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Interviews with Inpatient Psychiatric Facilities

A report by L&M Policy Research for the Medicare Payment Advisory Commission

The views expressed in this report are those of the authors. No endorsement by MedPAC is intended or should be inferred.

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425 I Street, NW | Suite 701 | Washington, DC 20001 | (202) 220-3700 | www.medpac.gov

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Interviews with Inpatient Psychiatric Facilities

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Prepared for:
Betty Fout and Jamila Torain
BFout@medpac.gov; JTorain@medpac.gov

Prepared by:
L&M Policy Research, LLC
1743 Connecticut Ave NW, Suite 200
Washington, DC 20009
Attn: Julia Doherty, MHSA
Senior Research Director
JDoherty@LMpolicyresearch.com

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AUTHORS

This report was authored by staff from L&M Policy Research (L&M). This collaborative effort included Julia Doherty, Heather McPheron, Madelyn McDonald, Amanda Dranch, and Margaret Johnson.

EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) engaged L&M Policy Research (L&M) to explore trends and issues in the delivery of psychiatric services in inpatient psychiatric facilities (IPFs). More specifically, this study aimed to support MedPAC's understanding of the differences in service provision, patient mix, and variation in the reporting of ancillary charges between freestanding IPFs and IPFs that are distinct units within acute care hospitals.

This report summarizes the empirical research and synthesis of interviews conducted with 10 IPFs. During each of these interviews, the research team and interviewees discussed the services that the IPFs deliver and the patients that the facilities and their affiliated systems treat, with a focus on the adult population, especially Medicare beneficiaries. In addition to learning more about the services offered and patients served, the interviews yielded rich insights into the resources required to care for patients with behavioral health diagnoses, how services have changed over time, and the differences in how IPFs report resource use, specifically ancillary services.

Methodology

The L&M team worked with MedPAC staff to identify an initial list of 10 primary IPFs and 25 alternate IPFs in geographically varied markets across the country. We aimed for diversity in ownership type, affiliation, type, size, all-inclusive designation, census region, and variation in ancillary service reporting.[1] Given the limit of 10 participating IPFs in the study, we excluded facilities with extremely small or large bed sizes to help ensure that the sample was as representative as possible. This intentional sample included a higher proportion of facilities that are part of large, for profit chains in order to explore the reasons fewer (and often zero) ancillary services are reported by such IPFs.

The team conducted 15 one-hour interviews with 21 individuals representing 10 IPFs between November 2022 and February 2023.[2] Interviews typically included a chief executive, financial or medical officer, and sometimes other staff with responsibility for these functions. The team used a semi-structured discussion guide to conduct the interviews (see the Appendices for the discussion guide). Two senior researchers led the interviews while a research assistant took notes organized according to the topics in the discussion guide. MedPAC staff attended interviews when possible. We conducted the interviews via Zoom and recorded them for notetaking purposes with permission from the participants. Following each IPF interview, the team created a profile identifying facility attributes and highlighting key findings about the patient population, financial practices, and market in which the facility operates (see the Appendices for the blinded IPF profiles). The team analyzed the interview notes and profiles by topic. This approach allowed for comparison and synthesis of findings across IPFs. Through this process and the ensuing team discussions, we identified key themes and findings.

[1] For the purpose of this report, all-inclusive refers to the designation on each IPF's Medicare cost report.
[2] The finance staff at the two government-owned IPFs could not speak to decisions related to ancillary billing, cost reports or reimbursement. Our team supplemented those two IPF interviews with four separate 15–20-minute conversations with individual finance staff at state offices responsible for cost reporting, billing, and reimbursement.

Summary of Key Findings

Ultimately, the L&M team interviewed two government-owned, four for profit, and four nonprofit facilities; eight are freestanding and the other two are part of an acute care hospital; and only two of the facilities reported not having a dedicated older adult unit or service.[3] Key findings from the interviews include:

- **IPFs in the study have similar referral sources and intake processes, but their admission criteria vary**. All IPF interviewees reported taking into consideration patients' psychiatric needs, medical needs, their age, and likely resource needs prior to admission whenever possible. None of the IPFs in the study admit patients in active withdrawal and all IPFs we interviewed admit patients with mood disorders. **Most freestanding facilities reported more restrictive admission criteria than psychiatric units that are part of an acute care hospital.** Patients admitted to freestanding IPFs with medical comorbidities generally have conditions that are well-controlled or stable, although within these freestanding IPFs, there is varied willingness and ability to admit and care for more medically complex and challenging patients. All IPFs reported that patients who develop acute medical needs are transferred to a medical bed in an acute care hospital.

- **When characterizing patients served by the IPFs in our study, we found that patients tend to fall into two different categories: a general adult population or populations with higher needs**. Higher need patients are often older, frailer, and require a higher staff-to-patient ratio. They tend to end up on different units than the general inpatient psychiatric population, often on what some IPFs designate as geriatric units.

- **There are two primary considerations that IPFs use to segment their units: (1) the level of care and staffing required and (2) patient's age**. Markedly aggressive patients are placed in separate units or at a minimum in private rooms with one-on-one staffing. These units may be locked and may include forensic patients.[4] Most facilities reported having a designated unit for geriatric-level care; those facilities that admit minors also have separate units for children and adolescents.

- **Most interviewees consistently expressed concern about the lack of available post-acute and outpatient placements and behavioral health providers**. Interviewees reported significant challenges with identifying safe and supportive discharge options for patients. These challenges can result in increased lengths of stay.

- **Most IPF executives reported struggling to adequately staff their facilities**. Eight of the IPFs were operating below capacity due to inadequate staffing. Interviewees at several facilities mentioned taking beds or entire units offline due to insufficient staff available to address patients' needs.

[3] Where we can, we parse out results by different facility characteristics, but due to the small sample size, it is not always appropriate.

[4] For the purposes of this report, forensic psychiatric patients are those with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings for committing often violent criminal acts.

- In addition to the themes shared above, interviewees were also asked to discuss their efforts to track and report ancillary services**. Interviewees in all the IPFs shared that they provide some ancillary services, but how they track and report them varies significantly**. All the IPFs track ancillary services internally, but only seven report them in cost reports and six report ancillary services on claims.[5] Notably, interviewees shared that even when they do report ancillary services on cost reports or in claims, the information is likely incomplete. They noted that reporting ancillary services is time-consuming and that they have little incentive to do so.

- **Whether or not patients require intensive staffing, financial and clinical executives alike reported that labor costs are the key driver of resource use in their IPF.** Interviewees emphasized repeatedly that diagnoses, age, and ancillary charges alone are not indicative of the costliness of a patient. Rather, interviewees said that looking at the staffing needed to appropriately care for a patient given the individual's combination of diagnoses, cognitive and functional capacity, and mental condition provides a more accurate picture of composite cost.

- **Several facilities noted that the Medicare 190-day lifetime limit was insufficient**. Interviewees said the cap for freestanding facilities is particularly challenging since patients are living longer with chronic illnesses and facilities are facing increased barriers to finding suitable post-discharge placement options.

- **Finally, IPFs provided mixed feedback on the adequacy of Medicare payment**. Some of the IPFs reported that the Medicare inpatient prospective payment system (IPPS) per diem rates are significantly less than what their facilities are paid under Medicare Advantage (MA), while others shared that the Medicare IPF PPS rate is favorable or at least comparable to other payers. A few IPFs stated that although the IPF IPPS per diem rates are lower than those paid by most MA plans, MA plans tend to approve fewer days, leading the facilities to provide uncompensated care.

Conclusion

Based on the limited sample of IPFs in this study, there appears to be significant variation in the types of patients that IPFs will admit, and the resources required to serve them. All IPFs in the study provide some ancillary services but the types and quantity of those services varies. Neither the distinction between freestanding and hospital-based units, the amount of ancillary services provided, nor profit status alone can explain the differences in the types of patients those IPFs admit, or the resources required to care for them.

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[5] Medicare cost reports, 2020; MedPAR data, 2020.

BACKGROUND

The Balanced Budget Refinement Act (BBRA) of 1999 required the Centers for Medicare & Medicaid Services (CMS) to establish a per-day prospective payment system (PPS) for inpatient hospital services furnished in psychiatric hospitals and psychiatric units in acute care hospitals. This payment approach, designed to replace the previous "reasonable cost"-based payment system, was established by CMS on November 15, 2004, as the inpatient psychiatric facility prospective payment system or the IPF PPS.[6] CMS updates the IPF PPS annually to account for changes in costs; the most recent updates to the IPF PPS were issued in a final rule in July 2022.[7]

Although differences in costs and types of services provided by inpatient psychiatric facilities (IPFs) have been documented, differences are not always observed in Medicare claims as many claims do not include adequate detail, including charges for ancillary services.[8,9] There is also evidence of substantial irregularities in the IPF reporting of costs for ancillary services.[10] In addition, payment accuracy may be affected by unmeasured patient severity since nearly 75 percent of IPF beneficiaries are grouped into one MS-DRG (psychosis). Daily resource use may also be affected by factors beyond diagnoses not measured in administrative data.[11] The combination of these factors has resulted in policymakers expressing concern about the accuracy and fairness of the current IPF PPS. To this end, the Consolidated Appropriations Act (CAA), 2023, specified the development of an assessment tool for IPFs and psychiatry units to submit standardized patient assessment data to be used in the IPF PPS to better capture patient characteristics that affect resource use. This tool is required to be implemented by 2028.[12]

In January 2022, the Chairman of the U.S. House Committee on Ways and Means requested that MedPAC conduct an overall analysis of mental health services in the Medicare program, including inpatient psychiatric services delivered to Medicare beneficiaries. To inform this work, MedPAC engaged L&M to conduct interviews with financial and clinical leaders from up to 10

[6] Medicare Program: Prospective Payment System for Inpatient Psychiatric Facilities, 69 Fed. Reg. 66921 (2004) (to be codified at 42 C.F.R. pts. 412, 413). https://www.federalregister.gov/documents/2004/11/15/04-24787/medicare-program-prospective-payment-system-for-inpatient-psychiatric-facilities

[7] Medicare Program: FY 2023 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update and Quality Reporting-Request for Information, 87 Fed. Reg. 46846 (2022) (to be codified at 42 C.F.R. pt. 412). https://www.federalregister.gov/documents/2022/07/29/2022-16260/medicare-program-fy-2023-inpatient-psychiatric-facilities-prospective-payment-system-rate-update-and

[8] The Bizzell Group, LLC. (2022). *Technical Report: Medicare Program Inpatient Psychiatric Facilities Prospective Payment System: A Review of the Payment Adjustments.* Centers for Medicare & Medicaid Services (CMS). https://www.cms.gov/files/document/technical-report-medicare-program-inpatient-psychiatric-facilities-prospective-payment-system.pdf

[9] Urban Institute. (2021). *Medicare's Prospective Payment System for Inpatient Psychiatric Care at 15 Years.* A Report produced for the Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2022/04/Apr22_IPF_CONTRACTOR_SEC.pdf

[10] Ibid.

[11] RTI International, Department of Health and Human Services. 2005. *Psychiatric Inpatient Routine Cost Analysis: Final Report*. Report prepared for the Centers for Medicare & Medicaid Services. Waltham, MA: RTI International. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/cromwell_2005_3.pdf.

[12] H.R.2617 - 117th Congress (2021-2022): *Consolidated Appropriations Act ...* (n.d.). Retrieved March 24, 2023, from https://www.congress.gov/117/bills/hr2617/BILLS-117hr2617enr.pdf Consolidated Appropriations Act, 2023, P.L. 117-328.

IPFs. The interviews were designed to shed light on the reasons for the variation in patient services provided by IPFs, associated costs and how they are reported across different IPFs. More specifically, the purpose of these interviews was to understand:

- the types of patients IPFs serve,
- the types of services Medicare patients receive,
- how these services have changed over time, and
- the differences in services and patients among various types of IPFs.

In addition, MedPAC sought to understand more about when, how, and why IPFs report—or, conversely, fail to report—ancillary charges when such services are provided.

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METHODOLOGY

Identification of IPFs

The L&M team worked with MedPAC staff to identify an initial list of 10 primary IPFs and 25 alternate IPFs in geographically varied markets across the country. We aimed for diversity in ownership type (for profit, nonprofit, government-owned), affiliation (part of a chain, academic/teaching hospital, independent), IPF type (freestanding, hospital-based), size (number of beds), all-inclusive designation, variation in ancillary service reporting (including zero reporting), and census region.[13] With a limit of 10 IPFs participating in the study, we selected facilities representing a range of bed sizes, excluding extremely small or large facilities (with 10 beds or 800 beds) to help ensure that the sample was as representative as possible. This intentional sample includes a higher proportion of facilities that are part of large, for profit chains in order to explore the reasons fewer (and often zero) ancillary services are reported by such IPFs. As part of the selection process, once candidate IPFs were initially identified, we reviewed their websites to confirm that the facilities included varied ownership types and affiliations. We also ensured that a subset of the selected IPFs had geriatric units.

Characteristics of the IPFs that participated in the study are provided below (Table 1).[14] Since the majority of the IPFs that report zero ancillary costs are affiliated with for profit chains, the study sample includes four for profit, chain-affiliated IPFs representing three different national chains. All but one of the facilities in the study are located in an urban area.

Table 1. Characteristics of IPFs in the Study

IPF Number	Ownership Type	Affiliation	Facility Type	Region	Bed Size	Dedicated Older Adult Unit or Service
1	For profit	National chain	Freestanding	South	<100	Geriatric service
2	For profit	National chain	Freestanding	Northeast	100 – 199	Unofficial specialized unit
3	Government	State-owned	Freestanding	South	200 – 299	Yes
4	Nonprofit	Part of a behavioral health network	Unit in acute care hospital, part of a health system	Northeast	<100	Yes
5	For profit	National chain	Freestanding	Midwest	100 – 199	Does not serve patients age 55+
6	For profit	National chain	Freestanding	Midwest	100 – 199	Yes

[13] For the purpose of this report, all-inclusive refers to the designation on each IPF's Medicare cost report.
[14] We excluded payer mix as a reference point since the data provided by MedPAC was sometimes significantly different than the estimates provided by interviewees. Further, the interviewees did not estimate payer sources using the same categories (e.g., not all facilities differentiated between Medicare and Medicaid managed care vs. other managed care payers, or Medicare fee-for-service and Medicare Advantage). Information as reported by each IPF is included in their individual IPF profile in the Appendix. All IPFs in the study treat significantly more non-Medicare patients than Medicare beneficiaries.

IPF Number	Ownership Type	Affiliation	Facility Type	Region	Bed Size	Dedicated Older Adult Unit or Service
7	Nonprofit	Affiliated with a university	Freestanding, part of a health system	Northeast	100 – 199	Yes
8	Nonprofit	Independent	Freestanding	Midwest	100 – 199	Yes
9	Government	County-owned	Unit in acute care hospital & Level 1 trauma center	South	<100	Yes
10	Nonprofit	Independent	Freestanding	West	100 – 199	Does not serve patients age 65+

Recruitment

We developed a letter of introduction from MedPAC to share with potential interview candidates and the executive director of the National Association for Behavioral Health (NABH). This letter stated that the goal of the study was to improve the accuracy and fairness of the IPF PPS and emphasized that the information gathered would not be attributed in MedPAC reports to individuals or the participating IPFs.

We began IPF recruitment after identifying primary and alternate candidates. In anticipation of low or slow response rates, we provided NABH with a list of IPF candidates and alternates and requested that NABH provide warm hand-offs to executives at some member IPFs. Our research team followed up on NABH's initial communications with the facilities of interest and arranged to interview senior executives working in those individual IPFs rather than with corporate-level executives in order to better understand individual IPF perspectives. We contacted executives at the candidate IPFs three to six times before making the decision to replace a facility with an alternate IPF using the same approach. The final 10 IPFs in the study include four facilities recruited directly by our team without an NABH introduction: the two government-owned freestanding facilities and two of the freestanding nonprofit IPFs.

Interviews

Our team conducted 15 one-hour interviews with 21 individuals representing 10 IPFs between November 2022 and February 2023.[15] Interviews typically included a chief executive, financial or medical officer and sometimes other staff with responsibility for these functions. Three interviews included executives able to speak to both financial and medical issues during the same call. For the two IPFs affiliated with health systems, one or more representatives from that health system or sponsoring university, in addition to IPF interviewees, joined the call. All the interviews were with senior executives, most of whom had decades of experience working in

[15] The finance staff at the two government-owned IPFs could not speak to decisions related to ancillary billing, cost reports or reimbursement. Our team supplemented those two IPF interviews with four separate 15–20-minute conversations with individual finance staff at state offices responsible for cost reporting, billing, and reimbursement.

IPFs as administrators. All of the senior clinical administrators with whom we spoke were licensed clinicians with between 10 and 40 years of behavioral health practice.

The team used a semi-structured discussion guide to conduct the interviews (see the Appendices for the full discussion guide). Two senior researchers led the interviews while a research assistant took notes organized according to the topics in the discussion guide. MedPAC staff attended interviews when possible. We conducted the interviews via Zoom and recorded them for notetaking purposes with permission from the participants. We sent interview notes to MedPAC for review and approval and met with MedPAC regularly to discuss the findings. Following each interview or set of interviews for a given IPF, the team developed an IPF profile identifying facility attributes and highlighting key findings about the patient population, financial practices, and market in which the facility operates (see the Appendices for blinded IPF profiles). The team analyzed the interview notes and profiles by topic. This approach allowed for comparison and synthesis of findings across IPFs. Through this process and the ensuing team discussions, we identified key themes as well as similarities and differences.

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FINDINGS

As part of each interview, we asked about the IPF's ownership and operating characteristics as well as the type of patients served and services provided, with a focus on the adult population, especially Medicare beneficiaries. We also asked about the resources required to serve the various populations, interviewees' perspective on Medicare payments and coverage, and if and how their facilities reported the costs of ancillary services. Where we can, we parse out results by different facility characteristics, but due to the small sample, it is not always appropriate.

Types of Patients and Services Provided by IPFs

In general, IPFs in the study have similar referral sources and intake processes, but their admission criteria and how they segment psychiatric units within their facilities vary. All IPF interviewees reported taking into consideration patients' psychiatric and medical needs as well as their age and likely resource needs prior to admission.

To determine whether they will admit a patient, IPFs typically assess the level of clinical care needed and an individual's medical comorbidities, if applicable. Facilities generally obtain the patient's medical history and current lab results from emergency departments (EDs) or acute care hospitals prior to accepting a patient for admission. Many of the interviewees reported that up to 70 percent of their patients are involuntarily admitted, often coming as referrals from EDs. Patients admitted involuntarily sometimes arrive as police drop-offs or under temporary detention orders.

Pre-admission screening is conducted either by dedicated intake staff or by nurses and other staff members depending on the facility. Several IPFs use clinical screening tools.[16] One IPF interviewee mentioned that IPFs in their area agree to work with area ED partners and use a SMART medical clearance tool[17] to communicate about potential referrals and indicate which patients meet medical clearance criteria. These screening procedures not only help IPFs determine whether to accept a referral, but also can assist facilities with estimating staffing requirements and resource allocation. The two IPFs affiliated with larger behavioral health systems have patient referral centers that conduct all screening, triage, and placement assessments. These referral centers take into consideration bed availability across their respective systems to identify the most suitable placement available at the time of the referral.

Additionally, both government-owned IPFs are required to take forensic patients.[18] Several other IPFs also accept some forensic patients, although the government-owned IPFs have a higher proportion of forensic patients than the other IPFs in the study.

[16] Interviewees at two large nationally recognized facilities mentioned working with a group of IPFs and the NABH to develop a standardized acuity scale to be used as a tool when assessing patients to help IPFs better anticipate required staffing and resource levels. The tool was in the early stages of development at the time of this report.
[17] https://smartmedicalclearance.org/
[18] For the purposes of this report, forensic psychiatric patients are those with a mental disorder who are currently undergoing, or have previously undergone, legal or court proceedings for committing often violent criminal acts.

Admission criteria vary across IPF types

Interviewees from all IPFs in the study indicated that they do not admit patients in active withdrawal. IPF interviewees most frequently mentioned they do not admit patients determined to be medically complex, compromised, or unstable during pre-admission screening. Although admission criteria vary across the IPFs, common exclusions include patients requiring IVs, drains, supplemental oxygen, dialysis, telemetry, and advanced wound care. IPFs generally reported that they will not admit patients with unstable cardiac conditions, severe seizure disorders, uncontrolled blood pressure or blood sugar, or individuals whose primary diagnosis is substance use disorder (SUD).[19] While some interviewees stated that their facilities are unable to accommodate patients with physical impairments, dementia, traumatic brain injuries or intellectual disabilities, others generally apply less stringent admission criteria during screening processes.

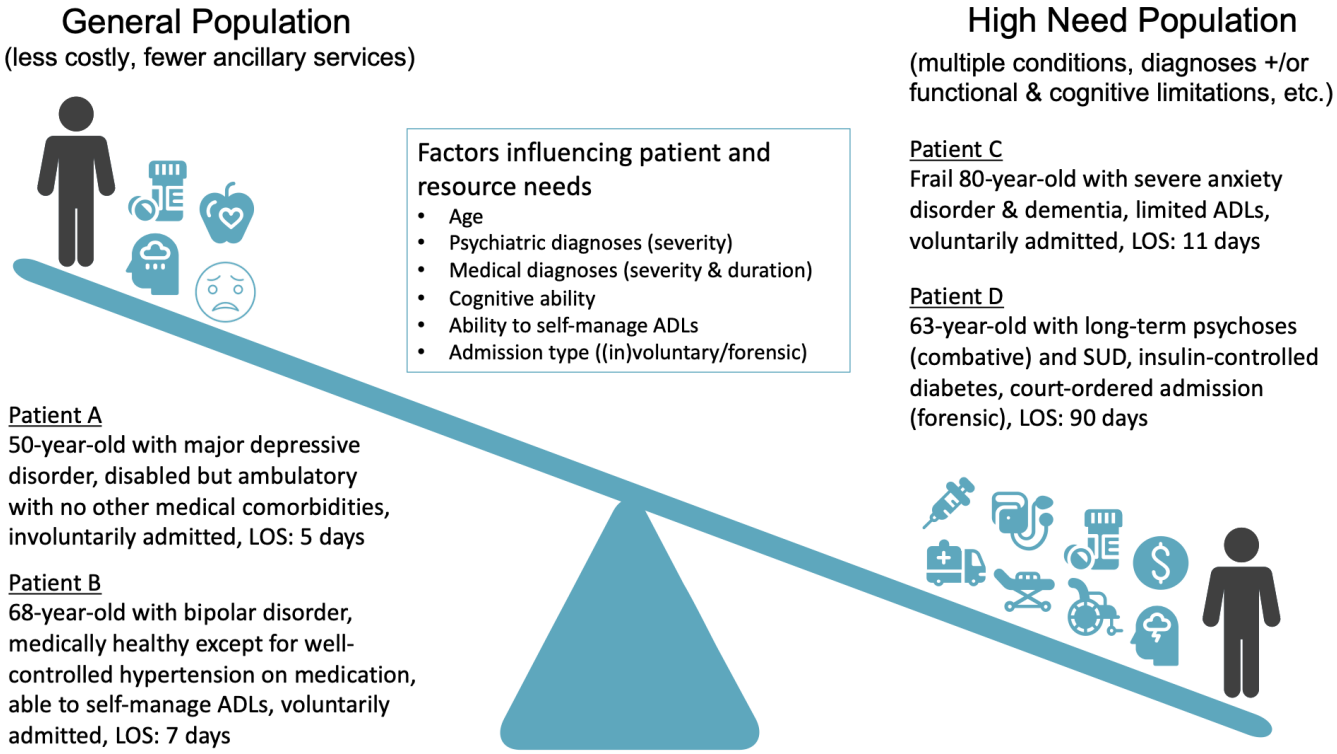
Several facilities with less stringent admission criteria reported having medical staff frequently monitoring patients with significant comorbidities. One freestanding government IPF has a nurse practitioner or physician's assistant assigned to every patient, and that clinician is responsible for managing the patient's medical comorbidities and primary care. An executive from another freestanding IPF accepting older patients with multiple comorbidities noted that internal medicine or family medicine practitioners are frequently involved in IPF patients' care.

Age is another determining factor for IPF admission. Some facilities admit patients below age 18, but four of the 10 IPFs we interviewed admitted adults only. Even when admitting only adults, the age range of patients accepted at the different IPFs varies. Two of the freestanding IPFs will not accept patients over age 55 and 65 respectively, with the rare exception made for patients with minimal or minor medical comorbidities. Interviewees at these two IPFs stated that they lacked the resources to treat conditions like dementia, cognitive decline, and patients who require assistance with activities of daily living (ADLs).

When characterizing patients served by the IPFs in our study, we found that patients tend to fall into two different categories: the general adult population and a population with higher needs. Typical examples of the diverse set of factors that influence the distinction are highlighted in Figure 1 below. The figure illustrates examples of some of the factors IPFs consider as they determine whether to admit a patient and criteria they use to anticipate the level of resources that may be required to care for them.

[19] Although SUD is one of the psychiatric diagnosis related groups (DRGs) in the IPF PPS, the facilities in our study generally stated that they do not accept patients whose primary diagnosis is SUD. However, some facilities noted that they accept patients with SUD as a secondary diagnoses.

Figure 1: Diverse Factors Influence Patient and Resource Needs



General adult population includes patients with fewer needs

Interviewees described the most common diagnoses for the general population as mood disorders such as major depression, anxiety, or bipolar disorder. Many patients with primary psychiatric diagnoses reportedly have a secondary diagnosis of SUD. Patients in the general adult population tend to have less severe psychiatric diagnoses and fewer or less severe medical comorbidities than the high need population. They are less likely to require visits to an ED or medical unit than patients with high needs. General population patients are usually not aggressive, do not present a physical threat to themselves or others, and are able to stay in dual-occupancy rooms. These patients are also more likely to be voluntarily admitted and have a shorter length of stay (LOS) than patients with high needs. Patients in this population, as reported by the IPF interviewees, are independently able to manage their ADLs, do not need adaptive equipment such as walkers or wheelchairs, and are unlikely to require one-on-one supervision.

For the most part, these patients require fewer resources and minimal specialized medical equipment since they are generally medically stable, healthy, and younger. Multiple interviewees noted that exceptionally healthy older adults are sometimes placed in general units rather than geriatric units. Similarly, since both age and clinical conditions are considered as part of the intake process, it is also not unusual for a younger, high need patient to be placed in a geriatric unit.

High need population defined by patients with complex needs

Higher need patients more commonly have diagnoses such as severe depression, suicidal ideation, schizophrenia and schizoaffective disorders, moderate to severe psychosis, dissociative identity disorder, and borderline personality disorder; sometimes these diagnoses are combined with cognitive disorders such as dementia as well as other functional disorders. Several clinical executives mentioned that these disorders are often accompanied by a secondary SUD diagnosis.

Higher need patients are often older, frailer, and require a greater staff-to-patient ratio. They tend to be placed on different units than the general population, often on what some IPFs designate as geriatric units. Patients in the higher need population are more resource-intensive than those in the general population for a variety of reasons. Geriatric patients generally require additional staffing to treat medical comorbidities, cognitive decline, mitigate fall risk, and assist with ADLs. IPF interviewees described higher need patients as those with more severe or long-term mental illness, multiple chronic conditions, and/or higher rates of medical comorbidities than the general population. In addition, this population typically includes more patients who are aggressive or combative, thus requiring single-occupancy rooms, and who may present a physical threat to themselves, to other patients, or to staff. To manage this type of high need patient, facilities with predominantly dual-occupancy rooms must take one of the beds in a room offline, reducing the IPF's capacity.

IPF interviewees at facilities that admit higher need patients reported that the average LOS for this population is typically longer compared to the general population, with discharge challenges contributing significantly to longer stays. On average, Medicare and Medicaid patients are reportedly more complicated, have longer LOS, and are more resource-intensive than other patients. Higher need patients are more likely to be involuntarily admitted than patients in the general population. Interviewees at the government-owned IPFs reported having proportionately more patients who were involuntarily admitted as well as forensic patients.

Units reflect level of care needed and often patients' age

The IPFs in the study tend to segment their units based on the level of care and staffing required rather than by diagnosis. Markedly aggressive patients are placed in separate units or at a minimum in double-occupancy rooms where one bed is taken offline or in private rooms with one-on-one staff. In the four IPFs that admit forensic patients, interviewees noted that even without medical comorbidities, forensic patients tend to require greater resources, can be aggressive, and require more supervision and monitoring.

Another organizing factor is age. The seven IPFs in the study that admit minors have separate units for children and adolescents. Additionally, most facilities reported having a designated unit for geriatric-level care. The geriatric units are set up to provide a more intensive level of services including increased monitoring, treatment of some comorbid medical disorders, and in some

instances, providing medical beds which are better suited to meet the needs of patients with both psychiatric and medical diagnoses.[20] One executive of a freestanding facility noted:

> *"[We] have a geriatric program, so that's where we will see a lot of the medical comorbidities and where we'll have medical beds. We have a very robust medical team on top of a psychiatric provider team to care for those patients."*

Geriatric units also tend to include other specialized equipment. As an executive from a different freestanding facility noted:

> *If it's a higher service need patient, we might have to install hand railings; we might have to look at non-slip flooring, because higher service need or geriatric patients, they're more of a fall risk…and then, instead of having your traditional [lay flat] psychiatric bed, you might have to get a more of a med-surg type of bed for a geriatric patient…and then with equipment, you have to have wheelchairs, possibly lifts, shower chairs, protective equipment."*

Increased staffing is also required to manage psychiatric care for those with severe and longer-term mental illness, often coupled with medical comorbidities. These patients tend to require more laboratory services and more intensive medication monitoring; they also often have a longer LOS. One interviewee estimated that the LOS on the specialized geriatric unit is probably double that of a generic adult unit.

Interviewees at several of the IPFs that do not have formally designated geriatric units described clustering patients with higher resource needs in one unit or part of the facility in order to best meet that population's needs.

> *"A 45-year-old schizophrenic can present as a 75-year-old. You don't want them on an acute unit or a crisis unit where they can get bumped into or whatever. So, we take both those into account: age and clinical presentation."*

When asked about how the patient population they serve has changed over the years, many IPF interviewees reported they are seeing more older patients with longer-term and severe mental illness, patients with more severe psychosis, and patients with more medical comorbidities, often combined with dementia or SUD. Some interviewees noted that patients seem to be delaying treatment until their condition becomes severe and take longer to stabilize as a result. Others noted that they are seeing more patients whose conditions are refractory to medication. An

[20] Unlike medical beds in acute care hospitals that are adjustable to meet the needs of patients with different medical conditions, many beds in IPFs are bolted to the floor and are not adjustable. The beds lay flat and are ligature-resistant to prevent self-harm and protect staff. These lay-flat beds do not readily accommodate patients with disabilities, those with limited ADLs or certain kinds of medical conditions.

interviewee from one of the facilities that is part of a large behavioral health network mentioned seeing significantly more patients with increased social needs over time:

> *"I think the more likely presentation is almost always secondary to many significant social determinants of health issues…as the economy declines and issues around homelessness and food insecurity and social disruptions – as those things advance, we see more people."*

These changes in the patient population have resulted in increases in the resources required to treat older patients and introduce greater challenges in identifying safe and adequate patient support upon discharge.

Discharge planning challenges

Most interviewees consistently expressed concern about the lack of available post-acute and outpatient placements and behavioral health providers, resulting in major challenges in identifying safe and supportive discharge options for patients. One executive emphasized, *"I think what's important is to recognize that the services in the community aren't there … there's no place to send these patients.*" Interviewees at all but two IPFs identified discharge planning as a significant challenge.

> *"Across the board we're seeing longer lengths of stay, both here and [psychiatric facility] where I used to work. As COVID pulled some of those resources out of the community, it's just harder to get folks anywhere after discharge, really. As mental health needs go up in the community, even access to basic outpatient care has been more challenging. The goal is to get folks an appointment within short order [after] discharge, but even that can be hard to find. That makes ED diversion harder; that makes inpatient discharge harder. I think it's pretty similar between here and other places I've practiced."*

Many interviewees also mentioned a decline in available state IPF beds and how their facility has experienced delays in discharging patients who are awaiting placement in state facilities.

> *"State hospitals are closing…which has created some pretty big challenges. We have folks in here months to a year at a time just waiting for that. We struggle big time with where to send patients, and being rural, we don't have resources right at our door."*

> *"There's an outlier group that have really severe, prolonged mental illness issues, and with the reduction of capacity in the state-operated system, we'll have somebody on a*

waiting list to get into the very small number of state-operated beds that are still available, and people can be on that waiting list for as long as 90-100 days."

Interviewees said that families of patients with severe mental illness, behavioral disturbances, or dementia may be unwilling or unable to accept them back into the home upon discharge. In general, referring organizations such as skilled nursing and assisted living facilities reportedly do not want to readmit patients who require a high level of care and supervision, especially if the patient has a history of confrontation or aggressive incidents.

"The resources here in [this state] are really bad... I have one patient here, this month will be a year [that he's been here], and I haven't been able to find a place to take him, and he does not belong here. I have patients here for 40- or 50-odd days that are just waiting for a placement…So [do] all the [other psychiatric] hospitals that I've worked in, it's been the same challenge."

While some interviewees reported that the limited available placement options were further exacerbated by COVID and staffing shortages, many indicated that the challenges of finding placement options and the lack of available behavioral health clinicians are longstanding problems. An interviewee from one of the freestanding facilities emphasized the shortage of available psychiatrists making it especially difficult to ensure patients get the support they need once discharged:

"We do try to meet the guidelines for a seven-day psychiatric follow-up…We'll refer them to see a therapist, and they might have to see them two or three times before they can get in with a psychiatrist. It could be two or three months to actually see the psychiatrist…there is a shortage of psychiatrists, the need is just growing and growing."

Even when certain facilities such as homeless shelters can accommodate additional clients, they are not able to meet the needs of patients who are medically complex or require ongoing supervision.

Many interviewees pointed out the implications of patients aging with long-term behavioral health and medical conditions. Older patients are likely to have more severe and sometimes treatment-resistant mental illness, often with concurrent medical and chronic conditions including dementia. One clinical executive noted that patients coming to IPFs with long-term illnesses take longer to stabilize. Another clinician noted:

"They never get back to where they were the last time [they were admitted]. It's a step down. You lose some certain measure of function permanently each time you have these psychotic or manic episodes."

In addition to contributing to longer LOS, the lack of discharge placement options has resulted in more long-term mentally ill patients being released back into the community, despite significant social, behavioral, and medical needs and inadequate support. Many of these patients are eventually readmitted.

Staffing shortages affect number of patients served

Most IPFs executives reported struggling to adequately staff their facilities. Only two facilities reported operating at full capacity, with an interviewee from one of them noting that fewer beds are occupied when beds in semi-private rooms are offline to meet the one-on-one needs of patients. All other IPFs were operating below capacity due to inadequate staffing. Interviewees at several facilities mentioned taking beds or units offline given the insufficient staff available to address patients' needs. As one administrator put it, *"we have the space, but we don't have the staff."* Another administrator reported using agency staff to address staff shortages and offering incentives to employed staff to pick up extra shifts, yet the lack of staff still forced the IPF to take one unit offline.

One of the administrators from the only rural IPF in the study mentioned that the facility faces increased labor costs given staffing shortages and discussed how difficult it is to hire staff. They stated that increased labor costs are attributable to using agency nurses.[21]

Patients Served Vary by IPF Type

As noted above, all IPFs in the study admit patients with mood disorders, but most freestanding facilities reported more restrictive admission criteria than psychiatric units that are part of an acute care hospital. Thus, patients admitted to freestanding IPFs with medical comorbidities generally have conditions that are well-controlled or less severe. Administrators at these IPFs reported that patients with an acute medical need are transferred to an acute care hospital to be stabilized. The extent to which freestanding IPFs accept patients with controlled but serious medical conditions requiring clinical monitoring and medical consultations also varies.

When asked why not provide services to patients with higher needs, one executive from a freestanding IPF stated:

> *""It's partly a financial consideration ... It's cheaper to build a freestanding hospital without all the [medical infrastructure]. And then there's the question of whether or not you're going to be reimbursed for having a medically complicated patient. I have it on good authority that the reimbursements don't necessarily incentivize trying to carve out med-psych units. In fact, [a colleague] attempted to open a med-psych unit at one point and realized that there was no financial incentive in doing so."*

[21] This IPF also reported other challenges related to its more remote location given limited community resources and a population with significant social needs: *"... we have very high welfare [rates,] transportation is horrible..."*

The two government-owned IPFs, as well as the one nonprofit IPF that is part of a larger acute care hospital, reported admitting a large number of higher need patients and having some patients with exceptionally long LOS.

> *"We take folks that no one else can manage. There are some patients who require very high levels of staffing. We're the safety net for this system, so if there are folks who have very unique needs that no one in the community wants to touch with any amount of money, they end up coming to us, and that ends up ... as staffing cost."*

Unlike the majority of the freestanding facilities in the study, interviewees from the both the IPF units that are part of acute care hospitals reported taking care of some patients with more significant medical comorbidities since medical equipment, imaging services, other specialists and additional medical support is more readily available.

Financial Tracking and Reporting

Our research team interviewed chief financial officers, executives, and state finance officials responsible for cost reporting and ancillary billing at all but one of the IPFs in the study. We aimed to learn how frequently these IPFs provide lab, pharmacy and other ancillary services, and the extent to which those services are reflected as ancillary on claims. CMS requires reporting of these ancillary services for IPFs that are not designated as having an all-inclusive rate but has found them to be inconsistently reported.[22,23] Specifically, CMS found that over 20 percent of IPF stays that should have reported ancillary costs or charges did not report any, and a study conducted on behalf of MedPAC noted similar findings.[24,25]Additionally, interviewees provided insights related to resource utilization and the adequacy of Medicare payments.

All IPFs provide some ancillary services; how they are tracked varies significantly

Interviewees from all of the IPFs reported that they provide ancillary services such as some laboratory and pharmacy services, although the number of labs drawn, for instance, correlates to the number of higher need patients admitted. One of the freestanding facilities affiliated with a

[22] Ancillary costs are for specific services (e.g., laboratory, radiology, drugs, therapy). Ancillary services vary by patient and should be recorded on each IPF claim for a stay, with the exception of IPFs designated by CMS as having an all-inclusive rate. Routine costs include nursing services and room and board, which are typically provided to all patients and are reported only at the facility level.

[23] A hospital can be designated by CMS as having an all-inclusive rate if they don't have the ability to apportion costs by ancillary department. Instead, the costs of ancillary services are expected to be combined with routine costs in one facility-level cost amount. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R485PR1.pdf

[24] Medicare Program; FY 2023 Inpatient Psychiatric Facilities Prospective Payment System-Rate Update and Quality Reporting-Request for Information, 87 Fed. Reg. 19415 (Apr. 04, 2022). https://www.federalregister.gov/documents/2022/04/04/2022-06906/medicare-program-fy-2023-inpatient-psychiatric-facilities-prospective-payment-system-rate-update-and

[25] Urban Institute. (2021). *Medicare's Prospective Payment System for Inpatient Psychiatric Care at 15 Years.* A Report produced for the Medicare Payment Advisory Commission. https://www.medpac.gov/wp-content/uploads/2022/04/Apr22_IPF_CONTRACTOR_SEC.pdf

large health system noted that *"we do have some [ancillary] costs, but I wouldn't say it's high by any stretch of the imagination."* The extent to which ancillary services are provided as well as how IPFs track and report ancillaries on cost reports and in claims, however, varies.

All facilities interviewed confirmed that they internally track some ancillary services provided, listing examples such as lab costs, pharmacy costs, EKGs, etc. However, with few perceived financial benefits to reporting comprehensive ancillary charges, nor any obvious repercussions for failing to provide the information, some executives questioned the utility of including ancillary service information on claims. One of the freestanding facilities affiliated with a large health system noted that *"we do have some [ancillary] costs, but I wouldn't say it's high by any stretch of the imagination."* When asked about why an IPF would bill ancillary charges, one CFO at an IPF that is part of a for profit chain of freestanding facilities that are typically all-inclusive stated:

> *"You got me. I don't know. [Billing ancillaries] just seems like a wasted step. If you're going to end up getting the same payment per day regardless of what you use or you provide, then what is the point of having somebody chase information, enter it into a system, make sure it's billed correctly, if it's just going to be written off?"*

A CFO from a nonprofit freestanding facility that is not all-inclusive similarly noted that billing ancillary services on claims is a time-consuming process and IPFs are paid based on per diem contract arrangements regardless of the scope or intensity of ancillary services provided:

> *"We could spend all day trying to take the time to bill [all ancillaries] out, tying yourself into knots detailing everything that happened over the [stay] but there is no incentive to bill it out that way…At the end of the day, you are going to get paid the same amount…there is no incentive to keep track of it."*

This same facility reports all costs using five categories: routine, labs, drugs, OT and other.[26]

The extent to which some ancillary services are wrapped into the routine service charges (room and board) also varies. For instance, one IPF executive acknowledged that carefully capturing ancillaries for inpatient psychiatry services is not a priority:

> *"We have three EKG machines [in the IPFs] that we probably use a couple of times a year... in an acute care hospital there's an EKG department, and there's a mechanism to create an ancillary charge for an EKG. But in our IPF world, the EKG unit is right there on the nursing unit, and if the patient needs one, they do the EKG. And there's no charge captured because we don't have an EKG tech doing it [in the IPF], it's the unit nurse or someone."*

[26] Medicare cost report, 2020.

When asked about how they report ancillary charges on claims, three of the eight IPFs that are not all-inclusive (see in Table 2 below) stated that they do not always capture comprehensive ancillary detail on claims. They typically report ancillaries using a limited set of categories such as labs, drugs, and therapy.

Also affecting what ancillary services may appear on claims, some facilities reported working with contracted phlebotomy/laboratory, pharmacy, and imaging (typically for x-rays, EKGs, ultrasound) providers rather than having those services in-house. Several IPFs that use vendors for ancillary services indicated these services would not appear on claims.

As noted in the table below, of the four freestanding IPFs that are part of proprietary chains, two identify themselves on their Medicare cost report as having an all-inclusive rate. A CFO from one of those chain IPFs said *"[w]e don't bill any payer any ancillary charges across the board. We don't enter drugs, we don't enter labs, we don't enter anything."* When asked if it is a corporate policy not to bill ancillaries or a facility-specific policy, the CFO replied, *"[o]h, its [chain name] corporate. When I first got here [a decade ago], we were entering everything every time, all they got in every lab, every service."*

The CFO at the other chain IPF designated as all-inclusive on Medicare cost reports indicated that their facility was already all-inclusive when the chain purchased it, and *"when we bill a claim, we're billing for the room and board for that stay. These ancillary charges, for example pharmacy and labs, are things that we as a facility are taking as an expense."*

The CFO at a third freestanding IPF that is part of a proprietary chain reported that the IPF is all-inclusive; however, the facility does not indicate being an all-inclusive rate hospital on its Medicare cost report. No charges for this IPF are reflected in the MedPAR data for 2020, and its Medicare cost report for the same year only reflects routine costs. The fourth freestanding IPF in this study affiliated with a proprietary chain indicated that the only reason that IPFs that are part of the chain in this state report ancillaries is because the state Medicaid agency requires that ancillaries be reported to reimburse claims. This CFO indicated that IPFs affiliated with the chain across the rest of the country typically report zero ancillaries.

Table 2. Ancillary Reporting of IPFs in the Study

IPF Number	Ownership Type	Affiliation	Facility Type	Medicare Cost Report Designation[1]	Ancillary Charge Notes from Interview
1	For profit	National chain	Freestanding	All-inclusive	Zero billing, no cost report submission
2	For profit	National chain	Freestanding	All-inclusive	Zero billing, no cost report submission
3	Government	State-owned	Freestanding	Not all-inclusive	State reports costs for all IPFs
4	Nonprofit	Part of a behavioral health network	Unit in acute care hospital, part of a health system	Not all-inclusive	Part of hospital/health system set up to track ancillaries

IPF Number	Ownership Type	Affiliation	Facility Type	Medicare Cost Report Designation[1]	Ancillary Charge Notes from Interview
5	For profit	National chain	Freestanding	Not all-inclusive	National chain normally zero billing; state requires all Medicaid claims to include ancillary charges
6	For profit	National chain	Freestanding	Not all-inclusive	Self-reports as all-inclusive; zero ancillary costs, only routine costs in 2020 cost report; zero charges in MedPAR data
7	Nonprofit	Affiliated with a university	Freestanding, part of a health system	Not all-inclusive	Part of hospital/health system set up to track ancillaries
8	Nonprofit	Independent	Freestanding	Not all-inclusive	Only reports labs, drugs, OT & other as ancillaries
9	Government	County-owned	Unit in acute care hospital & Level 1 trauma center	Not all-inclusive	State reports costs for all IPFs
10	Nonprofit	Independent	Freestanding	Not all-inclusive	Only reports labs and drugs as ancillaries

[1] *Data source: Medicare cost reports, 2020. A hospital can be designated by CMS as having an all-inclusive rate if they don't have the ability to apportion costs by ancillary department. Instead, the costs of ancillary services are expected to be combined with routine costs in one facility-level cost amount. https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/R485PR1.pdf Notably, during our interviews some IPF representatives may have been conflating a Medicare cost report all-inclusive rate designation with CMS IPPS per-diem payments.*

Staffing costs are the primary driver of resource use

IPF interviewees emphasized repeatedly that diagnoses, age, and ancillary charges alone are not indicative of the costliness of a patient. Rather, interviewees said that looking at the staffing needed to appropriately care for a patient given the individual's combination of diagnoses, cognitive and functional capacity and mental condition provides a more accurate picture of composite cost. When asked what drives resource use, one interviewee said:

> *"I don't know that we could universally say a given diagnosis will require more resources. For example, dementia may be part of a presentation along with depression, and this may be someone who is really mild-mannered and really doesn't require a higher level of resources. Or you might have an older adult with an acute manic episode that actually may require a lot of resources or similar to an individual with dementia. I really don't think we can base it just on diagnosis per se, but more on resource utilization from a staff, medication, and medical resources standpoint. Things like IVs, oxygen, that sort of thing."*

Executives generally cited three sources of cost that distinguish high resource-consuming patients:

1) staffing intensity based on a combination of individual patient variables including diagnoses, comorbidities, cognitive and functional impairment, history of aggressive behavior and if the patient is forensic,
2) double occupancy rooms that must be converted to private rooms for patient safety, thus taking one or more staffed beds offline, as well as other required specialized equipment, and
3) long LOS with declining per diem payment rates and patients who exceed Medicare's 190-day benefit cap for freestanding IPFs.

Whether or not patients require intensive staffing, financial and clinical executives alike reported that labor costs are the key driver of resource use in their IPFs. In contrast, they said that ancillary services represent a modest portion of overall expenses and given that facilities are not reimbursed for them separately from the per diem payment, they do not factor prominently into the facilities' considerations. As one interviewee put it: *"The number one issue for us is workforce, and the number two issue is workforce, and the number three issue is workforce."*

Coverage restrictions: Medicare 190-day lifetime limit

Medicare Part A currently covers up to 190 days of IPF hospital services provided in freestanding facilities during a beneficiary's lifetime. Interviewees from five IPFs in the study discussed implications for patients who reach the Medicare lifetime cap. Some interviewees noted that the limit can present significant issues for patients who need longer-term care or those who have multiple periodic inpatient stays, often as a result of chronic serious mental illness (SMI), such as schizophrenia. Two facilities report that after surpassing the 190-day limit, patients typically begin to receive uncompensated care from the IPF; while another noted that patients may become eligible for Medicaid coverage. As discussed in the section on discharge planning, several facilities considered the 190-day limit insufficient, notably for patients living longer with chronic illnesses, and increased challenges finding suitable post-discharge placement options, particularly for patients with both SMI and dementia.

Half of the IPFs also mentioned high-cost drugs can be a challenge

When asked about what ancillary services are particularly costly, at least five facilities mentioned some long-acting injectable intramuscular drugs such as Abilify Maintena, Geodon, Invega Sustenna or other costly medications such as HIV antiretrovirals. Clinicians and financial leaders alike estimated the cost of some of these drugs to be between $2,000 – $9,000 per month per patient, which can result in IPFs either absorbing some of those costs or identifying creative ways to reduce them. Some interviewees mentioned arrangements with pharmaceutical manufacturers to assist with the costs. A clinical executive at a nonprofit freestanding facility indicated that they are generally able to work around these expenses:

> *"We try to do some creative thinking around the long-acting [medications...] We try not to incur that cost on the unit, if at all possible. Very often we would either have the*

patient discharged, then use that patient's prescription benefit to access those drugs, or some other creative way of doing it.

Another IPF executive noted:

"We've taken the position at our organization that long-acting agents have been underutilized for treatment of these conditions, and so we're willing to lean into paying for it."

Mixed reports about Medicare payment adequacy

IPF interviewees provided mixed responses when asked about the adequacy of Medicare per diem rates. Among the seven IPFs that discussed per diem payment rates, four (three freestanding IPFs and one hospital unit) reported that the Medicare IPF PPS per diem is lower relative to payments their facilities receive for Medicare Advantage (MA) patients. One of these interviewees, from a large health system with over 300 IPF beds, said that "*Medicare does not cover the cost of care, full stop."* Another noted that Medicare is among "the worst" payers, though the comparison point seemed to be Medicare versus commercial payers. The same IPF executive noted:

"Medicare does not reimburse as well as it used to, it's just kind of the way it is, and so we have to be careful about that reimbursement and that cost. Our bigger concern is outpatient reimbursement for Medicare patients. It makes it hard to provide care for patients on discharge from the hospital, so having a place that they can go to is the biggest challenge."

Conversely, of the interviewees from the three IPFs that had more favorable things to say about Medicare per diems. The two freestanding IPFs—one for profit and one nonprofit—indicated that it is favorable compared to other payers' rates. The third IPF's CFO, from a freestanding for profit IPF, remarked that the Medicare per diem is comparable to other payers.

Interviewees from several IPFs noted that while MA per diem rates may be comparable, some MA payers approved fewer days per admission with remaining days becoming uncompensated care.

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CONCLUSION

Based on the limited sample of IPFs in this study, there appears to be significant variation in the types of patients that IPFs will admit and the resources required to serve them. Neither the distinction between freestanding and hospital-based units nor profit status alone can explain these differences. As one executive said: *"One size does not fit all when you're talking about an inpatient psychiatric practice or service."*

The costs of providing care to patients in IPFs seem to vary primarily due to the level of staffing required, which depends on a wide range of factors beyond age or diagnoses alone. Interviewees noted that these factors include the severity and longevity of a patient's mental illness, the extent of a patient's cognitive and functional capacity, their comorbidities, need for specialized equipment or single occupancy rooms, and if they require ongoing monitoring and one-on-one care. That said, interviewees from every IPF indicated that their patients receive laboratory and pharmacy services, with the amount of those services varying based on the individual patient needs.

The extent and accuracy of reporting ancillary services separately from routine charges on claims and Medicare cost reports also varies across IPFs. Interviewee feedback suggests that, without financial incentives or penalties, this is unlikely to change. Furthermore, even if ancillary services were consistently and accurately reported across IPFs, relying on ancillary service reporting without taking into consideration the constellation of factors discussed above may not be the best way to account for differences in costs of caring for inpatient psychiatric patients.

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APPENDICES

IPF Profiles

Profile 1

IPF 1 Interview Highlights				
Location	South		Urban	
Organization	For profit/Chain	Freestanding	All-inclusive	Non-teaching

Capacity and Occupancy Rate	• <100 licensed beds
	  ○ Small detox unit
	• Occupancy rate not noted
	• Admission volume:
	  ○ Majority of patients come via EDs
	  ○ 60-70% of admissions are involuntary			

Population Overview	*Adults*		*Adolescents/Children*	
	• Facility accepts adults only ○ 15-20% are geriatric		None	

	• Frequent diagnoses:
	  ○ >50% of patients are admitted with cooccurring disorders (psychiatric-primary and SUD-secondary)
	  ○ Severe depression, anxiety, schizophrenia, psychosis			

Average Length of Stay (ALOS)	• Facility-wide: 9 days • Temporary detention order (TDO) patients: 3 days			
Payer Mix (estimated)	• <25% Medicare (combined FFS & MA)* • No other payer mix information provided **per 2020 MedPAR data* • Medicare per diem is comparable to what the IPF receives from other payers			
Drivers of High Resource Use	• Older patients with co-morbid medical conditions (e.g., untreated diabetes, high blood pressure, cardiomyopathy) require more intensive treatment and longer appointments with providers, including daily assessments; also have longer LOS • Older patients in general who require standard labs, pharmacy, and imaging • Geriatric equipment (wheelchairs, handrails, walkers, med-surg hospital beds, anti-slip flooring to minimize fall risk) and lower patient-to-staff ratios on the geriatric unit, which increases costs			

IPF 1 Interview Highlights	
Ancillary Reporting	• Zero ancillaries reported • Interviewees unsure when the facility was designated by CMS as all-inclusive but report it was at least 10 years ago
Exclusion Criteria	• Not noted
Changes Over Time	• Not noted
Other Notable Characteristics and/or Findings	• When the ED sends a referral, sometimes the payer is blacked out and the IPF cannot determine whether the patient is near their [Medicare] lifetime cap or if the patient has exhausted the days before admitting the patient • Many patients who have previously been in state facilities come back to this IPF through the TDO process; IPF 1 has unsuccessfully tried to transfer patients to state facilities but there are no state beds
Quotes	• Reimbursement for Medicare patients: ○ *"… On average, our cost to treat [a] typical geriatric patient is at least 30-35% higher than [the] average commercial adolescent or adult…often on a much lower effective [reimbursement] rate…So we may get an effective rate of $300-450, depending on where [the patient is] in their lifetime reserve days, or if they're in their coinsurance days. Depending [on] where they are and what they've used for services before they come to our facility, a high percent of our Medicare patients are lower than the base Medicare rate for the geographical area."*

Profile 2

IPF 2 Interview Highlights				
Location	Northeast		Rural	
Organization	For profit/Chain	Freestanding	All-inclusive	Non-teaching

Capacity and Occupancy Rate	• 100-200 licensed beds
	  ○ 15% of licensed beds are offline due to lack of staffing
	• 80% of staffed beds are occupied
	• Admission volume:
	  ○ 80% of patients come via EDs
	  ○ 20% of admissions are walk-ins or self-referrals			

Population Overview	*Adults*		*Adolescents & children*	
	10% are “older” adults		Minimum age of 10	

	• Frequent diagnoses:
	  ○ SUD is a thread through all diagnoses; pervades even in the older years
	  ○ Schizophrenia, schizophrenia and dissociative identity disorder, major depression, borderline personality disorder, SUD
	• Seasonality: Decrease in adolescent population during summer and holidays; not significantly different in adult population; increase in patients 65+ during holidays and when caretakers go on vacation			

ALOS	• 12 days ○ Medicaid managed care ALOS = 20 days. Many of these patients are waiting for placement at state facilities and other locations			
Payer Mix (estimated)	• ~7% Medicare FFS* • No other payer mix information provided **per 2020 Medicare cost report*			
Drivers of High Resource Use	• Patients who require one-on-one staffing, e.g., patients with psychoses, aggression, combative (although they do not have that many) • Patients who require a single room because of behavioral issues (i.e., one bed closed in a semi-private room) • Patients with significant medical comorbidities, especially if in acute care for <72 hours • Patients who frequently go to the ED • A few chronic patients who are frequently readmitted and refuse to go to (hospital-based) med-surg units and don’t qualify for Medicaid • Insulin and wound management are areas of high cost			

IPF 2 Interview Highlights	
Ancillary Reporting	• Zero ancillaries reported • Facility uses vendors for labs, imaging, and in-house pharmacy • Facility does not bill ancillaries for any payers or routinely track ancillaries, even for internal purposes since paid on a per diem basis
Exclusion Criteria	• Patients with dementia or significantly older • Patients with severe physical impairments or intellectual disabilities • Patients unable to maintain their own ADLs • Medically compromised patients ○ IPF obtains labs before admitting a patient to confirm medical stability • Patients requiring personal care transfers, physical care, IVs, dialysis
Changes Over Time	• Higher number of psychotic and/or combative patients, and patients refractory to medication • Patients are sicker and can take longer to stabilize compared to 10 years ago

Other Notable Characteristics and/or Findings	• Pressure to meet margins is higher than that of other IPFs in that chain since it is in a market with a high welfare population, limited transportation, very rural; all supplies needed to run the IPF are shipped in
	• Medicare payment can be $300 a day lower than other payers; MA plans pay more than Medicare FFS
	• CFO reports that the facility sees patients exceeding 190-day cap “often”
	• SUD is a common issue that also affects older patients
	  ○ CMO has seen two dozen patients over 65 in the past year who were using meth
	• Medical facility next door
	  ○ IPF sends patients with acute medical conditions out (e.g., medically compromised patients with untreated diabetes, untreated CHF, etc.)
	  ○ Patients incur high costs in the ED that the IPF has to cover
	  ○ ED physicians can be dismissive of psychiatric issues (e.g., not always willing to look for organic/other medical causes; e.g., differentiating between delirium and dementia)

Quotes	• When asked tracking ancillary costs on claims:
	  ○ *“Medicare pays with PPS. We don’t bill any payer any ancillary charges across the board. We don’t enter drugs …labs … we don’t enter anything … it’s corporate [chain policy]. When I first got here, we were entering everything every time, all they got in every lab, every service.”*
	• When asked how the facility tracks expenses by patient:
	  ○ *“I honestly can’t even tell you that, I haven’t done any analysis on it. Our per diem rates are covering their costs, you just know in the end it sort of balances out.”*

Profile 3

<table>
<tr><th colspan="5">IPF 3
Interview Highlights</th></tr>
<tr><td>Location</td><td colspan="2">South</td><td colspan="2">Urban</td></tr>
<tr><td>Organization</td><td>• Nonprofit
• Government</td><td>Freestanding</td><td>Not all-inclusive</td><td>Teaching</td></tr>
<tr><td>Capacity and Occupancy Rate</td><td colspan="4">• 200-299 licensed beds
• 60% of licensed beds are staffed
• Staffed beds are generally fully occupied
• Room setup: 40% private; 60% dual occupancy
○ 4 Units: geropsychiatry, adolescent, extended stay, and medical
• Admission volume:
○ Pre-pandemic: 90% of patients were involuntary, either directly from EDs or as forensic patients
○ Since pandemic: 60% of admissions are voluntary walk-ins</td></tr>
<tr><td rowspan="2">Population Overview</td><td colspan="2">Adults</td><td colspan="2">Adolescents & children</td></tr>
<tr><td colspan="2">• Constitute the majority of patients
• 75% of patients in the geropsychiatry are < age 60</td><td colspan="2">Constitute a minority of patients</td></tr>
<tr><td></td><td colspan="4">• ~85% of patients have severe persistent mental illness
• ~60% of patients have comorbidities in addition to mental illness
• ~25% of patients are involuntarily committed persons from a forensic setting (jail) and found to be incapable of being in a non-psychiatric setting
• Frequent diagnoses for adults:
○ Major depression, dementia sometimes coupled with long-standing chronic mental illness like schizophrenia
• Frequent diagnoses for patients in geropsychiatry unit:
○ Early onset dementia, neurodegenerative disorders, severe cognitive decline</td></tr>
<tr><td>ALOS</td><td colspan="4">• Adults
○ Pre-pandemic: 21 days
○ Post-pandemic: 42 days
• Long-stay patients
○ Median: 9-10 months</td></tr>
<tr><td>Payer Mix (estimated)</td><td colspan="4">• "Our payer mix, what we have for our reimbursable, is very small."
• <5% Medicare and Medicare Advantage*
• No other payer mix information provided
*per 2020 Medicare cost report</td></tr>
</table>

IPF 3 Interview Highlights	

Drivers of High Resource Use	• Overall, patients at IPF 3 require higher staffing complement compared to most general psychiatric hospitals. This IPF takes patients who may have been rejected by/ejected from other facilities
	  ○ More patients who require one-on-one staffing
	  ○ More auxiliary staff and support services staff
	• Antipsychotic medications, which are an area of significant cost that the hospital monitors
	  ○ IPF 3 does not use many of the high-cost newer antipsychotics - "*always keeping in mind that our people tend to have very few resources, so once they leave the hospital, they're going to have to be able to get whatever it is that we're giving them.*"

Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, lab services, and physical therapy • 2020 MedPAR data does not include any ancillaries
Exclusion Criteria	• Patients who need invasive medical procedures or ED level of care • Patients who need telemetry (IPF 3 will have this capability in future)
Changes Over Time	• Admissions shifted from mostly involuntary pre-pandemic to mostly voluntary now
Other Notable Characteristics and/or Findings	• Upon admission, all patients are assigned a midlevel provider (NP or PA) who follows them medically regardless of the unit they're on. ○ These practitioners handle all primary care, secondary illnesses, chronic illnesses, and wellness care • Use an in-house ancillary services model where the facility brings care to patients on-site rather than sending them out (e.g., medical care, neurology, x-rays, IVs, oxygen) • As the safety net facility for a portion of the state, IPF 3 accepts some of the more difficult patients no other IPFs are willing to take

Quotes	• Describing the facility's patient population:
	  ○ *"The patients we tend to get are patients who had a severe persistent mental illness or committed some kind of spectacular behavior, maybe killed somebody or something like that… even though their behaviors are probably manageable in a nursing kind of facility."*
	• Describing high-resource use patients:
	  ○ *"We take folks that no one else can manage. There are some patients who require very high levels of staffing. We're the safety net for this system, so if there are folks who have very unique needs that no one in the community wants to touch with any amount of money, they end up coming to us, and that ends up ... as staffing cost."*

Profile 4

IPF 4 Interview Highlights				
Location	Northeast		Urban	
Organization	• Nonprofit • Part of a behavioral health network	Hospital unit within larger system	Not all-inclusive	Non-teaching
Capacity and Occupancy Rate	• <100 beds in IPF 4, which is a psychiatric unit within an acute care hospital ○ ~90% occupancy; sometimes a semi-private room is used as a single for patient unable to be managed around other patients • >300 licensed beds in the behavioral health network ○ ~90% occupancy rate across all of IPF beds • Admission volume: ○ Nearly all patients come via ED; direct referrals are rare unless it's a post-overdose patient coming from IPF 4 acute care hospital's med-surg unit ○ 30-35% of admissions are involuntary; 65-70% of admissions are voluntary			
Population Overview	*Adults*		*Adolescents/Children*	
	Facility accepts adults		Facility accepts adolescents and children (ages not specified)	
	• Relatively healthy, medically stable population ○ Patients with medical issues are admitted to the medical units in the acute care hospital and psychiatrist consults as secondary; patients may be admitted to the psychiatry unit of the facility once stabilized • Frequent diagnoses: ○ 45-50% of patients have affective disorders such as depression, bipolar ○ 25-30% of patients have psychotic disorders • Seasonality: ○ Decline in adult population in December and increase in January/February ○ Decline in child and adolescent population in summer and increase in October/November			
ALOS	• Facility-wide: 9.5 days • System-wide, behavioral health network: 8-11 days			

Payer Mix (estimated)	• 70% government (combines Medicare FFS, MA, Medicaid) • 30% commercial

Drivers of High Resource Use	• Patients who require one-on-one staffing
	  ○ Agitated or otherwise unstable patients who need private rooms, taking the second bed "offline" even if the facility can staff it
	• Geriatric patients who require higher staff (nursing, techs)-to-patient ratio than non-geriatric patients due to fall risk, dementia
	• Patients with comorbid medical conditions
	• Long-acting injectable medications
	  ○ Hospital system covers some of these at a loss because it's a better solution for patients

Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, lab services, and physical therapy • 2020 MedPAR data includes 11 categories of service • Organization reports that ancillaries are modest given the relatively healthy, medically stable population admitted to the IPF • Organization indicated it is likely more comprehensive about reporting ancillaries than other places but there's room for improvement
Exclusion Criteria	• Patients with any complex medical condition (e.g., serious COPD, dialysis) and/or patients deemed "medically compromised" • Patients whose primary diagnosis is SUD
Changes Over Time	• Social determinants of health driving more admissions • Fewer patients with psychotic disorders; treat more patients with affective disorders • Fewer readmissions due to availability of long-acting medications that have fewer side effects
Other Notable Characteristics and/or Findings	• Limited access to state IPF beds means IPF 4 sees an "outlier group" of patients with severe, prolonged mental illness who may be on a (state) waitlist for 90-100 days ○ IPF 4 often ends up discharging them to the community with wraparound supports although they need a higher level of care

Quotes	• Describing Medicare per diem payment:
	  ○ *"Medicare does not cover the cost of care, full stop."*
	• Describing labor expenses:
	  ○ *"The number one issue for us is workforce, and the number two issue is workforce, and the number three issue is workforce. But when we see these kind of headwinds in terms of traveler expenses, nurse expenses, workforce expenses, locum tenens expenses…"*
	• Describing ancillary services*:*
	  ○ *"[In] your standard inpatient psychiatric unit that's associated with an acute care hospital, the ancillary or additional services are frankly sort of modest. [All patients] see a hospitalist, the hospitalist is going to come in and do an H&P … remember that most of these patients, they've come*

	through the ED, and they've had some kind of blessing that there isn't a significant medical comorbidity or they would be in Medicine." • Suggested improvements to Medicare IPPS: ○ "*I think it's a shared responsibility… And so we have to do a better job of making sure that people have visibility into what it really costs to take care of somebody, and it would be good if they would partner and say, 'We'll get closer to what it actually costs you so that you don't always have to cost shift it to the commercial side of the world.'"*

Profile 5

<table>
<tr><th colspan="5">IPF 5
Interview Highlights</th></tr>
<tr><td>Location</td><td colspan="2">Midwest</td><td colspan="2">Urban</td></tr>
<tr><td>Organization</td><td>For profit/Chain</td><td>Freestanding</td><td>Not all-inclusive</td><td>Non-teaching</td></tr>
<tr><td>Capacity and Occupancy Rate</td><td colspan="4">• 100-199 licensed beds
○ Facility primarily serves children, but it has one adult unit serving ages ≤55
• Occupancy rate ~70% due to staffing shortages
• Admission volume:
○ Patients come primarily via EDs</td></tr>
<tr><td rowspan="2">Population Overview</td><td colspan="2">Adults</td><td colspan="2">Adolescents & children</td></tr>
<tr><td colspan="2">• 20-30% of population
• No patients over age 55</td><td colspan="2">70-80% of population</td></tr>
<tr><td colspan="4">• Frequent diagnoses:
○ Psychosis, bipolar disorder, schizophrenia, schizoaffective disorder (combination of schizophrenia with mood disorder) with comorbid SUD
• Seasonality: Adolescent/child occupancy rate declines in summer; during this time the facility accepts more adults beyond its adult unit’s capacity</td></tr>
<tr><td>ALOS</td><td colspan="4">• Adults: 5-7 days
• Facility-wide: 11-12 days</td></tr>
<tr><td>Payer Mix (estimated)</td><td colspan="4">• 75-80% Medicaid
• <2% Medicare
• <2% MA
• No other payer mix information provided</td></tr>
<tr><td>Drivers of High Resource Use</td><td colspan="4">• Patients who require one-on-one care (e.g., patients with impulse control issues, aggressive, combative)
• Older patients with co-morbid medical conditions
• Certain medications, e.g.,
○ Long-acting injectable antipsychotic medications such as Abilify Maintena (aripiprazole) and Invega Trinza (paliperidone palmitate) cost up to $9,000/injection
○ HIV retrovirals</td></tr>
<tr><td>Ancillary Reporting</td><td colspan="4">• 2020 Medicare cost report includes routine, ancillary drugs, and lab service
• 2020 MedPAR data includes laboratory and drugs charged to patients</td></tr>
</table>

IPF 5 Interview Highlights	
	• IPFs in state report ancillaries on claims due to state Medicaid requirement; the same national chain of IPFs does not report ancillaries in states that do not require it
Exclusion Criteria	• Patients who are older than 50-55 • Patients with any complex medical condition (e.g., serious COPD, dialysis) or patients deemed "medically compromised" • Patients with abnormal lab values or vital signs (blood sugar or blood pressure too high) • Patients who use oxygen or IV treatment • Patients who require telemetry • Patients who are wheelchair bound or who require other adaptive equipment
Changes Over Time	• Patients are more aggressive, sicker (e.g., psychotic), and more demanding • Increasing challenges staffing beds
Other Notable Characteristics and/or Findings	• Consider Medicare payment reasonable, especially when compared to Medicaid • Nursing and social worker shortages limit the number of beds IPF can staff; also, nurses not accustomed to treating patients with medical comorbidities
Quotes	• When asked what is benefit of reporting ancillary charges: ○ *"You got me. Seems like a wasted step, right? If you are going to end up getting the same payment per day regardless of what you use and provide, what is the point of having the person chase that information… if it is just going to be written off?"*

Profile 6

IPF 6 Interview Highlights				
Location	Midwest		Urban	
Organization	For profit/Chain	Freestanding	Not all-inclusive	Non-teaching
Capacity and Occupancy Rate	• 100-199 licensed beds ○ One unit offline due to staffing constraints; other units 90+% occupied ○ One older adult unit with mostly age 55+ and/or medically frail presenting as older, including adults with developmental disabilities and a mental illness ○ One adolescent unit • Admission volume: ○ >95% of patients come via EDs in the area ○ Few admissions are walk-ins (25 walk-ins in the most recent quarter)			
Population Overview	*Adults*		*Adolescents & children*	
	• ~10% of population is age 55+ • ~80% of population is age 18-55		~10% of population	
	• IPF accepts patients with diabetes, CHF, walkers, wheelchairs, and patients using CPAP machines • Frequent diagnoses: ○ Adults: Thought disorders, mood disorders, psychosis ○ Adolescents: Impulse control disorders, spectrum disorders, depression, anxiety			
ALOS	○ Adults: 15.5 days ○ Medicare patients: >20 days ○ ALOS is 2-4 days higher than earlier periods due to a few outliers (e.g., patients waiting 6 months for long-term placement)			
Payer Mix (estimated)	• ~12% Medicare FFS • ~8% Medicare Advantage • ~70% Medicaid • <5% commercial • No other payer mix information provided • Facility reports that it has all-inclusive per diem arrangements for Medicaid, commercial and MA payers			

IPF 6 Interview Highlights	
Drivers of High Resource Use	• Patients who require one-on-one care (e.g., aggressive, combative) • The older adult unit staffing ratio, which is higher in part because patients need assistance with ADLs • Long-term patients who are used to be in state facilities and were integrated into community settings but didn't thrive • Patients who clinically qualify for state facilities but cannot be admitted due to occupancy constraints
Ancillary Reporting	• Facility does not bill ancillary services separately on claims; does not submit a Medicare cost report • Facility internally tracks pharmacy costs, dietary costs, lab costs, etc.
Exclusion Criteria	• Patients with any complex medical condition (e.g., COPD) • Patients who use oxygen or IV treatment • Patients who require a feeding tube or have a tracheostomy
Changes Over Time	• Patients are more aggressive and violent • Closures of state IPFs in the last 15 years and deinstitutionalization efforts resulted in long-term mentally ill patients in the community; only 2 state IPFs remain open • Increased LOS in some units because of outlier patients who would otherwise be at a state IPF
Other Notable Characteristics and/or Findings	• Facility accepts higher acuity patients given its inner-city location compared to its sister facility in a more rural part of the state • IPF uses agency staff to compensate for staff shortages and pays incentives for employed staff to pick up extra shifts; still have one unit offline due to staff shortage • IPFs in the state are able to negotiate increased payments by the state for Medicaid cases in order to admit certain high need patients or those anticipated to stay longer than average
Quotes	• When asked what the impact would be if CMS no longer paid per diem unless facilities reported claims details (ancillaries): ○ *"You'd have to create another one of me [CFO], because you'd have all that data coming in there, and now we're not just talking about per patient day, we're talking about the financial class … Many times you have a Medicare patient come in, and at the time their 190 days is not exhausted, yet when they're here for 14 days, another claim is dropped, now they're exhausted, so now I put them under Medicare as their financial class, but now truly they're Medicaid... it would be a nonstop follow-up, editing, reviewing, and revising [claims] daily to make sure that it's accurate."*

Profile 7

<table>
<tr><th colspan="5">IPF 7
Interview Highlights</th></tr>
<tr><td>Location</td><td colspan="2">Northeast</td><td colspan="2">Urban</td></tr>
<tr><td>Organization</td><td>• Nonprofit
• Affiliated with university provider network</td><td>Freestanding (part of a health system with multiple IPFs)</td><td>Not all-inclusive</td><td>Non-teaching</td></tr>
<tr><td>Capacity and Occupancy Rate</td><td colspan="4">• 100-199 licensed beds
○ Four units, including geriatric, other adult, voluntary and involuntary
• 70-75% occupancy
○ 85% occupancy pre-COVID
○ Presently, fewer families want family members in institutions, and more are being treated in nursing homes
• Admission volume:
○ Majority of patients come via EDs; all patients screened first by centralized patient placement center
○ 60% of admissions are involuntary</td></tr>
<tr><td rowspan="2">Population Overview</td><td colspan="2">Adults</td><td colspan="2">Adolescents/Children</td></tr>
<tr><td colspan="2">• Facility accepts adults only
○ 20% geriatric; 80% mixed-age adults
• Average age on geriatric unit is 70-75</td><td colspan="2">None</td></tr>
<tr><td></td><td colspan="4">• Frequent diagnoses:
○ Geriatric unit: dementia with behavioral disturbance, neurocognitive disorders; admission to unit is not solely based on advanced age, sometimes due to cognitive disorder
■ Common comorbidities: controlled diabetes, hypertension, straightforward wound care, respiratory issues
○ Voluntarily admitted patients tend to have more SUD as secondary diagnosis</td></tr>
<tr><td>ALOS</td><td colspan="4">• ALOS varies significantly by unit
• Geriatric unit: 10-12 days
○ Patients with behavioral disturbance and dementia have longer LOS since they require slower medication management and must also address comorbidities
• Adult unit: 7-8 days
• Committed/involuntary unit: 9-11 days</td></tr>
</table>

IPF 7 Interview Highlights	
	• Voluntary unit: 6-7 days • Contributor to long LOS is difficulty with discharge due to limited safe places to move patients — 10% of patients are kept longer due to disposition issues
Payer Mix (estimated)	• ~8% Medicare (FFS/MA proportions not provided) • 80% Medicaid • Unknown % commercial • No other payer mix information provided

Drivers of High Resource Use	• Patients who require one-on-one staffing (e.g., patients with dementia, needing help with ADLs, preventing falls, and wandering off)
	  ○ Geriatric unit staffing includes aides who assist with ADLs
	• Patients who are involuntarily admitted (tend to be more resource-intensive than voluntary admissions)
	  ○ Staffing for involuntary unit is 3 patients:1 staff
	• Patients who require a single room because of behavioral issues (e.g., combative, high acuity) means closing a bed in a double occupancy room
	• Patients who require medical attention
	• Patients on many medications or expensive medications, such as long-lasting injectables

Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, and lab services • 2020 MedPAR data includes diagnostic radiology, CT scans, laboratory, drugs charged to patients, and emergency • Can track ancillary cost centers for drugs, labs, diagnostic radiology, etc. because they use the same system as the acute care hospitals in the network • Facility says ancillary services typically are not what drives costs, e.g., facility does not provide X-rays and does limited lab work
Exclusion Criteria	• *Note: Facility is part of >300-bed behavioral health system and all admissions come through a centralized screening/transfer center based on bed availability throughout system* • Patients who are medically unstable • Patients who require IVs, continuous oxygen, advanced wound care, in active withdrawal, or with abnormal lab results (e.g., dangerously low/high electrolyte levels)
Changes Over Time	• Older patients with SMI needing concurrent management of BH and medical conditions • Patients have more medical comorbidities and are older • Seeing more patients hitting the 190-day cap given they are older and have long-term SMI • Discharge/placement is more difficult, especially for patients who are older now than they used to be; also true for patients with SMI combined with dementia

IPF 7 Interview Highlights	
	• More families unwilling/unable to accept patients back into their homes, especially those with dementia
Other Notable Characteristics and/or Findings	• On a percentage basis approximately 25% of their Medicare patients exceed the 190-day cap • On the geriatric unit, the proportion of Medicare patients has decreased by half since COVID Broader Behavioral Health System: • Offsite patient placement center with clinical staff that oversee all behavioral health beds and make medical and psychiatric assessments, direct each patient to the appropriate facility. • Grant-funded screeners go with the police to assess patients and decide if they need hospitalization ○ Do not track individual ancillary charges and believe it is not necessary given per diem payment ■ e.g., when EKG machine is on a unit, nurses perform EKGs as part of the room and board charge (not billed to an imaging department)
Quotes	• Describing patients who reach the Medicare lifetime cap: ○ *"That [190 day] cap presents a lot of challenges for us, because very often these patients have been in the acute care hospitals already, and then by the time they come to us they've blown through their benefit allowances, and then they end up being basically charity care for us... Those are usually where we have placement issues. So they get stuck here for longer lengths of stay and there's a lot of uncompensated care."* • Describing discharge planning challenges: ○ *"Across the board we're seeing longer lengths of stay, both here and [at psychiatric facility] where I used to work. As COVID pulled some of those resources out of the community, it's just harder to get folks anywhere after discharge, really. Similarly, … as mental health needs go up in the community, even access to basic outpatient care has been more challenging. The goal is to get folks an appointment within short order [after] discharge, but even that can be hard to find. That makes ED diversion harder; that makes inpatient discharge harder. I think it's pretty similar between here and other places I've practiced."* • Describing frustration with per diem declining as LOS increases: ○ *"As the LOS goes on, we get paid less. Just because a patient is here longer it's not because they need fewer resources. They have longer LOS because they need that level of care and there are placement issues... I have an issue with our getting less money as a result of them staying here longer."*

Profile 8

IPF 8 Interview Highlights				
Location	Midwest		Urban	
Organization	Nonprofit	Freestanding	Not all-inclusive	Teaching

Capacity and Occupancy Rate	• 100-199 licensed beds
	  ○ Older adult unit
	  ○ Specialized units including severe and persistent mental illnesses, dual diagnoses of BH/SUD
	  ○ Unit for children and adolescents
	• 80% occupancy
	• Admission volume:
	  ○ 50% of patients come via EDs
	  ○ 50% of patients are walk-ins			

Population Overview	*Adults*		*Adolescents & children*	
	• 18% are older adults • Average age on older adult unit is late 60s-early 70s		Accept children and adolescents of all ages	

	• Frequent diagnoses:
	  ○ Adults: Major depressive disorder
	  ○ Older adults: cognitive disorders, especially dementia
	• Provide high levels of ECT			

ALOS	• 13-14 days
	  ○ General adult population ~7 days
	  ○ Patients with persistent mental illness ~10 days
	  ○ Older adults have longest LOS
	  ○ Some patients with 30-day stays awaiting beds in state IPFs			

Payer Mix (estimated)	• <30% Medicare (more MA than FFS with FFS trending down) • >30% Medicaid • >40% commercial • Facility considers Medicare the worst payer; Medicaid pays slightly more than Medicare and commercial rates tend to be the highest.			

IPF 8 Interview Highlights	

Drivers of High Resource Use	• Patients who require one-on-one staffing or one-on-two staffing (acutely agitated patients require more staff to avoid seclusion or restraints)
	  ○ Highest cost for the facility by far
	• Patients who require a private room
	• Patients on Medicare or Medicaid (tend to be more resource-intensive than commercially insured patients)
	• Older patients who:
	  ○ Have multiple comorbidities, especially when combined with cognitive issues
	  ○ Require more neural cognitive psychological testing (e.g., older patients almost routinely get a baseline EKG which is atypical of patients on the other adult units)
	  ○ Are at fall risk
	  ○ Need more medications and monitoring on top of being on the geriatric unit and having multiple comorbidities
	• Patients with a history of aggression, other social needs/SDOH drivers such as no family support, etc. (more difficult to discharge, leading to longer stays)
	• Patients who cause damage to facility equipment or injure staff (creates workers compensation claims and absences)
	• Long-acting injectable medications including Abilify

Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, and lab services • 2020 MedPAR data includes laboratory, occupational therapy, and drugs charged to patients • Facility reports 5 types of ancillaries for all patients (labs, meds, specific therapies, and other)

Exclusion criteria	• Patients will not be admitted if they have serious medical conditions as determined by the state medical and psychiatric assessment instrument
	  ○ E.g., patients with uncontrolled seizures, acute cardiac conditions, blood clots are considered medically unstable or compromised
	• Patients who require IVs or telemetry
	• Patients with a tracheotomy, Do Not Resuscitate (DNR) orders, or on oxygen
	  ○ Facility has taken a few patients on oxygen who are stable and well controlled, but normally do not due to ligature risk; same is true for patients with CPAP machines

Changes over time	• More older patients • Higher acuity of patients; patients are delaying treatment until conditions are more severe • Patients have greater social needs

IPF 8 Interview Highlights	
Other Notable Characteristics and/or Findings	• Facility does consults for its state operated IPFs, and accepts some patients with similar high needs • Facility has in-house general medicine physicians as well as APPs; accepts patients with multiple chronic conditions including high blood pressure, diabetes, asthma, high cholesterol and other metabolic and seizure disorders, chronic pain, autoimmune conditions, and HIV • Tracks over 190 different quality metrics • Worked with EHR partner to develop a behavioral health module • *State-specific:* State behavioral health system has centralized referral and case management structure and works closely with IPFs to ensure the [Medicaid] patients are appropriately referred ○ State negotiates case rates depending on the patient's acuity to ensure IPFs are willing and able to take patients requiring services

Quotes	• Describing the process of recording ancillary charges:
	  ○ *"We could spend all day trying to take the time to bill [all ancillaries] out, tying yourself into knots detailing everything that happened over the [stay] but there is no incentive to bill it out that way… At the end of the day, you are going to get paid the same amount. … there is no incentive to keep track of it."*
	• Describing the financial impact of staffing one-on-one and closing one bed in a semi-private room:
	  ○ *"That's an admission that doesn't come in, that's another per diem that we're unable to bill, and that makes that patient really, really expensive."*

Profile 9

<table>
<tr><th colspan="5">IPF 9
Interview Highlights</th></tr>
<tr><td>Location</td><td colspan="2">South</td><td colspan="2">Urban</td></tr>
<tr><td>Organization</td><td>• Nonprofit
• Government</td><td>Hospital unit in a Level 1 trauma center</td><td>Not all-inclusive</td><td>Teaching</td></tr>
<tr><td>Capacity and Occupancy Rate</td><td colspan="4">• <100 licensed beds in a large acute care hospital
○ One unit for adult patients with aggression, psychosis, thought disorders
○ One unit for geriatric or mood disorder patients with medical conditions, older patients with ambulatory issues, etc.
• Full occupancy unless some semi-private beds closed due to patients requiring one-on-one supervision
• Admission volume:
○ Patients may arrive as walk-in, family drop-off, or police drop-off, but all patients go through the hospital ED first
○ This IPF is one of several facilities in the county that accept 72-hour involuntary admissions; usually these patients are police drop-offs</td></tr>
<tr><td rowspan="2">Population Overview</td><td colspan="2">Adults</td><td colspan="2">Adolescents & children</td></tr>
<tr><td colspan="2">• Facility accepts adults only
○ 20-25% are age 65+
○ 5-15% are forensic patients</td><td colspan="2">None</td></tr>
<tr><td colspan="4">• Higher proportion of indigent patients than other area IPFs given affiliation with local government
• Higher proportion of patients age 65+ than most local IPFs
• Patients with significant medical comorbidities can be managed on psychiatric unit because it is in an acute care hospital with regular rounding by medical personnel (vs. a freestanding facility)
• Unit accepts patients with wheelchairs, colostomy bags, oxygen, CPAP machines, patients needing management of chronic diabetes
• Frequent diagnoses:
○ Younger adults: Depression, depressive disorders, bipolar disorder, schizophrenia, psychosis Not Otherwise Specified (NOS)
○ Older adults (65+): Depression, attempted suicide, other psychoses</td></tr>
<tr><td>ALOS</td><td colspan="4">• 5.2 days across all IPF units, do not track ALOS separately by unit</td></tr>
<tr><td>Payer Mix (estimated)</td><td colspan="4">• ≤5% Medicare FFS
• Unknown % Medicaid FFS
• 75% managed care (includes managed Medicaid and MA)</td></tr>
</table>

IPF 9 Interview Highlights	
	• 15-20% self-pay
Drivers of High Resource Use	• Patients who require one-on-one staffing (e.g., patients with dementia, needing help with ADLs, preventing falls, and wandering off) • Older adult unit staffing ratio: Greater number of nurses and patient care assistants • Patients who require a single room because of behavioral issues (i.e., one bed not used in a semi-private room) ○ E.g., forensic and non-forensic patients who are aggressive and need private rooms and supervision/monitoring are high resource use even without medical comorbidities
Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, lab services, and physical therapy • 2020 MedPAR data includes 15 categories of service
Exclusion Criteria	• Patients with unstable blood levels, e.g., elevated CK level, high levels of blood sugar • Patients with COVID (these patients remain on medical units) • Patients who require IV fluids
Changes Over Time	• Increase in comorbid & chronic conditions

Other Notable Characteristics and/or Findings	• Several patients with significant LOS (50-365 days) are awaiting placement in community or state facility
	  ○ These patients require ongoing monitoring and there are too few assisted living facilities to accept them
	  ○ Placement challenges are present for all area IPFs, yet costs of care do not decrease for patients with longer LOS
	• Area has experienced a reduction in available IPF beds; one acute care hospital closed its behavioral health unit due to financial concerns
	• When prescribing medications, notably long acting injectables, they make sure to prescribe what patients can access once discharged, especially because many patients are indigent

Quotes	• When asked what makes for a high resource use patient:
	  ○ *"It's a combination of their diagnoses, risk of fall, different risk factors. Some patients may come in with diabetes, but they may not need as much as someone who came in with high blood pressure and depression and is unstable on their feet and at high risk for fall."*
	• Financial impact of closing beds in semi-private rooms:
	  ○ *"With aggressive patients, you don't want to room them with anyone, so then it takes away one bed from each room, so that's an added expense."*

Profile 10

<table>
<tr><th colspan="5">IPF 10
Interview Highlights</th></tr>
<tr><td>Location</td><td colspan="2">West</td><td colspan="2">Urban</td></tr>
<tr><td>Organization</td><td>Nonprofit</td><td>Freestanding</td><td>Not all-inclusive</td><td>Non-teaching</td></tr>
<tr><td>Capacity and Occupancy Rate</td><td colspan="4">• 100-200 licensed beds
○ 60% of licensed beds are staffed
○ Double-room units; No formal designation by diagnosis or patient type
○ Single room units for higher acuity patients
■ Currently offline due to staffing shortage
• <60% occupancy of total beds; 90% occupancy of staffed beds
• Admission volume:
○ 30-50% of patients are admitted as walk-ins
○ 50-70% of patients come via EDs in the area with some EMT and police drop-offs
○ 60% of admissions are involuntary, 40% of admissions are voluntary</td></tr>
<tr><td rowspan="2">Population Overview</td><td colspan="2">Adults</td><td colspan="2">Adolescents/Children</td></tr>
<tr><td colspan="2">• Facility accepts adults only, ages 18-65
○ Occasionally accept healthy patients over age 65
○ Does not offer geriatric unit or any medical beds
○ Average age is 40s</td><td colspan="2">None</td></tr>
<tr><td></td><td colspan="4">• Most patients do not have medical comorbidities — IPF screens these patients out before admission
• Frequent diagnoses: psychotic and bipolar spectrum disorders, major depressive disorders; some present with severe PTSD or OCD
○ Many have secondary diagnosis of SUD</td></tr>
<tr><td>ALOS</td><td colspan="4">• 15 days
○ Recently have dedicated some beds to long-stay patients through a contract with the state by which they have agreed to take non-forensic patients transferring from state IPFs who require 90-day or 180-day holds. These patients increase the IPF’s overall ALOS</td></tr>
<tr><td>Payer Mix (estimated)</td><td colspan="4">• 30% Medicare & MA
• 50% Medicaid
• 12% commercial
• 8% other</td></tr>
</table>

Drivers of High Resource Use	• Staffing, in particular the tasks staff perform such as blood draws, documenting group therapy, point of care testing, etc. • Patients requiring one-on-one staffing • Long acting injectables; they aim to get patient their first dose while they're in the IPF and work with pharmaceutical companies to obtain favorable pricing/free first injections; occasionally anti-viral drugs
Ancillary Reporting	• 2020 Medicare cost report includes routine, ancillary drugs, and lab services • 2020 MedPAR data includes laboratory and drugs charged to patients
Exclusion Criteria	• Patients over 65 with few exceptions • Patients who need assistance with ADLs • Patients with medical comorbidities • Patients with dementia, TBI, or who are COVID-positive • Patients who require IV lines, drains, or oxygen
Changes Over Time	• Fewer discharge placement options, resulting in longer lengths of stay — patients that are most vulnerable are also the most likely to be denied days (e.g., those with Medicaid managed care)
Other Notable Characteristics and/or Findings	• CMO gave example of a behavioral health system in the area that tried to set up a medical-psychiatric unit but found it was not financially viable given the current payment structure • One state IPF will no longer accept civilian admissions; shifting focus to forensic patients
Quotes	• Describing discharge challenges: ○ *"You have patients who already come in with few community supports and many who don't have any place to live. You know if you discharge them to the same conditions, then there is a high likelihood that they're just going to decompensate and not take their meds. We live with that challenge every day…"* • Why not provide services to more medically complex patients?: ○ *"It's partly a financial consideration ... It's cheaper to build a freestanding hospital without all the [medical infrastructure]. And then there's the question of whether or not you're going to be reimbursed for having a medically complicated patient."*

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Interview Discussion Guide

Background

- Could you give us a general overview about your patients: Where are they coming from; what are their demographics, their top psychiatric diagnoses, etc.?
    - Could you estimate the proportion of your population whose primary reason for admission is mental health illness versus substance use disorder (SUD)? Has this changed over time?
    - What proportion of your patients have co-occurring medical and behavioral health conditions?
    - What proportion are involuntarily admitted/on temporary detention order (TDO)? Do you treat forensic patients?
    - On average what is your daily census? Does that or the type of patients you see change seasonally?
- When you are thinking about your population, what would you say are the characteristics that make a patient one that requires higher or lower level of resources?
    - How do patients that require higher/lower resource intensity differ by psychiatric diagnosis, age, or medical comorbidities?
    - What resources tend to be the most intensive in your particular setting?
- Has that mix of patients or their resource use changed over time? If so, what has driven that/those changes?

Resource Use

- Let's start with higher service-need patients. What diagnoses and types of services provided to patients result in higher costs?
- For patients who need less intense services (relative to the highest-need patients), what are common diagnoses? What types of services are typically provided to these patients?
- Can you speak to what are the most frequent factors/drivers that determine whether a patient will be higher or lower cost?

Ancillary Services

- Are there any standard labs that you obtain for all patients when they are admitted?

- Approximately what percentage of your patients usually receive ancillary services over the course of a stay?
    - Aside from labs and prescription drugs, what other ancillary services are frequently used?
- Which specific services (or equipment, supplies, or medication) are driving the bulk of your ancillary costs?

Medicare Patients

- Does your facility have an expertise in or specific unit tailored for geriatric psychiatry or neuropsychiatry? If so, how does this differ from other units within the facility?
    - Are there other differences that you typically associate with Medicare patients vs. other patients in your facility?
- Is your experience working with Medicare fee-for-service patients different from your experience working with patients who have Medicare Advantage?

Financial Overview

Payment Rates

- We understand that most payers pay IPFs on a per diem basis. How does Medicare's per diem rate compare to that of other payers?
    - How do the Medicare per diem payments and adjustments compare to the costs of providing services for the typical Medicare patient? Think about "over 65" Medicare patients separately from patients who have Medicare for other reasons, such as developmental disabilities.

Ancillary Charges – Frequency and Reporting

- What is your facility's current designation on Medicare cost reports: all-inclusive; not all-inclusive?
- If all-inclusive, when did you receive the all-inclusive designation?
- Why did you pursue the designation and what has it meant for your operations?
- What was the process for applying for this approval?
- Roughly, what is the share of routine versus ancillary costs to your facility (if you are able to say, given you may not separately track the costs)?

- If not all-inclusive, roughly, what is the proportion of routine versus ancillary costs at your facility?
- Are there ancillary services provided to IPF patients during a stay that are not billed directly by the IPF? Meaning, services provided by a contracted, potentially independent, entity (e.g., independent lab, imaging group, etc.)?
    - 1) Do those entities submit claims to CMS directly? 2) Are the costs associated with the services these entities provide reflected in your facility's Medicare cost reports under ancillary or other cost categories?
- What insights do you have about why this variation occurs – that is, with some IPFs reporting ancillary charges for between 1 and 20 different categories, while others report zero ancillaries?
- How does your organization think about reporting ancillary services?
    - What is the benefit of reporting ancillary charges?
    - Who makes the decision about tracking and/or charging for ancillary services provided?
- How does the information in your Medicare cost reports affect your IPF, or your facility's operations?
- Does what you put in your Medicare cost reports matter when negotiating reimbursement with different insurers?
- Is the reason it doesn't matter because your IPF costs are a small portion of the overall cost report? If not that, can you help us understand why it doesn't matter?

Deeper Dive on Patients Served

- Demographics: Average age, gender, disability status, common diagnoses, average length of stay (ALOS), other characteristics you think we should know?
- Payer mix: Tell us about your payer mix. Can you estimate the proportion that is: Medicare FFS, Medicare Advantage, Medicaid, dually eligible, Commercial, Private Pay?
- Treatment settings: When a patient has a psychiatrically acute episode, do you keep them in-house or transfer them to an emergency department (ED) or another facility?

- Can you help us understand the proportion of your IPF's patients with only behavioral health diagnoses compared to those medical co-morbidities such as chronic heart failure, chronic kidney disease, diabetes, chronic obstructive pulmonary disease, etc.?

- What co-morbidities are most common? Which co-morbidities are less common?

- For freestanding facilities, how frequently do you encounter patients meeting the 190-day limit? What happens when they reach that limit?

Payment System Changes and Wrap Up

- What would you make happen from a policy standpoint at the federal level to improve the IPF prospective payment system?

  - What changes would you recommend for encouraging more accurate or more comprehensive reporting of ancillary services?

  - When you are thinking about improvements, do you have any challenges in meeting the needs of Medicare beneficiaries given current coverage and benefits?

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