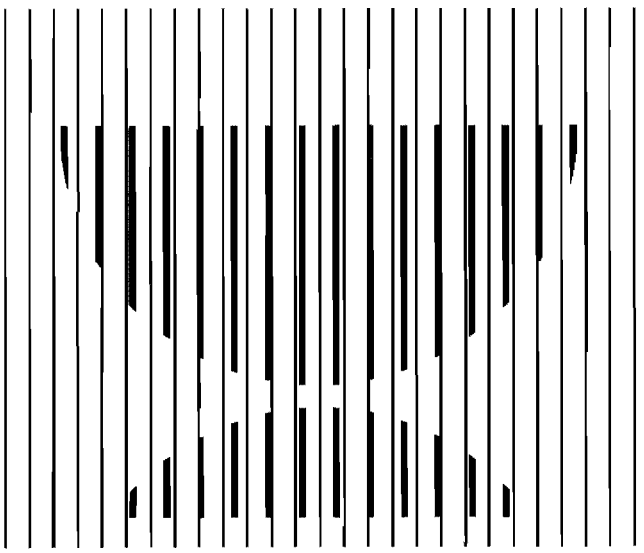
CBO STAFF MEMORANDUM

THE INPATIENT PSYCHIATRIC HOSPITAL BENEFIT UNDER MEDICARE

July 1993



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NOTE

Numbers in the text and tables of this memorandum may not add to totals because of rounding.

This Congressional Budget Office (CBO) Staff Memorandum examines the inpatient psychiatric hospital benefit under Medicare and, in particular, the provision that limits Medicare's coverage of inpatient care in psychiatric hospitals to 190 days in a beneficiary's lifetime. It was prepared in response to a request by the Committee on Finance of the United States Senate. In accordance with CBO's mandate to provide objective and impartial analysis, this report contains no recommendations.

The memorandum was prepared by Verdon S. Staines of CBO's Human Resources and Community Development Division under the supervision of Nancy Gordon and Kathryn Langwell. Jacquelyn Vander Brug generated the estimates in Table 4. Within CBO, Scott Harrison, Harriet L. Komisar, Kevin Quinn, and Bruce Vavrichek provided valuable comments. Sharman Stephens of the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services made available data and tabulations used in the analysis. Lisa Lang, Thomas G. McGuire, George Morey, and Sharman Stephens acted as independent reviewers and offered helpful suggestions.

Paul L. Houts edited the manuscript. Chris Spoor provided editorial assistance. Ronald Moore provided administrative assistance for the project and, along with Jill Bury, prepared the final layout of the manuscript.

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SUMMARY AND INTRODUCTION

The Medicare program covers both inpatient and outpatient mental health care needed by enrollees, including care for psychiatric conditions and for substance abuse and dependence.[1] Approximately 2.7 percent of Medicare's total spending in fiscal year 1987 paid for identifiable drug, alcohol, and mental health services (see Table 1).[2] In fiscal year 1993, the same share of Medicare-'s total projected expenditures would amount to $3.6 billion.

Medicare's spending on mental health care has overwhelmingly been for inpatient care. Independent estimates for 1986 put the proportion at more than 80 percent--and possibly at 90 percent if payments to psychiatrists for services to inpatients are included.[3] The proportion may have fallen since then because Medicare's limit on annual outpatient reimbursements per beneficiary was removed in 1990, but the data necessary to examine this possibility are not available. If the inpatient proportion in fiscal year 1993 were 80 percent, Medicare's spending on inpatient psychiatric care would be approximately $2.9 billion.

In fiscal year 1988, Medicare reimbursed hospitals for approximately 400,000 inpatient discharges for psychiatric and substance-abuse conditions (see Table 2). Discharges for psychiatric conditions were about five times as frequent as those for substance-abuse conditions. Discharges related to mental health conditions represented just under 4 percent of all Medicare-reimbursed discharges from inpatient hospital care, and they grew considerably faster than total discharges between fiscal years 1985 and 1988 (4.6 percent annually compared with 1.1 percent). Some analysts attribute the faster growth partly to an increasing number of people who were eligible for Medicare because they were enrolled, as a result of mental illness, in the Disability Insurance program under Social Security.[4]

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1. Terminology varies within the relevant literature. In this memorandum, "psychiatric hospital" refers to hospitals that specialize in treating either psychiatric conditions or conditions that involve the abuse of alcohol or other substances, or dependence on them. Medicare includes all of these as "psychiatric" conditions. In terms of diagnosis, psychiatric conditions (Medicare's diagnosis-related groups 424 to 432) are distinguished from conditions related to alcohol and substance abuse (diagnosis-related groups 433 to 438), with "mental health" including both categories. Research reports employ varying terminology, referring to "abuse" and "dependence" in relation to alcohol, "drugs," "substances," and "chemicals." In reporting that research, this memorandum tends to follow the particular researcher's terminology. In addition, it frequently uses the term "substance abuse" to refer generically to these conditions.

2. Judith R. Lave and Howard H. Goldman, "Medicare Financing for Mental Health Care," *Health Affairs*, vol. 9, no. 1 (Spring 1990), pp. 19-30.

3. See Carl A. Taube, "Funding and Expenditures for Mental Illness," in R.W. Manderschied and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), pp. 216-226, Table 5.5.

4. Lave and Goldman, "Medicare Financing for Mental Health Care."

TABLE 1. ESTIMATED MEDICARE PAYMENTS FOR ALL SERVICES AND FOR ALL IDENTIFIABLE ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH SERVICES, BY SOURCE OF MEDICARE FUNDS AND TYPE OF SERVICE, FISCAL YEARS 1985 TO 1987 (In millions of dollars)[a]

	Fiscal Year 1985			Fiscal Year 1986			Fiscal Year 1987		
		ADAMH Payments			ADAMH Payments			ADAMH Payments	
	Total Payments[a]	Total	Percentage of Total	Total Payments[a]	Total	Percentage of Total	Total Payments[a]	Total	Percentage of Total
Hospital Insurance									
Inpatient Hospital									
PPS	35,743	387	22.0	40,885	552	27.5	41,755	362	16.7
Non-PPS	9,274	900	51.2	5,157	921	46.0	5,087	1,235	57.0
Subtotal	45,017	1,287[b]	73.2[b]	46,042	1,473[b]	73.5[b]	46,842	1,597[b]	73.7[b]
Alcohol/Drug Use[c]	n.a.	162	9.2	n.a.	189	9.4	n.a.	201	9.3
Poisoning and Toxic Effects of Drugs[d]	n.a.	122	6.9	n.a.	120	6.0	n.a.	117	5.4
Skilled Nursing Facility	567	n.a.	n.a.	568	n.a.	n.a.	627	n.a.	n.a.
Home Health and Hospice	2,257	n.a.	n.a.	2,408	n.a.	n.a.	2,344	n.a.	n.a.
Total	47,841	1,571	89.4	49,018	1,782	88.9	49,813	1,915	88.3
Supplementary Medical Insurance									
Physician Supplier[e]	17,852	187[f]	10.6[f]	20,200	222[f]	11.1[f]	24,109[g]	253[f]	11.7[f]
Outpatient and Home Health	3,956	n.a.	n.a.	4,969	n.a.	n.a.	5,838[g]	n.a.	n.a.
Total	21,808	187	10.6	25,169	222	11.1	29,937[g]	253	11.7
Hospital Insurance and Supplementary Medical Insurance									
Total	69,649	1,758	100.0	74,187	2,004	100.0	79,750	2,168	100.0

SOURCE: Congressional Budget Office adapted from Judith R. Lave and Howard H. Goldman, "Medicare Financing for Mental Health Care," *Health Affairs*, vol. 9, no. 1 (Spring 1990), pp. 19-30, Exhibit 1, based on unpublished Health Care Financing Administration data.

NOTES: ADAMH = Alcohol, drug abuse, and mental health. n.a. = not available. PPS denotes payments under Medicare's prospective payment system.

a. Estimated benefit payments for all medical conditions.
b. Represents diagnosis-related groups (DRGs) 424 to 432 (mental diseases and disorders), regardless of type of hospital.
c. Excludes toxic effects of such use. Represents DRGs 433 to 438 (alcohol/drug use and alcohol/drug-induced organic mental disorder). Total payments are not shown in original source.
d. Represents DRGs 449 to 451 (poisoning and toxic effects of drugs). Total payments are not shown in original source.
e. Includes independent labs.
f. Represents all services by psychiatrists, psychiatric osteopaths, and independent psychologists, regardless of whether they were subject to the mental health coverage limits. Does not include services by other specialties.
g. Components in original source do not add to total.

TABLE 2. ESTIMATED NUMBER AND DISTRIBUTION OF INPATIENT HOSPITAL DISCHARGES REIMBURSED BY MEDICARE IN FISCAL YEAR 1988, AND AVERAGE ANNUAL GROWTH RATE FROM FISCAL YEAR 1985 TO FISCAL YEAR 1988, BY TYPE OF CONDITION AND SITE OF CARE (In percent)

	Number of Discharges (Thousands)	Discharges as a Percentage of: All Medicare Discharges	All Medicare Discharges for Psychiatric and Substance-Abuse Conditions	All Medicare Discharges for Specified Type of Condition	Average Annual Growth Rate, 1985-1988
Psychiatric and Substance-Abuse Conditions					
Psychiatric Hospital	88.9	0.83	22.1	22.1	7.6
General Hospital					
Psychiatric unit	140.7	1.32	35.0	35.0	17.0
Alcohol unit	8.7	0.08	2.2	2.2	-5.3
Other PPS	149.0	1.40	37.0	37.0	2.0
Other Non-PPS	15.0	0.14	3.7	3.7	-28.7
Total	402.3	3.77	100.0	100.0	4.6
Psychiatric Conditions[a]					
Psychiatric Hospital	79.8	0.75	19.8	23.6	7.7
General Hospital					
Psychiatric unit	134.7	1.26	33.5	39.8	17.4
Alcohol unit	0.2	0	0	0.1	-17.1
Other PPS	112.4	1.05	27.9	33.2	-0.5
Other Non-PPS	11.3	0.11	2.8	3.3	-30.3
Total	338.3	3.17	84.1	100.0	4.7
Substance-Abuse Conditions[b]					
Psychiatric Hospital	9.1	0.09	2.3	14.3	7.0
General Hospital					
Psychiatric unit	6.0	0.06	1.5	9.4	9.4
Alcohol unit	8.5	0.08	2.1	13.3	-5.0
Other PPS	36.7	0.34	9.1	57.2	11.4
Other Non-PPS	3.8	0.04	0.9	5.9	-22.6
Total	64.0	0.60	15.9	100.0	4.2
All Conditions					
All Sites	10,659	100.00	n.a.	n.a.	1.1

SOURCE: Congressional Budget Office calculations from tabulations provided by the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, based on the Health Care Financing Administration's Medicare Patient Records (MEDPAR) file.

NOTES: n.a. = not applicable; PPS denotes payments under Medicare's prospective payment system.

a. Represents diagnosis-related groups (DRGs) 424 to 432.
b. Represents DRGs 433 to 438.

Inpatient psychiatric care may be provided in several different settings, as long as the hospital participates in the Medicare program. These settings include:

- Freestanding psychiatric hospitals (including hospitals for treating substance abuse) that are either publicly owned--for example, state or county psychiatric hospitals--or privately owned;
- Psychiatric or substance-abuse units that are distinct parts of acute-care general hospitals; and
- "Scatterbeds" within acute-care general hospitals--that is, medical and surgical beds that are not located in psychiatric or substance-abuse units of such hospitals.[5]

Most of the inpatient psychiatric care that Medicare funds is provided in acute-care general hospitals. For example, scatterbeds were the most frequent overall setting in fiscal year 1988 for the inpatient care that Medicare funded for psychiatric and substance-abuse conditions (see Table 2). This pattern was especially marked for substance-abuse conditions. Psychiatric units in acute-care general hospitals were the next most common setting. Moreover, in 1984, general hospitals accounted for an estimated 82 percent of Medicare discharges for inpatient psychiatric care and for 73 percent of Medicare charges for such care. Proprietary and not-for-profit psychiatric hospitals accounted for a further 9 percent of the discharges and 15 percent of the charges, with the above-average charges per discharge perhaps reflecting longer stays and more complex conditions among their patients. Public psychiatric hospitals accounted for the remainder--10 percent of the discharges and 12 percent of the charges.[6]

Depending on the setting, however, Medicare enrollees may encounter limitations on their covered use of psychiatric services. In particular, Section 1812(b)(3) of the Social Security Act specifies that enrollees who seek care in psychiatric hospitals may receive no more than 190 inpatient days of covered care in this setting during their lifetime. No similar lifetime limit, however,

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5. Some researchers define "scatterbeds" as all beds in those acute-care general hospitals that do not have psychiatric or chemical dependency units. Others define scatterbeds as all beds in acute-care general hospitals other than beds in psychiatric or chemical dependency units--a broader definition that includes, for hospitals that have separate psychiatric or chemical dependency units, any beds that are not part of those units.

6. Howard H. Goldman, Carl A. Taube, and Stephen F. Jencks, "The Organization of the Psychiatric Inpatient Services System," *Medical Care*, vol. 25, no. 9, supplement (September 1987), pp. S6-S21, Table 2-1.

exists on coverage of psychiatric care obtained in other inpatient settings. Medicare's payment policy also differs among these settings.

When the Congress established Medicare in 1965, it included inpatient psychiatric care within Medicare's coverage. At that time, inpatient care for chronically mentally ill people was predominantly provided by specialty psychiatric hospitals, nearly all of which were state or county psychiatric hospitals. The 190-day limit was incorporated in the original Medicare program and has generally been seen as a method to contain federal costs by maintaining financial responsibility for care of chronically mentally ill people at its traditional level--namely, with state governments. Medicare's coverage of outpatient psychiatric care was also limited severely.

Critics of the 190-day limit typically argue that it has become outmoded because of subsequent changes in the mental health care industry. Since 1965, for example, the former emphasis on custodial institutional care has substantially diminished, the range of settings available for care has diversified, and providers appear to have specialized to some degree in the kinds of patients they serve. As a result, critics contend, limiting lifetime care in just one kind of setting now creates incentives within Medicare for resources to be used inefficiently and for certain enrollees and providers to be treated unfairly. Where once the 190-day limit affected Medicare payments for inpatient psychiatric care in a fairly comprehensive way, the critics claim, it now does so more selectively.

To evaluate these criticisms of the 190-day limit, or to estimate the extent to which the 190-day limit has reduced total Medicare payments, one would need additional information that is currently unavailable. This information includes what care enrollees receive as they approach or reach the 190-day lifetime limit and the relative costs of psychiatric care in different settings, if one holds constant the nature and severity of enrollees' psychiatric conditions.

Two options for changing policy in this area are to eliminate the limit or to extend it to all providers of inpatient psychiatric care. Because of the critical limitations on available data that were mentioned above, however, it is difficult to predict the effects of even these basic options for changing the 190-day limit. Provider organizations have also suggested more complex ways to restructure Medicare's inpatient psychiatric benefit. These approaches could involve an annual limit on covered days--either in place of, or in addition to, a lifetime limit--and access to lifetime reserve days for inpatient psychiatric care. Predicting the effects of restructuring the benefit in these ways is even more problematic: it would require additional information for Medicare enrollees

about the joint distributions of annual and lifetime days of inpatient psychiatric care, by site of care.

Consequently, substantial uncertainty surrounds the effects of any policy changes in this area. Multiple but differing sources of inpatient hospital care for psychiatric conditions are available, as are possible substitutes for such care, including outpatient care and nursing home care. Various behavioral changes are probable in response to any policy changes, but because of significant limitations on data, their magnitudes are only partly predictable.

THE 190-DAY LIMIT AND ITS CONTEXT

Coverage for inpatient psychiatric care--under Medicare's Hospital Insurance (HI) program--is subject to the same provisions applying to coverage for all inpatient care and to two additional provisions for care in psychiatric hospitals.[7] General coverage under HI includes 90 days of inpatient hospital care in a benefit period (also known as a spell of illness), which begins with the first day of illness and ends when the enrollee has not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days.

Enrollees may use an unlimited number of benefit periods and may also draw on a nonrenewable lifetime reserve of 60 days if they exhaust the 90 days available in a benefit period. An inpatient hospital deductible--$676 in 1993--applies for each benefit period, and in addition, significant coinsurance payments are required for each day after 60 days of inpatient hospital care during a spell of illness.[8]

Coverage of inpatient care within free-standing psychiatric hospitals, however, is subject to two additional constraints designed to limit coverage to acute care.

- o Lifetime Limit. Coverage of inpatient care within psychiatric hospitals is subject to a lifetime limit of 190 days. Inpatient psychiatric care provided within general hospitals and their specialized units is not subject to any such limit.

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7. Outpatient psychiatric services are covered under Medicare's Supplementary Medical Insurance program. Benefits are subject to a $100 deductible each year and, thereafter, Medicare pays no more than 50 percent of its allowable charge for each service.

8. Coinsurance equal to one-fourth of the hospital deductible is required for each of the 61st through 90th days of inpatient hospital care during a spell of illness. Coinsurance equal to one-half of the deductible is required for each of the 60 lifetime reserve days for inpatient hospital care.

- Inpatient Psychiatric Carryover Provision. A "carryover" provision limits Medicare's coverage of inpatient mental health services for people who are in a psychiatric hospital when they first become eligible for Medicare and who have received inpatient care in a psychiatric hospital during the previous 150 days.

The impact of the 190-day lifetime limit on Medicare's outlays reflects not only Medicare's coverage provisions but also its reimbursement provisions for inpatient psychiatric care (see Appendix A). The latter vary among care settings.

Hospitals that provide inpatient psychiatric care and that participate in Medicare are classified either as general hospitals or as psychiatric hospitals. Psychiatric hospitals must meet essentially all of the health and safety requirements for general hospitals, as well as two additional requirements that relate to staffing and medical records. Ordinarily, hospitals are classified as psychiatric hospitals if they specialize in treating conditions that involve abuse of alcohol or other substances, or dependence on them. However, general hospitals are not prohibited from treating patients with these conditions, and in practice they may treat a significant number of such patients while retaining their status as general hospitals.

The payment method applied to a hospital depends on its classification, however, not the makeup of its patient population. With one exception, a general hospital is paid under the prospective payment system (PPS; see below) for all inpatient psychiatric care that it provides. A psychiatric hospital is paid under arrangements established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA; see below) for all of its care. In addition--the exception noted above--a general hospital may set up a dedicated "distinct-part" unit that is excluded from the PPS and paid on the same basis as a psychiatric hospital.

Most episodes of inpatient care covered by Medicare are reimbursed under the PPS. In essence, under the PPS, each patient is classified in a diagnosis-related group (DRG), and the hospital receives a fixed payment for each patient in that DRG. Reimbursement rates depend on the particular DRGs to which patients are classified.

Some inpatient providers, however, either are automatically excluded or seek exclusion from the PPS. They are reimbursed instead on the basis of their reasonable costs, subject to limitations, under arrangements that were established by TEFRA and that have since been modified. A hospital's actual incurred costs are generally considered to be reasonable if they are not substantially out of line with those of similar hospitals in the area.

Under the TEFRA arrangements, a "target amount" for the hospital's inpatient operating costs per discharge is normally set for each year by indexing the hospital's historical cost in its base year. Medicare's reimbursement per discharge is then based on this target amount. If actual average costs per discharge are between 90 percent and 120 percent of the target amount, Medicare and the hospital share equally in the difference. For example, if a hospital's actual costs are 120 percent of the target, Medicare would pay it 110 percent of the target amount. If average costs are below 90 percent of the target, Medicare retains the additional surplus. If actual costs exceed 120 percent of the target amount, the hospital absorbs the additional deficit. For example, if average costs are 130 percent of the target amount, Medicare would still pay only 110 percent of the target amount. (Before October 1991, the target amount served as a ceiling on Medicare's reimbursement per discharge; hospitals with costs that exceeded their target amounts absorbed the full loss.)

Some providers are reimbursed under the TEFRA arrangements and others are reimbursed under the PPS. For example:

- Psychiatric hospitals are excluded from the PPS, as are most "distinct-part" psychiatric units of acute-care general hospitals. Inpatient care provided in these settings is reimbursed under the TEFRA arrangements. About one-third of all distinct-part units in 1985, however, were reimbursed under PPS arrangements.

- Inpatient psychiatric care provided in scatterbeds within acute-care general hospitals is reimbursed under the PPS. PPS reimbursement also applies for general hospitals, together with units that are distinct parts of general hospitals, that specialize in treating conditions related to alcohol and substance abuse. Before fiscal year 1988, however, such hospitals and units could also seek exclusion from the PPS and coverage instead under the TEFRA arrangements.

Changing Structure of the System Providing Psychiatric Care

The Congress included inpatient psychiatric care within Medicare's coverage when it established Medicare in 1965. At that time, inpatient care for chronically mentally ill people was predominantly provided by psychiatric hospitals, nearly all of which were run by states or counties. The 190-day limit was incorporated in the original Medicare program and has generally been seen as a method to contain federal costs by leaving financial responsibility for the care of chronically mentally ill people with state governments, as had been

traditional before 1965. Medicare's original coverage of outpatient psychiatric care was also limited severely by imposing an effective ceiling on Medicare's annual reimbursement for an enrollee's outpatient psychiatric services. That ceiling was $50 until 1981.

Since 1965, however, the financing and delivery of psychiatric care have changed considerably (see Appendix B). Overall, the range of settings available for care has diversified, the former emphasis on custodial institutional care has substantially diminished, and providers appear to have specialized to some degree in the kinds of patients they serve.

Use of community-based and outpatient care, instead of inpatient care, has become much more common for psychiatric conditions. In addition, Medicare's coverage of outpatient psychiatric care has been broadened substantially. The original effective ceiling of $50 on annual reimbursement per enrollee was raised three times during the 1980s and was then eliminated in 1990. Under Medicare's Supplementary Medical Insurance program, however, outpatient psychiatric services remain subject to a higher coinsurance rate (50 percent) than that for other services (20 percent).

Even for episodes of inpatient psychiatric care, the predominant setting has changed from specialized psychiatric hospitals to acute-care general hospitals. In addition, the number of inpatient beds for psychiatric care has fallen sharply, as has the proportion of these beds in state and county psychiatric hospitals. Expert opinion suggests that, for many people with psychiatric conditions, nursing homes have replaced state and county psychiatric hospitals as the site of continuing nonacute care. Factors often cited as contributing to this change are fiscal incentives facing state governments and professional support for a less institutionalized approach to psychiatric care.

Recent research suggests that different kinds of providers of inpatient psychiatric care systematically treat different groups of patients. Among providers other than state and county hospitals, specialized short-term psychiatric hospitals tend to use the most resources and to treat the most severe cases, followed by general hospitals that have psychiatric or chemical dependency units, with general hospitals that do not have such units tending to use the fewest resources and to treat the least severe cases. Similarly, for Medicare patients, on average, psychiatric hospitals appear to use more resources when providing care and to treat enrollees with more severe conditions than is true for psychiatric units within general hospitals that are reimbursed under TEFRA arrangements.

Psychiatric hospitals increasingly treat acute psychiatric conditions. Even people using extensive inpatient care do not necessarily have chronic conditions; some people who use more than 100 lifetime days of inpatient care are using multiple episodes of care for some psychiatric conditions.

For example, although the majority of enrollees who were discharged from inpatient psychiatric care during the period from fiscal year 1984 to fiscal year 1988 had only a single stay and used only a limited number of days of care, more than 40 percent of the enrollees had multiple stays, and more than 10 percent had at least five stays (see Table 3). In addition, one-third of them used more than 30 days of covered care, 9 percent used more than 90 days, and about 1.6 percent accumulated more than 190 days during the five-year period.

Criticisms Directed at the 190-Day Limit

Critics of the 190-day limit typically argue that it has become outmoded because of changes in the mental health care industry. Where once the limit affected Medicare's coverage of inpatient psychiatric care in a fairly comprehensive way, it now does so more selectively because state and county psychiatric hospitals provide a dramatically reduced share of such care. Consequently, critics contend, the limit now creates incentives within Medicare for resources to be used inefficiently and for certain enrollees and providers to be treated unfairly.[9]

Critics make the argument about efficiency by claiming that the 190-day limit creates an incentive for Medicare enrollees whose cumulative stays in psychiatric hospitals are approaching 190 days to seek subsequent care in a different setting, such as a general hospital. This incentive could lead to inefficient use of resources in two ways. First, the alternative provider might be less capable of providing the most appropriate care if psychiatric hospitals have specialized in treating certain kinds of patients--for example, those who need acute care for severe or complex conditions. Second, interrupting the continuity of care by otherwise unnecessary changes of provider might itself disrupt the process of treatment and recovery. It could result, for example, in duplicate documentation of case histories and diagnostic testing, a second learning curve for the new providers as they treat patients, and new experimentation with treatment regimens.

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9. See, for example, Jerry Cromwell and others, "Medicare Payment to Psychiatric Facilities: Unfair and Inefficient?" *Health Affairs*, vol. 10, no. 2 (Summer 1991), pp. 124-134.

TABLE 3. DISTRIBUTION OF MEDICARE ENROLLEES HOSPITALIZED FOR PSYCHIATRIC CONDITIONS OR SUBSTANCE ABUSE, BY NUMBER OF COVERED DISCHARGES OR DAYS OF CARE PER ENROLLEE, FISCAL YEARS 1984 TO 1988
(In percent)

Number of Discharges or Days of Care per Enrollee[a]	Period: One Year	Three Years	Five Years
Covered Discharges During the Period			
1	76.6	64.9	57.9
2	15.7	17.8	17.4
3	4.7	7.7	8.4
4	1.7	3.9	4.9
5	0.7	2.1	3.2
6	0.3	1.3	2.1
7	0.1	0.8	1.5
8-10	0.1	1.0	2.4
11-15	0	0.4	1.4
16 or More	0	0.1	0.7
Total	100.0	100.0	100.0
Covered Days of Care During the Period			
1-10	42.0	40.3	36.9
11-30	37.8	33.0	30.7
31-60	14.8	15.5	15.9
61-90	4.2	6.1	7.3
91-120	0.9	2.6	3.7
121-150	0.3	1.3	2.3
151-190	0	0.8	1.6
191 or More	0	0.4	1.6
Total	100.0	100.0	100.0
Memorandum:			
Total Number of Enrollees	1,325,683	648,453	255,521

SOURCE: Congressional Budget Office calculations from tabulations provided by the Office of the Assistant Secretary for Planning and Evaluation in the Department of Health and Human Services, based on the Health Care Financing Administration's Medicare Patient Records (MEDPAR) file.

a. Enrollees discharged from a hospital for conditions classified in diagnosis-related groups for psychiatric or substance-abuse conditions.

Critics also claim that the limit can create unfair outcomes for certain enrollees and providers. Specifically, the limit constrains the choices for care available under Medicare for one subset of enrollees who require extended or recurring episodes of inpatient psychiatric care--namely, enrollees with conditions best treated in specialized psychiatric hospitals. The limit also constrains Medicare revenue per inpatient for psychiatric care for one class of providers--psychiatric hospitals.

Evaluating the 190-Day Limit: Data Limitations

To evaluate these criticisms of the 190-day limit, or to estimate the extent to which the limit has reduced total Medicare payments, one would need certain items of empirical information that are currently unavailable. One such item is the extent to which, in practice, enrollees whose cumulative stays in psychiatric hospitals are approaching 190 days actually seek admission for subsequent care to general hospitals rather than psychiatric hospitals.

Other items relate to people who have reached the 190-day limit and who require additional care. For these people, one would need to know:

- The proportions of patients who do and do not receive this care;
- The distributions by site of care and by source of payment for those who do receive it; and
- The proportion of any additional care received that Medicare would not have covered anyway because of its general limitations on inpatient coverage (for example, its spell-of-illness restrictions).

A final category of needed information that is unavailable is the relative costs of psychiatric care in different inpatient settings for Medicare enrollees, if one holds constant the nature and severity of their psychiatric conditions.

ANALYZING THE IMPLICATIONS OF MEDICARE'S 190-DAY LIMIT

The implications of Medicare's 190-day limit for psychiatric care may be identified by considering the effects of the limit on enrollees who need psychiatric care, providers of such care, and total Medicare outlays.

Effects on Enrollees

Enrollees are affected if the limit alters the amount or quality of the care they receive, the site or type of care, or the out-of-pocket costs they incur. For example, the limit could discourage some enrollees from seeking care--namely, those who are approaching the limit, or who have already reached it. This response is more likely to occur among those who do not have secondary insurance coverage for inpatient psychiatric care. The impact of the limit is nevertheless constrained: if there were no limit, restrictions on spells of illness would eventually limit Medicare's coverage of continuous inpatient psychiatric care for any enrollee.

Little information is available, however, on what happens in practice to people who reach the limit. For example, some enrollees may continue to receive inpatient care in psychiatric hospitals for which they themselves pay out of pocket, a secondary insurer pays, the state pays through its funding for mental health care, or the hospital pays in the form of uncompensated care. Other enrollees may receive inpatient care from a different provider (such as a general hospital, where the limit does not apply) or may instead receive a different form of care (such as outpatient care, in which case their out-of-pocket costs will also change). Still others may obtain care that is not covered by Medicare, including nursing home care.[10] Finally, enrollees who consider alternative sources of covered care to be unsatisfactory substitutes may forgo care entirely, either because they are unable to pay for psychiatric hospital care themselves or because they choose not to do so.

By influencing the amount, site, and out-of-pocket costs of psychiatric care, the 190-day limit might also affect the appropriateness and quality of the care that enrollees receive. In some more complex cases, for example, psychiatric hospitals might be more appropriate, although no evidence is available on this question. Also, any break that the limit induces in the continuity of an enrollee's care might impede or delay progress toward recovery.

The limit also creates an incentive for enrollees to seek greater insurance coverage for expanded psychiatric hospital benefits. The impact of this incentive on their behavior is probably small, however, because such coverage is not readily available. For example, it is not included in any of the 10 standard "medigap" policies that people buy to supplement Medicare coverage.

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10. Medicare pays for nursing home care only for a limited period and only if the care is for an acute condition, follows a hospital stay of at least three days, and is provided in a skilled nursing facility certified by Medicare.

Effects on Providers

Any impacts on beneficiaries are likely to have corresponding effects on providers. Specifically, the 190-day limit could affect where care is provided, how much reimbursement it attracts, and whether providers choose to participate in the Medicare program.

For example, for enrollees approaching 190 lifetime days of care in a psychiatric hospital, the limit could divert their subsequent care from psychiatric hospitals to other providers, such as general hospitals, outpatient providers, or nursing homes. In that case, unless psychiatric hospitals could admit alternative, equally profitable, patients to offset the lost Medicare admissions, they would be adversely affected financially to the extent that Medicare's reimbursement rate exceeds the additional costs that psychiatric hospitals incur by providing such care. Conversely, other providers of psychiatric care would benefit financially to the extent that they gained additional patients for whom reimbursement levels would exceed the additional costs incurred to provide care.

For some psychiatric hospitals, one possible source of funding for uncompensated care that they provide is "disproportionate share" payments under the Medicaid program. Subject to various limitations, states may designate certain hospitals as serving a disproportionate share of Medicaid and other low-income patients. Hospitals so designated may qualify for additional payments under the Medicaid program. In some states, specialized psychiatric hospitals are among the hospitals that have received this designation and thus additional Medicaid funding.

Effects on Medicare's Outlays

The impact that the 190-day lifetime limit currently has on Medicare's total outlays in any given period reflects a number of factors. One is any effect that the limit has on the number of enrollees receiving benefits for psychiatric conditions during that period. Also, because the limit encourages enrollees who are approaching it to switch the site of their care, the most widely discussed of these factors relate to the limit's effects on the distribution of inpatient hospital care among types of providers and on reimbursement methods and rates for this care. In addition, for some enrollees, the limit may affect whether they receive covered care in hospitals, as outpatients, or in nursing homes. Note also that if enrollees switched from covered care in psychiatric hospitals to care not covered by Medicare in nursing homes, this step would tend to raise Medicaid's outlays, especially over time as individuals displaced to nursing homes exhausted their assets.

Number of Enrollees Receiving Benefits. One way the 190-day limit could decrease total Medicare outlays is by reducing the number of enrollees receiving benefits for psychiatric conditions during a given period. The number receiving benefits would be lower, however, only to the extent that some enrollees who have reached the lifetime limit and need additional care do not instead obtain either covered inpatient care in a general hospital or a different kind of covered care, such as outpatient care. Moreover, failing to obtain alternative covered care is probably an atypical response to the 190-day limit because of the incentive for enrollees to change providers as they approach the limit.

Mix of Inpatient Hospital Care and Method of Reimbursement. The 190-day limit affects Medicare's total outlays to the extent that it redistributes covered inpatient hospital care for psychiatric conditions among types of providers and, for certain types of providers, between Medicare's TEFRA and PPS methods of reimbursement. Enrollees who have reached or are approaching the 190-day limit have a clear incentive to change the site of their inpatient care from a psychiatric hospital to an acute-care general hospital, since Medicare could still cover care provided in the latter setting, depending on the coverage limits that apply to all inpatient care. This incentive applies whether the enrollee is admitted to a specialized psychiatric or substance-abuse unit in such a hospital or to a general medical or surgical bed.

For Medicare enrollees being readmitted for inpatient psychiatric care, available data are not adequate to show how the distribution of sites of readmission changes as patients' previous lifetime use of psychiatric hospitals approaches 190 days. Nevertheless, enrollees' patterns of readmission for inpatient psychiatric care can be examined by site if one ignores their levels of previous lifetime use of psychiatric hospitals.

Enrollees hospitalized at least twice for psychiatric care between January 1985 and September 1988 were in general more likely to be readmitted to the same site than to any other single site (see the diagonal of each panel in Table 4). Almost two-thirds of those using psychiatric hospitals who were readmitted used psychiatric hospitals again. The corresponding proportions were a little higher for psychiatric units of general hospitals that received TEFRA reimbursement and a little lower for scatterbeds and psychiatric units within general hospitals that received PPS reimbursement.

Also of interest, although not shown in Table 4, is that the proportion of those who used scatterbeds when being readmitted was lower than the proportion who used this setting for their most recent previous stays. In contrast, the proportion who, upon readmission, used psychiatric hospitals or psychiatric units in general hospitals receiving PPS reimbursement was slightly

TABLE 4. DISTRIBUTION OF SITES OF READMISSION FOR INPATIENT PSYCHIATRIC CARE FOR MEDICARE BENEFICIARIES, BY CURRENT TYPE OF CONDITION AND SITE OF CARE DURING MOST RECENT PREVIOUS EPISODE, JANUARY 1985 TO SEPTEMBER 1988 (In percent)

Site of Current Episode of Care	Site of Most Recent Previous Episode of Care: Psychiatric Hospital	General Hospital: Psychiatric Unit	General Hospital: Alcohol Unit	General Hospital: Other PPS	Other Non-PPS	Total
Psychiatric and Substance-Abuse Conditions						
Psychiatric Hospital	63.9	14.3	13.0	16.0	14.2	27.3
General Hospital						
Psychiatric unit (TEFRA)	17.7	67.8	19.3	25.2	14.6	37.0
Alcohol unit	1.2	1.5	35.9	3.5	1.2	3.2
Other PPS	14.2	14.9	29.8	53.5	11.1	27.2
Other Non-PPS	2.9	1.5	2.0	1.8	59.0	5.4
Total	100.0	100.0	100.0	100.0	100.0	100.0
Psychiatric Conditions[a]						
Psychiatric Hospital	65.9	14.6	24.3	17.4	16.7	29.3
General Hospital						
Psychiatric unit (TEFRA)	19.3	71.3	44.9	30.2	17.6	42.1
Alcohol unit	0	0.1	3.2	0.1	0	0.1
Other PPS	12.1	12.7	26.7	50.8	7.7	23.6
Other Non-PPS	2.7	1.3	1.1	1.5	57.9	4.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
Substance-Abuse Conditions[b]						
Psychiatric Hospital	49.4	10.2	7.5	11.1	5.1	17.1
General Hospital						
Psychiatric unit (TEFRA)	6.7	27.7	6.8	8.2	3.6	10.6
Alcohol unit	9.8	18.0	51.9	15.2	5.5	18.6
Other PPS	29.8	40.7	31.3	62.6	23.0	45.7
Other Non-PPS	4.3	3.5	2.5	3.0	62.8	8.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office calculations based on tabulations from a 5 percent sample of beneficiaries in the Health Care Financing Administration's Medicare Patient Records (MEDPAR) file.

NOTES: PPS denotes payments under Medicare's prospective payment system. TEFRA denotes payments under arrangements established by the Tax Equity and Fiscal Responsibility Act of 1982.

a. Represents diagnosis-related groups (DRGs) 424 to 432.
b. Represents DRGs 433 to 438.

higher than the proportion who used these settings for their most recent previous stays. Recent research suggests that providers of inpatient psychiatric care display a hierarchy in their levels of specialization that is reflected in their average levels of the use of resources and in the average severity of the cases they treat. If so, these patterns in readmission sites may reflect a tendency for enrollees who require repeated hospitalization to be readmitted to more specialized settings.

The 190-day limit may also redistribute covered inpatient care from the TEFRA method of reimbursement to the PPS method. One circumstance where that would usually occur is when care for psychiatric conditions involving substance abuse is displaced to general hospitals from psychiatric hospitals. The change in the method of payment results because care for conditions classified to DRGs that involve substance abuse is reimbursed under the PPS in two settings: scatterbeds within acute-care general hospitals, and distinct-part units within such hospitals (unless the units are reimbursed under TEFRA arrangements). Comparable care in psychiatric hospitals, however, is reimbursed under TEFRA arrangements.

If care for psychiatric conditions classified under DRGs that do not involve substance abuse is displaced from psychiatric to general hospitals, its method of reimbursement can also change from TEFRA to the PPS. Within psychiatric hospitals, care for such conditions is reimbursed under TEFRA arrangements. Within general hospitals, such care may be reimbursed under TEFRA if it is provided in PPS-excluded specialized psychiatric units. It is reimbursed under the PPS, however, when it is provided either in general medical or surgical beds or in specialized units that have been not exempted from the PPS.

Changes that the 190-day limit induces in the mix of inpatient hospital care can affect Medicare outlays in two main ways. First, when the site of care changes from a psychiatric hospital to a psychiatric unit in a general hospital receiving TEFRA reimbursement, the change in Medicare outlays for a particular enrollee will reflect:

- Any difference between the facilities in their TEFRA target amounts for inpatient operating costs per discharge--the basis for TEFRA reimbursement; and

- Any difference between the facilities in their actual costs for providing care to the individual, since Medicare now shares in the surpluses and deficits, relative to the target amount, that hospitals incur when providing care. The relative costs incurred

by different kinds of facilities when treating patients with specific psychiatric conditions of given severity, however, are unknown.

Assume for the moment, as critics of the 190-day limit claim, that the limit leads to inefficient use of resources because it diverts an enrollee's care to a less efficient site and interrupts the continuity of care for the person. Then, if an individual's care shifts to another facility reimbursed under TEFRA, Medicare's outlays would rise if the increase in the total costs of care exceeded any saving that would accrue to Medicare should the second facility be reimbursed at a lower target rate.

Alternatively, what if the site of care changes from a psychiatric hospital receiving TEFRA reimbursement to a setting in a general hospital that receives PPS reimbursement? In that case, in general, Medicare's outlays for an enrollee would change if the psychiatric hospital's target rate per discharge under TEFRA, plus Medicare's share of any difference between the hospital's actual care costs for the enrollee and the target rate, differs from the PPS reimbursement rate for the relevant DRG.

Mix of Covered Care Services. The 190-day limit also affects Medicare's total outlays to the extent that it changes how covered care for psychiatric conditions is distributed among inpatient care, outpatient care, and nursing home care. Some enrollees, for example, might consider either outpatient care or nursing home care their best alternative to additional care in a psychiatric hospital. Substituting outpatient care, in particular, has become easier as Medicare's outpatient psychiatric benefits have become less restrictive. Transferring from a psychiatric hospital to Medicare-covered care in a skilled nursing facility is also possible. Partly because Medicare's coverage of care in skilled nursing facilities is itself limited, however, such transfers seem likely to be less common than--or to precede--the substitution of outpatient for inpatient care.

The impact on Medicare's outlays of changes in the mix of psychiatric care depends on whether the services substituted for inpatient care cost Medicare more or less than additional inpatient care would have cost. The result would depend on the relative use of services and costs to Medicare (after allowing for copayments) of the services concerned. The existing data, however, do not permit such comparisons of the relative costs of services that hold constant the nature and severity of patients' conditions.

A Summing Up. Overall, little is known about the extent to which enrollees reaching or approaching the 190-day limit do without care entirely (a "discouraged care-seeker" effect); transfer to alternative sites of covered inpatient care; obtain outpatient or nursing home care instead; or continue to

receive, in a psychiatric hospital, inpatient care for which Medicare does not pay.

Similarly, when the 190-day limit diverts care from psychiatric hospitals to other covered settings, available data do not show whether the alternatives cost Medicare more or less than providing psychiatric hospital care beyond the 190-day limit. Consequently, the impact of the 190-day limit on total Medicare outlays is unclear.

The limit would unambiguously reduce total outlays if four propositions are all true. The first is that the limit reduces the number of enrollees receiving benefits for care for psychiatric conditions. Another is that, when the limit leads enrollees to forgo inpatient care in favor of covered outpatient or nursing home care, the alternative care would cost Medicare less, on average, than additional inpatient care.

The third such proposition is that, when the limit leads enrollees to switch their inpatient care from psychiatric hospitals to general hospital settings that are also reimbursed under TEFRA arrangements, the alternative care would cost Medicare less. This would require the TEFRA target amounts for inpatient operating costs per discharge, plus Medicare's share of the amounts by which actual treatment costs exceed the target amounts, to be less, on average, in the general hospital setting.

The last of these propositions is that, when the limit leads enrollees to switch their inpatient care from psychiatric hospitals to general hospital settings reimbursed under the PPS, the alternative care would once again cost Medicare less. This proposition would require that the PPS payments for the relevant DRGs be less, on average, than the average reimbursement to psychiatric hospitals under the TEFRA arrangements would have been for these patients.

The truth of these propositions--with the possible exception of the first--is uncertain, however. Although the net effect of the 190-day limit might be to reduce total Medicare outlays even if some of the propositions above are false, the question is an empirical one that cannot be answered with the data presently available.[11]

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11. An analogous set of conditions can be specified under which the 190-day limit would unambiguously increase total outlays. Their truth is similarly uncertain.

OPTIONS FOR CHANGING THE MEDICARE BENEFIT

The current 190-day limit on lifetime days of inpatient care in psychiatric hospitals could be changed by:

- Eliminating the limit on covered days of inpatient care in psychiatric hospitals; or
- Extending the limit to all providers of inpatient psychiatric care, including general hospitals, whether they provide this care in specialized psychiatric or chemical dependency units or in general medical and surgical beds.

The former option would expand the present benefit, while the latter option would contract it. Both options would level the playing field for providers of inpatient psychiatric care, however, because neither option would subject such care to limits on lifetime coverage that varied with the setting of care.

Variations of these options are, of course, possible.[12] Examples include increasing or reducing the maximum number of covered days, broadening the range of providers covered to include specialized units but not scatterbeds in general hospitals, or combining an increase in covered lifetime days with an extension of the limit to a broader class of inpatient facilities.

Provider organizations have also suggested more complex ways to restructure Medicare's inpatient psychiatric benefit that could involve an annual limit on covered days--either in place of, or in addition to, a lifetime limit--and access to lifetime reserve days for inpatient psychiatric care. Changes could also be considered in the inpatient psychiatric carryover provision, which restricts Medicare's coverage of inpatient mental health services for people who are inpatients of a psychiatric hospital when they become eligible for Medicare.

Because of critical limitations on data discussed above--in particular, lack of information about how the limit affects decisions on further care and thus how it affects total Medicare outlays--it is difficult to predict the effects of even the basic options for changing the limit. Predicting the effects of restructuring the benefit in more complex ways is even more problematic: it would require, in addition, knowledge of the joint distributions of enrollees' annual and lifetime use of inpatient psychiatric care for each site of care.

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12. See, for example, the statement of Malcolm D. Strickler, President of the National Association of Private Psychiatric Hospitals, before the Senate Finance Committee, June 18, 1987.

Consequently, substantial uncertainty surrounds the effects of any policy changes in this area.

Eliminate the 190-Day Lifetime Limit

Eliminating the lifetime limit could increase the total number of Medicare enrollees receiving inpatient psychiatric care benefits. Such an increase would result if, among enrollees who reach or approach the 190-day limit, some currently either:

- Continue to receive inpatient psychiatric care for which Medicare does not pay; or
- Are discouraged from seeking additional inpatient care in psychiatric hospitals, do not obtain alternative covered care, and remain otherwise eligible for additional Medicare-covered care within their current spell of illness.

In addition, eliminating the limit would almost certainly increase the number of Medicare enrollees receiving covered inpatient care in psychiatric hospitals, since it would remove the current incentive for enrollees at or near the 190-day limit to switch their care to another covered setting. Similarly, eliminating the limit would almost certainly reduce the number of Medicare enrollees receiving covered care for psychiatric conditions in these other settings. Presumably, psychiatric hospitals would derive additional revenue from Medicare, whereas other providers would derive less. Provided Medicare's rates of reimbursement for each class of provider cover the additional costs that they incur by providing the relevant care, psychiatric hospitals would probably be financially better off and other providers would be financially worse off as a result of this change.

It is unclear, however, whether removing the lifetime limit would increase or reduce total Medicare outlays. As discussed earlier, when enrollees substitute other covered care for inpatient care in a psychiatric hospital, the alternative care could cost Medicare either more or less than additional psychiatric hospital care would have cost. Hence, whether the current 190-day limit increases or reduces total Medicare outlays for the care of psychiatric conditions is uncertain. Accordingly, the effect of removing the limit is also unclear.

Extend the 190-Day Limit to All Providers of Inpatient Psychiatric Care

Extending the 190-day limit to all providers of inpatient psychiatric care would reduce the total number of Medicare enrollees receiving inpatient psychiatric care benefits, although to what degree is not fully known. One indicator of the scale of this effect is that 1.6 percent of Medicare enrollees who made any use of inpatient psychiatric care between fiscal years 1984 and 1988--about 4,000 people--used at least 190 days of covered care.

Life expectancy at age 65 is about 17 years. Moreover, eligible people under 65 can also qualify for Medicare because of a disability, including a psychiatric one.

Consequently, over time, extending the lifetime coverage limit of 190 days to all inpatient care for psychiatric conditions would presumably affect a proportion of enrollees needing inpatient psychiatric care that is greater than 1.6 percent, but how much greater is unknown. The enrollees affected would be those who, under current policy, receive inpatient care for psychiatric conditions in general hospitals.

Extending the limit would have a number of additional effects. First, it would create an incentive for enrollees at or near the 190-day threshold to substitute covered outpatient psychiatric care for inpatient care. The additional costs to Medicare of this outpatient care would offset Medicare's savings on inpatient care to an unknown degree and could raise the out-of-pocket costs for enrollees.

Second, extending the limit could alter both the amount of inpatient care that enrollees receive and its out-of-pocket cost to them. On reaching the limit, some enrollees might forgo care entirely or might pay for continuing inpatient care from their own resources. Others might have supplementary insurance coverage for inpatient psychiatric care, and still others might be able to obtain such care from providers on an uncompensated basis. By influencing the amount, type, and out-of-pocket costs of care for psychiatric conditions, the 190-day limit might also affect the appropriateness and quality of the care that enrollees receive.

In addition, broadening the scope of the 190-day limit would reduce the revenue that general hospitals derive from Medicare for inpatient psychiatric care for two reasons. First, it would curtail their revenue from care currently provided to enrollees who, even without the limit, would have chosen to receive their care in a general hospital and who have used more than 190 lifetime days of inpatient psychiatric care in any setting. Second, it would reduce their revenue from Medicare for those enrollees who respond to the present

incentive to substitute inpatient care in general hospitals for inpatient care in psychiatric hospitals as enrollees approach the current limit on lifetime care in freestanding psychiatric hospitals.

Finally, this redistribution of covered inpatient care among sites of care could also affect Medicare's total outlays for inpatient psychiatric care because care provided in different sites is sometimes reimbursed on different bases. The net impact of this change in the mix of reimbursement under TEFRA and reimbursement under the PPS, however, is uncertain.

APPENDIXES

APPENDIX A. MEDICARE'S COVERAGE, REIMBURSEMENT, AND FUNDING OF MENTAL HEALTH CARE

Since 1965, Medicare has covered outpatient and inpatient mental health care services from participating providers. Those services are subject to specified limits on coverage and reimbursement arrangements that sometimes differ from those for other health care services.

COVERAGE AND REIMBURSEMENT OF OUTPATIENT PSYCHIATRIC SERVICES

Outpatient psychiatric services are covered under Medicare's Supplementary Medical Insurance (SMI) program, which primarily covers payments for physicians and for related services and supplies that physicians order. Under SMI, beneficiaries must pay a monthly premium ($36.60 in 1993), unless a state Medicaid program pays this on their behalf under "buy-in" arrangements. Beneficiaries must also pay a $100 deductible each year as well as coinsurance based on Medicare's allowable charge for each service. Once allowable charges exceed the deductible, the coinsurance payment for most services is equal to 20 percent of the allowable charge plus the difference (if any) between the allowable charge and what the physician actually charges for the service. Actual charges currently may not exceed 115 percent of the allowable charge.

For outpatient psychiatric services, the Congress originally imposed an additional limit, effectively in the form of a $50 ceiling on annual reimbursement by Medicare. This limit was raised in 1981, 1988, and 1989 and was then eliminated in 1990. In addition, once the SMI deductible has been met, outpatient psychiatric services are subject to a higher coinsurance rate (50 percent) than other SMI services (generally 20 percent).

COVERAGE OF INPATIENT PSYCHIATRIC SERVICES

Inpatient psychiatric services are covered under Medicare's Hospital Insurance (HI) program. Coverage provisions for inpatient psychiatric care under HI are the same as for other inpatient care, except that:

- There is a 190-day lifetime limit on covered inpatient care in psychiatric hospitals; and
- A "carryover" provision limits Medicare's coverage of inpatient mental health services for people who are in a psychiatric hospital when they first become eligible for Medicare and who

have received inpatient care in a psychiatric hospital during the previous 150 days.

General coverage under HI includes 90 days of inpatient hospital care in a benefit period (or spell of illness), which begins with the first day of illness and ends when the beneficiary has not been an inpatient in a hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods an individual may use. The program also provides a nonrenewable lifetime reserve of 60 days if a beneficiary exhausts the 90 days available in a benefit period.

Under HI, the beneficiary is required to pay an inpatient hospital deductible for each benefit period. The amount, which is set annually based on a formula specified by law, is $676 in 1993. Coinsurance equal to one-fourth of the hospital deductible is required for the 61st through 90th days of inpatient hospital care during a spell of illness. Coinsurance equal to one-half of the deductible is required for the 60 lifetime reserve days for inpatient hospital care.

Medicare's coverage of inpatient psychiatric care is subject to the same general rules governing Medicare's coverage of inpatient care. In particular, inpatient psychiatric care is subject to the general rules governing benefit periods and lifetime reserve days.

Coverage of inpatient psychiatric care within hospitals, however, is subject to two additional limitations, both of which are generally seen as ways to limit covered inpatient psychiatric care to acute care.

Lifetime Limit. Coverage of inpatient care within psychiatric hospitals is subject to a lifetime limit of 190 days. Inpatient care within general hospitals and their specialized units is not subject to any such limit.

Inpatient Psychiatric Carryover Provision. Assume an individual who is an inpatient in a psychiatric hospital on the first day of his or her entitlement to HI benefits had also been an inpatient in such a hospital during the immediately preceding 150 days. In such a case, the number of such preceding days of inpatient care is subtracted from the 150 days that would otherwise have been available during the initial benefit period for inpatient mental health services in a psychiatric or general hospital. This limitation--known as the inpatient psychiatric carryover provision--is designed to preclude Medicare financing of long-term psychiatric inpatient care when people receiving such care first become eligible for Medicare.

Hospitals participating in Medicare that provide inpatient psychiatric services are classified either as general hospitals or psychiatric hospitals. Psychiatric hospitals must meet essentially all of the health and safety requirements for general hospitals and two additional requirements that relate to staffing and medical records.

Because conditions are considered psychiatric if they involve abuse of alcohol or other substances, or dependence on them, hospitals that specialize in treating these conditions are ordinarily classified as psychiatric hospitals. However, general hospitals are not prohibited from treating patients with these conditions, and in practice they may treat a significant number of such patients while retaining their status as general hospitals.

The payment method applied to a hospital depends on its classification, not the makeup of its patient population. If the hospital is a general hospital, it is paid under the prospective payment system (PPS; see below) for all its care, even though a significant number of its patients may be receiving treatment for psychiatric disorders (including alcohol- or drug-related conditions) rather than medical disorders. If a hospital is a psychiatric hospital, it is paid under arrangements established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA; see below), even though some of the care furnished its patients is for medical illnesses rather than exclusively psychiatric ones. In addition, a general hospital may set up a dedicated "distinct-part" unit that is excluded from the PPS and paid on the same basis as a psychiatric hospital. To obtain a PPS exclusion, however, the unit must meet essentially the same requirements relating to staffing and medical records as a psychiatric hospital.

Accordingly, covered inpatient psychiatric care can be given in a number of settings, provided the hospitals concerned participate in the Medicare program. These settings include:

- Freestanding psychiatric hospitals that are either publicly owned--for example, state or county psychiatric hospitals--or privately owned and that are reimbursed under the TEFRA arrangements;

- Psychiatric units that are distinct parts of general acute-care hospitals and that are reimbursed under the TEFRA arrangements;

- Psychiatric units that are distinct parts of general acute-care hospitals and that are reimbursed under the PPS;

- Acute-care general hospitals, and units of these hospitals, that specialize in treating alcohol and substance abuse but that do not qualify as psychiatric hospitals or units that are reimbursed under the PPS (though prior to fiscal year 1988 that were reimbursed under TEFRA arrangements); and

- "Scatterbeds" within acute-care general hospitals--that is, general medical and surgical beds that are not located in psychiatric or substance-abuse units of such hospitals and that are reimbursed under the PPS.

Provisions for reimbursing inpatient psychiatric care under HI vary by care settings. TEFRA established reimbursement arrangements, which were based on indexed historical costs, for all Medicare-financed hospital care. The Social Security Amendments of 1983 then established Medicare's prospective payment system to replace these arrangements for inpatient hospital care in all settings that were not explicitly permitted to be excluded from the PPS arrangements. Some inpatient psychiatric care settings were permitted to be excluded from the PPS arrangements but others were not.

- Psychiatric hospitals are excluded from the PPS. Also excluded are most "distinct-part" psychiatric units of acute-care general hospitals--units with separate staffing that are established to treat patients who have psychiatric diagnoses. Inpatient care provided in these settings is reimbursed under the TEFRA arrangements. About one-third of all distinct-part units in 1985, however, were reimbursed under PPS arrangements.[1]

- Inpatient psychiatric care provided in scatterbeds within acute-care general hospitals is reimbursed under the PPS system. Care in alcohol- and substance-abuse hospitals or similar distinct-part units of acute-care general hospitals is also reimbursed under the PPS. Before fiscal year 1988, however, such hospitals and units were also excluded from the PPS and so were covered by the TEFRA arrangements.

The TEFRA arrangements, which established a ceiling on the allowable rate of increase for hospital inpatient operating costs, reimburse hospitals and

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1. Howard H. Goldman, Carl A. Taube, and Stephen F. Jencks, "The Organization of the Psychiatric Inpatient Services System," *Medical Care*, vol. 25, no. 9, supplement (September 1987), pp. S6-S21.

distinct-part units excluded from the PPS on the basis of reasonable costs up to the ceiling. A "target amount" for the hospital's inpatient operating costs per discharge is set for each year by indexing the hospital's historical cost in its base year (usually 1983) by prescribed proportions for each year after the base year. Medicare's reimbursement to the hospital is then related to this target amount as follows.

- A hospital with inpatient operating costs below its target amount is paid its costs plus 50 percent of the difference between its costs and the target amount, up to a maximum of an additional 5 percent of the target amount.

- From October 1984 until September 1991, the target amount served as a ceiling on reimbursement per discharge for inpatient costs. Thus, hospitals with costs that exceeded their target amounts were not reimbursed by Medicare for the excess amount.

- For cost-reporting periods beginning on or after October 1, 1991, hospitals are reimbursed for 50 percent of costs in excess of the target amount, with the maximum additional payment limited to 10 percent of the target amount.

Adjustments to the process for setting the target amount are possible in certain circumstances where a hospital's cost environment or case mix changes substantially.

Where Medicare reimburses inpatient psychiatric care under the PPS, reimbursement rates depend upon the particular diagnosis-related groups in which patients are classified upon discharge.

APPENDIX B. THE FINANCING AND PROVISION OF PSYCHIATRIC CARE: RESEARCH FINDINGS

This appendix summarizes research findings about patterns of expenditures on psychiatric care, trends since 1965 in the provision of such care, and the roles of alternative inpatient providers. These findings are of interest for two reasons.

First, the impact of the 190-day limit depends on how it alters the complex industry that provides inpatient psychiatric care. Available data do not provide a systematic, comprehensive, and timely overview of the structure and functioning of this industry, although recent research has begun to address some of the gaps. Accordingly, the appendix provides an overview of what is known.

Second, the financing and delivery of psychiatric care have changed substantially since 1965, when the 190-day lifetime limit on Medicare's coverage of inpatient care in psychiatric hospitals was introduced along with Medicare itself. Since then, for example, the range of care settings available has diversified, the former emphasis on custodial institutional care has substantially diminished, and providers appear to have specialized to some degree in the kinds of patients they serve. These differences may affect one's assessment of the 190-day rule.

EXPENDITURES ON PSYCHIATRIC CARE

Mental health care is provided in a variety of settings and includes care for psychiatric conditions and for alcohol and drug dependence or abuse.

In 1980, mental health care absorbed about 8.4 percent of all personal health care expenditures. Of all mental health care spending, 55 percent went for inpatient hospital care. There are different kinds of hospital providers, however, and their relative importance as sources of inpatient psychiatric care has changed considerably in the last two decades.

In 1975, general hospitals accounted for only 35 percent of expenditures on inpatient psychiatric care, and psychiatric hospitals accounted for 65 percent (see Table B-1). By 1980, the shares had changed to 41 percent for general hospitals and 59 percent for psychiatric hospitals. The expanded share for general hospitals mainly reflected the growing importance of psychiatric units within general hospitals. The diminished share of expenditures for psychiatric hospitals reflected declining shares of expenditures primarily for state psychiatric hospitals and secondarily for Veterans Administration (VA)

TABLE B-1. EXPENDITURES FOR PSYCHIATRIC INPATIENT HOSPITAL CARE, 1975, 1980, AND 1986

	1975		1980		1986	
	In Millions of Dollars	As a Percentage of Spending	In Millions of Dollars	As a Percentage of Spending	In Millions of Dollars	As a Percentage of Spending
General Hospitals						
Psychiatric unit	796	11.9	1,711	16.8	2,883	13.4
Scatterbeds[a]	1,559	23.2	2,438	24.0	8,212	38.3
Subtotal	2,355	35.1	4,150	40.8	11,095	51.8
Psychiatric Hospitals						
State	3,185	47.5	4,125	40.6	6,346	29.6
Private	467	7.0	928	9.1	2,638	12.3
Veterans Administration	699	10.4	965	9.5	1,361	6.3
Subtotal	4,351	64.9	6,019	59.2	10,344	48.2
Total	6,705	100.0	10,168	100.0	21,439	100.0

SOURCE: Congressional Budget Office adapted from Carl A. Taube, "Funding and Expenditures for Mental Illness," in R.W. Manderscheid and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), Table 5.2, p. 223.

a. Estimated for 1986 by total days (discharges times average length of stay) for discharges with psychiatric diagnoses from general hospitals (based on published and unpublished data from the Hospital Discharge Survey conducted by the National Center for Health Statistics) minus days in psychiatric units times overall short-stay general hospital per diem from the American Hospital Association. The implications of using this method are discussed in the text.

psychiatric hospitals. These declines were offset somewhat by a rising share of expenditures for private psychiatric hospitals.[1]

Otherwise comparable estimates of 1986 expenditures on psychiatric inpatient hospital care are significantly affected by a change in the method used to estimate spending for care in scatterbeds. The latter spending is shown as more than trebling between 1980 and 1986. Subsequent analyses, discussed below, have found that the number of episodes of inpatient psychiatric care in scatterbeds was fewer in the 1985-1986 period than in 1980-1981 period, which makes spending growth of that magnitude seem highly implausible. As a result, the 1986 estimates presumably overstate by similar amounts both total spending in general hospitals and total spending overall. That would also distort the estimated distribution of spending by type of hospital setting. Nevertheless, the shares of total spending for care in state psychiatric hospitals and in VA hospitals probably continued to fall, while the share for care in private psychiatric hospitals again grew strongly.

Who funds this expenditure on inpatient psychiatric care? Within specialized psychiatric hospitals, Medicare was a comparatively minor funding source (see Table B-2). Medicare contributed 3 percent of total revenue for state and county psychiatric hospitals, although 12 percent of the patients in these hospitals were age 65 or more in 1986, and it contributed less than 10 percent of total revenue for private psychiatric hospitals, in which 9 percent of patients were age 65 or more. State mental health agencies were the primary funding source for the state and county hospitals, whereas fees from clients--which presumably included payments by private insurers--were the principal revenue source for the private hospitals. Comparable data are not available for general acute-care hospitals.

TRENDS SINCE 1965 IN THE PROVISION OF PSYCHIATRIC CARE

Available data, although neither comprehensive nor always comparable, nevertheless show clearly that the provision of psychiatric care changed greatly during the period since 1965. The changes reflect a reduced emphasis on institutional forms of mental health care. This change in emphasis, in turn, appears to have resulted partly from professional support for a movement to deinstitutionalize mental health care and partly from fiscal incentives for state and local government entities to reduce their total funding liabilities for mental

1. Carl A. Taube, "Funding and Expenditures for Mental Illness," in R.W. Manderschied and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), pp. 216-226.

TABLE B-2. DISTRIBUTION OF REVENUES FOR STATE AND COUNTY PSYCHIATRIC HOSPITALS AND PRIVATE PSYCHIATRIC HOSPITALS, BY SOURCE, 1983 AND 1986

Source of Revenue	State and County Psychiatric Hospitals		Private Psychiatric Hospitals	
	1983	1986	1983	1986
Revenues (In billions of dollars)				
Total	5.5	6.4	1.5	2.8
Distribution of Revenues (In percent)				
State Mental Health Agency Funds (Excluding Medicaid)	61.8	74.1	2.5	2.3
Other State Government	7.3	4.3	2.8	2.5
Medicaid (Including federal, state, and local share)	18.1	11.2	4.9	5.2
Medicare	2.8	3.1	9.7	8.1
Other Federal	2.1	0.3	3.0	3.2
Local Government	2.4	1.6	1.8	2.2
Client Fees Received	1.7	1.6	68.6	67.2
Client Fees Reverted to State	2.8	2.7	0.4	0.1
Contract Funds from Other Nongovernment Organizations	0.5	0	2.0	1.3
All Other Sources	0.5	1.1	4.3	7.9
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office adapted from Michael J. Witkin and others, "Specialty Mental Health System Characteristics," in R.W. Manderscheid and M.A. Sommenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), Table 1.13, p. 57.

health care by encouraging deinstitutionalization and by substituting care in nursing homes for care in state psychiatric hospitals.

Outpatient Care

Outpatient psychiatric care grew rapidly during this period. Overall, for all mental health organizations, the rate of outpatient additions to their programs (that is, new episodes of care) per 100,000 civilians approximately doubled between 1969 and 1986 from 576 to 1,156. Moreover, the number of ambulatory mental health organizations with outpatient services grew from 228 in 1970 to 1,243 in 1986, and the rate of additions to their outpatient programs per 100,000 civilians increased from 112 to 631 over the same period. Similarly, the number of ambulatory mental health organizations providing partial care (typically, care for an individual either during the daytime or at night) grew from 333 to 1,317 over the same period, and the rate of new additions to their partial care programs per 100,000 civilians rose from 9.9 to 51.1.[2]

Inpatient Hospital Care

Both the scale of inpatient psychiatric care and its distribution by setting have changed substantially since 1965. Available data, however, fall short of providing accurate, consistent, and timely estimates of the level of use of such care over time and its distribution by type of provider and type of client. The most significant data limitations are for care in scatterbeds within general hospitals and for care in state psychiatric hospitals.

Recent estimates suggest that the total number of episodes of inpatient psychiatric care grew slightly between 1980/1981 and 1985/1986, but the number of such episodes within hospitals fell slightly (see Table B-3).[3] Inpatient episodes in nonhospital settings grew substantially, apparently reflecting residential treatment programs, including those for seriously disturbed youth.

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2. Michael J. Witkin and others, "Specialty Mental Health System Characteristics," in R.W. Manderschied and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), pp. 1-138.

3. Charles A. Kiesler and Celeste Simpkins, "The De Facto National System of Psychiatric Inpatient Care: Piecing Together the National Puzzle," *American Psychologist*, vol. 46, no. 6 (June 1991), pp. 579-584.

TABLE B-3. DISTRIBUTION OF EPISODES OF INPATIENT PSYCHIATRIC CARE BY SITE, 1980/1981 AND 1985/1986

	Number of Episodes (Thousands)		Change Between Periods in Number of Episodes (Percent)	Episodes as Percentage of All Hospital and Other Inpatient Episodes		Episodes as Percentage of All Hospital Episodes	
	1980/1981	1985/1986		1980/1981	1985/1986	1980/1981	1985/1986
Inpatient Episodes in All Sites							
Hospitals							
State mental	499	445	-10.8	19.5	17.0	20.9	19.0
VA	209	204	-2.6	8.2	7.8	8.8	8.7
Military	34	34	0	1.3	1.3	1.4	1.5
Private psychiatric	177	258	45.9	6.9	9.9	7.4	11.0
General	1,470	1,401	-4.7	57.5	53.5	61.5	59.8
Subtotal	2,389	2,342	2.0	93.5	89.4	100.0	100.0
Other Inpatient							
Multiservice organization	128	103	-19.2	5.0	4.0	n.a.	n.a.
Indian health	4	4	0	0.2	0.2	n.a.	n.a.
Residential treatment center	34	47	38.8	1.3	1.8	n.a.	n.a.
Other	0	122	n.a.	0	4.7	n.a.	n.a.
Subtotal	166	276	66.6	6.5	10.6	n.a.	n.a.
Total	2,555	2,618	2.5	100.0	100.0	n.a.	n.a.
Inpatient Episodes in General Hospitals							
Specialty Beds							
Psychiatric units and services							
Psychiatric units	661	558	-15.6	25.9	21.3	27.7	23.8
Psychiatric services	20	139	588.4	0.8	5.3	0.8	5.9
Subtotal	681	697	2.3	26.7	26.6	28.5	29.8
Chemical units	159	118	-25.7	6.2	4.5	6.7	5.0
Subtotal	840	815	-3.0	32.9	31.1	35.2	34.8
Nonspecialty beds							
Scatter hospitals[a]	468	452	-3.5	18.3	17.3	19.6	19.3
Scatterbeds[b]	162	134	-17.2	6.3	5.1	6.8	5.7
Subtotal	630	586	-7.0	24.6	22.4	26.4	25.0
Total	1,470	1,401	-4.7	57.5	53.5	61.5	59.8

SOURCE: Congressional Budget Office calculations based on Charles A. Kiesler and Celeste Simpkins, "The De Facto National System of Psychiatric Inpatient Care," *American Psychologist*, vol. 46, no. 6 (June 1991), Table 2.

NOTES: VA = Veterans Administration; n.a. = not applicable.

a. Short-term general hospitals that do not have psychiatric or chemical dependency units but provide care for psychiatric conditions in general medical and surgical beds.

b. General medical and surgical beds of those short-term general hospitals that do have psychiatric or chemical dependency units.

The only types of hospital settings to experience an increase in episodes were private psychiatric hospitals, where episodes increased 46 percent, and psychiatric services in general hospitals, which grew by a factor of almost six. (The latter are organized psychiatric services that do not meet the American Hospital Association's definition of a psychiatric unit, adopted by the Joint Commission on Accreditation of Hospitals. This definition requires locked wards, a separate physical location, and minimum standards for numbers of professional personnel.) The growth in episodes experienced by these services was substantially offset by a decline in episodes within psychiatric units of general hospitals.

The estimated proportion of all inpatient hospital episodes that were treated in nonspecialized beds within general hospitals fell between 1980/1981 and 1985/1986. This trend contrasts with a reported sixfold increase between 1965 and 1980 in the number of episodes of care within general hospitals outside of psychiatric units.[4]

Of all patients receiving inpatient psychiatric care in 1980 within hospitals classed as general hospitals, 62 percent were in specialized settings--either hospitals where the principal diagnoses of patients were so uniformly psychiatric in nature as to make them, in practice, specialized hospitals, or specialized units within general hospitals. Only 38 percent of patients receiving inpatient psychiatric care were in scatterbeds, three-quarters of which were in hospitals with no specialized units.[5]

Specialized Inpatient Psychiatric Programs

Another, more limited indicator of the scale of inpatient psychiatric care is the number of hospital beds in specialized psychiatric inpatient programs. The National Institute of Mental Health (NIMH) has collected extensive information about care provided by specialized mental health organizations.[6]

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4. Charles A. Kiesler, Celeste Simpkins, and Teru Morton, "Predicting Specialty Psychiatric Inpatient Care in General Hospitals: Agreement Between Two Independent Methods," *Professional Psychology: Research and Practice*, vol. 22, no. 2 (1991), pp. 155-160.

5. Charles A. Kiesler, Celeste G. Simpkins, and Teru L. Morton, "Who Is Treated in Psychiatric Scatter Beds in General Hospitals? An Imputational Algorithm," *Professional Psychology: Research and Practice*, vol. 20, no. 4 (1989), pp. 236-243.

6. R.W. Manderschied and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990).

These data show variations over time and by type of provider setting, client characteristics, and source of payment. They do not include care for psychiatric conditions that was provided in short-term general hospitals, however, unless the hospital had an organizationally separate specialized psychiatric unit. Care for psychiatric conditions that was provided in hospitals with chemical dependency units (that is, alcohol- or substance-abuse treatment units) is excluded as well unless the hospitals also had separate psychiatric units. The NIMH data for psychiatric units of general hospitals do not match exactly the corresponding data in Table B-1, because of differences in the reference year, the source of data, and definitions used.

The NIMH data support several conclusions. First, the number of specialized inpatient beds fell dramatically between 1970 and 1986, both in absolute terms (from 525,000 to 268,000) and when expressed as a rate per 100,000 civilians (from 264 to 112; see Table B-4).

Second, over the same period, the distribution of care within specialized psychiatric inpatient programs also changed dramatically. For example, the number of beds in state and county mental hospitals per 100,000 civilians fell from 207 in 1970 to 50 in 1986, and the number of beds in VA psychiatric inpatient programs per 100,000 civilians decreased as well from 26 to 11. Offsetting these sources of decline in the supply of beds were increases in the corresponding rates for providers in two other settings: from 7 beds per 100,000 civilians to 13 beds for private psychiatric hospitals, and from 11 beds per 100,000 civilians to 19 beds for distinct-part psychiatric units within general hospitals.

Third, a review of days of care rather than beds available shows similar results. There was a substantial overall decline in the provision of inpatient psychiatric care, a dramatic reduction in the number of inpatient days within state and county psychiatric hospitals, and a smaller decline for VA hospitals. Partially offsetting these drops were increases in days of care within private psychiatric hospitals and distinct-part psychiatric units of general hospitals (Table B-5).

Average daily occupancy rates for specialized psychiatric inpatient providers have varied over time to some degree for all providers, but only for VA inpatient psychiatric facilities has there been a substantial downward trend (see Table B-6). In contrast, occupancy rates for nonfederal short-term general hospitals fell from 78.0 percent in 1970 to 64.6 percent in 1986.[7]

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7. Bureau of the Census, *Statistical Abstract of the United States: 1990*, 110th ed. (1990), Table 163, p. 105.

Nursing Home Care

It is widely accepted that, as the number of inpatient specialized psychiatric beds fell, nursing homes were increasingly used to provide care for people with mental health conditions. Although this belief may be true, the literature does not appear to provide statistical data documenting the trend toward increased nursing home provision of mental health care or establishing that increased nursing home use resulted from deinstitutionalization of mental health care.

Nevertheless, mental disorders are prevalent among nursing home residents. Of approximately 1.5 million nursing home residents in 1985, 65 percent had at least one condition that could be classified as a mental illness; many had more than one such condition. Moreover, among residents who were not cognitively impaired--that is, those not exhibiting organic brain syndromes (such as Alzheimer's disease) or mental retardation--at least 194,000 (or 13 percent of all residents) had other mental disorders, including alcohol or drug abuse, depressive disorders, schizophrenia or other psychoses, and anxiety disorders. The groups of residents with these mental disorders also required assistance, on average, with at least 2.5 activities of daily living out of six. So it is possible that a substantial proportion of these residents were admitted because of conditions other than their mental disorders.[8]

ROLES OF ALTERNATIVE INPATIENT PROVIDERS

Different kinds of providers of inpatient psychiatric care systematically treat different groups of psychiatric patients. This section presents evidence about how providers differ in the kinds of patients they treat and about the changing role of state psychiatric hospitals.

Providers' Niches Within the Market for Inpatient Psychiatric Care

The different kinds of providers (other than state and county psychiatric hospitals) differ systematically in their use of resources and the severity of cases treated, with specialized short-term psychiatric hospitals using the most resources and treating the most severe cases. General hospitals with psychiatric or chemical dependency units tend to use fewer resources and to treat less severe cases, while general hospitals without such units tend to treat

8. Genevieve W. Strahan, "Prevalence of Selected Mental Disorders in Nursing and Related Care Homes," in R.W. Manderschied and M.A. Sonnenschein, eds., *Mental Health, United States, 1990* (Department of Health and Human Services, National Institute of Mental Health, 1990), pp. 227-240.

TABLE B-4. NUMBER OF INPATIENT AND RESIDENTIAL TREATMENT BEDS, PERCENTAGE DISTRIBUTION, AND RATE PER 100,000 CIVILIAN POPULATION, BY TYPE OF MENTAL HEALTH ORGANIZATION, SELECTED YEARS 1970 TO 1986

Type of Organization	1970	1976	1980	1984	1986
Number of Inpatient Beds					
All Organizations	524,878	338,963	274,713	262,673	267,613
State and county mental hospitals	413,066	222,202	156,482	130,411	119,033
Private psychiatric hospitals	14,295	16,091	17,157	21,474	30,201
Nonfederal general hospitals with separate psychiatric services	22,394	28,706	29,384	46,045	45,808
VA medical centers[a]	50,688	35,913	33,796	23,546	26,874
Residential treatment centers for emotionally disturbed children	15,129	18,029	20,197	16,745	24,547
Federally funded community mental health centers[b]	8,108	17,029	16,264	n.a.	n.a.
All other organizations[b]	1,198	993	1,433	24,452	21,150
Percentage Distribution of Inpatient Beds					
All Organizations	100.0	100.0	100.0	100.0	100.0
State and county mental hospitals	78.7	65.6	57.0	49.6	44.5
Private psychiatric hospitals	2.7	4.7	6.2	8.2	11.3
Nonfederal general hospitals with separate psychiatric services	4.3	8.5	10.7	17.5	17.1
VA medical centers[a]	9.7	10.6	12.3	9.0	10.0
Residential treatment centers for emotionally disturbed children	2.9	5.3	7.4	6.4	9.2
Federally funded community mental health centers[b]	1.5	5.0	5.9	n.a.	n.a.
All other organizations[b]	0.2	0.3	0.5	9.3	7.9

(Continued)

TABLE B-4. CONTINUED

Type of Organization	1970	1976	1980	1984	1986
	Inpatient Beds per 100,000 Civilian Population				
All Organizations	263.6	160.3	124.3	112.9	111.7
State and county mental hospitals	207.4	105.1	70.2	56.1	49.7
Private psychiatric hospitals	7.2	7.6	7.7	9.2	12.6
Nonfederal general hospitals with separate psychiatric services	11.2	13.6	13.7	19.8	19.1
VA medical centers[a]	25.5	17.0	15.7	10.1	11.2
Residential treatment centers for emotionally disturbed children	7.6	8.5	9.1	7.2	10.3
Federally funded community mental health centers[b]	4.1	8.0	7.3	n.a.	n.a.
All other organizations[b]	0.6	0.5	0.6	10.5	8.8

SOURCE: Congressional Budget Office adapted from Michael J. Witkin and others, "Specialty Mental Health System Characteristics," in R.W. Manderscheid and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), Table 1.2, p. 31.

NOTES: VA = Veterans Administration; n.a. = not applicable.

Some organizations were reclassified as a result of changes in reporting procedures and definitions. For 1980, comparable data were not available for certain types of organizations and data for either an earlier or a later period were substituted. These factors influence the comparability of 1980, 1984, and 1986 data with those of earlier years. For details, see the original source.

a. Includes VA neuropsychiatric hospitals, VA general hospital psychiatric services, and VA psychiatric outpatient clinics.

b. Definitional changes between 1981 and 1986 largely accounted for changes between the categories "Federally funded community mental health centers" and "All other organizations." The latter category includes freestanding psychiatric outpatient clinics, freestanding partial care organizations, and multiservice mental health organizations. Multiservice mental health organizations were redefined in 1984. For details, see the original source.

TABLE B-5. NUMBER OF INPATIENT AND RESIDENTIAL TREATMENT DAYS, PERCENTAGE DISTRIBUTION, AND RATE PER 1,000 CIVILIAN POPULATION, BY TYPE OF MENTAL HEALTH ORGANIZATION, SELECTED YEARS 1969 TO 1986

Type of Organization	1969	1975	1979	1983	1986
Number of Inpatient Days					
All Organizations	168,934	104,970	85,285	81,821	83,413
State and county mental hospitals	134,185	70,584	50,589	42,427	39,075
Private psychiatric hospitals	4,237	4,401	5,074	6,010	8,568
Nonfederal general hospitals with psychiatric services	6,500	8,349	8,435	12,529	12,570
VA medical centers[a]	17,206	11,725	10,628	7,425	7,753
Residential treatment centers for emotionally disturbed children	4,528	5,900	6,531	5,776	8,267
Federally funded community mental health centers[b]	1,924	3,718	3,609	n.a.	n.a.
All other organizations[b]	354	293	419	7,654	7,180
Percentage Distribution of Inpatient Days					
All Organizations	100.0	100.0	100.0	100.0	100.0
State and county mental hospitals	79.4	67.2	59.3	51.8	46.8
Private psychiatric hospitals	2.5	4.2	5.9	7.3	10.3
Nonfederal general hospitals with psychiatric services	3.9	8.0	9.9	15.3	15.1
VA medical centers[a]	10.2	11.2	12.5	9.1	9.3
Residential treatment centers for emotionally disturbed children	2.7	5.6	7.7	7.1	9.9
Federally funded community mental health centers[b]	1.1	3.5	4.2	n.a.	n.a.
All other organizations[b]	0.2	0.3	0.5	9.4	8.6

(Continued)

TABLE B-5. CONTINUED

Type of Organization	1969	1975	1979	1983	1986
	Inpatient Days per 1,000 Civilian Population				
All Organizations	848.5	496.6	386.0	352.0	348.4
State and county mental hospitals	674.0	333.9	227.1	182.6	163.2
Private psychiatric hospitals	21.3	20.8	22.8	25.9	35.8
Nonfederal general hospitals with psychiatric services	32.6	39.5	39.3	53.7	52.5
VA medical centers[a]	86.4	55.5	49.5	32.0	32.4
Residential treatment centers for emotionally disturbed children	22.7	27.9	29.3	24.9	34.5
Federally funded community mental health centers[b]	9.7	17.6	16.2	n.a.	n.a.
All other organizations[b]	1.8	1.4	1.8	32.9	30.0

SOURCE: Congressional Budget Office adapted from Michael J. Witkin and others, "Specialty Mental Health System Characteristics," in R.W. Manderscheid and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), Table 1.5, p. 34.

NOTES: VA = Veterans Administration; n.a. = not applicable.

Some organizations were reclassified as a result of changes in reporting procedures and definitions. For 1979, comparable data were not available for certain types of organizations and data for either an earlier or a later period were substituted. These factors influence the comparability of 1979, 1983, and 1986 data with those of earlier years. For details, see the original source.

a. Includes VA neuropsychiatric hospitals, VA general hospital psychiatric services, and VA psychiatric outpatient clinics.

b. Definitional changes between 1981 and 1986 largely accounted for changes between the categories "Federally Funded Community Mental Health Centers" and "All Other Organizations." The latter category includes freestanding psychiatric outpatient clinics, freestanding partial care organizations, and multiservice mental health organizations. Multiservice mental health organizations were redefined in 1984. For details, see the original source.

TABLE B-6. AVERAGE DAILY INPATIENT AND RESIDENTIAL TREATMENT CENSUS AND PERCENTAGE OF OCCUPANCY, BY TYPE OF MENTAL HEALTH ORGANIZATION, SELECTED YEARS 1969 TO 1986

Type of Organization	1969	1975	1979	1983	1986
Average Daily Inpatient Census					
All Organizations	468,831	287,588	233,384	224,169	228,530
State and county mental hospitals	367,629	193,380	138,600	116,236	107,056
Private psychiatric hospitals	11,608	12,058	13,901	16,467	23,475
Nonfederal general hospitals with separate psychiatric services	17,808	22,874	23,110	34,328	34,437
VA medical centers[a]	47,140	32,123	28,693	20,342	21,242
Residential treatment centers for emotionally disturbed children	12,406	16,164	18,054	15,826	22,650
Federally funded community mental health centers[b]	5,270	10,186	9,886	n.a.	n.a.
All other organizations[b]	970	803	1,140	20,970	19,670
Percentage of Occupancy					
All Organizations	88.2	84.4	85.0	85.3	85.4
State and county mental hospitals	89.4	87.0	88.6	89.1	89.9
Private psychiatric hospitals	81.2	74.9	81.0	76.7	77.7
Nonfederal general hospitals with separate psychiatric services	79.5	79.7	78.6	74.6	75.2
VA medical centers[a]	93.0	89.4	84.9	86.4	79.0
Residential treatment centers for emotionally disturbed children	82.0	89.7	89.4	94.5	92.3
Federally funded community mental health centers[b]	65.0	59.8	60.8	n.a.	n.a.
All other organizations[b]	81.0	80.9	79.6	85.8	93.0

SOURCE: Congressional Budget Office adapted from Michael J. Witkin and others, "Specialty Mental Health System Characteristics," in R.W. Manderscheid and M.A. Sonnenschein, eds., *Mental Health, United States, 1990*, publication no. (ADM) 90-1708 (Department of Health and Human Services, National Institute of Mental Health, 1990), Table 1.6, p. 35.

NOTES: VA = Veterans Administration; n.a. = not applicable.

Some organizations were reclassified as a result of changes in reporting procedures and definitions. For 1979, comparable data were not available for certain types of organizations and data for either an earlier or a later period were substituted. These factors influence the comparability of 1979, 1983, and 1986 data with those of earlier years. For details, see the original source.

a. Includes VA neuropsychiatric hospitals, VA general hospital psychiatric services, and VA psychiatric outpatient clinics.

b. Definitional changes between 1981 and 1986 largely accounted for changes between the categories "Federally funded community mental health centers" and "All other organizations." The latter category includes freestanding psychiatric outpatient clinics, freestanding partial care organizations, and multiservice mental health organizations. Multiservice mental health organizations were redefined in 1984. For details, see the original source.

the least severe cases. Evidence for this--from a study of hospital discharges--takes several forms.[9]

For patients with mental disorders, patients in specialized hospitals stay the longest, followed by those in hospitals with psychiatric units, with the shortest stays in hospitals without psychiatric units. In addition, hospitals with both psychiatric and chemical dependency units typically have longer average lengths of stay than hospitals with just psychiatric units. For patients with alcohol and drug disorders who do not leave against medical advice, specialized psychiatric hospitals have the longest stays, and general hospitals with chemical dependency units typically have longer stays than those without such units.

Patients were admitted to scatterbeds rather than to specialized settings in predictable and clinically rational patterns. In general, the site of care depended on the age of the patient, the seriousness of the case, whether there was a secondary diagnosis of a physical disorder, and whether surgical procedures were involved. For example, among patients diagnosed as having mental disorders, scatterbed patients had shorter lengths of stay than those admitted to psychiatric units. They also tended to have diagnoses that did not include psychosis, as well as more secondary diagnoses of a physical disorder, and less complex conditions. In addition, they were more likely to be older, on Medicare, and not single. Among patients diagnosed as having alcohol and drug disorders, those admitted to scatterbeds tended to be less severely dependent on alcohol; they had more secondary diagnoses of physical disorders, and they were less likely to have secondary mental disorders.[10]

Specialized hospitals tended to have much the longest lengths of stay for all disorders and categories. They were primarily small and private, and over half their patients paid with commercial insurance--a much larger proportion than for other categories of hospitals. The role of insurance funding suggests that patterns of use reflect economic incentives as well as various clinical considerations.

State Psychiatric Hospitals

Although state psychiatric hospitals no longer dominate the inpatient psychiatric care sector as they once did, they still represented about one-fifth

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9. Charles A. Kiesler and others, "Characteristics of Psychiatric Discharges from Nonfederal, Short-Term Specialty Hospitals and General Hospitals with and without Psychiatric and Chemical Dependency Units: The Hospital Discharge Survey Data," *Health Services Research*, vol. 25, no. 6 (February 1991), pp. 881-906.

10. Kiesler, Simpkins, and Morton, "Who Is Treated in Psychiatric Scatter Beds in General Hospitals?" pp. 236-243. See also, Kiesler, Simpkins, and Morton, "Predicting Specialty Psychiatric Inpatient Care," pp. 155-160.

of all episodes in 1985/1986. National data on the characteristics of people using state psychiatric hospitals are not available, but information for eight states and the District of Columbia has been compiled for the period from 1977 to the mid-1980s.[11]

According to these data, most patients have short cumulative stays, whether measured over a single year (see Table B-7), a five-year period (see Table B-8), or a nine-year period. Nevertheless, a significant subgroup of all patients used more than 190 days over an extended period--5 percent over a one-year period, 11 percent over a five-year period, and 15 percent over a nine-year period. Moreover, patients age 65 or more were disproportionately heavy users--for example, over a five-year period, 28 percent of patients in this age group used more than 190 days, 19 percent accumulated more than 400 days, and 10 percent accumulated 1,001 to 2,000 days.

Many heavy users of care have multiple admissions. Of those using 191 to 1,000 days over a five-year period, for example, about one-quarter had at least three admissions and about one-half had at least two admissions. About two-thirds of those accumulating 401 to 1,000 days did so through multiple admissions.

The number of people in state psychiatric hospitals who meet the general eligibility conditions for Medicare but whose inpatient psychiatric care is not paid for by Medicare is not accurately known. In many cases, the care provided by the hospital is not intensive enough to meet the Medicare definition of "active treatment" and so cannot be covered. In hospitals that do provide active treatment, however, these people fall into three groups.

One group consists of those who have exhausted the 190-day limit. The Health Care Financing Administration reportedly estimated the number of people who by 1989 had exhausted their 190-day benefit at 21,000. Trutko and Aiuppa, however, suggested in their study that this may be an underestimate--for example, because state hospitals might not always have billed Medicare for covered days, especially before 1980. Their study found, within eight states and the District of Columbia, 4,375 patients age 65 or more who had exceeded 190 days of care during a five-year period.[12]

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11. John Trutko and Laura Aiuppa, "Analysis of Data on High Users of State Psychiatric Hospitals and the Implications for Medicare's 190-Day Lifetime Psychiatric Hospital Limit," Final Report to the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (December 1989).

12. Trutko and Aiuppa, "Analysis of Data," p. 85.

TABLE B-7. DISTRIBUTION AND CUMULATIVE PERCENTAGE OF STATE PSYCHIATRIC HOSPITAL PATIENTS ADMITTED IN 1979 AND 1981, BY ANNUAL DAYS OF CARE

Annual Number of Days	Distribution	Cumulative Percentage
1 - 10	41.5	41.5
11 - 30	24.3	65.8
31 - 60	15.2	80.9
61 - 90	6.3	87.3
91 - 120	3.6	90.9
121 - 150	2.3	93.2
151 - 190	2.1	95.3
191 - 300	3.1	98.4
301 - 365	1.6	100.0
Total	100.0	100.0
Total Number of Patients	179,779	179,779

SOURCE: Congressional Budget Office adapted from John Trutko and Laura Aiuppa, "Analysis of Data on High Users of State Psychiatric Hospitals and the Implications for Medicare's 190-Day Lifetime Psychiatric Hospital Limit," Final Report to the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (December 1989), p. vii.

NOTE: The figures show the percentage of patients admitted in 1979 or 1981 receiving specified numbers of days of care in state psychiatric hospitals during the year of admission. Data are from state psychiatric hospitals in Colorado, Georgia, North Carolina, New York, Ohio, Oklahoma, Tennessee, and Utah and from St. Elizabeth's Hospital in Washington, D.C.

TABLE B-8. DISTRIBUTION AND CUMULATIVE PERCENTAGE OF STATE PSYCHIATRIC HOSPITAL PATIENTS ADMITTED IN THE 1977 TO 1981 PERIOD, BY TOTAL DAYS OF CARE DURING THE FIVE YEARS AFTER FIRST ADMISSION

Total Number of Days	Distribution	Cumulative Percentage
1 - 10	33.4	33.4
11 - 30	23.4	56.8
31 - 60	15.8	72.6
61 - 90	7.0	79.7
91 - 120	3.9	83.6
121 - 150	2.6	86.2
151 - 190	2.4	88.6
191 - 400	5.0	93.6
401 - 1,000	3.2	96.8
1,001 - 2,000	3.2	100.0
Total	100.0	100.0
Total Number of Patients	206,455	206,455

SOURCE: Congressional Budget Office adapted from John Trutko and Laura Aiuppa, "Analysis of Data on High Users of State Psychiatric Hospitals and the Implications for Medicare's 190-Day Lifetime Psychiatric Hospital Limit," Final Report to the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services (December 1989), p. iii.

NOTE: The figures show the percentage of patients receiving specified numbers of days of care in state psychiatric hospitals in the five-year period beginning with the year of first admission. To be included in the analysis, a patient had to be admitted at least once during the 1977 to 1981 period. Data are from state psychiatric hospitals in Colorado, Georgia, North Carolina, New York, Ohio, Oklahoma, Tennessee, and Utah and from St. Elizabeth's Hospital in Washington, D.C.

If rates of use among aged people in the states they studied, which accounted for 22.7 percent of the U.S. aged population in 1979, were representative of those for the U.S. aged population as a whole, then the corresponding national figure would have been 19,300. Inflating this number for growth in the number of aged Medicare enrollees between 1979 and 1989 implies, under these assumptions, a national estimate of about 23,500 for the number of aged residents in state psychiatric hospitals who exhausted their benefits during a five-year period. This estimate can be compared more readily with the Health Care Financing Administration estimate for 1989 of 21,000. Although some of those 23,500 people might not have been eligible for Medicare (for example, because of the inpatient psychiatric carryover restriction), others who would not have been included in that number might have exhausted their 190-day lifetime benefit over longer periods of time, in settings other than state psychiatric hospitals, or while eligible for Medicare on the basis of disability before reaching age 65.

Another group comprises people who, for other reasons, are ineligible for Medicare coverage of their care. The Inspector-General of the Department of Health and Human Services reported in 1988 that 46,500 people aged 65 or older who were permanent residents in state psychiatric hospitals might be ineligible for Medicare for reasons other than having exhausted the 190-day limit.[13] For example, these people might have been in psychiatric hospitals when they became entitled to coverage under Medicare and so would have been subject to the carryover restriction that limits eligibility for the Medicare psychiatric inpatient benefit.

The remaining group consists of those patients who are eligible for Medicare coverage but for whom bills are not submitted to Medicare. The extent to which state psychiatric hospitals fail to bill Medicare for covered care is not known but is likely to have decreased in recent years.

13. Department of Health and Human Services, Office of the Inspector-General, "New Limits are Needed to Deal with Changing Conditions in the Delivery of Medicare Inpatient Psychiatric Care" (1988), cited in Trutko and Aiuppa, "Analysis of Data," p. 85.