

**Memorandum**

Date OCT - 5 1998

From June Gibbs Brown
Inspector General *June G. Brown*

Subject Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers
(A-04-98-02145)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is our final report entitled, "Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers." The objective of our review was to determine whether payments for partial hospitalization program (PHP) services to community mental health centers (CMHC) in the five States selected met Medicare requirements. Our work was performed as a cooperative initiative with Health Care Financing Administration (HCFA) staff. We are very grateful for the tremendous assistance provided to the Office of Inspector General (OIG) by these highly professional HCFA personnel.

We estimate that for the 12-month period ended September 30, 1997, Medicare fiscal intermediaries (FI) paid CMHCs, in the five States reviewed, \$229 million for unallowable and highly questionable PHP services--mathematically this equals 91 percent of the total of \$252 million paid to all CMHCs in these five States for PHP services. The CMHCs in these five States; Florida, Texas, Colorado, Pennsylvania, and Alabama, accounted for about 77 percent of CMHC PHP payments nationally during Calendar Year 1996.

In a program designed to pay for intensive outpatient psychiatric services provided to acutely ill individuals in order to prevent their hospitalization, Medicare was paying for PHP services to beneficiaries who had no history of mental illness or who suffered from mental conditions that would preclude them from benefitting from the program. In addition, Medicare was paying for therapy sessions that involved only recreational and diversionary activities such as drawing, arts and crafts, watching television, and playing bingo and other games.

We statistically selected for review 250 claims of which 229 (92 percent) were found to involve unallowable or highly questionable services. The 250 claims contained 6,736 units of PHP services. Of these, we were able to review claims containing 5,431 units of service and found 4,959 units (91 percent of the services reviewed) did not meet Medicare reimbursement requirements. The vast majority of the unallowable services were provided to beneficiaries who were ineligible for PHP services.

We believe that Medicare made payments to CMHCs for unallowable and highly questionable services, in part, because individuals/companies are allowed to provide self-attestation statements to obtain Medicare CMHC provider numbers. Through this self-attestation process, HCFA relies exclusively on the integrity of the applicants to certify that they comply with requirements of the Social Security Act (Act) and are in compliance with State licensure laws. It is important to note that only about 40 percent of the States have licensure requirements for CMHCs. The lack of State oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program. Additionally, we believe that prior limited reviews performed by FIs have been inadequate to prevent CMHCs from enrolling ineligible beneficiaries and from billing for unallowable PHP services.

In addition to OIG's audits, HCFA conducted an enrollment initiative in 9 States involving almost 700 CMHCs to determine whether these facilities meet the requirements set forth in the Act and therefore qualify to bill Medicare. Preliminary HCFA results indicate that a large number of the CMHCs reviewed did not meet the requirements of the Act. To assist HCFA, we performed some work to determine the compliance of selected CMHCs in Colorado and Pennsylvania. While the results of our work are reported in the OTHER MATTERS section of this report, we found problems of non-compliance with the Act.

Based on the results of our review and HCFA's enrollment initiative, we are recommending that HCFA take strong action against those facilities which HCFA determined did not meet the requirements to be CMHCs under the Act, including termination of provider agreements, where appropriate. We are also making a number of other recommendations regarding the recovery of overpayments and termination of CMHCs.

In view of the severity of the problems disclosed, we believe that HCFA should evaluate the propriety of allowing CMHCs to provide the PHP benefit. Should HCFA decide that the PHP benefit cannot be adequately provided by CMHCs, a legislative change should be sought to repeal Medicare coverage for this benefit in the CMHC setting. We have not evaluated the delivery of PHP benefits in the hospital outpatient setting. However, the extensive nature of the problems found with CMHCs causes us to be concerned in general with this benefit. We, therefore, encourage HCFA to include hospital outpatient claims in their overall evaluation of the PHP benefit.

In the interim, or if HCFA decides that Medicare should continue to provide coverage of the PHP benefit in the CMHC setting, we recommend that consideration be given to establishing a limit on the number of days of PHP services that are covered by Medicare. This coverage change would complement the planned prospective payment system daily rate for

PHP services. As contained in our report entitled "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers" (A-04-98-02146), we continue to recommend that the following actions be taken by HCFA:

- ◆ Either develop conditions of participation for CMHCs or conduct on-site surveys during the provider enrollment process to determine whether CMHCs comply with the requirements of the Act and therefore qualify as Medicare providers for PHP services.
- ◆ Instruct FIs to perform a detailed medical review of the first claim submitted for each new beneficiary receiving PHP services from a CMHC, and have HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

In its written response to our draft report, HCFA concurred with our specific recommendations. The HCFA recognized that the working together with OIG, significant problems were identified relating to the qualification of providers to deliver the mental health services which the program covers, the eligibility of the beneficiaries receiving the services, and the appropriateness of the services provided. To address the problems identified, HCFA developed a 10-point initiative which includes both immediate and long-term actions. Among other things, HCFA's initiative includes the termination of egregious CMHCs, intensified medical reviews, overpayment collections, and various legislative actions.

We believe HCFA's proposed initiative, when implemented, will help ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX F 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-04-98-02145 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**FIVE-STATE REVIEW OF
PARTIAL HOSPITALIZATION PROGRAMS AT
COMMUNITY MENTAL HEALTH CENTERS**



**JUNE GIBBS BROWN
Inspector General**

**OCTOBER 1998
A-04-98-02145**

**Memorandum**

Date OCT - 5 1998

From June Gibbs Brown
Inspector General *June G Brown*

Subject Five-State Review of Partial Hospitalization Programs at Community Mental Health Centers (A-04-98-02145)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our review of Medicare partial hospitalization program (PHP) services at community mental health centers (CMHC) in five States for the 12-month period ended September 30, 1997. The CMHCs in these five States, Florida, Texas, Colorado, Pennsylvania, and Alabama, accounted for about 77 percent of CMHC PHP payments nationally during Calendar Year (CY) 1996. The objective of this review was to determine whether payments for PHP services met Medicare requirements.

Our work was performed as a cooperative initiative with Health Care Financing Administration (HCFA) staff. We are very grateful for the tremendous assistance provided to the Office of Inspector General (OIG) by the highly professional HCFA personnel.

We statistically selected for review 250 claims of which 229 (92 percent) were found to involve unallowable or highly questionable services. The 250 claims contained 6,736 units of PHP services. Of these, we were able to review claims containing 5,431 units of service and found 4,959 units (91 percent of the services reviewed) did not meet Medicare requirements for reimbursement because:

**Medicare paid
\$229 million for
unallowable and highly
questionable PHP services over a
12-month period.**

- In the opinion of expert medical reviewers:
 - ✓ 4,309 units of service contained in 149 claims were provided to beneficiaries who were ineligible for PHP services.
 - ✓ 432 units of service contained in 15 claims were not reasonable and necessary for the patient's condition.

- ✓ 167 units of service contained in 18 claims were not properly authorized by or furnished under the general supervision of a physician.
- ✓ 25 units of service contained in 2 claims were not adequately documented.
- Services with no supporting documentation:
 - ✓ 26 units of service contained in 1 claim had no supporting documentation.

We could not complete our review of the remaining 1,305 units contained in 44 claims because the providers were either under investigation, suspended or terminated, or no longer operational. Although we could not complete our review of these claims, circumstances surrounding the termination/investigative actions make the allowability of these claims highly questionable.

We estimate that for the 12-month period ended September 30, 1997, Medicare fiscal intermediaries (FI) paid CMHCs, in the five States reviewed, \$229 million for unallowable (\$180 million) and highly questionable (\$49 million) PHP services--mathematically this equals 91 percent of the total of \$252 million paid to all CMHCs in these five States for PHP services.

In a program designed to pay for intensive outpatient psychiatric services provided to acutely ill individuals in order to prevent their hospitalization, Medicare was paying for PHP services to beneficiaries who had no history of mental illness or who suffered from mental conditions that would preclude them from benefitting from the program. In addition, Medicare was paying for therapy sessions that involved only recreational and diversionary activities such as drawing, arts and crafts, watching television, and playing bingo and other games.

In addition to OIG's audits, HCFA conducted an enrollment initiative in 9 States involving almost 700 CMHCs to determine whether these facilities meet the requirements set forth in the Social Security Act (Act)¹ and therefore qualify to bill Medicare. Preliminary HCFA results indicate that a large number of the CMHCs reviewed did not meet the requirements of the Act. To assist HCFA, we performed

¹Section 1861(ff)(3)(B) defines a CMHC as an entity which provides the services described in section 1916(c)(4) of the Public Health Service (PHS) Act; and meets the applicable State licensing or certification requirements.

some work to determine the compliance of selected CMHCs in Colorado and Pennsylvania. While the results of our work are reported in the **OTHER MATTERS** section of this report, we found problems of non-compliance with the Act .

We believe that Medicare made payments to CMHCs for unallowable and highly questionable services, in part, because individuals/companies are allowed to provide self-attestation statements to obtain Medicare CMHC provider numbers. Through this self-attestation process, HCFA relies exclusively on the integrity of the applicants to certify that they comply with requirements of the Act and are in compliance with State licensure laws. It is important to note that only about 40 percent of the States have licensure requirements for CMHCs. The lack of State oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program. Additionally, we believe that prior limited reviews performed by FIs have been inadequate to prevent CMHCs from enrolling ineligible beneficiaries and from billing for unallowable PHP services.

Based on the results of our review and HCFA's enrollment initiative, we recommend that HCFA:

- Take strong action against those facilities which HCFA determined did not meet the requirements to be CMHCs under the Act, including termination of provider agreements, where appropriate.
- Instruct FIs, for the HCFA identified CMHCs , to make appropriate recovery of overpayments including an audit of the closing cost reports for those CMHCs terminated.
- Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the CMHCs for the beneficiaries in our sample to identify and recover additional overpayments.
- Develop a plan to review all claims submitted by the remaining CMHCs across the nation. To implement this plan, HCFA could:
 - ✓ Instruct FIs to conduct medical reviews to identify and recover overpayments;
 - ✓ Encourage CMHCs, perhaps in conjunction with industry representatives, to conduct a self audit, with FI, HCFA, and/or OIG oversight, to identify overpayments for recovery by the FI; or

- ✓ Seek legislation to require CMHCs, should voluntary efforts prove unsuccessful, to have an independent medical reviewer identify overpayments for recovery by the FI.

In view of the severity of the problems disclosed, we believe that HCFA should evaluate the propriety of allowing CMHCs to provide the PHP benefit. Should HCFA decide that the PHP benefit cannot be adequately provided by CMHCs, a legislative change should be sought to repeal Medicare coverage for this benefit in the CMHC setting. We have not evaluated the delivery of PHP benefits in the hospital outpatient setting. However, the extensive nature of the problems found with CMHCs causes us to be concerned in general with this benefit. We, therefore, encourage HCFA to include hospital outpatient claims in their overall evaluation of the PHP benefit.

In the interim, or if HCFA decides that Medicare should continue to provide coverage of the PHP benefit in the CMHC setting, we recommend that consideration be given to establishing a limit on the number of days of PHP services that are covered by Medicare. This coverage change would complement the planned prospective payment system (PPS) daily rate for PHP services. We also continue to recommend² that the following actions be taken by HCFA:

- Either develop conditions of participation for CMHCs or conduct on-site surveys during the provider enrollment process to determine whether CMHCs comply with the requirements of the Act and therefore qualify as Medicare providers for PHP services.
- Instruct FIs to perform a detailed medical review of the first claim submitted for each new beneficiary receiving PHP services from a CMHC, and have HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

In its written response to our draft report, HCFA concurred with our specific recommendations. To address the problems identified, HCFA developed a 10-point initiative which includes both immediate and long-term actions. Among other things, HCFA's initiative includes the termination of egregious CMHCs, intensified medical reviews, overpayment collections, and various legislative actions.

We believe HCFA's proposed initiative, when implemented, will help to ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX F to this report.

²*These recommendations are also contained in our report entitled "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers" (A-04-98-02146).*

INTRODUCTION

BACKGROUND

Section 1861(ff)(2) of the Act generally defines PHP services as those (mental health) services that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. Section 1835(2)(F) of the Act requires physicians to certify that patients would otherwise require inpatient psychiatric care. Medicare regulations, 42 CFR 410.110(a), require that PHP services be "prescribed by a physician and furnished under the general supervision of a physician." The PHP services can be provided by either hospital outpatient departments or CMHCs.

A CMHC provides treatment and services to mentally ill individuals residing in the community. In 1963, the Community Mental Health Centers Act created a Federal grant program to help States in the construction of CMHCs. Section 4162 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) authorized Medicare coverage and payment for PHP services provided by CMHCs beginning on October 1, 1991. Prior to that time, the Medicare program did not provide coverage for PHP services provided by CMHCs.

The OBRA 1990 defined a CMHC as an entity that provides the services described in the PHS Act and also meets applicable State licensing requirements. The Act incorporates these requirements in section 1861(ff)(3)(B). However, about two-thirds of States do not have licensing requirements for CMHCs.

The HCFA requires that all CMHCs entering the Medicare program attest to the fact that they provide the five³ core services of a CMHC as required by section 1916(c)(4) of the PHS Act. The five core services are:

- ① Outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health services area who have been discharged from outpatient treatment at a mental health facility;
- ② 24-hour a day emergency care services;

³In 1992, the PHS Act was amended to require only four core services. The amendment eliminated the requirement to provide consultation and education services. The four core services are currently listed at section 1913(c)(1)(B) of the Act, which superceded section 1916(c)(4).

- ③ Day treatment or other partial hospitalization services or psychosocial rehabilitation services;
- ④ Screening for patients being considered for admission to state mental health facilities to determine the appropriateness for such admissions; and
- ⑤ Consultation and education services.

Since the enactment of the OBRA 90 provisions, the CMHC PHP program has grown substantially. Total Medicare payments to CMHCs for PHP services grew from \$60 million in 1993 to \$349 million in 1997, a 482 percent increase. This far exceeded HCFA's estimated cost of \$15 million per year for these services. Average payments per patient increased 530 percent over this same period, going from \$1,642 to \$10,352.

National Medicare Payments for CMHC/PHP Services

Calendar Year	Number of CMHCs	Total Payments	Average Per Patient
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 ⁴	10,352

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the CMHC PHP benefit. The FIs in the five States that we reviewed were: Blue Cross and Blue Shield of Florida, Mutual of Omaha, Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of Alabama, and Veritus of Pennsylvania.

The FIs are responsible for processing claims for CMHC PHP services, administering payment safeguard activities, performing liaison activities between HCFA and CMHCs, conducting audits of cost reports submitted by CMHCs, and disseminating information and educational materials.

⁴ This amount is as of March 31, 1998. Expenditures for 1997 will increase to reflect additional claims processed after March 31, 1998.

Section 1833(a)(2)(B) of the Act provides that CMHCs will be paid for PHP services on the basis of reasonable costs. During the year, the FI makes interim payments to the CMHC based on a percentage of its billed charges. These payments are intended to approximate the CMHC's reasonable costs. Upon receipt of the Medicare cost report for the year, the FI makes a final settlement based on the reasonable costs incurred.

In our report issued to HCFA entitled "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers (A-04-98-02146),"⁵ we summarized audit activity completed in concert with HCFA on the delivery of PHP services to Medicare beneficiaries in CMHCs. Although the report disclosed widespread problems at 14 CMHCs in Florida and Pennsylvania, we were not able to determine an overall error rate for ineligible beneficiaries and ineligible PHP services. In addition, HCFA performed independent reviews of 10 CMHCs in Illinois and Texas. These HCFA reviews disclosed that a significant percentage of beneficiaries were not eligible for PHP services. To determine the extent of and to quantify the problem, we selected a sample of claims from the five States that accounted for a majority (about 77 percent) of Medicare payments made to CMHCs for PHP services in CY 1996.

In the development of a hospital outpatient PPS as required by the Balanced Budget Act of 1997, HCFA proposed a bundled per diem approach to reimburse for PHP services at CMHCs. This system, which is to become effective on January 1, 1999, will be based on the median cost of PHP services furnished on a typical day in the hospital outpatient setting. Until such time as PPS is implemented, it is critical that HCFA instruct FIs to perform cost report audits and targeted medical reviews.

SCOPE

The objective of our review was to determine whether payments for PHP services to CMHCs in the five States selected met Medicare requirements.

Our sample was selected from the universe of claims paid by FIs servicing the five States for the period of October 1, 1996 through September 30, 1997. For the 12-month period, the FIs paid 123,284 PHP claims totaling \$252,012,580 for the five States.

Our sample consisted of 250 claims which included 249 Medicare beneficiaries who received PHP services from 158 providers. By chance, two claims for the same beneficiary were selected and represent two distinct sample items. The FIs paid \$517,741 for the 250 claims in our sample. Appendix D contains the details of our sampling methodology. Appendix E contains the results and projections of our sample.

⁵Although additional CMHCs were reviewed by HCFA and OIG in Florida and Pennsylvania, this report includes only the results of the CMHC reviews which were completed when our draft report was issued in April 1998.

To determine whether the beneficiary was eligible to receive PHP services and whether the PHP services were reasonable and necessary: we requested supporting medical records documentation maintained by the CMHCs for 206 claims; we requested the FIs' medical review personnel to review each record; and we interviewed the beneficiary, a family member, or a close acquaintance. We did not review the other 44 claims because the providers were either under investigation, suspended or terminated from participation in Medicare, or no longer operational.

We did not review the CMHCs' internal control structure or their cost reports. However, for each CMHC contacted we interviewed the principals to secure information related to marketing strategies, the beneficiary certification process and referral sources, as well as cost report items such as owners' compensation, cost of contracted services and management fees, unreasonable rent expenses, etc. Previous reviews showed that these areas are particularly vulnerable to fraud and abuse. This information will be made available to the FIs for their use in settling the final cost reports.

For each provider selected in Colorado and Pennsylvania, we obtained medical records documentation supporting the provision of the services required by the Act and requested assistance from the corresponding HCFA regional office for reviewing the records and making a determination as to whether the providers complied with the provisions of the Act. This effort was performed as an assist to HCFA to supplement their enrollment initiative being conducted in nine States.

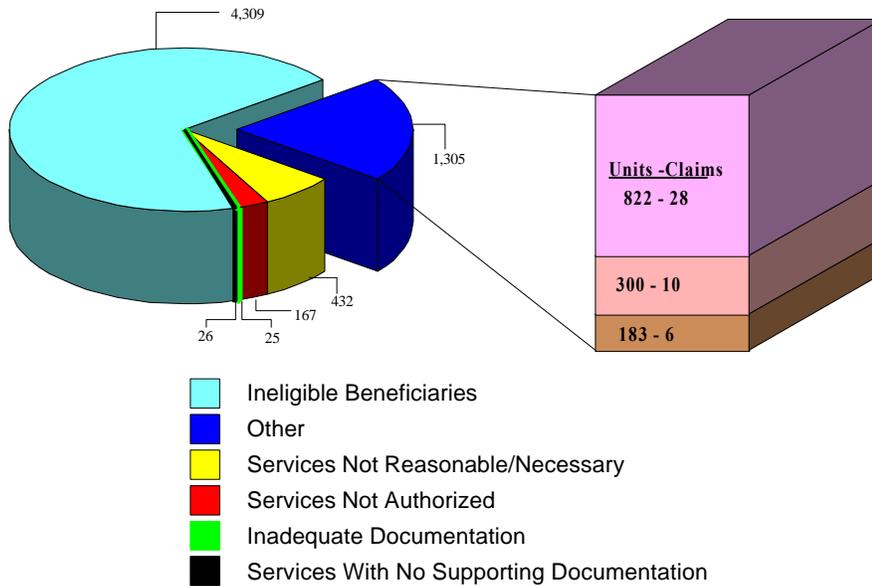
Our audit was conducted in accordance with generally accepted government auditing standards. The field work was conducted in Florida, Texas, Colorado, Pennsylvania, and Alabama. We visited the CMHCs' places of business or their administrative offices and the beneficiaries' places of residence. The field work was conducted from March 1998 to June 1998.

RESULTS OF REVIEW

We estimate that, for the 12-month period ended September 30, 1997, Medicare FIs paid CMHCs in the five States reviewed \$229 million for unallowable (\$180 million) and highly questionable (\$49 million) PHP services. During this period, a total of \$252 million was paid for PHP services to all CMHCs in these five States. The CMHCs in these five States received about 77 percent of total CMHC payments nationally during CY 1996.

We statistically selected for review 250 claims containing 6,736 units of service.⁶ Of these, we were able to complete our analysis on 5,431 units of service and found 4,959 units of service (91 percent) did not meet Medicare reimbursement requirements. The majority of services did not meet Medicare requirements because they were provided to ineligible beneficiaries, not reasonable and necessary for the patients' condition, not authorized by a physician, or not adequately documented. Another 1,305 units of service were not reviewed because the providers were either under investigation, suspended or terminated, or no longer operational.

Unallowable and/or Highly Questionable PHP Units of Services



Ineligible Beneficiaries

Our review showed that 4,309 units of services contained in 149 sample claims were provided to beneficiaries that did not meet the Medicare eligibility requirements for PHP services. In order for a Medicare beneficiary to be eligible for PHP services, he or she must exhibit a severe or disabling condition related to an acute psychiatric or psychological disorder, or an exacerbation of a severe and persistent mental disorder. In addition, a beneficiary must: be able to benefit from a coordinated program of services; have an adequate support system outside the program; have an ICD-9 diagnosis of mental illness; not be dangerous to themselves or others; and not require 24-hour care.

⁶The 6,736 units of services were contained in 250 claims of which 229 (92 percent) did not meet Medicare requirements or were highly questionable.

In short, *eligible beneficiaries would require inpatient psychiatric treatment in the absence of a PHP.*

The medical reviewers' findings that 149 sampled claims contained services that were provided to beneficiaries who were ineligible for PHP services were based on the fact that the beneficiaries either: (1) would not have required inpatient services in absence of the PHP services, (2) had no previous history of psychiatric disorders, (3) suffered from organic degenerative conditions that precluded them from benefitting from PHP services, (4) lacked an adequate support system, (5) were dangerous to themselves and to others, or (6) needed only recreational and socialization services.

In our sample, there were beneficiaries who did not meet Medicare eligibility requirements for PHP benefits. Examples of beneficiaries who were determined ineligible for the PHP benefit are presented in Appendices A and B.

Services Not Reasonable and Necessary

Our review showed that 432 units contained in 15 sample claims were for services that were not reasonable and necessary for the patient's condition. The Act describes a PHP as a distinct and organized intensive ambulatory treatment program offering less than 24-hour daily care which furnishes services that: (1) are reasonable and necessary for the diagnosis or active treatment of the individual's condition and (2) are reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization.

Medical reviewers determined that these claims included units of services which were not reasonable and necessary for the condition of the patient. Our review showed that at several CMHCs all beneficiaries received the same services without regard to their individual diagnosis and treatment plan. For example, the same group sessions were attended by all patients, including beneficiaries with hearing impairments and beneficiaries unable to actively participate in the group session. In addition, services provided were found to be recreational and diversionary in nature and therefore not reasonable and necessary under the PHP benefit (see Appendix C for an example of a beneficiary who received services that were not reasonable and necessary.)

Services Not Authorized

Our review showed that 167 units of services included in 18 sample claims were not properly authorized or supervised by a physician. Medicare regulations require that partial hospitalization services be "prescribed by a physician and furnished under the general supervision of a physician." The physician must certify (and periodically recertify) that the patient would require inpatient psychiatric care in the absence of partial hospitalization services, and the physician must establish and periodically review the patient's treatment plan.

Medical reviewers determined that medical records for these claims lacked evidence of physician authorization and supervision. Specifically, the records did not contain physician evaluations, certifications, signed plans of care, orders for services, and/or the physician progress notes which indicate general supervision of the patient's treatment.

Inadequate Documentation

Our review showed that 25 units contained in 2 sample claims lacked adequate documentation. Inadequate documentation included incomplete assessments, admission orders, physician certifications, treatment plans, physician notes, and progress notes.

Services With No Supporting Documentation

We found 1 claim containing 26 units of service related to 1 provider who could not produce any documentation to support that the beneficiary ever attended the program or received PHP services.

Other

Our review showed that 1,305 units of service contained in 44 sample claims related to providers who were either under investigation, suspended or terminated, or no longer operational.

Providers Under Investigation

We found 10 claims containing 300 units related to 6 providers in 1 State that are being investigated by OIG Office of Investigations.

Providers Suspended or Terminated by HCFA

We found 28 claims containing 822 units related to 12 providers that had been suspended or terminated from participation in the Medicare program by HCFA.

Providers no Longer Operational

We found 6 claims containing 183 units of service related to 4 providers that are no longer operational and could not be found.

During our review, we noted a number of beneficiaries who received PHP services for extended periods of time. Presently, there is no limitation on the length of time that beneficiaries can receive PHP services. Due to the extensive nature of the problems we have noted, limiting the number of days for which PHP services can be received could be an improvement in program controls. The planned PPS for hospital outpatient PHP services includes a daily rate that would be paid to an entity for bundled PHP services.

Establishing a length of treatment limitation would supplement the daily rate expenditure control. If necessary, special approval could be granted for an extended service period.

During the course of our review, several issues which may be a cause for concern came to our attention. These include patient recruitment strategies, movement of CMHCs without HCFA approval, determination of beneficiary eligibility, billing for and collection of beneficiary copayments, provider reimbursement rates, and inclusion of unallowable items on the CMHCs' Medicare cost reports. We are continuing our work in these other areas and when completed we will report those results to HCFA.

CONCLUSIONS AND RECOMMENDATIONS

We believe that Medicare made payments to CMHCs for unallowable and highly questionable services, in part, because individuals/companies are allowed to provide self-attestation statements to obtain Medicare CMHC provider numbers. Through this self-attestation process, HCFA relies exclusively on the integrity of the applicants to certify that they comply with requirements of the Act and are in compliance with State licensure laws. It is important to note that only about 40 percent of the States have licensure requirements for CMHCs. The lack of State oversight and the use of a self-attestation process permitted unscrupulous providers to participate in the Medicare program. Additionally, we believe that prior limited reviews performed by FIs have been inadequate to prevent CMHCs from enrolling ineligible beneficiaries and from billing for unallowable PHP services.

Based on the results of our review and HCFA's enrollment initiative, we recommend that HCFA:

- Take strong action against those facilities which HCFA determined did not meet the requirements to be CHMCs under the Act, including termination of provider agreements, where appropriate.
- Instruct FIs, for the HCFA identified CMHCs, to make appropriate recovery of overpayments including an audit of the closing cost reports for those CMHCs terminated.
- Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the CMHCs for the beneficiaries in our sample to identify and recover additional overpayments.
- Develop a plan to review all claims submitted by the remaining CMHCs across the nation. To implement this plan, HCFA could:

- ✓ Instruct FIs to conduct medical reviews to identify and recover overpayments;
- ✓ Encourage CMHCs, perhaps in conjunction with industry representatives, to conduct a self audit, with FI, HCFA, and/or OIG oversight, to identify overpayments for recovery by the FI; or
- ✓ Seek legislation to require CMHCs, should voluntary efforts prove unsuccessful, to have an independent medical reviewer identify overpayments for recovery by the FI.

In view of the severity of the problems disclosed, we believe that HCFA should evaluate the propriety of allowing CMHCs to provide the PHP benefit. Should HCFA decide that the PHP benefit cannot be adequately provided by CMHCs, a legislative change should be sought to repeal Medicare coverage for this benefit in the CMHC setting. We have not evaluated the delivery of PHP benefits in the hospital outpatient setting. However, the extensive nature of the problems found with CMHCs causes us to be concerned in general with this benefit. We, therefore, encourage HCFA to include hospital outpatient claims in their overall evaluation of the PHP benefit.

In the interim, or if HCFA decides that Medicare should continue to provide coverage of the PHP benefit in the CMHC setting, we recommend that consideration be given to establishing a limit on the number of days of PHP services that are covered by Medicare. This coverage change would complement the planned PPS daily rate for PHP services. We also continue to recommend² that the following actions be taken by HCFA:

- Either develop conditions of participation for CMHCs or conduct on-site surveys during the provider enrollment process to determine whether CMHCs comply with the requirements of the Act and therefore qualify as Medicare providers for PHP services.
- Instruct FIs to perform a detailed medical review of the first claim submitted for each new beneficiary receiving PHP services from a CMHC, and have HCFA, as part of its oversight activities, perform medical reviews of selected PHP claims.

In its written response to our draft report, HCFA concurred with our specific recommendations. The HCFA recognized that working together with OIG, significant problems were identified relating to the qualification of providers to deliver the mental health services which the program covers, the eligibility of the beneficiaries receiving the

²*These recommendations are also contained in our report entitled "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers" (A-04-98-02146).*

services, and the appropriateness of the services provided. To address the problems identified, HCFA developed a 10-point initiative which includes both immediate and long-term actions.

The immediate actions include: phased-in terminations of the most egregious non-compliant CMHCs; the release of clarifying instructions on CMHC participation requirements; enhanced scrutiny of new CMHC applicants; intensified medical review by FIs; increased auditing of CMHC cost reports; and collection of overpayments identified by OIG. Prior to any termination actions, HCFA will consider the needs of the beneficiaries whose PHP treatment may be disrupted and will coordinate a plan of action with mental health advocacy groups and State officials.

The HCFA's long-term actions include: the establishment of a new payment system for PHP services; regulations to require periodic reenrollment of CMHCs; and the enactment of current as well as possible additional legislative, regulatory, and policy changes in the PHP benefit.

We believe HCFA's proposed initiative, when implemented, will help to ensure the integrity of Medicare payments for this benefit. The complete text of HCFA's response is presented as APPENDIX F to this report.

OTHER MATTERS

Throughout our review of the PHP claims filed by CMHCs, we have worked very closely with HCFA staff, especially members of the Miami suboffice. Through the dedicated and professional expert assistance of these HCFA staff, we have jointly been able to address this problematic area of delivery of PHP services. We are very grateful for this assistance.

CERTIFICATION REVIEWS IN 11 STATES

CMHCs are required to provide the core services required by the Act in order to qualify as a PHP provider. The HCFA requires that all CMHCs entering the Medicare program attest to the fact that they provide these core services. The results of our certification reviews in two States and HCFA's enrollment initiative in nine States disclosed that a significant number of CMHCs reviewed did not provide the core services and therefore did not qualify as PHP providers.

TWO STATE CERTIFICATION REVIEW

For each CMHC provider selected in Colorado and Pennsylvania, we obtained medical record documentation supporting the provision of the required core services. We

requested assistance from the corresponding HCFA regional office to review the records and make a determination as to whether the providers complied with the provision of the required core services established by the Act. Our review of providers in Colorado and Pennsylvania disclosed that four of nine providers in Pennsylvania and one of eight in Colorado did not provide the required core services as set forth in the Act, and therefore did not meet the certification requirements as required by law. This effort was intended to supplement the HCFA Provider Enrollment Initiative being conducted in nine States and we encourage HCFA to terminate these additional non-compliant CMHCs.

HCFA'S NINE STATE ENROLLMENT INITIATIVE

In January 1998, HCFA began an enrollment initiative involving nearly 700 CMHCs in 9 States: Florida, Texas, Alabama, Arkansas, Georgia, Louisiana, Mississippi, South Carolina, and Tennessee. The initiative included site visits to every current Medicare CMHC and new CMHC applicant in these States. The site visits were partially designed to address the dramatic payment increases and abuses in PHP services.

While on-site, HCFA contractors obtained medical records and supporting documentation to substantiate that each CMHC is actually providing the core services and is in compliance with any applicable State licensing requirements. The HCFA was unable to locate a number of CMHCs and has suspended payments to them. The HCFA plans to send letters of noncompliance to any CMHC which is not able to substantiate that it provides the core services. The CMHC will be given 15 days to respond to this letter and submit additional documentation to rebut HCFA's determination. If the CMHC does not respond, or if the supplemental documentation does not change the earlier determination, HCFA plans to send a 15-day prospective termination notice. The HCFA also plans to publish a notice in the local newspaper informing the general public of the termination. Preliminary results indicate that a large number of the CMHCs reviewed did not meet Medicare requirements.

APPENDICES

EXAMPLE 1

An 84 year-old man who resided in an Assisted Living Facility (ALF) was enrolled in the PHP by the ALF physician. The beneficiary appeared weak and tired, but was coherent and responsive to the interviewer's questions. According to both the beneficiary and his nurse, he had no diagnosis or history of psychiatric disorders. He had never been hospitalized for a psychiatric illness, and suffered only from diabetes and the associated loss of circulation and mobility. The beneficiary began attending the PHP almost immediately after he moved to the ALF, and had never been in any similar type of program before. He stated that while at the PHP, he usually did not participate in the groups. He was usually too weak and tired, so he rested and observed the others. The beneficiary stated that he stopped attending the program because of his physical deterioration.

During a brief discussion with the ALF owner, we learned that the beneficiary was referred to the PHP program by a PHP employee who worked on-site at the ALF to identify prospective PHP patients. Most of the ALF residents had been in the PHP at one time or another. According to the ALF owner, he was unaware, prior to our visit, that this referral practice may be inappropriate.

The medical review determined that the beneficiary was ineligible for PHP services; the services were not reasonable and necessary for the patient; and the medical record documentation was inadequate.

The medical record revealed a diagnosis of depression. The only precipitating event which led to the PHP admission was the patient's sadness resulting from a move to Florida for placement in an ALF. The medical record contained no history of psychiatric illness, no documentation of any prior psychiatric treatment, and no documentation supporting the imminence or potential for inpatient hospitalization.

The treatment plan called for group therapy four times per day, with the treatment goals of:

- ▶ Identifying and expressing feelings,
- ▶ Focusing thoughts and problem solving, and
- ▶ Becoming more socially interactive.

These vague terms were found in virtually every PHP beneficiary's medical record.

EXAMPLE 2

An 85 year-old woman who resided independently was referred to (and enrolled in) the PHP by her personal psychiatrist, who also happened to be the Medical Director for the PHP. She had been a patient of this psychiatrist for 14 years, since she became depressed upon the death of her husband. Her depression was controlled through medication and periodic outpatient psychiatric visits. This beneficiary was entirely coherent and responsive. She strongly denied having any severe or disabling psychiatric condition and was certain that she was never in danger of hospitalization. She noted that while she occasionally talks to the therapist, the PHP takes her (and all of the patients) to an adult activities center where she engages in arts and crafts and exercise classes. In addition, she explained that she was originally told by her psychiatrist that her PHP treatment would last for 2 weeks, but received services for 18 months.

The medical review determined that: the beneficiary was not eligible for PHP services; the services were not properly authorized or supervised by a physician; the services were not reasonable and necessary for the patient; and medical record documentation was inadequate.

According to the beneficiary's medical record, she had a history of anxiety and depression. She was not psychotic or demented, and her memory and orientation to time, place, and person were intact. The intake screening and assessment were extremely perfunctory, and little description was provided about the patient upon enrollment. The prescribing physician projected a 60- to 90-day course of treatment in January 1997. (She was still a patient in April 1998). The treatment plan called for the following goals:

- ▶ To encourage her to share feelings in group therapy four times per week.
- ▶ To assist her in developing coping strategies.
- ▶ To re-frame her cognitive distortions.

The progress notes/group notes for the patient were almost identical from day to day.

EXAMPLE 3

A 99 year-old woman who resided in an ALF was enrolled in the PHP under the premise that she would be attending an adult day-care program. The ALF owner was visited by PHP staff who promoted a cost-free activity program for the residents. The ALF owner was led to believe the program would be suitable for all of the ALF residents, so everyone was sent to the program. It was never mentioned that the PHP was in fact, a psychiatric program. The beneficiary's guardian approved her enrollment because he thought she would benefit from social and recreational activities. He was unaware of the true nature of a PHP, and did not know that Medicare was paying for the services. The beneficiary denied any diagnosis or history of psychiatric disorders and had never been hospitalized for any mental illness. Prior to her admission to the PHP, she had never seen a psychiatrist. The beneficiary was extremely surprised and upset to learn that she had actually attended a program that was intended for the severely mentally disabled.

The beneficiary, as well as the other ALF residents, stopped attending the PHP after relatives learned through the Medicare Explanations of Benefits (E.O.B.) that Medicare had paid for "day-care disguised as therapy." Complaints were made to the ALF owner, who immediately pulled her residents from the program.

The medical review determined that the services rendered to this beneficiary were not reasonable and necessary (or appropriate) for this individual, and the medical record documentation was inadequate to support the claim.

According to the beneficiary's medical record, she had a psychiatric diagnosis of major depression, a medical diagnosis of glaucoma, but no history of any psychiatric treatment. In the initial assessment, the patient was described as "disoriented to time, place, person, or reality" and she was observed "day-dreaming" and "staring off into space." The treatment plan goals ranged from "developing effective interpersonal skills" to "improving her body image". It should be reiterated that the beneficiary was 97 years old at the time of assessment.

SAMPLING METHODOLOGY

OBJECTIVE

To determine whether the Medicare program incurred financial losses because Community Mental Health Centers (CMHCs) received payments for Partial Hospitalization Services that did not meet the Medicare eligibility and reimbursement requirements, and whether the CMHC-PHP providers in Colorado and Pennsylvania are providing the five core services required by section 1916(c)(4) of the Public Health Service Act.

POPULATION

We used the universe of paid partial hospitalization claims in Florida, Texas, Alabama, Colorado, and Pennsylvania for the period of October 1, 1996 through September 30, 1997.

The universe consisted of the following data:

Total HIC Numbers (beneficiaries):	22,367
Total ICN Numbers (claims):	123,284
Total Billed:	\$408,598,162.43
Total Reimbursed:	\$252,012,580.18

SAMPLE UNIT

The sample unit was a paid partial hospitalization claim for a Medicare beneficiary. A paid claim includes multiple units of partial hospitalization services claimed by a provider for the period of time covered by the claim.

SAMPLE DESIGN

An unrestricted random sample of paid claims (greater than zero) was used.

SAMPLE SIZE

The sample size was 250 claims.

ESTIMATION METHODOLOGY

Using the RAT-STATS Attribute Appraisal Programs, we projected the percentage of claims in Florida, Texas, Alabama, Colorado, and Pennsylvania that did not meet the Medicare eligibility and reimbursement requirements.

Using the RAT-STATS Variable Appraisal Program, we projected the amount of Medicare reimbursement for partial hospitalization claims in Florida, Texas, Alabama, Colorado, and Pennsylvania that did not meet the Medicare eligibility and reimbursement requirements.

PROJECTIONS					
<u>RESULTS OF SAMPLE:</u>					
<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>	<u>Units of Service</u>	<u>Units in Error</u>
250	\$517,740.73	229	\$465,110.81	6736	6264
<u>Variable Projections</u>					
Errors Identified in the Sample:			229		
Value of Errors in the Sample:			\$465,111		
Point Estimate:			\$229,362,884¹		
At the 90% Confidence Level:					
Lower Limit:			\$199,140,593		
Upper Limit:			\$259,585,176		
The following is a further explanation of the sample results to differentiate those claims we reviewed in detail (206 claims) and those we were not able to review completely (44 claims).					
206 ²	\$418,444.60	185	\$365,814.68	5431	4959
44 ³	\$ 99,296.13	44	\$ 99,296.13	1305	1305
<u>Variable Projections:</u> Claims with Review Errors					
Errors Identified in the Sample:			185		
Value of Errors in the Sample:			\$365,815		
Point Estimate:			\$180,396,388		
At the 90% Confidence Level:					
Lower Limit:			\$151,549,517		
Upper Limit:			\$209,243,259		

¹ The point estimate for the projection of 229 total errors equals the sum of the point estimates for the projections of 185 review errors and 44 questionable claims: (\$229,362,884 = \$180,396,388 + \$48,966,496)

²Cases reviewed by OIG.

³Cases not completely reviewed because the provider was under investigation, suspended or terminated, or no longer operational.

Variable Projections: Questionable Claims

Errors Identified in the Sample:	44
Value of Errors in the Sample:	\$ 99,296
Point Estimate:	\$48,966,496
At the 90% Confidence Level:	
Lower Limit:	\$32,406,036
Upper Limit:	\$65,526,956

Attribute Projections: 250 Claims

Claims in Sample:	250
Number of Claims in Error:	229
Error Rate in Sample:	91.6%
Projected Error Rate at 90% Confidence Level:	
Lower Limit:	88.1%
Upper Limit:	94.3%



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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"/>
EAG	<input type="checkbox"/>
SAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EC	<input type="checkbox"/>
DIG-EI	<input type="checkbox"/>
DIG-CI	<input type="checkbox"/>
DIG-I.P	<input type="checkbox"/>
AIG-LC	<input 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 11:30

GENERAL

Nancy-Ann DeParle

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.

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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

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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.

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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.

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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 2

**“Five-State Review of Partial Hospitalization Programs
at Community Mental Health Centers,” (A-04-98-02145)**

OIG Recommendation 1

Take strong action against those facilities which HCFA determined did not meet the requirements to be CMHCs under the Act, including termination of provider agreements, where appropriate.

HCFA Response 1

We concur. HCFA will phase in the terminations of non-compliant CMHCs beginning with the most egregious providers. In considering termination actions, HCFA will take into account the number of core services not provided, billing data for PH services, and local community needs, (i.e., the availability of alternative facilities and beneficiary needs). Any termination actions will be coupled with proactive efforts to address continued access to and continuity of care.

In addition, we are conducting site visits to new CMHC applicants to ensure that only those programs that meet all statutory 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.

OIG Recommendation 2

Instruct FIs, for the HCFA identified CMHCs, to make appropriate recovery of overpayments, including an audit of the closing cost reports for those CMHCs terminated.

HCFA Response 2

We concur. For those CMHCs terminated, HCFA, in collaboration with the appropriate law enforcement agency, will work to obtain any overpayments. An audit of closing cost reports will be included in the termination process.

OIG Recommendation 3

Instruct FIs to recover the specific overpayments we identified as part of our sample and review all other claims submitted by the CMHCs for the beneficiaries in our sample to identify and recover additional overpayments.

HCFA Response 3

We concur. All overpayments identified by the OIG as part of its review of claims in five states will be recouped by the FIs. In addition; we will make every reasonable effort to identify, review, and recover any additional overpayments.

Page 2 - Attachment 2

As indicated in our response to recommendation 2, we will implement intensified medical review by FIs in both outpatient and inpatient departments and CMHCs to determine patient eligibility for PH, in addition to medical review of claims of those receiving the benefit.

OIG Recommendation 4

Develop a plan to review all claims submitted by the remaining CMHCs across the nation. To implement this plan, HCFA could:

- Instruct FIs to conduct medical reviews to identify and recover overpayments;
- Encourage CMHCs, perhaps in conjunction with industry representatives, to conduct a self audit, with FI, HCFA, and/or OIG oversight, to identify overpayments for recovery by the FI; or
- Seek legislation to require CMHCs, should volunteer efforts prove unsuccessful, to have an independent medical reviewer identify overpayments for recovery by the OIG.

HCFA Response 4

We concur. Some FIs are currently conducting 100 percent medical reviews. HCFA is currently examining mechanisms to broadly implement intensified medical review by fiscal intermediaries (FIs) in both hospital outpatient departments and CMHCs to determine patient eligibility for PH before services are rendered, in addition to medical review of claims of those receiving the benefit. HCFA will increase the use of payment suspension when it is determined that services are not billed appropriately. Where fraud is suspected, FIs will forward information to the OIG for further investigation and coordination with law enforcement action. FIs will increase the amount of auditing of CMHC cost reports until such time as a prospective payment system (PPS) is implemented.

HCFA will also consider the recommendation regarding the self-audit and work with the Inspector General to define how such a self-audit program would work. As we move forward with a plan to review claims, we need to consider the resources we have available and that any plan will not negatively affect beneficiary access.

Once fully implemented HCFA will evaluate its medical review policy and procedures to determine the need to establish legislation that would establish an independent review function.