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Report to Congressional Requesters

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MEDICARE

Lessons Learned From HCFA's Implementation of Changes to Benefits

GAO/HEHS-00-31

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Health, Education, and
Human Services Division

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January 25, 2000

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable Ron Klink
Ranking Minority Member
Subcommittee on Oversight and Investigations
Committee on Commerce
House of Representatives

Medicare, the federal health insurance program serving over 39 million elderly and disabled Americans, has undergone numerous changes as the Congress has expanded and modernized the program. The Health Care Financing Administration's (HCFA) implementation of these changes has sometimes created program vulnerabilities. As a result, dishonest or unknowing providers have submitted claims for inappropriate services, unknowledgeable contractors have processed these claims, and HCFA has sometimes paid more than it should have. For example, before 1991, Medicare covered "partial hospitalization" mental health services only when they were provided by hospitals. Partial hospitalization is an intermediate level of outpatient treatment for beneficiaries with acute mental illness that is less intensive than inpatient care and more comprehensive than outpatient therapy. In 1991, legislation expanded Medicare's coverage of partial hospitalization services to include services provided by community mental health centers (CMHC). In 1998, the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) reported that, for five states in fiscal year 1997, over 90 percent of the partial hospitalization mental health benefit payments should not have been made.

The Balanced Budget Act of 1997 (BBA) set in motion additional significant changes to Medicare that were intended to modernize the program, expand benefits, and extend the life of the Medicare trust fund. For example, as a result of the BBA, the Medicare+Choice program now offers beneficiaries a wider array of health plan choices, comparable to options available from insurers through employers. Concerned that HCFA implement BBA changes to Medicare in a way that ensures beneficiaries' access to covered services without compromising the fiscal integrity of the program, you asked that we compare (1) HCFA's implementation of the

expansion of the partial hospitalization benefit and (2) HCFA's implementation of the more recent changes under the BBA to determine whether HCFA is acting upon lessons learned from the partial hospitalization program.

To do this work, we reviewed the BBA as well as HCFA documents on the partial hospitalization benefit, spoke with officials of HHS' OIG and HCFA, and met with representatives of three contractors that processed and paid almost two-thirds of total Medicare payments to CMHCs in 1997. We performed our work between November 1998 and November 1999 in accordance with generally accepted government auditing standards. For more detailed information on our study scope and methodology, see appendix I.

Results in Brief

HCFA has a difficult task in overseeing the implementation of changes to Medicare, yet this oversight is essential to counteract the opportunities that sometimes arise for dishonest providers to abuse the program. In the early 1990s, when HCFA implemented the expansion of the partial hospitalization benefit to include CMHCs, HCFA did not systematically evaluate the implications of the benefit's expansion. As a result, Medicare paid claims that should not have been paid. Moreover, HCFA did not provide its contractors with timely and adequate guidance on the partial hospitalization benefit, and neither HCFA nor its contractors systematically monitored claims for the new benefit until it had been in effect for several years. Finally, although individual Medicare contractors detected some improper payments in the early years of the partial hospitalization program, HCFA did not take prompt action to investigate these problems or share this information with its other contractors.

Taking advantage of its experience with CMHCs, HCFA has done better in implementing the benefit changes required by the BBA, but more needs to be done to determine whether corrective actions are needed. For example, HCFA created several internal groups to evaluate its implementation of certain changes under the BBA and to identify the potential for vulnerability to fraud and abuse that might result from these changes. In addition, HCFA has provided more timely explanation of the benefit changes to its contractors and providers, but it still needs to provide contractors with more specific instructions on how to review claims and detect inappropriate billing. Further, although HCFA has recognized the need to develop baseline data for use in identifying questionable claims, it has not yet begun to do so. Finally, HCFA has made limited progress in addressing

the recommendations of the groups that it charged with evaluating its implementation of several BBA benefit changes. For example, HCFA was advised to conduct a baseline study to determine the volume and type of services billed by nonphysician providers, but HCFA officials told us it had not yet done so largely because its resources were focused on year-2000 concerns. This report makes a recommendation to the HCFA Administrator to improve implementation of adjustments to Medicare's benefits.

Background

Established by the Social Security Act Amendments of 1965, Medicare provides two basic types of health insurance for the disabled and the elderly: part A, "hospital insurance," covers inpatient hospital, skilled nursing facility, hospice, and certain home health services; part B, "supplemental medical insurance," covers physician and outpatient hospital services, diagnostic tests, and other medical services and supplies. Under the Medicare fee-for-service program, physicians, hospitals, and other providers submit claims and receive payment for services they have provided to beneficiaries. HCFA contracts with a network of about 60 claims administration contractors to process and pay Medicare claims. Contractors that process part A claims are referred to as intermediaries, and those that process part B claims are called carriers.

In addition to processing claims, these contractors are responsible for carrying out program safeguard activities, such as claims reviews, audits, and fraud and abuse investigations. HCFA's Program Integrity Group serves as monitor and facilitator for these and other payment safeguard activities within HCFA. The group works to achieve program integrity through planning and implementing fraud and abuse detection activities for contractors, providers, and beneficiaries as well as for HCFA's program and staff offices.

Community Mental Health Centers and Medicare's Partial Hospitalization Benefit

Before the passage of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90), Medicare had covered only those partial hospitalization services that were provided by hospitals. OBRA '90 authorized Medicare to include CMHCs as covered providers of partial hospitalization services.[1] According to the Social Security Act, to participate as Medicare providers of partial hospitalization services, CMHCs are required to meet applicable state licensing or certification requirements and provide the following services:

[1]The Community Mental Health Centers Act of 1963 provided funding to help states construct CMHCs. HHS supported states' efforts to establish CMHCs, which would provide comprehensive mental health services in the community.

- outpatient services, including specialized services for children, the elderly, the chronically mentally ill, and those who have been discharged from inpatient treatment at a mental health facility;
- 24-hour emergency care services;
- day treatment, other partial hospitalization services, or psychological rehabilitation services; and
- screening for patients being considered for admission to state mental health facilities.

Specific services covered by Medicare partial hospitalization include individual or group therapy, diagnostic services, and occupational therapy. In addition to providing such services directly, a CMHC may also enter into a contractual arrangement with another provider to perform a particular service. Admitting a patient to a partial hospitalization program requires a physician's certification that without the partial hospitalization treatment, the patient would require inpatient hospitalization. CMHCs submit their claims for partial hospitalization services to HCFA's part A intermediaries.

Changes Under the BBA

The BBA embodies some of the most significant changes to Medicare since its inception more than 30 years ago. One provision of the BBA—the establishment of the new Medicare+Choice program—has considerably broadened the coverage options available to Medicare beneficiaries. Other provisions involve more narrowly focused changes aimed at improving coverage and making it more uniform. These changes include expanding benefits for diabetes self-management, standardizing coverage for bone mass measurements, and expanding authority for nurse practitioners and clinical nurse specialists to bill Medicare for services they perform.

HCFA's Implementation of the Partial Hospitalization Benefit Was Not Adequate

Introducing changes into the Medicare program, such as expanding or revising a benefit, has the potential for creating opportunities for dishonest providers to take advantage of the program. HCFA implemented the partial hospitalization program without adequately considering the problems that could occur as a result of enrolling a new group of providers. Moreover, HCFA did not provide its contractors with timely and adequate guidance on the partial hospitalization benefit—its scope, the type of patients it covers, the types and duration of services it covers, and the services CMHCs are required to provide. In addition, neither HCFA nor its contractors monitored the claims received for the new benefit, and, when improper payments were discovered, HCFA did not respond effectively.

HCFA Did Not Identify the Risks of Adding CMHCs to the Program

HCFA did not systematically evaluate the potential risks to Medicare that could result from extending the partial hospitalization program to CMHCs. According to HCFA officials, the agency expected that the nonprofit CMHCs that were originally established with federal assistance would be providing the partial hospitalization services. However, many other organizations entered the program, and it rapidly went out of control. HCFA's enrollment procedure relied solely on CMHCs' statements that they were providing all of the required services as the basis for making them eligible to bill Medicare. In signing these statements, CMHCs certified, under penalty of law, that they were not fraudulently trying to become eligible to participate in Medicare. HCFA did not recognize that under OBRA '90 dishonest individuals, particularly in states with no CMHC licensure requirements, could establish CMHCs and improperly bill Medicare for partial hospitalization services.

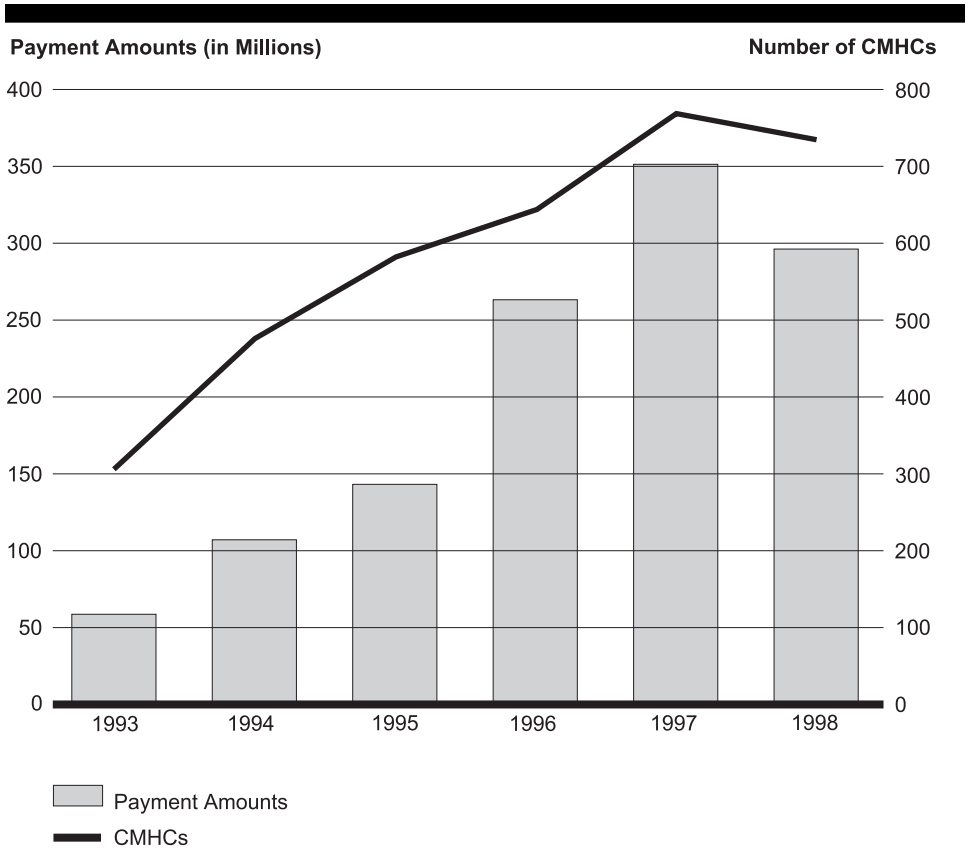
HCFA's limited evaluation of the risks and its lack of verification of CMHCs' qualifications resulted in rapid growth both in the number of participating CMHCs and in Medicare payments. The number of CMHCs participating in the partial hospitalization program more than doubled between 1993 and 1997—from 296 to 769—according to an HHS OIG report (see fig. 1).[2] HCFA had expected that the benefit would be narrowly applied and that it would cost, by one estimate, about $15 million to $20 million per year. Instead, Medicare payments to CMHCs for partial hospitalization services grew rapidly, from $60 million in 1993 to $349 million in 1997, an increase of 482 percent. Average payments per patient increased 530 percent over this same period, from $1,642 to $10,352. Another HHS OIG report estimated that over 90 percent of payments to CMHCs in five states during fiscal year 1997 were for claims that should not have been paid.[3]

Preliminary data show a slight decrease in the number of CMHCs and total payments made to them in 1998. We did not identify with certainty the specific reasons for this decline in benefit payments. However, by 1998, some Medicare contractors had begun to increase their review of CMHC claims. Also by that time, contractors were conducting more site visits to assess CMHC operations and to verify information provided by new CMHC applicants, particularly in the southern states.

[2]HHS, OIG, Review of Partial Hospitalization Services Provided Through Community Mental Health Centers (A-04-98-02146) (Washington, D.C.: HHS, Oct. 5, 1998).

[3]HHS, OIG, Five-State Review of Partial Hospitalization Programs at Community Mental Centers (A-04-98-02145) (Washington, D.C.: HHS, Oct. 5, 1998). The study examined claims from CMHCs in Alabama, Colorado, Florida, Pennsylvania, and Texas.

Figure 1: National Growth in the Number of CMHCs Participating in the Medicare Partial Hospitalization Program and Amount of Payments, 1993-98



Note: Data for 1998 are estimated.

Sources: HHS' OIG and HCFA's Office of Information Services.

Lack of Timely, Appropriate Guidance Hindered Contractor Efforts

At first, CMHC partial hospitalization services were expected to serve a limited group of beneficiaries, and HCFA initially gave its contractors little guidance on, or explanation of, the program beyond the implementing language of OBRA '90. As a result, contractors struggled to understand the parameters of the partial hospitalization benefit in the first years it was in effect. Our discussions with contractors and correspondence between contractors and HCFA regional offices show that contractors raised concerns over such issues as

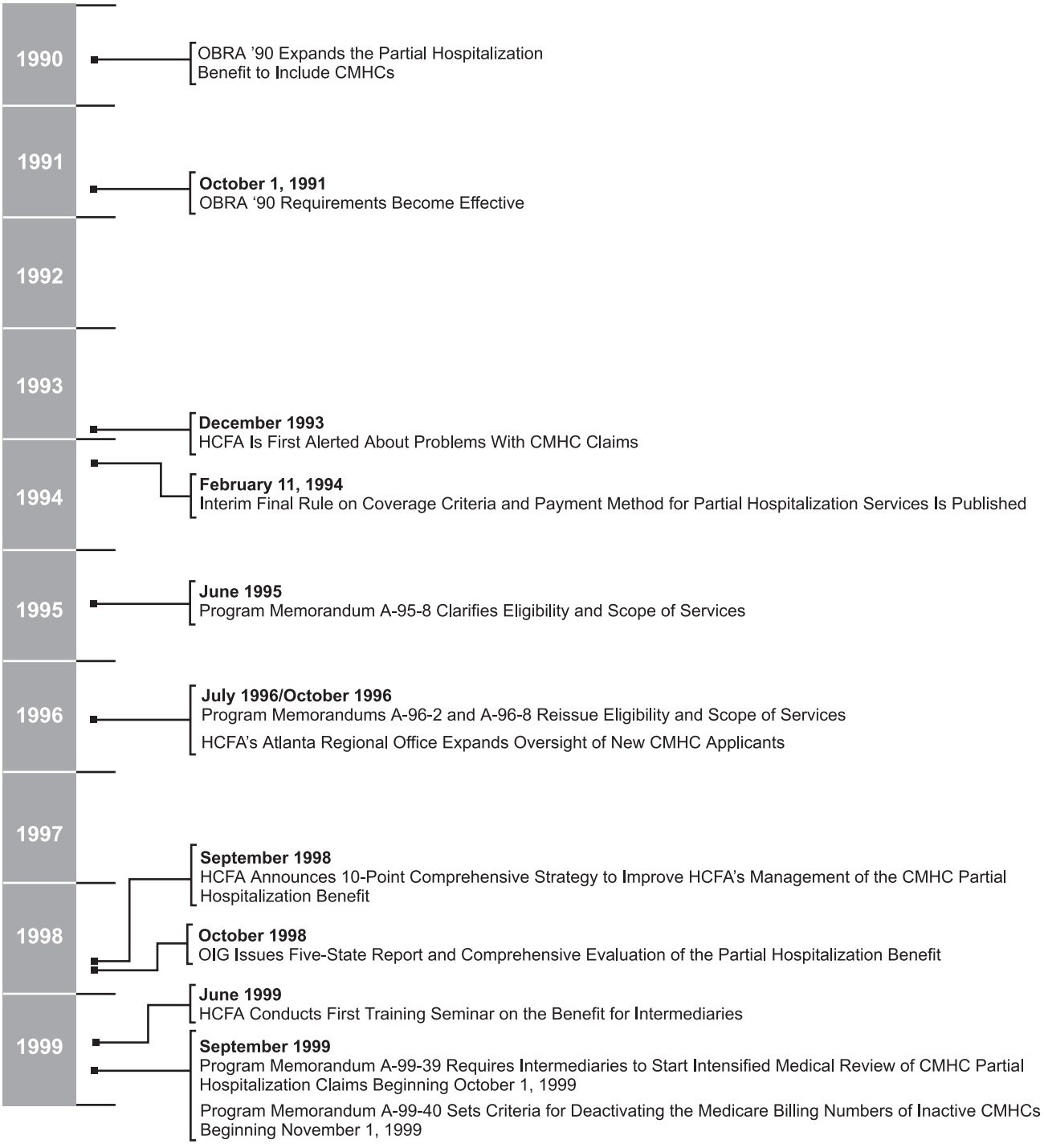
- whether partial hospitalization could cover organic conditions such as Alzheimer's, which are unlikely to improve;

- whether the benefit was available to only those patients with previous psychiatric treatment, or even further limited to only those who had previously been psychiatric inpatients;
- which specific services could be billed to Medicare as partial hospitalization services;
- how frequently services had to be delivered for Medicare to consider a beneficiary's treatment program as partial hospitalization; and
- the level of physician involvement required for services provided to the patient.

A February 1994 interim final rule for partial hospitalization services provided by CMHCs addressed the degree of physician supervision required, the services covered by partial hospitalization, and other matters. In June 1995, more than 3 years after the benefit was instituted, HCFA issued a program memorandum that gave contractors and providers clearer guidance regarding the scope and limits of the benefit, patient eligibility requirements, and the requirement that a physician certify that a patient warrants partial hospitalization.

HCFA has recently taken additional actions to augment its guidance to contractors that process CMHC claims. In June 1999, HCFA conducted a training seminar for intermediary claims review staff that covered the partial hospitalization program benefit at CMHCs. This was the first time HCFA had provided direct training to contractor staff on this issue. The training addressed the background of the partial hospitalization benefit, services and beneficiaries that Medicare covers under this benefit, problems found by the HHS OIG audits, and requirements for medical review of CMHC claims. In September 1999, HCFA issued two additional program memorandums, one setting forth the process for intermediaries to use when conducting medical reviews of partial hospitalization claims from CMHCs and the other instructing intermediaries to deactivate the Medicare provider numbers of CMHCs that have not submitted a claim in 12 months. Figure 2 shows the timing of HCFA guidance to address potential vulnerabilities of the partial hospitalization benefit, as well as the dates of related events.

Figure 2: Key Activities and Actions Related to the Partial Hospitalization Benefit



Lack of Monitoring Focused on the New Benefit Slowed Recognition of Problems

Consistent with its expectation that partial hospitalization would be a small and stable benefit provided by existing CMHCs, HCFA initially paid little additional attention to contractors' oversight of the program. Instead, HCFA relied on its contractors' ongoing safeguard activities, such as their focused medical review efforts, under which contractors analyzed their paid claims data to identify which benefits and providers warranted more detailed review. However, it can take some time to identify emerging problems through medical review. For example, a representative of the primary Medicare contractor for Florida—which has processed the largest amount of payments to CMHCs of any contractor since the benefit began—told us it had previously been aware of problems with individual CMHCs. However, it was not until focused medical review revealed the disproportionate level of CMHC activity in the state, relative to the rest of the country, that the contractor realized CMHCs posed a major problem. Thus, it was not until 1997, or 2 years after Medicare payments to CMHCs in Florida had begun to grow significantly, that the contractor realized the scope of the problem. Similarly, a representative of the Medicare contractor for Texas, which also has a large number of CMHCs, told us that it began focusing on CMHC claims at the end of 1995—4 years after the CMHC partial hospitalization benefit was initiated. These examples illustrate that without a specific effort to monitor CMHC claims in the initial years of the benefit, contractors and HCFA dealt with irregularities involving CMHCs as isolated incidents, without recognizing that there was a programwide problem until payments and losses became large.

HCFA's Failure to Respond to Emerging Partial Hospitalization Problems Allowed Improper Payments to Grow Unchecked

Despite the lack of a targeted monitoring program, some intermediaries did uncover instances of unnecessary and inappropriate services being provided by CMHCs and billed to Medicare in the early years of the partial hospitalization program. For example, in 1993, a CMHC in Washington came to the attention of its intermediary because of claims in excess of $10,000 per beneficiary per month. The CMHC operated residential board and care facilities with live-in aides who assisted residents with everyday needs, such as cooking, cleaning, and transportation. The CMHC was billing Medicare up to $100 per hour, per patient, for these uncovered services. Around the same time, CMHCs in Montana were also misinterpreting the partial hospitalization benefit guidelines to mean that all CMHC services were covered by Medicare and were submitting claims for noncovered services such as day care. Additional problems reported by other intermediaries in late 1993 included the following:

- Day care and geriatric care programs were being billed to Medicare as partial hospitalization.
- Arts and craft activities were being billed as occupational therapy or patient education.
- Family counseling services were being billed when there was no evidence of family member participation.
- Long-term psychiatric patients with controlled symptoms were being monitored in partial hospitalization programs for years.

One HCFA regional office reported its concern about many CMHCs' misinterpretation of the partial hospitalization benefit in a January 1994 memorandum to HCFA headquarters. However, at that time HCFA neither attempted to determine how widespread these misinterpretations were nor directed its contractors to increase their oversight of CMHC claims.

In addition to these early indicators of misinterpretation or misuse of the benefit, officials in HCFA's Atlanta regional office became concerned about the rapid increase in applications received from new CMHCs. In late 1995, the regional office began telephoning and visiting selected CMHCs that were already participating in the program, as well as some new applicants. Many of the telephone calls reached disconnected numbers, private residences, and nonmedical businesses. Site visits to previously enrolled CMHCs found that many were not located at the addresses they had provided to HCFA, and that prospective providers were applying for CMHC provider numbers without having viable facilities. In 1996, HCFA's Atlanta regional office began requiring its contractors to visit new CMHC applicants before they were issued a Medicare provider number.

Despite these early indications of problems, HCFA did not address the partial hospitalization benefit or CMHCs as a whole until the HHS OIG and HCFA together reviewed several CMHCs as part of Operation Restore Trust in calendar year 1997.[4] This focus on CMHCs culminated in the two reports issued by the HHS OIG in October 1998. In that same year, HCFA conducted site visits at about 700 CMHCs in the southern states, where CMHCs are concentrated. It was also not until 1998 that HCFA developed a comprehensive national approach—its 10-point plan for CMHCs—to ensure that Medicare beneficiaries with acute mental illness get quality treatment in CMHCs and that Medicare pays appropriately for these services. Further, HCFA's yearly budget and performance requirements (BPR), which are the agency's primary means for communicating annual performance goals to

[4]Operation Restore Trust, initiated in fiscal year 1995, involved the joint efforts of HHS, the HHS OIG, the Administration on Aging, the Department of Justice, and state agencies to identify and investigate fraud and abuse in the Medicare and Medicaid programs.

its contractors, did not identify CMHCs as a high-risk area until fiscal year 1999.[5] In 1999, HCFA provided intermediaries with its first specific instructions for conducting medical reviews of partial hospitalization claims from CMHCs, and for the first time HCFA set a quantitative goal for the percentage of CMHC claims that are to be medically reviewed.[6]

Implementation of BBA Changes Indicates Some Lessons Learned

With the changes made to the Medicare program as a result of the BBA, HCFA has done more to systematically identify areas that are potentially susceptible to fraud and abuse, although HCFA's actions to mitigate problems are not yet complete. HCFA has also provided contractors with more timely guidance for selected BBA benefit changes, although some identified vulnerabilities remain unaddressed. In addition, HCFA has recognized the need to develop baseline data to monitor claims, but much work remains to be done. Finally, the groups that HCFA charged with both evaluating the potential effects of several BBA changes on Medicare's integrity and assessing HCFA's implementation of these changes have recommended actions that could help determine whether potential vulnerabilities represent real weaknesses. As of November 1999, however, HCFA had made only limited progress in carrying out these recommendations.

HCFA Has Identified Some Program Vulnerabilities Related to BBA Changes

HCFA has made a more intensive effort to identify vulnerabilities that might result from implementing changes required by the BBA than it did for the partial hospitalization benefit change. HCFA formed groups to assess how certain changes, including changes in nonphysician provider reimbursement[7] and bone mass measurement coverage, would affect Medicare. However, HCFA has only begun to implement the recommendations of the groups.

The HCFA group evaluating the changes to nonphysician provider reimbursement under the BBA identified a potential vulnerability regarding

[5]HCFA's BPR for that year cited CMHCs as one of five high-risk areas that should be targeted for prepayment medical reviews. HCFA also directed that each intermediary conduct prepayment medical review on the first CMHC claim it received for a new beneficiary, but HCFA dropped this requirement because it could not be practically implemented using the intermediaries' claims processing systems. The BPR for fiscal year 2000 also identifies CMHCs as a concern but does not set specific targets for the number or percentage of CMHC claims to be reviewed.

[6]A September 1999 program memorandum directed contractors processing claims for the states of Florida, Texas, Colorado, Pennsylvania, and Alabama to review a minimum of 30 percent of the claims for each CMHC provider for a period of 90 days. The memorandum specified increasing or decreasing levels of review after the initial 90 days, depending on the claims denial rate experienced.

[7]Nonphysician providers include nurse practitioners, clinical nurse specialists, and physician assistants.

services provided by nurse practitioners and clinical nurse specialists. The BBA authorizes Medicare to reimburse these nonphysician providers for services that they are allowed to perform under their state laws. But state laws vary in both the services that nurse practitioners and clinical nurse specialists are allowed to provide and the settings in which they can provide services. HCFA currently does not have information on what the laws of each state allow. Without this information, Medicare is vulnerable to reimbursing providers who submit claims for services that are not within their allowed scope of practice. The group recommended that HCFA (1) survey the states to establish a national database of allowable practices for possible use in forming policies and (2) work with national accreditation bodies to establish standard minimum scopes of practice. In November 1999, HCFA officials informed us that they had not yet begun to collect data on services that nurse practitioners and clinical nurse specialists may provide. HCFA is currently trying to identify the best way to gather these data.

The bone mass measurement group discovered that, as a result of the BBA, bone mass measurements are no longer subject to a provision that limits the amount Medicare will pay physicians for services provided by outside suppliers. Prior to passage of the BBA, bone mass measurements were covered as general diagnostic tests, which are subject to payment limits when they are performed by outside suppliers and billed by the beneficiary's physician. The bone mass measurement group recommended that HCFA examine the Medicare claims history to determine the extent to which these payment limits had affected payments for bone mass measurements before the BBA change. However, as of November 1999, HCFA had not begun this work.

Guidance on BBA Changes Has Been More Timely, but Some Identified Vulnerabilities Remain to Be Addressed

For the BBA benefit changes we reviewed, HCFA has provided its contractors with more timely guidance, in the form of program memorandums and interim rules, than it did for the partial hospitalization changes. For the bone mass measurement and diabetes self-management benefit changes that became effective in 1998, HCFA issued initial program memorandums or interim rules either before or during the month the benefit change took effect. However, in one instance, this guidance was not implemented as HCFA had expected. Moreover, HCFA has not addressed some of the guidance concerns identified by one of the groups that assessed the vulnerabilities that might result from these benefit changes.

Before the BBA changes, bone mass measurements were covered under general Medicare provisions for diagnostic tests. Most Medicare contractors paid for the medically necessary use of these measures, although a few did not. The BBA established bone mass measurement as a specific benefit in an attempt to provide for uniform coverage and directed HCFA to establish a standard for how frequently a beneficiary could be eligible for this procedure. HCFA published an interim rule when the benefit went into effect in June 1998, establishing the conditions under which bone mass measurements were to be considered medically necessary and how frequently they could be provided. The HCFA group that reviewed the implementation of the new benefit found that many contractors had not standardized coverage provisions. Instead, contractors may have simply added the new BBA criteria to their existing coverage criteria. The group recommended that HCFA convene a committee of experts to develop an all-inclusive list of covered diagnoses, publish this list for use among its claims processing contractors, and monitor contractors' implementation of the defined coverage. HCFA officials told us that a list of the diagnoses for which bone mass measurements should be covered was developed and made available to contractors at the end of August 1999. Moreover, HCFA asked contractors to review their local medical review policies for consistency with the benefit as defined by the BBA.

The BBA also provided coverage of diabetes self-management training that is furnished by certified providers to individuals with diabetes. HCFA established the standard of up to 10 hours of training for a patient within a 12-month period, with 1 hour of follow-up training annually. The group that assessed this benefit change concluded that the following vulnerabilities might occur: Medicare might be billed for more than the 10 hours of training, for training that was not actually provided, or for multiple claims for the same beneficiary. The group recommended that HCFA create system edits that allow a beneficiary only 10 hours of training in a 12-month period, even if training is received at multiple training locations. In November 1999, HCFA officials informed us that they plan to implement this edit, but the agency's need to address year-2000 system concerns has resulted in a backlog of proposed system changes, so that the edit will not be implemented until next spring. Also, the group recommended that follow-up letters be sent to beneficiaries to confirm that they have received the training that was billed. HCFA has yet to formally instruct contractors to implement this recommendation.

Baseline Data Needed to Monitor Claims Under the BBA Changes

HCFA has recognized the value of developing baseline claims data for changes to Medicare resulting from the BBA. The group evaluating the bone mass measurement benefit noted that suppliers of this test could abuse this benefit in nursing homes, for example, by providing medically unnecessary tests that were not interpreted or used in the treatment of the patient. This group recommended that HCFA review the Medicare claims history to identify the extent to which these tests are being performed and billed without an interpretation of the results being performed and billed.

In addition, the group reviewing the changes for nonphysician providers recommended that HCFA conduct a baseline study to determine the volume and type of services billed by nurse practitioners and clinical nurse specialists. These types of baseline data can support analysis of claims submitted after the changes to reveal payment trends or patterns of claims that warrant investigation. As of November 1999, HCFA had not begun work on any of these analyses, largely because staff resources were focused on year-2000 concerns.

HCFA officials told us that HCFA is considering contracting out this work, but the agency has not yet instructed contractors to conduct any medical review or other monitoring of claims for these new benefits. Neither has HCFA itself begun reviewing the claims paid on the new BBA benefits to determine if the claims activity is consistent with expectations or if potential problems are emerging. Officials we spoke with in HCFA's Program Integrity Group noted that because the BBA changes took effect only in 1998, data would currently be available for only a year, or less—a period of time that is probably insufficient to reveal any trends.

HCFA Has Not Yet Determined That Corrective Actions Are Needed for the BBA Changes

Earlier this year, HCFA's groups that evaluated the potential effects of changes regarding nonphysician providers, bone mass measurement, and diabetes self-management made several recommendations for HCFA actions that could help determine whether potential vulnerabilities represent real weaknesses requiring corrective action. As of November 1999, HCFA had made only limited progress in carrying out these recommendations. Until HCFA and its contractors take these steps, they are not able to determine with any certainty what corrective actions are actually needed. Further, if indications of improper payments associated with these changes are detected, HCFA must be in a position to respond quickly.

Conclusions

The partial hospitalization program was more easily misused because HCFA did not assess the potential for problems with the expanded benefit and did not take appropriate action to ensure its integrity. Our review of HCFA's implementation of three changes to Medicare required by the BBA indicates that HCFA has now made a systematic effort to identify potential vulnerabilities with these changes and has done a better job of providing contractors with timely guidance on the changes than it did when it introduced the partial hospitalization benefit for CMHCs. However, HCFA made little progress in implementing recommendations intended to address potential vulnerabilities largely because it had been using its resources to address year-2000 concerns, according to HCFA officials.

Recommendation

We recommend that the Administrator of HCFA establish a process for implementing legislated Medicare changes that will ensure careful assessment of the potential effects of such changes on the program; sufficient explanation of the changes to enable contractors to review and correctly pay claims; adequate claims monitoring to detect irregularities, patterns of abuse, or other potential problems; and timely corrective action should problems with the changes arise.

Agency Comments

We provided HCFA officials an opportunity to review a draft of this report. HCFA concurred with our recommendation and highlighted the more proactive approach it is now taking to identify and eliminate abuse. HCFA noted that it has issued its first Comprehensive Plan for Program Integrity, which outlines the agency's overall national program integrity strategy as well as 10 initiatives HCFA is implementing to further safeguard Medicare program dollars. HCFA said that it is also conducting ongoing analysis of program benefits at the contractor level to identify problem areas. Finally, HCFA cited plans to implement regulatory and legislative recommendations made by internal work groups on changes made as a result of the BBA. HCFA officials also provided technical comments, which we have incorporated as appropriate. The text of HCFA's comments is presented in appendix II.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 14 days from the date of this report. At that time, we will send copies of this report to the Honorable Donna E. Shalala, Secretary of Health and Human Services; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; appropriate

congressional committees; and other interested parties. We will also make copies available to others upon request.

If you have any questions about the information presented in this report, please call me at (312) 220-7600. Other staff who made key contributions to this report include Paul D. Alcocer, Shaunessye D. Curry, and Donald Kittler.

Leslie G. Aronovitz
Associate Director, Health Financing
and Public Health Issues

Contents

Abbreviations

BBA	Balanced Budget Act of 1997
BPR	budget and performance requirements
CMHC	community mental health center
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OBRA	Omnibus Budget Reconciliation Act of 1990
OIG	Office of the Inspector General

Scope and Methodology

To compare the Health Care Financing Administration's (HCFA) implementation of Medicare's partial hospitalization benefit for community mental health centers (CMHC) with its implementation of the changes to benefits required by the Balanced Budget Act of 1997 (BBA), we reviewed HCFA program documents for the partial hospitalization benefit—including the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) reports, program memorandums, contractor manuals, local medical review policies, and correspondence—to examine how HCFA's review and monitoring of claims fell short of identifying inappropriate Medicare reimbursements. We spoke with officials of HHS' OIG to discuss their involvement in auditing the partial hospitalization benefit. We also met with representatives of three intermediaries—Blue Cross/Blue Shield of Florida, Blue Cross/Blue Shield of Texas, and Mutual of Omaha—to discuss their experiences with the partial hospitalization benefit. Although these intermediaries are not representative of all intermediaries and providers, they processed almost two-thirds of total Medicare payments to CMHCs in 1997. In addition, we reviewed the BBA to determine how the legislation changed other benefits. We also met with headquarters and regional HCFA officials who work directly with the partial hospitalization benefit and BBA benefit changes to determine how HCFA reviews the programs and oversees contractors' activities.

To determine how HCFA has incorporated lessons learned from past problems into its implementation of the BBA changes, we gathered information on the factors HCFA considered when it introduced or expanded other Medicare benefits. We also reviewed program memorandums and internal reports to determine the steps that HCFA took to implement Medicare-related BBA changes to nonphysician provider reimbursement and the bone mass measurement and diabetes self-management benefits. We also interviewed officials from the groups HCFA charged with identifying potential vulnerabilities associated with Medicare benefit changes and reviewed their recommendations for preventing fraudulent activities. Finally, we identified the guidance HCFA provided to contractors for performing medical review of claims submitted under the benefit changes.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: DEC 28 1999

TO: Leslie Aronovitz, Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: GAO Draft Report, "Medicare: Lessons Learned From HCFA's Implementation of Changes to Benefits" (GAO/HEHS-00-31)

Thank you for the opportunity to review and comment on your draft report to Congressmen Dingle and Klink concerning the progress the Health Care Financing Adminisration (HCFA) has made in enacting changes to benefits. We are pleased that GAO recognizes the lessons HCFA learned from its experiences in implementing the partial hospitalization benefit and acknowledges the more proactive approach HCFA is now taking to implementing benefit changes.

Under this new proactive approach, we are assessing the potential effects that new or modified benefits may have on the Medicare program, communicating with our contractors about these changes, establishing baselines where appropriate, and monitoring claims to detect aberrancies. Accordingly we concur with GAO's recommendation that HCFA establish a process for implementing legislated Medicare benefit changes. In fact, we have already begun this process. Earlier this year, HCFA published its first ever Comprehensive Plan for Program Integrity (Comprehensive Plan). The plan describes HCFA's overall program integrity strategy as well as 10 initiatives that the agency is implementing to further safeguard Medicare program dollars. Of particular interest among these strategies is the Balanced Budget Act of 1997 (BBA) initiative.

The BBA was a very significant piece of legislation that profoundly changed the Medicare program by modernizing certain programs and expanding many benefits. Because of the significant impacts the BBA had on the Medicare program, we took a very deliberate approach toward implementing these new legislative provisions. The BBA initiative under the Comprehensive Plan ensures that these new benefits are implemented properly and that program dollars are properly protected.

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In addition to our Comprehensive Plan, which provides a national approach, we are conducting an ongoing analysis of program benefits at the contractor level as required by the Medical Review program. The combined national and local efforts will further strengthen our ability to identify and eliminate abuse.

HCFA formed workgroups to assess the changes and address the potential vulnerabilities associated with these changes. The workgroups have made recommendations in seven different program areas, such as bone mass measurement and non-physician practitioners, and those recommendations are currently being implemented. Many of these recommendations require regulatory or even legislative changes and take considerable time to implement, but we are taking the steps necessary to ensure proper implementation.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised. We look forward to working with GAO on this and other issues.

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