REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Greater Assurances Are Needed That Emotionally Disturbed And Handicapped Children Are Properly Cared For In Department Of Defense Approved Facilities

The three major types of specialized treatment facilities approved for participation in the Civilian Health and Medical Program of the Uniformed Services are psychiatric residential facilities for children and adolescents, handicap facilities, and specialized inpatient treatment facilities.

Standards, inspections, case approvals, and other aspects of administration need to be improved so that these facilities provide acceptable quality care appropriate to patients' needs and that charges for such care are reasonable. Revising outdated financial provisions of the handicap portion of the program also should be considered.

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

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To the President of the Senate and the
Speaker of the House of Representatives

This report describes problems pertaining to the treatment of emotionally disturbed and handicapped children under the Civilian Health and Medical Program of the Uniformed Services.

A 1974 congressional investigation and previous reviews by us have disclosed many problems in the administration of this aspect of the program. This report assesses actions taken by the Department of Defense to correct these problems and discloses additional areas needing improvement.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Defense.

R.F. Keller

DEPUTY Comptroller General
of the United States

Contents

ABBREVIATIONS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
GAO	General Accounting Office
JCAH	Joint Commission on Accreditation of Hospitals
NIMH	National Institute of Mental Health
OCHAMPUS	Office for the Civilian Health and Medical Program of the Uniformed Services
SCOPCE	Select Committee on Psychiatric Care and Evaluation

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

GREATER ASSURANCES ARE NEEDED THAT EMOTIONALLY DISTURBED AND HANDICAPPED CHILDREN ARE PROPERLY CARED FOR IN DEPARTMENT OF DEFENSE APPROVED FACILITIES

D I G E S T

The Department of Defense needs greater assurances that emotionally disturbed and handicapped children are properly cared for in specialized treatment facilities participating in the Civilian Health and Medical Program of the Uniformed Services. Better assurances are also needed that charges for this care are reasonable.

These matters are of concern to the Congress and action has been taken to improve the program. GAO believes, however, that more needs to be done.

About 1,600 psychiatric, handicap, and specialized inpatient treatment facilities throughout the U.S. have been approved by the Department of Defense to care for emotionally disturbed and handicapped children and adolescents. Payments by the Department to those facilities in 1974 were about $18 million. (See pp. 3 and 4.)

Within about the past 2-1/2 years, the Department has taken actions, primarily in the psychiatric area, to improve the facility approval and case approval process in order to correct known problems.

Important actions taken on facility approvals were the adoption of new standards for psychiatric facilities and improved facilities inspections.

Changes in case approval procedures involving psychiatric care for children and adolescents involved the establishment of an independent case review and the obtaining of more complete information from facilities for evaluation purposes.

These actions have resulted in a large number of psychiatric facilities being excluded

from the program and greater assurances of the capability of facilities remaining in the program to provide quality care. Also, improved case review procedures have resulted in terminations of care considered unnecessary and have provided greater assurances that extensions of care granted patients are medically necessary. (See pp. 6 to 8.)

Problems have continued, however, with psychiatric residential facilities for children and adolescents approved under the new standards. These problems have included lack of treatment programs, minimum involvement in treatment by professional medical staff, unsanitary conditions, hazardous and unsatisfactory physical plants, and excessive charges to the program.

Standards for participation of handicap and specialized inpatient treatment facilities providing handicap care are limited. GAO visits to 14 of these facilities showed that few could meet minimal standards. (See pp. 8 to 17.)

Many facilities have been approved without having been inspected even though an inspection requirement has existed since 1972. In addition past inspections of handicap and specialized inpatient facilities have been of questionable value because the standards by which facilities were measured were limited, and qualifications were not established for inspectors. (See pp. 17 to 23.)

GAO visits to facilities showed that children and adolescents were (1) not always placed in facilities most appropriate to their needs and (2) kept too long in some facilities. In addition, parents were not always involved in their children's treatment programs, and medical care, when not part of facility programs, was not always provided to or arranged for patients by facilities.

Procedures for approving initial and continued care for handicapped children are inadequate, as are procedures for approving the first 120 days of care for children and adolescents placed in psychiatric facilities. Facilities

cannot be relied upon to properly handle these matters because they do not all use utilization review or discharge planning programs, nor do they all involve parents in their children's treatment programs. (See pp. 35 to 47.)

Questionable charge practices existed at facilities we visited which included charging higher rates for program beneficiaries than for others, charging rates which were not supportable by costs, and failing to collect cost-sharing amounts from sponsors. Participation agreements are needed which would provide for negotiations of reasonable rates based on examination of financial records.

The $350 maximum Government payment under the program for the handicapped plus the sponsor's required share of the cost, which were established in 1966, is generally not adequate to cover the cost for residential care of the handicapped. (See pp. 49 to 58.)

The Secretary of Defense should:

--Develop standards for the delivery of care at handicap and specialized inpatient treatment facilities, and adopt additional standards to cover aspects of care at psychiatric facilities not covered by existing standards. (See p. 31.)

--Require (1) periodic inspections of all specialized facilities providing care to program beneficiaries and (2) prompt inspection of those facilities which have never been inspected. (See p. 31.)

--Set qualification standards for inspectors. (See p. 31.)

--Adopt preadmission approval procedures for care of emotionally disturbed children and adolescents whose sponsors apply for psychiatric benefits. (See p. 47.)

--Adopt procedures for approving initial and continued care for patients at all facilities

which require that definite determinations be made as to the

.appropriateness of the admission,

.length of treatment,

.benefits to be obtained from treatment,

.need to involve children's parents in treatment programs,

.opportunities for children to function normally while undergoing treatment, and

.opportunities for care by means other than residential care. (See p. 47.)

--Require that all approved facilities adopt utilization review and discharge planning programs. (See p. 48.)

--Study cases involving long-term care to determine whether sponsors require, and are receiving, special assistance to enable them to deal with their concurrent, but perhaps conflicting, responsibilities to their families and the military departments. (See p. 48.)

--Enter into formal written contracts for services and charges with facilities caring for program beneficiaries, considering the specific services to be provided individual patients. (See p. 55.)

--Determine an appropriate maximum Government payment and equitable sponsor's payments for residential handicap care and prepare legislation to effect these program changes. (See p. 58.)

The Department of Defense generally agreed with GAO's findings and recommendations and indicated that all of the problems discussed in this report are receiving attention. (See app. I.)

CHAPTER 1

INTRODUCTION

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) provides financial assistance for medical care provided by civilian sources to dependents of active duty members, retirees and their dependents, and dependents of deceased members of the uniformed services. 1/ The program was authorized by the Dependents' Medical Care Act of 1956 (Public Law 84-569) which provided benefits only to dependents of active duty members. The Military Medical Benefit Amendments of 1966 (Public Law 89-614) expanded program benefits and added new classes of beneficiaries.

CHAMPUS benefits are divided into two categories--basic and handicap. Basic benefits cover inpatient and outpatient medical services, including such services as medical treatment and surgery, psychiatric care, drugs, X-rays, and clinical laboratory tests. As required by law, the Government and the beneficiary share the costs of program benefits. For basic benefits, dependents of active duty members pay a total of $25, or $3.90 a day, whichever is greater, for inpatient care; other beneficiaries pay 25 percent of total charges. For outpatient care, there is a deductible of $50 for each beneficiary ($100 maximum deductible for each family) each fiscal year, after which active duty dependents pay 20 percent and other beneficiaries pay 25 percent of the remaining charges. There is no limit on the Government payment under the basic program.

Handicap benefits cover remedial and custodial services provided to moderately or severely mentally retarded or severely physically handicapped spouses and children of active duty members only. Under the program for the handicapped, benefits are available for residential and day care. Sponsors pay a specified monthly amount according to rank, and the Government pays remaining charges up to a maximum of $350 a month. Any charges in excess of these amounts are the responsibility of the sponsors.

1/ The "uniformed services" are the Army, Navy, Air Force, Marine Corps, and Coast Guard and the commissioned corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

PROGRAM ADMINISTRATION

The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), located at Fitzsimons Army Medical Center near Denver, under the policy guidance and operational direction of the Assistant Secretary of Defense (Health Affairs).

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 other 17 States, Canada, and Mexico. Physician, drug, and handicap claims are paid by 44 different fiscal agents.

In August 1973 the Department of Defense (DOD) began to make major changes in allowable program benefits. DOD determined that the laws and regulations had previously been interpreted too liberally and that authorized benefits had exceeded the intent of the laws and regulations. These changes eliminated or modified some benefits, such as services for children with learning disabilities.

APPROVAL OF FACILITIES FOR CHAMPUS PARTICIPATION

Children with emotional problems or handicaps who need long-term care are treated in the following three types of specialized facilities which OCHAMPUS approves: psychiatric residential treatment facilities for children and adolescents, handicap facilities, and specialized inpatient treatment facilities.

Psychiatric facilities serving children and adolescents primarily assess, treat, and rehabilitate children and adolescents with emotional and behavior disorders. These facilities are approved under the basic program. Facilities approved under the program for the handicapped include day-care and private nonprofit and public residential facilities. They serve the physically handicapped and mentally retarded. Facilities classified as specialized inpatient treatment centers do not meet the definition of a hospital but provide inpatient medical care for such problems as alcoholism; drug addiction; and chronic neurological and associated disorders, such as cerebral palsy. Further, State and private facilities

for the mentally retarded, which provide a full range of medical services to those who have problems related or secondary to mental retardation, are included in this classification. Patients in specialized inpatient treatment facilities may receive either handicap or basic program benefits.

The number of each type of facility approved by OCHAMPUS as of September 1976 was:

Type of facility	Number
Psychiatric treatment facility primarily for children and adolescents	75
Handicap and specialized inpatient treatment facilities	1,499
	1,574

OCHAMPUS evaluates facilities applying for approval on the basis of information supplied by the facilities. Facilities' inspections are part of the approval process. OCHAMPUS inspects psychiatric residential facilities for children and adolescents, while its fiscal agents inspect handicap and specialized inpatient treatment facilities. Once a facility has been approved for participation in the CHAMPUS program, neither OCHAMPUS nor the fiscal agents can withdraw this approval unless DOD concurs.

APPROVAL OF REQUESTS FOR CARE

Psychiatric residential facilities for children and adolescents submit justifications to OCHAMPUS to obtain approval for care extending beyond 120 days. OCHAMPUS must approve handicap care in advance, and only approved handicap facilities may provide the care. Long-term cases approved by OCHAMPUS in specialized inpatient treatment facilities usually come under the program for the handicapped.

COSTS OF CARE IN CHAMPUS-APPROVED SPECIALIZED FACILITIES

For calendar year 1975, total CHAMPUS cost for psychiatric care amounted to 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 calculated separately, and not all payments to these facilities could be identified. However, our analysis showed that at least $12 million was paid to

these facilities in 1973 for inpatient care, excluding professional fees, and about $11.3 million in 1974. This analysis could not be made for 1975, because at the time of our fieldwork some claims for services had not been submitted to OCHAMPUS.

Charges for residential care in these facilities ranged from about $450 to $4,000 per month in January 1975. Some facilities' monthly charges included professional fees for such services as individual psychotherapy, group therapy, and diagnostic evaluations, while professional staff at other facilities charged separately for these services. The charges for individual psychotherapy generally ranged from about $25 to $50 per hour; group therapy charges per patient were lower.

Total handicap costs in 1975 were estimated at about $10.3 million. Payments to facilities under the program for the handicapped in 1973 were about $8 million out of a total handicap cost of $23.4 million and about $7 million in 1974 out of a total handicap cost of $13.5 million. Handicap payments to specialized inpatient treatment facilities under the program are included in the above figures; data on payments to them under the basic program were not readily available.

SCOPE OF REVIEW

We visited 22 specialized treatment facilities subject to OCHAMPUS approval:

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

--12 handicap facilities, and

--2 specialized inpatient treatment facilities.

Major considerations in selecting the facilities visited were to include facilities of each of the three types approved by OCHAMPUS, facilities in States with the largest numbers of approved facilities while retaining some geographic dispersion, and facilities with various numbers of CHAMPUS beneficiaries. At the time of our visits, there were 208 CHAMPUS beneficiaries in the 8 psychiatric facilities, 123 in the 12 handicap facilities, and 65 in the 2 specialized inpatient treatment facilities.

At each facility, we reviewed the physical plant and facilities, patient case records, financial records and charges, and professional staff qualifications. We were assisted by two medical advisors who reviewed the care provided patients. We contacted officials at military installations who made patient referrals to facilities, and State licensing authorities and school districts in some States visited.

We reviewed the legislative history of the CHAMPUS program; and at OCHAMPUS and at nine OCHAMPUS fiscal agents who process claims for payment, we reviewed regulations, policies, and practices relating to OCHAMPUS facility approval, inspection, and patient care approval. In addition, we reviewed facility files, inspection reports, and patients' medical records maintained by OCHAMPUS. We also reviewed professional literature on treatment philosophy, standards, and practices in facilities of the types visited and discussed these matters with officials of the Joint Commission on Accreditation of Hospitals (JCAH) and the National Institute of Mental Health (NIMH).

CHAPTER 2

BETTER CRITERIA AND INSPECTION PROCEDURES NEEDED IN APPROVING FACILITIES

Starting in fiscal year 1974, OCHAMPUS, under DOD guidance, began improving its criteria and inspection process for approving psychiatric residential facilities for children and adolescents. As a result, the number of approved facilities declined substantially--from over 340 to 75 as of September 1976--and OCHAMPUS has obtained greater assurance of the quality of care provided patients by facilities in the program. However, OCHAMPUS inspections continue to disclose problems at approved facilities, and OCHAMPUS is considering the development of additional standards. Our visits to facilities showed that better standards for patient care are needed.

Approval criteria and inspection procedures for handicap and specialized inpatient treatment facilities have not been significantly changed. Criteria which these facilities must meet to participate in the program are not definitive or comprehensive. Few handicap and specialized inpatient treatment facilities met many of the minimum professional standards developed for such facilities by our medical advisors and concurred in by OCHAMPUS. Also, OCHAMPUS does not have an effective facility inspection program for handicap and specialized inpatient treatment facilities. Many approved facilities were not inspected, and the inspections made by fiscal agents were of questionable value because the criteria used to evaluate facilities were limited and qualifications of inspectors were unknown.

PROGRESS AND PROBLEMS IN APPROVING PSYCHIATRIC FACILITIES

Before September 1, 1973, a psychiatric facility, to be approved for participation under CHAMPUS, had to meet only two criteria:

1. It had to be operated in accordance with the laws of the jurisdiction in which it was located.

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

OCHAMPUS determined whether a facility met these criteria on the basis of information the facility submitted in response to a questionnaire.

In a July 9, 1971, report 1/ to the House Committee on Appropriations, we reported that OCHAMPUS was approving psychiatric facilities that did not meet the above criteria. We cited several examples of such facilities and reported that they were engaging in questionable treatment and charge practices. We recommended that more definitive criteria be established and enforced.

OCHAMPUS issued interim standards for psychiatric residential facilities for children and adolescents, which facilities had to meet after August 31, 1973, and required all facilities previously approved to apply for reapproval. These standards covered such additional criteria as offering a broad range of services (psychiatric, psychological, social work, family therapy, academics, activity programs, etc.), supervision of these services by professional people qualified in the specific field and assisted by qualified staff, active and continuing involvement by a psychiatrist in the treatment program and individually with patients, written treatment programs and case files for each patient, and a physical plant in full compliance with all local and State regulations pertaining to fire, safety, and sanitation.

A review by the Senate Permanent Subcommittee on Investigations of psychiatric care provided to CHAMPUS beneficiaries culminated in hearings in July 1974. The hearings disclosed ineffective OCHAMPUS program management and detailed a wide variety of problems at two facilities. Problems affecting patients included bizarre and unorthodox treatment, physical abuse, cruel punishment, illegal drug usage, and excessive charges for services.

Subsequent to the hearings, the Principal Deputy Assistant Secretary of Defense (Health Affairs) told the Subcommittee Chairman that intensified efforts were being made to solve problems associated with psychiatric services, including problems occurring at residential facilities for children and adolescents. Among the efforts cited was the establishment of a policy, which became effective on July 1, 1974, requiring that all psychiatric facilities providing

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

care to children either be accredited by the Joint Commission on Accreditation of Hospitals under newly developed JCAH standards or apply for JCAH accreditation and meet OCHAMPUS interim standards.

As a result of the new standards, the number of CHAMPUS-approved psychiatric facilities for children and adolescents declined from over 340 to 75, as of September 1976. Of these 75 facilities, 14 were State-operated facilities which DOD decided did not have to meet JCAH requirements or OCHAMPUS interim standards. According to OCHAMPUS, the primary 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 OCHAMPUS denied approval as a result of its evaluation of the application or its onsite inspection.

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

--Facilities approved under the interim standards were surveyed by JCAH and not accredited.

Problems still exist in the approval of psychiatric residential facilities for children and adolescents

OCHAMPUS, in its approval process, tries to insure that facilities are capable of providing at least a minimum level of care, that such care is provided in a safe environment, and that the charges for care are the same to CHAMPUS patients as to other patients for the same services. OCHAMPUS inspections of facilities approved under interim standards and those accredited by JCAH have disclosed serious deficiencies in the operations of these facilities, including lack of treatment programs, questionable treatment programs, minimal medical personnel involvement in patient care, unsanitary conditions, excessive charges, deficient clinical records, and hazardous and unsatisfactory physical plants.

Examples of problems at facilities approved under OCHAMPUS interim standards and subsequently disapproved on the basis of inspections are:

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

--A 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. The buildings were unsanitary, and the grounds were not well maintained.

Examples of problems found by OCHAMPUS inspection teams in facilities that JCAH had accredited but which were then disapproved by OCHAMPUS follow:

--A facility's clinical records examined in February 1975 showed that no psychiatric services had been provided since October 1974. The consultant nurse had not been involved in the program for 3 months. The facility had no current State license or current fire and sanitation report. The residential building was in a deteriorated, filthy condition. Sanitation reports prepared by local authorities cited many major deficiencies, none of which had been corrected. The basis for 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 was poorly maintained. Not all clinical records contained a full psychiatric report and some had no evidence of a psychiatric examination. The justifications for care in a residential facility were in some cases inadequate and in one case inappropriate. No treatment program for patients was evident. Charges to States ranged from $789 to about $1,000 per patient per month, while CHAMPUS was charged $1,752 per patient per month for the same program, plus additional amounts for family and individual therapy. There were no private pay patients in the facility.

--OCHAMPUS inspectors believed that another facility's treatment program conflicted with patients' rights. All new patients entered a locked area for at least 6 to 8 weeks. They were not allowed to leave this area until they had taken a polygraph test to assure that they had been honest. In addition, polygraph tests were given to patients after they returned from a home visit or off-ground activities. The treatment philosophy required that all patients stay at least 1 year, and preferably 2, although the facility director admitted that some patients progressed well enough to leave within 6 months.

As of September 30, 1975, 11 of 32 facilities, or 34 percent, which OCHAMPUS had approved under interim standards were later disapproved as a result of OCHAMPUS inspections. By the same date, OCHAMPUS had inspected 16 JCAH-accredited facilities and found 6 (38 percent) to be unacceptable for the OCHAMPUS program. Four of the six were disapproved, a decision on one was pending, and the other was given a temporary 6-month approval.

Our visits, on which we were accompanied by our medical advisors, 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. According to our medical advisors, however, admissions to these facilities were sometimes inappropriate, needed services were sometimes not provided patients, and facilities tended to retain patients longer than necessary. Questionable facility billing practies were also noted.

An OCHAMPUS official stated that, shortly after psychiatric facilities for children and adolescents were required to be JCAH-accredited, it became apparent that this accreditation alone could not fulfill OCHAMPUS needs. JCAH has assisted OCHAMPUS in achieving some of its goals; however, according to an OCHAMPUS official, JCAH accreditation does not adequately assure OCHAMPUS that patients' needs are being met and that charges to CHAPMUS are reasonable.

Specific OCHAMPUS concerns over reliance on JCAH accreditation include:

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

--JCAH inspections are announced ahead of time to the facility 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 unannounced inspections.

--JCAH views itself more in the role of advisor, 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 to patients.

--JCAH has no incentives to withhold accreditation because it depends upon funds from facilities applying for survey to continue its operations.

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

--JCAH does not evaluate the reasonableness and appropriateness of charges, which are major concerns of 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 times; the duration of treatment; and more specific diagnoses as criteria for treatment.

According to JCAH officials, JCAH accepts no responsibility for providing OCHAMPUS with any assurances other than those represented by its accreditation.

Because JCAH facility standards did not give OCHAMPUS the assurances it needs, it developed new standards for psychiatric facilities for children and adolescents and submitted them to DOD for approval in June 1975. The new standards address many of the concerns OCHAMPUS has regarding JCAH's approval process. According to DOD, the new standards will be adopted in 1976.

STANDARDS FOR APPROVING HANDICAP AND SPECIALIZED INPATIENT TREATMENT FACILITIES

The CHAMPUS criteria for approving a handicap facility require that a facility have appropriate personnel and be operated in accordance with the laws of the jurisdiction within which the facility is located. A specialized inpatient treatment facility, in addition to meeting the same criteria as a handicap facility, must have its course of treatment prescribed and supervised by a physician.

OCHAMPUS has no guidelines for determining what constitutes appropriate personnel. A review of 38 facility files, including those we visited and others randomly selected, showed that 2 facilities were approved without having any personnel information, and an additional 9 facilities were approved without a detailed description of staff makeup and qualifications. In reviewing 12 handicap and 2 specialized inpatient treatment facilities, our medical advisors concluded that some did not have appropriate personnel to perform at least some of the services they told OCHAMPUS that they offered patients.

Some States have set licensing requirements and standards for facilities. OCHAMPUS's information on standards was outdated at the time of our fieldwork but OCHAMPUS had updated it by October 1975. In reviewing State requirements, we noted that it was common for the standards to cover only some types of facilities and not others and to cover only certain aspects of facility operations. For example, one State we visited had standards for handicap facilities but they were educational in nature and only applied to public facilities. Another State issued licenses but the license meant that health and sanitation, fire, safety, and building requirements were met, and did not cover program adequacy. However, if the facility received State money, it had to

meet additional program standards. In another State, private schools were required only to have health and fire inspections.

Our medical advisors developed 10 standards which they believed handicap and specialized inpatient treatment facilities should be expected to meet as a minimum. OCHAMPUS officials reviewed these standards and believed them to be reasonable. A comparison by the medical advisors of the capabilities of the 14 approved handicap and specialized inpatient treatment facilities with these standards showed that 10 of the facilities failed to meet at least half of the standards. Only 1 facility met all 10 standards while 3 other facilities met more than half the standards.

Ability of CHAMPUS-approved
Handicap and Specialized Inpatient Treatment
Facilities to Meet Mimimum Standards
Developed by GAO Medical Advisors

Minimum professional standards	Not meeting the standard	Partially meeting the standard	Fully meeting the standard
A physician should be on duty or on call at all times.	6	1	7
There should be either a registered nurse or licensed practical nurse on duty at all times. Sufficient nursing staff should be available to manage day-to-day problems of patients and assist in remediation.	7	-	7
Physical, occupational, and/or speech therapy should be available for patients who have defects which may be improved by such therapy or for which such therapy would be of material assistance in helping the patient with everyday living.	8	4	2
Channels should exist for referring children to other professional personnel or facilities when necessary.	5	2	7
Psychological testing and social work services should be available either onsite or by arrangement.	5	4	5
Educational, vocational, social, and recreational programs should be geared to the children's needs and abilities.	1	7	6
All patients should have a physical examination and psychological-behavioral evaluation before entering the facility, repeated as necessary but at least annually.	2	2	10
Treatment goals should be developed and recorded within 30 days after admission.	11	1	2
Regular progress reports should be recorded in the patient's file approximately every 3 months.	10	2	2
Medications should be maintained under controlled conditions, dispensed only under a physician's orders, and updated at least every 3 months.	3	2	9

Other weaknesses our medical advisors observed in facilities' operations included inappropriate admissions of patients or admissions of patients for whom the facility had little to offer, the lack of utilization review, the lack of adequate discharge planning, and the lack of provisions for obtaining parental involvement or contact. These weaknesses are discussed in chapter 3. Also, some facilities were not able to perform all of the services represented to OCHAMPUS.

The following example illustrates some of these problems:

A handicap day-care facility that treated retarded and physically handicapped children had never had an inspection visit. Approval from OCHAMPUS was received in November 1970. It had 25 children between the ages of 2 to 13 years, 7 of whom were CHAMPUS beneficiaries. There was considerable staff turnover. The director of the facility had limited training in special courses on handicapped children and operated the program in a personal, informal way without consultation. The director supervised and trained the other staff members but did not systematically evaluate their performance. A busy oncall pediatrician had minimal contact with the facility and recommended further extensions of care without knowledge of the program or the specific children. Only the half-time licensed practical nurse had first aid training even though several children were subject to seizures. First aid supplies were very limited. One building was supposedly not in use because it did not meet safety standards. The rooms in another building were small and somewhat crowded with children and staff.

Although the facility operated a day program, most of the children left at 12:30 and the few that remained had no afternoon educational program. Children remained or left according to parent wishes rather than program objectives. Only 1-1/2 hours of the morning program involved training and educational activities; the remaining 2 hours involved rest, snacks, lunch, and free play. No home visiting or personal counseling of parents was done even though family counseling was listed as a service provided. The facility reported to OCHAMPUS that 13 specialized conditions were accepted, including autism, 1/ cerebral palsy, and mild to

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1/A condition of early childhood characterized by absence of emotional relationship to parents and others, stereotyped behavior patterns, and lack of language development.

severe mental retardation. It also reported that 13 specialized services were provided, including psychiatric and psychological consultation, perceptual motor and visual motor training, and behavior modification. These services were either nonexistent or provided in an inadequate, informal way. Most medical records on patients were incomplete. There was little evidence that children left the program except as a result of family moves, of which there were four examples. The facility did not meet 7 of the 10 minimal standards listed on page 14.

Of seven current CHAMPUS cases reviewed, three had problems which were not being addressed and two had been at the facility too long in the opinion of our medical advisors. A child age 5 years and 8 months had been admitted at age 1 year and 11 months. There was documented evidence of moderate mental retardation, but considerable progress had been made. On questioning, the director stated that the child had made considerable progress and might have been considered for public school placement. A child age 4 years and 4 months had been at the facility for 4 months. The director admitted there were psychological problems but was reluctant to seek help elsewhere. Charges for CHAMPUS patients were $150 per month, less the sponsor's share of from $25 to $50. A maximum of $50 was charged non-CHAMPUS children in this same program. Little effort was made to collect CHAMPUS sponsors' shares.

OCHAMPUS could use Federal, State, and JCAH standards to develop its own standards for approving facilities providing care to the handicapped. In January 1974 the Department of Health, Education, and Welfare published standards that intermediate care facilities for the mentally retarded must meet to participate in the Medicaid program.

JCAH has standards for residential facilities and community agencies caring for the mentally retarded. These standards require facilities to have an active habilitation program 1/ for each resident and to provide services within an as normal as possible environment that respects the rights and dignity of each resident. JCAH applies about 600 standards in performing an accreditation survey. In June 1975, there were only 27 residential facilities throughout the United States which were JCAH-accredited.

1/This involves active treatment, training, education, and related activities.

OCHAMPUS officials said that OCHAMPUS has not adopted the JCAH standards for mental retardation and handicap facilities because many OCHAMPUS-approved facilities offer primarily custodial care and not the active habilitative care JCAH standards require. OCHAMPUS is, therefore, concerned that adopting JCAH standards would preclude many good handicap facilities from CHAMPUS participation, thereby greatly reducing the number of facilities available to military dependents.

DOD told us that it recognized the need for standards for handicap facilities, and said it was planning to contract for the development of such standards.

INCREASED AND MORE EFFECTIVE INSPECTIONS NEEDED

When OCHAMPUS adopted its interim standards for psychiatric residential facilities for children and adolescents (see below), it also improved its procedures for inspecting these facilities. Although OCHAMPUS had not inspected all approved facilities at the time of our fieldwork, additional professionals were being hired to make the inspections.

The requirement for inspection of handicap facilities and specialized inpatient treatment facilities was adopted in May 1972, but many facilities approved since then have never been inspected. No provisions for inspecting facilities approved before 1972 were made, and no requirements for periodic inspections were established. Inspections have had limited effectiveness because OCHAMPUS standards for these facilities are minimal and qualifications for inspectors have not been established.

Inspections of psychiatric residential facilities for children and adolescents

When OCHAMPUS adopted its interim standards in fiscal year 1974, it decided to inspect psychiatric facilities for children and adolescents rather than have fiscal agents perform this function. OCHAMPUS policy is to inspect all such facilities, except those operated by States. Inspections are made to evaluate the quality of medical care provided patients.

As of September 1976, of the 61 approved facilities requiring inspections, 16 had not been inspected by OCHAMPUS because of a staff shortage.

OCHAMPUS has been authorized to hire eight additional inspectors, and as of September 1976, seven had been hired. With these additional inspectors, OCHAMPUS plans to inspect psychiatric facilities periodically, although it has not decided how frequently each facility will be inspected.

Periodic inspections are important so that OCHAMPUS can keep up to date on any major changes in the staffing and operations of a facility which may affect its approval status. Facilities have not always notified OCHAMPUS promptly of such changes. For example, a report to OCHAMPUS from a psychiatric facility showed that the facility's staff consisted of a psychiatrist, four psychologists, a social service consultant, a social service worker, a nurse, and a physical education and recreation director. When we visited this facility 8 months after the date of the report, the facility no longer had three of the four psychologists, the social services consultant, the nurse, or the physical education and recreation director but had added a social worker. OCHAMPUS had not been notified of these changes.

OCHAMPUS initially selected for inspection those facilities which submitted incomplete or conflicting information when applying for approval. Qualified OCHAMPUS personnel made the inspections, sometimes accompanied by consultants. These inspections have been more thorough than those previously performed by fiscal agents. Whereas fiscal agent inspectors previously made few inquiries into facility operations, OCHAMPUS personnel inspect the facilities' organizational structure and policies, staffing, programs and services, medical and clinical recordkeeping, physical plant, compliance with State and local laws, admission policies, and financial charges.

Inspections of handicap and specialized inpatient treatment facilities

Before May 1972 OCHAMPUS approved facilities on the basis of information the facilities supplied or information extracted from books or publications. In May 1972 OCHAMPUS established a policy that facilities would be inspected by fiscal agents and that OCHAMPUS would grant interim approval pending such inspection. These inspections are made at

OCHAMPUS' request. OCHAMPUS exempted State-operated facilities and facilities accredited by a recognized accreditation agency from the policy. OCHAMPUS does not normally inspect handicap and specialized inpatient treatment facilities; usually OCHAMPUS visits facilities only when complaints are received or when fiscal agents request visits.

The following table shows the number of facilities approved and inspected as of September 1975.

Type of facility	Number approved	Number of non-State facilities	Number inspected
Handicap	1,128	913	254
Specialized inpatient treatment	362	194	74
	1,490	1,107	328

Of the 1,107 non-State facilities, 459 were approved after May 1972, and only 234 (51 percent) of these have been inspected. Although 104 of the 648 facilities approved before May 1972 were inspected, no provision was made to inspect the others. Most inspections were not made apparently because OCHAMPUS never requested fiscal agents to inspect all facilities. Our visits to six fiscal agents showed that when requests were received from OCHAMPUS, inspections were made.

The lack of comprehensive standards has lessened the effectiveness of inspections. OCHAMPUS officials said that, because criteria are so limited for handicap and specialized inpatient treatment facilities, disapproving these facilities has been difficult. They said that the standards for approval are very limited and ambiguous and that disapproving a dirty or hazardous facility would be difficult since standards do not address these issues.

Fiscal agents are provided inspection checklists which contain only 10 questions (an additional 12 questions are included if it is an inpatient facility). Many questions are very general, such as one that asks whether the composition, qualification, and number of staff are adequate. No guidelines or specific standards exist on which to base these determinations, no narrative explanation is required to support the determinations, and no criteria are provided on the number of checklist questions which must be answered satisfactorily for the facility to be recommended for approval. In

addition, the checklist does not cover such areas as administrative structure and policies, programs and services, medical and clinical records, and financial charges.

Because OCHAMPUS has not established requirements for qualifications for fiscal agents' inspectors and maintains no information on their qualifications, it has no assurances that the inspectors are qualified. According to an OCHAMPUS official, many fiscal agents' inspectors are not qualified and the policy of having fiscal agents perform inspections has not proven satisfactory.

In some instances OCHAMPUS has no information on the background or discipline of the inspectors. A random sample of 70 inspection reports showed that inspections were performed by the following:

	Number who performed the inspections	Number of inspections performed
Physicians	3	7
Nurses	8	15
Personnel with administrative job titles	11	33
Unsigned	Unknown	15
Total		70

An OCHAMPUS official explained that inspections of handicap facilities have been limited because there is often a high degree of community involvement with such facilities and they, therefore, do not need to be inspected as closely as psychiatric facilities. This official added that such facilities need less monitoring since less child abuse occurs there and less chance for monetary abuse exists because of the $350 ceiling on monthly payments.

The Department of Health, Education, and Welfare requires that intermediate care facilities under title XIX of the Social Security Act (including institutions for the mentally retarded) undergo periodic onsite inspections by independent professional review teams. The teams must include one or more physicians or registered nurses and other appropriate health and social service personnel. Teams inspecting institutions for the mentally retarded must also include at least one member knowledgeable about the specific problems and needs of the mentally retarded. The frequency

of inspections depends on the quality of care provided, but they are to be made at least annually. Inspection reports must be forwarded to the facility involved, to the State licensing agency, and to other involved agencies. The designated State agency is responsible for insuring that appropriate action is taken to correct deficiencies reported.

OTHER PROBLEMS

Problems noted include the following:

--OCHAMPUS did not require inspections to be performed within specified time frames.

--Not all fiscal agents' inspection reports were on hand at OCHAMPUS and, of those on hand, some were blank and others incomplete.

--There was no evidence in the files to indicate that corrective actions were requested on some deficiencies disclosed by fiscal agent inspectors, and OCHAMPUS followup inspections recommended by fiscal agents were not always made.

--OCHAMPUS approved, without written justification, facilities that fiscal agent inspectors rated as unacceptable or poor and recommended for disapproval.

--No centralized file existed on complaints about facilities, and there was no assurance that the facility files contained all complaints or that such complaints were properly investigated.

--Because of the lack of a contractual basis or other formal criteria upon which to base withdrawal of approval, facilities found to be deficient have sometimes continued to participate in the program.

--Procedures were not well developed for receiving notification from JCAH of the accreditation status of facilities; as a result, payments were made to facilities that were not accredited.

--Many facilities classified as specialized inpatient treatment facilities should have been classified as handicap facilities to preclude payment for ineligible beneficiaries.

--Information about facilities maintained by OCHAMPUS in a facility directory, used to assist sponsors in choosing a facility, is unreliable and inaccurate.

These problems have apparently resulted primarily from a lack of OCHAMPUS written policies and procedures, and supervision. The chief of the division responsible for approving facilities has devoted only limited time to supervisory functions because of having to make many of the OCHAMPUS psychiatric facility inspections. The shortage of other qualified staff to make these visits necessitated his involvement. He told us that administrative activities will be better supervised once the additional inspectors are hired.

Inspection time frames not established

OCHAMPUS has not established a policy requiring that inspections be made within a specified time after receipt of a facility's application for approval. A review of 65 randomly selected inspection reports filed during 1972 through 1975 showed that an average of 80 days elapsed between the time OCHAMPUS requested an inspection and the time the fiscal agent notified OCHAMPUS that the inspection had been performed. The elapsed periods for these inspections ranged from 15 to 348 days.

In March 1974 OCHAMPUS established a procedure to follow up within 60 days on outstanding requests for inspections by fiscal agents. Only a few requests were outstanding at the time of our review; however, for one request on which followup action had been planned in 60 days, followup action was not taken until 129 days after the inspection was requested. We were unable to obtain an explanation for the delay in followup action.

Inspection reports unavailable, blank, or incomplete

Reports were not available for 4 of a random sample of 74 handicap and specialized inpatient treatment facilities listed in the CHAMPUS directory as having been inspected. Of the 70 reports on hand, information in 5 of them was either incomplete or the reports were blank. For example, the inspector of one facility did not complete 9 of the 22 questions on the two-part inspection report. No answers were checked to such questions as the adequacy of the staff and whether safety hazards existed. Also, the inspector made no recommendation as to whether the facility should be approved and assigned no overall rating of acceptability.

Another report did not contain answers to 6 of 22 questions, including whether the facility was licensed or operating in accordance with the laws of its jurisdiction. This report also did not contain a recommendation on approval or a rating.

Also, in two instances OCHAMPUS was aware that fiscal agent personnel had made inspections by telephone, yet it accepted the reports.

No systematic followup on inspection results

OCHAMPUS has no procedures for systematically following up with facilities when deficiencies or problems are cited in the fiscal agent inspection reports. Of our sample of 65 completed inspection reports, 15 contained written comments on problems or deficiencies. The problem areas and number of times each was cited follows:

	Number of times cited
Staffing	9
Physical plant	5
Records	3
Appropriateness of placement	1
Program deficiencies	3
	21

The files contained no evidence indicating that the problems noted by inspectors had been corrected by or even communicated to 10 of the 15 facilities. Some actions had been taken in relation to the other five facilities.

No formal policy or criteria had been developed for deciding when OCHAMPUS would visit facilities that fiscal agents recommended be visited. Fiscal agent recommendations that OCHAMPUS visit facilities were contained in 6 of the 65 reports. OCHAMPUS had visited only one of the six facilities. The files did not show why visits were not made to the other five. OCHAMPUS personnel said that, in deciding upon whether to make visits, they consider, from their personal knowledge, such factors as qualifications of the inspectors, creditability of the inspectors, and criticisms about the facilities. Also, OCHAMPUS postpones inspections if there are no CHAMPUS beneficiaries in the facility when the recommendations for visits are made.

OCHAMPUS approval of facilities rated by inspectors as unacceptable or poor

Some facilities were approved although fiscal agents had recommended disapproval. However, facility files contained neither justifications for these OCHAMPUS approvals nor correspondence showing that facilities made improvements that would warrant approving the facilities against inspectors' recommendations. For example, one inspector, a registered nurse, rated a facility caring for retarded children as unacceptable, citing such problems as improper staffing and a program that dealt little, if at all, with mental retardation. Another facility rated unacceptable was cited for having staff with inadequate educational backgrounds and a poor environment. The residential students were living in an old house and were preparing to move into a condemned nursing home. OCHAMPUS approved both facilities.

In another instance, the fiscal agent gave a facility a poor rating but made no approval recommendation. OCHAMPUS approved the facility, without further inquiry, although the report showed that the building was very old and run down and needed structural and hygienic improvements. According to the inspection report on another facility, the facility's interior had burned out about 1 month before the inspection, and children were occupying an unused hospital room during building restoration. The inspector did not recommend approval or disapproval, but did recommend a followup inspection in 2 months. No such inspection was made, but OCHAMPUS approved the facility.

Inadequate controls to assure that complaints about facilities were properly investigated

As noted on page 7, children have been improperly treated in CHAMPUS-approved facilities. In fulfilling its obligation to assure that care provided to CHAMPUS beneficiaries is of an acceptable nature, we believe complaints about facilities should be properly controlled and investigated.

Investigation procedures, however, need to be improved because:

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

--No centralized control is maintained over complaints; OCHAMPUS has a complaint file, but it does not contain all complaints received.

--Records on the disposition of complaints and on actions pending are incomplete.

After our fieldwork, OCHAMPUS began drafting written procedures for investigating complaints.

Difficulties in withdrawing facility approval

As disclosed during the July 1974 hearings before the Senate Permanent Subcommittee on Investigations, OCHAMPUS has had difficulty in withdrawing approval of facilities found to be providing improper treatment. OCHAMPUS has no contractual agreement with facilities that includes payment terms for care of CHAMPUS beneficiaries, nor has it 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 for care of CHAMPUS beneficiaries, OCHAMPUS eliminated from the program many facilities that could not meet these standards.

Because of the lack of a contractual basis or other formal criteria upon which to base withdrawal determinations, DOD officials sometimes disagree as to whether approvals should be withdrawn. For example, a June 1975 inspection of a residential psychiatric facility by OCHAMPUS officials and consultants showed deficiencies in such areas as medical records, treatment programing, and discharge planning. OCHAMPUS recommended that the facility approval be withdrawn but was overruled by DOD, which instructed OCHAMPUS to approve the facility and then reevaluate it after new facility standards proposed by OCHAMPUS are adopted.

Delays in receiving notices about results of JCAH accreditation reviews

OCHAMPUS has not always obtained prompt notification from JCAH on facilities that JCAH had surveyed but not accredited. As a result, such facilities received CHAMPUS payments although they were 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 no clear procedure had been established for JCAH to

communicate its decisions to OCHAMPUS, and OCHAMPUS did not routinely followup with JCAH, CHAMPUS payments to the facility were continued until July 1975. The payments for this period amounted to about $19,000. In another case, OCHAMPUS did not learn for 2 months that a facility was not accredited and paid about $1,700 to the facility during that time.

Reclassification of specialized inpatient treatment facilities needed

As of September 1975, OCHAMPUS had approved 362 facilities classified as specialized inpatient treatment facilities. Most CHAMPUS patients in these facilities are approved under the program for the handicapped, which limits benefits to handicapped dependents of active duty members and limits the maximum monthly Government payment to $350. However, these facilities are also eligible for payment under the basic program, which covers additional benefits and classes of beneficiaries and has no monthly Government payment limitation. Of 481 patients approved by OCHAMPUS for long-term care, 469 (98 percent) were under the program for the handicapped.

According to an OCHAMPUS official, in the past, when program benefits were still being interpreted liberally, some facilities were classified as specialized inpatient treatment facilities to allow payments to be made under the basic program for handicapped beneficiaries who were not eligible under the program for the handicapped. Examples of cases approved reportedly involved handicapped dependents of retired personnel and beneficiaries not handicapped seriously enough to qualify as being moderately or severely retarded or as seriously physically handicapped. Had the facilities treating these patients been classified as handicap facilities, they would not have been eligible to receive payments under the basic program.

For example, in one case the patient was a child of a military member who retired in 1972. In that year, OCHAMPUS approved care for the child under the basic program in a specialized inpatient treatment facility. The diagnosis was severe cerebral palsy with an I.Q. of 30. The facility charged CHAMPUS $525 per month. Our medical advisors said the case involved a handicapped condition. In April 1975, OCHAMPUS reached the same conclusion and terminated benefits because the child was ineligible under the basic program.

Nothing particularly distinguished the two specialized inpatient treatment facilities we visited from some of the

handicap facilities visited. The former offered services for similar types of handicaps and had staff with basically the same qualifications as some of the latter. Both types had physicians associated with the facilities who prescribed and supervised treatment. All the patients in the two specialized inpatient treatment facilities were approved under the program for the handicapped.

According to an OCHAMPUS official, the only facilities now being classified as specialized inpatient treatment facilities are drug and alcohol facilities. However, of the 362 facilities previously classified as specialized inpatient treatment facilities, about 292 facilities were classified under the past policy. OCHAMPUS is considering reclassifying these 292 facilities as handicap facilities.

Unreliable and inaccurate facility information

OCHAMPUS maintains a facility directory to assist sponsors in choosing appropriate facilities. The directory lists approximately 6,000 facilities, including psychiatric, handicap, and specialized inpatient treatment facilities. Upon request and after matching the patient's diagnosis with information in the directory, OCHAMPUS gives sponsors a list of approved facilities in the geographic area where placement is desired. About 390 requests for information are received monthly.

The directory contains such information as approval status, location, financial charges, services, and licensing status. OCHAMPUS obtains much of the information from questionnaires completed by facilities. OCHAMPUS policy is to periodically update this information by having facilities submit new questionnaires.

The facility questionnaire includes a list of 53 specialized medical conditions and 50 specialized services; the facility is to check which conditions it treats and which services it provides. OCHAMPUS had not defined the terms on the checklist as to the skills or programs necessary to adequately provide a particular service and had not required the facilities to describe how they intend to provide a particular service. The questionnaire responses were often unreliable because, as our medical advisors learned when they

visited facilities, in checking items showing medical conditions treated or services provided, the facilities' concept often differed from the professional concept of skills or programs needed to provide the service. Some facilities also checked items showing medical conditions they accepted but for which they had no programs. Facilities' officials explained that they meant to indicate that they did not exclude these conditions when they were secondary to a primary problem, such as mental retardation. The OCHAMPUS questionnaire does not distinguish between primary and secondary medical conditions.

Examples of unreliable and invalid information in the questionnaires about medical conditions accepted and services provided follow:

--One residential facility for mentally retarded and physically handicapped children indicated that it accepted patients with affective disorders, overt homosexuality, addiction, unusual sexual behavior, and excessive drug use. The facility director told us that when he included this information on the OCHAMPUS questionnaire, he did not mean that the facility offered treatment programs for these conditions, but that the facility did not exclude mentally retarded and physically handicapped children who have these conditions.

--Another facility which provided day treatment for developmental problems, including mental retardation and mild to moderate physical handicaps, indicated that it provided services such as chemotherapy, family therapy, music therapy, recreational therapy, milieu therapy, and occupational therapy. Our review revealed that medications prescribed by outside physicians were administered by an untrained aide; that there were no musical, recreational, or occupational therapists on the staff; and that family therapy consisted of monthly parent/staff programs and occasional teacher-parent meetings.

Information in the facility directory was erroneous and out of date. A comparison of 27 facility questionnaires, including those of all facilities we visited, with the facility directory showed that only 2 questionnaires completely agreed with the directory. Examples of the inconsistencies in recorded data follow.

--One facility reported nine medical conditions that were accepted and two services that were offered which were not recorded in the directory. On the other hand, the directory included four services which the facility did not provide.

--Another facility reported that 31 medical conditions were accepted, but none were shown in the directory. In addition, the directory showed 14 services that were provided which the facility did not identify as being provided.

--A third facility reported nine medical conditions that were accepted and two services that were provided which were not listed in the directory. The directory also contained three conditions and eight services which the facility had not reported it accepted or provided.

A review of 136 facility questionnaires selected at random showed that 38 were more than 1 year old. Also, the expiration date of licenses for 39 facilities, which were submitted with the most recent questionnaire on file at OCHAMPUS, had passed.

In addition, OCHAMPUS was not coding the facility directory to show those facilities that inspectors had rated as unacceptable. Instead, OCHAMPUS coded the directory to show that the facility had not been rated.

In discussing these problems with OCHAMPUS officials, we were told that, to a large extent, they occurred because sufficient staff was not available to properly supervise the personnel assigned to maintain the facility directory.

CONCLUSIONS

DOD needs to strengthen its policies and procedures for approving specialized facilities for participation in CHAMPUS so that it has adequate assurance that CHAMPUS beneficiaries are receiving acceptable care.

Since August 1973 DOD has improved its process for approving psychiatric residential treatment facilities caring for children and adolescents eligible for CHAMPUS benefits. DOD's new standards and better inspection procedures have greatly reduced the number of OCHAMPUS-approved psychiatric residential facilities for children and adolescents. OCHAMPUS

now has greater assurances that facilities remaining in the program can provide quality care.

However, OCHAMPUS inspections show that problems continue at some facilities, and OCHAMPUS has proposed improved standards to DOD.

Because CHAMPUS standards for handicap and specialized inpatient treatment facilities are not definitive or comprehensive, OCHAMPUS does not have assurance that approved facilities can provide quality care. Existing criteria are of little value because licenses are not required for many facilities and OCHAMPUS has not specified what constitutes an appropriate staff. Few of the facilities we visited could meet the minimum standards considered essential by our medical advisors. More comprehensive standards exist which CHAMPUS could use in developing its standards. DOD has not given adequate attention to these types of facilities; however, it recently began developing better standards for handicap facilities. Most of the specialized inpatient treatment facilities may be reclassified as handicap facilities and will be subject to these standards. Standards still need to be developed for facilities retaining the classification of specialized inpatient treatment facilities.

Some facilities have been classified as specialized inpatient treatment facilities, although they treat handicapped patients, to allow payments to be made under the basic program for handicapped beneficiaries who were not eligible under the handicap program. Improvements have been made in the inspection of psychiatric residential facilities for children and adolescents, but similar improvements have not been made in the inspections of handicap and specialized inpatient treatment facilities. Many facilities have never been inspected, including a large number approved since an inspection requirement was established. Periodic inspections are not required. Many inspections that are made are superficial because inspection criteria are limited. OCHAMPUS has no standards for inspectors' qualifications and has little knowledge about inspectors' qualifications.

OCHAMPUS' lack of written policies and procedures and inadequate supervision has resulted in poor administrative practices. This has weakened its ability to evaluate facility operations and to provide reliable information to sponsors choosing facilities for their children.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary of Defense require the Assistant Secretary of Defense (Health Affairs) to:

--Adopt standards for psychiatric residential facilities for children and adolescents which address areas that OCHAMPUS believes are not adequately reviewed by JCAH.

--Issue comprehensive standards for handicap facilities.

--Reclassify specialized inpatient treatment facilities caring for the handicapped as handicap facilities, and develop comprehensive standards for those retaining the specialized inpatient treatment facility classification.

--Establish qualifications' standards for CHAMPUS inspectors.

--Inspect, using the new standards for handicap and specialized inpatient treatment facilities, all approved facilities caring for CHAMPUS beneficiaries and require periodic inspections of the facilities.

--Strengthen OCHAMPUS administrative practices by

1. requiring that inspections be made within specified time frames;

2. assuring that inspection reports are properly completed, and that facilities correct deficiencies reported by inspectors;

3. requiring that all complaints be centrally filed, investigated, and a written record prepared as to disposition;

4. establishing criteria for withdrawing facility approvals;

5. developing an effective procedure for obtaining timely notice from JCAH on the results of its inspections; and

6. eliminating inaccurate and outdated information from the facility directory and developing procedures to assure the accuracy and reliability of information put in the directory in the future.

AGENCY COMMENTS

In commenting on our report, DOD generally agreed with our findings and recommendations. (See app. I.) Specifically, DOD said:

"In 1973 reports of abuses involving several children at psychiatric residential treatment facilities approved under then existing OCHAMPUS guidelines forced reassessment of [DOD's existing] policy. Congressional and DOD review of then existing guidelines concluded that they were inadequate to prevent abuses of either the beneficiary or the CHAMPUS program. With a direct Congressional mandate DOD assumed the responsibility for assuring quality psychiatric services were provided in the CHAMPUS approved psychiatric facilities, a level of responsibility far exceeding that of any other private or governmental health insurance program. Since this decision in June 1974, DOD has been working on a three year schedule to achieve this transition. A more rapid transition was not possible due to limited resources and the complexity of the problem."

* * * * *

"Since its beginning, this effort encompassed two approaches, constructing standards for facilities approved to provide care under the CHAMPUS program and devising peer review systems to assure that services were appropriate. At the time of publication of this report new tough standards for residential treatment centers have been adopted, extensive administrative reporting requirements including financial data have been implemented and peer review programs are nearing the goal of providing meaningful assessment of the psychiatric care provided to CHAMPUS beneficiaries in residential treatment centers.

"Some of the weaknesses noted in this report have not been fully remedied, but all are receiving active attention. * * *"

CHAPTER 3

PROCEDURES NEEDED TO AVOID INAPPROPRIATE ADMISSIONS AND EXCESSIVE LENGTHS OF STAY

After reviewing patient cases at psychiatric, handicap, and specialized inpatient treatment facilities, our medical advisors concluded that some patients were placed in facilities inappropriate to their needs and that some patients were kept in facilities longer than necessary. During our review, DOD implemented revised procedures for approving long-term psychiatric care for children and adolescents which should provide greater assurance that extended care is medically necessary and that lengths of stay are appropriate. Further improvements are needed in psychiatric case approval procedures to obtain earlier assurance that admissions are appropriate and to accelerate the case review process.

Improved case approval procedures, like those developed for psychiatric care, are needed for handicap care provided in both handicap and specialized inpatient treatment facilities. As noted on page 26, most of the care provided in specialized inpatient treatment facilities is for handicap care. DOD also needs to insure that psychiatric, handicap, and specialized inpatient treatment facilities use effective procedures to avoid inappropriate placements and excessive lengths of stays.

RESULTS OF CASE REVIEWS BY MEDICAL ADVISORS

Our medical advisors' reviews of patient cases at selected facilities disclosed inappropriate placements and questionable lengths of stay as shown in the table on the following page.

	Number of facilities visited	Cases reviewed	Questionable length of stay		Questionable appropriateness of placement	
			Number	Percent	Number	Percent
Psychiatric residential treatment facilities for children and adolescents	8	128	37	29	25	20
Handicap and specialized inpatient treatment facilities	14	101	24	24	31	31

Following are examples of the 25 psychiatric cases our medical advisors considered inappropriately placed.

--An adolescent diagnosed as neurotic was being treated in a residential facility in the city in which the parents resided. Only outpatient care appeared to be needed, but no evidence was in the file to indicate that it had been considered.

--An adolescent patient who had a Korean mother and limited English language skills was placed in a facility that was unable or unwilling to obtain Korean translators to assist in treatment and evaluation. As a result, little progress had been made.

--After about 11 months of treatment in a facility, an adolescent's condition worsened. The estimated duration of treatment had been successively increased; first from 6 months to 1 year and, at the time of our visit, it had been increased again from 1 year to 2 years. Because of the patient's worsening condition, alternative types of treatment offered by other facilities would be more appropriate than increasing the duration of treatment at the same facility.

--An adolescent was near the maximum age for acceptance when admitted to a facility that did not offer vocational training. Because the duration of treatment was

expected to be relatively brief, vocational training should have been considered in facility selection.

--An 18-year-old adolescent with limited intelligence and longstanding problems, including runaways, stealing, fighting, and difficulties with authorities, had made little progress in treatment. Formal vocational training, which was needed, was not available at the facility or in the community.

Following are examples of the 31 handicap cases for which our medical advisors considered placement inappropriate:

--A child with a diagnosis of mental retardation, classified as moderately severe, was in a facility which taught children with learning disabilities. The facility director said that there was little the facility could do for the child, but the child was accepted because of the desires of the parents. The facility did not represent to OCHAMPUS that it provided services related to mental retardation.

--A child with a diagnosis of mental retardation and severe hearing loss had been in a facility for 3-1/2 years. The facility had no program for deaf children.

--A child with the diagnosis of autism and who was not talking was in a facility that provided no psychological or psychiatric services. No other autistic children were in the facility. The facility's purpose was to provide special education and remedial services to children with developmental disabilities.

--A child with mental and motor retardation and visual and speech problems was in a facility with no capability to treat the visual and speech problems.

--A 2-year-old child with an unsubstantiated diagnosis of moderate mental retardation had been at a facility for 3 months. According to the facility director, the child could have been cared for at home but the mother wanted the child to remain at the facility.

--A child with a diagnosis of mental retardation and epilepsy had been in a facility for 3-1/2 years. The facility was essentially a day-care center for emotionally disturbed children and was not equipped to handle this type of patient. The facility psy-

chiatrist agreed that the child could probably function in a less intensive treatment environment.

--A 19-year-old girl with a diagnosis of mental retardation from Mongolism could have benefited from vocational training but was in a facility that had no vocational programs for adolescents.

The following are examples from the 37 psychiatric cases involving excessive lengths of stay:

--The stated policy of one facility was to retain patients no longer than 18 months. One CHAMPUS patient, however, had been at the facility for 18 months and discharge was not planned. Progress from treatment was disappointing. The patient was finally discharged after 29 months as a result of an OCHAMPUS-sponsored review. Another patient had been at this facility for 18 months and had reached the highest achievement level which one could attain at the facility. The patient was discharged 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. There were no plans to discharge her, to involve the parent in the child's treatment program, or to consider other placement.

--A child who had been rejected by his family was admitted at age 7 and had been at the facility for nearly 4 years. Although treatment was initially needed, it had long been obvious to the facility director that it was no longer necessary. However, he deemed it undesirable to return the child to the unstable family environment, and no 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 and that no progress had been made since then.

--An adolescent had received 5 years of CHAMPUS-supported treatment, including 2 years at the facility visited. Because of a lack of progress the

facility was planning to reduce the intensity of treatment rather than consider an alternative plan.

Following are examples from the 24 handicap cases in which our medical advisors questioned the lengths of stay:

--An adolescent had been at a facility for 6-1/2 years. The initial goal of participation in a public school system had been forgotten. OCHAMPUS continued to approve the case although no psychological testing occurred between 1968 and 1974. Recent intelligence tests showed scores in the mild retardation range (60-70).

--An adolescent had spent 11 years in institutional treatment, 8 of them supported by CHAMPUS. Throughout the case history there was little documentary support for the various diagnoses given, some of which were contradic ory--organic brain syndrome, moderate mental reta dation (although intelligence tests scores were between 75 and 89), childhood schizophrenia, epilepsy, and specific learning disability. The family had rejected the boy and did not want him at home.

--A child reportedly being treated for a serious speech defect had been in a facility for 6 months. Discussions with the child indicated only a very mild speech defect.

--A child admitted to a facility at age 6 months had remained there for almost 4-1/2 years. According to the facility administrator the child was ready for discharge but would remain at the facility because the parents were not interested in him and the State had made no plans for foster care.

IMPROVEMENTS NEEDED IN PSYCHIATRIC CASE APPROVALS

Procedures adopted in September 1974 provided that after 120 days of care, psychiatric cases involving children and adolescents were to be evaluated and an OCHAMPUS determination made about the necessity for further care. Fiscal agents processing claims for inpatient care are responsible for reviewing the medical necessity of such care for the first 120 days.

Before July 1974, residential psychiatric care beyond 90 days required OCHAMPUS approval. Under those procedures approvals and extensions were normally granted for 1-year periods upon requests from the facilities. OCHAMPUS made little evaluation of the effectiveness of care provided or the need for extended care. Consequently children often remained in facilities for many years. Because of numerous problems identified at psychiatric residential facilities (see ch. 2), DOD decided to limit benefits for inpatient psychiatric care to a total of 120 days, effective July 1, 1974. However, because of beneficiaries' complaints, this limitation was removed in September 1974, and the new procedures requiring evaluations at the end of 120 days were established.

DOD has arranged with the National Institute of Mental Health for these evaluations on a special project basis. The arrangement 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 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 to recommend approval or disapproval of facility requests for psychiatric care beyond 120 days. OCHAMPUS, however, has retained the authority to make the final decision.

The estimated cost of the project, which began in October 1974, is about $290,000, of which $220,000 is for consultants' services. A report on the SCOPCE project results is to be made upon the project's completion.

An objective of the SCOPCE project is to develop criteria for reviewing patient cases that OCHAMPUS could adopt at the end of the project. The SCOPCE teams are to review cases, and SCOPCE members and OCHAMPUS officials plan to jointly inspect about 20 residential treatment facilities. The SCOPCE review of cases includes determining the need for residential care, the appropriateness of the treatment program, the length of stay, other professional review parameters, and the reasonableness of charges. In requesting approval for extended care, facilities must respond to 11 questions about patients, providing OCHAMPUS for the first time with standardized information on such matters as a history of the present illness and reason for admission, a treatment plan, a prognosis, a description of parental involvement, and charge information.

When the project ends, NIMH apparently intends to recommend that DOD continue to contract with consultants for independent case reviews.

As of March 11, 1976, 1,117 cases had been sent to SCOPCE teams for review. Extension of care was granted in 437 of the cases. Extensions were normally for 1 to 6 months as opposed to the 1-year extensions granted under previous OCHAMPUS policies. Care was terminated in 505 cases. In the other 175 cases either the decisions were pending or the cases had been withdrawn for reasons not related to the SCOPCE review.

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

--CHAMPUS costs for psychiatric care for children and adolescents in residential treatment facilities have been lowered for the first time.

--The use of independent professionals to evaluate cases has lent credibility to decisions to extend or terminate care.

--Facilities have become aware that OCHAMPUS is enforcing the requirement that care after 120 days have OCHAMPUS approval.

--Uniform patient data is submitted for case reviews.

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

Need for preadmission approvals

Our medical advisors' reviews of psychiatric cases involving children and adolescents indicate a need for preadmission approvals. Approval before admission would give OCHAMPUS the opportunity to consider such factors as alternative types of treatment, benefits to be expected from treatment, extent of parental involvement required, and the type of environment the patient requires after treatment is completed.

OCHAMPUS officials said that, with a few exceptions, fiscal agents were probably not adequately reviewing cases during the first 120 days. Visits by OCHAMPUS officials

have disclosed that many fiscal agents do not have written guidelines for utilization reviews. In June 1975 OCHAMPUS sent questionnaires to all fiscal agents requesting information on their utilization review systems. Analysis of the replies indicated the need for a standardized utilization review system. OCHAMPUS is now developing a minimum utilization review system for all fiscal agents. Facility officials with whom we discussed the issue believed that preadmission approval should be instituted to avoid interruptions of treatment programs. NIMH officials told us they were considering recommending to DOD that preadmission approval procedures be adopted.

Under the Medicaid program, before a person under age 21 can receive inpatient psychiatric care, it must be determined that the person needs inpatient care in the type of facility proposed, that appropriate alternatives are not available, and that the care can reasonably be expected to improve the patient's condition to the point that such care will no longer be necessary.

Our review of individual psychiatric cases showed a need for greater use of local community mental health facilities before resorting to long-term residential care, which was often provided in facilities located at great distances from where the parents resided. Using community resources would encourage greater parental involvement and possibly avoid long-term inpatient stays.

CHAMPUS does not now require use of community resources. Sponsors are free to choose the facility and type of treatment, and OCHAMPUS does not evaluate cases for approval until the length of stay exceeds 120 days. If preadmission approvals were required, alternatives such as community treatment could be considered. One community resource is the community mental health centers program, which is partly funded through Federal grants and which allows emotionally disturbed persons to be treated in their own communities. These centers emphasize prevention, treatment, and rehabilitation at the local level and confine patients on an inpatient basis only as a last resort. The centers offer such alternatives to residential care as outpatient care, partial hospitalization, and consultation and education services.

Need to expedite case reviews

Although most problems encountered in implementing the SCOPCE project have been resolved, an extensive period

of time elapsed in processing requests for extended-care authorizations. OCHAMPUS does not retroactively disapprove care; therefore, it is important to process requests for extended care promptly in order 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 for OCHAMPUS to reach a decision. Most of this delay occurred at OCHAMPUS. The requests were with OCHAMPUS and SCOPCE for the following average periods:

OCHAMPUS between end of 120-day period and submission of case to review team	52 days
SCOPCE review team	33 days
OCHAMPUS awaiting final decision	15 days

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

The delay in decisions on extended care also created an unnecessary hardship for psychiatric treatment facilities, for patients, and for their families. Uncertainty about continued treatment made it difficult to insure ongoing treatment planning, to develop alternative treatment plans, and to stabilize work with patients and their families.

IMPROVEMENTS NEEDED IN HANDICAP CASE APPROVALS

OCHAMPUS evaluates cases to determine whether the handicap qualifies as moderate or severe mental retardation or as a serious physical handicap. Evaluations are based on physicians' statements on the diagnosis and recommended treatment. OCHAMPUS generally approves handicap care, and extensions of care, for 1-year periods. Requests for extensions are generally submitted by facilities' professional staffs. OCHAMPUS clerical personnel evaluate cases to determine whether they qualify for the handicap program and whether extensions should be granted, but questionable cases are referred to medical personnel for disposition.

In two prior reports, 1/ we recommended that DOD improve handicap case approval procedures and pointed out the need for specific and comprehensive standards for use in approving requests for care; greater involvement of medical personnel in evaluating cases; and a standard format for physicians to use in reporting diagnoses to help them prepare a complete medical treatment for submission to OCHAMPUS.

In the opinion of our medical advisors, OCHAMPUS needs to extensively evaluate cases for initial approval or extensions to determine whether the patient could function outside of a facility and whether the placement was appropriate. Once a case was approved, extensions were granted routinely without requiring adequate justification for continued treatment and evidence that the treatment was still appropriate to the patient's needs. Only about one-third of the cases reviewed were referred by clerks for medical advice, and cases referred were normally never again referred when additional extensions of care were sought. OCHAMPUS does not require periodic psychological tests and evaluations to determine changes in patients' conditions, definite information on discharge planning, information on parental involvement, or the reason the child should remain at the facility.

Another problem related to approval of handicap care was that handicap cases involving learning disabilities, which were declared ineligible for benefits effective July 1, 1974, were later reapproved for benefits as moderate mental retardation without adequate medical statements substantiating the retardation.

FACTORS CONTRIBUTING TO INAPPROPRIATE PLACEMENTS AND EXCESSIVE LENGTHS OF STAY

OCHAMPUS case approval efforts, without supporting efforts from facilities, are of limited effectiveness in controlling patient admissions and lengths of stays. We believe

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1/"Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen," B-133142, March 16, 1971.

"Management of the Civilian Health and Medical Program of the Uniformed Services Needs Improvement," MWD-76-48, November 21, 1975.

that facilities need to adopt procedures to provide more effective utilization reviews, better and earlier discharge planning, and greater parental involvement. Handicap facilities also need to adopt programs to give patients a chance to lead as normal lives as possible.

Our medical advisors observed that many of the psychiatric cases reviewed involved patients with severe, longstanding disorders, low functioning intelligence, evidence of brain dysfunction, and continued family disorganization and instability. In such cases our medical advisors did not question that the children needed treatment; rather, they believed that the patients should demonstrate sufficient improvement over time to justify continued treatment at the same facilities, which provide intensive care--often at high cost. They further observed that an issue of treatability existed in these cases, especially when parents were not involved or were not participating in the treatment program.

Need for improved utilization review and discharge planning

Objectives of utilization review include determining the necessity for admissions and continued stay at facilities. Five of the eight psychiatric residential facilities for children and adolescents we visited had no formal utilization review programs. One of the five facilities implemented utilization review procedures just before the JCAH accreditation survey but dropped them immediately after the survey. Since we found cases of inappropriate placement and questionable lengths of stay at 10 of the 14 handicap and specialized inpatient treatment facilities visited, it appears that these facilities also did not perform effective utilization reviews.

Facility officials may be biased, to the disadvantage of the patients, in requesting extended treatment authorizations. Such a bias may occur when facilities depend upon CHAMPUS for much of their revenue. For example, one facility we visited derived 65 percent of its revenue from CHAMPUS; another facility visited obtained 51 percent.

Discharge planning was a problem at most facilities visited. For many patients, discharge planning either was not performed or was not organized to expeditiously discharge patients or to insure that needed services would be provided upon discharge. Discharge planning involves early and ongoing preparation, including determining home condi-

tions, family attitudes, and local resources available to continue services needed upon discharge. The facilities visited frequently had not adequately planned for discharges.

A case illustrating the need for discharge planning involved a patient at a psychiatric residential facility whom our medical advisor considered ready for discharge. Facility officials, however, believed that, since the father had died just 4 months earlier, returning the patient home to the mother was difficult. Yet, 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 psychiatric facility for 17 months. The patient had previously experienced an unstable family life, having been shuffled from natural mother to adoptive parents to half sister. At the time the patient was ready for discharge, no plans had been made for permanent placement, so the child remained at the facility.

Facilities participating in CHAMPUS have not been required to perform utilization review and discharge planning. Such review and planning are required under Medicaid for all intermediate care facilities, including institutions for the mentally retarded.

Need to increase parental involvement in treatment

Another problem at some facilities is the lack of parental involvement in treatment programs, including assistance to parents when it is essential and beneficial in 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 resided far from treatment facilities, or were unwilling to become involved in their children's treatment. As a result, children were remaining in facilities longer than necessary. Parental involvement may be hindered by transfers of sponsors to duty stations far from the location where their children are receiving treatment.

Our medical advisors questioned the value of psychiatric treatment without parental involvement since discharges frequently resulted in children returning to the environment from which their problems were originally derived witnout

any improvement in that environment. According to NIMH officials, although measuring the extent of benefit from parental involvement is difficult, psychiatric treatment is unlikely to be beneficial without it. Our medical advisors' review of case records indicated that psychological disturbances frequently existed among the patients' parents and that there was a general lack of attention by facilities and others to providing parents psychological help which would aid them when their children returned home.

Children admitted to psychiatric facilities were frequently from out of State; for example, 80 percent of the admissions to one facility involved out of State patients. Parental involvement was often limited to initial placement and consultation during crises. A review of 60 psychiatric cases at facilities showed that parental involvement was lacking or inadequate in 22 (37 percent) of them. 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 both resided outside the State in which the child was being treated. Neither parent was involved in the treatment, and one opposed 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, but the child still showed concern for his family and about being away from home.

The lack of parental involvement was also a problem in handicap and specialized inpatient treatment facilities visited. Of 57 cases reviewed, 44 cases (77 percent) lacked sufficient parental involvement. Eleven of 44 cases involved parents who lived out of State. In some cases, the lack of parental involvement prevented or delayed discharges. Some parents were unwilling to accept the child back into the home or had abandoned the child at the facility. In the opinion of our medical advisors, with greater parental interest, many children in residential facilities could have been attending special day-care facilities and some day-care students could have been attending special public school programs.

Need for handicap facilities to provide opportunities for a more normal life

A factor which our medical advisors believe delays discharges and lowers the quality of care for handicapped children is the failure of facilities to fully recognize the

normalization principle, a theory widely accepted among leaders in the field of mental retardation. This principle involves making available to the mentally retarded patterns and conditions of everyday life as close as possible to the norms and patterns of the mainstream of society.

The normalization process allows many patients to achieve greater independence and social integration. Others can develop relative independence, though they may always need some assistance. Even those who are severely or profoundly retarded or who are afflicted with complicating medical, psychological, or social handicaps should, no matter their degree of dependency, have life conditions, facilities, and services that follow the normal patterns of society as much as possible.

In our review of handicap facilities and their patients' case records, we noted that facilities appeared to take over parental functions without providing normal homelike and community opportunities. Facilities failed to make efforts to discharge children, and parents and children tended to become overly dependent upon facilities.

OCHAMPUS has not required facilities to demonstrate that they provide normalizing opportunities to handicapped children. In accrediting residential facilities for the mentally retarded, JCAH requires the facility to provide active habilitation programs for all residents within a normalized environment. The JCAH-required normalized environment must be physically as homelike as possible and must allow residents to be divided into small groups. Specific direct-care staff are to be responsible for each group so that individualized attention can be given to residents' developmental needs.

CONCLUSIONS

Inappropriate placements and excessive lengths of stay not only increase program costs but also adversely affect the lives of patients and their families. Improvements in the psychiatric program for children and adolescents have shortened or terminated extended care authorizations and have provided greater assurance that cases approved for extended care actually require it.

Such assurance is still missing, however, during the first 120 days of psychiatric care, and patients' lengths of stays are sometimes unnecessarily extended because of

OCHAMPUS administrative delays. Insuring the appropriateness of placements and lengths of stays is also a problem under the handicap program. OCHAMPUS cannot adequately deal with this problem simply by improving case review procedures. Complementary efforts are needed at psychiatric and handicap facilities.

Our observations on inappropriate placements and excessive lengths of stays, which sometimes appeared related to the absence of parental involvement, raise the question as to whether military departments are unknowingly transferring personnel away from their children. Worse, some parents may be abandoning their children because they are unable to cope with being responsible for emotionally ill or handicapped children. We did not study these questions, but believe they are important enough to warrant DOD's attention.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

To assure that CHAMPUS beneficiaries are receiving appropriate and necessary care and to improve program administration, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to:

--Require preadmission approvals of psychiatric cases before benefits are authorized in residential psychiatric facilities for children and adolescents considering such factors as benefits to be expected from the admission, possible alternative types of treatment or placement, length of treatment needed, extent of parental involvement required, and the environment in which the patient will be placed upon completing treatment.

--Accelerate the administrative process for approving psychiatric care extending beyond 120 days.

--Require that, in approving requests for handicap care and for extensions of care, determinations be made as to whether the patient will benefit from the care proposed, whether the placement is appropriate, and whether the proposed length of treatment is reasonable.

--Require that handicap cases be carefully evaluated to insure that only the moderately or severely mentally retarded and seriously physically handicapped are approved for care as provided by law.

--Require that facilities adopt utilization review and discharge planning programs and, as much as possible, involve parents in treatment programs and provide patients opportunities to function as normally as possible.

--Study cases involving extensive long-term care to determine whether sponsors require, and are receiving, special assistance to enable them to deal with their concurrent, but perhaps conflicting, responsibilities to their families and the military departments.

AGENCY COMMENTS

DOD generally agreed with our findings and recommendations. (See app. I.) Specifically, it said:

> "This office is in basic agreement with the findings and recommendations put forth in this report. During the past three years the DOD has changed its policy regarding its responsibility to assure that quality psychiatric care is provided in facilities approved for CHAMPUS beneficiaries. Prior to 1973 DOD and the CHAMPUS program assumed that parents and the local professional community would assure that CHAMPUS beneficiaries received quality health services. OCHAMPUS served to assist beneficiaries in locating potential sources of care and reimbursed the beneficiaries or institutions in accordance with the program guidelines."

CHAPTER 4

IMPROVED CONTROLS OVER FACILITY FINANCIAL CHARGES NEEDED

OCHAMPUS procedures need improvement to insure that specialized facilities' financial charges for services provided beneficiaries are reasonable and proper. Many facilities charged higher rates for CHAMPUS beneficiaries than for most other patients, charged rates higher than appeared supportable by costs, and were not collecting cost-sharing amounts from sponsors as required. Fiscal agents are not required to review charges of handicap facilities and specialized inpatient treatment facilities while inspecting these facilities, and OCHAMPUS has only recently adopted procedures for reviewing charges of psychiatric facilities during inspections.

CONTROLS OVER CHARGES OF PSYCHIATRIC RESIDENTIAL FACILITIES FOR CHILDREN AND ADOLESCENTS

Fiscal agents paying CHAMPUS claims are required to determine and pay only reasonable charges, which CHAMPUS defines as charges not exceeding charges to the general public for similar care. However, fiscal agents have no authority to require audits of facility financial records to insure that charges to CHAMPUS are reasonable and do not exceed those to other patients. Fiscal agents accepted facilities' notifications of rate increases without requiring adequate justification. OCHAMPUS does not formally evaluate charges when considering facilities for approval and DOD believes it has no legal access to facility financial information.

The monthly charges of the eight facilities we visited ranged from $800 to $2,250 per child. Five of the eight facilities' charges included all professional fees, but the other three facilities charged additional fees for services provided by such professionals as psychiatrists and psychologists. Monthly professional fees of about $400 per child were common in the facility which charged $2,250.

For comparable services, facilities often had different rates for patients with different sponsors, such as State welfare agencies, CHAMPUS, and private citizens; CHAMPUS was generally charged rates at the high end of the range. For example, one facility's rates ranged from $850 to $1,500, and CHAMPUS was charged from $1,300 to $1,500. Another facility's rates ranged from $500 to $1,000 per month and CHAMPUS was

charged from $850 to $900. Facility officials generally explained that different rates were charged in accordance with either the various sponsoring organizations' or individuals' ability to pay, or amounts were negotiated with the various sponsoring organizations.

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

--One facility's charges for care provided 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 by the session. A test of 14 cases showed that therapy charges ranged from nothing 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. All were involved in the same treatment program. 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 by $100 per month on January 1, 1975, and immediately placed in effect for the 11 CHAMPUS patients in the facility. The new rates were not applied to non-CHAMPUS patients then in the facility but were applied to all patients admitted thereafter.

--A nonprofit facility increased its daily charge from $65 to $75 in February 1975 on the basis of a lower patient census and increased costs. The facility's unaudited financial statements for 1974 showed revenues exceeded expenses by over $100,000, a figure 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 informed OCHAMPUS that its $900 per month fee included psychotherapy. We found, however, that the CHAMPUS patients were billed additional amounts for therapy, which was provided by a facility psychologist or psychiatrist. We were told that this charge was made because CHAMPUS would pay it.

CONTROLS OVER CHARGES OF FACILITIES SERVING THE HANDICAPPED

Fiscal agents visited were not making determinations of reasonableness of charges of facilities providing services under the program for the handicapped. According to the agents, they did not determine whether charges were excessive because OCHAMPUS approved the care and had a record of the facilities' rates, and because the Government's share is limited to $350 per month. Although the fiscal agents inspected facilities when OCHAMPUS requested them to do so, they did not obtain information on reasonableness of rates since OCHAMPUS did not request it.

OCHAMPUS procedures for approving handicap facilities also do not include determining the reasonableness of facility charges. OCHAMPUS officials considered the $350 maximum monthly payment as adequate control.

Of 14 handicap and specialized inpatient treatment facilities visited, we found the rates charged by 4 facilities to be questionable. All patients in these facilities received essentially the same services.

--At one residential facility, charges for CHAMPUS beneficiaries generally ranged from $375 to $435 per month consisting of the Government's $350 maximum payment plus the sponsor's required contribution. Parents of non-CHAMPUS residents were never charged more than $200 per month, and most were charged $100 or less.

--A day treatment facility charged non-CHAMPUS children at most $50 per month and CHAMPUS beneficiaries at least $150 per month.

--Another day treatment facility charged its non-CHAMPUS children $40 per month but charged its one CHAMPUS beneficiary $140 per month--$100 to CHAMPUS and $40 to the parents.

--Another proprietary day treatment facility reportedly based the $375 monthly charge for CHAMPUS beneficiaries on the amount CHAMPUS would pay ($350 plus the sponsor's share). Financial data to support the charge did not exist. The charges of another facility in the same city for comparable services were $55 per month plus an initial entrance fee of $150 for all patients.

FACILITIES OFTEN NOT COLLECTING SPONSOR'S SHARE

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. Facilities' failure to collect the sponsor's share not only eliminates the sponsor's incentive to be concerned about lengths of stays and appropriateness of admissions, but also may result in higher facility charges, which are passed on to CHAMPUS to compensate for amounts not paid by sponsors.

Many facilities we visited were not collecting amounts due from sponsors. Facility officials usually said that sponsors' shares were not collected because of financial hardship. However, facilities often made little effort to determine if sponsors could afford to meet cost-sharing requirements. Children were often said to be on "scholarships" when sponsors' shares were not collected although scholarship funds were not set aside. Many facilities had no documentation to show that they had attempted to collect sponsors' shares.

Four of the eight psychiatric facilities we visited did not collect the required amount from sponsors. For example, one facility's monthly charge for each CHAMPUS patient was $1,125. Sixteen of the CHAMPUS patients in the facility were dependents of retired personnel, whose share of the cost (25 percent) should have been $281. Only 4 of the sponsors were charged $281; the other 12 were charged from nothing to $100 per month.

Some of the handicap and specialized inpatient treatment facilities we visited also failed to collect the sponsors' full shares. Two day-care facilities routinely waived sponsors' charges. Another facility not only did not charge some sponsors but also made refunds to other sponsors after CHAMPUS claims were paid. One day-care facility, whose only admissions were military dependents, automatically waived 60 percent of the sponsors' share of charges.

The effect of not collecting sponsors' shares can be illustrated using a case at the facility which waived 60 percent of the sponsors' charges. This facility charged $370 per month per patient. If the facility had charged properly, a captain would have paid his full share of $45 and CHAMPUS would have paid $325. However, since the facility waived 60 percent of the sponsor's share, a captain paid only 40 percent of $45 ($18) and the facility billed CHAMPUS the maximum of $350 in order to recover as much of the unpaid amount ($352) as possible.

ACTIONS TAKEN OR PROPOSED TO IMPROVE CONTROLS OVER FACILITY CHARGES

Before February 1974, inspections of psychiatric facilities did not include an assessment of charging practices. However, since that time, OCHAMPUS has added six specific questions concerning financial practices to its inspection checklist. Since these new requirements were implemented, OCHAMPUS inspection teams' findings regarding facility financial practices have been similar to our findings. No facilities, however, have been disapproved solely on the basis of questionable charging practices. The checklists OCHAMPUS provides to fiscal agents for inspecting handicap facilities still have no questions on facility financial practices.

In our March 16, 1971, report, "Improved Management Needed in the Program Providing Benefits to Handicapped Dependents of Servicemen" (B-133142), we recommended that determinations be made of the reasonableness of charges for handicap care. In our November 21, 1975, followup report, "Management of the Civilian Health and Medical Program Needs Improvement" (MWD-76-48), we again reported that reasonableness of charges was not being determined. In response to the second report, DOD indicated that future plans included the use of participation agreements, which would include a negotiated rate for care of CHAMPUS beneficiaries.

OCHAMPUS has developed proposed regulations on participation agreements, which it submitted to DOD in July 1975. These participation agreements, if signed by facilities, 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.

--Make onsite inspections, including interviews with employees, members of the staff, and patients, to verify the facility's capability 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.

According to DOD, the use of participation agreements will be adopted during 1976.

CONCLUSIONS

OCHAMPUS has begun to obtain information on financial charges during facility inspections of residential psychiatric facilities, but its procedures are still not adequate or comprehensive enough to determine whether charges by all specialized facilities are reasonable and proper. OCHAMPUS does not have sufficient direct knowledge of facility charge practices, and its access to this information is limited. Also, OCHAMPUS does not act to insure that sponsors are charged and pay their share of the cost. The participation agreements now being considered by DOD will enable the negotiation of reasonable rates after examination of facilities' financial records. Such agreements, accompanied by periodic financial audits, would better assure OCHAMPUS that charges for treatment are appropriate.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to:

--Assure that charges of facilities are reasonable and proper by using contractually binding participation agreements that include negotiated rates for services.

--Require that facilities attempt to collect sponsors' shares as provided in the laws authorizing benefits and require facilities to document such attempts.

AGENCY COMMENTS

DOD generally agreed with our recommendations. (See app. I.)

CHAPTER 5

THE FINANCIAL PROVISIONS OF THE PROGRAM FOR THE HANDICAPPED NEED TO BE RECONSIDERED

When the handicap program was established in 1966, the $350 maximum monthly payment was considered adequate to meet the costs of most handicap treatment facilities. Ten years later the $350 is still considered adequate to cover cost and charges of day-care facilities, but it is inadequate for residential facilities. The charges for handicap care questioned in chapter 4 related primarily to day-care facilities.

COST-SHARING REQUIREMENTS

The Military Medical Benefits Amendments of 1966 require that active duty members of the uniformed services share in the costs of any benefits provided under the program for the handicapped. The members in the lowest enlisted pay grade are to pay the first $25 and those in the highest commissioned pay grade the first $250 of costs incurred each month. The rates for the other pay grades were determined under joint regulations prescribed by the Secretaries of Defense and Health, Education, and Welfare. The rates established in implementing the program are as follows:

Sponsors's Share of Cost for Handicap Care

Grade	Minimum monthly share
E-1 through E-5	$ 25
E-6	30
E-7 and O-1	35
E-8 and O-2	40
E-9, W-1, W-2, and O-3	45
W-3, W-4, and O-4	50
O-5	65
O-6	75
O-7	100
O-8	150
O-9	200
O-10	250

(E = enlisted; W = warrant officer; O = officer)

In addition to the sponsor's share, the legislation authorized CHAMPUS to pay a monthly maximum of $350. Any charges exceeding the CHAMPUS payment plus the sponsor's share are the sponsor's responsibility.

Since 1966, military pay has increased about 100 per cent. Beginning in January 1974, the active duty members' daily charge for inpatient care under the basic program has been annually adjusted. However, the active duty members' cost-sharing under the program for the handicapped has not been similarly adjusted.

CURRENT CHARGES OF FACILITIES

Rates charged by residential facilities approved by OCHAMPUS to care for the handicapped were generally more than the monthly maximum of $350 which CHAMPUS is permitted to pay. The rates charged by facilities for which charge information was available are shown in the following schedule.

Rates of CHAMPUS-approved Residential Handicap Facilities as of October 1975

Monthly rate	Number of facilities	Number of facilities
$350 or less		97
$351-$400	35	
401- 450	35	
451- 500	36	
501- 750	65	
over 751	38	
Facilities charging $351 or more		209
Total number of facilities		306

At four of the six residential handicap and specialized inpatient treatment facilities we visited, the $350 monthly maximum CHAMPUS payment plus the sponsors' share was not sufficient to cover the cost of care. At another facility the total payments were sufficient, but that facility provided only custodial care since the residents were so profoundly retarded that little training or education was possible. Cost data was not available at the sixth facility. According to the director of one facility,

CHAMPUS beneficiaries may have to be excluded in the future because total CHAMPUS and sponsor payments did not meet costs of the facility, which was operating at a considerable deficit.

The total of the CHAMPUS payment plus the sponsor's payment was still generally adequate to pay for day care. Of the 207 day-care facilities approved by OCHAMPUS as of October 1974, 168 (about 80 percent) charged $350 or less per month.

CONCLUSIONS

The $350 maximum CHAMPUS payment plus the sponsor' share under the program for the handicapped is generally not sufficient to cover the cost of residential handicap care. Despite substantial increases in health care costs and military compensation since this benefit was established in 1966, no changes have been made in either CHAMPUS' or the sponsors' share.

RECOMMENDATIONS TO THE SECRETARY OF DEFENSE

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to:

--Determine an appropriate CHAMPUS payment for handicap care reflecting the increased costs of such care.

--Determine an equitable sponsors' share of the cost of handicap care reflecting the significant increases in military pay since 1966.

--Propose legislation to increase OCHAMPUS' and the sponsors' payments for handicap services.

AGENCY COMMENTS

DOD generally agreed with our recommendations. (See app. I.)

APPENDIX I

ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301

HEALTH AFFAIRS

August 24, 1976

Mr. Gregory J. Ahart
Director, Manpower and
Welfare Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

This is in reply to your letter to Secretary Donald Rumsfeld regarding the review of the GAO Draft Report, dated June 4, 1976, "Greater Assurances are Needed that Emotionally Disturbed and Handicapped Children are Properly Cared for in Department of Defense Approved Facilities" (OSD Case #4385).

This office is in basic agreement with the findings and recommendations put forth in this report. During the past three years the DoD has changed its policy regarding its responsibility to assure that quality psychiatric care is provided in facilities approved for CHAMPUS-beneficiaries. Prior to 1973 DoD and the CHAMPUS program assumed that parents and the local professional community would assure that CHAMPUS beneficiaries received quality health services. OCHAMPUS served to assist beneficiaries in locating potential sources of care and reimbursed the beneficiaries or institutions in accordance with the program guidelines.

In 1973 reports of abuses involving several children at psychiatric residential treatment facilities approved under then existing OCHAMPUS guidelines forced reassessment of that policy. Congressional and DoD review of then existing guidelines concluded that they were inadequate to prevent abuses of either the beneficiary or the CHAMPUS program. With a direct Congressional mandate DoD assumed the responsibility for assuring quality psychiatric services were provided in the CHAMPUS approved psychiatric facilities, a level of responsibility far exceeding that of any other private or governmental health insurance program. Since this decision in June 1974, DoD has been working on a three year schedule to achieve this transition. A more rapid transition was not possible due to limited resources and the complexity of the problem.

APPENDIX I

Cooperation with professional organizations, the National Institute of Mental Health and other government agencies has been essential to devise the necessary methods to create an effective quality assurance program.

Since its beginning, this effort encompassed two approaches, constructing standards for facilities approved to provide care under the CHAMPUS program and devising peer review systems to assure that services were appropriate. At the time of publication of this report new tough standards for residential treatment centers have been adopted, extensive administrative reporting requirements including financial data have been implemented and peer review programs are nearing the goal of providing meaningful assessment of the psychiatric care provided to CHAMPUS beneficiaries in residential treatment centers.

Some of the weaknesses noted in this report have not been fully remedied, but all are receiving active attention. Most of the recommendations have already been implemented and those remaining are only awaiting the development techniques to accomplish their objectives. Reduction of the backlog of work created by the introduction of these new administrative and professional review procedures will decrease the delays in processing to more acceptable levels. Moving to this more aggressive role of assuming a greater responsibility for evaluation of the health services in CHAMPUS approved facilities has clearly resulted in decreasing the potential for inappropriate treatment of children in CHAMPUS approved facilities.

Sincerely,

Sherman Lepson for
Vernon McKenzie
Acting Assistant Secretary of Defense

APPENDIX II

PRINCIPAL DOD OFFICIALS RESPONSIBLE FOR ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY, DOD:		
Donald H. Rumsfeld	Nov. 1975	Present
James R. Schlesinger	July 1973	Nov. 1975
William P. Clements, Jr. (acting)	May 1973	June 1973
Elliot L. Richardson	Jan. 1973	May 1973
Melvin R. Laird	Jan. 1969	Jan. 1973
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS):		
Dr. Robert N. Smith	Sept. 1976	Present
Vernon McKenzie (acting)	Mar. 1976	Sept. 1976
Dr. James R. Cowan	Feb. 1974	Mar. 1976
Dr. Richard S. Wilbur	July 1971	Sept. 1973
DEPUTY ASSISTANT SECRETARY (HEALTH RESOURCES AND PROGRAMS):		
Col. Theodore Wood (acting)	Sept. 1976	Present
Sherman Lazrus	Apr. 1975	Sept. 1976
Vernon McKenzie	July 1971	Apr. 1975