REPORT OF THE
JOINT SUBCOMMITTEE STUDYING

Certain Practices Among Psychiatric Professionals

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 41

COMMONWEALTH OF VIRGINIA
RICHMOND
1990

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Senator John C. Buchanan
Delegate Jay W. DeBoer
Delegate William J. Howell
Senator Thomas J. Michie, Jr.
Senator Emilie F. Miller
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Report of the
Joint Subcommittee to Study Certain Practices
Among Psychiatric Professionals
to
The Governor and General Assembly of Virginia
Richmond, Virginia

To: Honorable Lawrence D. Wilder, Governor of Virginia,
and
The General Assembly of Virginia

AUTHORITY FOR STUDY

The Joint Subcommittee to Study Certain Practices Among Psychiatric Professionals was created pursuant to Senate Joint Resolution No. 191 (1989), which directs the subcommittee to evaluate, among other things, (i) diagnoses and insurance coverage for admissions to psychiatric facilities as well as release policies, (ii) payment to psychiatric professionals and other related personnel involved in the treatment process, and (iii) advertising practices by psychiatric institutions. The joint subcommittee is directed to complete its work and present its recommendations to the 1990 Session of the General Assembly. (See Attachment A.)

EXECUTIVE SUMMARY

The general climate surrounding the treatment of psychiatric and substance abuse has changed dramatically during recent years. No longer are the mentally ill kept hidden at home or sent away to an institution for a lifetime. The evolution in social mores has contributed to an enlightened general public and removed much of the stigma attached to receiving treatment. This, together with the development of better treatment methods has contributed to the increase in the number of affected persons who seek treatment. Many state governments, including Virginia's, have encouraged this change in climate by providing for or mandating insurance coverage to include treatment for mental disabilities and saying to the insurance industry that this treatment should be reimbursed no less favorably than treatment for any other physical illness.

At the same time, the number of hospitals with psychiatric or substance abuse wards as well as freestanding facilities have increased dramatically. This increase can be attributed to a number of factors. Sheer population growth with the concurrent increase in the numbers of persons who may need treatment accounts for a large proportion of the increase of clients needing treatment. Insurance now covers inpatient, as well as some types of outpatient, treatment. Recent government cost-control measures and strict monitoring of the Medicaid and Medicare programs have freed up many hospital beds which have been converted into psychiatric beds. Advertising by psychiatric facilities is a relatively new phenomenon which performs a social function to identify the types of treatment available and where to find such treatment. Families today do not form the traditional nuclear unit that was once the norm, thereby diluting the family support structure that many see as necessary to a stable family unit. Drugs are more prevalent and easily obtained, and addiction has given rise to new and different treatments. In all, there is no one factor that explains the increase in the number of inpatient beds, but it is a phenomenon resulting instead from a myriad of factors.

The joint subcommittee heard testimony about a variety of perceived problems which cover the entire scope of treatment from admission to reimbursement by third-party payors. The more prevalent issues discussed included methods of payment to clinicians or other hospital officials, advertising, plans for treatment after release from a facility, utilization review for treatment and third-party payor reimbursement, and the effects of the thirty-day insurance mandate on treatment decisions.

The joint subcommittee agreed that clear and specific policies are needed to delineate the state's position on treatment of clients who have psychiatric or substance abuse problems. The effect would be two-sided: it would make a positive statement about what the state feels is a proper role for all entities and individuals involved in the treatment process; and it would correct any isolated problems which might now exist.

The joint subcommittee recommends that:

- Advertising by facilities as defined in § 37.1-179 of the Code shall follow general guidelines with respect to truth and accuracy, fairness, use of clinical staff, depiction of patients and hospital setting, and the depiction of the need for services. Additional requirements for the disclosure of fees and payment for services shall also be included. The State Mental Health, Mental Retardation and Substance Abuse Services Board shall promulgate regulations to delineate and enforce these guidelines.

- Entities which provide utilization review for treatment and reimbursement purposes shall be required to be certified by the Commissioner of Insurance. Certification would require (i) a review plan describing standards to be used in evaluating hospital care and provisions for appeal of decisions by the private review agent, (ii) minimum standards for the qualifications of personnel who will perform reviews, (iii) procedures ensuring availability of private review agents during normal business hours, (iv) procedures to protect confidentiality of medical records, (v) materials to inform patients and providers of requirements of the utilization review plan and those standards to be used to evaluate care, and (vi) a list of third-party payors for which the private review agent is performing utilization review.

- Any form of remuneration to professionals involved in the treatment process shall not be based on numbers of admissions or any other form of payment which might provide incentive to admit. Remuneration includes, but is not limited to, kickbacks, bonuses, and preferential patient assignment. Such statute shall also prohibit the denial of admitting privileges based upon the criterion of number of patient admissions. The Board of Health and State Board of Mental Health, Mental Retardation, and Substance Abuse Services shall promulgate regulations to effect this change.

The joint subcommittee supports, by resolution, the concept of insurance coverage for alternative levels of care which is being studied by several other committees. Insurance has traditionally covered only inpatient care for psychiatric and substance abuse services. The concept being developed recognizes other levels of care appropriate to treatment and would establish a conversion ratio whereby inpatient days of care could be converted and used to pay for the other designated levels. The ratio will be based on a cost formula which will attempt to guarantee that benefits are not decreased and treatment is maximized.

BACKGROUND

Current Virginia Law

A person may be voluntarily admitted to a state hospital pursuant to § 37.1-65 if he is determined by the local community services board and a physician on the staff of such hospital to be in need of hospitalization for mental illness. Persons brought before the judge on a petition for involuntary commitment must also be provided an opportunity for voluntary admission pursuant to § 37.1-65 if such person is determined by the judge to be willing to accept and capable of accepting voluntary admission.

Procedures set out in § 37.1-67.1 et seq. govern involuntary commitment and provide for a commitment hearing in which the respondent is represented by counsel. The respondent must be examined by a licensed physician or psychologist, who must certify that there is probable cause to believe that he is or is not mentally ill, presents an imminent danger to himself or others, and does or does not require involuntary hospitalization. The community services board must report as to whether the person is deemed to be mentally ill, an imminent danger to himself or others and in need of involuntary hospitalization, and whether there is no less restrictive alternative to institutional confinement. This report must also provide recommendations for the person's treatment. At the conclusion of the hearing, the judge may order that the person be placed in a hospital for treatment for a maximum of 180 days if he finds that the person (i) presents an imminent danger to himself or others as a result of mental illness, or (ii) has been proven to be so seriously mentally ill as to be substantially unable to care for himself, and (iii) that alternatives to involuntary confinement and treatment have been investigated and deemed unsuitable.

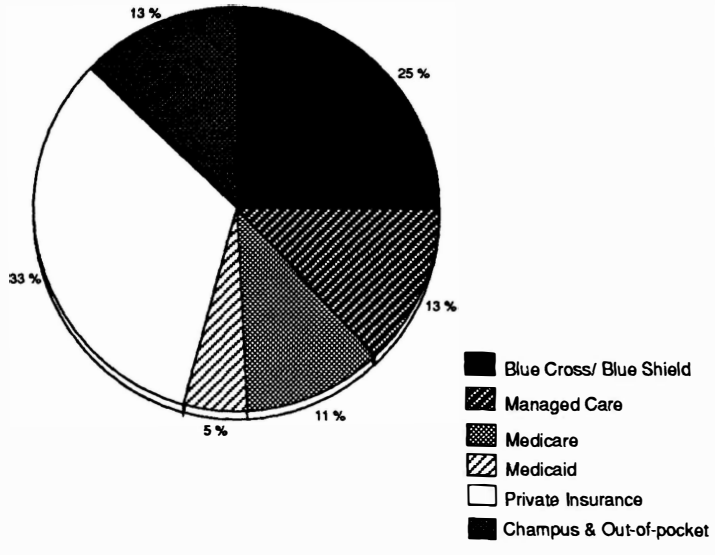
FINDINGS OF THE JOINT SUBCOMMITTEE

The joint subcommittee agreed that it needed to gather data from private as well as public hospitals which provide psychiatric and substance abuse treatment in the state. Since the Department of Mental Health, Mental Retardation and Substance Abuse Services maintains a wide variety of data on public facilities under its purview, a survey was developed to gather similar information from private voluntary and proprietary hospitals. The survey asked questions about (i) the number of licensed psychiatric or substance abuse beds, (ii) the provision of outpatient care, (iii) the provision of discharge plans for treatment, (iv) case management after discharge, (v) where patients were discharged to, (vi) the provision of treatment teams, (vii) operation of crisis hotlines, (viii) reasons for transfer to state facilities from private hospitals, (ix) admissions status by age, (x) length of stay by diagnosis, (xi) payment source by diagnosis, and (xii) credentials of persons working hotlines. There is limited discrepancy in the information between private and state facilities. For instance, insurance coverage is not a salient factor in the information about public facilities since only a very small percentage of patients are covered by third-party insurance. (See Attachment B.)

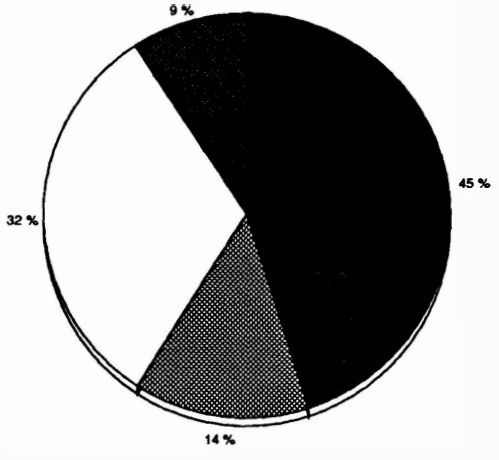
The survey covered the most recent fiscal or calendar year, depending on the particular fiscal operation of each facility. Surveys were sent to forty private hospitals and psychiatric facilities and the response rate was sixty percent. The Virginia Hospital Association was instrumental in the collection and tabulation of this information and has provided helpful comment throughout the course of this study. General trends among these private facilities indicate that:

- fifty percent provide outpatient treatment and/or partial hospitalization;
- ten percent of the general voluntary hospitals provide a discharge plan of treatment;
- ten percent of the general voluntary hospitals provide case management after discharge;
- a majority keep records of discharge or transfer sites;
- a majority provide treatment teams;
- a small percentage operate crisis hotlines;
- most admissions were voluntary admissions of adults;
- the need for extended treatment is the primary reason for transfer of a client to a state facility;
- reasons for non-admission to a private facility include referral to other services, lack of financial resources, and admissions criteria which did not indicate commitment was necessary.
- the majority of clients remain in care for less than 90 days, with the majority receiving care for 30 days or less;
- approximately one-third of admissions are readmissions; and
- Blue Cross/Blue Shield and other private insurance reimburse for the great majority of treatment. (See Attachment C for survey results.) (See Tables)

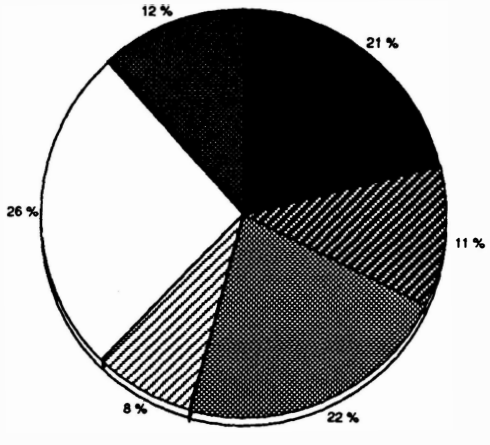
General Voluntary Hospital: Payment Source with a Diagnosis of Substance Abuse



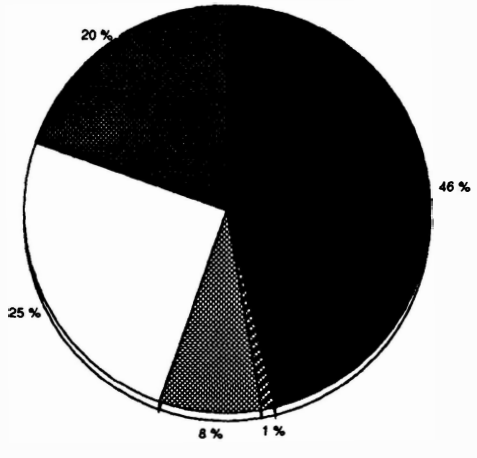
Proprietary Psychiatric Hospital: Payment Source with a Diagnosis of Substance Abuse



Payment Source with a Psychiatric Diagnosis



Payment Source with a Psychiatric Diagnosis



State facilities are required by law to furnish most of the above services to clients, including discharge plans, case management teams, and records of discharge and transfer sites. Most admissions to state facilities are (i) involuntary admissions of adults, (ii) male clients, (iii) predominantly readmission of some type, and (iv) for treatment which can last up to twenty-five years or more, but generally falling in the range of 0-182 days. (See Attachment D for statistics on state facilities.)

ISSUES AND RECOMMENDATIONS

The basic provisions of the joint subcommittee's recommendations are described below. These recommendations are contained in several legislative drafts which are included as attachments.

Advertising

Advertising by medical professionals and facilities is a relatively new field. Advertisers must walk a thin line of taste and propriety due to the very nature of the product being sold. Emotional problems are frequently misunderstood and place the affected individual and his family in a vulnerable position in deciding whether treatment is necessary and where to seek treatment. Since advertising for psychiatry is new, consumers are likely not to be educated in assessing its appropriateness, nor do they know where to voice their complaints if they feel that the ads are somehow lacking in taste and veracity.

The state regulates advertising generally in § 18.2-216, which prohibits untrue, deceptive or misleading advertising. Section 54.1-2403 expands this prohibition to include persons regulated by the Department of Health Professions. Complaints can be lodged with the Division of Consumer Affairs within the Department of Agriculture and Consumer Services.

The profession also tries to regulate itself in a number of ways. Individual practitioners are covered, to a degree, by the Council on Ethical and Judicial Affairs of the American Medical Association. The AMA provisions address only deceptive advertising with no other restrictions. Advertisers are encouraged to use terminology readily understandable by the general public and to avoid aggressive, high pressure advertising and publicity if they create unjustified medical expectations or are accompanied by deceptive claims.

The National Association of Private Psychiatric Hospitals addressed this problem more specifically. Advertising is controlled by a code of ethics composed of five criteria: truth and accuracy; fairness; use of clinical staff; depiction of patients and hospital setting; and depiction of the need for services.

The question which arose during the deliberations of the joint subcommittee is where is the line between truly deceptive advertising and that which is not inherently untrue, but which uses unprofessional tactics to create a need for services which may not be necessary.

The legal questions about advertising by psychiatric facilities and professionals are addressed in Bigelow v. Virginia, 421 U.S. 809, 44 L.Ed.2d 600, which holds that it is legal to regulate advertising which is false or misleading or which proposes illegal commercial activity. Questionable advertising would have to be addressed on a case-by-case basis and weighed against the public interest in quality health care. Criteria for evaluation include whether the ads adversely affect quality of care by leading the public to seek services which might not be necessary; are placed to increase the profit of the provider; and use "scare" tactics to encourage patients to seek treatment. Truth in advertising with respect to disclosure of certain information such as fees and insurance requirements is within the realm of regulation, but does not address the central question. Even though an ad may be entirely factual, it could still be encouraging persons to seek unnecessary treatment.

The joint subcommittee acknowledges that while some advertising is questionable in taste and tactics, the overriding concern is to make treatment for psychiatric and substance abuse problems available to those in need. Advertising as a method of information for recognizing treatable problems and identification of where help can be obtained is a viable method of achieving that goal.

RECOMMENDATION: The state shall adopt advertising guidelines similar to those used by the National Association of Private Psychiatric Hospitals. Guidelines include criteria such as truth and accuracy, fairness, use of clinical staff, depiction of patients and hospital setting, and depiction of the need for services. Additional requirements for the disclosure of fees and payment for services shall also be included. The State Mental Health, Mental Retardation and Substance Abuse Services Board shall promulgate regulations to delineate and enforce these guidelines.

Utilization Review

Utilization review is the review of admissions to medical facilities and of treatment to determine the appropriateness of care and reimbursement for such care. Utilization review companies, begun in 1974, are contracted with by insurance companies and other entities to review each case and determine what treatment the insurance will pay for. Managed care, as it is called in the aggregate, is done prior to admission, during treatment, and upon release. Utilization review has posed some problems because, although its intent to reduce costs and guarantee appropriate treatment may be admirable, it often pre-empts a clinician's plan of treatment. Other drawbacks to utilization review programs include the reluctance of some companies to disclose the standards they use in making treatment decisions and lack of training or training standards for personnel making treatment decisions.

Three states, Arkansas, North Carolina, and Maryland, have recently adopted statutory language to address some of these problems. The Arkansas statute authorized the Commissioner of Insurance to promulgate by August 1, 1990, rules governing preadmission certification practices and utilization review organizations. North Carolina only requires utilization review agents to register with the State Department of Health.

Maryland's law sets out the most detailed regulations governing utilization review organizations. The statute applies to review by nonhospital-affiliated entities. Requirements include identification of standards to be used in evaluating hospital care and provisions for appeal of decisions; notification of qualifications of persons who will perform reviews; procedures ensuring availability of private review agents during normal business hours; procedures to protect confidentiality of medical records; materials to inform patients and providers of requirements of the plan; and a list of third-party payors for which the private review agent is performing the review. The act also provides for penalties and for judicial review to persons aggrieved by a decision.

RECOMMENDATION: The state shall adopt a statute governing utilization review for medical treatment which is similar to the Maryland statute. Additionally, the statute shall provide for minimum requirements for the persons making review decisions and will require the company providing utilization review to share the standards being used for treatment or reimbursement decisions with the facility or practitioner requesting treatment.

Kickbacks and Bonuses

Kickbacks and bonuses have long been issues of concern in the business world and are no less so among professionals who provide health services. Kickbacks and bonuses can take a number of different forms from purely monetary reward to more indirect methods of rewards, such as the assignment of additional patients or prolonging release of a patient to maximize insurance benefits or other payment sources.

The federal government, through its Medicaid/Medicare provisions, has addressed this issue of kickbacks and bonuses. Statutory language refers to the prohibition of illegal remuneration of any kind to or by any individual

> "in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under subchapter XVIII of this chapter or a state health care program, or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any goods, facility, service, or item for which payment may be made in whole or in part under subchapter XVIII of this chapter or a state health care program."

The statute also addresses the receipt of remuneration of any form as a precondition of admission of a patient or as a requirement for the patient's continued stay in a facility. The term "anyone" is being interpreted as including anyone involved in the treatment process, including hotline personnel who counsel potential clients by phone and arrange for them to be seen by a mental health clinician for possible admittance to the facility.

In § 54.1-2964, the Code of Virginia currently provides for the disclosure of personal interest by a practitioner in referral facilities and clinical laboratories. Any practitioner of the healing arts shall, prior to any referral to a facility in which he has a material interest, make such interest known to the patient. This includes testing from an independent clinical laboratory. A civil fine not to exceed $1,000 is provided. The Code also expressly prohibits fee splitting, which is the sharing of fees between doctors who are not in practice together.

The American Medical Association addresses the kickback issue by including in its description of unethical practices such things as treatment or hospitalization that is willfully excessive or inadequate, contingent fees, fee splitting, and clinic or laboratory referrals. Clinics, laboratories, hospitals, and other health care facilities that compensate physicians based solely on the amount of work referred by the physician to a facility are considered to be engaged in fee splitting. Persons guilty of such conduct are subject to censure by the Association.

The joint subcommittee heard testimony from several individuals which documented isolated cases of such practices occurring in facilities around the state. Though such practices are not believed to be widespread, the joint subcommittee agrees that any perception of such a problem is unacceptable and must be addressed in a forthright manner.

RECOMMENDATION: **The giving or taking of any form of kickbacks or bonuses which compensates physicians or any other individual involved in the treatment process based on the amount of work or number of patients referred to any given facility or committed to a physician's care shall be illegal. Such remuneration includes, but is not limited to, kickbacks, bonuses, and preferential patient assignment. Such statute shall also prohibit the denial of admitting privileges or preferential patient assignment to appropriate, qualified clinicians which are based on the number of patient admissions and length of stay. The Board of Health and State Board of Mental Health, Mental Retardation, and Substance Abuse Services shall promulgate regulations to effect this provision.**

Mandated Insurance Coverage

During recent years, insurance coverage for treatment of mental and substance abuse disorders has become almost commonplace. In Virginia, coverage for such treatment is mandated by § 38.2-3412, which provides that insurance policies written in the state must provide coverage for mental and nervous disorders and that benefits shall not be any more restrictive than for any other illness except that they can be limited to thirty days of active treatment in any given policy year. Benefits for alcohol and drug treatment may be different if the benefits cover the reasonable cost of necessary services.

The trend in insurance has been expansion of mental health coverage. This expansion can be attributed to many things, such as new and better types of treatment, development of a variety of treatment settings, and increased public acceptance of mental health treatment. The federal and state policy of deinstitutionalization has also contributed to the expansion of mental health services on the local level.

Treatment for mental and nervous disorders, including drug and alcohol dependence, has been shown to be effective in terms of outcome and cost. For example, alcohol is the most widely used intoxicant in the United States today, and this translates into an average of $117 billion per year in lost productivity and medical bills. According to the National Institute of Drug Abuse, 14 to 18 percent, or about 16.5 to 21.2 million, of workers abuse alcohol or drugs or both. Not included in these numbers are the family members who also abuse substances or who are affected in some way by the family member who does. It is estimated that 85% of people with drug and alcohol problems never receive treatment.

As the state-of-the-art in treatment has been developing and the attitude of society has gradually changed, traditional methods of dealing with treatment for psychiatric and substance abuse disorders have changed. Today there is more emphasis on quality, appropriateness, and effectiveness of treatment. Preadmission testing, case management, education campaigns, wellness efforts, and employee assistance programs, among other things, have grown out of this need to provide adequate, proper treatment for clients at a reasonable cost with quality and utilization review built in to aid in good management of funds. There has been a gradual recognition that inpatient care, as currently mandated, is not always the best type of care. Indeed, inpatient care may serve to be more destructive to certain clients by removing them from their home environment and their jobs. Insurance continues to emphasize inpatient care over proven methods of outpatient care even though outpatient care has been shown to be just as effective as inpatient treatment and is less costly. Many patients find they must choose inpatient care because of the disproportionate share of the cost which they must otherwise pay. Outpatient coverage, in many cases, requires a fifty percent copayment while inpatient requires only twenty percent.

Currently, there are two task forces examining the concept of mandated insurance coverage for psychiatric and substance abuse treatment. A common thread for both groups is the provision of services on a continuum of care involving different levels of services. The concepts of comprehensive assessments, specific admissions criteria to each level, common definitions, and treatment of family members have provided the general theme of study. The Task Force Studying Insurance Coverage for Substance Abuse Treatment, authorized by Senate Joint Resolution No. 169 (1989), has endorsed the concept of conversion of inpatient coverage to other levels of care. The intent is to provide flexibility within current mandates to allow insurance coverage for cost effective treatment and provide more appropriate care based on diagnosed need. Final resolution of conversion ratios has not been determined at this time.

RECOMMENDATION: **The joint subcommittee unanimously supports the concept of alternative levels of care for psychiatric and substance abuse treatment and the efforts to make insurance coverage for such treatment more flexible within current mandates. Outpatient treatment of various types has been shown to be at least as effective as traditional inpatient treatment, and insurance coverage must recognize these changes so that clients may fully utilize more appropriate levels of care. The joint subcommittee supports the concept of conversion ratios whereby days of traditional inpatient care can be traded for a proportionate amount of other types of care as are determined to be the best course of treatment for any particular client.**

Respectively submitted,

Delegate Warren G. Stambaugh, Chairman
Senator John C. Buchanan
Delegate Jay W. DeBoer
Delegate William J. Howell
Senator Thomas J. Michie, Jr.
Senator Emilie F. Miller
Senator Yvonne B. Miller
Delegate Kenneth R. Plum
Delegate Marian Van Landingham
Joel J. Silverman, M.D.
Mr. Matthew E. Weinstein

Attachment A

1989 SESSION

SENATE JOINT RESOLUTION NO. 191

Establishing a joint subcommittee to study certain practices among psychiatric professionals and institutions.

Agreed to by the Senate, February 23, 1989
Agreed to by the House of Delegates, February 21, 1989

WHEREAS, a significant number of persons suffer from emotional, mental and other psychological and personality abnormalities and illnesses, necessitating out-patient psychiatric care or commitment; and

WHEREAS, often these conditions are the result of organic health problems or substance abuse, and such persons are committed to facilities which specialize in such care; and

WHEREAS, the costs of medical care for these individuals is often covered by third party health care insurers, and psychiatric services are mandated health services under Title 38.2 of the Code of Virginia; and

WHEREAS, it has been alleged that some psychiatric professionals and institutions have recommended commitment of disabled members to their families for the thirty days required by the mandated services, and have discharged such persons when the thirty day limit expires, whether the patient is or was in need of further treatment and care; and

WHEREAS, this practice is unfair to the patient, burdensome for his family, and potentially dangerous for society if the patient is released prematurely; and

WHEREAS, the effect of the manner in which some psychiatric professionals and institutions misuse the thirty day inpatient mandated benefit is to increase the costs of health care for all insureds; and

WHEREAS, resolution of this problem requires a thorough investigation of psychiatric practices; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee is established to study certain practices among psychiatric professionals and institutions. The joint subcommittee shall determine the rate of commitment for purposes of psychiatric treatment relative to the number of insureds with such benefits, identify the type of disorders most often resulting in commitment, the functional level of such persons upon admission and discharge, assess the plans for medical follow-up and support services for such individuals upon their return to the community, and identify the problems created by the early release of such individuals on the costs of psychiatric care, insurance premiums, the family and society. The joint subcommittee shall recommend any statutory, regulatory and policy changes which they deem necessary to protect the patient, his family and society. The joint subcommittee also shall consider the current regulatory framework applicable to public and private reviewing organizations, and shall recommend any changes it deems necessary or desirable to improve the efficiency, effectiveness and competence of such organizations in reviewing inpatient psychiatric admissions.

The joint subcommittee shall be composed of eleven members to be appointed as follows: two members of the Senate Committee on Education and Health and one member each of the Senate Committees on Rehabilitation and Social Services, and on Finance to be appointed by the Senate Committee on Privileges and Elections, two members of the House Committee on Health, Welfare and Institutions, one member each of the House Committees on Appropriations, on Corporations, Insurance and Banking and on Courts of Justice to be appointed by the Speaker of the House and one representative each of the Medical Society of Virginia and the Virginia Hospital Association, to be appointed by the Governor.

All agencies of the Commonwealth shall provide assistance upon request as the joint subcommittee may deem appropriate.

The joint subcommittee shall complete its work in time to submit its findings and recommendations to the Governor and the 1990 General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

The indirect costs of this study are estimated to be $13,255; the direct costs of this study shall not exceed $9,100.

Attachment B

PSYCHIATRIC ADMISSION QUESTIONNAIRE

Name of facility _____

Name and title of person completing this form

_____

_____

A. Type of facility (please circle one):

1. psychiatric unit of general proprietary hospital

2. psychiatric unit of general voluntary hospital

3. psychiatric unit of a governmental hospital (eg., MCV, UVA)

4. proprietary psychiatric hospital

5. voluntary psychiatric hospital

B What is the total number of licensed psychiatric beds in your facility? ___

What is the total number of licensed substance abuse beds in your facility? ___

C. Does your facility provide outpatient and/or partial hospitalization psychiatric services in addition to inpatient care? YES NO

If yes, are outpatient and/or partial hospitalization services provided

1. to former patients and their families? YES NO

2. to the general public? YES NO

D. Is the admission decision routinely reviewed prior to or immediately following the patient's admission? YES NO

1. Is it your policy to require an in-house evaluation (by a member of your staff) prior to admission? YES NO

2. Are your admissions subject to public and private utilization reviews? YES NO Please indicate number of reviewing entities. ___
Please list reviewing entities and location:

E. Except in the case of a TDO (temporary detention order) or AMA (against medical advice) situation, do you provide a discharge plan for every patient? YES NO
Who is involved in the development of the plan?

What is included in the plan?

If you have a discharge plan form, please attach a copy.

F. Do you have a record of where clients are discharged or transferred? YES NO
If you maintain these records, in the past fiscal or calendar year how many of your clients were discharged or transferred to:

State facility ____
Community facility ____
Home ____

G. Do you provide case management after discharge? YES NO

Who conducts case management activities?

What are the functions of the case manager?

___ *Outreach to clients, family members and others.*

___ *Ongoing assessment and reassessment of individual client needs.*

___ *Planning for services, eg. support, medical and social services, rehabilitation services, housing.*

___ *Linking clients to services.*

___ *Monitoring.*

___ *Advocacy on behalf of clients and families.*

H. Do you provide treatment teams? YES NO

In responding to the following questions please use data from your 1988 calendar or 1989 fiscal year, whichever is more appropriate to your records management system. *(Please specify timeframe for data.)*

I. What is the legal status and age of all admissions to your facility?

Admissions Status by Age

TYPE OF ADMISSION	Adolescent (under 18)	Adult (18-64)	Geriatric (over 65)
Voluntary			
Involuntary			
Temporary detention order			

J. What are your admissions criteria? (please attach if necessary)

How many persons brought to your facility were not admitted? _____

Reasons:	*Number:*
1. did not meet admission criteria	___
2. lack of financial resources	___
3. referral to other services (please specify where and how many times used)	___
4. other (please specify)	___
5. _____	___

K. *Does your facility operate any type of crisis "hotline"? YES NO*

If yes, how many calls did you receive last year? ___

Of these calls, how many resulted in admission to your facility? __

What other types of referrals were made?

How are the persons who staff such a hotline paid?

Training Level of "Hotline" Personnel

	M.S.W. or Masters of Psychology	R.N.	Clinical Nurse Practitioner	B.A.	M.H. Worker	Ph.D.	M.D.
NUMBER OF STAFF							

Of those patients admitted to your facility through this means, please delineate by diagnosis and payment source (State facilities will be providing this information in the following format. If you can use this format, please do; if not, please follow it as closely as possible based on your patient information.):

Crisis Hotline Admissions
Payment Source by Diagnosis
(in numbers of admissions)

		PAYMENT SOURCE								
	DIAGNOSIS	Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
	Mental Retardation									
Psychiatric	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

L. *How many of your total admissions for the year constituted readmission? (Readmission is defined as a second or subsequent admission during the year.)* ___

M. *Of admitting physicians, how many are:*

1. *full-time hospital staff (employees)* ___

2. *physicians with hospital privileges* ___

What other persons or groups of persons have admitting privileges?

N. *What is the length of stay by diagnosis in your facility? (State facilities will be providing this information in the following format. If you can use the format, please do; if not, please follow it as closely as possible based on your patient information.)*

Length of Stay by Diagnosis
(in numbers of admissions)

		LENGTH OF STAY					
	DIAGNOSIS	0-14 days	15-30 days	31-90 days	91-365 days	over 365 days	
Substance Abuse	Drug						
	Alcohol						
	Mental Retardation						
Psychiatric	Organic brain syndromes						
	Depression						
	Schizophrenia						
	Other psychoses						
	Other neuroses						
	Personality disorders						
	Pre-adult disorders						
	Other mental disorders						
	Social maladjustments						
	General psychiatric exam						
	Nonspecific conditions						
	Unclassifiable						

O. *In your overall discharges, what is the payment source by diagnosis? (State facilities will be providing this information in the following format. If you can use this format, please do; if not, please follow it as closely as possible based on your client information.)*

Payment Source by Diagnosis
(in numbers of discharges)

		PAYMENT SOURCE								
	DIAGNOSIS	Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
	Mental Retardation									
Psychiatric	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

P. What is the average length of stay by diagnosis and payment source?

Average Length of Stay (in days)
by Diagnosis and Payment Source

	DIAGNOSIS	PAYMENT SOURCE								
		Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
	Mental Retardation									
Psychiatric	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

Q. *How many clients have a secondary diagnosis of:*

Substance abuse:
- *drug* ___
- *alcohol* ___

Mental retardation ___

Psychiatric:
- *organic brain syndromes* ___
- *depression* ___
- *schizophrenia* ___
- *other psychoses* ___
- *other neuroses* ___
- *personality disorders* ___
- *pre-adult disorders* ___
- *other mental disorders* ___
- *social maladjustments* ___
- *general psychiatric exam* ___
- *nonspecific conditions* ___
- *unclassifiable* ___

R. *How many patients have been transferred from your facility to state facility operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services?* _____

Indicate the number and reasons why these patients were transferred:

Reasons:	*Number:*
1. Need for extended treatment	___
2. Termination of Insurance coverage	___
3.	___
4.	___
5.	___
6.	___

	DIAGNOSIS	AVERAGE LENGTH OF STAY PRIOR TO TRANSFER
Substance Abuse	Drug	
	Alcohol	
	Mental Retardation	
Psychiatric	Organic brain syndromes	
	Depression	
	Schizophrenia	
	Other psychoses	
	Other neuroses	
	Personality disorders	
	Pre-adult disorders	
	Other mental disorders	
	Social maladjustments	
	General psychiatric exam	
	Nonspecific conditions	
	Unclassifiable	

Admissions Status by Age

TYPE OF ADMISSION	Adolescent (under 18)	Adult (18-64)	Geriatric (over 65)
Voluntary			
Involuntary			
Temporary detention order			

Length of Stay by Diagnosis
(in numbers of admissions)

		LENGTH OF STAY					
	DIAGNOSIS	0-14 days	15-30 days	31-90 days	91-365 days	over 365 days	
Substance Abuse	Drug						
	Alcohol						
	Mental Retardation						
Psychiatric	Organic brain syndromes						
	Depression						
	Schizophrenia						
	Other psychoses						
	Other neuroses						
	Personality disorders						
	Pre-adult disorders						
	Other mental disorders						
	Social maladjustments						
	General psychiatric exam						
	Nonspecific conditions						
	Unclassifiable						

Average Length of Stay (in days) by Diagnosis and Payment Source

DIAGNOSIS		PAYMENT SOURCE								
		Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
Psychiatric	Mental Retardation									
	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

Crisis Hotline Admissions
Payment Source by Diagnosis
(in numbers of admissions)

PAYMENT SOURCE

DIAGNOSIS		Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
	Mental Retardation									
Psychiatric	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

	DIAGNOSIS	AVERAGE LENGTH OF STAY PRIOR TO TRANSFER
Substance Abuse	Drug	
	Alcohol	
	Mental Retardation	
Psychiatric	Organic brain syndromes	
	Depression	
	Schizophrenia	
	Other psychoses	
	Other neuroses	
	Personality disorders	
	Pre-adult disorders	
	Other mental disorders	
	Social maladjustments	
	General psychiatric exam	
	Nonspecific conditions	
	Unclassifiable	

Training Level of "Hotline" Personnel

	M.S.W. or Masters of Psychology	R.N.	Clinical Nurse Practitioner	B.A.	M.H. Worker	Ph.D.	M.D.
NUMBER OF STAFF							

Payment Source by Diagnosis
(in numbers of discharges)

		PAYMENT SOURCE								
	DIAGNOSIS	Blue Cross/Blue Shield	PPO	Champus	HMO	Medicare	Medicaid	Private insurance co.	Out-of-pocket	
Substance Abuse	Drug									
	Alcohol									
	Mental Retardation									
Psychiatric	Organic brain syndromes									
	Depression									
	Schizophrenia									
	Other psychoses									
	Other neuroses									
	Personality disorders									
	Pre-adult disorders									
	Other mental disorders									
	Social maladjustments									
	General psychiatric exam									
	Nonspecific conditions									
	Unclassifiable									

Attachment C

VIRGINIA HOSPITAL ASSOCIATION

Materials

Presented to

S.J.R. 191

Admission Questionnaire Results
for
Psychiatric Units of General Proprietary Hospitals

A. Licensed Beds

Psychiatric:
Mean = 71
Range = (52 - 89)

Substance Abuse:
Mean = 19
Range = (13 - 24)

B. Provision of Outpatient and/or Partial Hospitalization Services

Yes - 50%
No - 50%

provided to former patients and their families but not necessarily to the general public.

C. Provision of Discharge Plan

Yes - 0%
No - 100%

D. Case Management after Discharge

Yes - 0%
No - 100%

E. Record of Discharge/Transfer Sites

Yes - 100%
No - 0%

Destination:
State facility (15%)
Community facility (65%)
Home (20%)

F. Provide Treatment Teams

Yes - 100%
No - 0%

G. Operate Crisis Hotline

Yes - 0%
No - 100%

H. Reasons for Transfer

Insufficient data

I. Reasons for Non-Admissions

Insufficient data

J. Admissions by Legal Status

Insufficient data

Admission Questionnaire Results
for
Psychiatric Units of General Voluntary Hospitals

A. Licensed Beds

Psychiatric:
Mean = 25
Range = (12 - 54)

Substance Abuse:
Mean = 23, if available
Range = (0 - 30)

B. Provision of Outpatient and/or Partial Hospitalization Services

Yes - 50%,
No - 50%

all of which provide services to former patients and their families as well as to the general public.

C. Provision of Discharge Plan

Yes - 90%
No - 10%

D. Case Management after Discharge

Yes - 10%
No - 90%

E. Record of Discharge/Transfer Sites

Yes - 50%
No - 50%

Destination:
State facility (5%)
Community facility (6%)
Home (89%)

F. Provide Treatment Teams

Yes - 70%
No - 30%

G. Operate Crisis Hotline

Yes - 10%
No - 90%

H. Reasons for Transfer

Need for extended treatment (91%)
Termination of insurance coverage (2%)
Other (7%)

I. Reasons for Non-Admissions

Did not meet criteria (11%)
Lack of financial resources (32%)
Referral to other services (44%)
Other (13%)

J. Admissions by Legal Status

Voluntary (90%)
Involuntary (1%)
Temporary Detention Order (9%)

Admission Questionnaire Results for Proprietary Psychiatric Hospitals

A. Licensed Beds

Psychiatric:
Mean = 102
Range = (60 - 186)

Substance Abuse:
Mean = 25, if available
Range = (16 - 30)

B. Provision of Outpatient and/or Partial Hospitalization Services

Yes - 95%
No - 5%

all of which provide services to former patients and their families as well as to the general public

C. Provision of Discharge Plan

Yes - 100%
No - 0%

D. Case Management after Discharge

Yes - 0%
No - 100%

E. Record of Discharge/Transfer Sites

Yes - 75%
No - 25%

Destination:
State facility (4%)
Community facility (4%)
Home (92%)

F. Provide Treatment Teams

Yes - 100%
No - 0%

G. Operate Crisis Hotline

Yes - 40%
No - 60%

H. Reasons for Transfer

Need for extended treatment (100%)
Termination of insurance coverage
Other

I. Reasons for Non-Admissions

Did not meet criteria (50%)
Lack of Financial resources (13%)
Referral to other services (14%)
Other (23%)

J. Admissions by Legal Status

Voluntary (83%)
Involuntary (4%)
Temporary Detention Order (13%)

FISCAL YEAR 1987

HOSPITAL:	Gross Patient Revenue	Bad Debt	Charity Care	Bad Debt % of Gross Rev	Char Care % of Gross Rev
Charter Colonial Inst	$10,442,279	$218,275	$148,341	2%	1%
Charter Hosp of Charltsvl	$6,784,242	$166,893	$0	2%	0%
Charter Westbrook	$19,865,312	$293,980	$377,291	1%	2%
Dominion Hospital	$14,939,503	$157,149	$0	1%	0%
Graydon Manor	$4,743,585	$205,910	$140,592	4%	3%
Norfolk Psychiatric Center	$8,642,106	$1,005,097	$0	12%	0%
Peninsula Psych Hospital	$12,296,065	$507,221	$273,670	4%	2%
Poplar Springs Hospital	$12,591,654	$235,118	$1,064,839	2%	8%
Portsmouth Psych Center	$22,290,021	$2,685,927	$479,203	12%	2%
Psych Inst of MC of HR	$8,150,404	$975,768	$205,420	12%	3%
Psych Institute of Richmond	$8,537,961	$324,261	$0	4%	0%
Roanoke Valley Psych Center	$16,004,324	$452,239	$28,286	3%	0%
Saint Albans Hospital	$20,404,951	$2,151,802	$406,040	11%	2%
Springwood Psych	$8,931,402	$299,411	$706,445	3%	8%
Tidewater Psych - Norfolk	$16,023,319	$534,202	$376,123	3%	2%
Tidewater Psych - VA Beach	$11,476,886	$326,416	$191,095	3%	2%
	$202,124,014	$10,539,669	$4,397,345	5%	2%

SOURCE: Virginia Health Services Cost Review Council

Hospital Financial Data for 1988

HOSPITAL	Gross Revenue	Net Revenue	Operating Expenses	Operating Margin	Oper.Mar/ Net Rev.
Charter Colonial Inst	$11,779,302	$9,083,969	$8,979,575	$173,070	2%
Charter Hosp of Charltsvl	$8,018,415	$5,820,806	$6,469,754	($604,861)	-10%
Charter Westbrook	$24,031,951	$16,871,032	$17,008,761	$116,653	1%
Dominion Hospital	$17,395,219	$15,518,467	$13,025,518	$2,608,881	17%
Graydon Manor	$5,243,391	$4,206,342	$3,958,304	$281,382	7%
Norfolk Psychiatric Center	$10,708,141	$6,035,937	$6,475,098	($349,064)	-6%
Peninsula Psych Hospital	$16,427,426	$11,919,870	$11,228,114	$799,469	7%
Poplar Springs Hospital	$14,373,322	$10,684,472	$9,344,686	$1,422,978	13%
Portsmouth Psych Center	$26,022,258	$14,346,364	$14,356,170	$254,864	2%
Psych Inst of MC of HR	$7,557,566	$5,527,621	$5,702,733	($44,411)	-1%
Psych Institute of Richmond	$11,835,137	$8,944,461	$8,786,285	$374,773	4%
Roanoke Valley Psych Center	$17,463,722	$13,132,708	$12,593,969	$617,826	5%
Saint Albans Hospital	$22,005,573	$16,410,007	$15,639,185	$1,123,499	7%
Springwood Psych	$11,340,380	$10,023,584	$8,287,760	$1,941,757	19%
Tidewater Psych - Norfolk	$20,371,063	$11,718,522	$10,162,504	$1,795,648	15%
Tidewater Psych - VA Beach	$17,280,415	$8,842,161	$8,395,229	$498,543	6%
	$241,853,281	$169,086,323	$160,413,645	$11,011,007	7%

SOURCE: Virginia Health Services Cost Review Council

Admissions Status by Age
Psychiatric Unit of General Voluntary Hospital

	Adolescent	Adult	Geriatric
Voluntary	88%	90%	93%
Involuntary	0%	0%	0%
Temporary Detention Order	12%	9%	7%

Admissions Status by Age
Proprietary Psychiatric Hospital

	Adolescent	Adult	Geriatric
Voluntary	93%	81%	96%
Involuntary	3%	0%	0%
Temporary Detention Order	4%	19%	4%

Length of Stay by Diagnosis
Psychiatric Unit of General Voluntary Hospital
(in numbers of admissions)

	0-14 days	15-30 days	31-90 days	91-365 days	365+ days
Substance Abuse					
Mean	62	22	5		
Range	6 - 125	2 - 102	1 - 15	0 - 1	0
Psychiatric					
Mean	306	101	33		
Range	124 - 600	56 - 170	8 - 65	0 -4	0

Length of Stay by Diagnosis
Proprietary Psychiatric Hospital
(in numbers of admissions)

	0-14 days	15-30 days	31-90 days	91-365 days	365+ days
Substance Abuse					
Mean	86	75	7		
Range	13 - 202	3 - 182	1 - 11	0	0
Psychiatric					
Mean	155	162	158		
Range	6 - 356	8 - 403	3 - 317	0 - 9	0

Payment Source by Diagnosis
Psychiatric Unit of General Voluntary Hospital
(in numbers of discharges)

	Blue Cross/ Blue Shield	Managed Care	Medicare	Medicaid	Private Insurance	Other*
Substance Abuse	19%	18%	9%	10%	20%	19%
Psychiatric	81%	82%	91%	90%	80%	81%

Payment Source by Diagnosis
Proprietary Psychiatric Hospital
(in numbers of discharges)

	Blue Cross/ Blue Shield	Managed Care	Medicare	Medicaid	Private Insurance	Other*
Substance Abuse	16%	0%	17%	0%	20%	8%
Psychiatric	84%	100%	73%	0%	80%	92%

* composed of Champus and "out-of-pocket"

Diagnosis by Payment Source
Psychiatric Unit of General Voluntary Hospital
(in numbers of discharges)

	Blue Cross/ Blue Shield	Managed Care	Medicare	Medicaid	Private Insurance	Other*
Substance Abuse	25%	13%	11%	5%	33%	13%
Psychiatric	21%	11%	22%	8%	26%	12%

Diagnosis by Payment Source
Proprietary Psychiatric Hospital
(in numbers of discharges)

	Blue Cross/ Blue Shield	Managed Care	Medicare	Medicaid	Private Insurance	Other*
Substance Abuse	45%	0%	14%	0%	32%	9%
Psychiatric	46%	1%	8%	0%	25%	20%

* composed of Champus and "out-of-pocket"

CRISIS "HOTLINE" DATA

	ALL PROPRIETARY HOSPITALS	ALL VOLUNTARY HOSPITALS
TOTAL RESPONSE	8	12
% WITH HOTLINE	25%	8%
MEAN # OF CALLS	1397	1500
ADMISSIONS	102 (7%)	15 (10%)
STAFFING:		
B.A.	4	1
M.H. Worker	2	0
R.N.	0	14
M.S.W.	0	1

The attached data described discharges from state mental health facilities* during fiscal year 1987-88. The data is based on information reported by each facility to the Automated Reimbursement System (ARS).

In this report, discharges were categorized using the following criteria:

1. Forensic Discharges
   a. any patient discharged from the forensic ward at Central State Hospital

2. Children/Adolescent Discharges
   a. Any patient discharged from Dejarnette or Virginia Treatment Center
   b. Any patient less than 18 years old discharged from any other facility
   c. if not categorized above

3. Geriatric Discharges
   a. Any patient discharged from Piedmont
   b. any patient 65 year or older discharged from any other facility
   c. if not categorized above

4. Mentally Retarded Discharges
   a. any patient with a primary diagnosis of mental retardation discharged from any facility
   b. if not categorized above

5. Alcoholic Discharges
   a. any patient with a primary diagnosis of alcoholism discharged from any facility
   b. if not categorized above

6. Other Mental Health Discharges
   a. any discharge patient not categorized above

Please direct question, comments, or requests for additional information of the EUCC Section of the Department of MHMRSAS at (804) 786-1010.

* Hiram Davis Medical Center is excluded from these tabulations.

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF HOSPITAL BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
Eastern	0	152	69	11	223	1394	1849
Western	0	6	83	5	412	910	1416
Central	686	106	13	11	269	741	1826
Southwestern	0	106	64	21	413	650	1254
Dejarnette	0	155	0	0	0	0	155
Catawba	0	1	120	6	9	224	360
VA Treatment Center	0	289	0	0	0	0	289
Piedmont	0	0	80	0	0	0	80
N V M H I	0	25	27	2	63	800	917
S V M H I	0	34	3	11	65	787	900
TOTAL	686	874	459	67	1454	5506	9046

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF SEX BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
Male	607	557	206	43	1224	3124	5761
Female	79	317	253	24	230	2382	3285
TOTAL	686	874	459	67	1454	5506	9046

TABLE OF RACE BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
White	329	603	328	46	1144	3520	5970
Black	352	253	128	21	308	1893	2955
Other	5	18	3	0	2	93	121
TOTAL	686	874	459	67	1454	5506	9046

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF LEGAL STATUS BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
Voluntary	5	319	142	17	623	1781	2887
Involuntary	681	555	317	50	831	3725	6159
TOTAL	686	874	459	67	1454	5506	9046

TABLE OF STATUS BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
First Admission	314	439	122	10	350	1041	2276
Readmission	368	388	276	52	1095	4251	6430
Transfer	4	47	61	5	8	210	335
Unknown	0	0	0	0	1	4	5
TOTAL	686	874	459	67	1454	5506	9046

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF AGE GROUP BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
0 - 5	0	15	0	0	0	0	15
6 - 12	0	245	0	0	0	0	245
13 - 17	9	613	0	0	0	0	622
18 - 20	70	1	0	6	41	294	412
21 - 30	287	0	0	24	334	2042	2687
31 - 45	259	0	0	22	634	2069	2984
46 - 64	54	0	0	15	445	1101	1615
65 - 75	6	0	284	0	0	0	290
76 +	1	0	175	0	0	0	176
TOTAL	686	874	459	67	1454	5506	9046

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF LOSDAYS BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
0 - 2 DAYS	91	30	25	7	336	339	828
3 - 6 DAYS	91	29	27	0	482	365	994
7 - 13 DAYS	130	50	16	6	243	528	973
14 - 29 DAYS	182	165	36	16	197	1250	1846
30 - 59 DAYS	103	147	55	10	121	1395	1831
60 - 89 DAYS	30	110	50	4	29	589	812
90 - 182 DAYS	32	191	79	6	29	635	972
183 - 365 DAYS	13	106	48	5	11	233	416
1 - 2 YEARS	7	29	24	4	3	97	164
2 - 5 YEARS	3	14	47	4	3	44	115
5 - 10 YEARS	3	3	25	2	0	21	54
10 - 15 YEARS	1	0	14	1	0	4	20
15 - 25 YEARS	0	0	3	0	0	4	7
25 + YEARS	0	0	10	2	0	2	14
TOTAL	686	874	459	67	1454	5506	9046

Mental Health Discharges
From July 1, 1987 through June 30, 1988
STATEWIDE

TABLE OF DX BY DISTYPE

	Forensics	Children	Geriatrics	Mentally Retarded	Alcoholics	Other M H	TOTAL
M R	5	17	7	67	0	0	96
Alcoholism	34	5	74	0	1454	0	1567
Drug Dep. - Intox	18	19	1	0	0	380	418
O B S	9	14	153	0	0	176	352
Depression	54	212	70	0	0	1378	1714
Schizophrenia	192	56	96	0	0	2231	2575
Other Psychoses	121	17	17	0	0	369	524
Other Neuroses	3	5	2	0	0	30	40
Personality Disorders	4	11	3	0	0	144	162
Pre-adult Disorders	6	325	1	0	0	17	351
Other Mental Disorders	182	151	15	0	0	598	946
Social Maladjustments	5	14	3	0	0	44	66
Psychiatric Exam	27	4	0	0	0	14	45
Nonspecific Conditions	20	15	2	0	0	46	83
Unclassifiable	4	9	15	0	0	79	107
TOTAL	686	874	459	67	1454	5506	9046

Attachment E

1990 SESSION

LD1439574

SENATE BILL NO. 110

Offered January 16, 1990

A BILL to amend the Code of Virginia by adding a section numbered 38.1-3404.1, relating to accident and sickness insurance.

Patrons–Stallings and Miller, E.F.; Delegate: Stambaugh

Referred to the Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 38.1-3404.1 as follows:

§ 38.1-3404.1. Telephone access provided for consumer complaints.–The Commission shall maintain the capability for receiving by telephone without toll during regular business hours consumer complaints from persons insured under accident and sickness insurance policies or contracts. Each insurer, corporation, or health maintenance organization issuing such policies or contracts shall include on any identification card it issues on a new or renewed accident or sickness insurance policy or contract the telephone number maintained for this purpose.

1990 SESSION

LD0547574

SENATE BILL NO. 129

Offered January 17, 1990

A BILL to amend the Code of Virginia by adding a section numbered 37.1-188.1, relating to licensed facilities and institutions for treatment of mentally ill or mentally retarded persons or persons addicted to drugs, alcohol, or other stimulants.

Patrons–Miller, E.F., Stallings, Michie and Buchanan; Delegates: Stambaugh, Plum, Byrne, Mayer, Van Landingham, DeBoer and Howell

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Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding a section numbered 37.1-188.1 as follows:

§ 37.1-188.1. Advertising by licensed facilities or institutions.–The Board shall promulgate regulations governing advertising practices of any facility or institution licensed pursuant to this chapter. Such regulations shall include but need not be limited to principles stated in the current guidelines for advertising developed by the National Association of Private Psychiatric Hospitals and shall require that any such facility's or institution's advertisement not contain false or misleading information or representations as to fees charged for services.

Attachment G

1990 SESSION

LD0546574

SENATE BILL NO. 107

Offered January 16, 1990

A BILL to amend the Code of Virginia by adding sections numbered 32.1-135.2, 37.1-186.1, and 54.1-2962.1, relating to remuneration of practitioners of the healing arts for referrals.

Patrons–Stallings and Miller, E.F.; Delegate: Stambaugh

Referred to the Committee on Education and Health

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding sections numbered 32.1-135.2, 37.1-186.1, and 54.1-2962.1 as follows:

§ 32.1-135.2. Offer or payment of remuneration in exchange for referral prohibited.–No hospital licensed pursuant to this chapter shall knowingly and willfully offer or pay any remuneration directly or indirectly, in cash or in kind, to induce any practitioner of the healing arts to refer an individual or individuals to such hospital. For purposes of this section, remuneration shall include but not be limited to preference with respect to professional hospital privileges of such practitioner. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall be developed in conjunction with the State Mental Health, Mental Retardation and Substances Abuse Services Board and shall be consistent with regulations adopted by such Board pursuant to § 37.1-186.1.

§ 37.1-186.1. Offer or payment of remuneration in exchange for referral prohibited.–No facility or institution licensed pursuant to this chapter shall knowingly and willfully offer or pay any remuneration directly or indirectly, in cash or in kind, to induce any practitioner of the healing arts to refer an individual or individuals to such facility or institution. For purposes of this section, remuneration shall include but not be limited to preference with respect to professional hospital privileges of such practitioner. The Board shall adopt regulations as necessary to carry out the provisions of this section. Such regulations shall be developed in conjunction with the State Board of Health and shall be consistant with regulations adopted by such Board pursuant to § 32.1-135.2.

§ 54.1-2962.1. Solicitation or receipt of remuneration in exchange for referral prohibited. –No practitioner of the healing arts shall knowingly and willfully solicit or receive any remuneration directly or indirectly, in cash or in kind, in return for referring an individual or individuals to a facility or institution as defined in § 37.1-179 or a hospital as defined in § 32.1-123. For purposes of this section, remuneration shall include but not be limited to preference with respect to professional hospital privileges of such practitioner. The Board shall adopt regulations as necessary to carry out the provisions of this section.

HOUSE BILL NO. 328

Offered January 18, 1990

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.1 and by adding in Title 38.2 a chapter numbered 53, consisting of sections numbered 38.2-5300 through 38.2-5311, relating to hospital utilization review; penalty.

Patrons–Stambaugh, Plum, Van Landingham, DeBoer and Howell; Senators: Stallings, Miller, E.F., Michie and Buchanan

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Referred to the Committee on Corporations, Insurance and Banking

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Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Article 1 of Chapter 34 of Title 38.2 a section numbered 38.2-3407.1 and by adding in Title 38.2 a chapter numbered 53, consisting of sections numbered 38.2-5300 through 38.2-5311, as follows:

§ 38.2-3407.1. Utilization review by certain insurers; payment when medical necessity of provision of benefit is disputed.–A. Each (i) insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense incurred basis, (ii) each corporation providing individual or group accident and sickness subscription contracts, and (iii) each health maintenance organization providing a health care plan for health care services shall:

1. Have a certificate in accordance with Chapter 53 of this title;

2. Contract with a private review agent that has a certificate in accordance with Chapter 53 of this title; or

3. Contract with or delegate utilization review of services provided in a hospital setting to that hospital's utilization review program.

B. For claims where the medical necessity of the provision of a covered benefit is disputed, any such insurer, corporation, or health maintenance organization that does not meet the requirements of subsection A of this section shall pay any person or hospital entitled to reimbursement under the policy, contract, or plan (i) in cases involving inpatient care, in accordance with the determination of medical necessity by the hospital utilization review program and (ii) in cases involving outpatient care, by an independent expert or panel of experts in the field of medicine or health care relevant to the case.

§ 38.2-4214. Application of certain provisions of law.–No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, 38.2-1300 through 38.2-1310, 38.2-1312, 38.2-1314, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3409, 38.2-3411 through 38.2-3419, 38.2-3501, 38.2-3502, 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3500, 38.2-3541 ~~and~~ , 38.2-3600 through 38.2-3607 *and Chapter 53 (§ 38.2-5300 et seq.) of this title* shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.–A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 of this title, 38.2-1317 through 38.2-1321, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, ~~and~~ 38.2-3418.1 , *and Chapter 53 (§ 38.2-5300 et seq.) of this title* shall be applicable to any health maintenance organization granted a license under this chapter.

This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

CHAPTER 53.

PRIVATE REVIEW AGENTS.

§ 38.2-5300. Definitions.—In this chapter, the following words have the meanings indicated:

"Certificate" means a certificate of registration granted by the Commissioner to a private review agent.

"Commissioner" means the Commissioner of Insurance.

"Physician advisor" means a physician licensed to practice medicine in the Commonwealth who provides medical advice or information to a private review agent in connection with the utilization review activities.

"Private review agent" means a nonhospital-affiliated person or entity performing utilization review that is either affiliated with, under contract with, or acting on behalf of (i) an insurer issuing individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense incurred basis, (ii) a corporation providing individual or group accident and sickness subscription contracts, (iii) a health maintenance organization providing a health care plan for health care services, or (iv) a self-insured employer.

"Utilization review" means a system for reviewing the allocation of hospital, medical, or other health care services given or proposed to be given to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, prepaid health plan, health maintenance organization, or other entity or person. For purposes of this chapter, "utilization review" shall include but not be limited to pre-admission review, medical necessity review, length-of-stay review, and review relating to the appropriateness of the site at which services were or are to be delivered.

"Utilization review plan" means a description of the standards and procedures governing utilization review activities performed by a private review agent.

§ 38.2-5301. Certificates required; issuance; transferability; regulations.—A private review agent may not conduct utilization review in the Commonwealth unless the Commissioner has granted the private review agent a certificate. The Commissioner shall issue a certificate to an applicant that has met all the requirements of this chapter and all applicable regulations of the Commission. A certificate issued under this chapter is not transferrable. The Commission, after consultation with payors, including the Health Insurance Association of America and the Virginia Association of Health Maintenance Organizations, and providers of health care, including the Virginia Hospital Association, and the Medical Society of Virginia, shall adopt regulations to implement the provisions of this chapter. Such regulations shall include the following minimum requirements:

1. Patient-specific medical records and information shall be kept strictly confidential but may be released as authorized by the patient or by regulation.

2. Nurse reviewers and other health care providers who review cases shall be required to be licensed in the Commonwealth and to have no less than five years of relevant experience in the field or fields of medicine or health care in which they review cases. Physician advisors shall be Board certified or have equivalent training or experience in any specialty or subspecialty in which they review cases or provide medical advice or information.

3. Any length-of-stay criteria adopted by the private review agent shall have a sound

medical basis which takes community standards into consideration.

4. The private review agent shall fully disclose and communicate effectively to patients and affected health care providers its utilization review plan as such pertains to such patients and health care providers.

5. No final determination or recommendation adverse to a patient or to any affected health care provider shall be made by a reviewer on any question relating to the necessity or justification for any form of hospital, medical, or other health care services without prior evaluation and concurrence in the adverse determination or recommendation by a physician advisor. The attending physician or other appropriate health care provider shall have an opportunity to consult with the physician advisor prior to a final denial of third-party reimbursement or denial of precertification for hospital, medical, or other health care services. Any notice of such adverse determination to the patient or to any affected health care provider shall include the evaluation, findings, and conclusions of the physician advisor.

6. Exceptions to precertification requirements shall be provided to address situations in which preauthorization reasonably cannot be obtained in sufficient time to avoid medical risk to the patient.

7. An appeals procedure available to patients and to affected health care providers shall be established which includes a provision for review of adverse determinations by an independent expert, or panel of experts, in the field of medicine or health care relevant to the case.

§ 38.2-5302. Same; application; fees.—An applicant for a certificate shall submit an application to the Commissioner and pay to the Commissioner the application fee established by regulation. The application shall be on a form and accompanied by supporting documentation as required by regulation and shall be signed and verified by the applicant. The application fees required under this section or § 38.2-5304 of this chapter shall be sufficient to pay for the administrative costs of the certificate program and any other costs associated with carrying out the provisions of this chapter.

§ 38.2-5303. Same; additional information.—In conjunction with the application, the private review agent shall submit the following information:

1. A utilization review plan that includes:

a. A description of review standards and procedures to be used in evaluating proposed or delivered hospital, medical, or other health care services;

b. The provisions, in compliance with regulation, by which patients, physicians, or hospitals may seek reconsideration or appeal of adverse decisions or recommendations by the private review agent;

c. The type and qualifications of the personnel either employed or under contract to perform the utilization review;

d. The procedures and policies to ensure that a representative of the private review agent is reasonably accessible to patients and providers five days a week during normal business hours; and

e. The policies and procedures to ensure that all applicable state and federal laws and regulations to protect the confidentiality of individual medical records are followed.

2. A copy of the materials designed to inform patients and providers of the requirements of the utilization review plan.

3. A list of the entities for which the private review agent is performing utilization review in this Commonwealth.

4. Any other information required pursuant to regulations promulgated by the Commission.

§ 38.2-5304. Same; expiration; renewal.—Each certificate shall expire on the second anniversary of its effective date unless the certificate is renewed for a two-year term as provided in this section. A certificate may be renewed for an additional two-year term if the applicant is otherwise entitled to the certificate, pays to the Commissioner the renewal fee set by regulations, submits to the Commissioner a renewal application on a form

prescribed by the Commissioner, submits satisfactory evidence of compliance with the requirements of this chapter and updates information on file with the Commissioner pursuant to § 38.2-5303. If the requirements of this section are met, the Commissioner shall renew a certificate.

§ 38.2-5305. Same; denial; revocation.—A.1. The Commissioner shall deny a certificate to any applicant if, upon review of the application, he finds that the applicant proposing to conduct utilization review does not:

a. Have available the services of sufficient numbers of qualified persons to carry out its utilization review plan; and

b. Meet any applicable regulations the Commission adopts under this chapter relating to the qualifications of private review agents or the performance of utilization review.

2. The Commissioner shall deny a certificate to any applicant that does not provide assurances satisfactory to the Commissioner that:

a. The procedures and policies of the private review agent will protect the confidentiality of patient medical records in accordance with applicable state and federal laws and regulations; and

b. The private review agent will be accessible to patients and providers five working days a week during normal business hours in this Commonwealth.

B. The Commissioner may revoke a certificate if the holder does not comply with performance assurances under this section, violates any provision of this chapter, or violates any regulation adopted pursuant to any provision of this chapter.

C. Before denying or revoking a certificate under this section, the Commissioner shall provide the applicant or certificate holder with reasonable time to supply additional information demonstrating compliance with the requirements of this chapter and the opportunity to request a hearing. If an applicant or certificate holder requests a hearing, the Commissioner shall send a hearing notice by certified mail, return receipt requested, at least thirty days before the hearing. The Commissioner shall conduct the hearing in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.).

§ 38.2-5306. Waiver of requirements of chapter.—The Commissioner may waive the requirements of this chapter for a private review agent that operates solely under contract with the federal government for utilization review of patients eligible for hospital services under Title XVIII of the Social Security Act.

§ 38.2-5307. List of private review agents.—The Commissioner shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to the Virginia Chamber of Commerce, the Virginia Hospital Association, the Medical Society of Virginia, all hospital utilization review programs, and any other business or labor organization requesting the list.

§ 38.2-5308. Reporting requirements.—The Commissioner may establish reporting requirements to evaluate the effectiveness of private review agents and to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable regulations.

§ 38.2-5309. Disclosure or publication of medical records or information.—A private review agent shall not disclose or publish individual medical records or any other confidential medical information obtained in the performance of utilization review activities.

§ 38.2-5310. Penalties.—A person who violates any provision of this chapter or any regulation adopted under this chapter is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding $1,000. Each day a violation is continued after the first conviction is a separate offense.

§ 38.2-5311. Judicial review.—Any person aggrieved by a final decision of the Commissioner in a contested case under this chapter may take a direct judicial appeal. The appeal shall be made as provided for the judicial review of final decisions pursuant to the Administrative Process Act (§ 9-6.14:1 et seq.).

2. That the Commissioner of Insurance shall report to the General Assembly by July 1,

1991, and annually thereafter on the number of private review agents conducting utilization review, the criteria used to perform utilization review, the feasibility of adopting uniform standards for one or more aspects of utilization review, including standardized forms for data collection, and the medical procedures for which preauthorization and second surgical opinions shall be required.

SENATE JOINT RESOLUTION NO. 22

Offered January 17, 1990

Expressing the General Assembly's support of the development of alternative levels of care for psychiatric and substance abuse treatment and insurance coverage that will reimburse for such care.

Patrons–Miller, E.F., Stallings, Michie, Miller, Y.B., Buchanan and Saslaw; Delegates: Stambaugh, Plum, Byrne, Mayer, Van Landingham, DeBoer and Howell

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Referred to the Committee on Rules

WHEREAS, in recent years insurance coverage for treatment of mental and substance abuse disorders has become almost commonplace, and such coverage is mandated in Virginia by § 38.2-3412 of the Code; and

WHEREAS, expansion of mental health coverage can be attributed to a number of factors, including new and better types of treatment, development of a variety of treatment settings, increased public acceptance of mental health treatment, and the state and federal policy of deinstitutionalization; and

WHEREAS, treatment for mental and nervous disorders, which include drug and alcohol dependence by definition, has been shown to be effective in terms of clinical outcome and costs; and

WHEREAS, while the state-of-the-art in treatment has been evolving and the attitude of society toward treatment has changed, traditional methods of treatment have also changed; and

WHEREAS, today there is more emphasis on effective treatment at the most appropriate, least restrictive level of care; and

WHEREAS, preadmission testing, case management, educational campaigns, wellness efforts, and employee assistance programs have grown out of this need to provide adequate, proper treatment for clients at a reasonable cost with quality and utilization review built in to aid in good management of funds; and

WHEREAS, there has been a gradual recognition that inpatient care, as currently mandated, is not always the most effective type of care for psychiatric and substance abuse disorders, and other levels of outpatient care may provide more efficacious treatment depending on the needs of the particular client; and

WHEREAS, many patients currently choose inpatient care over other, possibly more appropriate types of outpatient care, because of the disproportionate share of copayments or deductibles they must pay; and

WHEREAS, outpatient coverage, in many cases, requires a fifty percent copayment while inpatient coverage requires only twenty percent; and

WHEREAS, several task forces have been evaluating mandated insurance coverage for psychiatric and substance abuse treatment in order to determine possible avenues of change that will allow reimbursement for treatment at a level of care other than inpatient; and

WHEREAS, these studies have recommended the conversion of current inpatient coverage to proportionate allotments of treatment at other approved levels of care; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the General Assembly supports in theory the development of types of care in addition to traditional inpatient care for the treatment of psychiatric and substance abuse disorders; and, be it

RESOLVED FURTHER, That in recognizing the need for alternative types of care, it is also acknowledged that insurance coverage should be consistent, should not discriminate on the basis of type of illness, and should recognize these other types of care; and, be it

RESOLVED FINALLY, That conversion ratios where days of inpatient care may be converted in a proportionate manner to cover alternative treatment are seen to be a viable

solution to the provision of appropriate care to all clients based on individual need, and benefits to clients are maintained, and cost of coverage does not increase.