Scrutiny of mental health centers is scant in fraud-prone states: report

By Joe Carlson
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Despite years of warnings, the private companies that monitor for problems in Medicare community mental health centers still aren't actively looking for problems in some the states most prone to fraud for those services, such as Louisiana and Texas, a new review of 2010 data shows.

And when government officials did gather enough evidence to kick a community mental health center out of Medicare, it took an average of 42 weeks to be removed from the list of approved providers. Nine agencies in Florida received payments totaling $2.5 million between when their exclusions were approved and when their bills ceased to be paid, the report says.

The audit released Tuesday (PDF) by HHS' inspector general's office about community mental health centers was the second report in a week's time to pinpoint minimal oversight of Medicare programs that have previously been shown to have documented issues with suspicious payments.

Last week, the office found that the company hired to look for fraud in Medicare Advantage and Medicare's prescription-drug benefit program devoted very little time to investigating its own suspicions of fraud. And most of the company's investigations are focused on the prescription program, which spends far less money than Medicare Advantage.

Regarding community mental health centers, HHS auditors have said previously that such services may be particularly vulnerable to fraud, even though government contractors tasked to look for problems in the most fraud-prone areas report scant investigative activity in the area.

Nationally, 206 community mental health centers received $219 million in 2010 to provide about 25,000 Medicare patients with intense outpatient health services designed to help beneficiaries trying to avoid psychiatric institutionalization. But past HHS inspector general work has found about half of the community-based providers had submitted “questionable” bills in 2010, two-thirds of which hailed from eight cities in Florida, Louisiana and Texas.

Two types of companies are charged with rooting out such fraud: Medicare administrative contractors, which mainly process Medicare claims, and the fraud-hunting zone program integrity contractors.

The new report finds that the Medicare administrative contractors in Texas and Louisiana did no work to identify fraud in community mental health programs, while the cases reported by MACs in Florida resulted mainly from the work of a collaborative, targeted enforcement program called the South Florida High-Risk Provider Enrollment Project.

Among zone program integrity contractors, more than 90% of all the cases investigated were in Florida, even though past research has found high levels of questionable bills in Baton Rouge, La., and Houston, the report says.

HHS officials acknowledged the vulnerability to fraud in the program, but said recent efforts to screen providers in high-risk programs and the monitoring of Medicare bills in real time using predictive analytic technology would help address the problem.

“CMS is building reliable models” in the Fraud Prevention System that can detect and generate alerts for suspicious billing behavior by all major provider and supplier types, including community mental health centers, acting CMS Administrator Marilyn Tavenner wrote in response to the audit report.