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DEFENSE HEALTH CARE

Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries

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SUMMARY

GAO's testimony focuses on past, present, and planned efforts by the Department of Defense (DOD) to assess whether quality mental health care is being delivered to its beneficiaries.

GAO believes that DOD's management of mental health care has improved since the 1980s and that DOD is headed in the right direction with its various mental health care reforms. It now has in place more effective controls over utilization of mental health benefits; it has developed a quality assurance plan for the future; and its managed care techniques being tested around the country are beginning to contain mental health care costs. However, GAO also has substantial concerns about the quality and appropriateness of mental health care provided to DOD beneficiaries and believes that DOD needs to take more aggressive actions in dealing with problem providers.

The kinds of problems that DOD is now uncovering are not new. During the 1970s many similar problems were found and steps were taken at that time to address them. But during the 1980s little monitoring was done and now DOD is faced with the very difficult task of addressing these problems again. It needs to maintain and enhance its efforts to avoid future repeats of these problems.

Madam Chairwoman and Members of the Committee:

We are pleased to be here today to discuss the Department of Defense's (DOD) management of mental health benefits under its Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).[1] My testimony will focus on past, present, and planned efforts by DOD to (1) assess whether quality mental health care is being delivered to its beneficiaries, (2) identify instances of program abuse by mental health care providers, and (3) reform its health care delivery system.

In this regard, Madam Chairwoman, you asked that we address the following five specific issues:

-- the results of DOD's on-site surveys of residential treatment centers,
-- the results of DOD's medical record reviews of care provided,
-- the potential for success of utilization review in monitoring mental health services,
-- the current status of DOD's quality assurance program for mental health services, and
-- the efforts of the DOD Inspector General and other auditing or review groups to assess problems in this area.

In summary, as we testified last year,[2] we believe that DOD's management of mental health care has improved since the 1980s and that DOD is headed in the right direction with its various health care reforms. It now has in place more effective controls over utilization of mental health benefits, and its managed care techniques being tested around the country seem to be working to contain mental health care costs. However, we continue to have substantial concerns about the quality and appropriateness of mental health care provided to DOD beneficiaries and believe that DOD needs to take more aggressive actions to deal with problem providers.

I will elaborate momentarily on each point, but I would first like to briefly describe, for context purposes, some of the history, background, and current initiatives related to DOD's provision and financing of mental health care.

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[1]CHAMPUS pays for a substantial portion of the medical care provided to DOD beneficiaries by civilian hospitals, physicians, and other providers. Retirees and their dependents, active duty dependents, and dependents of deceased members obtain care from these providers when they cannot obtain it from military facilities.

[2]Appendix I contains a list of the various reports and testimonies that GAO has issued on CHAMPUS mental health care since 1975.

Background

CHAMPUS offers a comprehensive mental health benefit. Coverage includes 30 days annually of inpatient care for adults, 45 days for children, and 150 days of care for children and adolescents in residential treatment centers. In unusual circumstances, additional days of care are authorized. Most private insurers do not offer residential care coverage. CHAMPUS authorizes about twice as many outpatient visits as private insurers do, and it does not impose lifetime benefit or dollar limits for mental health care as most others do.

CHAMPUS costs for mental health services increased tremendously during the 1980s, but have recently leveled off. The eligible beneficiary population has remained relatively constant. Between fiscal years 1980 and 1989, increases in CHAMPUS mental health costs averaged 20 percent per year, and between fiscal years 1985 and 1989, these costs increased 126 percent, reaching $613 million. In the last two fiscal years, however, costs have stabilized, with fiscal year 1991 costs totaling about $631 million. Inpatient mental health care represents $500 million or 79 percent of that total. Much of that inpatient care, about $305 million, is for treatment of children and adolescents. About $165 million was paid to residential treatment centers.

DOD's problems administering the CHAMPUS mental health program date back many years. For example, congressional hearings in 1974 disclosed ineffective program management, with testimony focusing on a wide variety of patient care problems, including bizarre and unorthodox treatment, physical abuse, cruel punishment, illegal drug use, and excessive billings. We reported in 1975 and again in 1976 on a wide variety of problems DOD was encountering in its administration of the mental health program, primarily those involving residential treatment care. Among the recommendations we made at that time were that the number of facility inspections be increased, closer scrutiny be provided to avoid inappropriate patient placements and excessive lengths of stay, and criteria be established for deciding whether facility approval should be withdrawn. As I will describe shortly, these problems still exist today.

I should point out, however, that we have found over the years that managing mental health care is very difficult and presents unique challenges. The reasons for this include (1) the subjective and variable nature of mental health disorders; (2) variability between providers in treatment intensity, duration, and level of care; (3) the lack of generally accepted mental health standards and criteria; (4) variability in approaches used to determine the quality and appropriateness of care; and (5) the lack of outcome data associated with particular treatment approaches.

Management Initiatives

In the late 1980s DOD began to make management improvements that appear to have resulted in the leveling off of CHAMPUS mental health costs and are beginning to address quality-of-care issues. Among the improvements were payment reforms, the award of a national mental health utilization management contract, and several "managed care" demonstration projects for the delivery of mental health services for CHAMPUS beneficiaries.

CHAMPUS no longer pays billed charges for inpatient psychiatric care, but instead has adopted a per diem system (a daily rate), that limits yearly increases in costs. This system restricts yearly increases in facility rates to inflation factor indexes.

To control mental health care usage and assess quality, DOD has established a utilization review program by contracting with Health Management Strategies, International, Inc. (HMS). Under this program, mental health care admissions are precertified and periodically reviewed for continued stay necessity. Additionally, HMS performs on-site surveys of residential treatment centers to determine compliance with CHAMPUS requirements. Also, HMS retrospectively reviews medical records of a sample of patients to validate that admissions and continued stays were necessary, adequately supported with documentation, and that the care met quality criteria.

Under various DOD demonstration projects, special efforts have been directed at managing mental health care costs, quality, and access. These efforts include establishing networks of providers; negotiating provider discounts; intensive utilization review involving face-to-face assessments and individual case management; and use of a wider range of alternative care settings, such as partial hospitalization,[3] than are normally available under CHAMPUS.

As for the future, DOD's plan for reforming military health care does not prescribe any particular model of managed health care. The plan, however, does call for continued use of utilization management, increased emphasis on seeking provider discounts, creation of a partial hospitalization benefit, and establishment of a quality assurance monitoring contract. We think all of these measures are appropriate and necessary.

Now I would like to address the specific issues you requested.

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[3]Partial hospitalization involves the hospitalization and intensive treatment of patients for less than 24 hours at a time.

Surveys of Residential Treatment Centers

DOD-sponsored surveys conducted by HMS, which began on a regular basis in 1990, are finding a number of systemic problems potentially affecting the quality of care being provided to children and adolescents in residential treatment centers. As a result, several facilities have withdrawn or been terminated from the CHAMPUS program and others either have withdrawn their applications to become CHAMPUS-authorized providers or had them denied. Many others have promised to correct the problems noted during surveys. However, in our view, there is some question as to whether DOD has acted aggressively enough to verify that facilities have corrected deficiencies as promised.

As of March 31, 1992, HMS had conducted an on-site survey of every CHAMPUS-approved residential treatment center at least once and 44 facilities that had applied for CHAMPUS certification. In all, 137 surveys had been conducted. Currently there are 75 CHAMPUS-approved residential facilities.

HMS's surveys have frequently uncovered a number of serious problems that potentially affect the quality of care provided to DOD beneficiaries. These problems relate to facility staffing, treatment modalities, patient rights, and medical record documentation. Examples of such problems include

- -- unqualified staff providing individual, group, and family therapy;
- -- patient treatment not being directed by a qualified psychiatrist;
- -- registered nursing services not being available 24 hours a day, thereby resulting in instances where child care workers are assessing the need for and administering medications;
- -- excessive use or misuse of restraints and seclusion as methods of behavior management;
- -- therapeutic services not being provided;
- -- restrictions being placed on mail, telephone calls, and visits with family for all patients regardless of individual circumstances;
- -- strip searches being conducted without justification; and
- -- admission, continued stay, and discharge criteria not being stated or followed.

These surveys have achieved some positive results. Many facilities have either corrected or promised to correct the deficiencies noted by HMS surveyors. For example, in some instances facilities have replaced their unqualified staff with licensed mental health professionals; they now provide 24 hour a day nursing care as required; and the use of restraints and seclusion is more selectively and appropriately used. These types of responses demonstrate the value of conducting on-site

surveys. Also, 26 facilities no longer are CHAMPUS-approved residential centers--4 were terminated by DOD and 22 voluntarily withdrew from the program. Twelve withdrew after being notified of a scheduled HMS on-site visit and 10 others withdrew following the visit. Four more have been served termination notices and another has expressed its intention to withdraw.

Notwithstanding these positive results, we believe that DOD has not always taken sufficient steps to verify that the improvements promised by facilities have in fact been made. Presently, facility plans of corrective action are reviewed by HMS and compared with survey findings to determine their sufficiency. In thirteen instances, facilities that were found to have significant problems were re-surveyed to verify implementation of corrective action plans. On average these follow-up visits occurred 13 months after the initial survey. Several of these facilities were found to be nearly as deficient in the subsequent surveys. One of them recently had a CHAMPUS patient commit suicide; that facility is now being terminated by DOD.

DOD and HMS officials told us that when they embarked on the survey process in 1990 they did not expect to find such serious and pervasive problems. Therefore, they were unprepared and unequipped to deal with the problems once they were uncovered. They did not, for example, anticipate that verification of promised corrective actions might be needed.

Medical Record Reviews of Care Provided

Problems similar to those found during surveys of residential treatment centers are also being uncovered by HMS during its retrospective reviews of patient medical records for care provided in acute psychiatric hospitals, residential centers, and outpatient settings. Although, these efforts have been underway for some time, the results are not yet conclusive because, at this point, there has been no opportunity for facilities to comment on the findings or provide additional information for the reviews. Nonetheless, the preliminary results are alarming, suggesting widespread inappropriate admissions and continued stays, and frequent failure to meet critical criteria for care. DOD is now trying to decide exactly how it will pursue these matters after it receives comments from the affected facilities.

Beginning in 1990, HMS has been randomly sampling 2 percent of the closed mental health care cases each quarter and reviewing the medical records of each.[4] The purpose of these reviews is

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[4]The number at cases reviewed, as a result of this sampling ranged from 113 to 164 per quarter.

to validate that CHAMPUS beneficiaries receive high quality, medically necessary care; delivered at the appropriate level; and that services billed are substantiated by the record. The reviews also identify facilities and professional providers for further investigation--referred to as focused reviews. Four quarterly reports have been drafted thus far, the most recent being October through December 1990. Also, there have been 11 focused reviews conducted, and 8 reports drafted at this time. Sixty-three more facilities have been identified for focused reviews.

Both the quarterly and focused reviews have produced disturbing results. For example, the quarterly reviews have found that

-- in one-third of the cases, the medical record indicated that the admission was medically unnecessary or did not substantiate that the admission was medical necessary, and,
-- two-thirds of the cases either did not meet critical quality-of-care criteria or lacked sufficient evidence to determine that they did meet the criteria. One such criteria requires having adequate safety plans for those patients considered a risk to themselves or others.

An analysis in two of the quarterly reviews showed that in addition to the potentially unnecessary admissions, 31 percent of the medical records either indicated that the lengths-of-stay were unnecessarily long or did not support the medical necessity of the lengths-of-stays which occurred. This caused HMS reviewers to question at least one-fifth of the lengths-of-stay for these cases.

The focused reviews have yielded similar results, with unnecessary admissions ranging from 26 to 91 percent of the cases HMS reviewed; another 2 to 43 percent involved admissions that could be supported but lacked support for the appropriateness of the entire length of stay and nearly all of the cases failed to meet critical quality-of-care criteria.

Examples of the types of inappropriate admissions include

-- admissions for environmental or social reasons, such as difficult family situations,
-- admissions in lieu of incarceration in a penal institution, and
-- admissions for diagnostic testing or treatment that could have been provided in a different setting.

DOD plans to provide facilities the opportunity to respond to these findings and offer additional information to refute them. After the facilities comment and additional documentation

is analyzed, DOD will make final determinations regarding the questioned cases. DOD is considering several options for dealing with problem providers, including such steps as recouping money for unnecessary care and removing certain facilities as authorized CHAMPUS providers--but it has established no timeframes for making decisions on these matters.

Potential for Success of Utilization Review

Results from DOD's utilization review activities have been encouraging as they have contributed significantly toward controlling mental health costs. These utilization review efforts have shown that they can have a significant effect on admissions and lengths of stay and, as we have already discussed, help identify instances of quality-of-care problems at psychiatric facilities. DOD has approached utilization review in different ways under its health care demonstration programs, and each approach has merit but also some drawbacks.

The mental health utilization review contract operated by HMS, which preauthorizes care and certifies continued stays by telephone, has shown positive results. For example, approximately 8 percent of requested admissions have been determined medically unnecessary and about 14 percent of requests for continued stays have been unnecessary. Further, average lengths-of-stay have been reduced significantly.

It is troubling, however, that there are a significant number of unnecessary admissions, excessive stays, and quality problems being identified by HMS through its retrospective review of medical records for cases it authorized by telephone. DOD needs to determine the causes of these discrepancies.

DOD's managed health care demonstration projects in California and Hawaii, as well as in the Tidewater, Virginia, area have shown similar positive results from their utilization review activities. Both use face-to-face and on-site assessments as well as retrospective reviews. The contractor for the Tidewater area has reduced inpatient lengths of stay significantly and has directed patients to alternative types of care, such as partial hospitalization and outpatient care. The contractor for California and Hawaii, according to the Rand Corporation, which is evaluating the program, has reduced mental health costs overall by reducing admissions and the number of outpatient visits per user.

However, because both contractors are at risk for the cost of any care provided above fixed contract prices and therefore have fiscal incentives to restrict care, some questions remain about the efficacy of their utilization review activities. A recent congressional hearing in the Tidewater area focused on these concerns. Also, Rand data raise some concerns in

California and Hawaii, because of high inpatient readmission rates in the two states.

Status of Quality Assurance Program

In addition to its utilization review activities, DOD has begun taking other steps to improve the quality of mental health care provided to its beneficiaries. It has developed a plan which outlines the program's goals and direction over the next several years. The plan has two key components.

First, it calls for standards of care to be to developed over the next several years, against which all CHAMPUS mental health care providers will be measured. Presently there are no commonly or generally accepted standards. Such standards, as envisioned by DOD, will identify and specify acceptable and expected modes of treatment for various mental health diagnoses. DOD officials see this as a long-term effort that will take several years to achieve.

Second, DOD plans to award a contract in January 1993 to retrospectively monitor the quality of mental health care provided to CHAMPUS beneficiaries around the country. The contractor will be expected to evaluate the performance of DOD's utilization review contractors, perform a peer review on individual cases, and assist DOD in its development of mental health standards of care.

DOD Audits of CHAMPUS Mental Health Benefits

In recent years there has not been a great deal of DOD audit or investigative activity involving mental health care, even though several DOD organizations potentially could be involved. These organizations are the Inspector General; the audit and investigative groups of each military service; and the CHAMPUS Office of Program Integrity, an internal review group.

The last programmatic review or audit was done by the former Defense Audit Service (now part of the Inspector General) that issued a report in 1979. It commented on the lack of controls over psychiatric services, resulting in abuses on the part of both providers and beneficiaries.

There have been several investigative efforts. The Defense Criminal Investigative Service (DCIS)--also part of the Inspector General--is looking into a number of specific instances of potential fraud and abuse around the country. It currently has 53 investigations underway involving CHAMPUS mental health care, principally of professional providers and facilities. Since 1983, which is as far back as their records go, DCIS has obtained 7 convictions on CHAMPUS cases involving mental health and recommended recoupment of funds in several other instances.

The CHAMPUS Office of Program Integrity involvement has been primarily in response to complaints received from beneficiaries. This office opened 67 cases in 1990 and 61 in 1991, most of them involving allegations of services billed but not provided. Recoupments of $139,000 were made on 18 cases in 1990 and $20,000 on 3 cases in 1991. Thirteen of the 1990 and 26 of the 1991 cases are still being developed. Additionally, 10 cases in 1990 and 19 in 1991 were referred to other agencies, such as DCIS and the Federal Bureau of Investigation. The remainder of the cases (39) were dismissed as unprovable. Officials in the Office of Program Integrity told us that they do not know what their mental health care case activity was during the years prior to 1990.

Conclusions

DOD management of mental health care has improved significantly since the late 1980s. Its planned health care reforms--including the introduction of managed health care--offer the potential to improve access to and the quality of care for beneficiaries while controlling costs.

We also commend DOD for its recent efforts to evaluate mental health care providers. However, considering that DOD is finding such significant problems with the care being provided to its beneficiaries, it needs to aggressively take action against those providers found to be out of compliance with its requirements and standards.

As we noted early in our statement, the problems that DOD is now uncovering are not new. During the 1970s many of the same problems were found and steps were taken at that time to address them. But during the 1980s little monitoring was done, and DOD faces the very difficult task of addressing these problems again. DOD needs to vigorously pursue these matters to avoid future repeats of these problems.

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Madam Chairwoman, this concludes my prepared statement. We will be glad to answer any questions you or other Members of the Committee may have.

Appendix I

Related GAO Products

Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991).

DOD's Management of Beneficiaries' Mental Health Care (GAO/T-HRD-91-30, May 15, 1991).

DOD's Management of Beneficiaries' Mental Health Care (GAO/T-HRD-91-18, Apr. 24, 1991).

Defense Health Programs: Changes in Administration of Mental Health Benefits (GAO/HRD-86-98FS, June 12, 1986).

Extent of Billings by Nonpsychiatric Specialty Physicians for Mental Health Services Under CHAMPUS (HRD-80-113, Sept. 11, 1980).

Greater Assurances Are Needed That Emotionally Disturbed and Handicapped Children Are Properly Cared for in Department of Defense Approved Facilities (HRD-76-175, Oct. 21, 1976).

Information on Psychiatric Benefits Under The Civilian Health And Medical Program of the Uniformed Services (HRD-76-55, Nov. 14, 1975).

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