

DOCUMENT RESUME

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[Proposed Legislation to Strengthen the Capability of the Government to Detect, Prosecute, and Punish Fraudulent Activities under the Medicare and Medicaid Programs]. HRJ-77-65; B-142983. March 10, 1977. 7 pp.

Report to Rep. Harley O. Staggers, Chairman, House Committee on Interstate and Foreign Commerce; by Robert F. Keller, Acting Comptroller General.

Issue Area: Law Enforcement and Crime Prevention (500); Health Programs (1200).

Contact: Human Resources Div.

Budget Function: Law Enforcement and Justice: Federal Law Enforcement and Prosecution (751); Health: General Health Financing Assistance (555).

Organization Concerned: Department of Health, Education, and Welfare.

Congressional Relevance: House Committee on Interstate and Foreign Commerce.

Authority: Social Security Amendments of 1967, sec. 229 (P.L. 90-248). Social Security Act. H.R. 3 (95th Cong.). H. Rept. 90-544. S. Rept. 90-744.

Several revisions would improve H.R. 3, 95th Congress, the purpose of which is to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs.

Findings/Conclusions: Sections 3 and 8 of the bill, which relate to the disclosure of ownership and financial information and disclosure by providers or owners convicted of certain offenses, should be conformed to apply to the same programs since they appear to be applicable to many of the same providers and organizations. Section 5, which relates to changes in the Professional Standards Review Organizations (PSROs), should be modified to include a statement that the General Accounting Office has access to all PSRO records for the purpose of any audit, investigation, examination, analysis, review, or evaluation authorized by law with respect to titles V, XI, XVIII, or XIX of the Social Security Act. This section should also be modified to require the annual report to Congress on the PSRO program to report the results of PSRO effectiveness assessments that were made by the Department of Health, Education, and Welfare and the actions taken or proposed to be taken to improve the effectiveness of the PSROs so assessed. Section 11 of the proposed legislation should merely prohibit Federal sharing in State Medicaid expenditures which result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for Medicaid. (SC)

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20541



B-142982

MAR 10 1977

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The Honorable Harley O. Staggers
Chairman, Committee on Interstate
and Foreign Commerce
House of Representatives

Dear Mr. Chairman:

This is in response to your letter dated February 24, 1977, requesting our comments on H.R. 3, 95th Congress, the purpose of which is to strengthen the capability of the Government to detect, prosecute, and punish fraudulent activities under the Medicare and Medicaid programs, and for other purposes. Our comments on H.R. 3 follow.

Sections 3 and 8 - Disclosure of
Ownership and Financial Information
and Disclosure by Providers of Owners
Convicted of Certain Offenses

These two sections appear to be closely related. They would apply to many of the same providers and organizations participating in one or more of the programs authorized by the various titles of the Social Security Act. However, section 3 applies to programs established under titles XVIII (Medicare), XIX (Medicaid), and V (Maternal and Child Health and Crippled Children's Services) while section 8 applies to programs established under titles XVIII, XIX, and XX (Social Services). Thus, each section applies to a title not included in the other section. The rationale for the differences in the titles to which the two sections apply is not clear to us since the provisions of both sections appear to be applicable to many of the same providers and organizations. Therefore, we suggest that sections 3 and 8 be conformed to apply to the same programs.

Section 8(e) sets the effective date of the provisions relating to disclosure of criminal convictions of owners of providers. Section 8(e) states that these provisions apply to contracts, agreements, and arrangements entered into and approvals given to applications or requests made after the first day of the fourth month after enactment. Many providers, particularly institutional providers, have agreements with

the programs which do not terminate until terminated by one of the parties. Many of these providers must be periodically recertified as eligible to participate in the program but do not necessarily apply for or request recertification. Because of these circumstances, it is possible that providers currently participating in one or more of the programs, whose present or future owners are subsequently convicted of an applicable crime, might not have to disclose this fact to the Secretary. Therefore, we suggest that section 8(e) be modified to include language requiring disclosure at the time of recertification.

Section 5 - Amendments Related to
Professional Standards Review
Organizations

Section 5(b)(2) would amend section 1154 of the Social Security Act to allow the Secretary to extend the conditional designation of a PSRO for an additional period not to exceed 24 months if he finds that the conditional PSRO has been unable to satisfactorily perform all of its required duties and functions.

On June 17, 1976, in a letter to the Secretary, we questioned the legality of HEW plans to extend the conditional status of a PSRO beyond the existing legislatively mandated maximum 24-month period. This amendment would legalize the action taken by HEW in June 1976 to extend the conditional status of 14 PSROs beyond the 24-month period. The intent of section 5(b)(2) appears to be to allow conditional PSROs additional time in which to develop so that they can meet requirements and be certified as qualified PSROs. Presumably, under present law, if the Secretary could not designate a PSRO as qualified after 24 months in conditional status, he would have to terminate the agreement with the PSRO and begin the selection process again. However, the law is silent as to the action HEW should take if a PSRO cannot be designated as qualified after 24 months as a conditional PSRO. The proposed amendment is also silent as to what should be done after the 24-month extension.

As pointed out above, HEW decided to extend the period of conditional status of 14 PSROs when their 24-month conditional period expired in June 1976. We believe that the law should address the issue of what action HEW should take if, after the 24-month extension, the Secretary cannot designate a PSRO as

qualified and we suggest that section 5(b)(2) be modified accordingly. Such a modification could prevent HEW from continuing a PSRO in conditional status for a number of years without it ever becoming qualified and fully meeting the intent of the PSRO legislation.

Section 5(e) would amend the Social Security Act to make it clear that PSRO determinations regarding the medical necessity of services and the appropriateness and quality of medical services shall be final and binding on the Medicare and Medicaid programs. We believe that section 5(e) will clarify the existing PSRO legislation and emphasize the need to prevent duplication of PSRO review activities by organizations and agencies administering the Medicare and Medicaid programs. If section 5(e) is enacted, providers and program recipients would retain their hearing and appeal rights concerning PSRO determinations while the Federal and State Governments would have to accept these determinations and could not overrule them. Since the States fund a substantial portion of their Medicaid programs, many of them have expressed concern about having to accept PSRO determinations. In an effort to ease this concern, HEW has issued proposed regulations allowing the States and Medicare intermediaries and carriers to utilize a monitoring system to evaluate conditional PSRO effectiveness and communicate their findings to the Secretary for his action. We believe that authority for such a monitoring system should be formalized in the law to make it clear that that course is available to the States as a method of ensuring that State funds are properly expended.

Section 5(i) would amend the Social Security Act to clarify the types of information PSROs can disclose and the agencies to which the information can be disclosed. This section authorizes the Secretary (1) to recognize Federal and State agencies responsible for identifying and investigating fraud and abuse under the act and agencies responsible for health planning and (2) to establish the types of information PSROs should provide to these various agencies.

During our study of the PSRO program, we have encountered some resistance from PSROs in providing us access to the records we need to evaluate the efficiency, economy, and effectiveness of the program. The PSROs and HEW are apprehensive about providing GAO with medical records which identify any patient, physician, or hospital. We believe it is necessary for GAO to

have access to all of the records of PSROs in order to fulfill our responsibilities to the Congress. Therefore, we suggest that section 5(i) be modified to include a statement that the General Accounting Office has access to all PSRO records for the purpose of any audit, investigation, examination, analysis, review, or evaluation authorized by law with respect to titles V, XI, XVIII, or XIX of the Social Security Act.

Also, such a modification should make clear that the sanctions applicable to the improper disclosure of PSRO data by agencies receiving such data would also apply to the General Accounting Office except for referrals of any possible cases of illegal activity to those Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud and abuse.

Section 5(l) would amend the Social Security Act by adding a section which describes the types of information which must be included in the Secretary's annual report to the Congress on the PSRO program. We believe that section 5(l) should be modified to include a requirement to report the results of PSRO effectiveness assessments that were made by HEW and the actions taken or proposed to be taken to improve the effectiveness of the PSROs so assessed. This would provide the Congress with additional information on the effectiveness of the PSRO program.

Section 11 - Medicaid as Payer of Last Resort

Section 11 of H.R. 3 would add section 1902(a)(38) to the act which would require a State's Medicaid plan to provide that no expenditure would be made under the plan for care or services which another party would have been obligated to pay under a State law or a contract, except that the State law or the contract limits or excludes payment for care or services covered by Medicaid and provided to Medicaid eligibles. This proposed provision could have the effect of the State Medicaid plan overruling or at least conflicting with a State law or a contract. In addition, if a State chooses not to have such a conflict, the failure to include the provision required by proposed section 1902(a)(38) in the State Medicaid plan could have the effect of precluding Federal participation in the entire Medicaid program because the Secretary could not approve the plan.

We believe it would be preferable to include such a provision in section 1903, which deals with Federal payment to States, prohibiting Federal sharing in expenditures for care or services which meet these circumstances. This would eliminate the possibility that a State plan would be required to be in conflict with a State law and also eliminate the possibility that a State's inability to comply with the provision would prevent the Secretary from approving the State's Medicaid plan.

Our concerns in this area are based on information developed in a review of HEW and State compliance with section 1902(a)(25) of the Social Security Act, which we expect to report on shortly. Section 1902(a)(25) requires that State plans must provide that the State or local agency administering the Medicaid program take all reasonable measures to ascertain the legal liability of third parties to pay for care and services provided to Medicaid recipients. The section also requires that where the State or local agency knows that a third party has such a legal liability, the liability will be treated as a resource of the individual receiving Medicaid benefits. In addition, when third party liability is found to exist after Medicaid benefits have been provided, the State or local agency must seek reimbursement to the extent of such liability.

Section 1902(a)(25) of the Social Security Act was added by section 229 of the Social Security Amendments of 1967 (Public Law 90-248). The legislative history of the law, as contained in the reports of the House Committee on Ways and Means (H.R. Report No. 90-544, August 7, 1967) and the Senate Committee on Finance (S. Report No. 90-744, November 14, 1967) indicates that the Congress did not want the Medicaid program to pay for the cost of medical care necessitated by injury or illness for which someone else was obligated to pay. Thus, we believe it was intended that liable third parties would be the primary resource for medical payments for eligible recipients and that Medicaid would be used when other resources were not available, or were exhausted. However, we have identified instances where States have allowed Medicaid to be treated as the primary resource for payments in lieu of insurance companies.

Section 11 of H.R. 3 essentially seeks to address such situations. For example, Hawaii has a no-fault automobile insurance law which provides that no-fault medical benefits be paid secondarily to public assistance laws. As a result, the

automobile medical insurance coverage is not treated as a liable third party in Hawaii, and Medicaid is considered as the primary resource.

Hawaii's no-fault motor vehicle insurance statute was enacted in 1974 and provided, in essence, that a person who is injured in an automobile accident is entitled to payment for the cost of his or her medical care, rehabilitation, and other benefits up to a maximum of \$15,000 per person. The State, however, had not taken steps to collect no-fault insurance benefits applicable to automobile accident victims who received Medicaid services on account of their injuries.

Because the 1974 law did not clearly exclude the availability of no-fault coverage to Medicaid recipients, we questioned this practice. The Office of the State Attorney General, in March 1976, advised us that to guarantee that public assistance recipients obtain no-fault coverage as required by the State law, the State Legislature required that insurers provide policies to welfare recipients at no cost. In exchange for this free coverage, the legislature intended that benefits under the no-fault policies would be secondary to benefits available under the Social Security Act. According to the State Attorney General, the 1974 State law was not an attempt to substitute Medicaid for existing insurance liability because if the State, through Medicaid, had not continued to assume responsibility for medical care to welfare recipients, the no-fault insurance contract would probably not have existed.

Apparently to resolve the problems raised by our questions, the Hawaii Legislature, in May 1976, enacted a bill which amended the no-fault insurance law as it relates to public assistance recipients. In essence, the State law now specifically provides that the medical coverage under no-fault insurance is not applicable to recipients of public assistance.

In addition to the Hawaii situation, we noted that in Oklahoma, the State Insurance Commissioner has approved health insurance policies which contain a provision that limits the insurance companies' liability to the amount not paid by Medicaid.

Because the practice of States excluding or limiting third-party coverage for individuals eligible for public assistance can blunt the impact of HEW's recent initiatives to maximize

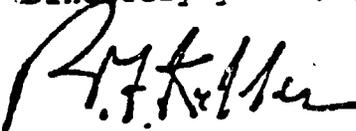
third-party payments and to reduce Medicaid costs, we support section 11 of H.R. 3 as a reaffirmation of our understanding of the congressional intent that liable third parties rather than Medicaid be considered as the primary resource for medical costs.

However, because State laws and contracts excluding Medicaid eligibles exist, we believe it would not be appropriate to require States to modify their Medicaid plans to conflict with such existing laws and contracts. We believe that if the Committee wants to clearly establish the position that Medicaid is to be the payor of last resort, it would be preferable to merely prohibit Federal sharing in State Medicaid expenditures that result from State laws or contracts which exclude or limit insurance benefits because an individual is eligible for Medicaid.

We also note that the language of section 11 of the bill suggests the possibility that a State law or contract could be drafted that would avoid a direct reference to a limitation or exclusion because an individual is eligible for or receives care under a Medicaid plan. This could be accomplished by basing the limitation or exclusion on entitlement to benefits under other related Social Security Act Programs such as Supplemental Security Income or Aid to Families with Dependent Children. Therefore, we suggest that the language on line 17 page 35 be revised to read as follows: "contract which has the effect of limiting or excluding such obligation because * * *."

I trust that these comments will be of assistance to the Committee in its deliberations on H.R. 3. We would be happy to work with you or your staff to develop specific changes in the bill reflecting our comments.

Sincerely yours,


Acting Comptroller General
of the United States