Five-State Review of CMHC Partial Hospital Programs Finds $229 Million in Questionable Medicare Payments

A review of Medicare claims for partial hospitalization services provided by community mental health centers (CMHCs) in five states indicates that in fiscal year 1997 an estimated $229 million was paid to the centers for services that were unallowable or highly questionable. The questionable payments constituted 91 percent of all payments for partial hospitalization services in the five states—Florida, Texas, Colorado, Pennsylvania, and Alabama—during fiscal 1997.

Reports detailing the problems identified by the claims review were released in early October by Nancy-Ann Min DeParle, administrator of the Health Care Financing Administration (HCFA), which oversees the Medicare program, and June Gibbs Brown, inspector general of the Department of Health and Human Services (HHS). The review was prompted by HCFA concerns about the dramatic increase in Medicare payments for partial hospitalization services and by site visits by HCFA staff that pointed to significant misuse of the benefit by some CMHCs.

Between calendar year 1993 and 1997, total payments for CMHC partial hospitalization services increased from $60 million to $349 million, or 482 percent, far exceeding HCFA's estimated cost of $15 million annually for these services. During the same period, average payments per patient increased 530 percent, from $1,642 to $10,352. The number of CMHCs participating in the program grew from 296 in 1993 to 769 in 1997. The five states reviewed accounted for about 77 percent of CMHC partial hospitalization payments nationally during calendar year 1996.

Medicare coverage for CMHC partial hospitalization services was authorized by the Budget Reconciliation Act of 1990 (OBRA 1990) and became effective on October 1, 1991. Before then, Medicare provided no coverage of CMHC partial hospitalization services.

OBRA 1990 requires all CMHCs entering the Medicare program to attest that they provide the core services of a CMHC defined by the Public Health Service Act: outpatient services, 24-hour emergency services, day treatment or other partial hospitalization or psychosocial rehabilitation services, and screening for patients being considered for admission to state mental health facilities. OBRA 1990 also requires CMHCs to meet state licensing requirements. However, about two-thirds of the states do not have licensing requirements for CMHCs.

In addition, the law requires that partial hospitalization services must be prescribed by a physician and furnished under the general supervision of a physician, who must certify that the patient would otherwise require inpatient psychiatric care. The services must be reasonable and necessary for the diagnosis or active treatment of the patient's condition, reasonably expected to improve or maintain his or her condition and functional level, and reasonably expected to prevent relapse or hospitalization.

Reviews of 14 CMHCs in Florida and Pennsylvania conducted by the HHS Office of the Inspector General in concert with HCFA 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 the 14 CMHCs. HCFA subsequently suspended payments to all 14 CMHCs and terminated ten of them from the Medicare program.

To halt the abuse of the program, HCFA plans to more strongly monitor the application process for participation in the Medicare partial hospitalization program and reinforce the need for CMHCs to meet all existing statutory and regulatory requirements. New CMHC applicants for the program will receive increased scrutiny through site visits. However, HCFA has promised to consider the local needs of beneficiaries before terminating any CMHCs from the program.

Over the longer term, HCFA is working to develop a prospective payment system that will eliminate the financial incentives to provide inappropriate, unnecessary, or inefficient care. Together with the HHS Office of the Inspector General, it will conduct an overall review of the partial hospitalization benefits in both CMHCs and hospital outpatient departments. More claims will be reviewed to ensure that Medicare pays only for appropriate services to qualified beneficiaries.

A report on the Medicare partial hospitalization review, entitled *Protecting Medicare Partial Hospitalization Benefits in Community Mental Health Centers,* dated September 29, 1998, can be found on the Internet at www.hhs.gov/news/press/1998.html.

Mental Health, Substance Abuse Programs Receive 15 Percent Funding Hike

Federal funding for mental health and substance abuse research and services for fiscal year 1999 increased by about 15 percent over 1998 funding levels under the budget approved by Congress and President Clinton in October. The final appropriations are 9 percent higher than the amount requested by President Clinton in the budget he submitted to Congress last February and about 1 percent above the level recommended by the House Appropriations Committee. Fiscal 1999 began October 1.

Table 1 shows the level of funding for mental health and substance abuse programs for fiscal years 1998 and 1999. Agencies within the Substance Abuse and Mental Health Services Administration (SAMHSA) received appropriations totaling $2.5 billion, an increase of almost 16 percent over fiscal 1998. The Center for Substance Abuse Treatment (CSAT) had the biggest gain, with an increase of almost 20 percent. Most of that increase was generated by extra funding for CSAT's block grant to the states for

Table 1

Appropriations for federal mental health and substance abuse programs for fiscal 1998 and 1999 and change from fiscal 1998, in millions of dollars

Agency and activity	1999	1998	Change $	Change %
Substance Abuse and Mental Health Services Administration (SAMHSA)				
Center for Mental Health Services (CMHS)				
Knowledge Development and Application program	$ 97,964	$ 57,964	$ 40,000[1]	69.0
Mental health Performance Partnership block grant to states	288,816	275,420	13,396	4.9
Children's mental health program	78,000	72,927	5,073	7.0
PATH grants to states for the homeless	26,000	23,000	3,000	13.0
Protection and advocacy services	22,957	21,957	1,000	4.6
Total, CMHS	$ 513,737	$ 451,268	$ 62,469	13.8
Center for Substance Abuse Treatment (CSAT)				
Knowledge Development and Application program	$ 171,868	$ 155,868	$ 16,000	10.3
Substance abuse Performance Partnership block grant to states	1,585,000	1,310,107	274,893	21.0
Total, CSAT	$1,756,868	$1,465,975	$290,893	19.8
Center for Substance Abuse Prevention (CSAP)				
Knowledge Development and Application program	$ 157,000	$ 151,000	$ 6,000	4.0
High-risk grants for youth	7,000	6,000	1,000	16.7
Total, CSAP	$ 164,000	$ 157,000	$ 7,000	4.5
Program management, buildings, and facilities	$ 53,400	$ 54,913	–$ 1,513	–2.8
Data collection	$ 18,000	$ 18,000	—	—
Total, SAMHSA	$2,488,005	$2,147,156	$340,849	15.9
National Institutes of Health (NIH)				
National Institute of Mental Health	$ 861,208	$ 748,841	$112,367	15.0
National Institute on Alcohol Abuse and Alcoholism	259,747	226,752	32,995	14.6
National Institute on Drug Abuse	603,274	526,192	77,082	14.6
Total, NIH mental health and substance abuse research	$1,742,229	$1,501,785	$222,444	14.8

[1] Includes $40 million to improve school-based mental health services for children with emotional and behavioral disorders who are at risk of violent behavior

substance abuse treatment, which is 21 percent above the fiscal 1998 level.

Appropriations for SAMHSA's Center for Mental Health Services increased by almost 14 percent, primarily because of $40 million in additional funding for the center's Knowledge Development and Application program. The increase was the product of an amendment sponsored by Rep. David Obey (D.-Wisc.), who sought the extra funds to improve school-based mental health services for children with emotional and behavioral disorders who are at risk of violent behavior.

The Center for Substance Abuse Prevention received the smallest increase of the three SAMHSA agencies, 4.5 percent.

The 1999 budget includes a total of $1.7 billion for the three research institutes within the National Institutes of Health, about 15 percent above the fiscal 1998 level. The National Institute of Mental Health received a 15 percent increase, closely followed by 14.6 percent increases for both the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse.

Guide Helps Public-Sector Agencies Draft Stronger Managed Care Contracts

The Center for Substance Abuse Treatment has issued a comprehensive guide to help state and county agencies improve the procurement of managed behavioral health care. Medicaid authorities and other agencies in many states have implemented plans to purchase managed behavioral health services from private-sector organizations or nonprofit agencies. Badly written contracts have left some public purchasers and their clients vulnerable to poor-quality services and restricted access to care.

Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers emphasizes the importance of sound contracts that clearly delineate the duties of the managed care organization. The guide outlines a three-stage, ten-step process for designing, procuring, and implementing a managed care system in the public sector. Many states conduct a competitive procurement process, in which managed care organizations are selected based on their technical qualifications and the price they charge for the service package. Such procurements create complex organizational and legal tasks for purchasers, which the guide helps purchasers understand and carry out.

The guide offers practical suggestions for selecting financial features of the managed care system and discusses the complex financial issues involved in health care procurements, such as risk shifting and incentives and sanctions. It also looks at funding streams that can be used to pay for services and describes restrictions about how Medicaid dollars can be spent in managed care initiatives.

A major aim of the guide is to help public purchasers define the scope of the coverage agreement with the managed care organization. Many behavioral health plans developed for the public sector include only a portion of the full range of services needed to prevent, treat, and provide rehabilitation for mental and addictive

disorders. Thus in many states the responsibility for service delivery is divided between the purchaser and the managed care organization. Without careful delineation of responsibilities, splitting the continuum of care can lead to cost shifting, a fragmented system, and lack of accountability, the guide states.

Because services in a managed care program are delivered through a network of providers, careful selection of providers is critical, the guide notes. It describes how the contract can be used to specify the capacity and composition of the managed care network. It also addresses how public purchasers can establish qualification standards for staff of provider agencies and monitor providers' performance.

Many purchasers assume they can rely on the management information system of the managed care organization, which is not always the case, the guide warns. It shows purchasers how to clearly state the required functions of the management information system and how to determine whether the organization's system will be adequate.

The guide concludes with a discussion of ways to protect the interests of consumers and their families. It emphasizes that because managed care organizations may lack experience with public-sector consumers, many of whom have severe impairments, purchasers of managed care services must be especially careful to include contract provisions protecting the interests of all consumers.

Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers is number 22 in the Center for Substance Abuse Treatment's (CSAT's) Technical Assistance Publication (TAP) series. TAP 22 can be ordered from the National Clearinghouse for Alcohol and Drug Information at 800-729-6686 and is also available on the Web via the CSAT link at www.samhsa.gov.

NMHA, NAMI Launch Separate Initiatives to Improve Community Care for Adults With Severe Mental Illness

In early October the National Mental Health Association (NMHA) and the National Alliance for the Mentally Ill (NAMI) each announced major national initiatives to address the treatment needs of adults with severe mental illness. The campaigns are responses to the growing realization that most states and local governments have not fulfilled the 30-year-old promise of deinstitutionalization—to develop and maintain a comprehensive continuum of community-based care. NMHA and NAMI will seek to replicate model programs in communities across the country through the efforts of their state and local affiliates.

Through Partners in CARE (Community Access to Recovery and Empowerment), NMHA and its 340 affiliates will encourage community leaders to reorganize their public systems of care into comprehensive, linked services. NMHA has selected for replication six model programs that span the care continuum. They are the Village Integrated Service Agency in Los Angeles, which uses an integrated approach to serve participants with multiple needs; ACCESS (Access to Community Care and Effective Services and Supports) West Philly, an intensive case management project and multiservice drop-in center with an after-hours diversion program for consumers in crisis; Community Residences of Arlington County, Virginia, which provides a continuum of housing and supports; Consumer Connections of New Jersey, a program that trains mental health consumers for employment in mental health and human service agencies; Fast Track to Employment in New York City, which offers job training and job matching; and Schizophrenics Anonymous (SA), a self-help consumer-run organization with about 80 groups in the U.S. and abroad.

The NAMI initiative focuses on the Program for Assertive Community Treatment (PACT) model, which employs a team approach to provide individualized psychiatric, medical, social, and vocational services and which has been shown to reduce hospitalization and encourage independent living. Only six states have statewide PACT programs, 19 states have at least one pilot program, and 25 states have none. NAMI's goal is to have a PACT program in every state by the year 2002.

The centerpiece of the NAMI strategy is a new manual produced by the organization, *The PACT Model of Community-Based Treatment for Persons With Severe and Persistent Mental Illness.* It provides instructions for starting and operating a PACT program. NAMI will distribute the manual to its more than 1,200 affiliates as well as to state agencies, legislators, and policy makers.

For more information about the Partners in CARE program, contact Laura Young, senior director of adult mental health services for the National Mental Health Association in Alexandria, Virginia, at 703-838-7520. To obtain information about the PACT initiative, call Mary Rappaport, director of communications at the National Alliance for the Mentally Ill in Arlington, Virginia, at 703-312-7886.