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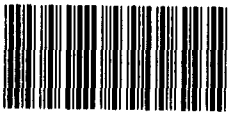

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DOD's Management of Beneficiaries' Mental Health Care

Statement of
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Before the Subcommittee on
Manpower and Personnel
Committee on Armed Services
United States Senate

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SUMMARY

GAO's testimony focuses on (1) how mental health benefits under DOD's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) compare with those under private sector and other governmental health plans and (2) DOD's efforts to manage the mental health care provided to its beneficiaries.

CHAMPUS mental health care benefits and beneficiary cost-sharing requirements--when viewed as a package--are more generous than those offered in the private sector and by other government plans, even considering last year's legislative changes, which imposed somewhat stricter limits on allowable mental health services.

Moreover, DOD's management of mental health care has improved since the 1980s, and GAO believes the Department is headed in the right direction. Last year's legislative changes and DOD's management initiatives enhance the prospects for gaining control over mental health care costs while assuring that necessary care is available and affordable to beneficiaries.

However, several areas need further DOD attention. Among the most important of these is the need to improve its quality assurance program for mental health services. DOD's efforts to assure that beneficiaries receive quality mental health care have been insufficient. It has done little to assess the quality of care provided. Its recent efforts to use its utilization review contractor to begin monitoring quality of care, and its plans to contract for a continuing independent quality review of mental health care services, represent important steps that should result in better assurance that the quality of care will be sufficiently evaluated.

Finally, many questions remain as to how DOD will ultimately implement the plans set forth in its recent report to this Subcommittee and others on mental health care. How and how well the Department and the military services implement DOD's mental health care plans will be key determinants of the success of their efforts.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our evaluation of several key components of the Department of Defense's (DOD) management of beneficiaries' mental health care under its Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).[1] My testimony will focus on:

-- how mental health benefits compare with private sector and other government program benefits and

-- DOD's demonstration projects, utilization review activities, quality assurance programs, and future plans.

Mr. Chairman, we believe that the management of mental health care in DOD has improved since the 1980s and that DOD is headed in the right direction. It now has in place what appear to be more effective controls over the utilization of mental health benefits. In addition, its managed care techniques being tested around the country seem to be working to contain costs and improve access. Last year's legislative changes and DOD's management initiatives enhance the prospects for gaining control over 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 civilian 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.

costs while assuring that necessary care is available and affordable to beneficiaries.

Nonetheless, there are areas that need further DOD attention. These include improving its quality assurance program, reducing beneficiaries' incentives to use inpatient care, and designing alternatives to costly inpatient care. We also want to caution that, while we support DOD's concept of Coordinated Care[2] and believe it offers significant potential in the mental health care arena, many key difficult operational decisions still need to be made. It is also crucial that the lessons learned from past initiatives be incorporated into DOD's implementation plans.

Mr. Chairman, before we elaborate on these matters, I will provide some background information on mental health care cost trends in DOD through fiscal year 1989, the most recent year of complete data.

Mental health costs in DOD have skyrocketed over the last several years. In fact, between 1985 and 1989 they have doubled to more than $600 million per year even though the number of

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[2]DOD's Coordinated Care concept envisions that DOD will manage or regulate most of the health care received by CHAMPUS beneficiaries in an effort to reduce unnecessary and uneconomical services. See The Military Health Services System--Prospects for the Future, Statement of David P. Baine, Director, Federal Health Care Delivery Issues, Human Resources Division, U.S. General Accounting Office, Before the Subcommittee on Defense, Committee on Appropriations, United States Senate (GAO/T-HRD-91-11, Mar. 14, 1991).

eligible beneficiaries has remained relatively constant. Inpatient care comprised the largest and fastest growing component of CHAMPUS's mental health costs, having increased from about $200 million to almost $500 million over the 5-year period. Mental health care provided to children and adolescents in hospitals and residential treatment centers accounted for 3 out of every 4 days of inpatient mental health care and 73 percent of the total DOD spent for such care in fiscal year 1989.

While we view these data as a clear indication that mental health care costs need to be better controlled, we also believe that it is critical for DOD beneficiaries to have high-quality, affordable, and accessible, but necessary, mental health care benefits. Certainly the stresses caused by the recent Persian Gulf conflict have heightened everyone's concern that beneficiaries get the care they need and deserve. Obviously, only a well-managed program can achieve these goals. This hearing is an important part of the effort to improve the management and delivery of mental health benefits in DOD.

I would now like to turn to several specific topics related to these issues.

BENEFIT LEVELS

CHAMPUS mental health care benefits and beneficiary cost-sharing requirements--when viewed as a package--are more generous than those offered in the private sector and by other government plans, even considering last year's legislative changes. We believe, though, that the mental health benefit needs some additional modification so that beneficiaries are able to obtain more affordable and adequate care, when they need it.

The legislative changes enacted last year imposed somewhat stricter limits on acute inpatient and residential treatment center care. In most cases, coverage for inpatient acute care will be limited to 30 days per year for adults and 45 days per year for dependents under 19 years of age.[3] Care in residential treatment centers will be limited to 150 days per year rather than the current unlimited benefit. The legislation also requires that DOD establish procedures under which these limits can be waived in cases where care is determined to be medically or psychologically necessary. On April 1, 1991, annual deductibles for many beneficiaries (which apply to medical care as well) were raised from $50 to $150 per person and from $100 to $300 per family.

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[3]Public Law 101-511, dated October 24, 1990, established new mental health care day limits. Public Law 102-28, dated April 10, 1991, specified that implementation of these limits would begin on October 1, 1991. Currently, 60 days of care per year are allowed unless more care is needed as a result of extraordinary circumstances.

The vast majority of medium and large U.S. firms impose limits on mental health care coverage in the form of annual day limits on inpatient care and/or lifetime dollar limits on all types of mental health care. Several surveys of such firms show that about half of them impose annual day limits on inpatient care, most commonly 30 days. Also, about half of the firms impose lifetime dollar limits on mental health care, usually $50,000 or less (equivalent to about 100 days of inpatient care over a lifetime). CHAMPUS has no such lifetime limits.

CHAMPUS mental health benefits are more generous than those of most other plans in several other respects. For example, unlike most employer-sponsored health plans, DOD offers residential treatment care. In contrast to most private sector plans and plans in the Federal Employees Health Benefits Program, DOD requires no employee premiums, requires less enrollee cost sharing, and offers better annual catastrophic protection for dependents of active duty members. Moreover, the recent legislation allows for waivers to permit patients to exceed the limits it imposed; private firms' plans generally do not.

We believe the benefit package needs some additional modification to overcome an existing financial bias toward the provision of inpatient care to CHAMPUS beneficiaries. For example, dependents of active duty members now have substantial incentives to use expensive inpatient care rather than outpatient

services because inpatient care is essentially free while both a deductible and a 20-percent copayment must be satisfied before DOD begins paying for outpatient services. DOD has stated in its recent report to your Committee and others[4] that it intends to study how best to systematically correct this bias.

There is also a need for other mental health care options that may be less costly than inpatient care, such as coverage for partial hospitalization. Such a continuum of care option, which involves hospitalization and intensive treatment of patients for less than 24 hours at a time, could benefit both patients and DOD's efforts to control costs. It could also improve mental health care outcomes. Adult patients generally could return to their families and to an income-producing status sooner than if they were confined to hospitals. Adolescents and children could also be reunited with their families more quickly than they can now.

DOD has the legislative authority to establish these services as covered benefits, and it appears, based on our review of DOD's recently issued report, that it plans to do so.

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[4]Report to the Committees on Armed Services and Appropriations: DOD's Efforts to Control the Costs of CHAMPUS Mental Health Care, March 1991.

MANAGEMENT INITIATIVES

In the last several years, DOD has initiated and is testing several managed care demonstration programs for the delivery of mental health services for CHAMPUS beneficiaries. In addition, DOD has contracted to help it establish a mental health utilization management program in those areas not covered by its demonstration projects. The techniques DOD is using in these initiatives are similar to those employed in the private sector, which is also wrestling with ways to control mental health care costs. Preliminary results of DOD's efforts indicate that savings are being achieved. However, we believe that the quality of care being provided needs to be more fully evaluated before DOD makes final decisions on implementing a nationwide approach. DOD recognizes this need and is planning to address the quality issues.

Savings of CHAMPUS funds are accruing as a result of reduced provider charges, shorter lengths of stay, and the use of less costly care settings. For example, the CHAMPUS Reform Initiative achieves savings primarily by negotiating provider discounts and conducting utilization management. The Contractor Provided Arrangement project in the Virginia Tidewater area has achieved its savings largely from provider discounts, individual case management, and the use of a wider range of alternative care settings, such as partial hospitalization, than are normally available under CHAMPUS. Health Management Strategies

International, Inc. (HMS), DOD's utilization management contractor, is achieving results principally from pre-authorization of admissions and concurrent review activities. Early data indicate that HMS is reducing lengths of stay both in inpatient acute care settings and in residential treatment centers. But not until later this year will sufficient information be available for a better assessment of the impact that its utilization review activities are having.

As for the future, DOD's plan does not specify which of its initiatives, if any, will become part of its Coordinated Care Program. The plan, however, does call for continued use of utilization management, increased use of provider discounts, and establishment of a partial hospitalization benefit, all of which we think are steps in the right direction. We believe, though, that DOD needs to assure that high-quality mental health care is provided to beneficiaries. I would now like to address this issue.

NEED FOR IMPROVED QUALITY ASSURANCE EFFORTS

DOD's efforts to assure that beneficiaries receive quality mental health care have been insufficient. It has done little to assess the quality of care provided. DOD's efforts over the past year to use its utilization review contractor to begin monitoring the quality of care, and its plans to contract for a continuing

independent quality review of mental health care services provided to its beneficiaries, represent important improvement steps. These efforts should result in better assurance that the quality of care will be sufficiently evaluated.

DOD has for many years relied principally on the accreditation efforts of the Joint Commission on the Accreditation of Healthcare Organizations to help it assure that hospitals and residential treatment centers providing mental health care to military beneficiaries demonstrate the capability to provide high-quality care. DOD requires mental health care providers to obtain Joint Commission reviews (and accreditation) every 3 years. However, DOD has not, until this past year, begun making independent assessments of the quality of care provided.

Only one of DOD's demonstration projects has been independently evaluated with respect to quality of care. A March 1990 report done under contract for DOD concerning its Contractor Provided Arrangement project in Tidewater concluded that there were serious quality-of-care problems related to the appropriateness of treatment, delays in treatment, and level of care provided. A follow-up analysis by the same contractor of 1990 cases resulted in similar findings. However, the contractor pointed out that it is not known how these results compare to those elsewhere under CHAMPUS. DOD is assessing the report to determine what actions it will take.

DOD-sponsored site visits to residential treatment centers have been infrequent. Before 1990, 20 of 88 approved facilities had never been site surveyed, and 27 others had not been reviewed for at least 8 years.

In the past year, HMS began conducting on-site surveys of residential treatment centers. This effort is separate from its role as DOD's utilization review contractor. As of March 1991, HMS had conducted 34 surveys, and by early 1992, it expects to visit every residential treatment center. Of the 34 facilities surveyed, 11 were CHAMPUS-approved centers and 23 were facilities seeking CHAMPUS certification.

None of the 11 CHAMPUS-approved facilities met all CHAMPUS certification standards. Although the degree of noncompliance varied, each facility was found to have problems serious enough to be required to submit corrective action plans to bring it into compliance. Seven plans had been submitted to DOD as of March 1991; four had not. Two of the 11 facilities are in the process of being decertified. One of these two facilities and an additional one were prohibited from admitting new patients pending the submission of satisfactory corrective action plans.

HMS's site surveys and its concurrent review activities have identified a number of systemic problems with the quality of care

being provided to children and adolescents in established residential treatment centers. For example:

-- Many facilities relied on staff who did not meet CHAMPUS's qualification requirements to provide most of the necessary services. For example, a majority of residential treatment centers surveyed were not following DOD's requirement that individual, group, and family therapy be provided by licensed professional staff. Facilities with less qualified staff tended to have longer lengths of stay, relied on rigid behavioral management techniques, and had poor documentation of treatment progress and the effectiveness of treatment interventions.

-- In many residential treatment centers, restraint and seclusion were a major method of behavioral control. Staff ordering seclusion were neither properly trained nor clinically privileged to do so. Staff used "time out," "quiet room," and "holding" as control interventions without the necessary safeguards or clinical assessment and adequate professional involvement. Also, in some facilities registered nurses or physicians were not making assessments indicating the need for patients to remain in seclusion.

-- Medication interventions at some facilities were not used for appropriate therapeutic purposes but, instead, for other purposes such as controlling patients' behaviors.

-- Documentation problems existed at almost every facility. Medical records were incomplete, treatment plans lacked specificity, and progress notes lacked detail on patient responses to treatment interventions.

-- Discharge criteria (the level of functioning that would be required to move the patient to a lesser level of care) usually lacked patient-specific goals and objectives. Discharge criteria not tailored to the condition or needs of each patient can lead to longer lengths of stay or the premature discharge of patients.

-- Many facilities had inadequate staff-to-patient ratios, which can result in too few nurses to tend to patient medical needs, child care workers not available for 24-hour coverage, and shortages of staff on weekends.

Some of the facilities surveyed have responded positively to HMS's determinations. For example, unlicensed staff are in the process of obtaining licensure and, in some instances, unqualified staff have been replaced; facilities have improved documentation, including preparing more specific treatment plans and revising

discharge criteria; and staff-to-patient ratios have been improved. These types of responses demonstrate the value of conducting on-site surveys.

DOD's plan for improving its mental health care quality assurance program calls for awarding an independent quality monitoring contract in fiscal year 1992. The contractor will retroactively review mental health care provided to all CHAMPUS beneficiaries. This function will be similar to the external peer review process for medical and surgical care that DOD now has in place. This action should help address what DOD itself recognizes as an area needing attention.

CONCLUSIONS

As I stated at the outset, we believe the recent changes in DOD's management of beneficiaries' mental health care, and those expected in the near future, represent positive steps that will help the Department improve this important element of the military health care benefit. Nevertheless, many questions remain as to how DOD will ultimately implement the plans set forth in its recent report on mental health care. Moreover, as is the case with its Coordinated Care plans, how and how well the Department and the military services implement DOD's mental health care plans will be key determinants of the success of their efforts. Because of their importance to millions of military beneficiaries, these are

matters that warrant the Subcommittee's continued attention. We, of course, would be glad to assist you in your authorization and oversight efforts.

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This concludes my prepared statement. We would be happy to respond to your questions.