

DATA TO SUPPORT INPATIENT HOSPITAL REDUCTIONS

This document provides data and evidence to support the inpatient hospital reductions proposed in the FY 2001 President's Budget. Over FYs 2003-2005, the Budget proposes to reduce the inpatient update by 0.8 percent for urban hospitals (i.e., market basket minus 0.8 percentage points) and 0.4 percent for rural hospitals (i.e., market basket minus 0.4 percentage points). This proposal is smaller—both in terms of scope and duration—than was proposed last year in the context of the FY 2000 Budget and the President's Medicare Reform Plan. Unlike last year, the FY 2001 Budget does not propose reducing the hospital update before 2003; the FY 2000 Budget proposed an "update" freeze for FY 2000, saving \$9.1 billion over 10 years.¹

Data and Evidence:

MedPAC Reports High Hospital Margins. In December 1998, MedPAC reported that hospitals' Medicare inpatient margins were 16 percent in FY 1997 and would remain at these levels for the next several years, even taking into account the BBA's payment reductions. MedPAC also reported that hospitals' total margins were at record high levels (i.e., 6 percent). Further, MedPAC projected hospitals' inpatient margins for FY 2002 to be 15 percent, assuming all of the BBA payment reductions and higher-than-actual cost growth. These figures are higher than hospitals' margins before 1997 when the BBA was enacted.

HCFA Actuaries Believe MedPAC Understates Hospitals' Total Margins. Following release of several high-profile industry-sponsored studies, HCFA's Office of the Actuary (OACT) undertook a review of MedPAC's margin calculations in the Summer 1999. OACT determined that MedPAC had understated hospitals' total margins by about 4 percentage points because it had included non-allowable costs in its margin calculations. MedPAC staff acknowledged OACT's review at its December 1999 meeting and is working with OACT to refine its methodology.

Hospitals' Margins Will Improve Under the BBRA. The Balanced Budget Refinement Act of 1999 (BBRA) included many provisions that will increase hospitals' margins. While inpatient rates were not significantly affected, the BBRA included a provision to increase outpatient payments by \$16.2 billion over 10 years (both legislative and administrative changes). The BBRA also included payment increases for skilled nursing and home health providers. To the extent that hospitals are involved with these lines of businesses, their total margins will be higher due to these payment increases.

Summary of Inpatient Hospital Update Proposed in the FY 2001 Budget:

| | |
|----------------|---|
| FY 2001: | Current law (i.e., MB - 1.1) |
| FY 2002: | Current law (i.e., MB - 1.1) |
| FYs 2003-2005: | MB - 0.8 for urbans; MB - 0.4 for rurals (Current law = full market basket) |

¹Note: both the FY 2000 and FY 2001 Budgets include a proposal to reduce Medicare Bad Debt payments. Approximately 40 percent of the \$5.6 billion in 10-year savings would come from hospitals.

DISTRIBUTION OF MEDICARE PAYMENT REDUCTIONS

This document provides the distribution according to health care provider type of the FY 2001 President's Budget Medicare savings proposals.

Traditional Provider Payment Reductions; Waste, Fraud, and Overpayment Proposals. The Budget proposes to reduce the payment updates to inpatient hospitals and certain ancillary providers during FYs 2003-2005 which will save \$24.9 billion over 10 years. The Budget also includes several proposals to reduce Medicare fraud, waste, and overpayment, saving an additional \$18.7 billion over 10 years. The distribution of these payment reductions according to provider types is as follows.

| Provider Type | Percent of Total Reductions |
|--|-----------------------------|
| Hospitals | 57% |
| Skilled Nursing Facilities | 4% |
| Physicians | 1% |
| Traditional Program Integrity (e.g., MSP, EPO) | 15% |
| Other Part B Program Integrity (e.g., labs, DME) | 21% |
| Managed Care | 2% |
| Total | 100% |

Note, these calculations do not include interactions and premium offsets. The managed care line does not include the indirect effects of lower fee-for-service spending on managed care payment rates.

In addition, the FY 2001 Budget proposes other Medicare savings, including:

Fee-for-Service Modernization. The FY 2001 Budget proposes to modernize the traditional fee-for-service Medicare program to improve health care quality and provide incentives for providers to become more efficient. The Modernization proposals are estimated to save \$15.4 billion over 10 years—68 percent of the savings would derive from hospitals and other Part A providers; and 32 percent of the savings would derive from physicians and other Part B providers.

Competitive Defined Benefit. The FY 2001 Budget proposes to reform Medicare's payment methodology for managed care plans. The proposal would save \$11.9 billion over 10 years—all of the savings would derive from managed care plans.

Cost-Sharing. The Budget proposes to reinstate the Part B deductible and coinsurance for laboratory services and index the Part B deductible to CPI. The proposals would save \$10.0 billion over 10 years, with the savings derived from increased beneficiary out-of-pocket contributions. Note, that the FY 2001 Budget proposed to waive beneficiary cost-sharing for preventive benefits.

**PRESIDENT CLINTON UNVEILS LEGISLATIVE AND ADMINISTRATIVE PROPOSALS
TO FIGHT MEDICARE FRAUD, WASTE, AND ABUSE**

December 7, 1998

Today, President Clinton announced additional steps to fight fraud, waste, and abuse in the Medicare program, building on the Administration's longstanding efforts in this area. The President unveiled a legislative package that will save Medicare over \$2 billion. He also announced new administrative measures to crack down on fraud, including efforts to make Medicare contractors more effective and accountable. Today in an event with the Administrator of the Health Care Financing Administration (HCFA), the HHS Inspector General, Senator Tom Harkin, and the Older Women's League, the President:

ANNOUNCED NEW LEGISLATIVE PACKAGE THAT WILL SAVE MEDICARE OVER \$2 BILLION BY COMBATING FRAUD, WASTE, AND ABUSE. President Clinton will send Congress a comprehensive legislative package to fight fraud, waste, and abuse in the Medicare program as part of his FY2000 budget proposal. These proposals, which are consistent with recommendations made by the HHS Office of the Inspector General (OIG) in recent reports and some of which have been recommended to Congress before, will give HCFA more tools to root out fraud, abuse, and waste in Medicare. The proposals include:

- **Eliminating Excessive Medicare Reimbursement for Drugs.** A recent report by the OIG confirmed that Medicare currently pays hundreds of millions of dollars more for 22 of the most common and costly drugs than it would if it used market prices. For more than one-third of these drugs, Medicare paid more than double the average wholesale price, and in one case paid ten times the amount. This proposal would base Medicare payments on the actual acquisition cost of these drugs to the provider, eliminating current mark-ups and thereby substantially reducing Medicare costs.
- **Ending Overpayments for Epogen,** a drug used to treat anemia related to chronic renal failure. An OIG report found that the current reimbursement rate of \$10 per 1,000 units of Epogen exceeds the current cost of the drug by approximately 10 percent. The Administration's proposal reduces Medicare reimbursement to reflect current market prices.
- **Preventing Abuse of Medicare's Partial Hospitalization Benefit.** A recent OIG report found that providers are abusing Medicare by billing for partial hospitalization services that were never given or provided to many fewer patients than were billed for. This proposal would ensure that Medicare reimburses only for services actually given by placing stricter controls on the provision of these services.
- **Ensuring Medicare Does Not Pay for Claims Owed by Private Insurers.** Private insurers of working Medicare beneficiaries are required under law to be the primary payor of health claims. These insurers, however, do not always pay the claims for which they are responsible. This proposal prevents this abuse by requiring private insurers to report all Medicare beneficiaries they insure to HCFA. This proposal also would give HCFA greater authority to fine private insurers, including the authority to recoup twice the amount owed if insurers intentionally allow Medicare to pay claims for which they are responsible.
- **Empowering Medicare to Purchase Cost-Effective High-Quality Health Care.** Medicare now has limited demonstration authority to contract out with institutions that have a track record of providing exceptionally high-quality care at a reasonable price, called centers of excellence. This proposal would expand this authority to urban areas that have multiple providers, thereby enabling the Medicare program to provide higher quality health care at less cost.

- **Requesting New Authority to Enhance Contractor Performance.** HCFA still does not have the authority it needs to terminate more expeditiously contractors who do not effectively perform their duties. This proposal would give HCFA authority to contract with a wider range of carriers to administer the program, and then to terminate them if they fail to perform effectively. The proposal would give HCFA greater authority to oversee contractor performance of such functions as enrolling providers, investigating fraud, and collecting overpayments.

TOOK NEW ACTIONS TO HELP ENSURE MEDICARE CONTRACTORS FIGHT FRAUD, WASTE, AND ABUSE. Today, the President is also unveiling new administrative efforts to ensure contractors are cracking down on fraud and abuse. These include:

- **Contracting with Special Fraud Surveillance Units to Ensure Detection of Fraudulent Activities.** OIG reports have shown that many Medicare contractors do a poor job of investigating fraud, in part because they have a wide variety of other functions, and in part because they have multi-faceted relationships with providers that may create conflicts of interest. The Administration fought to include in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) new authority to contract with specialized fraud, waste, and abuse surveillance units or "fraud fighters," which are better equipped to audit cost reports and conduct activities that are vital to the detection of fraud, waste, and abuse. The first fraud surveillance units will begin their efforts this spring.
- **Implementing the Competitive Bidding Demonstration for Durable Medical Equipment.** The OIG recently found that Medicare rates for hospital beds are substantially higher than rates paid by other payers. HCFA will begin a demonstration this spring that will use competitive bidding to decrease Medicare payment for hospital beds and other durable medical equipment, thereby lowering program costs.
- **Requiring Contractors to Report Fraud Complaints to the Inspector General Right Away.** Many contractors now defer reporting cases of suspected fraud to the OIG when the dollar amounts are low, even though these reports could show significant patterns of fraud. This month, HCFA will send program memorandums to all contractors requiring them to refer suspected fraud to OIG immediately, regardless of the amounts involved.
- **Announcing That A New Comprehensive Plan to Fight Fraud and Abuse Will Be Completed By Early Next Year.** To improve efforts to cut down on fraud and abuse, HCFA will release a new Comprehensive Plan for Program Integrity early next year. This plan will outline new strategies to fight fraud, including enhanced use of audits and improved management tools.

BUILDING ON LONGSTANDING COMMITMENT TO FIGHTING FRAUD, WASTE, AND ABUSE. The new steps the President took today build on the Administration's longstanding commitment to crack down on fraud, waste, and abuse. Since 1993, the Administration's efforts have saved taxpayers more than \$20 billion, with health care fraud convictions increasing by more than 240 percent. The Administration has assigned more federal prosecutors and FBI agents to fight health care fraud than ever before. HIPAA created, for the first time ever, a stable funding source to fight fraud and abuse, and in FY1997 alone -- the first full year of funding under HIPAA -- nearly \$1 billion in fraud and abuse savings was returned to the Medicare Trust Fund.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

FISCAL INTERMEDIARY FRAUD UNITS

JUNE GIBBS BROWN - INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

The purpose of this report is to provide national information on fiscal intermediary fraud units.

BACKGROUND

Fiscal intermediaries are companies under contract with the Health Care Financing Administration (HCFA) to administer a major part of the Medicare program. Individual fiscal intermediaries vary in many ways including the amount of claims and payments they process. Likewise, their fraud units differ from one another. But, all must meet requirements outlined in the Medicare Intermediary Manual. Fiscal intermediaries were responsible for \$130 billion, or 75 percent, of total Medicare payments in 1996. The other 25 percent was handled by companies called carriers.

The HCFA requires that fiscal intermediaries and carriers have distinct units to detect and deter fraud and abuse. These units are part of HCFA's overall Medicare integrity program and are monitored by HCFA regional offices. The HCFA is currently planning to separate future anti-fraud functions from other intermediary and carrier operations. These activities will become the purview of a few contractors to be known as program safeguard contractors.

For this report, we surveyed all 41 fiscal intermediary fraud units that were under contract with HCFA in 1996 and still under contract in 1998. We collected fraud unit data for fiscal year 1996.

FINDINGS

Fraud units differed substantially in the number of complaints and cases handled. Some units produced few, if any, significant results.

While one would expect units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads.

- ▶ *Fraud units handled between 3 and 1,892 complaints per unit.*
- ▶ *The number of cases handled by each fraud unit ranged from 0 to 625.*
- ▶ *Fraud units referred between 0 and 102 cases to the Office of Inspector General.*

Despite HCFA's expectation that fraud units proactively identify fraud, half of the fraud units did not open any cases proactively.

More than one-third of fraud units did not identify program vulnerabilities.

Key words and terms related to fraud unit work vary in meaning. This hinders HCFA's ability to interpret fraud unit data and measure fraud unit performance.

RECOMMENDATIONS

The HCFA and fiscal intermediary fraud units have significant responsibilities in identifying and deterring fraud in a part of the Medicare program where \$130 billion is at risk. The variation in fraud detection, especially among units with similar resources, raises concern about possible poor performance by some fraud units.

Although HCFA currently conducts performance evaluations of fraud units, we believe there is a need to strengthen the monitoring and oversight of contractors' efforts to identify fraud and abuse. In recent years, HCFA has focused on continuous improvement as a method of evaluating contractor performance. In light of the disparity in fraud detection among contractors, the agency may need to refocus its evaluation efforts to include some type of return on investment analysis.

In order that HCFA may have a better understanding of fraud unit performance, which in turn will lead to making better decisions about fraud unit funding, selecting future contractors, and working collaboratively with other anti-fraud entities, we recommend that HCFA:

- ▶ Improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.
- ▶ Require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.
- ▶ Establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.
- ▶ Establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.
- ▶ Provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.



The Administrator
Washington, D.C. 20201

DATE: OCT 27 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Fiscal Intermediary Fraud Units," (OEI-03-97-00350)

We welcome the suggestions in the above-referenced report that provides national information on the performance of fiscal intermediary fraud units. We appreciate OIG's efforts to help us strengthen the monitoring and oversight of fraud unit efforts.

The data collected for the report covered fiscal year (FY) 1996. Beginning in 1997, the Health Care Financing Administration (HCFA) mandated that fiscal intermediaries (FIs) use the HCFA Customer Information System as a fraud detection tool. The tool will enable the FIs to proactively identify fraud. In addition, during FY 1999, HCFA contractors will attend OIG regional training sessions that will further educate them about the proper development of cases to be referred to law enforcement agencies.

We concur with the report's recommendations. Our specific comments follow:

OIG Recommendation #1

HCFA should improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

HCFA Response

We concur and plan to develop specific national objectives to be evaluated during FY 1999. In September 1998, we visited 13 contractor fraud units to gather information that will help us develop ambitious, but practical, objectives. In addition, HCFA through its contractor has just completed gathering the requirements to be used in the design of a new program integrity management information system. The process required that the data metrics needed to evaluate Medicare contractor medical review and benefit integrity effectiveness be identified before building the new system. A contract has been let to build the new system.

OIG Recommendation #2

HCFA should require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

HCFA Response

We concur with the intent. The fraud unit contractor performance evaluation standards are being re-examined and will reference national objectives. Our regional offices have the authority to negotiate individual performance objectives with each contractor, so the creation of regional standards may not be necessary.

OIG Recommendation #3

HCFA should establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

HCFA Response

We concur. In March 1998, HCFA identified and distributed a list of the most significant data metrics for regional office use in the FY 1998 contractor evaluation process. The development of national objectives will include the data metrics to be used in determining if objectives have been met.

OIG Recommendation #4

HCFA should establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

HCFA Response

We concur. We will review the definitions of key words in our current Medicare Intermediary Manual. To the extent that we find inconsistencies, we will make appropriate revisions.

OIG Recommendation #5

HCFA should provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

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HCFA Response

We concur. In March 1998, HCFA convened a national conference to identify best practices in fighting waste, fraud, and abuse. The conference brought together representatives from Medicare contractors, private industry, law enforcement, health care providers, and beneficiaries, in order to discuss ways to combat fraud. HCFA listened to these experts, and we are working to incorporate their effective methods into our own program integrity strategy.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Comparing Drug Reimbursement:
Medicare and
Department of Veterans Affairs**



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 1998
OEL-03-97-00293**

EXECUTIVE SUMMARY

PURPOSE

To compare Medicare allowances for prescription drugs with drug acquisition prices currently available to the Department of Veterans Affairs.

BACKGROUND

Medicare allowances for prescription drugs totaled almost \$2.3 billion in 1996. In 1997, allowances rose to approximately \$2.75 billion.

Medicare does not pay for over-the-counter or most outpatient prescription drugs. However, under specific circumstances, Medicare Part B covers drugs used with durable medical equipment or infusion devices. Medicare also covers certain drugs used in association with organ transplantation, dialysis, chemotherapy, and pain management for cancer treatment. Additionally, the program covers certain vaccines, such as those for influenza and hepatitis B.

Physicians and suppliers usually bill Medicare directly for the prescription drugs they provide to beneficiaries. Medicare Part B reimburses covered drugs at 95 percent of the drugs' average wholesale prices (AWPs). The beneficiary is responsible for a 20 percent coinsurance payment.

Unlike Medicare, the Department of Veterans Affairs (VA) purchases drugs for its healthcare system directly from manufacturers or wholesalers. There are several purchase options available to the VA, including the Federal Supply Schedule, Blanket Purchase Agreements, and VA national contracts.

We focused our inspection on 34 drug codes, each with over \$10 million in Medicare allowed charges for 1996. We then compared the amount Medicare reimbursed for these drugs to the VA's Federal Supply Schedule acquisition costs during the first quarter of 1998.

FINDINGS

Medicare and its beneficiaries could save \$1 billion in 1998 if the allowed amounts for 34 drugs were equal to prices obtained by the VA.

After comparing the median Medicare allowance with the corresponding median VA acquisition cost for 34 drugs, we estimated that Medicare and its beneficiaries could save \$1.03 billion in 1998 if the Medicare allowed amounts for 34 drugs were equal to prices obtained by the VA under the Federal Supply Schedule.

This savings represents almost half of the \$2.07 billion in reimbursement that Medicare and its beneficiaries paid for these 34 drugs in 1997. The estimated savings for individual drugs ranged from a high of \$276 million for J9217 (leuprolide acetate) to a low of \$16,460 for K0523 (concentrated metaproteranol sulfate).

Medicare allowed between 15 and 1600 percent more than the Department of Veterans Affairs paid for the 34 drugs reviewed.

The Medicare allowance was greater than the VA acquisition cost for every drug reviewed. For 3 of the 34 drugs, Medicare allowed more than 16 times the VA acquisition cost. Eleven drugs had Medicare allowances that were between two and six times higher than the VA cost. For only two drugs was the difference between Medicare reimbursement and VA cost less than 25 percent.

RECOMMENDATIONS

The Department of Veterans Affairs purchases drugs for its healthcare system directly from manufacturers or wholesalers. Conversely, Medicare reimburses doctors and suppliers for drugs which they administer or supply to beneficiaries. We recognize that the Health Care Financing Administration (HCFA) and the VA operate under different statutory constraints. Nevertheless, the fact remains that another Federal agency can get prescription drugs for a drastically lower price than Medicare.

Previous reports of the Office of Inspector General found that actual wholesale prices available to physicians and suppliers are often significantly lower than the Medicare allowed amounts. This report provides additional evidence that the published AWP's used in determining the Medicare allowed amounts for certain prescription drugs can be many times greater than the actual acquisition costs available in the marketplace.

We believe our current findings provide further support for recommendations made in earlier reports. We previously recommended that HCFA reexamine its Medicare drug reimbursement methodologies with the goal of reducing payments as appropriate. The HCFA concurred with this recommendation. We outlined a number of options for implementing this recommendation, including: (1) greater discounting of published average wholesale prices, (2) basing payment on acquisition costs, (3) establishing manufacturers' rebates similar to those used in the Medicaid program, and (4) using competitive bidding.

We continue to support the need for a comprehensive statutory reform of Medicare's prescription drug reimbursement methodology. A number of proposals addressing reform have been offered by both the Administration and members of Congress. However, until legislation can be enacted providing for such reform, we recommend that HCFA utilize the new inherent reasonableness or competitive bidding authorities provided in the Balanced Budget Act of 1997 to reduce Medicare's unreasonably high payments for certain drugs.

AGENCY COMMENTS

The HCFA concurred with our recommendations, stating that it appreciates the OIG's continuous efforts to assist it in obtaining the lowest prices for covered drugs. The HCFA noted that it has made several efforts to reduce excessive reimbursement rates, including using an inherent reasonableness adjustment for albuterol sulfate. The OIG supports these efforts and we believe HCFA should continue to use its inherent reasonableness authority to lower inappropriate payments for other drugs with excessive reimbursement rates.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Medicare Reimbursement for
Hospital Beds in the Home**

Prices



**JUNE GIBBS BROWN
Inspector General**

**NOVEMBER 1998
OEI-07-96-00221**

EXECUTIVE SUMMARY

PURPOSE

To determine the reasonableness of Medicare's reimbursement for rental of hospital beds in the home when compared to other Federal, State, private insurance companies, and managed care organizations.

BACKGROUND

Medicare authorizes beneficiaries to obtain hospital beds for use in their home. This is done on the basis of a rental schedule with an option to purchase the bed. Suppliers receive monthly reimbursement from the Medicare Durable Medical Equipment Regional Carriers based upon a fee schedule. This schedule is limited by the Health Care Financing Administration's (HCFA) established national payment ceilings, and is adjusted annually for inflation based upon the Consumer Price Index. The rental fee schedule caps the rental payments at 120 percent of the allowable charge for purchase. In calendar year (CY) 1996, Medicare allowed charges of over \$272 million for the four categories of hospital beds included in this study. Semi-electric beds (code E0260) comprised 86 percent of this total while total electric beds accounted for less than one-half of one percent.

We surveyed sampled entities from Medicare risk managed care organizations, Medicaid State Agencies, the top 50 health insurance companies as ranked by policies in force, and a listing of companies providing national and local coverage in the Federal Employees Health Benefits program. Overall, we achieved an 82 percent response rate.

This is one of two reports examining Medicare's policies and reimbursement for hospital bed equipment. A companion report "*Medicare Reimbursement for Hospital Beds in the Home: Payment Methodology*" OEI-07-96-00222 compares Medicare's rental reimbursement payment methodologies to those of other medical insurance payers.

FINDING

Medicare Rates for Rental of Hospital Beds for Home Use Are Substantially Higher than Rates Paid by Most Other Payers

Comparison of Average Monthly Rental Payments for Semi-Electric Beds

Ninety-seven percent of our respondents pay for rental of hospital beds (72 of 74 respondents). We analyzed the rates for each hospital bed to identify the entities that paid uniform rates for rental and those that paid variable rates which depend on locale and market competition.

Of the 51 entities furnishing information on both the rental rates and the frequency of these payments for the four categories of hospital beds included in this inspection, 37 (72.6 percent) use a uniform monthly rate schedule, and 14 (27.4 percent) pay variable rates.

We found that on average, other payers' uniform monthly rental rates were more than 14 percent lower than the corresponding Medicare monthly rate for semi-electric hospital beds. For entities using a variable rate schedule, their highest rate ranged from 22 percent above to almost 23 percent below the corresponding Medicare average rate for this bed. We found similar results for manual, manual-adjustable, and total-electric hospital beds.

Comparison of Actual Monthly Rental Rates for Semi-Electric Beds

Since Medicare, unlike other entities, pays an enhanced rate for the first 3 months of rental, we also compared their actual rate for months 1 - 3 and months 4 - 15 to the rates of other entities. We found Medicare's rates for months 1 - 3 were from 18 percent to 38 percent higher, and for months 4 - 15 were from 9 percent lower to 18 percent higher.

Maximum Potential Rental Payments

We compared Medicare's rental payments for a semi-electric hospital bed during the maximum potential rental period of 15 months to other payers' maximum rental payments. We found entities paying a uniform rate were on average over 30 percent lower than Medicare's maximum payments. Also, entities who predominately reimburse from their highest variable rate schedule were on average 30 percent lower. Those payers primarily paying from their lowest rate schedule were on average 43 percent lower. Similar results were obtained for manual, manual-adjustable and total-electric hospital beds.

RECOMMENDATION

HCFA Should Take Immediate Steps to Reduce Medicare Payments for In-Home Hospital Beds

Medicare's monthly rates for the four types of hospital beds studied, when considered with total rental payments during the 15 month extended rental period, exceed the rates of other payers by more than 14 percent. The Balanced Budget Act of 1997 provides HCFA with the necessary tools to immediately reduce rates if there is compelling evidence that their rates exceed those generally being paid in the marketplace. We believe that this is the case here. If this authority is exercised for the four types of hospital beds surveyed, we estimate that annual savings at a 12 - 15 percent reduction would be approximately \$32.7 to \$40.9 million. Projected over 5 years, Medicare would save over \$163 to \$204 million.

We also believe that the payment method used by Medicare inappropriately overcompensates for rental use during the first 3 months of each rental period. We discuss this more thoroughly in our companion report, "*Medicare Reimbursement for Hospital Beds in the Home: Payment Methodology*" OEI-07-96-00222. In that report we include a recommendation that HCFA seek legislation to correct that aspect of the problem. Overall, we believe that a combination of both approaches would be best. However, the savings would not be additive.

AGENCY COMMENTS

The HCFA concurs with the intent of our recommendation and is undertaking a comparison of hospital bed rates and a competitive bidding demonstration project as a prelude to making hospital bed rate changes. Appendix F contains the complete text of these comments. We remain available to provide technical assistance to HCFA on this matter.

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**



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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 14¹ 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.

¹Subsequent 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.

Page 2 - Nancy-Ann Min DeParle

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.

**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 14¹ 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.

¹Subsequent 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**

Date OCT - 5 1998

From June Gibbs Brown
Inspector General *June G Brown*

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

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with a summary of audit activity on the delivery of mental health services through partial hospitalization programs (PHP) for Medicare beneficiaries in community mental health centers (CMHC) in Florida and Pennsylvania. Our 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. 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 14¹ 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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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 five² 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.

²In 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.

| <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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

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).

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| OGC/IG | / |
| ExecSec | / |
| Date Sent | 9-18 |

The Administrator
Washington, D.C. 20201

SEP 18 1998 1:10

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.

PARTIAL HOSPITALIZATION REVIEWS

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

¹Final OIG reports

²Draft OIG reports

³Joint reports

⁴Preliminary calculations - no reports issued to date

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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

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.

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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 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.

President's Medicare Fraud, Waste and Abuse Legislative Proposals

Eliminating Wasteful Excessive Medicare Reimbursement for Drugs

Proposal. Base Medicare's payment for drugs on the provider's actual acquisition cost of the drug instead of charges.

5-Year Savings: \$690 million

Background. While Medicare does not have an expansive outpatient drug benefit, it does cover certain kinds of outpatient drugs, e.g., specific drugs that are used with home infusion or inhalant equipment, and drugs that are prescribed for dialysis and organ transplant patients. Medicare typically pays for these drugs based on the charge submitted by providers, usually physicians or pharmacies. Information from the HHS/OIG suggests that Medicare currently pays 15 to 30 percent more than what the provider paid for the drug.¹ The OIG has also reported that Medicare payments for drugs significantly exceed the Department of Veterans Affairs acquisition costs.²

Discussion. By basing Medicare's payment on the provider's acquisition cost of the drug, you eliminate payment for the mark-up which providers place on drugs.

Under the BBA, the Medicare payment limit for drugs is now 95 percent of the average wholesale price. Physician and pharmaceutical groups will be against this proposal because Medicare will be reimbursing them at a lower rate than it has in the past.

This proposal was included in the President's FY 1999 Budget.

Eliminating Overpayments for EPOGEN

Proposal. Reduce Medicare's reimbursement for EPO by \$1.00 per dose.

5-Year Savings: \$320 million

Background. EPO is a drug used to treat anemia related to chronic renal failure. It is a sole source drug, meaning that its manufacturer (Amgen) is competitively protected under the Orphan Drug Act. Medicare reimbursement for EPO totals nearly \$1 billion per year. The HHS IG concluded in a 1997 that Medicare reimbursement for EPO should be reduced to reflect current

¹"Appropriateness of Medicare Prescription Drug Allowances" HHS/OIG, May 1996.

²"Comparing Drug Reimbursement: Medicare and Department of Veterans Affairs" HHS/OIG, November 1998

market prices³. The HHS IG report recommended that Medicare reduce payments to \$9 per 1,000 units administered. This is a \$1.00 reduction over Medicare's current payment rate of \$10.00.

Discussion. This policy would reduce Medicare's reimbursement for EPO by \$1.00 percent per dose and would capture the savings from the manufacturers rebate. Dialysis facilities, ESRD-related beneficiary groups and the manufacturer of EPO are likely to object to this change. This proposal was not included in the proposal to pay the acquisition cost for drugs because, unlike other drugs, we know exactly how much Medicare overpays for EPO. Therefore, rather than reducing payment to actual acquisition costs, this proposal cuts the payment by the amount Medicare is overpaying.

This proposal was included in the FY 1999 Budget.

Eliminating Abuse of Medicare's Partial Hospitalization Benefit

Proposal. Preclude providers from furnishing partial hospitalization services in a beneficiary's home or in clinically inappropriate settings such as an inpatient or nursing home. Provides the Secretary with broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems.

5-Year Savings: \$120 million

Background. Currently, Medicare covers partial hospitalization services connected with the treatment of mental illness. Partial hospitalization services are covered only if the individual otherwise would require inpatient psychiatric. The course of treatment must be prescribed, supervised, and reviewed by a physician. The program must be hospital-based or hospital-affiliated and must be a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.

Partial hospitalization services include individual and group therapy sessions, occupational therapy, services of social workers, drugs and biologicals, family counseling and diagnostic services.

Discussion. This proposal would discourage partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities. The HHS/OIG has found large abuses in Medicare's outpatient mental health benefits including billing for services provided in group settings that are unnecessary or

³ "Review of EPOGEN Reimbursement" HHS/OIG, November 1997.

inappropriate⁴.

The partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

This proposal was in the FY 1999 Budget

Ensure Medicare does not Pay for Claims Owed by Private Insurers

Proposal. Require Medicare's contractors to match their enrollment records with Medicare's on a real-time basis to ensure (before a claim is paid) that Medicare is not paying when private payers are liable.

5-Year Savings: \$690 million

Background. Currently, Medicare is prohibited from requiring its contractors -- most of whom are commercial insurance companies or Blue Cross/Blue Shield plans -- to share data on their commercial enrollee populations to identify situations in which Medicare is the secondary, rather than primary payer. In other words, Medicare's contractors, in some situations, are paying claims on behalf of Medicare that the contractor knows it is responsible for paying as a private company. The contractor then waits to be "caught" by the normal matching process (which may take up to five years) before it re-pays Medicare.

Discussion. In the fight against fraud and abuse, Medicare secondary payer checks are important. HCFA estimates that the return on investment for this activity is 26:1. This proposal would increase this return on investment by decreasing the cost to Medicare of undertaking this activity. Currently, there is no incentive for contractors to identify situations in which Medicare might be secondary payer because the contractor may actually be the primary payer. This proposal would eliminate the need for an incentive. Insurance companies that currently contract with Medicare will be opposed this proposal.

This proposal was included in the FY 1999 Budget.

Enable Medicare to Capitate Payments for Certain Routine Surgical Procedures Through a Competitive Pricing Process with Providers

Proposal. Expand the current HCFA Centers of Excellence demonstration which enables

⁴ "Review of Partial Hospitalization Services Provided Through Community Mental Health Centers" HHS/OIG, October 1998

Medicare to negotiate payment rates for certain routine surgical procedures through a competitive bidding process with providers in exchange for assured market share. The demonstration would be expanded from 10 states to include all urban areas.

5-year savings: \$560 million

Background. Currently, HCFA is conducting a demonstration that will pay facilities in 10 states, considered to be "centers of excellence" a flat fee for coronary artery bypass graft (CABG) surgery or other heart procedures, knee surgery, hip replacement surgery, and other procedures that the HHS Secretary determines to be appropriate.

Providers will negotiate with HCFA a flat payment to cover all of the costs (hospitals and physicians) associated with the procedure. HCFA expects up to 100 total facilities to participate in the current demonstration. This demonstration developed from a smaller HCFA demonstration during the early 1990s of seven sites that performed CABG and cataract surgery. An independent evaluation determined that, on average, the flat payment mechanism resulted in reduced costs to the Medicare program without any change in the health status of patients who receives care from these centers. The Administration supported expanding the demonstration in the Balanced Budget Act; however, the provision was dropped from the conference agreement.

Discussion. Even though the Medicare program is the largest purchaser of medical care in the US, it does not receive volume discounts like other large purchasers. At the same time, hospitals may not have enough patients to become more proficient providers of care and thus be able to offer the highest quality of care to beneficiaries. The Centers of Excellence demonstration is intended to enable the Medicare program to receive volume discounts on routine surgical procedures and, in return, enable hospitals to increase their market share and gain clinical expertise.

Expanding the demonstration may incur resistance from some providers. Even though the demonstration does not require patients to receive care at participating facilities, expanding it further may split the market for these procedures. Providers who are not likely to be selected to participate would argue that they would lose market share of the demonstration were expanded.

This proposal was included in the FY 1999 Budget.

Medicare Benefits File



Elizabeth R. Newman
07/01/98 09:48:27 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: Statement by the President: New Medicare Benefits

THE WHITE HOUSE

**Office of the Press Secretary
(Shanghai, People's Republic of China)**

For Immediate Release

July 1, 1998

**STATEMENT BY THE PRESIDENT
ON NEW MEDICARE BENEFITS**

I am pleased to announce that starting today Medicare will cover two new preventive benefits to help detect osteoporosis and manage diabetes. These important benefits were part of the Balanced Budget Act I signed into law last year, which contained the most significant reforms in Medicare since the program's enactment in 1965.

Medicare's new prevention benefits will provide older American the tools they need to fight some of our most devastating chronic diseases. While one out of two women over the age of 50 will have an osteoporosis-related fracture during her lifetime, many women are not aware that they have this disease until they have a broken bone or fracture. I am extremely pleased that the First Lady, Mrs. Gore and Secretary Shalala will be helping to publicize this new benefit to help women detect this disease early. Also, the new diabetes benefit is critical to the over 7 million Medicare beneficiaries who suffer from this disease. This benefit is part of our diabetes initiative that the American Diabetes Association believes is "as important to people with diabetes as the discovery of insulin in 1921."

This month marks the 33rd anniversary of the Medicare program --one of our nation's most important commitments to older Americans and people with disabilities. I am extremely pleased that we can strengthen this important program and help some of our most vulnerable Americans stay healthier and stronger.

New Medicare Benefits
July 1, 1998

New Benefit To Help Women Detect Osteoporosis. Twenty-five million Americans suffer from osteoporosis, and one out of two women over the age of 50 will have an osteoporosis-related fracture during her lifetime. Unfortunately, many women are not aware that they have this disease until they have a broken bone or fracture. Medicare will now cover bone mass measurement tests to ensure that women are aware if they are at risk and can take the steps they need to prevent it.

New Diabetes Management Benefit. Medicare will also now cover blood glucose monitors and testing strips, as well as a wide range of education programs to help people with diabetes manage this disease. Sixteen million Americans and nearly 20 percent of Americans over the age of 65 suffer from this devastating disease. Too often, these Americans do not have the information or tools to manage diabetes and prevent costly side effects, such as blindness or amputations. This new benefit is critically important to the over 7 million Medicare beneficiaries with diabetes and it is part of the diabetes initiative the President signed into law that the American Diabetes Association praised as being "as important to people with diabetes as the discovery of insulin in 1921."

Builds on Other Important Prevention Benefits the Administration Implemented Last January. Today's announcement builds on the other Medicare screening benefits for breast cancer, colorectal cancer, and cervical cancer implemented last January. Medicare now guarantees annual mammograms for every Medicare beneficiary over 40, and waives the deductible, making annual breast cancer screenings more affordable. Coverage was also expanded for the early detection of cervical cancer and for regular examinations for colorectal cancer.

PRESIDENT CLINTON ANNOUNCES RECORD PROGRESS IN FIGHTING HEALTH CARE FRAUD AND ABUSE

January 24, 1998

Today, President Clinton released a new report by the Departments of Justice and Health and Human Services documenting the Clinton Administration's unprecedented success in fighting health care fraud and abuse. Collections and court awards from fraud and abuse cases reached an all-time high, more cases were opened, more convictions were obtained, and \$988 million [check] was returned to the Medicare Trust Fund -- much more than ever before. The report is the first annual evaluation of the Health Care Fraud and Abuse Control Program created under the landmark Health Insurance Portability and Accountability Act of 1996, signed into law by President Clinton.

THE HEALTH CARE FRAUD AND ABUSE PROGRAM. The Clinton Administration consolidated and strengthened its on-going efforts to attack fraud and abuse in federal health programs under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provided powerful new criminal and civil enforcement tools, expanded resources for the fight against health care fraud, and established a national framework for coordinating the fraud fighting efforts of law enforcement agencies, the private sector, and the public. HIPAA also provided that fines and penalties from health care fraud convictions would be dedicated to the Medicare Trust Fund, instead of being deposited in general revenues as they had been previously.

UNPRECEDENTED SUCCESS. The first annual report of the Health Care Fraud and Abuse Control Program shows that we are making dramatic new headway in rooting out health care fraud and abuse. During FY 1997, the first full year of anti-fraud and abuse funding under HIPAA, the federal government recorded the most successful year ever in the nation's efforts to detect and punish fraud and abuse against federal health programs, in particular the Medicare and Medicaid programs. In FY 1997, the federal government:

- Collected \$1.087 billion in criminal fines, civil judgements and settlements, and administrative actions -- the largest amount ever collected in one year.
- Returned \$988 million [check] to the Medicare Trust Fund -- up ___ percent from 1996 and by far the highest amount ever for a single year.
- Excluded more than 2,700 individuals and entities from doing business with Medicare, Medicaid, and other federal and state health care programs for engaging in fraud or abuse of the programs -- a 93 percent increase over 1996.
- Increased convictions for health care fraud-related crimes to 363 in 1997, up from 307 in 1996 -- an 18 percent increase.
- Opened 4,010 civil health care matters -- an increase of 61 percent over 1996.
- Identified approximately \$1.2 billion for collection in total fines, restitutions, penalties, settlements, and recoveries -- nearly three times more than in the previous best year.

NEW MEASURES TO FIGHT FRAUD. To build on this success, the President called on Congress to pass legislation to enact additional anti-fraud measures that would save an additional \$2 billion over 5 years. These include proposals to require an application fee for prospective Durable Medical Equipment providers, and to close a loophole that allows Medicare and Medicaid providers and suppliers found to be engaging in fraudulent activity to escape penalty by declaring bankruptcy.

BUILDING ON A STRONG RECORD. The Clinton Administration has focused unprecedented attention on the fight against fraud, abuse and waste in the Medicare and Medicaid programs. Since taking office, the Administration has significantly increased investigations to root out unscrupulous providers, created new management tools to better identify wasteful mispayments to health care providers, and strengthened standards for home health and Durable Medical Equipment providers to prevent fly-by-night providers from ever entering federal health care programs. President Clinton also launched Operation Restore Trust, a comprehensive health care anti-fraud program which has identified \$23 in overpayments for every \$1 invested. Since 1993, actions affecting HHS programs alone have saved taxpayers more than \$20 billion [check] and increased health care fraud convictions by 240 percent [check].



U.S. Department of Justice

Office of the Deputy Attorney General

Washington, D.C. 20530

FAX TRANSMISSION SHEET

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1/22/98

NUMBER OF PAGES (including this cover sheet):

6

MESSAGE:

Please see attached memo w/ explanation

Note: The information in this facsimile should be considered confidential.

January 22, 1998

To: Chris Jennings
From: John Bantivoglio ~~JS~~
Subj: Examples of health care fraud recoveries

Attached are examples in FY 1997 where we have recovered large amounts of money in civil health care fraud cases. The best examples of large dollar recoveries are in civil cases because the settlements require upfront payment of the settlement amounts. In criminal cases, we frequently seek to recover lost funds through forfeiture, restitution, and the like, but this can take time and we frequently don't recover our losses dollar for dollar.

I'm still looking for one or two good criminal cases in the relevant time period (FY 1997, since that's the period of the report). If you don't need criminal examples, please let me know.

FY 1997: Significant Civil Health Care Fraud Recoveries*Independent Clinical Labs*

In one of the two largest False Claims Act settlements ever reached, SmithKline Beecham Clinical Laboratories, headquartered in Philadelphia, paid \$325 million to resolve federal and state fraud claims alleging overcharges to the Medicare, Medicaid, Federal Employees Health Benefits, Railroad Retirement, and the Department of Defense Tricare (formerly known as CHAMPUS) health care programs. A wide range of different types of fraud schemes were alleged in the settlement arising out of SmithKline's performance of laboratory tests, including billing for laboratory tests not provided, not requested by the referring physician, or not medically necessary; and paying various forms of kickbacks to referring physicians. SmithKline was also alleged to have obtained payment from Medicare by inserting false "diagnosis" codes on claims, and to have double billed for tests for kidney dialysis patients. The settlement resolved three qui tam actions filed against SmithKline while Operation LABSCAM was under way.

Also arising out of the Department's LABSCAM investigation was an \$83.7 million civil settlement with Damon Clinical Laboratories, Inc., formerly headquartered in Needham, Massachusetts, for fraud on the same federal and state-funded health care programs. In response to Medicare fee reductions, Damon bundled together certain groups of tests which it marketed as a package to physicians. The laboratory made it difficult for physicians to order the tests separately, and did not inform physicians that if they ordered the package Damon would bill Medicare and other federal health care programs separately for each test. As a result, physicians ordered, and government programs paid for, millions of medically unnecessary tests. Two qui tam plaintiffs who filed lawsuits against Damon during the government's investigation received a total of approximately \$10.5 million of the settlement amount.

In a third major LABSCAM settlement reached this year, Laboratory Corporation of America (LabCorp) agreed to pay \$182 million to resolve allegations of fraudulent billings to federal and state health insurance programs by Allied Clinical Laboratories, Inc.; Roche Biomedical Laboratories, Inc., and

National Health Laboratories, Inc. (NHL). These three entities merged to form LabCorp in 1995. Allied, Roche and NHL also marketed tests to physicians in a bundled fashion -- making it difficult for physicians to order separate tests -- without disclosing that when a physician ordered "bundled" tests the laboratories would bill government programs a separate charge for each test. In 1992, NHL had entered a criminal guilty plea and paid a \$100 million civil settlement arising out of this conduct, which nonetheless continued after the settlement date. The Labcorp settlement also resolved allegations that NHL overbilled the government for mileage charges for phlebotomists who drew blood from nursing home patients. Five qui tam lawsuits filed during the government's investigation resulted in total payments to the qui tam plaintiffs of approximately \$12 million.

Home Health

In the home health area, the nation's largest home health provider, First American Health Care of Georgia, Inc., and its purchaser, Integrated Health Services, Inc., agreed to reimburse the federal government about \$252 million for overbilled and/or fraudulent Medicare claims submitted by the company. First American, which operated 425 facilities in more than 30 states, billed Medicare for personal expenses of First American's senior management, and for marketing and lobbying expenses. First American filed for bankruptcy protection last year in Georgia and its purchaser in bankruptcy agreed to pay the government on First American's behalf.

Carrier Fraud

Blue Shield of California, one of the government's Medicare carriers, paid \$12 million to resolve allegations that it had obstructed efforts by the Health Care Financing Administration to review Blue Shield's performance under its Medicare contract by altering or destroying documents that showed claims processing errors. Blue Shield substituted backdated and altered documents for those containing errors, and manipulated random samples of files pulled by HCFA to create the impression that the company's performance was better than it was. A qui tam plaintiff received \$2.1 million in connection with this settlement.

- 3 -

Violations of Anti-kickback Statute

Other significant recoveries in Fiscal Year 1997 were the Department's settlements with Baptist Medical Center (\$17 million), Apria Healthcare Group, Inc. (\$1.65 million), and OrNda Healthcorp (\$12.6 million) for submitting claims to Medicare for goods and services provided pursuant to prohibited kickback arrangements.

Baptist Medical Center, a hospital located in Kansas City, Missouri, agreed in September 1997 to pay the United States \$17.5 million to settle allegations that it paid more than \$1 million in kickbacks to a local medical group in return for the group's referral of Medicare-eligible patients. The agreement resolves claims that Baptist submitted false cost reports and fraudulent Medicare claims for patients whose referrals it received through various kickback schemes. The United States claimed that Baptist entered into sham consulting contracts with Robert C. LaHue, D.O.; Ronald H. LaHue, D.O.; and Robert C. LaHue, D.O., Chartered d/b/a the Blue Valley Medical Group (collectively referred to as "Blue Valley"). The agreement also settles claims that Baptist violated the Stark I statute, by submitting clinical laboratory claims for Medicare patients referred by Blue Valley, with which the hospital had a financial relationship.

Apria Healthcare Group Inc., one of the nation's largest suppliers of durable medical equipment, agreed to pay the United States \$1.65 million to settle allegations it submitted false claims for oxygen supplied to patients referred pursuant to kickback arrangements between Apria and providers in Georgia and Florida. Georgia Lung Associates, a group of four physicians practicing in Austell, Georgia, is paying the United States almost \$350,000 to settle allegations that patient referrals for oxygen supplies were provided to Apria in return for kickbacks, and two other providers are paying additional sums to settle similar allegations. We alleged that Apria entered into sham consulting contracts with GLA and other physicians in Florida in order to induce referrals.

OrNda Healthcorp, recently acquired by Tenet Healthcare Corporation, will pay the United States \$12.6 million to resolve claims that OrNda hospitals paid physicians for referrals of Medicare patients and that the hospitals received referrals from

physicians with whom they had prohibited financial relationships under applicable law. The United States claimed that the hospitals, which OrNda acquired as a result of a merger with Summit Healthcare Ltd. in 1994, entered into sham directorship contracts with numerous physicians and provided other inducements, such as reduced lease payments and loans which were later forgiven, so the doctors would refer Medicare patients to the hospitals. The agreement settles a dispute originally brought as a *qui tam* case, United States ex rel. Montagano v. Midway Hospital Medical Center, Inc., OrNda Healthcorp and Summit Health Ltd. (C.D. CA). As part of the settlement, relator James Montagano, M.D. will receive \$2,339,814 of the recovery.

Quality of Care

The Department achieved a significant legal victory, as well as a noteworthy civil settlement, in U.S. ex rel. Aranda v. Community Psychiatric Centers of Oklahoma, Inc., Civ-94-608-A (W.D. Okla.), a case involving allegations of patient abuse and seriously inadequate care at psychiatric centers for youth that were financed by the Medicaid Program. In response to a motion to dismiss filed by the Defendant, the Court rejected the Defendant's arguments that a False Claims Act action can not be based on allegations of inadequate care, and ruled that nothing bars the Government from basing a False Claims Act case on such a theory. 945 F. Supp. 1485 (W.D. Okla. October 1, 1996.) The United States then reached a \$750,000 settlement with the Defendant in February 1997.