practices, but apparently to a lesser extent than private insurers * * *

Some federal control weaknesses do exist which have resulted in unnecessary hospital admissions, excessive stays, and sometimes inadequate quality of care * * *

DOD has also identified numerous instances of quality problems and unnecessary hospital admissions. GAO Report #2, pp. 9–10.

These two recent Comptroller General Reports, as well as a substantial body of other documentation, highlight the need for a very active quality assurance program. As discussed further below, two primary issues are presented. First, there is a need for clear, specific standards for psychiatric facilities on staff qualifications, clinical practices, and all other aspects directly impacting the quality of care. These standards are needed for residential treatment facilities, substance use disorder rehabilitation facilities, and partial hospitalization programs. These standards will help bring those facilities, a minority in the industry, that have been unwilling or unable to comply with necessary requirements, up to an appropriate standard of care.

The second key issue is reimbursement rates. As documented by the Comptroller General, CHAMPUS needs to discontinue payment rates based on historical billed charges and establish payment rates based on the actual costs of providing the services.

This final rule puts into place as part of the CHAMPUS regulation comprehensive quality of care certification standards for residential treatment facilities, substance abuse rehabilitation facilities, and partial hospitalization programs. It also modifies current payment methodologies, which will result in rates approximating the costs of providing services in psychiatric hospitals and moving toward cost levels for residential treatment facilities. In addition, the rule addresses several other issues, addressed below.

II. Provisions of Rule to Reform Certification Standards for Mental Health Care Facilities

The Comptroller General's call for stronger management by CHAMPUS to assure quality of care in the mental health programs was based partially on a review of serious abuses on the part of some providers. The GAO presented audit findings identifying program weaknesses. Texas, which is one of four states which account for more than half of CHAMPUS mental health hospital costs, surfaced in recent audits as number one in CHAMPUS mental health expenditures. Of particular

concern are practices described during 1991 hearings conducted before the Texas state senate and summarized in GAO Report #2. In over 80 hours of testimony, 175 witnesses—some beneficiaries of federal programsbrought forth allegations which included exorbitant charges for care never rendered; kickbacks for patient referrals; restraint of voluntary patients against their will; discharge of patients upon exhaustion of benefits, regardless of their condition; and isolation of family from patients, including withholding of visitation and mail/ telephone privileges. While privately insured patients are the most common target of unethical practices, increasing benefit limits and payment controls by private third party payers may place federal programs at increased risk for fraudulent practices. GAO auditors point out that, because CHAMPUS reimburses mental health at rates higher than other federal programs, it may be particularly vulnerable to the minority of unethical providers seeking additional revenue sources.

In recent years, the Department has worked to strengthen oversight and monitoring of mental health programs, particularly with respect to treatment of children and adolescents. Through the contract with HMS, and other efforts, CHAMPUS has paid much more attention to care in RTCs. In [insert 30 days after date of publication] of 1992, Health Management Strategies International (HMS) expressed specific concerns about several of the CHAMPUS-authorized residential treatment centers. Numerous quality of care issues surfaced during on-site facility visits to residential treatment centers where CHAMPUS beneficiaries were receiving care.

Here are several examples:

- —Staff qualifications were deficient. In some cases, patient treatment was not being directed by qualified psychiatrists. At one facility, psychiatry residents were acting as facility medical directors. In some facilities, one psychiatrist may be responsible for as many as 90 children and their families, seriously limiting professional time available for individual attention. In some RTCs, group therapy was being conducted by child care workers with high school diplomas.
- —Several facilities failed to individualize treatment plans. At one facility all treatment plans were the same, regardless of history, needs or problems. Similarly, some facilities were discovered to focus on one type of treatment to the exclusion of all

- other approaches. This was true regardless of whether or not patients responded to this type of treatment.
- —In several facilities, registered nurses were not available on a full-time basis. For example, at one facility children were ordering their own medications "as needed" and medications were dispensed—without further evaluation—by untrained child care workers. In one instance a child who developed tardive dyskinesia (a motion disorder resulting from medication) was described by a child care worker as having a "nervous tic."
- There was evidence of excessive use of restraints and seclusion as methods of behavioral management. Examples including placing children as young as three or four in restraint and seclusion. In one facility, seclusion was used 146 times in one month. The practice of zipping children into so-called "body bags" was employed by several facilities. Use of a body bag, which leaves an opening only for the head, carries risk of overheating to the point of lethal hyperthermia. One facility policy governing this practice did not require physician evaluation of the patient for 72 to 96 hours after the event.
- -Certain RTCs employed unnecessary strip searches and other intrusive acts. Searches involve adult authority figures for forcing children between the ages of four and 18 to remove all clothing and submit to cavity searches. Cavity searches involve finger probes to the mouth, vagina, and rectum. Some facilities were requiring such searches whenever the patient returned from a pass or having a visitor. In many cases, children subjected to such searches were victims of abuse and, for some, these methods of search re-enact the original trauma.

These HMS case findings pointed out shortcomings in practices in some RTCs that can be addressed through improved standards. Although standards for residential treatment centers exist, they have evolved over time from attempts to address individual issues with incremental change. Further, existing CHAMPUS standards for residential treatment centers were written as supplements to standards employed by the Joint Commission on Accreditation of Hospital Organizations (JCAHO). In recent years, the JCAHO has moved toward a more general set of facility standards, with less specific reference to unique requirements of medical specialties. The result has been that CHAMPUS standards—which were not