REPORT ON

REIMBURSEMENT FOR

SERVICES OF INSTITUTIONS

COMMONWEALTH OF VIRGINIA

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VIRGINIA COMMISSION
FOR ECONOMY IN GOVERNMENTAL EXPENDITURES

(A permanent joint commission of the General Assembly
of the Commonwealth of Virginia)

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REPORT OF THE
COMMISSION FOR ECONOMY IN GOVERNMENTAL EXPENDITURES
on
REIMBURSEMENT FOR SERVICES OF INSTITUTIONS

Richmond, Virginia
May 4, 1970

To: His Excellency Linwood Holton, *Governor of Virginia*

and

The General Assembly of Virginia

The Commission for Economy in Governmental Expenditures submits herewith a report on a study of the reimbursement procedures of the institutions of the Department of Mental Hygiene and Hospitals and the Department of Health. The Commission was assisted by Mr. Wesley R. Ellms, Consultant, of the firm of Louis T. Klauder and Associates.

The study included a review of the historical background of the reimbursement requirements, the related statutes, and the policies, practices and procedures now in effect.

The report includes recommendations which if adopted should provide greater equity to patients and at the same time cause additional revenues to accrue to the State from insurance companies for patient care. Legislative changes are also outlined which appear necessary to accomplish the objectives of the recommendations.

The Commission gratefully acknowledges the cooperation of the officials and employees of the agencies whose operations were reviewed and the assistance given by other individuals and other States during the course of the study.

Respectfully submitted,

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COMMISSION FOR ECONOMY IN GOVERNMENTAL EXPENDITURES

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FOREWORD AND APPROACH

This study reviews the reimbursement practices and policies of certain State institutions providing services for patients. The principal activities are in the Department of Mental Hygiene and Hospitals and the State Department of Health.

The study pursued three objectives:

1) To improve and assure equity in the policies and administration of reimbursement activities.
2) To increase reimbursement revenues to more nearly cover the cost of services rendered without imposing an undue hardship on patients or responsible persons.
3) To simplify and make more businesslike the administration of reimbursement activities.

The findings and recommendations reflect an analysis of the detailed reimbursement policies, practices and performance of the appropriate institutions in Virginia and in other states.

Following are the specific sources of information utilized in the study:

1. Reports made available by the Council of State Governments relating to reimbursement practices of several other states were reviewed.
2. A questionnaire on reimbursement policies and practices was sent to fourteen states. The replies were analyzed and in some instances clarified or elaborated upon by telephone discussion.
3. The philosophy of responsibility for reimbursement was reviewed in literature made available by the Council of State Governments.
4. The following reports issued by the Department of Mental Hygiene and Hospitals were reviewed and analyzed:

   (a) Operating Statistics and Costs, 1959-69
   (b) Collections *vs* Costs of Collection
   (c) Quarterly Reports by Type of Service
   (d) "Proposed Revision of Patient Charge Method", Assistant Commissioner, Mental Hygiene and Hospitals

5. The Annual Reports (1964-68) of Catawba Sanatorium and Blue Ridge Sanatorium were analyzed.
6. Several special or informal reports prepared by Mental Hygiene and Hospitals and by the Bureau of Tuberculosis Control of the Health Department were discussed and analyzed.
7. The available statistics bearing on reimbursement were reviewed.
8. Blue Ridge Sanatorium was visited.
9. A small random sample of mental patients' reimbursement files was examined and analyzed.
10. The statutes bearing on reimbursement and related subjects were studied.
11. The Report of the Governor's Study Commission on Vocational Rehabilitation (1968) was reviewed.

12. Persons holding the following positions were interviewed or conferred with (some many times):

Commissioner of Health
Commissioner of Mental Hygiene and Hospitals
Assistant Commissioner—Administration, Mental Hygiene and Hospitals
Chairman, State Hospital Board
Director, Department of Vocational Rehabilitation
Director, Administrative Services, Mental Hygiene and Hospitals
Superintendent of Catawba Sanatorium
Superintendent of Blue Ridge Sanatorium
Business Manager of Catawba Sanatorium
Business Manager of Blue Ridge Sanatorium
Social Worker at Blue Ridge Sanatorium
Reimbursement Investigators, Mental Hygiene and Hospitals
Reimbursement Investigator, Virginia Treatment Center for Children and Piedmont State Hospital
Reimbursement Director, Mental Hygiene and Hospitals
Director, Virginia Treatment Center for Children
Statistician, Department of Mental Hygiene and Hospitals
Director, Virginia Medical Assistance Program (Medicaid)
Director, Special Health Services, Department of Health
Director, Tuberculosis Control, Department of Health
Director, Alcoholic Studies and Rehabilitation, Department of Health
Director, Medical Social Services, Department of Health
Director, Medical and Hospital Services, Department of Health
Deputy Commissioner—Administration, Department of Health

13. The report of the Commission on Mental, Indigent and Geriatric Patients (1970) was reviewed.

The Commission acknowledges the conscientious cooperation of the many officials in the agencies and institutions from whom information and advice was solicited.

SUMMARY

Reimbursements for services to patients of the principal State institutions of the Department of Mental Hygiene and Hospitals, and the State Department of Health included in this study have increased steadily during recent years. They amounted to about 17% of the cost of operation and maintenance in 1969 and the proportion is expected to increase significantly during the next few years.

An analysis in February 1970, indicated reimbursements of about $8,840,000 per year were being received for care in the mental hospitals. Reimbursements for care at the Tuberculosis Sanatoria and the Division of Alcoholic Studies and Rehabilitation amounted to over $600,000 in fiscal 1969. About half of the mental hospital reimbursements are from patients or persons responsible for them, whereas only about 2% of the Sanatoria reimbursements come from such sources. The balance is received from insurance, Social Security, Medicare, Blue Cross, and Medicaid.

Reimbursements are received for 47% of the mental patients and 25% of the tubercular patients while the remainder are treated free. Although other institutions receive some reimbursements from individuals the amounts are not significant compared with those of the institutions studied.

A need for improving equity and consistency in charging patients was revealed. Although the problems in this area are complex, recommendations in this report regarding policies, procedures and statutory changes should provide substantial improvements when they are implemented.

The following increases in annual reimbursement revenues from insurance may be expected if suggested recommendations are adopted:

	Recommendation	*Estimated Annual Income Increases*
1)	Charging for the cost of the particular type of service in the mental hospitals rather than the per capita cost (Recommendation I)	$475,000
2)	Charging for the actual cost—Virginia Treatment Center for Children (Recommendation III)	150,000
3)	Charging for services to parents and other relatives —Virginia Treatment Center for Children (Recommendation IV)	10,000
4)	Obtaining accreditation of the Virginia Treatment Center for Children (Recommendation V)	20,000
5)	Charging for the particular type of service rather than the hospital per capita cost—TB Sanatoria (Recommendation XI)	100,000
	Total	$755,000

Revision of the charging policy to obtain these added insurance revenues would affect only a few individuals and in no instance would the increased payments cause them undue financial hardship.

These increased revenues would be realized immediately by the adoption of the measures recommended and there is also a strong probability that they would become substantially greater in the near future because of the expanding coverage by health insurance.

Beyond the increased insurance reimbursements, significant advantages would also evolve from a recommended companion policy to consider programs in terms of their *net cost* to the General Fund. Under such a policy, early intensive treatment, for example, would be shown as being much less expensive because of the substantial offsetting reve-

nues it produces. This should encourage a more realistic and socially beneficial approach to the funding of such programs.

Organization changes are recommended which would centralize and strengthen the reimbursement activities of the State Department of Health. In addition, the need is pointed out for better coordination among the agencies concerned with reimbursements connected with Federal programs. An example is given to show that substantial revenues have been foregone because of deficiencies in this area.

In analyzing reimbursement policies questions arose regarding the fairness of the charging policy for certain types of patients. This report deals with this subject and recommends that the Department of Mental Hygiene and Hospitals determine the cost of the various alternatives before any particular policy is established or changes in statutory provisions are requested.

A. REIMBURSEMENT PERFORMANCE—PAST AND PRESENT

1. *Mental Hygiene and Hospitals*

a. Hospitals and Training Schools

Reimbursement has been solicited and accepted from patients and committees since the first mental hospital in the United States was established toward the close of the 18th Century at what is now Eastern State Hospital. Through the 19th Century and the first part of the 20th, payments were voluntary, small and probably infrequent. Efforts to force collections were rebuffed by the courts* which held that it was the "policy of the State to take care of insane persons without expense to them."

In the 1948 session, the General Assembly revised Section 1058, Code of Virginia, to require payment by the patient, or a person legally responsible for the patient, for the cost of care not to exceed the actual per capita cost of maintenance or $40 per month whichever amount was the lesser. The legislation provided further that the rate of reimbursement could be individually set at a lesser amount with "due regard for the financial condition and estate of the patient or inmate, his present and future needs and the present and future needs of his dependents." No person who was otherwise eligible was to be denied care because of his inability to pay.

In that same year, a Claims Investigation Supervisor was engaged and on January 1, 1949, the Reimbursement Bureau (later the Reimbursement Division) was established and enforcement of the new law began.

In the first six months of 1949, $85,500 was collected and in each year since then collections have increased (Appendix 1.). By 1969, reimbursements were $6,723,890, representing 17.4% of the $38,597,426 cost of operation (Appendix 2.). The proportion of reimbursements to operating costs varies greatly from institution to institution depending upon the type of service and the economic status of the patients and their guarantors. For example, Petersburg Training School had a 1969 reimbursement rate of only 3.9% of costs, while Eastern State Hospital had a rate of 24.3% and the Virginia Treatment Center for Children had a rate of 31.2%. The higher-cost institutions and services tend to have higher reimbursement rates because intensive, short-term treatment is more frequently covered by insurance of some kind, while low-cost, long-term chronic or custodial care is rarely so covered.

An analysis of patient accounts in all the mental institutions except DeJarnette State Sanatorium was made in early February 1970 (Appendix 6.). This showed reimbursements from the various sources as follows:

Patients whose reimbursement is provided by themselves, relatives, or fiduciaries	4,514
Proportion of hospital census	30.4%
Average amount paid per day	$2.76
Total amount, annual basis	$4,480,000
Proportion of total reimbursements	50.8%

*Brown's Committee vs Western State Hospital, 110 Va. 321, 66 S.E. 48 (1909); Commonwealth vs Mason, 177 Va. 684, 15 S. E. 2d 114 (1941)

Patients whose Social Security payments are assigned to Mental Hygiene and Hospitals	2,824
Proportion of hospital census	19.3%
Average amount paid per day	$1.77
Total amount, annual basis	$1,803,858
Proportion of total reimbursements	20.5%
Patients paid for by Blue Cross	163
Proportion of hospital census	1.1%
Average amount paid per day	$11.13
Total amount, annual basis	$653,512
Proportion of total reimbursements	7.4%
Patients paid for by CHAMPUS	95
Proportion of hospital census	.6%
Average amount paid per day	$9.52
Total amount, annual basis	$335,383
Proportion of total reimbursements	3.7%
Patients paid for by other insurance	236
Proportion of hospital census	1.6%
Average amount paid per day	$9.33
Total amount, annual basis	$773,001
Proportion of total reimbursements	8.7%
Patients paid for by Medicare (Part A only)	119
Proportion of hospital census	.8%
Average amount paid per day	$7.90
Total amount, annual basis	$338,287
Proportion of total reimbursements	3.8%
Patients paid for by Medicaid	183
Proportion of hospital census	1.2%
Average amount paid per day	$6.92
Total amount, annual basis	$455,629
Proportion of total reimbursements	5.1%

The total number of patients included in the above categories is 8,134. However reimbursements for some patients come from more than one source and if this factor is taken into account, the actual number of patients for whom reimbursement is received is found to be 6,955. We then have the following breakdown:

	Number	*Percent*
Hospital census as of February 1, 1970	14,888	100
Patients for whom reimbursement is received	6,955	46.7
Patients for whom no reimbursement is received (difference)	7,933	53.3

The amounts of the reimbursements shown above are based on the actual situation existing during the period of the account analysis in February 1970. The distribution among the categories varies from day-to-day, of course, but in view of the large population covered, the figures shown are believed to be reasonably accurate. The total of the reimbursements shown amounts to about $8,840,000, which compares closely with the rate of actual collections in recent months.

It will be noted that about 50% of total reimbursements

come directly from patients or from persons responsible for them. Another 20% comes from patients' Social Security payments and about 24% comes from insurance, including Blue Cross and Medicare. The remainder is from Medicaid.

Of the estimated 4,514 individuals—patients or persons responsible for them—who make reimbursements from their private funds, 982 (22%) pay the total charge. These patients are located as follows:

	Individuals Paying Full Amount	*Census (May 1969)*	%
Western State Hospital	305	2,716	11.2
Lynchburg Training School and Hospital	216	3,314	6.5
Eastern State Hospital	273	2,382	11.5
Piedmont State Hospital	3	221	1.4
Petersburg Training School	3	273	1.1
Central State Hospital	118	4,288	2.8
Southwestern State Hospital	64	1,573	4.1
Total	982	14,767	6.6

Clear up-to-date information on sources and amounts of reimbursement is extremely difficult to obtain with the present manual system of keeping patient accounts and records. Obtaining even the above information required considerable effort. A computerized data handling system now in development is expected to facilitate the gathering of more current and useful information by the end of 1970.

b. Virginia Treatment Center for Children

This institution is small (forty-bed), highly specialized, and understandably organized toward professional rather than administrative objectives. It has educational and medical, but not management, ties with the Medical College of Virginia. Since the institution is neither a member of the American Hospital Association nor accredited by the Joint Commission on Accreditation, certain insurance claims on behalf of patients are denied.

In the years prior to 1968, reimbursements averaged about 10% of the costs of maintenance and operation. Apparently as the result of more vigorous pressing of insurance claims, plus an increasingly greater coverage of patients by insurance, reimbursements increased to 21.7% in fiscal 1968 and to 31.2% ($221,413 collections vs $707,398 costs) in 1969. (See Appendix 2.)

Spot-checks during the period from June 1969 to February 1970, showed that of an average of thirty-three inpatients, thirteen were being paid for by relatives or guarantors. The amount paid per day ranged from $1.75 to $7.50 and averaged about $3.27. Fifteen were covered by insurance, and five patients were free.

Although these spot-checks show that individuals make some reimbursement for about half the patients, the amount reimbursed from this source accounts for only 2.8% of the costs, while third-party payments account for approximately ten times that proportion.

The following table shows the sources of reimbursements to the Center:

REIMBURSEMENT PAYMENTS (1969)
VIRGINIA TREATMENT CENTER FOR CHILDREN

Source	*Amount*	*Percent of Costs*
Payment by parents or guarantors		
Outpatients	$ 602	.1
Day-care patients	975	.1
Inpatients	18,669	2.6
Total	$ 20,246	2.8
Insurance of all kinds	201,167	28.4
Total reimbursements	$ 221,413	31.2

2. *State Department of Health*

a. Tuberculosis Sanatoria

In the five years ended June 30, 1968, the total annual reimbursement to Blue Ridge and Catawba Sanatoria increased from $215,000 to $506,000. The first amount equalled 9.7% of the total operating costs and the latter 17.3%. A wide but consistent difference in collection performance existed between the two institutions through fiscal 1967 (Appendix 3.). In fiscal 1968 performance became nearly equal. Although no specific reason for this change could be ascertained, it apparently resulted from the combined effect of Medicare and a change in admission policies which took effect during 1967.

The present accounting systems of these institutions prevent a precise determination of the sources of reimbursements, but a spot-check showed (Appendix 4.) that both institutions provided approximately the same proportion, 78% and 70%, of free beds. In each institution, four patients (approximately 2%) made daily payments ranging from $1.00 to $5.00. All other patients' reimbursements were by Medicare, Blue Cross or other insurance.

b. Division of Alcoholic Studies and Rehabilitation

The Division has centers at the Medical College of Virginia and the University of Virginia Hospital. Twelve beds are provided at MCV and a variable but lesser number at the University. The normal course of treatment consists of about two weeks of resident care and therapy followed by outpatient treatment and counseling at one of the Division's nine clinics located throughout the State.

The Division reimburses the two hospitals at negotiated rates that include all normal hospital services. Specialist services in alcoholism are provided at the hospitals by part-time clinicians employed by the Division. Each of the nine clinics employs a full-time social worker and a full-time secretary as well as one or more part-time clinicians.

In fiscal 1968, 296 new patients were treated. Follow-up

visits of former patients raised the total number of persons treated to 2,073.

Hospitals charged the Division $148,512 for services rendered in 1968. The Division in turn was reimbursed as follows:

	Reimbursements for Hospital Costs	*Proportion of Hospital Costs (%)*
Payments by patients	$ 27,900	18.8
Insurance payments, including Blue Cross	64,170	43.2
Medicare, Social Security and Armed Services	5,110	3.4
Other—Welfare, etc.	1,050	.8
Total	$ 98,230	66.2

Operating costs of the Division, in addition to the above hospital charges, are estimated at $360,000 for fiscal 1968. The reimbursements against these, consisting almost entirely of $3.00 per visit payments by outpatients at clinics, totalled $28,700 in fiscal 1968.

The $360,000 was expended for several important purposes other than the treatment of patients. About $25,000 is granted to each of the two medical colleges for investigative activities concerning alcoholism. Close relationships are maintained with Alcoholics Anonymous, medical associations and other groups. Professional members address meetings and write articles on alcoholism. Medical students and social workers are trained in various ways. Accurately segregating the costs of these activities is difficult, but it seems safe to assume that they account for one-third of the $360,000. Therefore, the remaining two-thirds ($240,000) may be assumed to be expended for the specific and direct benefit of patients. The reimbursement by patients at the clinics ($28,700) is thus about 12% of the operating costs ($240,000) incurred for their benefit.

Combining the above figures gives the following:

	Patient Costs	*Reimbursements*	*Percent*
Hospitals	$148,512	$ 98,230	66
Clinics	240,000	28,700	12
Total	$388,512	$126,930	33

3. Summary of Present Reimbursement Performance

The tables on the following page summarize the present reimbursement performance of the institutions reviewed.

B. REIMBURSEMENT PERFORMANCE—FUTURE

Personal and employer insurance, Blue Cross, CHAMPUS, Medicare and Medicaid should all tend to increase reimbursements during the next few years. Personal reimbursements are not likely to increase significantly and in fact may decrease considerably if certain classes of payors, such as the parents of mentally retarded patients, are successful in obtaining limitations upon their liability for payment. (Turn to p. 7)

REIMBURSEMENTS COMPARED TO OPERATING COSTS

Institution	*Total Maintenance and Operating Costs*	*Reimbursements*	*Percent*
Mental Hospitals (1)	$38,597,426	$6,723,889	17.4
Tuberculosis Sanatoria (2)	2,920,336	506,253	17.3
Alcoholic Studies and Rehabilitation (3)	388,512	126,930	33.0
Total	$41,906,274	$7,357,072	17.6

SOURCES OF REIMBURSEMENT

Institution	*Blue Cross Medicare and Other Insurance*		*Medicaid Social Security and R. R. Retirement*		*Patient or Guarantors*		*Total Payors*		*Total Patients Covered (1)*		*Charity Patients*		*Total Patients*
	No.	% of Census	No.	% of Census	No.	% of Census	No.	% of Census	No.	% of Census	No.	% of Census	No.
Mental Hospitals (4)	613	4.1	3007	20.2	4514	30.4	8134	54.6	6955	46.7	7933	53.3	14,888
Tuberculosis Sanatoria (5)	103	23.3	.....		8	1.8	.....		111	25.1	331	74.9	442
Alcoholic Studies and Rehabilitation (6)													2,073

(1) Fiscal year ended June 30, 1969. All mental institutions except DeJarnette State Sanatorium. See Appendix 2 for individual institutions.
(2) Fiscal year ended June 30, 1968. Blue Ridge and Catawba Sanatoria. See Appendix 3 for details.
(3) From text above.
(4) Appendix 6.
(5) Appendix 4.
(6) No source data were conveniently available except total patients; however, the relatively high proportion of reimbursements suggests strongly that a high proportion of patients provided some type of reimbursement.

Because the various third-party sources will provide a much greater volume of reimbursements, agency managements should take steps to maximize such payments. However, since many third-party payments are available only to the extent that the protected individual would otherwise be personally liable, careful consideration should be given to the method and the effect of limiting such personal liability.

C. REIMBURSEMENT POLICY

1. *Mental Hygiene and Hospitals*

Reimbursement policy is stated in Article 8, Chapter 2 of Title 37.1, Code of Virginia. This Article is ambiguous and the Department has found it necessary to obtain clarification through a number of rulings by the Attorney General. For example, the persons legally liable for payment are not spelled out but have been interpreted to mean those legally liable for support as defined in Title 20 of the Code of Virginia, which deals with desertion and support of relatives in necessitous circumstances.

In brief, the reimbursement policy stated in the Article is that patients, or persons legally liable for them, must reimburse the State for the per capita cost of maintenance and treatment, provided that such reimbursement does not impose an undue financial hardship. The Article further stipulates that in determining "hardship" the present and future needs of patients, or persons legally liable for them, as well as such needs of their lawful dependents, shall be taken into consideration. The Article offers nothing more definitive than the descriptive words given above. Since the Department has no written statement of criteria, the amount of reimbursement is left largely to the judgment of the Department's representatives.

2. *State Department of Health*

a. Tuberculosis Sanatoria

The statutory authority concerning reimbursement for care and treatment at TB sanatoria is stated in Section 32-312.1, Code of Virginia. This provides for the Department of Health to determine, after admittance, what the patient or person legally liable for the patient is "—able to pay in whole or in part—and shall consider whether such patient or other person can make such payment and meet his other financial responsibilities for the support of himself and his family—".

As in the case of Mental Hygiene and Hospitals, the determination of what constitutes ability to pay hinges on a personal judgment as to what is meant by such terms as "support", "family", or "able to pay". The determinations are made by a local health officer or social worker in the patient's home community. Each case is subject to review at the sanatoria. Few means are available to assure consistent implementation of the loosely worded statute.

Reimbursement policy for individuals and guarantors is rather academic because, at the time of this study, only eight patients or their guarantors in the two sanatoria paid anything personally. Substantial sums were, of course, collected from insurers.

b. Division of Alcoholic Studies and Rehabilitation

Sections 32-375 and 32-376, Code of Virginia, set forth the policy concerning reimbursement by and for, persons treated by the Division. These sections state simply that the State Board of Health shall set rates *based* on actual or estimated costs and that patients shall pay "insofar as they are able to do so—". As with the institutions discussed earlier, the statutes offer no guidance as to how the rates shall relate to current costs or how severely reimbursements may be allowed to impair the payor's financial condition.

3. Statewide Reimbursement Policy

As noted in the preceding sections the elements of State policy regarding reimbursement are not clearly set forth but must be ascertained from many statutory provisions, some of which are not clear, some conflicting, and some poorly implemented. Many important policy determinations are left to agencies, appointed boards, and individual employees.

The present State services with which we are primarily concerned were originally authorized where:

(1) The interest of public health required patient isolation and treatment that was unavailable or inadequate at the local level, public or private. Example: Tuberculosis sanatoria.
(2) Private treatment of large numbers of afflicted individuals was too expensive and/or inadequate to encourage rehabilitation, and lack of treatment would cause severe social loss. Example: Division of Alcoholic Studies and Rehabilitation.
(3) Private treatment was so expensive and limited as to be beyond the reach of those people—relatively few in number—who were faced with an overwhelming need. Example: Virginia Treatment Center for Children.
(4) Private treatment was virtually nonexistent, and the large number of patients could not be humanely cared for elsewhere. Example: The mental hospitals.

Over the years the picture has changed substantially, particularly in respect to the services of the mental hospitals and the TB sanatoria. New and more effective treatments have reduced the devastating nature of many illnesses; increased the number cured; and, incidentally, greatly increased the unit cost (i.e., the cost per patient day).

Concurrently, medical advances, combined with the improved economic status of a large part of the general population, have made local public and private treatment more effective, more available, and frequently more desirable than the State services. Also concurrently, other State and local services have been made available for afflicted persons, particularly those with physical handicaps: the blind, deaf, mute, crippled, and similarly disabled. These latter services have tended to be free or nearly free, either by statute or by administrative option.

Greater understanding and better treatment of the whole spectrum of afflictions have tended to eliminate some of the clean-cut distinctions that prevailed when many State institutions were first established. Today, for example, an alcoholic may be considered as—

(1) A person with a serious problem that can be treated by the Division of Alcoholic Studies and Rehabilitation.
(2) A person with an incapacitating problem who should be admitted to a hospital of the Department of Mental Hygiene and Hospitals.
(3) A person subject to vocational rehabilitation by the Department of Vocational Rehabilitation.

Similar blurred distinctions in respect to definition, treatment and administrative responsibility are found among patients having other afflictions. In many instances, local public and private institutions now provide services parallel or supplementary to those of State institutions.

Federal funding has introduced a new and important factor. The definition, type of treatment, and administrative responsibility for treatment may be of crucial importance in deciding to what extent costs are subject to Federal reimbursement. As an example, there has been great confusion and vacillation for over a year concerning which categories of mental patients are covered by Medicaid. Beyond this, development of improved treatments for mental and tubercular patients has tended to obscure the reasons for distinguishing between these and other categories of afflicted people in respect to free service from State-supported institutions.

D. REIMBURSEMENT ADMINISTRATION

1. *Mental Hygiene and Hospitals*

a. Reimbursement Division

Reimbursement activities are located in the Department's Reimbursement Division. The organization consists of a Director, two Assistant Directors, eleven Reimbursement Investigators and twenty-one clerical employees. One or more investigators and clerks are located at each institution where they work with the staff, although reporting administratively to the Reimbursement Division.

b. Activities of Reimbursement Investigators

The reimbursement investigator is the key to equitable and effective administration of the Mental Health reimbursement laws. The great complexity of many cases, the extensive variety of situations, and the many agencies involved, all result in an operation difficult to systematize. The records of the Division, comprising statements by the patients and persons responsible for the patient, court orders and similar documents, frequently furnish only the beginning of the information necessary to make a determination of an amount which can be paid "without undue financial hardship."

In determining such an amount the conscientious investigator should consider among others, the following

—total income of the payor
—income of dependents of the payor
—total assets
—number and age of dependents
—payor's present age and anticipated remaining productive years
—provision for payor's retirement income

—current obligations
—anticipated obligations
—condition of health and provision for illness

The investigator must also consider the extent to which following actions should be taken:

—reducing or disposing of assets
—curtailing dependents' education or the provision for future education
—reducing provisions for retirement or sickness
—eliminating payments on expensive club dues, boats, second cars, etc.
—stretching out debt payments
—reducing payments to savings plans, stock purchase plans, etc.

The investigator must consider the long-range financial plans and requirements of payors. One payor may be discharging such heavy obligations that he has little disposable income, while another in the same income bracket may be living more humbly and saving a large part of his income. The investigator must use care not to penalize the more frugal payor. The first payor, though he may have a much higher net worth, may have no no liquid assets, nor divertible income. Again, one payor may have an ambitious education plan for his children, while a similarly situated payor has not thought that far ahead.

The investigator must question and often verify the validity of statements of payors concerning obligations and perhaps of undisclosed income and assets. Sensing the existence of such situations the investigator may negotiate by intuition as much as by analysis. He may suggest a figure higher than the bare facts justify in the hope of obtaining more information or negotiating downward to an "equitable" amount.

2. *State Department of Health*

a. Tuberculosis Sanatoria

(1) Organization

The Sanatoria Superintendents report to the State Board of Health, "when in session"; at all other times to the Commissioner. The sanatoria are relatively independent of the central staff functions of the Department. This has caused difficulties and confusion of responsibilities in reimbursement administration. For example, Medicare was in effect for some time before Blue Ridge Sanatorium was notified.

The reports of the two sanatoria differ in format, so that statistical, cost and revenue comparisons are sometimes difficult or misleading. Neither institution reports reimbursement revenues by source; i.e., Blue Cross, Medicare, personal insurance, etc.

Policies and practices regarding criteria for determining reimbursement payments are not coordinated between the two sanatoria or in the patient's community.

(2) Reimbursement Procedure

The administration of reimbursement is conducted separately by each sanatorium, without specific instructions

from the Department regarding methods or standards for determining reimbursement.

The basic determination is made at the local level when a Department of Health nurse or social worker prepares a departmental form relating to the prospective patient's ability to pay and discuss it with him. The form is reviewed several times and finally by the Superintendent of the sanatorium. Upon the latter's approval, the patient or a responsible person signs a part of the form which then constitutes an "agreement to pay."

Although this procedure appears to have ample built-in reviews, there is apparently little critical analysis of a patient's ability to pay beyond the local interview, at which time the emphasis is primarily focused on getting the patient removed from his family or other contacts as quickly as possible. At the sanatorium the patient's well-being is emphasized and freedom from worry over financial problems is considered essential.

b. Division of Alcoholic Studies and Rehabilitation

This organization's reimbursement collection problems are somewhat similar to those of the sanatoria. Hospital charges are covered to a large extent by Blue Cross or other insurance and the patients follow much the same admission pattern as regular hospital patients. Clinic outpatients are charged $3.00 per visit, usually paid in cash at the time of the visit.

If a patient does not have hospitalization insurance, the physician, social worker or secretary of the local clinic analyzes his ability to pay, prepares a financial statement and consummates a written agreement.

Unlike the sanatoria, the Division employs a Hospital Accounts Collector. The proportion of reimbursements to operating costs—about 33%—is much higher than at the sanatoria. Although this reimbursement performance is relatively good, care is said to be exercised not to press patients or former patients unduly.

E. RECOMMENDATIONS

I. BASE HOSPITAL CHARGES ON THE ACTUAL COSTS OF THE TYPE OF SERVICE PROVIDED

Comment

This recommendation applies to institutions which have more than one specific, clearly defined type of service, such as intensive therapy, custodial care or medical. At present, all patients in the hospitals studied are charged the same rate based on the per capita cost, regardless of the cost of the particular type of service they receive.

Amplifying and Supporting Statements

1. Adoption of this recommendation would increase reimbursement revenues by nearly $475,000 annually at the four major mental hospitals. The increased revenues would be generated from patients' insurance, most of which applies for a relatively short period after admission. During this early period a patient usually receives much more costly

evaluation and treatment than if he were under long term care. See Appendix 7 for estimation of the increased revenue.

2. Adoption of this recommendation *would not result in any individual being required to increase payments to an extent that would cause undue financial hardship.* Only individuals now paying the full charge—982 out of the 4,514 patients who pay from private funds—would be affected. The charges for about half the 982 payors would be decreased and about half would be increased.

   A widespread misunderstanding should be cleared up here. Payment amounts are determined solely by ability to pay without undue financial hardship—not on the amount of the full charge.

3. The argument has been advanced in opposition to this recommendation that no patient, or person legally liable for him, regardless of his ability to pay, should be required to pay more than the per capita rate of a State mental hospital. The basis of this argument is that a tax-supported institution should maintain low rates in relation to private institutions so that any taxpayer using its services would benefit financially, regardless of his ability to pay. However, tax funds are expended *only* to provide services for those individuals who do not have the financial ability to pay. If the services were made free for everyone regardless of ability to pay, a substantial addition to the tax load would result. Furthermore the present system of charging the per capita rate to all patients results in inequities. Patients who pay the per capita rate for custodial or chronic services are partially subsidizing the patients who receive more expensive kinds of service.
4. There are well-established precedents for basing charges on the cost of the different types of services. The practice is followed in nearly all general hospitals, many of which are partially tax-supported. Other states which have recently adopted the practice for mental institutions have obtained substantial economic benefits.
5. The accounting and other administrative procedures necessary to implement this recommendation are already in effect. In fact, Medicare and Medicaid are now making reimbursements on this basis. Implementation could therefore be accomplished at little, if any, additional cost.

II. MAXIMIZE THE LONG-RANGE ECONOMIC AND SERVICE BENEFITS OF COST-BASED CHARGES FOR EACH TYPE OF SERVICE

Amplifying and Supporting Statements

1. As was pointed out in the first recommendation, a policy of separate charges for each type of service would substantially increase insurance reimbursements during the early intensive—and expensive—period of a patient's treatment. Beyond the immediate increase in revenues, the same combination of factors would also reduce the net *added* cost if the treatment during this early period were improved. Appendix 8, An Analysis of the Long-Range Cost Effects of Charging for the Actual Cost of Services Provided shows

that, using current costs, the net added cost of improving early treatment under the recommended charging policy would be reduced 25%.

2. The same analysis shows that if account is taken of the probable reduction in the long term patient population resulting from improved early treatment, the *net added cost of such improvement would be more than wiped out over a 10-year period.*
3. The importance of establishing a policy of separate charges for the different types of service will rapidly become greater. There is a strong and accelerating trend toward greater hospital insurance coverage both in terms of the number of admissions covered and the extent of the individual benefits.
4. By improving the quality—and thus increasing the cost—of early intensive treatment at the four major mental hospitals, those individuals who have insurance intended to provide such improved treatment may utilize it.

   At present only persons who live near the Northern Virginia Mental Health Institute have this opportunity from a State-supported institution. A person in the southwestern part of the State, for example, may have insurance which would provide for treatment costing $60 per day, but the only service available to him is the low cost type provided at Southwestern State Hospital.

III. ELIMINATE THE LIMITS ON PER CAPITA CHARGES AT THE VIRGINIA TREATMENT CENTER FOR CHILDREN

Comment

The Center is limited to a maximum charge of $30 per day for inpatients by Section 37.1-105, Code of Vir-Virginia. At present the actual per capita costs exceed $65 per patient day. The Center is the only State institution thus limited.

Amplifying and Supporting Statements

1. Adoption of this recommendation would increase reimbursement by an estimated $150,000 annually from Blue Cross, CHAMPUS and commercial insurance companies.
2. Adoption of this recommendation *would not result in any individual being required to increase payment to an extent that would cause undue financial hardship.* In fact, only twice in five years have individuals been required to pay the $30 per diem statutory maximum charge. At present the average payment by relatives is about $3 per day and many patients are treated without charge. (See Section A.1.b. of this report.) Adoption of this recommendation would not change this situation.
3. A principal reason for placing the limits in the statute was a concern that higher rates based on actual costs would arouse public criticism which might indirectly result in curtailed appropriations for the necessarily expensive treatment. It is believed however that if the pertinent facts were known, the case for high quality psychiatric treatment for children would be fostered rather than discouraged by charging for the actual costs.

   Maintenance and operation of the Center cost about $707,-

000 in 1969. With a total of 223 patients treated, the average cost per patient was thus approximately $3,200. Reimbursements of about $221,000, of which $201,000 (91%) was from insurance, reduced the cost to the State to $2,200 per patient. By charging the full cost, as recommended, the cost to the State would be reduced through insurance payments by another 32% to $1,500 per patient.

These relationships demonstrate convincingly that it is in the State's best interest to charge the actual cost as recommended. A budget request for an additional Child Treatment Center that was previously denied might have been approved had the facts been presented in this manner. Deducting the present insurance revenues makes the net cost to the General Fund only 68% of the actual cost. Deducting the estimated insurance revenues available under a full charge policy would further reduce the net cost to the General Fund to only 48% of the actual cost.

If a duplicate center were established having the same operating costs and output, and at the same time the limitation on charges was removed, the following would apply.

	Present Center	*Duplicate Center*	*Total*
Present Cost of Operations (1969)	$707,000	$707,000	$1,414,000
Present Reimbursements	221,000	221,000	442,000
Present Net General Fund Cost	$486,000	$486,000	$ 972,000
Estimated Additional Revenue	150,000	150,000	300,000
Projected Net General Fund Cost	$336,000	$336,000	$ 672,000

Thus, if the present limitation were removed, the two centers could operate for a net General Fund cost of $672,000 as compared to the present (1969) net General Fund cost of $486,000. This would be a net General Fund increase of $186,000 ($672,000 minus $486,000). Stated another way, an increase of 39% in net General Fund cost could provide a 100% increase in the number of patients treated.

4. Another argument for the statutory limitation is that the Center has dual functions: 1) treatment of patients, and 2) teaching and training professionals in the various disciplines associated with the treatment. It is argued that a large part of the high cost is the result of the teaching and training functions.

   Inasmuch as the present accounting system does not segregate such costs accurately an analysis of the Center's payroll was made (see Appendix 10.). This shows that only an estimated 6.32% of total General Fund maintenance and operation expenditures are for teaching and training functions. This low cost to the General Fund results from most of these activities being financed by Federal or by Medical College of Virginia funds.

   Such a proportion of expenses for continuing staff training and development is well within the range for most modern hospitals. It is normally included as an element of cost that is charged to the patient.

5. The precedent of the limitation on charges at the Center, if

not eliminated, might be extended to other hospitals. Should the limit be $30 per day at the Center when individuals are currently paying $40 per day at Northern Virginia?

6. A revision to Article 8, Chapter 2, Title 37.1 included in Recommendation XV would implement this recommendation.

IV. CHARGE FOR ALL MAJOR SERVICES—VIRGINIA TREATMENT CENTER FOR CHILDREN

Comment

Section 37.1-61 of the Code of Virginia limits admissions to children under sixteen years of age. This has been interpreted to mean that parents and other relatives may not be charged for counseling, testing and other services.

Amplifying and Supporting Statements

1. The counseling and outpatient therapy of parents and other relatives is a necessary adjunct to the treatment of patients and is engaged in extensively.
2. Substantial reimbursements for these, largely from insurance, are available but not charged because of the interpretation noted above.
3. Lumping such costs with regular inpatient costs tends to inflate the patient per capita costs.
4. Implementation of this recommendation would result in an estimated increase in reimbursements of $10,000 annually.
5. Implementation of this recommendation would make the charging practices at the Center consistent with those of the other mental institutions. The same protection would be extended against requiring payments that would result in financial hardship to individuals.
6. A suggested Bill to amend Section 37.1-61 to allow implementation of this recommendation appears as Appendix 11.

V. SECURE ACCREDITATION OF THE VIRGINIA TREATMENT CENTER FOR CHILDREN—MENTAL HYGIENE AND HOSPITALS

Amplifying and Supporting Statements

1. The Center should pursue its efforts to become a member of the American Hospital Association and to be accredited by the Joint Commission on Accreditation.

   Note: Lack of accreditation results from technicalities and implies no reflection on the quality of service or the caliber of the staff.

2. Lack of membership and accreditation lessens and impairs reimbursements by insurance companies and Blue Cross.
3. The revenue foregone is difficult to estimate, but would probably amount to $20,000 annually.

VI. BASE CHARGES ON RECENT COSTS—MENTAL HYGIENE AND HOSPITALS

Comment

At present Section 37.1-105 of the Code of Virginia places responsibility for setting charges on the State

Hospital Board without stipulation except that the charges shall not exceed costs.

Amplifying and Supporting Statements

1. This study revealed that although rates had not been revised by the Hospital Board since February 1, 1967, it had decided at its January 1969 meeting (as it had in January 1968) not to increase them to meet the rapidly rising costs. The rates were again considered by the Board at its April 1969 meeting and were increased effective July 1, 1969, to match the average cost for the period July 1, 1968 to February 28, 1969 (Appendix 5.). The increased annual revenues that resulted from this action is estimated at $800,000 and the delay in increasing the rates caused a comparable loss of revenue in the earlier period.
2. The Board's delay is understandable, inasmuch as rate increases have sometimes resulted in complaints. It is believed, however, to be neither appropriate nor necessary to make the Board responsible for setting rates without furnishing more specific limits and a more specific indication of legislative intent.
3. A proposal to revise Section 37.1-105 to require the Department (rather than the State Hospital Board) to review costs at least annually, and to adjust charges accordingly, is included in Recommendation XV.

VII. ESTABLISH SYSTEMATIC METHODS FOR HANDLING REIMBURSEMENT COMPLAINTS—MENTAL HYGIENE AND HOSPITALS

Amplifying and Supporting Statements

1. An easily established system could reduce all complaints to writing and permit them to be classified according to type, source, repeats, and follow-up action.
2. Analysis of complaints would be valuable in improving communications, revising procedures, evaluating performance, and modifying policies.
3. Announcement and explanation of revised charges should be made well in advance because this apparently reduces protests and complaints. An announcement, including an explanation, of the most recent increases which were effective July 1, 1969 was made on May 22, 1969. Although the increases were the largest ever made, the complaints were minimal compared to those resulting from revisions in earlier years. The favorable response is believed to be the result of payors being given ample time to accommodate to the new rates as well as their being satisfied with the carefully prepared explanation.
4. A sixty-day period should be provided for making changes in the programming of the computerized billing procedures, obtain new reimbursement agreements from payors, and properly accomplish other administrative details.

VIII. PROVIDE DEFINITE REIMBURSEMENT CRITERIA—MENTAL HYGIENE AND HOSPITALS

Amplifying and Supporting Statements

1. The Department of Mental Hygiene and Hospitals has in-

formal unwritten criteria as to what is acceptable to them for a payor's allowable expenses and obligations in various circumstances. These are not revealed to a payor unless the latter makes claims which seem unacceptable.

2. The Reimbursement Investigator makes a personal judgment as to the payor's financial needs for retirement, children's education, maintaining a standard of living, and similar factors. He then makes a second judgment as to the amount the payor can afford to reimburse the State. If the payor disagrees with this, an amount is negotiated. If agreement cannot be reached, or if the payor later defaults on his payment, he may be brought to court for adjudication of his obligation. The courts are said to almost always arrive at a charge equal to that claimed by the Department. The Department employs experienced legal counsel to represent them in court, while individual payors may find it too expensive to be represented by counsel.
3. The import of Investigators' judgments can be awesome. For example, some young parents with a permanently institutionalized child can look forward to paying the State more than $2,000 annually for the rest of their lives. Should they be allowed enough savings to put other children through college? Should they be allowed an annual vacation? If the wife works, should her earnings be treated as full income?

   Not having formal criteria covering these situations avoids the unpleasant and difficult task of dealing incisively with such questions—and there are a great many similar ones —but the lack of criteria permits wide variations in the determination of payments.
4. No other states were found to have formal detailed criteria covering the factors mentioned above. Respondents in a survey indicated the complex variations of circumstances were considered too formidable to permit reducing them to specific quantitative schedules.
5. A few states have set up schedules of specific amounts based on income and number of dependents. However, all of these simply establish maximum payments that may be reduced at the discretion of the agency.
6. Although specific quantitative schedules are believed impractical, the Department should at least state the factors which are used in its determination of an equitable payment. The payor should be informed of these on the same form employed to record his financial status. In this way he will be reminded that he may claim allowances for such expenses as providing for retirement, the education of his children, the treatment of other illness in the family and similar factors bearing on his financial ability.
7. In the event a payor is brought to court for adjudication of his obligation, the stated factors should be considered by the court.
8. The factors are likely to be modified from time to time in light of the Department's experience. Therefore they are not recommended to be spelled out in the statutes. However, the statutes should require the Department to develop and employ such factors and to modify them from time to time as experience dictates.
9. The statutory revision to accomplish the above is covered in Recommendation XV.

IX. STIPULATE CLEARLY WHO IS LEGALLY LIABLE FOR REIMBURSEMENT—MENTAL HYGIENE AND HOSPITALS

Amplifying and Supporting Statements

1. The present statute stipulating the persons responsible for making reimbursement for the care and treatment of patients (Section 37.1-105, Code of Virginia) refers simply to "—the person legally liable for the support of any such person—." This has consistently been interpreted to mean the persons stated in Sections 20-61 and 20-88 of the Code of Virginia, which deal with desertion of wives by husbands, children by fathers and parents by children in necessitous circumstances.
2. The two sections leave room for interpretation in their application to reimbursement responsibility. Furthermore, with liability determined in statutes dealing with misdemeanors of this type, the possibility is introduced that a responsibility may be implied that is greater than warranted and that court judgments could be more severe than justified by the circumstances.
3. Recommendation XV providing for a revision of Article 8, Chapter 2 of Title 37.1 of the Code of Virginia makes the Article self-contained and independent of Sections 20-61 and 20-88. The revision would raise the age of liable children from 17 years to 20 years, provide that the mother as well as the father shall be responsible for a child and that either spouse be responsible for the other whereas at present only the husband is responsible.
4. Inasmuch as wives and mothers are fully protected against being required to make reimbursements which would cause undue hardship, it appears reasonable to make them responsible on the same basis as husbands and fathers. By doing this, the practice of a husband assigning his assets and income to his wife as a means of avoiding payment would be discouraged.
5. This revision should enhance the equity and uniformity of court judgments where the courts make a determination of the charges.

X. SIMPLIFY PATIENT BILLING AND CONTRACTING PROCEDURES—MENTAL HYGIENE AND HOSPITALS

Amplifying and Supporting Statements

1. The statutes should be revised so that the Department may discontinue the procedure it now follows of obtaining a signed agreement prior to billing the responsible party. In some instances under this system payors have agreed to payments for which they are not liable or which have been excessive in view of their financial circumstances.

   Instead of this procedure the Department should simply bill the responsible party in the same manner as many general hospitals. Attached to or printed on the bill rendered to the responsible person should be a statement informing the person that if he believes payment of the charges will impose an undue financial hardship, he may complete a financial statement which will be furnished to him and from which the Department will determine the amount he is required to pay. On this statement form would be printed the factors or cri-

teria which the Department considers in determining the amount the person can pay without undue financial hardship.
2. Inclusion of the factors or criteria on the statement form will ensure the person liable for the patients' expenses being aware of the guidelines which are used in evaluating his financial needs, present and future.
3. Billing in this manner would make it unnecessary for fiduciaries to obtain court approval of contracts. This would eliminate the necessity of the Department having a representative at such court appearances.
4. A further improvement in equity would be achieved by having the responsible relatives spelled out in the statute, a copy of which is furnished to all payors. At present, there can be contracts with nonliable relatives—a condition that results in confusion and unnecessary correspondence.
5. The statutory modifications to implement this proposal are included in Recommendation XV.

XI. DETERMINE COSTS AND ESTABLISH CHARGES FOR DIFFERENT TYPES OF SERVICE—TB SANATORIA

Amplifying and Supporting Statements

1. At the present time the same per capita cost is charged all patients. A surgical patient's care would probably cost $50 per day as compared with the average per capita cost of $20. Many patients require intensive nursing, bed feeding, and similar services that probably cost $40 per day. On the other hand, many ambulatory patients are simply waiting for negative tests, and their actual cost is much less than the per capita cost.
2. A spot-check of reimbursement categories of patients in April 1969 (Appendix 4.) showed that of the 442 patients then in residence, 174 had been covered by hospital insurance upon their admittance but a much less number were currently covered. This indicates that most of the insurance revenues are received for patients in the earlier part of their hospital stay.
3. Inasmuch as the more intensive care is usually required soon after admittance and during the early treatment stages, Blue Cross, Medicare and insurance contracts could be expected to cover a greater proportion of these more expensive treatment periods. Hence charging in relation to the cost of the service rendered would increase reimbursement revenues.
4. The increased insurance revenues that would result from this recommendation are estimated to exceed $100,000.
5. Implementation of this recommendation requires the establishment of a simple cost accounting system at the sanatoria. This would be inexpensive to accomplish and would provide other advantages for managerial control.

XII. CENTRALIZE THE REIMBURSEMENT RESPONSIBILITIES OF THE DEPARTMENT OF HEALTH

Amplifying and Supporting Statements

1. The Division of Alcoholic Studies and Rehabilitation employs a Hospital Accounts Collector and reimbursement performance is very good. The TB sanatoria do not employ a similar person and reimbursement performance is poor in comparison.

2. To provide uniform supervision, consideration should be given to having the Hospital Accounts Collector report to the Director of Special Health Services. The latter, being responsible for both Alcoholic Studies and Rehabilitation and Tuberculosis Control, would be in a good position to coordinate reimbursement as a distinct function. The present Hospital Accounts Collector could make a trial run at the sanatoria to determine the amount of improvement such a specialist could expect to accomplish on a permanent basis.
3. A central reimbursement function in the Department of Health would be in a position to:

   —work closely with the Social Service Division of the Department of Health to expedite discharge of cured patients and provide for after care.
   —arrange for compatible and uniform operating reports from the sanatoria.
   —remain in close touch with the State medical program and take steps to assure maximum reimbursement.
   —devote full attention to reimbursement problems.

4. Although increases in reimbursement revenues from insurance would be expected from this recommendation, no prediction of amount is made because of scanty information. Determination of the potential improvement would require further study within the Department of Health. However, reimbursement results respond to vigorous pressing of insurance claims and whether this can be done by present staff members who have many other responsibilities is doubtful.

XIII. ARRANGE FOR OPERATING REPORTS, BUDGET REQUESTS AND SIMILAR MANAGEMENT CONTROLS OF INSTITUTIONS TO SHOW NET COST TO THE GENERAL FUND

Amplifying and Supporting Statements

1. If management controls were based on programs set out in terms of long-range total net costs (i. e., costs less revenues) and benefits, clearer analyses and more understanding evaluations would be probable. This would encourage more effective management of the limited resources available to the institutions. For example, budget reviewers would attach greater importance to the desirability of more intensive early treatment because the total economic benefits would be more evident.
2. More information should be available on patient flow so that the effects of various programs could be more easily determined.
3. It is believed the Department of Mental Hygiene and Hospitals should initiate implementation of this recommendation. When the problems and advantages have been explored, other institutions could follow, benefiting from the experience.

XIV. IMPROVE INFORMATION SYSTEMS INVOLVED IN REIMBURSEMENT—ALL AGENCIES

Comment

Agency management has tended to devote little attention to information systems involving reimbursement

administration. However, with the much more extensive use of health insurance, together with reimbursement through Federal programs, the volume of reimbursement revenues has grown to become an important financial responsibility of agency management and merits systematic attention.

Amplifying and Supporting Statements

1. None of the agencies record or report reimbursements by source: patients, relatives, insurance, Medicare, and so on. As a result it is impossible to accurately measure collection performance or to project future revenues from various sources and under different policies.
2. There are no statistics on the number of paying patients in the various categories.
3. There are almost no written procedures on how the various reimbursement situations are to be handled. Although the Department of Mental Hygiene and Hospitals now has a procedure manual under development, more attention should be given to new systems and controls.

XV. AMEND ARTICLE 8 OF CHAPTER 2 OF TITLE 37.1 OF THE CODE OF VIRGINIA

Amplifying and Supporting Statements

1. Changes in Article 8 are necessary to implement several of the preceding recommendations. Since the changes involve rewording of several of its sections, the Article is recommended to be repealed and a new Article reenacted in its place. The latter, in the form of Senate Bill No. 456, appears as Appendix 12 of this report.
2. The major changes in the Article are as follows:
   a) Section 37.1-119.1 (Corresponds to present Section 37.1-105)
      1) Line 29, page 1—The proposed wording states "—per capita cost of maintenance for the particular type of service rendered—". Present wording of Section 37.1-105 refers only to "per capita cost of maintenance". This revision enables the implementation of Recommendation I.
      2) Lines 30 and 31, page 1—The proposed wording states "—and shall be determined no less frequently than annually by the Department of Mental Hygiene and Hospitals—". Present wording states only that the rates shall be fixed by the Board. This revision enables the implementation of Recommendation VI.
      3) The proposed section omits the present limits on the charges of the Virginia Treatment Center for Children. This revision enables the implementation of Recommendation III.
   b) Section 37.1-119.4 (Corresponds to present Sections 37.1-108 and 37.1-109)
      1) The wording of the present sections requires the Department to "assess or contract" with the person or persons it finds legally responsible for and financially

able to pay for the expenses of each patient. This wording has been interpreted to mean that the Department much enter into contracts with all payors. The proposed wording states simply that the Department shall charge the legally liable person the actual per capita costs of the type of service rendered. If the person then claims inability to pay he will furnish the necessary financial information to enable the Department to determine the amount to be paid. This wording eliminates the need for contracts except in very unusual situations and provides other advantages as discussed in Recommendation X.

2) Lines 11 and 12, page 3—The proposed wording requires that when a contract is made with a nonliable person, the contract "shall stipulate that the person would not be liable except for the contract".

This requirement has been added to assure that all payors are either liable or knowingly assume the liability.

c) Section 37.1-119.5 (Corresponds to present Section 37.1-110)

1) Line 26 et seq., page 3—This paragraph sets out the persons liable for the expenses of a patient. The present Article does not stipulate who is legally liable although it has been construed that Sections 20-61 and 20-88 are applicable. This revision would implement Recommendation IX.

d) Section 37.1-119.13 This is a new section and would permit the Department to place a lien for unpaid expenses of care upon the estate of a patient or former patient at his death. This would preclude the frequent instances under the present statutes where estates go to nonliable relatives or other persons who had little concern for the patient.

e) Section 37.1-119.15 (Corresponds to present Section 37.1-118)

1) Lines 5, 6, 7 and 8, page 6—This paragraph would require the Department to inform the payor as to the specific factors considered by the Department in determining the amount to be paid. This provision would implement Recommendation VIII.

XVI. CONSIDER ORGANIZATION CHANGES TO IMPROVE REIMBURSEMENT COORDINATION AMONG AGENCIES

Comment

Analysis of reimbursement policies and procedures led this study into the realm of management coordination among several agencies. Recognizing that the problems of reimbursement do not constitute a sufficient insight into the total management picture to recommend a specific interagency reorganization, it nevertheless appears worthwhile to set out certain observations and conclusions.

Amplifying and Supporting Statements

1. Although agencies attempt to coordinate with one another, particularly in respect to Federal programs, the present autonomous nature of their organizations, coupled with the absence of a central coordinating function severely limits effective cooperation in the same or closely related programs. The following example illustrates the lack of coordination:

   —Vocational Rehabilitation has an arrangement with Eastern State Hospital whereby the former has taken over one building in which patients capable of being rehabilitated are treated and trained to take up useful occupations upon their discharge. This arrangement has permitted Vocational Rehabilitation to include the total cost for these patients in programs where Federal funds contribute 80% of the cost, provided the patients do not reimbuse the Department of Mental Hygiene and Hospitals. About half the patients (i.e., about 250) *do* reimburse the Department. In these cases the State pays the difference between the amount reimbursed and the actual cost in the usual way.

   —No figures are easily obtainable, but if one assumes the same proportion of reimbursement exists in this group as in the hospital as a whole, the proportion of reimbursement to cost is about 20%. Therefore, assuming a cost of $8 per patient day, the following holds:

   Present annual cost to State:
   250 patients × $8 per pay × 365 days/year × 80%
   = $584,000
   Annual cost if these patients *did not* reimburse:
   250 patients × $8 per day × 365 days/year × 20%
   = $146,000
   Annual revenue foregone as a result of these patients reimbursing the State:
   $584,000 — $146,000 = $438,000

   —Similar opportunities for increasing revenues in the Medicaid program, in the vocational rehabilitation of alcoholics, and in the training of educable retarded children have been foregone. These opportunities were passed by not as a deliberate policy but because responsibility was not definite and the combination of factors was seldom viewed in one piece.

2. The availability of important Federal funding has been known for a long time. Apparently the reason no group has worked out the actual details to qualify for the funding is that no one organization or position is responsible for overall coordination. For example:

   (1) The Division of the Budget is not responsible for recommending realignments of organization and policies. Furthermore, the Division is not expected to make judgments concerning professional services.
   (2) The Mental Retardation Council has made plans, but has not been authorized to come to grips with the managerial and administrative aspects of coordination.

(3) All groups, including the agencies involved, appear to have reservations in taking the initiative toward resolving interrelated administrative problems.

3. Key individuals at the administrative level believe reorganization toward a consolidated agency would provide for greater effectiveness and economy.
4. The review included in this study revealed no fundamental impediments to the realignments of responsibilities and systems necessary to the operation of a consolidated reimbursement agency.
5. Officials of the Department of Mental Hygiene and Hospitals are of the opinion that the reimbursement activities of the Department would be better handled by another agency—one basically concerned with revenue.

XVII. CONSIDER LIMITING THE TOTAL REIMBURSEMENT FROM ANY ONE INDIVIDUAL

Amplifying and Supporting Statements

1. The success of the overall reimbursement program is lessened by tensions and resentments resulting from heavy long term financial demands that are imposed on certain categories of payors. Understandable complaints from such quarters tend to inhibit the orderly revision of policies bearing on reimbursement. They tend to polarize the views of those who believe all services should be free, as opposed to those who believe all individuals except indigents should reimburse.
2. Placing a limit on the length of time, or the total amount for which a relative is to be held responsible, would ameliorate many family situations, reduce tensions, and limit the inequities of a system that will always be unavoidably inequitable in some aspects of its application or from some viewpoints.
3. The most insistent complaints and some of the most cogent arguments for arbitrary limits come from the parents of retarded children. These people pay taxes that support a school system for normal children. The school system provides transportation, recreation, social and cultural activities. For physically, mentally and emotionally handicapped children who do not require institutional care, the system provides specialized services without charge. Should the parents of such children pay nothing when the parents of children who are slightly more handicapped are required to pay the full cost?
4. If such a comparison is valid, then should the parents of a mentally ill (as distinguished from a retarded) child be required to pay the full cost? Should children be required to pay for parents over a span of years?
5. Equity would appear best served if limits were established strictly on the duration of the reimbursement period rather than the nature of the disability or the relationship of the payor to the patient. An additional factor is that if arbitrary limits were placed on reimbursement payments from the time the patient was admitted considerable insurance reimbursement would be foregone.
6. Inasmuch as time limits would have a significant effect on reimbursement revenues, it is believed the Department of Men-

tal Hygiene and Hospitals should prepare estimates of foregone revenues that would result from several alternative policies, for example:

1) Discontinue reimbursement after 5 years
2) Discontinue reimbursement after 10 years
3) Discontinue reimbursement after 15 years
4) Discontinue reimbursement after 20 years
5) Reduce reimbursement by 50% after five years and discontinue after 10, 15, or 20 years
6) Reduce reimbursement by 50% after 10 years and discontinue after 15 or 20 years

When the revenues that would be lost by these alternative policies have been determined a sounder judgment may be made as to which is the more acceptable.

7. Implementation of this recommendation would require a revision of the present Section 37.1-105, Code of Virginia.

DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS

COLLECTIONS BY HOSPITALS

Appendix 1

Fiscal Year	Eastern State Hospital	Western State Hospital	Southwestern State Hospital	Central State Hospital	Petersburg Training School	Lynchburg Training School and Hospital	Virginia Treatment Center for Children	Piedmont State Hospital	Northern Virginia Mental Health Institute	Net Total Collections[1]	Collection Cost	Percent of Collections (%)
1949 (6 mos.)										$ 85,457	$ 12,257	14.3
1950										309,687	19,617	6.3
1955										844,992	55,100	6.5
1960	$ 480,294	$ 523,064	$ 180,436	$ 267,391	$ 7,466	$ 402,583				1,777,270	89,250	5.2
1961	586,678	660,162	200,750	327,678	9,649	502,369				2,189,257	101,478	4.6
1962	719,593	788,719	231,505	396,963	15,104	584,865	$ 426			2,610,388	111,940	4.3
1963	874,338	920,727	257,537	465,960	10,533	682,511	16,708			3,075,547	126,082	4.1
1964	935,725	935,784	265,596	545,260	16,307	740,690	44,752			3,314,451	138,281	4.2
1965	1,045,971	1,025,737	306,743	600,018	16,081	796,247	80,049			3,669,499	148,254	4.0
1966	1,114,934	1,084,414	369,003	656,958	21,599	863,328	43,718			3,919,965	159,487	4.1
1967	1,192,272	1,134,791	399,948	708,448	19,029	944,775	46,704			4,211,905	220,966	5.2
1968	1,261,206	1,428,072	511,866	993,082	35,275	1,092,259	155,402	$ 75,322	$ 19,560	5,283,175	301,635	5.8
1969	1,504,956	1,583,932	675,959	1,255,497	36,454	1,215,304	221,413	411,159	200,697	6,723,890	358,696	5.3

[1] Adjusted for refunds

TOTAL COSTS OF OPERATION COMPARED TO TOTAL COLLECTIONS

MENTAL HOSPITALS - FISCAL YEARS 1960 through 1969

Appendix 2

TOTAL COSTS OF OPERATION COMPARED TO TOTAL COLLECTIONS

MENTAL HOSPITALS - FISCAL YEARS 1960 through 1969

Appendix 2

Fiscal Year		Eastern State Hospital	Western State Hospital	Southwestern State Hospital	Central State Hospital	Petersburg Training School	Lynchburg Training School and Hospital	Virginia Treatment Center for Children	Piedmont State Hospital	Northern Virginia Mental Health Institute	Total
	Total Costs[1]	$3,082,863	$3,414,341	$ 2,020,855	$5,313,292	$ 313,937	$3,420,938				$17,566,226
1960	Collections[2]	480,294	523,064	180,436	267,391	7,466	402,583				1,777,270
	Percent	15.6	15.3	8.9	5.0	2.4	11.8				10.1
	Total Costs[1]	$4,171,639	$4,675,774	$ 2,570,457	$7,235,456	$ 644,757	$4,924,044	$ 499,110			$24,721,237
1965	Collections[2]	1,045,971	1,025,737	306,743	600,018	16,081	796,247	80,050			3,669,499
	Percent	25.1	22.0	11.9	8.3	2.5	16.2	16.0			14.8
	Total Costs[1]	$4,430,372	$5,357,436	$ 2,797,737	$7,669,417	$ 698,467	$5,393,692	$ 539,353			$26,886,474
1966	Collections[2]	1,114,934	1,084,414	369,003	656,958	21,599	863,328	43,718			3,919,965
	Percent	25.2	20.2	13.2	8.6	3.1	16.0	8.1			14.5
	Total Costs[1]	$5,129,909	$6,064,653	$ 3,094,233	$8,365,896	$ 776,456	$6,511,127	$ 572,679			$30,514,953
1967	Collections[2]	1,192,272	1,134,791	399,948	708,448	19,029	944,775	46,704			4,211,905
	Percent	21.8	18.7	12.9	8.5	2.4	14.5	8.1			13.8
	Total Costs[1]	$5,486,903	$6,736,930	$ 3,385,798	$8,982,742	$ 852,043	$7,188,715	$ 715,218	$1,381,672	$ 384,329	$35,114,350
1968	Collections[2]	1,261,206	1,428,072	511,866	993,082	35,275	1,092,259	155,403	75,322	19,560	5,233,178
	Percent	23.0	22.1	15.1	11.0	4.1	14.0	21.7	5.5	5.1	14.9
	Total Costs[1]	$6,197,914	$7,122,272	$ 3,747,946	$9,795,922	$ 927,869	$8,004,299	$ 707,398	$1,401,376	$ 692,430	$38,597,426
1969	Collections[2]	1,504,956	1,583,932	675,959	1,255,497	36,454	1,215,304	221,413	411,159	200,697	6,723,890
	Percent	24.3	22.2	18.0	12.8	3.9	15.2	31.2	29.4	29.0	17.4

[1] From reports of Mental Hygiene and Hospitals

[2] From Exhibit I. Individual hospital amounts are gross. Total is adjusted for refunds.

OPERATING COSTS AND REIMBURSEMENTS
TUBERCULOSIS SANATORIA
(Fiscal Years 1964-1968)

Appendix 3

Topic	Institution	1964	1965	1966	1967	1968
Cost of Maintenance and Operation	Blue Ridge	$1,239,429	$1,289,614	$1,381,016	$1,520,585	$1,730,727
	Catawba	986,532	1,029,988	1,050,127	1,107,430	1,189,609
	Total	$2,225,961	$2,319,602	$2,431,143	$2,628,015	$2,920,336
Reimbursement from Patients and Third Parties*	Blue Ridge	$ 168,427	$ 165,020	$ 210,886	$ 277,383	$ 318,754
	Catawba	46,510	56,982	60,076	54,205	187,499
	Total	$ 214,937	$ 222,002	$ 270,962	$ 331,588	$ 506,253
Percent of Cost Reimbursed	Blue Ridge	13.5	12.8	15.2	18.2	18.4
	Catawba	4.7	4.4	5.7	4.9	15.8
	Combined	9.7	9.6	11.1	12.6	17.3
Cost Per Patient Day	Blue Ridge	$13.27	$15.78	$16.67	$18.96	$18.39
	Catawba	16.07	16.07	18.58	22.60	21.89
	Combined	14.39	15.94	17.35	20.34	19.69
Reimbursement Per Patient-Day	Blue Ridge	$1.80	$2.03	$2.55	$3.46	$3.39
	Catawba	.76	.89	1.05	1.11	3.46
	Combined	1.39	1.53	1.93	2.57	3.41
Number of Patient-Days	Blue Ridge	93,417	81,241	82,850	80,219	94,108
	Catawba	61,320	64,240	57,805	48,998	54,199
	Combined	154,737	145,481	140,155	129,217	148,307
Average Number Patients	Blue Ridge	255	223	227	220	257
	Catawba	168	176	157	134	148
	Combined	423	399	384	354	405

* Adjusted for refunds.

ANALYSIS OF REIMBURSEMENTS
TUBERCULOSIS SANATORIA
(April 3, 1969)

Appendix 4

REIMBURSEMENT CATEGORY WHEN ADMITTED	Blue Ridge Patients	Blue Ridge %	Catawba Patients	Catawba %	Blue Ridge Catawba Combined Patients	Blue Ridge Catawba Combined %
Free	156	58	104	60	260	59
Medicare (Social Security Title XVIII)	75	28	41	24	116	26
Blue-Cross	13	5	11	6	24	5
Other Insurance	20	7	14	8	34	7
Patient or relative payment:						
$5.00 per day	1		0		1	
$2.00 per day	0		1		1	
$1.50 per day	1		0		1	
$1.00 per day	2 4	2	3 4	2	5 8	2
Total	268	100	174	100	442	99[3]
REIMBURSEMENT CATEGORY - CURRENT						
Free	209	78	122	70	331	75
Medicare (Social Security Title XVIII)	32	12	17[1] / 23[2]	10 / 13	72	16
Blue-Cross	6	2	4	2	10	2
Other Insurance	17	6	4	2	21	5
Patient or relative payment:						
$5.00 per day	1		0		1	
$2.00 per day	0		0		0	
$1.50 per day	1		0		1	
$1.00 per day	2 4	2	4 4	2	6 8	
Total	268	100	174	99[3]	442	98[3]

[1] Both A and B parts of Medicare [2] B part (About 80c per day) [3] Error due to rounding

COMPARATIVE COSTS AND CHARGES

MENTAL INSTITUTIONS

Appendix 5

Institution	Average Per Capita Daily Cost 7 1 66 to 1 1 67	Daily Charge 2 1 67 to 6 30 69	Daily Per Capita Cost 7 1 68 to 2 28 69	Daily Charge Starting 7 1 69	Increase in Daily Charge		Daily Cost Per Patient for Various Types of Service (Quarter Ending March 31, 1969)							
					Amount	Percent	Intensive Treatment	Criminal Service	Children's Service	Geriatric Service	Medical Service	Custodial Care	Chronic Care	Vocational Rehabilitation Care
Eastern State Hospital	$ 5.17	$ 5.17	$ 7.05	$ 7.05	$ 1.88	36%	$ 8.86	$ -	$20.60	$ 7.28	$15.74	$ 5.59	$ -	$ 7.79
Western State Hospital	5.33	5.33	7.11	7.11	1.78	34%	9.62	-	-	7.69	27.60	5.96	5.57	-
Southwestern State Hospital	5.17	5.17	6.28	6.28	1.11	21%	11.74	12.07	-	5.27	12.56	4.18	5.82	-
Central State Hospital	4.83	4.83	6.31	6.31	1.48	31%	12.63	19.29	8.01	6.93	31.68	4.75	4.14	6.10
Petersburg Training School	6.30	6.30	9.04	9.04	2.74	43%	-	-	-	-	-	-	-	-
Lynchburg Training School and Hospital	4.66	4.66	6.54	6.54	1.88	40%	8.64*	-	7.88*	9.52*	31.78*	3.80*	5.84*	-
Virginia Treatment Center for Children	-	30.00	69.16	30.00	**	-	-	-	-	-	-	-	-	-
Northern Virginia Mental Health Institute	-	40.00	41.16	40.00	***	-	43.41	-	-	-	-	-	-	-
Piedmont State Hospital	-	12.00	16.52	16.52	4.52	38%	15.33	-	-	-	19.82	-	-	-

* Definition of this service varies from the column heading because of the type of institution

** No change; rate fixed by statute

*** No change; rate adjusted earlier in year

ESTIMATED ANALYSIS OF REIMBURSEMENTS—BY SOURCE AND INSTITUTION
DEPARTMENT OF MENTAL HYGIENE AND HOSPITALS

Appendix G

Item Description	Eastern State Hospital	Western State Hospital	Southwestern State Hospital	Central State Hospital	Petersburg Training School	Lynchburg Training School and Hospital	Virginia Treatment Center for Children	Piedmont State Hospital	Northern Virginia Mental Health Institute	Total
Hospital Census [1]	2,397	2,579	1,833	4,149	285	3,590	32	235	78	14,888
Patient Charges Paid By Individuals [2]										
Number of Payors	937	976	486	850	39	1,202	15	53	6	4,514
Percent of Census	39.1	36.4	28.5	20.5	13.7	34.4	46.8	22.8	7.7	30.4
Total Amount Paid Annually	$1,100,216	$1,265,677	$373,551	$668,512	$18,312	$932,829	$17,640	$56,280	$46,839	$4,479,857
Percent of Total Annual Reimbursements	60.8	64.3	55.5	47.0	26.0	56.3	7.1	29.3	5.9	50.8
Average Amount Per Patient-Day	$3.26	$3.60	$2.38	$2.18	$1.28	$2.15	$3.27	$2.94	$21.67	$2.76
Patients for Whom Social Security Payments Are Assigned to the Department										
Number of Patients	644	813	274	639	16	541		97		2,824
Percent of Census	26.9	22.9	17.9	15.4	5.6	15.5		41.3		19.3
Total Amount Paid Annually	$486,347	$338,110	$174,064	$412,599	$6,345	$312,994		$53,399		$1,803,858
Percent of Total Annual Reimbursements	26.8	18.2	25.8	29.0	9.8	18.9		27.7		20.5
Average Amount Per Patient-Day	$2.10	$1.42	$1.76	$1.79	$2.00	$1.61		$1.53		$1.77
Patients Paid For By Blue Cross										
Number of Patients	36	34	10	36	4	6	7		30	163
Percent of Census	1.5	1.3	.6	.9	1.4	.2	21.9		38.5	1.1
Total Amount Paid Annually	$72,885	$69,818	$18,230	$65,318	$10,173	$11,008	160,480		$345,600	$653,512
Percent of Total Annual Reimbursements	4.0	3.5	2.7	4.6	14.4	.7	24.3		43.4	7.4
Average Amount Per Patient-Day	$5.61	$5.70	$5.00	$5.03	$7.00	$5.10	$24.00		$32.00	$11.13
Patients Paid for By CHAMPUS										
Number of Patients	11	8	1	30	4	28	4	1	8	95
Percent of Census	.5	.3	.1	.7	1.4	.8	12.5	.4	10.3	.6
Total Amount Paid Annually	$20,908	$15,494	$2,223	$66,150	$10,195	$64,209	$40,680	$5,364	$110,160	$336,383
Percent of Total Annual Reimbursements	1.2	.8	.3	4.7	14.5	3.9	16.4	2.8	13.8	3.7
Average Amount Per Patient-Day	$5.27	$5.38	$4.58	$5.23	$7.08	$6.36	$28.25	$14.92	$38.25	$9.62
Patients Paid for By Other Insurance										
Number of Patients	8	39	11	86	10	44	15		23	236
Percent of Census	.3	1.5	.7	2.1	3.4	1.3	46.9		29.5	1.6
Total Amount Paid Annually	$16,196	$80,085	$20,052	$156,038	$25,430	$80,640	$129,600		$264,960	$773,001
Percent of Total Annual Reimbursements	.9	4.1	3.0	11.0	36.1	4.9	52.2		33.3	8.7
Average Amount Per Patient-Day	$5.61	$5.70	$5.00	$5.03	$7.08	$6.36	$24.00		$32.00	$9.33
Patients Paid for By Medicare (Part A only)										
Number of Patients	26	49	24	12				6	2	119
Percent of Census	1.1	1.8	1.6	.3				2.6	2.6	.8
Total Amount Paid Annually	$65,800	$125,773	$54,691	$27,216				$36,007	$28,800	$338,287
Percent of Total Annual Reimbursements	3.6	6.4	8.1	1.9				18.7	3.6	3.8
Average Amount Per Patient-Day	$7.03	$7.13	$6.33	$6.30				$16.67	$40.00	$7.90
Patients Paid for By Medicaid										
Number of Patients	20	21	14	11		110		7		183
Percent of Census	.8	.8	.8	.3		3.1		3.0		1.2
Total Amount Paid Annually	$50,616	$53,902	$31,903	$24,948		$252,252		$42,008		$455,629
Percent of Total Annual Reimbursements	2.7	2.7	4.7	1.8		15.3		21.8		5.1
Average Amount Per Patient-Day	$7.03	$7.13	$6.33	$6.30		$6.37		$16.67		$6.92
Total Annual Reimbursement - All Payors (From above)	$1,812,968	$1,968,869	$674,714	$1,420,782	$70,455	$1,653,932	$248,400	$193,058	$796,359	$8,839,527
Total Payors (From above)	1,682	1,740	770	1,664	73	1,931	41	164	69	8,134
Total Patients Paid For (Analysis of accounts 2/2/70)	1,359	1,553	604	1,262	44	1,846	25	186	76	6,955
Total Multiple Payors (Difference)	323	187	166	402	29	85	16	-22	-7	1,208
Total Patients Without Reimbursement (Census less Patients paid for)	1,038	1,126	928	2,887	242	1,654		49	2	7,933
Total Patients Paid For (%)	56.7	58.0	39.4	30.4	15.4	52.7	78.1	79.1	97.4	46.7
Total Patients Not Paid For (%)	43.3	42.0	60.6	69.6	84.6	47.3	21.9	20.9	2.6	53.3

[1] February 2, 1970.

[2] Estimated from analysis of accounts about January 26, 1970. Includes some payments from individuals who had been reimbursed by insurance payments payable to them but not assigned to the Department.

ANALYSIS OF THE INCREASES IN INSURANCE REIMBURSEMENTS WHICH WOULD RESULT FROM A POLICY OF CHARGING FOR THE ACTUAL COST OF THE SERVICE PROVIDED

SUMMARY

Using the best available data on insurance coverage of patients at the four major Virginia State mental hospitals, this analysis shows that, accepting certain reasonable assumptions, the reimbursements from insurance would increase nearly $475,000 per year if charges were based on the cost of the type of service provided.

1. Reimbursements from insurance sources (except Medicare) account for the following proportions of total reimbursements in the four major mental hospitals—Eastern State, Western State, Southwestern State and Central State (see Appendix 6):

Type of Insurance	*No. of Patients*	*Proportion of Hospital Census* %	*Total Annual Reimbursements*	*Proportion of Total Annual Reimbursements* %
Blue Cross.....	116	1.1	$226,251	3.8
CHAMPUS.....	50	.5	104,775	1.8
Other Insurance	144	1.3	272,371	4.6
Total.....	310	2.9	$603,397	10.2

2. Although, as indicated above, only 2.9% of the patients are covered by insurance at any one time, the insurance is almost entirely applicable to newly admitted patients. A spot analysis by the Department in April 1969 showed the following proportions of admissions covered by insurance:

	a	*b*	*c*
Hospital	*Proportion of Admissions Covered by Insurance (Does Not Include Medicare)* %	*Number of Admissions and Readmissions Year Ended June 30, 1969*	*Annual Number of Admissions and Readmissions Covered by Insurance (a x b)*
Eastern State.....	33	2,019	666
Western State.....	34	1,778	605
Southwestern State.....	19	1,199	228
Central State.....	17	2,601	442
Total.....	25.5	7,597	1,941

3. Knowing the estimated average number of patients and the admissions covered by insurance from 1. and 2. above, the estimated average number of days covered by insurance may be determined from the following formula:

Let.

A = Number of admissions annually covered by insurance per covered patient.

Rp = Average daily reimbursement from insurance per covered patient.

Ra = Total annual reimbursement from insurance.

T = Average number of days an insured patient is covered.

then,

$$T = \frac{Ra}{A \times Rp}$$

now,

$$Ra = \$603{,}397 \text{ (from 1. above)}$$
$$A = 1941 \text{ (from 1. above)}$$
$$Rp = \$5.33\left(\frac{\$603{,}397}{310 \times 365 \text{ days}}\right)$$

therefore,

$$T = \frac{\$603{,}397}{1941 \times \$5.33}$$
$$= 58.3 \text{ days (round to 58 days).}$$

4. Taking the annual number of admissions covered by insurance (calculated in 2. above) and extending them by 58 average insured days (determined in 3. above) we have:

Hospital	*Annual Number of Admissions Covered by Insurance*	*Annual Patient-Days Covered by Insurance (Admissions Times 58)*
Eastern State	666	38,628
Western State	605	35,090
Southwestern State	228	13,224
Central State	442	25,636
Total	1,941	112,578

5. Most of the intensive therapy service is administered to newly admitted patients and would be reimbursed at its higher cost were it not for the present policy of charging all patients the average hospital per capita cost. The following calculation determines the reimbursement that is thus foregone by multiplying the number of insured patient-days by the difference between the cost of intensive therapy and the per capita cost.

Hospital	*a* *Annual Insured Patient Days (1)*	*b* *Intensive Therapy Cost Per Patient Day (2)*	*c* *Per Capita Cost Per Patient Day (3)*	*d* *Present Added Cost for Intensive Therapy (b minus c)*	*Foregone Annual Reimbursement (a x d)*
Eastern State	38,628	$ 9.59	$7.05	$2.54	$ 98,115
Western State	35,090	9.72	7.11	2.61	91,585
Southwestern State	13,224	18.53	6.28	12.25	161,994
Central State	25,636	15.85	6.31	9.54	244,567
Total (Avg.)	112,578			$5.30	$596,261

(1) From 4. above

(2) For quarter ended December 31, 1969

(3) From Appendix 5

6. Inasmuch as insurance contracts frequently cover less than the full charge, the estimated foregone revenue shown above is reduced by 20% to give:

$596,261 × .8 = $477,008 (round to $475,000)

ANALYSIS OF THE LONG-RANGE COST EFFECTS OF CHARGING FOR THE ACTUAL COST OF SERVICES PROVIDED

SUMMARY

The analysis in Appendix 7 indicates that establishing a policy of basing mental hospital charges on the actual cost of each particular service would increase current reimbursements from insurance by about $475,000 per year. In addition, however, such a policy should encourage the future improvement of the more important services such as intensive therapy because these, tending to be reimbursed to a greater extent by insurance, could then be improved with less proportionate drain on the General Fund than under the present policy of charging at hospital per capita rates.

This analysis presents an example showing that "ploughing back" the increased payments could probably achieve a 50% improvement in the quality of intensive therapy at no additional cost to the General Fund or to individuals. The improvement would be partially accomplished by taking advantage of the increased insurance reimbursements mentioned above. In addition, however, there would be a substantial long-range cumulative saving from the reduced number of long-term patients brought about by the improved therapy.

1. If the quality of intensive therapy were increased it is reasonable to assume that the cost would increase proportionately for that part of the service beyond the basic custodial service. For a 50% improvement in intensive therapy, the added costs per patient day would be therefore:

Hospital	*a* *Present Cost of Intensive Therapy (1)*	*b* *Present Cost of Custodial Service (1)*	*c* *Present Added Cost of Intensive Therapy (a — b)*	*d* *Further Added Cost to Improve Intensive Therapy by 50% (.5 x c)*
Eastern State	$ 9.59	$ 5.81	$ 3.78	$ 1.89
Western State	9.72	6.01	3.71	1.86
Southwestern State	18.53	4.66	13.87	6.93
Central State	15.85	4.75	11.10	5.55

(1) Average for the quarter ended December 31, 1969

2. The added *annual cost* of a 50% improvement in intensive therapy would be:

Hospital	*e* *Annual Intensive Therapy Patient Days (1)*	*d (from above)* *Added Cost Per Patient Day*	*f* *Added Annual Cost (e x d)*
Eastern State	206,628	$ 1.89	$ 390,527
Western State	230,588	1.86	428,894
Southwestern State	29,340	6.93	203,326
Central State	77,432	5.55	429,748
Total	543,988	$ 2.67	$1,452,495

(1) Based on quarter ended December 31, 1969

3. The added annual reimbursement from insurance would be:

Hospital	*Annual Insured Patients Days (1)*	*Added Cost Per Patient Day For 50% Improvement (2)*	*Added Annual Reimbursement*
Eastern State.....	38,628	$1.89	$ 73,007
Western State.....	35,090	1.86	65,267
Southwestern State.	13,224	6.93	91,642
Central State.....	25,636	5.55	142,280
			$372,196

(1) From Section 4, Appendix 7

(2) From 1. d on preceding page

The net cost to the General Fund would then be

	$1,452,495	
Less:	372,196	(25.6%)
	$1,080,299	

4. An analysis of the ages of patients at admission for November and December 1969 showed that 12.5% of new admissions and readmissions were age 65 or over. In the absence of more specific information, it seems safe to assume that half these admissions, or 6.2%, would be covered by Medicare or Medicaid. Since both these plans pay the full cost, we can assume a further reduction in cost to the General Fund of

$$\$1,452,495 \times .062 = \$90,055$$

and the net cost would then be

	$1,080,299
Less:	90,055
	$ 990,244

5. Referring to Appendix 9 Hospital Population and Patient Flow, it can be seen that by far the largest part of the mental hospital population is made up of long-term patients. Patients who have been resident for less than one year compose only about 20% of the total. Of the approximately 8,800 persons entering the hospital system in an average year, about 1,600 are estimated to remain longer than one year. The median stay of the latter is about ten years.

Improving the intensive therapy service to the newer patients should reduce the flow of patients into the long-term population. If a quality improvement of 50% reduced the flow of patients from 1,600 to 1,500 per year (a 6.25% reduction), there would be a cumulative reduction in the long-term population and in the cost of its care and treatment. Assuming the median of such patients to be 10 years and the cost of care and maintenance to be $6.00 per day, the cost saving for a ten-year period would be:

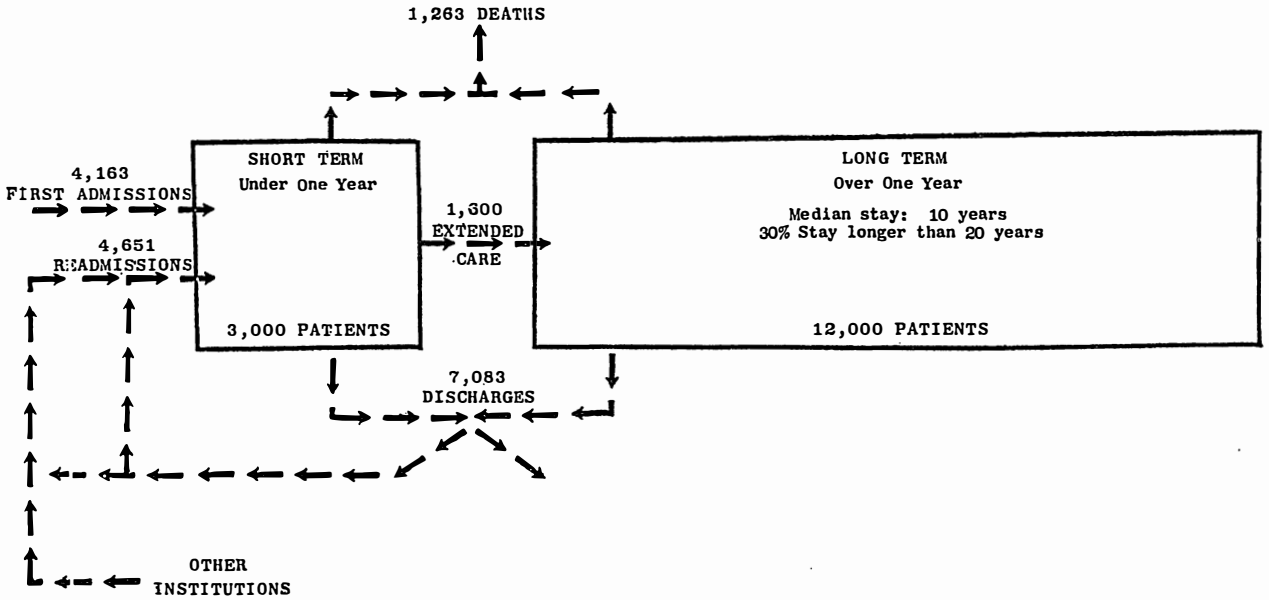
Year	*Years Effective*	*Patient Reduction*	*10-Year Cost Reduction*
1	9.5	100	9.5 × 100 × $6 × 365 = $ 2,080,500
2	8.5	100	8.5 × 100 × $6 × 365 = 1,861,500
3	7.5	100	7.5 × 100 × $6 × 365 = 1,642,500
4	6.5	100	6.5 × 100 × $6 × 365 = 1,423,500
5	5.5	100	5.5 × 100 × $6 × 365 = 1,204,500
6	4.5	100	4.5 × 100 × $6 × 365 = 985,500
7	3.5	100	3.5 × 100 × $6 × 365 = 766,500
8	2.5	100	2.5 × 100 × $6 × 365 = 547,500
9	1.5	100	1.5 × 100 × $6 × 365 = 328,500
10	.5	100	.5 × 100 × $6 × 365 = 109,500
	Total		$10,950,000

During the same 10-year period, the net additional annual General Fund expenditures would have been $990,244 (from 4. above), or for the 10-year period a total of $9,902,440. Thus, predicated on only a 6.5% reduction in the flow of short-term to long-term patients, the 10-year additional expenditures would be nearly $1 million less than the 10-year cost saving of $10,950,000.

HOSPITAL POPULATION AND PATIENT FLOW

(Based on year ended June 30, 1969)

Eastern State, Western State, Central State
and Southwestern State Hospitals



Appendix 10

ANALYSIS OF ACTUAL COST OF PATIENT TREATMENT AT THE VIRGINIA TREATMENT CENTER FOR CHILDREN

SUMMARY

This analysis determines the proportion of total expenditures the Center directs specifically to the welfare of the patient. The analysis indicates that about 92% is spent directly on patient treatment (including administrative overhead) and 2% on patient instruction, making a total of 94% devoted to the patient. The remaining 6% is spent for in-service instruction—an activity necessary for a continuing staff of suitably skilled and trained people.

1. The basic analysis (next page) consists of distributing the Center's payroll over the four functions:

   1) Patient instruction
   2) Patient treatment
   3) In-service instruction
   4) General administration

   General administration is subsequently distributed over the other three functions proportionately.

2. Expenses other than salaries—$113,000 per year (1968-1969)—are ignored because they would logically be distributed about the same as the salaries and thus would not affect the final distribution percentages.

3. Since in-service training and psychiatric field work are funded by Federal grants their expenses are not included. Patient instruction is performed by teachers of the Richmond public schools at no cost to the State and so their salaries are not included in the analysis.

4. The proportion of State funds expended for in-service instruction (6%) is well within the range of such costs normally included in hospital charges.

ESTIMATED DISTRIBUTION OF EXPENSES BY MAJOR FUNCTIONS
VIRGINIA TREATMENT CENTER FOR CHILDREN

Distribution of Salaries	Annual Salaries and Wages	Distribution By Function: Patient Instruction %	Patient Instruction Amount	Patient Treatment %	Patient Treatment Amount	In-Service Instruction %	In-Service Instruction Amount	General Administration %	General Administration Amount
Regular Staff Positions									
Director	$ 24,900			25	$ 6,225	25	$ 6,225	50	$12,450
Other Administrative Personnel	53,712							100	53,712
Buildings, Grounds and Housekeeping	58,920	10	$ 5,892	75	44,190	5	2,946	10	5,892
Director of Education	9,600	95	9,120			5	480		
Food Service Dietician (Half-time)	4,584			95	4,354	5	230		
Balance of Food Service Personnel	29,174			100	29,174				
Resident Physician in Child Psychiatry	4,675			80	3,740	20	935		
Volunteer Services Supervisor (Half-time)	3,516			100	3,516				
Medical Records Clerks (5)	21,960			100	21,960				
Staff Physician (4)	79,600			95	75,620	5	3,980		
Superintendent of Nursing	13,728			30	4,118	35	4,805	35	4,805
Balance of Nursing Personnel (9)	69,120			90	62,208	10	6,912		
Nursing Instructor	9,600					100	9,600		
Psychologists (4)	48,840			95	46,398	5	2,442		
Social Workers (6)	54,600			95	51,870	5	2,730		
Recreation (3)	19,320			90	17,388	10	1,932		
Occupational Therapists (3)	20,904			90	18,814	10	2,090		
Child-Care Technicians (52)	261,101			100	261,101				
EEG Technician (1)	5,135			100	5,135				
In-Service Training (Paid from HEW grant)							25,000		
Nurse Instructor Head Nurse (2) Clerk-Typist									
Field Unit (Paid from HEW grant)							85,000		
Staff Physician, Social Work Supervisors (2) Clerk-Typist C Teachers (2)									
Patient Instruction Staff									
Teachers (6 to 8 positions) (Salaries paid by City of Richmond)									
Total - All Salaries on Payroll (100%)	$792,989	1.89	$15,012	82.71	$655,811	5.71	$45,307	9.69	$76,859
Redistribution of General Administration Salaries	$ 76,859		$ 1,611		$ 70,385		$ 4,863		
Final Salary Distribution - Total (100%)	$792,989	2.10	$16,623	91.58	$726,196	6.32	$50,170		

NOTES: The Director and Assistant Director of the Treatment Center estimated the distribution of time shown in percent for each position or class. Expenses other than those for personal services amounted to about $113,000 in the year 1968-69. This comprised only 14% of the total expenses and appeared to be allocable substantially according to the same distribution as salaries.

A BILL to amend and reenact § 37.1-61 of the Code of Virginia relating to admissions and transfers to the Virginia Treatment Center for Children.

Be it enacted by the General Assembly of Virginia:

1. That § 37.1-61 of the Code of Virginia be amended and reenacted as follows:

§ 37.1-61.—(a) Only mentally ill or emotionally disturbed children under sixteen years of age shall be admitted or transferred to a treatment center *as patients. Children under sixteen years of age may be treated as outpatients if they are former patients or if they are being evaluated as potential patients. Parents, other relatives and guardians of patients or outpatients may be counselled or evaluated when this is deemed advisable by the director.*

(b) Voluntary admissions may be made, in the discretion of the director, upon application signed by the parent or parents or legal guardian of the child.

(c) Transfers to the centers may be made as provided in § 37.1-48 with respect to transfers between other institutions under control of the Board. Upon application made by any State department, institution or agency having custody of any child who is mentally ill or emotionally disturbed, such child may, with the approval of the Commissioner, be admitted for study, care and treatment at the center.

NOTE: The suggested amendment consists of the addition of the italicized portion. The remainder is not changed.

SENATE BILL NO. 456

Offered February 16, 1970

A BILL to repeal Article 8 of Chapter 2 of Title 37.1 of the Code of Virginia, which article contains §§ 37.1-105 through 37.1-119, relating to expenses of care, treatment and maintenance of patients in State hospitals; and to amend the Code of Virginia by adding in Chapter 2 of Title 37.1 thereof an article numbered 8.1 containing sections numbered 37.1-119.1 through 37.1-119.16, relating to the same matters.

Patron—Mr. Bird, D. W.

Referred to the Committee on Finance

Be it enacted by the General Assembly of Virginia:

1. Article 8 of Chapter 2 of Title 37.1 of the Code of Virginia, which article contains §§ 37.1-105 through 37.1-119, is repealed.

2. That the Code of Virginia be amended by adding in Chapter 2 of Title 37.1 thereof an article numbered 8.1 containing sections numbered 37.1-119.1 through 37.1-119.16, as follows:

Article 8.1

Expenses of Care, Treatment and Maintenance

§ 37.1-119.1.—Any person who has been or who may be admitted to any State hospital, or any person who is the subject of counselling or who receives treatment from the staff of any State hospital, who for the purposes of this Article shall be deemed to be a patient, or the estate of any such person or the person or persons legally liable for the support of any such person, shall be liable for the expenses of his care, treatment and maintenance in such hospital. Such expenses shall not exceed the actual per capita cost of maintenance for the particular type of service rendered and shall be determined no less frequently than annually by the Department of Mental Hygiene and Hospitals, in accordance with standard accounting practices, but recovery of such charges shall not be permitted for amounts more than five years past due. A certificate of the Director or Assistant Director of Reimbursement of the Department shall be proof for all purposes of the actual per capita cost of maintenance for the particular type of service rendered.

§ 37.1-119.2.—All funds collected by the Department pursuant to this article shall be paid into the general fund of the State treasury.

§ 37.1-119.3.—Nothing in this title shall be construed to forbid any hospital to charge for the removal, care and maintenance of any nonresident mentally ill, inebriate or mentally deficient who has been admitted to such hospital, and whose fiduciary or any person on his behalf has contracted with such hospital for the care and maintenance of such person, nor shall it be construed to permit the admission or retention of any nonresident to the exclusion of a resident of the Commonwealth.

§ 37.1-119.4.—The Department shall charge the patient, the estate of the patient, the guardian, trustee, committee, or the person or persons legally liable the actual per capita cost of the type of service rendered.

Upon receipt of a written statement asserting financial inability to pay the actual per capita cost signed by the patient, the guardian, trustee, committee or the person or persons legally liable for his support and maintenance, the Department shall investigate and ascertain the financial ability of the patient, the estate of the patient, the guardian, trustee, committee or of the person or persons legally liable therefor to pay the expenses of the care, treatment and maintenance, however, such investigation shall not necessarily be made unless expressly requested by the person or persons so charged.

After such investigation and in arriving at the amount to be paid, the Department shall have the due regard for the financial condition and estate of the patient, his present and future needs and the present and future needs of his lawful dependents and the Department shall have due regard for the financial condition of the person or persons legally liable for such support, their present and future needs and the present and future needs of their lawful dependents and the Department may assess a sum for such maintenance less than the actual per capita cost thereof. The estate of such patient during his life other than income shall not be depleted below the sum of Two Thousand Five Hundred Dollars for the purpose of reimbursement of expenses of care, treatment and maintenance, but may be depleted for the personal requirements and comfort of the patient. Nothing contained in this title shall be construed as making any charge permanently binding upon the Department or prohibiting it from periodically re-evaluating the actual per capita cost of care, treatment and maintenance and the financial condition and estate of any patient, his present and future needs and the present and future needs of his lawful dependents, or from periodically re-evaluating the financial condition of the person or persons legally liable for his support and the present and future needs of their lawful dependents, and thereby charging a new amount to be due from the patient, the estate of the patient, the guardian, trustee, committee or the person or persons liable for his support and maintenance.

Nothing contained herein shall be construed as prohibiting the Department from entering into agreements with any person who may be legally liable or who may assume the responsibility of reimbursing the Department for the cost of care, treatment and maintenance of any patient. Contracts with nonliable persons shall stipulate that the person would not be liable except for the contract.

§ 37.1-119.5.—Upon the failure of any patient, the guardian, committee, trustee or other person legally liable for his expenses, to make payment of the same and whenever it appears from investigation that such patient, his parent, guardian, committee, trustee, or other person or persons legally liable for the support of such person, has sufficient estate, or there is evidence of ability to pay such expenses, the Department shall petition any court of record having jurisdiction over the estate of the incompetent or for the County or City of which he is a legal resident, or from which he was admitted to said hospital, or to any Court having jurisdiction for the County or City in which the person legally liable for the support of such patient resides, for an order to compel payment of such expenses, past and future, by the person liable therefor, and in the following order:

First, by the patient or his estate; and secondly, by the person or persons legally liable for the support of such patient, such person or persons shall be; the father, mother, husband, wife, or children of the patient, provided the child or children have obtained the age of 20 years. The liability of such persons and estates shall be a joint and several liability.

§ 37.1-119.6.—Notice of any hearing, on the petition of the Department for an order to compel payment of such expenses, shall be served on the patient, and if there be one, upon his committee, guardian, or trustee, or upon the person or persons legally liable for the support of the patient, or upon the person or persons against whom the proceedings are instituted, at least fifteen days prior to the hearing, and in the manner provided for the service of civil process.

§ 37.1-119.7.—At such hearing the court shall hear the allegations and proofs of the parties and shall by order require payment of maintenance or any part thereof by the parties liable therefor, if of sufficient ability, having due regard for the financial condition and estate of the patient, his present and future needs, and the present and future needs of his lawful dependents, if such proceeding is to charge the patient with such expenses; and if such proceeding is to charge any other person legally liable for such expenses, the court shall have due regard for the financial condition and estate of such person, his present and future needs, and the present and future needs of his lawful dependents.

§ 37.1-119.8.—Upon application of any interested party and upon like notice and procedure, the court may at any time modify such order. If the application is made by any party other than the Department, the notice shall be served on the Commissioner.

§ 37.1-119.9.—Any party aggrieved by such order or by the judgment of the court may appeal therefrom in the manner provided by law.

§ 37.1-119.10.—Any order or judgment rendered by the court hereunder shall have the same force and effect and shall be enforceable in the same manner and form as any judgment.

§ 37.1-119.11.—This article shall not be held or construed to require the Department to collect the expenses of the care, treatment, and maintenance of any indigent patient from such person, or to collect such expenses from any person legally liable therefor, where investigation discloses that such person legally liable for the support is without financial means, or that such payment would work a hardship on such person or his family. Neither shall it be the duty or obligation of the Department to institute any proceedings provided for in this article to effect such collection where investigation discloses that such proceedings would be without effect, or would work a hardship on such patient, or the person legally liable for his support.

§ 37.1-119.12.—The estate of any patient, or former patient, dying shall be liable for the unsatisfied portion of any judgment rendered by a court in a proceeding had under this article, and, in addition, shall be liable for such charges remaining unpaid, provided, that as to such charges remaining unpaid, recovery shall not be permitted for amounts more than five years past due. Upon the death of any patient or former patient the prohibition of § 37.1-119.4 prohibiting depletion of the patient's estate for the purpose of reimbursement of expenses below the sum of Two Thousand Five Hundred Dollars shall have no further application, and such sum may be applied to the charges of the Department remaining unpaid or may be applied to the unsatisfied portion of any judgment.

§ 37.1-119.13.—Upon the death of any patient or former patient in the event amounts remain unpaid for his care, treatment and maintenance the Department, having reason to believe that such patient died possessed of property, either real or personal, from which reimbursement may be

had, shall prepare and acknowledge as deeds are acknowledged, a notice showing the name of such patient, the actual per capita cost of maintenance due, and shall file the same in the office of the Clerk of the Court in which deeds are admitted to record in the County or City in which the real or personal property is located, within four months of the date of death of the patient. The Clerk of Court shall docket this notice as a judgment is docketed, indexing it in the name of the patient and in the name of the Department of Mental Hygiene and Hospitals. The filing of such notice shall create a lien against the estate, both real and personal, of such patient, prior to all other claims except prior liens, funeral expenses, other hospital bills, physicians bills, and medical expenses.

§ 37.1-119.14.—No such claim shall be enforced against any real estate of the estate of the patient dying, however, while such real estate is occupied by the surviving spouse of the patient, or while such real estate is occupied by any dependent child or children of the patient.

§ 37.1-119.15.—The Commissioner may prescribe statement forms which shall be completed by those persons legally liable under § 37.1-119.5 for the support of the patient. Such statement shall be signed by such person and returned to the Commissioner within thirty days from the time such statement was mailed to such person. Should such person fail to return such statement to the Commissioner, properly completed, within thirty days, the Commissioner shall send another statement by registered or certified mail and if the statement properly completed, is not then returned within thirty days the person to whom it was sent by registered or certified mail shall be assessed five dollars each week or part of each week in excess of the thirty-day period that the statement is overdue, which sum or sums shall be collected by the Department in the same manner as other sums due for the care, treatment and maintenance of patients from the persons whose duty it was to complete each statement, and, when collected, such sum or sums shall be paid into the same fund which other collections are paid under this article.

A copy of this section shall be placed in a prominent place, in bold face type, upon each statement form.

In addition those factors considered by the Department of Mental Hygiene and Hospitals in determining the amount to be paid by those persons who are unable to pay the actual per capita cost shall be set forth upon each statement form.

§ 37.1-119.16.—The bills for the support of patients who are placed at board in families under the provisions of Chapter 3 (§§ 37.1-120, et seq.) of this title shall be payable monthly.

3. This act shall be in force on and after October one, nineteen hundred seventy.