MEDICAID FINANCING OF PUBLIC PSYCHIATRIC HOSPITALS

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Myth or Reality?

- Few people are served by public psychiatric hospitals today
- Public psychiatric hospitals receive no Medicaid funds because of certain statutory exclusions
This Project Examines

- The sources and magnitude of Medicaid funds that public psychiatric hospitals receive

- Changes in Medicaid funding policy over the past 10 years affecting these public institutions

- Forces currently affecting funding of these public institutions
Policy Importance of This Project

To better understand the potential impact, if any, of changes in Medicaid financing policies on public psychiatric hospitals.
Primary Research Methods

- Literature review
- Expert advisory panel
- Case studies of 5 states – Iowa, California, Maryland, Arkansas, and New Jersey
- Telephone interviews of CMS regional office staff
Respondents

Semi-structured interviews using standardized interview protocols:

- State mental health authority
- State Medicaid agency
- State budget office
- Governor’s office
- State psychiatric hospitals
- County psychiatric hospitals
- Advocacy groups
- Other state specific organizations
Presentation Overview

- Contextual background on Medicaid funding of public psychiatric hospitals
- Potential sources of Medicaid funding
- Current funding pressures
Historical Factors Influencing Public Psychiatric Hospitals’ Funding

- Growth of community mental health centers
- Creation of the Medicaid Program
- Deinstitutionalization
- Advent of managed care
Growth of Community Mental Health Centers

- The goal of CMHCs was to reduce state hospital admissions by 50% over a 10 year period of time. Sources: Gronfein 1985; Foley and Sharfstein 1983

- CMHCs grew rapidly during the 1960s and 1970s. Sources: Gronfein 1985; Foley and Sharfstein 1983
Creation of the Medicaid Program

- Created in 1965 (as was the Medicare program)
- Customized programs by state with wide state-to-state variation
- Shifted sites of care for many persons with mental illness
The IMD Exclusion

- Precludes Medicaid reimbursement, and any federal matching dollars, for services received by IMD patients (ages 21-64)

- Does not imply the loss of individuals’ Medicaid eligibility

Sources: DHHS 1994; HCFA 1992
Inpatients by Age in Public Psychiatric Hospitals, 1997

- 18-64: 83%
- 65 and Older: 12%
- Under 18: 5%

Policy Underlying the IMD Exclusion

Long-term care of persons being treated in public or private psychiatric hospitals is the responsibility of the states.

Source: DHHS 1992
Historical Context of the IMD Exclusion

- Predates Medicaid
- Relaxed under the creation of the Medicaid program in 1965 and with the passage of subsequent amendments in 1972

Source: DHHS 1992
Generally, The IMD Exclusion Today Pertains To…

- Public and private psychiatric hospitals and residential substance abuse programs
- Other facilities such as nursing homes may also be designated as IMDs if they meet certain criteria

Source: DHHS 1992
Medicaid’s Impact on Nursing Homes

- Until 1970, nursing homes ranked second to psychiatric hospitals in terms of the number of institutionalized persons. Sources: Gronfein 1985; Kramer 1977

- The shift is largely due to the transfer of elderly with symptoms of mental illness from public psychiatric hospitals to nursing homes. Sources: Grob 2001; GAO 1977
Deinstitutionalization

“Deinstitutionalization has been the formal policy of the Federal government with regard to mental illness since 1963.”  
Source: Gronfein 1985
Besides CMHCs and Medicaid...

Other factors also facilitating deinstitutionalization:

- Psychotropic drugs
- Patient rights movement

Source: Gronfein 1985
Number of Psychiatric Hospitals by Ownership Type, 1970-1998

<table>
<thead>
<tr>
<th>Year</th>
<th>Public</th>
<th>Private</th>
<th>Non-Federal General Hospitals w/Psychiatric Units</th>
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<td>664</td>
<td>150</td>
<td>150</td>
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<tr>
<td>1980</td>
<td>310</td>
<td>280</td>
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<td>1990</td>
<td>273</td>
<td>184</td>
<td>1571</td>
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<tr>
<td>1998</td>
<td>229</td>
<td>348</td>
<td>1593</td>
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Number of Psychiatric Hospital Beds by Ownership Type, 1970-1998

Managed Care

- Encourages the use of less restrictive levels of care
- Often there are different care delivery systems for mental health services
- Medicaid managed care grew rapidly after 1993
- Nearly 21 million Medicaid beneficiaries are enrolled in managed care
Previous Research Suggests

Medicaid provides 18% of the funding of public psychiatric hospitals (based on 1994 data)

Source: Manderscheid et al. 2001
Which Brings Us to Our Current Research Interests

- What financing role does Medicaid currently play in public psychiatric hospitals?
- How might this role be changing?
- What pressures are influencing change?
Medicaid Funding Sources of Interest

- Optional services
- Medicaid managed care
- Disproportionate share hospital (DSH) payments
- Enhanced payments/upper payment limits
- Administrative payments
Medicaid State Plan Options for IMDs

- Under age 21 population – inpatient psychiatric care
- Age 65 and older population – inpatient psychiatric care and hospital and nursing care

Sources: State Medicaid Plans; NASMHPD 2001
Medicaid Managed Care and Behavioral Health

- Eight states have IMD expenditure authority under 1115 waivers
  Sources: Kuo and Draper 2002; CMS 2001

- Public psychiatric hospitals are not precluded from participating in behavioral managed care provider networks
Supplemental funding provided to hospitals serving a disproportionate share of Medicaid and/or low-income persons
DSH Payments and IMDs

- In the early 1990s, states’ Medicaid DSH strategies began to include IMDs

- For states, the inclusion of IMDs increased the number of hospitals eligible for DSH payments

Source: Coughlin and Liska 1998
IMD DSH Caps Created by the Balanced Budget Act of 1997

- FY 1998-2000 – states could spend no more on DSH for IMDs than it did in 1995

- DSH allocation on IMDs is limited to:
  > FY 2001 – 50%
  > FY 2002 – 40%
  > FY 2003 and after – 33%

- Based on 1999 DSH payments, 10 states are subject to IMD caps

Sources: CMS 2001; HCFA 1997
Upper Payment Limits (UPL)/Enhanced Payments

- Under UPL programs, states pay facilities more than their costs in order to increase federal reimbursements.
- States appear to use UPL strategies mainly for general hospitals and nursing homes.
- Unclear whether any public psychiatric hospitals participate.
Administrative Payments

- The IMD exclusion applies to services and may not apply to administrative costs

- Examples: discharge planning, eligibility determinations, medication management

- Administrative payments do not appear to be a major source of Medicaid funding, if any, for public psychiatric hospitals
Current Pressures

- States’ fiscal challenges
- Continuing shift to community-based treatment
- Changing configurations and roles of public psychiatric hospitals
- Mental health parity
States Face Major Fiscal Challenges

- At least 40 states are facing major budget shortfalls, totaling $40 billion
- Medicaid accounts for about 15 percent of states’ spending
- Annual increases in Medicaid spending are in the double digits

Source: NGA 2002, KFF 2002
Shortfalls in States’ Medicaid Programs

- 2001 - 39 states
- 2002 - 28 states
- Total expected shortfall for all states for FY2001 and FY2002 = approximately $7.1 billion (combined)

Source: NGA 2002
Medicaid Cost Pressures

- 15%+ annual increases in overall prescription drug costs
- Eligibility expansions
- Service utilization increases
- Higher unit costs
- New technologies
- Plan and provider payment rate increases

Source: NGA 2002
Continued Shift to Community-Based Treatment

- Continued emphasis on community-based treatment options vs. institutional care
- Olmstead Supreme Court decision
Changing Configurations and Roles of Public Psychiatric Hospitals

In 2001, for example, states reported:

- Closing one or more hospitals (17)
- Downsizing one or more hospitals (10)
- Reorganizing within one or more hospitals (2)
- Consolidating 2 or more hospitals into 1 hospital (1)

Source: NASMPD 2001
Growing Forensic Population

- For at least 4 states in 2001, the percentage of criminally committed patients exceeded the percentage civil commitments. 

- Reduces the number of Medicaid beds available.
Lack of Mental Health Parity

The lack of parity between medical and mental health insurance coverage places additional pressure on public providers of care when benefit limits are met.
More Reality Than Myth

- Public psychiatric hospitals continue to serve large numbers of persons with mental illness
- Medicaid does play a role in the financing of these facilities
Focus of the Final Report

- Current Medicaid funding sources and how these vary by state
- Local circumstances that influence the particular Medicaid funding strategies states pursue
- Forces affecting Medicaid funding of public psychiatric hospitals