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REPORT TO THE PERMANENT SUBCOMMITTEE ON INVESTIGATIONS SENATE COMMITTEE ON GOVERNMENT OPERATIONS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

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Information On Psychiatric Benefits Under The Civilian Health And Medical Program Of The Uniformed Services

Department of Defense

A Subcommittee investigation and hearing held in July 1974 disclosed deficiencies in the administration of psychiatric care benefits provided under the program. This interim report contains information requested by the Subcommittee on actions taken by the Department of Defense to correct these deficiencies and problems which still exist.

MWD-76-55 906608 NOV. 14, 1975

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-133142

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The Honorable Henry M. Jackson
Chairman, Permanent Subcommittee
on Investigations
Committee on Government Operations
United States Senate

S. 1504

Dear Mr. Chairman:

This interim report is in response to a request from your office on October 24, 1975. We were asked to provide you with our findings and tentative conclusions on actions taken by the Department of Defense to improve the administration of psychiatric care benefits provided under the Civilian Health and Medical Program of the Uniformed Services. We had agreed, pursuant to your October 17, 1974, request, to include an evaluation of these actions as part of a more comprehensive review we had initiated dealing with psychiatric, handicap, and other specialized treatment facilities authorized under the program.

During hearings before your Subcommittee in July 1974, a number of deficiencies were disclosed in the administration of psychiatric care provided to children and adolescents under the program, and you requested that we determine what action the Department of Defense had taken to

--improve procedures for approving psychiatric residential treatment facilities for participation in the program,

--improve procedures for approving long-term psychiatric care,

--monitor the acceptability of care provided in psychiatric care facilities,

--monitor and audit facility charges for psychiatric care, and

--improve its psychiatric care data base for management purposes.

In general, the Department has taken some action in each of the areas of concern to the Subcommittee. However, problems still exist and further action is needed. Details about the actions taken and our tentative conclusions on the adequacy of these actions are included in appendix I.

The most important actions taken by the Department in these areas were adopting more stringent standards of care which psychiatric facilities must meet to participate in the program and establishing an independent review process for authorizing long-term care. As a result of these actions, many facilities were eliminated from the program and the Department obtained

greater assurances that extensions of long-term psychiatric care are medically necessary. Briefly, the more significant areas still in need of improvement include

--developing facility standards covering program aspects that are not reviewed by the Joint Commission on Accreditation of Hospitals,

--increasing the number of facility inspections,

--reviewing facility operations to assure that techniques used avoid inappropriate patient placements and excessive lengths of stay,

--establishing criteria for deciding whether facility approvals will be withdrawn,

--developing a system for handling complaints,

--determining that charges for services provided beneficiaries are appropriate, and

--improving the management information system to obtain more useful, complete, and accurate financial and program data.

We expect to issue a final and more comprehensive report in early 1976, which will address care provided to program beneficiaries in specialized treatment facilities, including psychiatric facilities.

As your office requested, we did not obtain written comments from the Department of Defense on this report, but the contents were discussed with Department representatives.

Sincerely yours,

Comptroller General
of the United States

APPENDIX I

INTRODUCTION

Benefits under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) cover a wide range of health and medical services, including residential psychiatric care for children and adolescents. This care is provided at treatment facilities whose function is to assess, treat, and rehabilitate children and adolescents with emotional and behavioral disorders. Psychiatric facilities and long-term psychiatric care are subject to approval by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS).

The Secretary of Defense and the Secretary of Health, Education, and Welfare are responsible for overall policy guidance for the implementation of CHAMPUS. The Assistant Secretary of Defense (Health and Environment) has been responsible for administering CHAMPUS since July 1, 1972. Prior to that time, this responsibility had been delegated by the Secretaries to the Director, OCHAMPUS, who functioned under the jurisdiction of the Surgeon General, Department of the Army. OCHAMPUS, located at Fitzsimons Army Medical Center near Denver, Colorado, is now designated a field activity under the policy guidance and operational direction of the Assistant Secretary of Defense.

OCHAMPUS has contracted with the Blue Cross Association and Mutual of Omaha to serve as fiscal agents for processing inpatient claim payments. The Blue Cross Association, through subcontracts with 52 Blue Cross Plans, pays inpatient claims in 33 States, the District of Columbia, and Puerto Rico. Mutual of Omaha pays inpatient claims in the remaining 17 States, Canada, and Mexico.

Costs for psychiatric care in residential treatment facilities for children and adolescents

For calendar year 1975, CHAMPUS costs for psychiatric care are estimated at about $86 million, or 15.5 percent of the estimated total program costs of about $554 million. Costs for psychiatric care provided in facilities for children and adolescents are not categorized separately from total costs for psychiatric care, and not all payments to these facilities could be identified. However, at least $12 million was paid to these facilities for calendar year 1973 inpatient care, excluding professional fees, and about $11.3 million for 1974. Charges for residential care in these facilities ranged from about $450 to $4,000 a month in January 1975. Monthly charges by some facilities included professional fees for such services as individual psychotherapy, group therapy, and diagnostic evaluations; other facilities charged separately for these services. The charge for individual psychotherapy generally ranged from about $25 to $50 an hour; group therapy charges were lower.

Subcommittee hearings

In July 1974, the Permanent Subcommittee on Investigations, Senate Committee on Government Operations, held hearings on the administration of the CHAMPUS program pertaining to psychiatric facilities for children and adolescents and the practices of two of these facilities. These hearings disclosed ineffective program management; testimony indicated a wide variety of problems, including bizarre and unorthodox treatment, physical abuse, cruel punishment, illegal drug use, and excessive charges to CHAMPUS. In the Department of Defense (DOD) response to the Subcommittee on the hearings, a number of new policies were proposed to correct the deficiencies disclosed, and DOD stated that intensified efforts were being made to solve problems associated with psychiatric services, including those provided in residential facilities for children and adolescents.

Scope of review

We made a comprehensive review of specialized treatment facilities that were subject to OCHAMPUS approval. We visited 22 facilities

--8 psychiatric residential treatment facilities for children and adolescents,

--12 handicap facilities, and

--2 specialized inpatient treatment facilities.

This interim report contains information only on the portion of the program pertaining to psychiatric facilities for children and adolescents.

In addition to the reviews at the eight psychiatric facilities discussed in this report, work was also conducted at OCHAMPUS and at seven OCHAMPUS fiscal agents who process claims for payment. We also held discussions with officials of the Joint Commission on Accreditation of Hospitals (JCAH) and the National Institute of Mental Health (NIMH).

We reviewed legislation, regulations, policies, and practices relating to OCHAMPUS facility approval and inspection and to patient approval. In addition, we reviewed OCHAMPUS facility files, inspection reports, patients' medical and treatment records maintained by OCHAMPUS and the facilities, and financial records including claims, billing and payment records, and financial statements.

The following sections address the five areas of particular interest to the Subcommittee. (See app. II.)

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APPROVAL OF PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN AND ADOLESCENTS

We were requested to report on the status and, if possible, provide an assessment of the effectiveness of a three-step process proposed by DOD in approving psychiatric facilities. DOD reported to the Subcommittee that its three-step process involved accreditation by JCAH, onsite surveys by OCHAMPUS, and contacts with State officials to assure that facilities were appropriately licensed and that the States had no reservations concerning facility operations.

According to OCHAMPUS testimony before the Subcommittee in July 1974, about 1,000 facilities were authorized to provide psychiatric care under CHAMPUS as of August 1973. At least 342 of these were authorized to provide psychiatric care to children and adolescents. Since that time, these numbers have been greatly reduced. As of September 1975, there were 380 psychiatric care facilities approved by OCHAMPUS, of which 94 were for children and adolescents.

Changes in approval policies

To explain this decrease, it is first necessary to discuss OCHAMPUS's past approval policies. For years, to be approved for participation under CHAMPUS, a psychiatric facility had to meet only two criteria:

1. The facility had to be operated in accordance with the laws of the area where it was located.

2. The facility had to have professional staff which included a full- or part-time psychiatrist and such appropriate ancillary psychiatric personnel as psychologists and social workers.

OCHAMPUS determined whether a facility met this criteria based on information submitted by facilities in response to a questionnaire.

In a July 9, 1971, report[1/] to the House Committee on Appropriations, we reported that psychiatric facilities were being approved by OCHAMPUS although they did not meet criteria for approval. We cited several examples of facilities not meeting the criteria, and also reported that the facilities were engaging in questionable treatment and charge practices. We recommended that more definitive criteria be established and enforced.

[1/] Costs of Physician and Psychiatric Care--Civilian Health and Medical Program of the Uniformed Services (B-133142).

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In May 1972, OCHAMPUS incorporated a facility inspection into its approval process. However, these inspections were often not made. OCHAMPUS issued interim standards which psychiatric facilities for children and adolescents had to meet after August 31, 1973; and all of the previously approved facilities were required to apply for reapproval. Another policy issued in May 1974 required that by July 1, 1974, all psychiatric facilities providing care to children and adolescents had to have received accreditation by JCAH under newly developed JCAH standards or to have applied for JCAH accreditation and met OCHAMPUS interim standards. Psychiatric facilities, other than those for children and adolescents, were also required to be accredited by JCAH. However, different standards are applied to these types of facilities.

Inquiring into the three-step approval proposed by DOD, we learned that the adoption of OCHAMPUS interim standards and requirements for JCAH accreditation greatly reduced the number of CHAMPUS-approved psychiatric facilities. Although about 1,000 facilities were approved before adoption of these standards, as of September 25, 1975, only 380 were approved, of which only 94 were approved to provide psychiatric care to children and adolescents.

Of these 94 facilities, 22 were State-operated facilities which DOD decided did not have to meet JCAH requirements or OCHAMPUS interim standards. Of the 72 facilities approved under OCHAMPUS interim standards, 70 had received JCAH accrediation.

Among the more important reasons for the substantial reduction in the number of approved facilities were:

--Facilities did not apply for approval under the interim standards, presumably because they could not meet the more stringent standards.

--Facilities applied for approval under the interim standards but approval was denied after OCHAMPUS' evaluation of the application or as a result of OCHAMPUS onsite inspections.

--Facilities approved under the interim standards canceled their applications for JCAH accreditation or did not apply for accreditation.

--Facilities approved by OCHAMPUS were surveyed by JCAH and were not accredited.

OCHAMPUS inspections

When OCHAMPUS adopted the interim standards after August 31, 1973, it assumed responsibility for inspecting psychiatric facilities for children and adolescents. OCHAMPUS policy is to inspect all such facilities, except those operated by States. However, because of a staff shortage, not all approved facilities have been inspected. As of September 1975, 38 of the 72 approved facilities requiring inspections had not been inspected.

OCHAMPUS has authority to hire eight additional people to make inspections and is now trying to obtain these people.

The facilities selected for inspection by OCHAMPUS were those which submitted incomplete or conflicting information when applying for approval. Qualified OCHAMPUS personnel made the inspections, and sometimes professionally qualified consultants accompanied them. These inspections have been more thorough than when performed by fiscal agents.

The inspections included contacts with State licensing authorities when OCHAMPUS was unaware of the licensing requirements of the State or when OCHAMPUS had reservations on whether the facility should be approved. Also, the interim standards provide that a facility be licensed if the State so requires. No procedure has been established by OCHAMPUS for regularly contacting State and local agencies to obtain their views on facilities being inspected.

The OCHAMPUS inspections have disclosed problems. Eleven facilities inspected by OCHAMPUS using the interim standards as criteria were not approved. Serious problems were found in such areas as lack of, or questionable, treatment programs, minimal medical involvement, unsanitary conditions, excessive charges, deficient clinical records, and hazardous and deplorable physical plants.

One facility, visited by OCHAMPUS in July 1975, had been given interim approval based on an application which stated that the facility conducted a viable year-round therapeutic treatment program. However, during a site visit by OCHAMPUS it was found that the children were away on a 3-month camping program (a benefit not authorized under CHAMPUS). The facility had been converted, for this period, into a summer camp for private paying guests. The children were camping in another State, and the campsite was found to be unsanitary and unsafe. There was no medical coverage, and counselors had no formal training in camping. Several of the children and one of the counselors were ill. The children who were ill were sent to a nearby hospital for emergency medical care, and the counselor was advised to seek medical help.

Another facility OCHAMPUS visited in August 1974 did not have a planned schedule of activities for the children and seclusion was used for punishment. Educational activities were being conducted by unqualified staff. Unsanitary conditions existed in the buildings, and the grounds were not well maintained.

OCHAMPUS inspections of JCAH-accredited facilities also have disclosed problems similar to those identified during OCHAMPUS visits to facilities approved under its interim standards. As of September 30, 1975, OCHAMPUS had found six JCAH-accredited facilities to be unacceptable for the CHAMPUS program. Four of the six have been disapproved by OCHAMPUS, a decision on one facility is pending, and the other facility has been given a temporary 6-month approval.

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Examples of problems found by OCHAMPUS inspection teams at facilities which had previously received JCAH accreditation follow.

--Clinical records examined by OCHAMPUS during a visit to a facility in February 1975 failed to show psychiatric services being given since October 1974. Also the consultant nurse had not been involved in the program for 3 months. The facility had no current State license nor current fire and sanitation report. The residential building showed much destruction, deterioration, abuse, and filth. Sanitation reports showed many major deficiencies, none of which had been corrected. Billings to CHAMPUS for therapy could not be substantiated in the facility records. CHAMPUS was charged for art therapy for one child while the child was away at camp.

--The residential cottage of another facility had large holes in the wall, no plates over electrical switches, broken windows, and unsanitary bathrooms. In another building housing patients, bathrooms were unsanitary and the outside area showed no signs of maintenance. Clinical records did not always contain a full psychiatric report and, for some, there was no evidence of a psychiatric examination. The justifications for care in a residential facility were inadequate in some cases and, in one case, inappropriate. No program was evident for patients. The facility was charging States considerably less than it charged CHAMPUS. The range of charges to States was $789 to about $1,000 per patient per month while CHAMPUS patients were charged $1,752 per month for the same program, plus additional amounts for family and individual therapy. There were no private patients in the facility.

--OCHAMPUS inspectors expressed concern about the treatment program of another facility, which they believed was in conflict with the patients rights. All new patients entered a locked area for a minimum of 6 to 8 weeks. They were not allowed to leave this locked area until they had taken a polygraph test to assure that they had been honest. In addition, the polygraph tests were used on patients after they returned from a home visit or off-ground activities. An average of 10 percent of the patients were treated for dermatitis. The facility nurse stated the reason was probably the long periods of confinement without exposure to fresh air and sunshine. The treatment philosophy required that all patients stay at least 1 year and preferably 2, although the facility director said that some patients did well enough to leave within 6 months.

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Problems still exist in approving facilities

An OCHAMPUS official stated that, shortly after the requirement that psychiatric facilities for children and adolescents be JCAH-accredited was instituted, it became apparent that this accreditation alone was not sufficient to meet OCHAMPUS needs. OCHAMPUS believes its purpose in approving facilities is to obtain assurances that facilities are capable of providing at least a minimum level of professional care in meeting patient needs, that such care is provided in a safe environment, and that the charges for care are the same to CHAMPUS as to the general public. JCAH has assisted OCHAMPUS in achieving some of these goals; however, an OCHAMPUS official informed us that JCAH accrediation does not provide OCHAMPUS adequate assurances that patient needs are being met and that the charges to CHAMPUS are reasonable.

Some of the specific OCHAMPUS' concerns over reliance on JCAH accreditation include:

--JCAH inspections are usually made by one inspector. OCHAMPUS uses a team approach, which allows the psychiatrist time to examine psychiatric areas while other areas are evaluated by other team members.

--JCAH inspections are announced while OCHAMPUS inspections are not. OCHAMPUS feels that the only way to determine what is going on in a facility on a day-to-day basis is to make evaluations on an unannounced basis.

--JCAH views itself more in the role of adviser, counselor, and teacher; as a result, accreditation will not be withheld unless the facility is obviously unacceptable. OCHAMPUS is more concerned with the facility's ability to provide appropriate services for the patient.

--JCAH does not have incentives to withhold accreditation because it depends upon funds from facilities applying for survey for continuation of its operations.

--OCHAMPUS has no assurances that JCAH-accredited facilities continue to meet JCAH standards after the accreditation survey or that a facility will correct problems that JCAH uncovers.

--JCAH does not concern itself with reasonableness and appropriateness of charges, which is of major concern to OCHAMPUS.

--JCAH standards do not specifically address such areas as the need for admitting a child; the treatment plans, with means for reaching goals within specific time periods; the duration of treatment; and more specific diagnoses as criteria for treatment.

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JCAH officials informed us that the use of JCAH by facilities is voluntary. JCAH officials accept no responsibility for providing OCHAMPUS assurances other than those represented by its accreditation.

OCHAMPUS has not obtained timely information on facilities that were surveyed by JCAH, but did not receive accreditation. As a result, such facilities have received CHAMPUS payments although they are ineligible to participate in the program. In one case, JCAH notified a facility on February 21, 1975, that it had not been accredited. However, because of inadequate procedures to obtain notice of JCAH's decision, CHAMPUS payments were continued to the facility until July 1975. CHAMPUS payments to the facility for this period amounted to about $19,000. In another case, it took about 2 months for OCHAMPUS to learn that a facility had not received accreditation. During this period about $1,700 was paid to the facility.

According to OCHAMPUS officials, JCAH accreditation of a facility does not provide OCHAMPUS the assurance it needs. Therefore, OCHAMPUS has developed new standards for psychiatric facilities for children and adolescents which have been submitted to DOD for approval. DOD plans to distribute these proposed standards to such groups as NIMH, the American Psychiatric Association, and the Child Welfare League of America for comment.

Our visits, accompanied by medical advisers, to eight psychiatric residential treatment facilities, seven of which were JCAH-accredited, disclosed no evidence that facility staff abused, maltreated, or took punitive disciplinary measures against children. Our medical advisers were of the opinion, however, that the facilities tended to retain patients longer than necessary, that needed services were sometimes not provided, and that admissions to these facilities were sometimes inappropriate. Also, we found questionable billing practices by these facilities.

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PROCEDURES FOR APPROVING LONG-TERM PSYCHIATRIC CARE

We were requested to review the review and approval process for long-term psychiatric care for patients under CHAMPUS and to determine whether the controls over such care were adequate.

The approval process for long-term psychiatric care has undergone a number of revisions in recent years. Before July 1974, residential psychiatric care beyond 90 days required approval by OCHAMPUS. Approvals and extensions were normally granted for 1-year periods on the basis of requests from the facilities in which the CHAMPUS beneficiaries resided. Little evaluation of the need for extended care or the adequacy of the care provided was made by CHAMPUS. Because of numerous problems identified at residential psychiatric treatment facilities, DOD decided to limit benefits for inpatient psychiatric care to a total of 120 days, effective July 1, 1974. However, this limitation was removed in September 1974 because of complaints by beneficiaries. New procedures were adopted and made retroactive to July 1, 1974, which, instead of limiting care to 120 days, established the 120 days as the point in time when cases were to be evaluated and a determination made on whether further care was necessary.

DOD has made arrangements with NIMH, on a special project basis, for the evaluation of facility requests for extensions of patient care beyond 120 days in psychiatric facilities for children and adolescents. Inpatient psychiatric care beyond 120 days in all other facilities is evaluated by fiscal agents using Federal Employees Health Benefits Program guidelines.

Fiscal agents who process claims for inpatient care are also responsible for reviewing medical necessity for inpatient care for the first 120 days. Utilization review by fiscal agents is to be continuous from the date of admission and is to include determinations of whether a patient is receiving significant benefit or merely custodial care. In the latter case, patients are ineligible for CHAMPUS benefits. OCHAMPUS officials informed us that, with a few exceptions, fiscal agents were probably not performing this function adequately. This opinion was supported by the findings of our medical advisers, who questioned whether care, in some cases, was medically necessary and whether admissions were appropriate.

Visits by OCHAMPUS Contract Performance Review teams have disclosed that many fiscal agents do not have written guidelines for utilization reviews. In June 1975, OCHAMPUS sent questionnaires to each fiscal agent requesting information on their utilization review systems. The replies are to be analyzed as part of an effort to develop a stronger utilization review capability among the fiscal agents.

The arrangement between DOD and NIMH to make case reviews of CHAMPUS patients in residential facilities for children and adolescents involved the formation of a committee in October 1974 known as the Select Committee on Psychiatric Care and Evaluation (SCOPCE). NIMH has served as an intermediary in identifying, appointing, and clearing consultants for the SCOPCE case review teams. These teams, consisting of a psychiatrist and one or two other qualified professionals, have been established throughout the country to review cases and make recommendations for approval or disapproval of facility requests for continued psychiatric care beyond 120 days. OCHAMPUS, however, has retained the authority to make the final decision on approval of cases.

The estimated cost of the project, which began in October 1974 and is scheduled to end in July 1976, is about $290,000, of which $220,000 is for consultants' services.

One of the objectives of the SCOPCE project is to develop standards for reviewing patient cases which could be adopted by OCHAMPUS at the end of the project. Eight hundred cases are to be reviewed by the SCOPCE teams. Also, SCOPCE members and OCHAMPUS officials plan to jointly inspect about 20 residential treatment facilities. The SCOPCE review includes determinations as to need for residential care, the appropriateness of the treatment program, the length of stay, and other professional review parameters, as well as the reasonableness of charges. In requesting approval for extended care, facilities are for the first time being required to submit standardized information on 11 questions about patients, including a history of the present illness and reason for admission, a treatment plan, a prognosis, a description of the parental involvement, and charge information. OCHAMPUS, however, does not require pre-admission approval for these long-term cases, and information is not readily available showing the number of patients in these residential facilities except when the length of stay extends beyond 120 days.

Importance of peer review

As of June 30, 1975, 695 cases had been sent to SCOPCE teams for review. Extension of care was granted in 221 cases. However, extensions were normally for 1 to 6 months compared to the 1-year extensions granted under previous OCHAMPUS policies. As a result of the review process, care was terminated in 351 cases. Decisions on the remaining cases were either pending or the cases had been withdrawn for reasons not related to SCOPCE review.

According to OCHAMPUS officials, improvements from the SCOPCE case reviews have been:

--Psychiatric costs involving children and adolescents in residential treatment facilities have been lowered for the first time.

--The use of independent professionals to evaluate cases lends creditability to decisions to extend or terminate care.

--Facilities have become aware that care may be denied after 120 days.

--Uniform patient data is being submitted for case reviews.

--More information is available on the extent of discharge planning by facilities and on parental involvement in treatment.

Although most problems encountered in implementing the project have been resolved, we noted that an extensive period of time elapsed in processing each request for extended-care authorization. OCHAMPUS does not retroactively disapprove care, therefore, it is important to process requests for extended care promptly to minimize payments for care that is subsequently disapproved. For 14 randomly selected cases, it took an average of 100 days, beyond the first 120 days of authorized care, before OCHAMPUS reached a decision. Most of this delay occured at OCHAMPUS as follows:

End of authorized 120 day period until OCHAMPUS submission to review team	52 days
With review team	33 days
With OCHAMPUS awaiting final decision	15 days

OCHAMPUS officials informed us that the initial delay was often attributable to the necessity of obtaining additional information from the facilities. However, an analysis of the initial 52 days indicated that 24 days were required to obtain information from the facilities, and during the remaining 28 days, the requests were in the hands of caseworkers or supervisory personnel at OCHAMPUS.

A report on the results of the SCOPCE project is to be made after completion of the project in July 1976. Apparently, NIMH intends to recommend that DOD continue to contract with consultants for independent case reviews. NIMH may also recommend adoption of procedures for pre-admission reviews.

Continuing an independent peer review procedure, such as provided through the SCOPCE project or through some other arrangement, and requiring pre-admission approvals, seems desirable based on the results of case reviews made by our medical advisers at selected psychiatric facilities.

A review of 128 CHAMPUS cases at 8 psychiatric residential treatment facilities disclosed that (in the opinion of GAO's medical advisers) 37 patients had been in the facilities for longer periods than was

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considered necessary and 25 patients were in facilities that were inappropriate in relation to the patients' particular requirements for care. The principal reasons for these situations were that facilities needed more effective utilization review, discharge planning needed to be better organized and started earlier in the treatment program, and greater parental involvement was needed in the treatment process.

Following are examples of cases involving questionable lengths of stay:

--The stated policy for one facility was to retain patients no longer than 18 months. One CHAMPUS patient, however, had been at the facility for 18 months at the time of our visit and discharge was not planned. Progress from treatment was disappointing. The case was finally terminated after 29 months as a result of SCOPCE review. Another patient was still at this facility after 18 months and had reached the highest achievement level to which one could aspire at the facility. This case was terminated after almost 22 months as a result of an OCHAMPUS case review.

--An adolescent whose primary problem was that she couldn't get along with her stepmother had been at a facility for 26 months, with no plans for discharge or for involving the parent in the child's treatment program.

--A child who had been rejected at home was admitted at age 7 and had been at the facility for nearly 4 years. While treatment was initially needed, it had been obvious for a long time that it was no longer necessary. However, it was deemed undesirable to return the child to the unstable family environment, and no other alternative to continued care at the facility was considered.

--An adolescent with a diagnosis of paranoid schizophrenia had been at the facility for 4-1/2 years. The facility psychiatrist indicated that maximum benefit from treatment at the facility had been achieved after 2-1/2 years.

--An adolescent had received 5 years of CHAMPUS-supported treatment, including 2 years at the facility visited. The facility was planning to reduce the intensity of treatment because of a lack of progress.

Examples of placements our medical adviser considered inappropriate involved use of another treatment mode, lack of parental involvement and rehabilitation training.

--An adolescent diagnosed as neurotic was being treated in a residential facility in the same city where the parent resided. It appeared that outpatient care was all that was needed. No evidence existed to indicate outpatient care was considered.

--An adolescent was admitted to a facility for the second time. The first admission ended after 4 months against medical advice. The adolescent was born of a Korean mother and had limited English language skills. The facility had not used Korean translators in treatment and the mother was not involved. Little progress had been made.

--An adolescent had been in treatment in a facility for 10 months with very limited progress. Divorced parents were in conflict about the treatment and were interfering.

--An adolescent had two periods of psychiatric treatment in residential facilities before the current admission. The adolescent was near the maximum age for acceptance in the facility when admitted. No long-range or vocational planning had taken place.

--An 18-year-old adolescent with limited intelligence and long-standing problems including running away, stealing, fighting, and difficulties with authorities had made little progress in treatment. Vocational training, which was needed, was not available at the facility.

Our medical adviser observed that facilities tended to retain patients despite limited or no progress in treatment. They observed that many of the cases reviewed involved patients with severe, longstanding disorders, low-functioning intelligence and continued family disorganization and instability. In such cases, our medical advisers did not question that the children needed treatment; rather, they believed that the patients should have demonstrated a sufficient rate of change over time to justify continued treatment at the same facility. Further, they observed that there was an issue of treatability in these cases, especially when parents were not involved or were not collaborating in the treatment.

Facility officials may be biased, to the disadvantage of the patients, in requesting extended treatment authorization. Such bias may occur when facilities are dependent upon CHAMPUS for a large portion of their revenue. For example, one facility we visited derived 65 percent of its revenue from CHAMPUS. Another obtained 51 percent of its revenue from CHAMPUS.

Utilization review is one safeguard against such bias. Its use, of course, is not limited to this purpose, but its objectives include determining the necessity for admission and continued stay at facilities. However, our analysis of utilization reviews at eight facilities showed that

five facilities had no formal utilization review programs. One of these five facilities implemented utilization review procedures just before the JCAH accreditation survey but dropped the procedure immediately following the survey.

Other factors contributing to excessive lengths of stay

Two additional factors which we believe contribute to excessive lengths of stay are the lack of discharge planning programs at the facilities and a lack of parental involvement in the treatment program.

Discharge planning was a problem at facilities visited. In many patient cases discharge planning was not performed; and in other cases, it was not organized to expeditiously discharge patients or to assure arrangement for other resources needed to provide services upon discharge. Discharge planning involves initial and ongoing preparation for patient discharge, including determining home conditions, family attitudes, and local resources available to continue services needed upon discharge. When patients were ready for discharge, the facilities frequently had not made adequate plans for discharge.

A case which illustrates the need for discharge planning involved a patient whose father had been killed. Our medical adviser considered the patient ready for discharge. Facility officials, however, stated that since the father had died just 4 months prior to this time, it was difficult to return the patient home to the mother. No alternative plans had been made for placement. The patient had been at the facility 18 months. Another case involved a patient who had been at a facility for 17 months. The patient had previously experienced an unstable family life, being shuffled from natural mother to adoptive parents to half sister. When the patient was ready for discharge, no plans had been made for permanent placement and the child remained at the facility.

Another problem existing at some facilities is the need for parental involvement in treatment programs, including providing psychiatric assistance to parents when it would be beneficial to treating the child. This problem hinders early discharges and, when discharges occur, may prevent patients from deriving continued benefit from the treatment provided. Parents of CHAMPUS beneficiaries were frequently either unable, because they were stationed at great distances from treatment facilities, or unwilling to become involved in the treatment of their children. For these reasons, children were remaining in facilities longer than necessary.

Our medical advisers questioned the value of treatment when parents were not involved since discharges frequently meant returning children to the same environment from which they problems were originally derived

without any effort having been made to improve that environment. NIMH officials also informed us that, although it is difficult to measure the extent of benefit from having parents involved, it is unlikely that treatment is beneficial if there is no parental involvement. Review of case records by our medical advisers indicated that psychological disturbances frequently existed among parents of the children and that there was a general lack of attention by facilities or others to providing parents psychological help which would aid them when their children returned home.

Children admitted to facilities were frequently from out-of-State; 80 percent of the admissions to one facility involved patients from other States. Parental involvement was often limited to initial placement and to consultations in crisis situations; however, some placements were made by the courts. A review of 60 cases showed that parental involvement was lacking, or inadequate, in 22, or 37 percent of the cases. Eight of the 22 cases involved parents who lived out-of-State. One case involved parents who were divorced just before the child was admitted to the facility, and each parent resided in a State different from the one where the child was being treated. Neither parent was involved in the treatment and one was against the placement. Another case involved a child who had been at the facility for nearly 4 years. The parents lived in another State and showed no interest; the child showed concern for his family and about being away from home.

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ACTIONS TAKEN TO PREVENT IMPROPER TREATMENT

We were requested to determine:

--How OCHAMPUS views its role in assessing the acceptability of care provided.

--What action has been taken to assure that complaints are properly investigated.

--What action can be taken against an approved institution when improper care or treatment has been found.

OCHAMPUS officials have stated that they have a definite responsibility in assuring that care provided is of an acceptable nature and in accordance with the needs of the patients. Actions taken to provide greater assurance regarding the acceptability of care include the adoption of more comprehensive standards for facilities, more thorough inspections of facilities, and improved review of cases involving extended care. These actions were discussed previously. (See pp. 5, 6, and 11.)

We found that there was a need to improve procedures for investigating complaints because:

--OCHAMPUS had no written guidelines or instructions for dealing with complaints.

--No centralized control was maintained over complaints; OCHAMPUS had a complaint file, but there was no assurance that it contained all complaints received.

--Records on the disposition of complaints or actions pending were incomplete.

Following the completion of our fieldwork, OCHAMPUS began drafting written procedures for investigating complaints.

OCHAMPUS, as disclosed during the July 1974 hearings before the Subcommittee, has experienced considerable difficulty in the past on withdrawing approval of facilities found to be providing improper treatment. OCHAMPUS has no contractual agreement with facilities which include payment terms for care of CHAMPUS beneficiaries, nor has it yet established definitive criteria for determining whether facility approvals should be withdrawn. Nevertheless, by insisting that facilities meet JCAH standards or interim OCHAMPUS standards to be eligible for payment to care for CHAMPUS beneficiaries, OCHAMPUS eliminated many facilities from the program that could not meet these standards.

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Lacking a contractual basis or other formal criteria upon which withdrawal determinations could be based, situations do arise where DOD officials disagree as to whether approvals should be withdrawn. For example, a June 1975 inspection of a residential psychiatric facility by OCHAMPUS officials and consultants disclosed noncompliance with CHAMPUS interim standards in such areas as medical records, treatment programing, and discharge planning. OCHAMPUS recommended that the facility be disapproved but was overruled by DOD, who instructed OCHAMPUS to approve the facility for 6 months and then reevaluate it under new facility standards proposed by OCHAMPUS.

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ACTIONS TAKEN BY OCHAMPUS TO MONITOR AND AUDIT FACILITY CHARGES FOR PSYCHIATRIC CARE

In response to disclosures by the Subcommittee of excessive and improper charges for psychiatric care, OCHAMPUS stated that action would be taken to audit and monitor these charges. The Subcommittee requested that we review and determine the acceptability of the specific actions taken.

CHAMPUS procedures are still inadequate to assure that charges by facilities are reasonable and proper. Fiscal agents paying CHAMPUS claims are required to determine and pay only reasonable charges, which are defined by CHAMPUS as not in excess of charges to the general public for similar care. However, fiscal agents have no procedures for regularly examining charges or requiring audits of financial records of psychiatric facilities for children and adolescents to assure that charges to CHAMPUS are reasonable and do not exceed those to other patients. Also, fiscal agents accept notifications of rate increases from facilities without requiring adequate justification. Fiscal agents often have agreements with hospitals under their own private programs which give them certain rights to examine costs and charges but no such agreements existed for these facilities. OCHAMPUS procedures for approving facilities for program participation have not included examination of charges or justifications for the level of charges established.

Our review of charges by eight residential psychiatric treatment facilities disclosed questionable charges to CHAMPUS. Facilities with one treatment program for all patients were charging higher rates for CHAMPUS beneficiaries than for other patients; they were charging rates higher than appeared supportable by costs; and they were not collecting cost-sharing amounts from sponsors as required under CHAMPUS. It was quite common for a facility to have different rates for patients with different sponsors, such as State welfare agencies, CHAMPUS, and private citizens; CHAMPUS was invariably charged the higher rates. For example, one facility's rate ranged from $850 to $1,500 with CHAMPUS charged from $1,300 to $1,500. Another facility's rates ranged from $500 to $1,000 per month with OCHAMPUS charged from $850 to $900. Facilities generally explained that different rates were charged in accordance with (1) the sponsor's ability to pay, or (2) amounts negotiated with sponsors. Under the CHAMPUS criterion that charges to CHAMPUS not exceed those to the general public, a facility would be in technical compliance if it charged only one non-CHAMPUS patient the same rate as it charged CHAMPUS.

Charges to CHAMPUS by five of the eight facilities visited were considered questionable, as follows:

--Charges by one facility for its 24 CHAMPUS patients and 4 of 79 non-CHAMPUS patients consisted of a basic fee of $800 per month for room and board plus $325 per month for therapy. Most non-CHAMPUS patients were charged up to the same $800 basic fee but were charged for therapy on a session basis. A test of 14 cases showed that therapy charges ranged from zero to $172. All patients at the facility were in the same treatment program.

--Another facility had 58 CHAMPUS patients, 24 patients placed by State and county welfare departments, and 16 private patients. The CHAMPUS patients were charged about $2,000 per month. With one exception, charges for State and county patients were less than CHAMPUS, ranging from about $400 to $1,600 per month. About half of the private patients were charged rates comparable to those charged to CHAMPUS; the others were charged less.

--At another facility, rates were increased on January 1, 1975, by $100 per month and immediately placed in effect for the 11 CHAMPUS patients in the facility at the time. The new rates were not applied to non-CHAMPUS patients then in the facility, but were applied to all patients admitted after January 1, 1975.

--A nonprofit facility justified an increase in its daily charge from $65 to $75 in February 1975, on the basis of a lower allowable patient census and increased costs. The facility's unaudited financial statements for 1974 showed a profit of over $100,000, which was equal to about 10 percent of revenues and 25 percent of invested capital. The daily rate did not include psychiatric fees. A psychiatrist at the facility also received about $117,000 in 1974 and about $109,000 in 1973 for hospital care and psychotherapy provided to CHAMPUS beneficiaries. At the time of our visit, the psychiatrist was billing each of the 16 CHAMPUS patients in the facility $12 a day, including weekends and holidays, for hospital care, which was defined by the psychiatrist as essentially review and analysis of patients' records.

--Another facility had informed OCHAMPUS that its $900 per month fee included psychotherapy. We found, however, that CHAMPUS patients were billed additional amounts for therapy, which was provided by a facility psychologist or psychiatrist. We were advised this occurred because CHAMPUS would pay for it.

The CHAMPUS legislation provides that costs of care are to be shared by the beneficiary and the Government. Cost-sharing requirements are intended to provide some assurance that beneficiaries obtain only necessary care since they must share in the cost. For inpatient care, dependents of active duty personnel pay $3.70 a day, or a minimum of $25 for each admission. Retirees, their dependents, and dependents of deceased personnel pay 25 percent of costs. For outpatient care, after payment of a deductible of $50 per fiscal year ($100 maximum per family), dependents of active duty personnel pay 20 percent and other dependents pay 25 percent.

Failure of the facilities to collect the sponsor's share not only removes the incentive for the sponsor to reduce lengths of stay and assure appropriate admissions, but it may also result in higher charges being passed on to CHAMPUS through rate increases affected by facilities to makeup for amounts not paid by sponsors.

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Four of the eight psychiatric facilities visited did not collect required amounts from sponsors. These facilities made little effort to determine if sponsors could meet cost-sharing requirements.

--At one facility, the monthly charge for each CHAMPUS patient was $1,125. Sixteen of the CHAMPUS patients were dependents of retired personnel, whose share of the cost (25 percent) should have been $281. Only four of the sponsors were charged $281. Sponsor's charges for the remaining 12 patients ranged from zero to $100 per month. Four were charged $50 per month.

--Two other facilities, one with 58 and the other with 16 CHAMPUS patients, did not collect the sponsor's full share for many of the CHAMPUS patients.

Before February 1974, facility inspections did not include an assessment of the charging practices. However, OCHAMPUS has added six specific questions concerning financial practices to its inspection checklist. The findings of OCHAMPUS inspection teams regarding facility financial practices since implementing these new requirements have been similar to our findings. No facilities had been disapproved solely on the basis of questionable charge practices.

DOD is considering the use of participation agreements with facilities, which would permit OCHAMPUS to negotiate reasonable rates with each facility. OCHAMPUS submitted proposed regulations to DOD regarding participation agreements which would permit OCHAMPUS to

--examine fiscal and other records pertaining to services provided CHAMPUS beneficiaries,

--audit records of the institution or facility to determine the services being provided and the basis for charges,

--examine reports of evaluations and inspections by State and private agencies and organizations, and

--make onsite inspections, including interviews with employees, members of the staff, and patients to verify the capability of the facility to provide services, the manner in which services are being provided and the extent thereof, and conformity with licensing requirements and applicable laws and regulations relating to fire, health, sanitation, and safety.

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AVAILABILITY OF PSYCHIATRIC CARE DATA FOR MANAGEMENT PURPOSES

Because the Subcommittee investigation disclosed that OCHAMPUS had an inadequate data system, we were asked to determine if changes had been made in its data processing capability and whether the system could produce the following information for management purposes.

--The number of psychiatric patients treated annually with a breakdown by age, sex, and diagnosis.

--Psychiatric treatment costs for both inpatient and outpatient treatment broken down by age, sex, and diagnosis.

--The annual amount paid to each institution approved as a provider of inpatient psychiatric care.

--The annual amount paid to each physician or clinic furnishing outpatient psychiatric treatment.

OCHAMPUS has taken some action to improve its information system regarding psychiatric care. However, other changes are still needed to provide more complete data for managing the psychiatric portion of the program.

In February 1975, OCHAMPUS began producing a new report which includes data on the number of psychiatric patients treated on an inpatient basis with a breakdown by age and sex. This report, the "CHAMPUS Cost and Workload Regionalization Report," also provides other data, such as average length of stay, average daily patient load, and average costs. Data on disorders other than psychiatric disorders is also included.

OCHAMPUS also produces a report providing information on psychiatric care by age groups, sex, and diagnosis. However, the data pertains only to nine States and the District of Columbia. In addition, as of July 1, 1975, OCHAMPUS began obtaining more precise diagnostic information. Since 1963, OCHAMPUS has been preparing two other reports which contain data on psychiatric benefits. However, these reports contain more general information, such as number of claims and amounts paid by type of specialist, total and average costs, and patient-day costs.

OCHAMPUS does not regularly prepare reports on amounts paid to psychiatric facilities or to individual psychiatrists. Special automatic data processing runs are required to provide this information. OCHAMPUS has no reports on the costs of the portion of the program pertaining to psychiatric facilities for children and adolescents. Nor is information readily available on the number of children in these psychiatric facilities and their lengths of stay. OCHAMPUS also does not have complete detailed information on outpatient psychiatric costs by diagnosis.

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Because OCHAMPUS has not maintained a computer file of facility identification codes which it needs to relate facilities to payment data submitted by fiscal agents, it has difficulty in providing information in response to special requests for amounts paid to psychiatric facilities. Facility codes submitted by fiscal agents exceeding a certain number of digits were not recorded by OCHAMPUS computer equipment. In some cases fiscal agents assigned one code for a group of facilities, or assigned erroneous codes to facilities. In responding to requests for amounts paid to individual psychiatrists, OCHAMPUS cannot separate amounts paid for claims submitted by ancillary personnel when their services were ordered by the psychiatrist.

In verifying the accuracy of a report made for the Subcommittee on payments to selected facilities, we found a number of errors. These included differences between amounts paid to facilities and amounts reported by OCHAMPUS, failure to include payment data for all CHAMPUS beneficiaries in some facilities, and an overstatement of about $48,000 of payments to one facility.

We also found that OCHAMPUS had not accurately recorded much of the information submitted by facilities in such areas as services offered and conditions accepted for treatment. This information is maintained by OCHAMPUS to respond to sponsors and others who often make inquiries when deciding upon placements.

DOD plans to issue a request for bids to develop a comprehensive management information system for the CHAMPUS program. DOD representatives anticipate development of a system that will provide adequate information to effectively manage all aspects of the program, including psychiatric care benefits. As of November 11, 1975, however, no firm estimate was available as to when such a system would be implemented.

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TENTATIVE CONCLUSIONS

Since August 1973 DOD has made substantive improvements in the process for approving residential psychiatric treatment facilities for children and adolescents eligible for CHAMPUS benefits. The main thrust of the action taken was two-fold. First, DOD conditions its approval on the facilities' obtaining JCAH accreditation or meeting OCHAMPUS interim standards while awaiting JCAH inspection and approval. Second, OCHAMPUS has improved the onsite inspection process to obtain better assurances that approved facilities are providing adequate care in an appropriate environment. Under certain conditions, OCHAMPUS also determines State licensing requirements.

These actions have significantly reduced the number of facilities approved by OCHAMPUS, and they have been effective in eliminating submarginal facilities from the program. The inability of facilities to meet either OCHAMPUS interim or JCAH standards was a principal reason for this reduction. However, OCHAMPUS believes that the JCAH review is not sufficiently comprehensive to cover all aspects of a facility's operation with which OCHAMPUS is concerned. We believe that OCHAMPUS needs also to be concerned with the appropriateness of admissions, lengths of stay, and reasonableness of charges.

OCHAMPUS inspectors review such matters during onsite inspections, but, because of staff shortages, many facilities have not been inspected. OCHAMPUS is attempting to improve the approval and inspection process by developing facility standards to meet program requirements and by increasing the size of its inspection staff.

OCHAMPUS procedures for approving long-term residential care for children and adolescents have been improved through the use of independent professional reviewers, more thorough review procedures, and by obtaining better patient data from the facilities. Thus, extended-care authorizations have been shortened or withdrawn. OCHAMPUS can further reduce unnecessary long-term care by accelerating the review process, which sometimes takes as long as 100 days beyond the 120-day point for review. Pre-admission approval procedures are needed to better assure that the first 120 days of care are medically necessary and admissions are appropriate.

OCHAMPUS needs to assure that the facilities also make improvements to avoid excessive patient lengths of stay. Utilization review programs need to be established or improved, as do discharge planning programs. Also, greater involvement of parents in treatment programs for their children is needed and may result in earlier releases and more successful treatment.

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Greater assurance that patients are properly treated has been provided through the adoption of more comprehensive standards for facilities, better inspections, and improved review of extended-care cases. However, improvement is still needed in procedures for investigating complaints and for withdrawing facility approval. The adoption by DOD of OCHAMPUS proposed participation agreements with facilities could facilitate withdrawal decisions by providing formal criteria for such action.

OCHAMPUS has begun to obtain information on financial charges during facility inspections, but OCHAMPUS procedures are still inadequate to determine whether charges are reasonable and proper. Action also needs to be taken to assure that CHAMPUS sponsors are charged and pay their share of the cost. The participation agreements now being considered by DOD would provide for negotiation of reasonable rates after examination of financial records. Such agreements, and periodic financial audits, would provide greater assurance that charges are appropriate.

Some action has been taken to provide better data on psychiatric care for management purposes, but OCHAMPUS still needs to develop the capability to provide more complete and accurate information on payments to facilities, improve the accuracy of the data in reports, and accurately record data received from facilities.

APPENDIX II

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United States Senate

COMMITTEE ON
GOVERNMENT OPERATIONS
SENATE PERMANENT SUBCOMMITTEE
ON INVESTIGATIONS
(PURSUANT TO SEC. 4, S. RES. 280, 91ST CONGRESS)
WASHINGTON, D.C. 20510

October 17, 1974

B-133142

My dear Mr. Comptroller General:

As you are aware, this Subcommittee held public hearings on the administration of the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) on July 23 through 26, 1974.

Following these hearings, the Honorable Vernon McKenzie, Principal Deputy Assistant Secretary of Defense for Health and Environment wrote to me as Chairman of the Subcommittee on September 9, 1974, setting out certain new policies which the Defense Department is adopting to correct deficiencies in its administration of the program. A copy of this letter is attached.

It is my understanding that the General Accounting Office is now conducting a review of specialized treatment facilities--such as psychiatric and handicap facilities--which have been approved under CHAMPUS. I would like to request that the following areas be included in the scope of this review and in the ultimate report:

1. CHAMPUS indicated it proposed a three-step process prior to approval of a psychiatric institution:

   (a) Approval by the Joint Commission on Accreditation of Hospitals.

   (b) Approval by State and local agencies.

   (c) Approval by a CHAMPUS inspection team.

   Please report the status of the implementation of this three-step approval cycle and, if possible, an assessment of its effectiveness.

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The Comptroller General

2. Shortly before our hearings, the Defense Department announced a policy of limiting all psychiatric hospitalization to a maximum of 120 days per year per patient. There had been no limit previously, but care beyond 90 days required CHAMPUS approval in advance. On September 6, 1974, the 120-day limitation on psychiatric hospitalization was rescinded. At the present time, therefore, psychiatric hospitalization for 120 days can take place without any advance approval. Psychiatric hospitalization beyond 120 days apparently does require some type of review and approval, but it is not clear how and by whom. I request, therefore, that your review cover how long-term psychiatric care is reviewed and approved and whether the controls on such long-term care are adequate.

3. Our hearings disclosed the use of bizarre and unorthodox types of psychiatric treatment in CHAMPUS approved facilities and the existence of physical abuse and cruel punishment for CHAMPUS patients. Further, the investigation disclosed numerous complaints lodged in CHAMPUS files without any action. It was brought out that CHAMPUS had no procedures of its own whereby it could terminate the use of an institution when abuses or fraud took place. Therefore, I would like to request that you determine:

   (a) How does CHAMPUS view its role in assessing the acceptability of care provided.

   (b) What action has been taken by CHAMPUS to assure that complaints are properly investigated and to monitor the acceptability of care received by CHAMPUS beneficiaries.

   (c) How can action take place against an approved institution when improper care or treatment has taken place.

4. The Subcommittee investigation disclosed instances where the charges for psychiatric hospitalization and out-patient care were excessive; where the Government was charged more for the same services than other clients and where bills submitted for payment by the Government contained improper charges. CHAMPUS has indicated it will initiate a system for monitoring and auditing these

charges in order to investigate excessive, improper and fraudulent charges. Please provide us with the specific actions CHAMPUS has taken to implement the monitoring and auditing actions and provide us with your views on the acceptability of these actions.

5. The Subcommittee investigation disclosed that the CHAMPUS Administration has an inadequate data system. We believe that in order to properly manage the program, CHAMPUS should have the following:

   (a) Data as to the number of psychiatric patients treated annually with breakdown by age, sex and type of diagnosis.

   (b) Psychiatric treatment costs for both in-patient and out-patient treatment broken down by age, sex and type of diagnosis.

   (c) The annual amount paid to each institution approved as a provider of in-patient psychiatric care.

   (d) The annual amount paid to each physician or clinic furnishing out-patient psychiatric treatment.

Please determine what changes, if any, CHAMPUS has made in its data processing facility and whether it can produce the above data for management purposes.

I would also like to ask your office to undertake a separate review involving the feasibility of consolidating CHAMPUS' many fiscal agents. At the present time CHAMPUS uses about 45 fiscal agents to process and pay claims. I would like you to evaluate the advantages and disadvantages of consolidating these fiscal agents to determine whether the interests of the program could not be better served if the number of fiscal agents was drastically reduced with the responsibilities being concentrated into a few regional fiscal agents.

The Permanent Subcommittee on Investigations staff recently met with members of your staff at which time it was agreed that the review of the feasibility of consolidating CHAMPUS' fiscal agents would be undertaken after your office completes the work involving specialized treatment facilities.

Thank you for your assistance and cooperation.

Sincerely yours,

Henry M. Jackson
Chairman

The Honorable Elmer B. Staats
The Comptroller General
of the United States
Washington, D. C.