

**Memorandum**

Date . . . . . OCT - 5 1998

From June Gibbs Brown  
Inspector General *June G Brown*

Subject Review of Partial Hospitalization Services Provided Through Community Mental Health Centers (A-04-98-02146)

To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

Attached is a copy of our final report entitled "Reviews of Partial Hospitalization Services Provided Through Community Mental Health Centers." This report provides you with a summary of audit activity on the delivery of mental health services through partial hospitalization programs (PHP) for Medicare beneficiaries at community mental health centers (CMHC) in Florida and Pennsylvania. The Office of Inspector General's (OIG) and the Health Care Financing Administration's (HCFA) work indicated widespread problems in this program. As you know, our offices have worked closely in reviewing this fast growing benefit area. We want to share with you our thoughts on possible actions that can be taken to address this problem issue of partial hospitalization services.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) authorized Medicare coverage and payment of partial hospitalization services provided by CMHCs that are reasonable and necessary for the diagnosis and active treatment of an individual's mental condition in order to prevent a relapse or hospitalization. Joint reviews between HCFA staff and OIG offices in Florida and Pennsylvania showed that in 14<sup>1</sup> CMHCs:

- ▶ certification requirements to qualify as a CMHC were not always met;
- ▶ most of the beneficiaries were found to be ineligible for PHP services;
- ▶ many of the services provided to beneficiaries were not reasonable and necessary...nor were they eligible PHP services; and
- ▶ provider cost reports contained costs that were not always allowable, reasonable, and necessary.

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<sup>1</sup>Subsequent to the issuance of our draft report, 6 additional HCFA reviews in Florida disclosed problems similar to those found in the 14 reviews of CMHCs (12 in Florida, 2 in Pennsylvania) reported herein. Five of the six facilities reviewed by HCFA are no longer in business.

Because localized approaches were used between our staffs in reviewing these 14 CMHCs, we are not able to provide an overall average error rate for these above noted error types. However, improper payments on behalf of ineligible beneficiaries or facilities that did not qualify as a CMHC totaled over \$31 million for these 14 providers. The HCFA suspended Medicare payments to all 14 providers and terminated the provider numbers for 10 of the 12 facilities in Florida. Eleven of the 14 providers were referred to the OIG Office of Investigations for further analysis of their activities.

The OIG recently completed a review of PHP services in 5 States, representing about 77 percent of CMHC PHP payments nationally. This review was designed to determine the extent of ineligible beneficiaries enrolled in the program and provide input to HCFA on the reasonableness and necessity of the services provided by the CMHCs. The 5-State review disclosed that a substantial percentage of both claims and services were unallowable or highly questionable. The HCFA also recently completed a provider enrollment initiative in which on-site reviews were conducted at 700 CMHCs in 9 States. With the assistance of your office, we will also continue to target CMHCs around the country for individual reviews for eligibility and the allowability, reasonableness, and necessity of the costs reported on the cost reports.

This report presents our thoughts on changes that could be considered in an effort to eliminate the abusive practices being found in this program. We support: HCFA's efforts to develop a prospective payment system (PPS) for PHP services at CMHCs; the development of proposed rules that address surety bonds for CMHCs and the enrollment/re-enrollment process for CMHCs to participate in the Medicare PHP program; and HCFA's current 9-State enrollment initiative. As a PPS system is developed, we recommend that HCFA determine the costs of unnecessary care and other excessive costs (as shown in reviews completed thus far), and eliminate them from the cost data used to establish the PPS. We also offer the following recommendations for your consideration:

- Concerning the enrollment of ineligible providers, we suggest that HCFA either develop Conditions of Participation or conduct onsite surveys during the enrollment process to address qualifications issues. This would include compliance with laws and regulations including State licensure laws, furnishing appropriate services, and other patient health and safety issues.
- In regard to ineligible beneficiaries and services, we suggest that the fiscal intermediary (FI) perform a detailed review of the first claim for each new beneficiary receiving PHP services, including a review of medical records, and that HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

- Regarding unallowable and unreasonable costs claimed on cost reports, we encourage HCFA to develop ways to improve the cost reporting process. For example, require FIs to perform some in-depth cost report audits of CMHCs. This would require allotting several weeks for performing on-site audits of several cost categories where abuses have been found and documented in this report.

In its written response to our draft report, HCFA concurred with three of the four recommendations and planned corrective action. With regard to our recommendation regarding the development of Conditions of Participation, HCFA concurred with the intent of the recommendation but believed it did not have the statutory authority to set additional criteria for CMHC enrollment or participation in Medicare. However, HCFA will continue to pursue a legislative proposal which would grant the Secretary the authority to set additional requirements for CMHCs. The complete text of HCFA's response is presented as Attachment B to this report.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions or need clarification on the report, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-98-02146 in all correspondence relating to this report.

Attachment

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF  
PARTIAL HOSPITALIZATION SERVICES  
PROVIDED THROUGH  
COMMUNITY MENTAL HEALTH  
CENTERS**



**JUNE GIBBS BROWN  
Inspector General**

**OCTOBER 1998  
A-04-98-02146**

**Memorandum**

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The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) authorized Medicare coverage and payment of partial hospitalization services provided by CMHCs that are reasonable and necessary for the diagnosis and active treatment of an individual's mental condition in order to prevent a relapse or hospitalization. Since the enactment of OBRA 90, the program has grown from \$60 million in 1993 to \$349 million in 1997...far exceeding HCFA's estimates of \$15 million a year. Joint reviews between HCFA staff and OIG offices in Florida and Pennsylvania showed that in 14<sup>1</sup> CMHCs:

- ▶ certification requirements to qualify as a CMHC were not always met;
- ▶ most of the beneficiaries were found to be ineligible for PHP services;
- ▶ many of the services provided to beneficiaries were not reasonable and necessary...nor were they eligible PHP services; and
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Because localized approaches were used between our staffs in reviewing these 14 CMHCs, we are not able to provide an overall average error rate for these above noted error types. However, improper payments on behalf of ineligible beneficiaries or facilities that did not qualify as a CMHC totaled over \$31 million for these 14 providers. The HCFA suspended Medicare payments to all 14 providers and terminated the provider numbers for 10 of the 12 facilities in Florida. Eleven of the 14 providers were referred to the Office of Inspector General (OIG) Office of Investigations for further analysis of their activities.

The OIG, with the assistance of HCFA, recently completed a review of CMHC claims in 5 States, representing about 77 percent of CMHC PHP payments nationally. This review was designed to determine the extent of ineligible beneficiaries enrolled in the program and provide input to HCFA on the reasonableness and necessity of the services provided by the CMHCs. The 5-State review disclosed that a substantial percentage of both claims and services were unallowable or highly questionable. The HCFA also recently completed a provider enrollment initiative that resulted in on-site reviews being conducted at 700 CMHCs in 9 States. With the assistance of your office, we will also continue to target CMHCs around the country for individual reviews for eligibility and the allowability, reasonableness, and necessity of the costs reported on the cost reports.

This report presents our thoughts on changes that could be considered in an effort to eliminate the abusive practices being found in this program. We support: HCFA's efforts to develop a prospective payment system (PPS) for PHP services at CMHCs; the development of proposed rules that address surety bonds for CMHCs and the enrollment/re-enrollment process for CMHCs to participate in the Medicare PHP program; and HCFA's current 9-State enrollment initiative. As a PPS system is developed, we recommend that HCFA determine the costs of unnecessary care and other excessive costs (as shown in reviews completed thus far), and eliminate them from the cost data used to establish the PPS. We also offer the following recommendations for your consideration:

Concerning the enrollment of ineligible providers, we suggest that HCFA either develop Conditions of Participation or conduct on-site surveys during the enrollment process to address qualifications issues. This would include compliance with laws and regulations including State licensure laws, furnishing appropriate services, and other patient health and safety issues.

In regard to ineligible beneficiaries and services, we suggest that the fiscal intermediary (FI) perform a detailed review of the first claim for each new beneficiary receiving PHP services, including a review of medical records, and that HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

Regarding unallowable and unreasonable costs claimed on cost reports, we encourage HCFA to develop ways to improve the cost reporting process. For example, require FIs to perform some in-depth cost report audits of CMHCs. This

would require allotting several weeks for performing on-site audits of several cost categories where abuses have been found and documented in this report.

In its written response to our draft report, HCFA concurred with three of the four recommendations and planned corrective action. With regard to our recommendation regarding the development of Conditions of Participation, HCFA concurred with the intent of the recommendation but believed it did not have the statutory authority to set additional criteria for CMHC enrollment or participation in Medicare. However, HCFA will continue to pursue a legislative proposal which would grant the Secretary the authority to set additional requirements for CMHCs. The complete text of HCFA's response is presented as Attachment B to this report.

## **Background**

The CMHCs provide treatment and services to mentally ill individuals residing in the community. In 1963, the Community Mental Health Centers Act established CMHCs, and the Public Health Service (PHS) was designated as the regulatory agency to oversee their operations.

The OBRA 90 authorized Medicare coverage and payment of partial hospitalization services provided by CMHCs. Prior to that time, the Medicare program did not provide coverage for PHP services at CMHCs. The OBRA 90 defined a CMHC as an entity that provides the services described in the PHS Act and also meets applicable State licensing or certification requirements. However, about 60 percent of States do not have licensing requirements for CMHCs.

The HCFA required that all new CMHCs entering the program attest to the fact that they provide the five<sup>2</sup> core services of a CMHC. The five core services are: specialized outpatient services; 24-hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screenings to determine appropriateness of admission to State mental health facilities; and consultation and education services.

### Growth of PHP Services at CMHCs

Since the passage of OBRA 90, average annual per patient payments are growing at an alarming rate, as shown in the following table. Rapid growth occurred from 1993 to 1997 with total program payments going from \$60 million to \$349 million, about a 482 percent increase; and the average payment per patient increased 530 percent, from \$1,642 to \$10,352.

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<sup>2</sup>In 1992, the PHS Act was amended so that only four core services are required. The amendment eliminated the requirement to provide consultation and education services.

<b>National Medicare Payments for CMHC Services</b>			
<u>Calendar Year</u>	<u>Number of CMHCs</u>	<u>Total Payments</u>	<u>Average Per Patient</u>
1993	296	\$ 60,000,000	\$ 1,642
1994	475	108,000,000	2,190
1995	581	142,000,000	3,524
1996	646	265,000,000	6,874
1997	769	349,000,000	10,352

## **METHODOLOGY**

Our work to date has primarily focused on whether: the provider met the certification requirements for CMHCs; beneficiaries were eligible to receive PHP services; the PHP services provided were reasonable and necessary; and whether selected costs claimed on the cost report were allowable, reasonable, and necessary. The CMHCs were selected for review based on an analysis of the HCFA Customer Information System (HCIS) billing data, and other selected parameters. We judgmentally selected Medicare beneficiaries for review based on the total payments made on their behalf. For each beneficiary, the services in each claim were examined for the entire time period of the reviews. Generally, for each beneficiary, we interviewed the beneficiary or a close relative, the physician who signed the plan of care, and the beneficiary's personal physician, if identified.

The HCFA and the OIG conducted joint reviews of selected CMHCs in the States of Florida and Pennsylvania. The OIG also completed a review of PHP services in 5 States that represent about 77 percent of the total Medicare PHP outlays. The HCFA also performed reviews of selected CMHCs in the States of Texas and Illinois. The reviews utilized HCFA and intermediary medical review personnel to review the beneficiaries' medical records to determine whether the claimed services met Medicare eligibility and reimbursement requirements.

The limited scope audit work performed to date has been completed in accordance with generally accepted government auditing standards.

## **RESULTS OF REVIEW**

Since the enactment of OBRA 90, the CMHC PHP program has grown substantially. Total program costs increased about 482 percent between 1993 and 1997 to a total of \$349 million...far exceeding HCFA's estimated costs of \$15 million per year for PHP services. More troubling is the fact that 14 reviews completed in concert with HCFA and the OIG in Florida and Pennsylvania found that a large number of payments were made on behalf of ineligible beneficiaries or to facilities that did not qualify as CMHCs. These reviews identified about \$31 million in improper payments to these 14 CMHCs (see Attachment A). As a result of our joint efforts, HCFA suspended payments to all 14 providers and terminated 10 of these 14 providers from the Medicare program. Eleven of the 14 providers were referred to the OIG's Office of Investigations.

The HCFA also performed independent reviews (not involving the OIG) of 10 CMHCs in Illinois and Texas. Of the 5 reviews conducted in Illinois, between 20 percent and 80 percent of the judgmentally selected beneficiaries were found ineligible to receive PHP benefits. The beneficiaries did not require the intensive services of the PHP. Two of the providers reviewed were part of a chain, and voluntarily withdrew from the program. The results of HCFA's Illinois reviews were provided to the contractor for their evaluation. In Texas, HCFA selected a random sample of claims from each of five CMHCs. The HCFA found that between 90 percent and 100 percent of the beneficiaries were not eligible for PHP services. All five of these CMHCs were referred to the OIG's Office of Investigations.

The following results are provided on the CMHC's administration of the PHP benefit, as well as on CMHC's reporting of costs on their Medicare cost reports.

### Certification of CMHCs

Site visits at CMHCs showed that 5 of the 14 providers, jointly reviewed by OIG/HCFA staff in Florida and Pennsylvania, and 2 of 5 providers independently reviewed by HCFA staff in Illinois, did not meet the requirements to qualify as a CMHC. Some of the providers were unable to produce any documentation or evidence that the facility was ever in compliance with the PHS Act and its five core requirements of services to be provided. For example, although a CMHC signed a statement attesting that it provided the required core services of the PHS Act, the CMHC was unable to provide satisfactory records or documentation to substantiate this assertion.

In addition to not meeting the requirements of the PHS Act, a site visit at one CMHC disclosed health and safety conditions that greatly concerned us. We found that the physical

structure of the facility was in extreme disrepair, and the interior of the building was filthy and uninhabitable. Local health and safety officials were notified of the unsafe and unhealthy conditions, and the facility was condemned.

#### Ineligible Beneficiaries

Significant error rates were found where beneficiaries were not eligible to receive PHP services. In order for a Medicare patient to be eligible for partial hospitalization services, a physician must (1) certify that the individual would require inpatient psychiatric care in the absence of PHP services and (2) establish (and periodically review) an individualized plan for furnishing the services. In addition, the PHP treatment is for patients who: are likely to benefit from a coordinated program of services; do not require 24-hour care and have an adequate support system outside the hospital; have a diagnosis of mental illness; and are not judged to be dangerous.

The PHP services are to provide acutely ill individuals with intensive psychiatric services to prevent a period of hospitalization. However, reviews of medical records by FI medical review staff found that a high percentage of patients were not eligible for those services. The patients sampled at these CMHCs did not have a history of mental illness diagnoses nor would they have required hospitalization if PHP services had not been provided. These CMHCs enrolled patients who were not in need of the intensive services covered under PHP.

In some cases, the patients were unable to participate in or benefit from the services provided. For example, one patient had a diagnosis of senile dementia. There was no evidence that the treatment plan would alter or modify the patient's clinical course. This is an organic condition (disease of the brain) and cannot be improved through the use of psychiatric services. Therefore, psychiatric services provided as a treatment for this patient's dementia were not covered by Medicare because the services did not improve the patient's condition or prevent relapse or hospitalization.

In other cases, beneficiaries did not have diagnosed mental conditions. At one CMHC, none of the 20 beneficiaries in the sample appeared to require the intensive services of a PHP because they did not show symptoms of severe psychiatric disorders. Our interviews of six beneficiaries corroborated these findings and, in fact, beneficiaries were surprised to hear that the PHP services were for patients with mental illnesses. All denied ever having psychiatric problems.

#### Unreasonable, Unnecessary, and Ineligible Services

The review of medical records by the FI medical review staff found that for many CMHCs, none of the services provided to beneficiaries in our sample were reasonable and necessary.

At one CMHC, the same group sessions were recommended for all patients. The reviews determined that the content of the group sessions was social, recreational, and diversionary, rather than psycho-therapeutic in nature. The services were determined not medically necessary because they did not improve or maintain the individual's condition and functional level to prevent relapse or hospitalization. At one provider, beneficiaries spent time attending classes in arts and crafts, music, and story telling. Beneficiaries also played dominoes and bingo, listened to music, and socialized with other senior adults.

### Cost Report Reviews

During the year, a CMHC receives interim payments based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable cost. Upon receipt of the Medicare cost report for the year, the intermediary makes a settlement payment based on the reasonable costs incurred. The OIG has performed cost report reviews at seven CMHCs, and an additional two cost report reviews are in process. We found that cost reports submitted by CMHCs contained costs that were not allowable and allocable under Medicare cost reporting principles. The CMHCs are paid for PHP services on the basis of reasonable costs, which must be related to the care of Medicare beneficiaries. Medicare cost principles limit reimbursement to costs that would be incurred by a reasonable, prudent, and cost-conscious management.

As part of our review, we traced judgmentally selected costs on the cost report to the CMHC's accounting records. These reviews showed that the CMHCs included unallowable and non-reimbursable items in their cost reports. The current cost report process involving CMHCs cannot be used as a valid basis for settling year-end payments because we found they do not contain correct cost information. The types of problems found included:

- undisclosed related party transactions involving leasing, consulting, computer services, billing services, management services, and accounting services.
- excess utilization of services provided under arrangement.
- excessive compensation to owners and key personnel.
- supplies and other costs not related to patient care, such as recreational supplies, party favors, Christmas cards and presents, holiday decorations, flowers, and bowling.
- lack of documentation to support the costs claimed in the cost reports.

### Other Reviews

The OIG is working with HCFA and the intermediaries on the following reviews:

We completed a 5-State review of PHP CMHC claims to determine if the claimed services met Medicare's reimbursement requirements. The five States are Florida, Texas, Pennsylvania, Alabama, and Colorado. These States represent about 77 percent of CMHC PHP payments. We selected a statistical sample of 250 claims (each claim has multiple services) for the period October 1, 1996 through September 30, 1997 for review. The 5-State review disclosed that a substantial percentage of both claims and services were unallowable or highly questionable.

In addition to the 5-State review of claims, we will continue to select additional individual CMHCs for review. These CMHCs will be selected based on HCIS billing information and other criteria, and will include reviews of services, as well as reviews of cost report information.

The HCFA is working on the following initiative involving CMHCs:

The HCFA's central office and its Southern Consortium (Regions 4 and 6) have completed a project to verify initial enrollment information provided by CMHCs. Each CMHC signed an attestation statement that it provided the five core services required to become a CMHC. The project involves nine States (Texas, Florida, Alabama, Louisiana, Arkansas, Georgia, South Carolina, Tennessee, and Mississippi). Each CMHC in these States was visited and asked to provide medical documentation showing that it provided the five core services.

## **Conclusions and Recommendations**

The partial hospitalization problems noted in our work to date mirror the conditions we found in reviewing home health agency claims. The problems involve provider certification issues, ineligible beneficiaries, claims for services that are not supported by a medical need, and submission of cost reports that contain unallowable or improper cost items. We applaud your early suspended payment and provider termination actions to address growing problems with PHPs. Particularly, the work among our two offices has been highly productive to ferret out the bad providers in this newly expanded Medicare benefit area. And, that work is continuing.

In 1998, the Secretary submitted a draft bill to the Congress entitled "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1998," that included payment reforms to help limit overutilization and bring some control to the CMHC PHP benefit. Specifically, the Secretary proposed language to eliminate payments for partial hospitalization services in an individual's home, including an institutional setting. The bill would also impose

civil monetary penalties for false certification of need for partial hospitalization services and require CMHCs, as a condition of receiving payments for partial hospitalization services, to meet additional conditions designed to improve the health and safety of patients. The HCFA officials also informed us that they are developing a PPS for partial hospitalization services provided at a CMHC facility. We understand that HCFA is also developing proposed rules for surety bond and enrollment and re-enrollment requirements for CMHCs to participate in the Medicare program.

We support the Department's and HCFA's proposed changes to the CMHC PHP program. However, we are also recommending that HCFA consider additional actions that would address unscrupulous providers, the medical necessity of services, and inappropriate cost reporting on Medicare cost reports until a PPS system is put in place.

First, concerning the establishment of a PPS rate, our concern is how adjustments to PPS rates will be made for medically unnecessary care and/or other improper payments. These improper payments should be eliminated from the PPS rate to prevent an unwarranted financial windfall to CMHC providers. The kinds of improper payments as disclosed in our current eligibility work in our 5-State sample should be eliminated from the cost data used to establish the PPS rate.

Second, concerning the enrollment of providers, we would suggest that HCFA develop Conditions of Participation to include health and safety requirements and qualifications of staff.

Third, in regard to the problem of ineligible beneficiaries and services, we suggest that the FI conduct a detailed review of the first claim for each new beneficiary receiving services, including a review of medical records, to be sure the beneficiary is eligible for PHP services and that the services provided are appropriate for the medical condition. We also suggest that HCFA, as part of its oversight activities, routinely perform medical reviews of selected PHP claims (e.g., perform the same type of reviews of PHP services that we have been jointly performing). Claims could be selected based on high cost CMHCs, high costs claimed per beneficiary, randomly, or other criteria.

Fourth, regarding the unallowable and unreasonable costs claimed on the cost reports, we encourage HCFA to develop ways to improve the cost reporting process. For example, as part of the FI's cost report review process, HCFA should require FIs to perform some in-depth cost report audits of CMHCs. This would require allotting several weeks for performing on-site audits of certain cost categories where abuses are likely, such as undisclosed related party transactions, cost of services not related to patient care, and excessive compensation to owners and key personnel.

In its written response to our draft report, HCFA concurred with three of the four recommendations and planned corrective action. With regard to our recommendation

regarding the development of Conditions of Participation, HCFA concurred with the intent of the recommendation but believed it did not have the statutory authority to set additional criteria for CMHC enrollment or participation in Medicare. However, HCFA will continue to pursue a legislative proposal which would grant the Secretary the authority to set additional requirements for CMHCs. The complete text of HCFA's response is presented as Attachment B to this report.

## PARTIAL HOSPITALIZATION REVIEWS

<u>CMHC</u>	<u>AMOUNT QUESTIONED</u>
Florida - A <sup>1</sup>	\$ 2,311,945
Florida - B <sup>2</sup>	1,709,245
Florida - C <sup>3</sup>	1,826,243
Florida - D <sup>3</sup>	2,554,314
Florida - E <sup>3</sup>	4,510,161
Florida - F <sup>3</sup>	3,216,575
Florida - G <sup>3</sup>	2,281,730
Florida - H <sup>4</sup>	1,945,820
Florida - I <sup>4</sup>	1,868,940
Florida - J <sup>3</sup>	2,899,083
Florida - K <sup>3</sup>	645,627
Florida - L <sup>4</sup>	3,760,000
Pennsylvania - M <sup>4</sup>	880,949
Pennsylvania - N <sup>4</sup>	877,919
<b>TOTAL</b>	<b>\$31,288,551</b>

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<sup>1</sup>Final OIG reports

<sup>2</sup>Draft OIG reports

<sup>3</sup>Joint reports

<sup>4</sup>Preliminary calculations - no reports issued to date



SEP 18 1998

DATE:

TO: June Gibbs-Brown  
Inspector General

FROM: Nancy-Ann Min DeParle  
Administrator

SUBJECT: Office of the Inspector General Draft Reports:  
(1) "A Review of Partial Hospitalization Services Provided Through  
Community Mental Health Centers," (A-04-98-02146); and  
(2) "Five-State Review of Partial Hospitalization Programs at Community  
Mental Health Centers," (A-04-98-02145).

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
SAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EC	<input type="checkbox"/>
DIG-LI	<input type="checkbox"/>
DIG-CI	<input type="checkbox"/>
DIG-IP	<input type="checkbox"/>
AIG-LC	<input checked="" type="checkbox"/>
OGC/IG	<input checked="" type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	9-18

The Administrator  
Washington, D.C. 20201

SEP 18 1998

GENERAL

Summary

The Health Care Financing Administration (HCFA) and the HHS Office of Inspector General (OIG) have been working together for more than a year to identify problems of misuse of Medicare's Partial Hospitalization benefit by a significant number of Community Mental Health Centers (CMHCs). This benefit was created to provide outpatient services for beneficiaries with mental illness who would otherwise need to be treated, at higher cost and less appropriately, on an inpatient basis.

Beginning in 1996, site visits performed by HCFA as part of the Operation Restore Trust Initiative identified significant problems pointing to abuse of the program by some CMHCs. Further work undertaken by HCFA last year indicates that many CMHCs are not providing, and are unable to provide, the core services that are required by statute and necessary for proper care of these patients. The reports by the Inspector General further corroborate the problems in this program.

The conclusions in the OIG reports are consistent with HCFA's findings. The Partial Hospitalization (PH) benefit is being significantly misused by some CMHCs, and the program is in need of fundamental repair. HCFA is taking immediate steps to ensure that providers are properly qualified to deliver the mental health services which the program covers; that beneficiaries receiving the services are indeed those who need them; that Medicare is paying only for appropriate services that are covered under the law. CMHCs which are clearly unqualified to provide these services should be terminated from Medicare and steps should be taken to ensure that all remaining CMHCs are qualified. In addition, CMHCs believed to have defrauded Medicare should be referred for further investigation and potential prosecution. HCFA is already in the process of implementing a plan which includes these and other steps.

Page 2 - June Gibbs-Brown

At the same time, as we repair our program, we must be careful to protect Medicare beneficiaries. In particular, we must ensure that those with mental illness are under proper care. Even as we phase in terminations of unqualified providers, we will work with communities to ensure that beneficiaries receive proper care.

As an area initially investigated under Operation Restore Trust(ORT), these problems among CMHCs have been uncovered relatively early and our corrective actions can be taken before the problem grows worse. The OIG has played a significant cooperative role in identifying these problems and developing solutions.

### **CMHC Requirements**

To be covered by Medicare, PH services must be reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. The statute recognizes two types of providers of PH services: services provided by hospitals to its outpatients, or services provided by CMHCs.

In order to participate in Medicare as a CMHC, an entity must meet the statutory requirements at section 1861(ff)(3)(B) which defines a CMHC as an entity that provides the services listed in section 1916(c)(4) of the PHS Act (now section 1913(c)(1)). CMHCs enroll in the Medicare program by signing an attestation statement that they comply with the PHS and Social Security Acts and State licensing laws. By statute, a CMHC must provide four services to members of the community and the services are:

- (1) outpatient services to children, and the elderly, and individuals who are severely mentally ill, outpatient services for residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;
- (2) 24-hour a day emergency care services;
- (3) day treatment or other PH services or other psychosocial rehabilitation services; and,
- (4) screening for clients being considered for admission to state mental health facilities to determine the appropriateness of such admission.

### **Evidence of Fraud and Abuse**

There has been growing evidence that the PH benefit is being abused. The strongest evidence of fraud and abuse in this benefit has been associated with the CMHC setting. As part of our regular monitoring and analysis of expenditures by benefit and provider type, HCFA detected a significant and unanticipated growth in expenditures for this benefit. Particularly aberrant was the growth in expenditures to CMHCs for partial hospitalization services.

In the CMHC setting, between 1993 and 1996, total payments for PH rose from \$60 million to \$265 million (a 342 percent increase). The average payment per patient during this same time period rose from \$1,642 to \$6,874 in 1996 (a 319 percent increase). Preliminary figures show

Page 3 - June Gibbs-Brown

that Calendar Year (CY) 1997 payments have risen to \$349 million, and the average payment per patient has risen to \$10,352. The growth in CMHC expenditures is focused in certain Southern States which account for approximately 25 percent of the nation's beneficiaries, but **85 percent** of all Medicare payments to CMHCs in CY 1996.

### HCFA Activities

In response to this rapid growth in expenditures, HCFA has taken several actions. Beginning in 1996, under the auspices of ORT, approximately twenty CMHCs were selected for site reviews in several states based upon their aberrant billing patterns. These reviews found a significant percentage of beneficiaries to be ineligible for PH services.

Reviews conducted by Florida's Miami ORT Satellite Office, in conjunction with the OIG, found that 17 of 18 CMHCs reviewed did not provide the required core services and thus did not meet the statutory requirement to be a CMHC; 89 percent of sample beneficiaries were ineligible, and 100 percent of the services were not Medicare covered services. Related overpayment reviews identified significant fraudulent costs. Payments were suspended to all 18 providers and referrals were made to law enforcement agencies for further investigation and/or prosecution.

The second major action undertaken by HCFA began in July 1997. Based upon findings from ORT reviews, HCFA conducted an enrollment initiative to determine the veracity of the CMHC owner's initial attestation that they were in compliance with applicable State licensing laws and provided the core services required under the statute. Site visits were conducted at all current Medicare CMHCs and selected applicants within the states of Florida, Texas, Georgia, Mississippi, Arkansas, Alabama, South Carolina, Tennessee, and Louisiana. The site visits began in late January 1998 and were completed by August 30.

Preliminary information suggests that some CMHCs are not providing the required core services and are, therefore, subject to termination because they do not meet the statutory definition of a CMHC. HCFA has instituted processes to ensure that any noncompliant CMHCs are afforded due process and an opportunity to rebut our determination of noncompliance.

Overall, we have a 10-point initiative to tackle problems that we and the Inspector General have identified with the PH benefits. Those action points are:

### Immediate Actions

1. **Terminating the worst offenders.** Medicare will end its relationship with those CMHCs that fail to meet all four of the program's core requirements. Other CMHCs that are not as far out of compliance will be given an opportunity to correct identified problems.

Page 4 - June Gibbs-Brown

2. **Reinforcing Medicare's CMHC standards.** HCFA, through its regional offices and state survey agencies, will more strongly enforce the application process and reinforce the need for prospective CMHCs to meet all existing statutory and regulatory requirements for participation in the program.
3. **Increasing scrutiny of new applicants.** HCFA will require site visits nationwide to ensure new applicants meet all of Medicare's core requirements. Already, the agency denied more than 100 applicants because they failed to provide all the required services.
4. **Protecting beneficiary access to covered services.** HCFA will consider the local needs of beneficiaries before it terminates any centers. The agency will work with mental-health advocates, state officials, and others to ensure beneficiaries receive appropriate services from Medicare, and when appropriate, other social-service agencies.

#### Longer-Term Actions

5. **Implementing a prospective payment system.** HCFA is working to develop a new payment system for hospital outpatient services, as required by the Balanced Budget Act of 1997. The new system will apply to partial hospitalization benefits in CMHCs and will eliminate the financial incentives to provide inappropriate, unnecessary, or inefficient care.
6. **Conducting a broad evaluation of the benefit.** With the Inspector General, HCFA will conduct an overall review of the PH benefits in both community mental health centers and hospital outpatient departments. We will take appropriate steps to address problem areas identified during that review.
7. **Intensifying medical review of claims.** HCFA and its contractors will review more partial hospitalization claims to ensure Medicare pays only for appropriate services to qualified beneficiaries. This will involve claims from CMHCs and hospital outpatient departments.
8. **Minimizing losses to the Medicare Trust Fund.** HCFA will suspend payments to providers when services are not billed properly. Medicare will also demand that centers repay improper claims and will refer suspected fraud to the Inspector General.
9. **Pursuing the President's proposed legislative reforms.** In January, President Clinton asked Congress to act on proposals to strengthen CMHC enforcement activities by 1) authorizing fines for falsely certifying a beneficiaries' eligibility for PH services; 2) prohibiting PH services from being provided in a beneficiaries' home or other residential setting; and 3) authorizing the Secretary to set additional requirements for CMHCs to participate in the Medicare program. In addition, HCFA will consult with other groups to consider appropriate, additional changes.

Page 5 - June Gibbs-Brown

10. **Evaluating the need for re-enrollment requirements.** HCFA will consider new regulations that would require CMHCs to re-enroll periodically in the Medicare program and to serve a minimum number of non-Medicare patients.

Together, these initiatives address each of the Inspector General's recommendations. Our specific responses to the recommendations outlined in each report are attached.

Attachment 1

**“A Review of Partial Hospitalization Services Provided Through  
Community Mental Health Centers,” (A-04-98-02146)**

**OIG Recommendation 1**

As HCFA develops a prospective payment system (PPS), we recommend that HCFA determine the costs of unnecessary care and other excessive costs and eliminate them from the cost data used to establish the PPS.

**HCFA Response**

We concur. Under the Balanced Budget Act of 1997, HCFA will establish a PPS for hospital outpatient department services. HCFA's new payment system will include PH services rendered by both CMHCs and hospital outpatient departments. We will consider the costs of unnecessary care and other excessive costs when developing the PPS.

**OIG Recommendation 2**

HCFA should develop conditions of participation or conduct onsite surveys during the enrollment process in order to address health and safety requirements and qualifications of staff.

**HCFA Response**

Although we concur with the intent of the recommendation, section 1861(ff) of the Social Security Act (governing Medicare coverage of partial hospitalization services provided by CMHCs) only requires CMHCs to provide the range of services specified in the PHS Act, and to meet applicable state licensing or certification requirements. Thus, we do not currently have statutory authority to set additional criteria for CMHC enrollment or participation in Medicare. However, we will continue to pursue a legislative proposal that was included in the President's FY 99 budget, which would grant the Secretary the authority to set additional requirements for CMHCs.

Meanwhile, we are planning to conduct site visits to CMHCs nationwide in order to validate information submitted by the CMHCs at the time of their enrollment in Medicare. We are also conducting site visits to new CMHC applicants to ensure that only those programs that meet all statutory core requirements are granted a new Medicare billing number. Recently, HCFA issued instructions to the Regional Offices and provided model letters for the denial of applicants based on failure to meet the core requirements.

Page 2 - Attachment 1

OIG Recommendation 3

Fiscal intermediaries should conduct a detailed review of the first claim for each new beneficiary receiving services, including a review of medical records, to be sure the beneficiary is eligible for P.H. services. As part of its oversight activities, HCFA should routinely perform medical review of selected P.H. claims.

HCFA Response

We concur. Currently, some fiscal intermediaries (FIs) perform 100 percent review of claims from CMHCs. HCFA is examining mechanisms to more broadly implement intensified medical review by FIs in both hospital outpatient departments and CMHCs to determine, before-hand, whether the beneficiary is eligible for the partial hospitalization (PH) benefit. Furthermore, HCFA will continue to routinely use focused medical review to target select PH claims that are possibly indicative of fraud or abuse.

OIG Recommendation 4

HCFA should develop ways to improve the cost reporting process.

HCFA Response

We concur. We have scheduled focused reviews for the audit of CMHCs for FY 1999. This is part of the Budget and Performance Requirements for the coming budget year.