APPENDIX H

March 31, 1995

Mr. Bernard E. Beidel, Director
U.S. House of Representatives
H2 172 Ford House Office Building
Washington, DC 20515

Dear Bern:

Enclosed are the most recent versions of hard copies of the information sent previously. One set is for the CBO and one for the GAO.

Revisions you may deem necessary can be easily made.

Again, my appreciation for all you are doing on this.

Sincerely,

James T. Wrich

BRIEF SUMMARY OF AUDIT FINDINGS

of

MANAGED BEHAVIORAL HEALTH CARE SERVICES

prepared for

THE CONGRESSIONAL BUDGET OFFICE

by

James T. Wrich

March 28, 1995

BRIEF SUMMARY OF AUDIT FINDINGS

of

MANAGED BEHAVIORAL HEALTH CARE SERVICES

prepared for

THE GENERAL ACCOUNTING OFFICE

by

James T. Wrich

March 28, 1995

MANAGED BEHAVIORAL HEALTH CARE:
SUMMARY BRIEFING OF PERFORMANCE AUDITS
By J. Wrich & Associates, LLC

As complaints from employees and practitioners mounted, a number of employers have enlisted outside consultants to conduct performance audits of their managed behavioral health care providers. All employers, including the Federal Government, have compelling reasons for concern with the performance of health care systems. In addition to the hundreds of billions they spend each year on care of their own employees, through taxes and cost shifting they also finance a large portion of the care for added millions of Americans who have no insurance.

The following outlines the findings of audits of MBHOs conducted by J. Wrich & Associates, Inc[1]. , a Chicago based consulting firm with nearly 30 years experience in health systems performance. The audits summarized here were commissioned by employers and are of MBHOs which provide service to more than forty percent of the 160 million Americans enrolled in such plans.

Methodology. The methodology incorporated both direct and indirect research methods to review two major categories of information:

1. The Provider's Documentation. This included policies, procedures, internal reports, customer reports, internal audits and evaluations, monitoring processes, the proposal to the customer from which the contract resulted, and the contract itself. The documentation was reviewed with the provider's staff and others as necessary to determine if variances existed between the written material and actual operation.

2. Patient Files. Generally this part of the audits consisted of random sample retrospective reviews of case managers' patient files. Samples were generally stratified by gender, diagnostic categories, age, geography and work groups. Some were also stratified by race. When a service had been in operation a short time, a multi-stage, dense sampling technique was used so the problems

[1] J. Wrich & Associates, Inc. (JWA) is a health systems performance company with twenty-seven years experience in the systems development and evaluation areas of substance abuse, mental health, EAP and managed care. Since 1978 we have performed benefit to cost analyses, performance audits and outcome evaluations of EAP and managed care services on behalf of employers and unions including Amoco, Burlington Northern Railway Company, General Motors, Hughes Aircraft Company, the State of Ohio, the State of Minnesota, the City of Chicago, Bridgestone/Firestone, Levi Strauss, Milwaukee County, United Airlines, the United Auto Workers and AFS/CME. We have assisted health care providers such as the Mayo Clinic, Hazelden and Shawnee Mission Medical Center and numerous others on various programmatic issues. Recognized experts are utilized in each of the specific areas reviewed and their respective findings are integrated into comprehensive audit reports.

normally associated with implementation during the early stages of a contract could be delineated from the ongoing performance.

In some instances interviews with patients and treatment providers were also conducted.

Scope. The audits generally focus on four major areas:

1. Quality of Care. This involves an in-depth review of diagnoses, referral and treatment. It com-pares type, level and length of care authorized with patients' needs as indicated in the patients' charts. Actual care delivered is also compared to written clinical policies and protocols.

2. Administration**.** Management of the service is reviewed, to assess the impact of administrative practice on clinical services. Included is quality assurance, accuracy of reported data, and the MBHO's relationship to an EAP or other health care related entities is also assessed.

3. The Provider Network. The network is reviewed for its appropriateness and completeness including a rationale for assuring that the capabilities of selected providers will match expected high prevalence disorders among enrollees.

4. Costworthiness**.** The ratio of premiums paid to cost of direct services delivered is a major focus. If applicable, we also attempt to assess the comorbid impact of inappropriate behavioral health care practices on the customer's overall medical surgical costs.

In addition to other audit procedures, JWA may review hundreds of pages of the MBHO's policies and procedures; interview several MBHO key management and clinical staff; analyze hundreds of case managers' patient charts; converse with network treatment providers; review claims paid; observe the managed care contractor's intake and screening process; observe the contractor's provider selection process by setting-up double blind mock interviews.

Findings. A number of the audit findings caused concern. While they should not be generalized to the entire managed care industry, there is significant similarity in placement criteria, practice guidelines, network development procedures and pricing among many of the firms to warrant concern. Therefore, caution is warranted when organizations turn the management of their health care programs over to a managed care organization. The following findings, while not universal, are not uncommon in audits we have performed.

1. Overstated utilization. With few exceptions, there was a tendency among MBHOs to overstate utilization. In some instances multiple patient numbers were assigned. One provider issued a new case number each time it authorized additional care. In other instances, case numbers were assigned on an annual basis, thereby counting enrollees more than once if service was provided in two or more calendar years. Several providers combined re-entries with first time users in their counts leading employers to believe utilization was twice the actual rate. One large MBHO typified this problem. While reporting to the customer that more than 5000 patients had used the

program, the audit found the number to be less than 3500, an overstatement variation of 45%.

2. Timeliness of Service. Timeliness of service to generally fell far outside of the providers' own performance parameters. The contractor's typical written standards:

Routine cases shall receive service within:	5 days
Urgent cases shall receive service within:	24 hours
Emergency cases shall receive service within:	2 hours

From these standards a blended average elapsed time can be computed for the entire group of enrollees seeking service when the proportions of emergency, urgent and routine cases are known. Based on a sample of more than 1000 patient files JWA has found the following percentages: emergency -- 5 percent, urgent -- 13 percent and routine cases -- 82 percent.

Blended average standard for elapsed time of ………. 4.32 days
Actual performance in of the audited MBHOs showed that the blended average for all cases reviewed by audit ranged from .... 8.5 to 19.3 days

The variation between the contractors' written standards versus actual elapsed time ranged from ………………………………..97% to 347%.

3. Network Development. When MBHOs serve employee groups in multiple locations, we have found considerable unevenness in provider network development and accessibility.

While it can be difficult and time consuming, it has been JWA's long held position that all providers should be interviewed face to face before patients are referred to them by the MBHO. More recently, the National Council on Quality Assurance (NCQA) incorporated this as a standard. Simply requesting paper confirmation of credentials and liability insurance is not a sufficient basis for assuring that the provider is competent. There was a wide variation in this crucial area from one MBHO to another. The smaller local and regional providers generally did a better job than the large national firms. Although one large national MBHO had actually conducted face to face interviews with virtually all of its network providers and facilities, this was extremely rare. Well over half of the MBHOs audited did not conduct an interview at all or in only a spotty fashion, and of those that did, most interviewed the providers over the telephone.

Site visits are also important is assessing the quality of care. It was in this area that showed the widest variation in quality of performance. Two firms actually visited the sites of more than 90 percent of its network providers and had regularly scheduled repeat site visits. However, the majority of MBHOs had never seen the offices or facilities of more than 75 percent of its

providers. One with several thousand providers had not site visited any except for those against whom there was a serious complaint about service.

Coverage is also crucial and it was frequently spotty, although from a geographic standpoint it has improved over the past seven years. However, when one considers that the vast majority of providers who become network members had been practicing in nearly every locale prior to the commencement of managed care, question arises as to the validity of MBHOs' claims of having "created" a network. Such claims are particularly specious when there has been little effort to personally interview or site-visit providers.

In the implementation phase of a contract, MBHOs can enjoy substantial margins between premium and expense as they build a network. In the case of one MBHO serving a statewide enrollee group, the contractor's proposal and initial agreement called for a minimum of one chemical dependency and one mental health provider in each county. Two years into the contract there were still major gaps in the provider coverage:

- 15% of counties representing 6% of the state's population had no providers
- 32% representing 19% of the population had no substance abuse providers
- 16% representing 7% of the population had no mental health providers
- 25% representing 12% of the population had no adolescent/child providers
- 21% representing 9% of the population had no family counselors

The customer paid the full premium on 100 percent of the plan's enrollees during that time frame even though the MBHO's network was never completely in place to serve all of them.

4. Matching Service to Enrollees' Problems. This is one of the most fundamental requirements in delivering effective health care. Yet, provider networks are rarely developed with adequate consideration of expected incidence of high risk disorders. Two landmark studies of incidence and prevalence -- the Epidemiologic Catchment Area Study (ECA) and, more recently the National Comorbidity Study (NCS) -- indicate that as many as 80 percent of the adult population with a current behavioral health disorder have one of four major diagnosis or some combination thereof: substance use disorders, major depressive episode, anxiety disorder and phobia. Only one small regional firm of the managed care organizations audited in this sample had built their networks on a research based rationale of expected patient need reflecting these high incidence disorders. None of the large MBHOs used such a rationale.

   These audits found that some MBHOs allow providers to claim expertise in multiple specialties without actually checking competency. In one network audit involving more than 100 providers, the average number of specialties claimed was fourteen with several claiming more than twenty and none showing fewer than five.

   In addition, contractor reports on employing minority providers can be misleading. One ploy included high percentages of Asian and Indian providers many of whom were recent immigrants, anxious to build their practices and willing to work for lower fees, as opposed to established

African American providers who would have more closely profiled the culture and ethnicity of the target population, which was roughly 20% African American versus less than 5% Asian and Indian.

5. Patient Chart Reviews. The MBHO case managers charts were reviewed to assess both the clinical and administrative handling of cases. Chart audits revealed the percentage of problems found in the manner in which cases were handled clinically across the full spectrum of service components normally expected from any organization claiming expertise in behavioral health care. Among the more serious findings were:

- Significant problems in the diagnostic and referral area (all patient charts reviewed)... 30% to 58%

- Failure to properly evaluate/diagnose/treat substance abuse/ addiction of cases where a substance use disorder was present in the chart documentation, or where there were strong indications of its presence .... 54.8% to 78.3%

- Failure to properly evaluate/diagnose/treat substance abuse/ addiction of total cases reviewed .... 21.9% to 31.3%

- Failure to properly evaluate/diagnose/treat psychiatric disorders of cases where symptoms were present in the chart documentation or where there were strong indications of the presence of a psychiatric disorder .... 4.3% to 8.6%

- Failure to refer patient to provider with a specialty in the diagnosed disorder for which the patient required treatment .... 4.0% to 13.2%

- Failure to follow-up .... 6.3% to 78.8%

- Failure to follow-up on cases indicating symptoms which put the patient at risk .... 5.4% to 19.1%

- Instances in which patient had not received care within three months of initial contact due to delays in authorization or other administrative/clinical problems .... 4.1% to 26.0%

The frequency of administrative problems which had an impact on delivery of care varied widely among MBHOs. This included delays in answering telephone inquiries; failure to authorize care in a timely manner; problems with payment of claims.

Instances where there were significant administrative handling problems .... 6.5% to 26.7%

When charts with clinical problems are combined with those having administrative handling problems these audits found care to be potentially jeopardized in a very significant number of cases ……………………………………………………...….37.0% to 86.0%.

6. Patient Placement Criteria. Some of the problems found in the patient chart review resulted directly from the MBHO's practice guidelines, the most significant being in the patient placement criteria. The audits showed that the criteria for inpatient, residential or intensive outpatient treatment is often extremely restrictive. For example, one audit found that the MBHO required **all** of the following for treatment above the individual outpatient level:

- Treatment limited to Axis I, DSM III R diagnosis. Excluded Axis II disorders, including the various personality disorders, obsessive-compulsive disorder, and mental retardation.
- Several types of disorders, including substance abuse/addiction required prerequisite treatment failure at a lower level of care before inpatient or intensive outpatient care, was authorized, and ...
- An attempt to harm self within the previous 24 hours, or significant action or harm to another person within previous 24 hours, or significant threatening action to damage property with high lethality in order to receive inpatient care and, in some instances, intensive outpatient care.

Another audit revealed that the criteria itself for admission to detoxification services put the patient at risk because it required a confirmed diagnosis of addiction plus indication of delirium tremens (DTs). Most experts agree that a major purpose of detoxification services is to prevent DTs. Moreover, intoxication with withdrawal symptoms in itself indicates a need for detoxification services without a time consuming, confirming diagnosis of addiction. Yet another audit found discharge from detoxification was required simply if the patient was no longer dysfunctional due to delusions or hallucinations without regard for other serious symptoms that may have necessitated continued stay.

7. Premium Allocation: Administrative Loadings and Profit versus Direct Care Expenditures (Loss Ratio) In these audits administrative loadings and profit totaling 50 percent or more of the premium paid in "at-risk" carve-outs were commonplace. JWA has stated that to date it has yet not reviewed such an arrangement in which the combination of administra-tive loadings and profit was less than 45 percent of the employer's premium. Because of this, the State of Maryland passed legislation in 1999 requiring MBHOs to disclose their loss ratios.

One audit in this report showed that during a two year period the MBHO had a maximum pay-out of 38.5 percent (including the direct service cost of its own staff) for clinical service resulting in estimated administrative and profit loadings of approximately 61.5 percent ($7,000,000 annual premium vs. $2,292,000 year 1 and $2,595,000 year 2 in direct care expenditures.)

In another audit the estimated MBHO's pay-out for direct care was 49.5% of premium. But during the audit, the MBHO was simultaneously offering the customer a five year cap on the current premium while inducing its network providers to accept a "case rate" or capitated fee system at $275 per case for MSW's and Ph.D's and $425 for M.D.s in exchange for a waiver of case management or utilization review. Had all providers accepted this "case rate" system, the MBHO's direct care pay out could have been reduced to as little as 28 percent of premium. If only half the providers had accepted, the estimated direct care payouts would have amounted to approximately 36 percent of the premium. Both estimates included the actual dollar amount for residential care that was expended under the original contract.

IMPLICATIONS

The implications of these findings are very significant. Traditionally, in plans that cover DSM disorders, we have found that behavioral health care represented less than 10 percent of total health care costs with the other 90 percent expended on medical surgical disorders. More recently, the estimates range from 3 to 5 percent for behavioral health care. In conducting studies of medical surgical claims, like many other health care consultants, JWA reports that it consistently finds that a PARETO group generally consisting of 15 percent of the enrollees represent approximately 75 to 80 percent of the claims expenditures, with 5 percent consuming 40 percent to 55 percent of the total expenditures. It is estimated that chronic behavioral health problems, largely undiagnosed and untreated, are involved in 70 to 75 percent of these PARETO cases. Even if behavioral health issues were totally absent among the remaining 85 percent of claimants, they would still have a bearing on more than 50 percent of total health costs. In other words, roughly half the money spent on medical problems is less likely to result in a permanent solution because mental health and substance use disorders are either ignored or improperly treated. Case records indicate that the single most frequent undiagnosed or improperly treated behavioral health problem is substance use disorder followed by anxiety disorders and major depressive episode.

End.