An osteopathic doctor had his license revoked in Michigan in February 1977 for misrepresenting himself as a medical doctor and for selling drugs. He moved to Florida where he had an active license and participated in the Medicare and Medicaid programs. He billed Medicare about $45,000 and was paid over $20,000. He was also paid about $6,000 in Medicaid funds.

In December 1980, Florida revoked the doctor's license based on the Michigan action because the doctor demonstrated an inability to practice osteopathic medicine with reasonable skill and safety. Although his Florida license was revoked in December 1980, he continued to receive Medicaid and Medicare payments in 1981. The Florida Medicaid agency recouped $1,340 from this doctor, and the Medicare carrier also plans to initiate an action to collect improper payments. Medicare payments made to this osteopathic doctor while he was unlicensed may exceed $10,000.

In January 1984, we referred this doctor to HHS' Office of Inspector General for appropriate action.

Malpractice and gross negligence

A New Jersey doctor lost his license due to gross malpractice and neglect and was considered to be professionally incompetent to practice medicine because he lacked good moral character. In August 1976, the New Jersey Board of Medical Examiners issued an order suspending the doctor for gross malpractice. The Board permanently revoked his license in January 1978, after finding him guilty of 11 counts of gross malpractice and neglect.

During the period between suspension and revocation of the doctor's license by New Jersey--about 1-1/2 years--he moved to Pennsylvania, where he had an active license and resumed the practice of medicine. From 1977 to 1979, he billed Medicare patients over $23,000 and was paid over $3,400. Pennsylvania eventually revoked his license in May 1978 based on his New Jersey offenses.

Sexual offenses

A Michigan medical doctor was cited in 1976 for performing sexual acts with his patients. While he was being investigated for these acts, the doctor obtained a Wyoming license. In lieu of a formal disciplinary action, the doctor signed a Michigan Medical Licensing Board consent order permanently surrendering his license.

He moved to Wyoming and participated in the Medicare program from 1980 to 1983. He billed Medicare over $8,000 and was paid almost $1,900. He also received over $2,600 from Medicaid. Because the Michigan Medical Board did not take a formal action against the doctor, but permitted him to surrender his license, the Wyoming Medical Board, in its opinion, had no legal basis to revoke his Wyoming license; therefore, no action was taken. However, he was later indicted in 1983 in Wyoming for the death of a patient that was caused by his prescribing habits. The doctor is scheduled for trial during April 1984. Effective March 13, 1984, the state licensing board plans to revoke the physician's license for conduct endangering his patients and for gross negligence.

Practitioners with criminal convictions practice in other states

Eleven of 39 practitioners were initially sanctioned because of criminal activities. They moved to other states and participated in the Medicare and/or Medicaid programs. Three were later excluded by HHS, and eight had not been excluded

as of October 1983. Six of these cases involved private insurance fraud and diversion of controlled substances which are currently not subject to exclusion. Exclusion action against one practitioner is pending, while the other practitioner was not excluded because of his agreement to move to a poverty area and practice medicine. Two of the practitioners HHS did not exclude became involved in the same criminal-type activities in another state. For example:

--The Michigan Medical Board revoked the license of a medical doctor in July 1979 for sale and delivery of controlled substances. He received $24,250 in payments from Michigan Medicaid in 1976 and 1977. When the Michigan complaint was lodged against him for sale of controlled substances, he moved to Florida. In January 1981, he also lost his Florida license for the same reason. This doctor also practiced in New York, where, from 1977 through 1982, he billed Medicare $28,832 and received over $13,700 in Medicare payments.

He also received over $10,000 in New York Medicaid payments in 1978 and 1979. As of August 1983, in addition to his active New York medical license, he had a Pennsylvania license and had been issued a Medicare provider number that permits him to bill Medicare for services provided in Pennsylvania.

--A Michigan osteopathic doctor was originally licensed in Michigan in 1949. He also had licenses in 13 other states. In March 1951 he was arrested and convicted of unlawfully selling drugs. He then moved to Texas and did not renew his Michigan license. In Texas he was again convicted of unlawfully selling drugs in 1964.

He then went to Iowa on a Public Health Service grant but was asked to resign when his 1964 conviction became known. From 1965 until 1969, he worked in private practice and in hospital residency programs in several states until he began working at a Veterans Administration hospital in April 1969. By this time all of the states where he held licenses had revoked or suspended them. However, he was allowed to work for the Veterans Administration as long as he was in a residency program.

He left the Veterans Administration, and in May 1971 began working as a pathologist at the Winfield state hospital in Winfield, Kansas. His Michigan license was reinstated in January 1972, and he joined a group practice that served

patients at five Detroit clinics. Between 1979 and 1982 the clinics were paid about $760,000 in Medicaid funds. In October 1982, while working at the clinics, he was convicted of illegal drug sales as part of a multimillion-dollar interstate drug ring and was sentenced to 10 years' imprisonment.

SUMMARY

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

CHAPTER 3

BETTER INFORMATION AND INCREASED FEDERAL AUTHORITY NEEDED TO PROTECT MEDICARE AND MEDICAID BENEFICIARIES

Practitioners who in one state do not meet minimum professional standards, fail to provide quality care, or are involved in criminal activities are able to move to other states and practice under the Medicare and Medicaid programs primarily because the other states are not informed of the practitioners' problems. When states are informed, it takes up to 3 years to sanction practitioners because of the procedures that must be followed and the shortage of personnel to carry them out. Also, HHS is not acting to exclude these practitioners nationwide from participation in its programs because it does not have the authority to do so based on a state's sanction unless the practitioner's act is directly related to Medicare or Medicaid. If HHS is to prevent state-sanctioned practitioners from participating in the Medicare or Medicaid programs in other states until they correct their problems, it must obtain additional legislative authority.

A system is being developed by HHS to provide information on practitioners with problems. Initially, this system will be limited to exclusions taken by HHS and will not include state licensing board sanctions. Although plans have not been finalized, it is expected that some data on state licensing board sanctions will be included in the system. We believe, however, that complete information is needed.

STATES RESTRICTED IN TAKING ACTION AGAINST SANCTIONED PRACTITIONERS

A primary reason why sanctioned practitioners were able to go to other states to practice was that the other states never learned about the practitioners' previous offenses or, by the time they did, many months or years had passed. Specifically, for the 39 practitioners that we identified as relocating and practicing under Medicare and/or Medicaid after a state licensing board had revoked or suspended their licenses, as of October 1983, 18 had their licenses suspended or revoked in the other states where they held licenses and 21 still held licenses. The time elapsed between the initial sanctioning action and action by the other states averaged about 2.6 years, ranging from 6 months to 5.2 years. On the average, 3.5 years had elapsed

since the 21 practitioners still holding licenses had been sanctioned by the initial state. The range was from 10 months to 8.7 years.

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

The lack of awareness by state licensing boards was a more serious problem for boards responsible for regulating chiropractors, dentists, pharmacists, and podiatrists. These boards relied on individual states' reporting actions to each other; boards that regulate medical physicians (and osteopathic physicians in some states) relied on a national disciplinary reporting network administered by the Federation of State Medical Boards. Some state medical and osteopathic licensing board officials expressed concern that some states are not reporting all their disciplinary actions or that actions are reported late.

States are slow to act

When one state is informed of another state's action against a practitioner, considerable time is needed to implement a state's procedures to revoke or suspend a practitioner's license based on the other state's action. State boards must follow various legal and administrative procedures, which are time consuming. In addition, according to state licensing board officials, the amount of time is often extended by personnel shortages. Often a personnel shortage causes a state board to take 3 years or more to suspend or revoke the license of a practitioner another state has already disciplined. Several examples of delays follow.

--In New York we were told there is a shortage of state attorneys to present cases for hearing. This problem was cited in several cases in which sanctioned practitioners had moved to New York. In one case, an anesthesiologist moved to New York before surrendering his Michigan license in November 1980 for improper drug prescribing practices and usage. The New York state licensing board formally charged him in April 1981 based in part on the problems cited by Michigan and similar drug problems in other states. In October 1983, this doctor was still licensed to practice medicine in New York. We were told

by a licensing board official that very little progress has been made on this case because of New York's shortage of attorneys. In the meantime, this doctor has billed Medicare $156,273 and was paid over $90,000 in Medicare funds since moving to New York in 1980.

--In Wisconsin, two hearing examiners serve 19 state licensing boards, and three attorneys work for these boards. A licensing board official said that given existing caseloads, this is insufficient and causes delays.

--In Nebraska, licensing board officials told us that staff cuts accompanied by a hiring freeze have prevented licensing personnel from reviewing sanctions taken by other states and published by the Federation of State Medical Boards. These sanctions were previously reviewed monthly to determine if doctors holding Nebraska licenses had been sanctioned by other states.

HHS INFORMATION SYSTEM ON SANCTIONED PROVIDERS SHOULD BE EXPANDED

Officials from state licensing boards, Medicare carriers, state medical agencies, professional organizations, HHS, and other federal agencies recognize the need for better communication on disciplinary actions taken against practitioners. For example, officials from 14 licensing boards in states where we traced sanctioned practitioners told us the sanctioning process could be improved by a national clearinghouse for sanction information. The only existing clearinghouse is one operated by the Federation of State Medical Boards, which provides sanction information on physicians to member boards. The National Association of Boards of Pharmacy is working to establish a similar system.

HHS, in cooperation with the President's Council on Integrity and Efficiency, is developing a Health Care Program Violations Information System to provide information on individuals excluded from federal health programs and from other public and private health care payment programs that chose to participate in the system. Although plans have not been finalized, at least some data on state licensing board sanctions are expected to be included in the system. We believe that, if this system is to be effective, it should include complete information on all state sanctions against practitioners. Including such information in the system would help ensure that Medicare and Medicaid

beneficiaries receive quality care by alerting federal authorities about practitioners' previous problems. It could also be used by federal agencies when hiring practitioners.

The HHS information system being designed to serve as a clearinghouse for public information on persons or organizations excluded from Medicare/Medicaid and other health care related programs will be established in three phases. The first phase, which will provide information from HHS agencies and programs, will be operational in July 1984. Specific time frames for the other two phases, which will provide information from other federal agencies (such as the Veterans Administration) and the private sector, have not been established. HHS is waiting for the Office of Management and Budget to approve the form that will be used to obtain the information before it establishes specific time frames.

According to an HHS official, most of the information initially in the system will be obtained from HHS exclusions. For example, 80 percent of phase I data will be Medicare and Medicaid program violations. Most state licensing board sanctions, like those discussed in chapter 2, will not be initially included. We do not believe a system excluding such information is sufficient to identify unqualified practitioners for Medicare, Medicaid, and other federal programs. For example, only 15 of the 328 practitioners sanctioned by Michigan, Ohio, and Pennsylvania were also excluded by HHS; however, these three states also considered the problems of the other 313 serious enough to remove their licenses and thereby prevent them from participating in Medicare and Medicaid in their states.

Information on sanctions against those in federal employment--past and present--is difficult to obtain and should be incorporated in HHS' new records system. The system should also provide quick reference to sanctions against those applying for federal employment.

In our review of state licensing boards' records, we found references to prior federal employment by 11 of the 328 sanctioned practitioners. Because these practitioners had prior employment, we attempted to determine if any of the 328 practitioners were employed by federal agencies after Michigan, Ohio, or Pennsylvania had taken a sanction action against them. However, most of the civilian medical employment by federal agencies, except for the Public Health Service, is decentralized, and the agencies could not reference a single file for employment information. Specific information was needed on current place of employment in most cases before a practitioner could be located by the federal agency. Because we lacked this information, we could not effectively determine whether practitioners obtained federal employment after being sanctioned by a state.

We were able to tie two of the practitioners into federal employment after they were sanctioned. One of the practitioners was employed by the Public Health Service after his license was removed for illegal drug usage, and the other by the Veterans Administration after he was convicted of illegal drug sales.

HHS NEEDS ADDITIONAL AUTHORITY TO INITIATE NATIONAL EXCLUSIONS

Under current law, HHS can exclude practitioners from participation in Medicare for various reasons:

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

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

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

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

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

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

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

We believe that HHS' current practitioner exclusion authority is insufficient in several respects. First, if a state sanctions a practitioner for Medicaid, it is required to notify HHS (section 1902(a)(41)). However, if the reason the state excluded the provider is not a criminal conviction for acts against Medicaid or title XX, HHS cannot exclude the practitioner on the basis of the state's Medicaid exclusion alone. To use the sanction authority of section 1862(d), the law requires

HHS to have evidence of a Medicare-related abuse, so HHS would have to develop information that the practitioner excluded from Medicaid by a state also abused Medicare. This could take a long time, during which the practitioner could continue treating Medicare patients or, if he or she had a license in another state, relocate and treat both Medicaid and Medicare patients.

Second, if a practitioner is sanctioned by a state licensing board, HHS cannot exclude him or her nationally from participation in Medicare and Medicaid. Again, HHS would have to develop information about Medicare abuse before it could exclude the practitioner for that program. If the sanctioned provider held a license in another state, he or she could relocate and treat Medicare and Medicaid patients.

Third, if HHS excludes a practitioner for Medicare under section 1862(d) or a state excludes a practitioner for other than a conviction against Medicaid or title XX, HHS cannot exclude the practitioner nationally from Medicaid. He or she could relocate and continue to treat Medicaid and/or Medicare patients.

Fourth, if a practitioner is convicted of a crime not directly related to Medicare, Medicaid, or title XX, HHS cannot exclude the practitioner on this basis alone. For example, if the practitioner is convicted of violating the controlled substance laws by indiscriminately prescribing addictive drugs or of defrauding a commercial insurance company or worker's compensation program, HHS cannot exclude the practitioner.

These kinds of situations involve serious problems. Practitioners have been found unfit to practice, or to participate in Medicare or Medicaid, in a particular state. We believe that to protect all Medicare and Medicaid patients from such practitioners, HHS needs the authority to nationally exclude them from participation in these programs after reviewing the findings that caused action to be taken against them.

However, as the Office of Inspector General acknowledges, the Social Security Act does not give HHS this authority. In fact, the Office plans to submit legislation which will expand the current exclusion authority to cover convictions for drug-related offenses and other crimes and to exclude nationally from Medicare and Medicaid practitioners excluded from either program for reasons other than a criminal conviction against one of the programs. HHS plans to submit the proposed legislation during the spring of 1984. However, the draft of the proposal as written on April 2, 1984, is too limited and would not provide for a national exclusion based on a state licensing board sanction.

CONCLUSIONS

Because of limitations included in HHS' Medicare and Medicaid exclusion authority, when practitioners are sanctioned for other than criminal convictions or civil monetary penalties,

--practitioners who lose their right to participate in Medicaid in one state can continue to practice under Medicare in that state or relocate to another where they hold a license and practice under both programs,

--practitioners who lose their right to participate in Medicare can continue to participate in Medicaid in any state where they hold a license,

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

--practitioners who are convicted of crimes not directly related to Medicare and Medicaid can continue to practice under both programs.

We believe that HHS could better protect Medicare and Medicaid patients and the programs themselves if it had authority to exclude practitioners in the situations enumerated above. Also, such expanded authority would enable HHS to better protect Medicare and Medicaid beneficiaries from unqualified practitioners who are sanctioned by their state licensing board in one state but relocate to another state where they hold a license. If HHS could exclude nationally a practitioner sanctioned by a state licensing board, it would help eliminate the lag in time between action in one state and action in other states where a practitioner holds licenses. HHS should, in our opinion, expand its legislative proposal for increased exclusion authority to cover all of the situations listed above.

Also, we believe that HHS should include, in the information system, consistent with the Privacy Act (5 U.S.C. 552a), data on practitioners who have been sanctioned by state licensing boards. This would make the system more complete.

RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary revise HHS' practitioner exclusion legislative proposal so that it includes provisions authorizing HHS to sanction nationally for Medicare and Medicaid practitioners who

--are excluded by any state Medicaid program,

--are excluded by Medicare,

--are convicted of crimes involving any federal or nonfederal health program, or

--are sanctioned by any state licensing board.

Suggested language for adding, to the April 2, 1984, draft legislative proposal, exclusion authority for practitioners sanctioned by state licensing boards is provided in appendix IV.

We also recommend that the Secretary direct the HHS Inspector General to include in the Health Care Program Violation Information System all practitioners sanctioned by state licensing boards.

LICENSING BOARD SANCTIONS FROM JANUARY 1, 1977, THROUGH DECEMBER 31, 1982, IN MICHIGAN, OHIO, AND PENNSYLVANIA

Type of action	Medical doctors	Osteopathic doctors	Podiatrists	Chiropractors	Dentists	Pharmacists	Total
Suspended							
Ohio	5	2	0	2	7	4	20
Michigan	24	4	1	3	1	30	63
Pennsylvania	7	2	0	0	0	5	14
Subtotal	36	8	1	5	8	39	97
Revoked							
Ohio	4	2	0	0	6	27	39
Michigan	20	9	0	1	1	19	50
Pennsylvania	24	15	1	3	9	10	62
Subtotal	48	26	1	4	16	46	151
Surrendered							
Ohio	41	3	3	0	6	0	53
Michigan	19	0	0	0	2	4	25
Pennsylvania	0	0	0	1	1	0	2
Subtotal	60	3	3	1	9	4	80
Total by state							
Ohio	50	7	3	2	19	31	112
Michigan	63	13	1	4	4	53	138
Pennsylvania	31	17	1	4	10	15	78
Total	144	37	5	10	33	99	328

REASONS PRACTITIONERS WERE SANCTIONED

Category	Number	Percent
Actions that affect the quality of care provided or the practitioners' ability to meet professional standards		
Prescribing practices	64	20
Drug use or possession	46	14
Gross negligence/incompetence/malpractice	22	7
Sexual or immoral conduct	21	6
Mental illness and/or physically unfit	16	5
Alcohol abuse	6	2
Not conforming to minimum medical standards	7	2
Practicing without license or outside scope of license	4	1
Permitting unlicensed person to treat patients	3	1
Subtotal	189	58
Drug trafficking, drug sales, or violation of the controlled substance act		
Drug trafficking or drug sales	60	18
Violation of controlled substance act	15	5
Subtotal	75	23
Criminal act, insurance fraud, or submitting false information on application		
Convicted of criminal act or obstruction of justice	23	7
Mail fraud, insurance fraud, and deceiving the public	6	2
Subtotal	29	9
Submitting false Medicare or Medicaid claims	28	8
Other	7	2
Total	328	100

SUMMARY OF MEDICARE/MEDICAID PARTICIPATION BY SANCTIONED PRACTITIONERS

Category	Medical doctors	Osteopathic doctors	Dentists	Chiropractors	Podiatrists	Pharmacists	Total
Sanctioned in three states	144	37	33	10	5	99	328
Less: Those with active licenses in only the sanctioning state	74	15	27	4	4	82	206
Those with multiple-state licenses	70	22	6	6	1	17	122
Less: Those who corrected their problem, retired, or died	23	5	0	2	0	0	30
Those who did not correct their problem and moved	47	17	6	4	1	17	92
Movement of practitioners							
Moved to other state(s) and received funds for treating Medicare and/or Medicaid patients	21	5	3	2	1	2	34
Moved to other state(s) and enrolled in Medicare and/or Medicaid programs but did not receive direct payments	3	1	0	1	0	0	5
Relocated to other State(s) but could not be identified with the Medicare or Medicaid programs	2	1	1	0	0	6	10
May have relocated but their whereabouts could not be determined	21	10	2	1	0	9	43
	47	17	6	4	1	17	92

APPENDIX III

SUGGESTED LANGUAGE FOR EXCLUSION AUTHORITY FOR PRACTITIONERS SANCTIONED BY STATE LICENSING BOARDS

The text of HHS' draft legislative proposal relating to gaps in Medicare and Medicaid exclusion authority is presented below. Our suggested language to expand the proposal to cover practitioners sanctioned by state licensing boards is presented in brackets.

"(b) The Secretary may exclude from participation in the programs under title XVIII, and may direct State agencies to exclude from participation in the program under title XIX, in accordance with the provisions of this section, --

"(1) any individual or entity that has been convicted, under Federal or State law, in connection with the delivery of health care items or services or with respect to any program operated by or financed in whole or in part by any Federal, State, or local government agency, of --

"(A) fraud, theft, embezzlement, breach of fiduciary responsibility, or other offense related to financial abuse, or

"(B) neglect or abuse of patients;

"(2) any individual or entity that has been convicted, under Federal or State law, of unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

"(3) any individual or entity that the Secretary determines --

"(A) has knowingly and willfully made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under title XVIII or XIX or for use in determining the right to a payment under title XVIII or XIX, or

"(B) has submitted or caused to be submitted bills or requests for payment under title XVIII or XIX containing charges (or in applicable cases requests for payment of costs) for services rendered substantially in excess of such individual's or entity's customary charges (or, in applicable cases, substantially in excess of such individual's or entity's costs) for such services, unless the Secretary finds there is good cause for such bills or requests containing such charges or costs, or

"(C) has furnished items or services to patients (whether or not eligible for benefits under title XVIII or XIX) substantially in excess of the needs of such patients or of a quality which fails to meet professionally recognized standards of health care;

"(4) any individual whose license has been suspended or revoked by a State licensing board or who has surrendered his license for cause to such board."

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