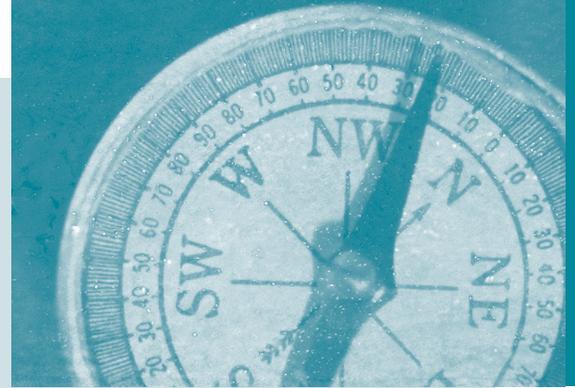


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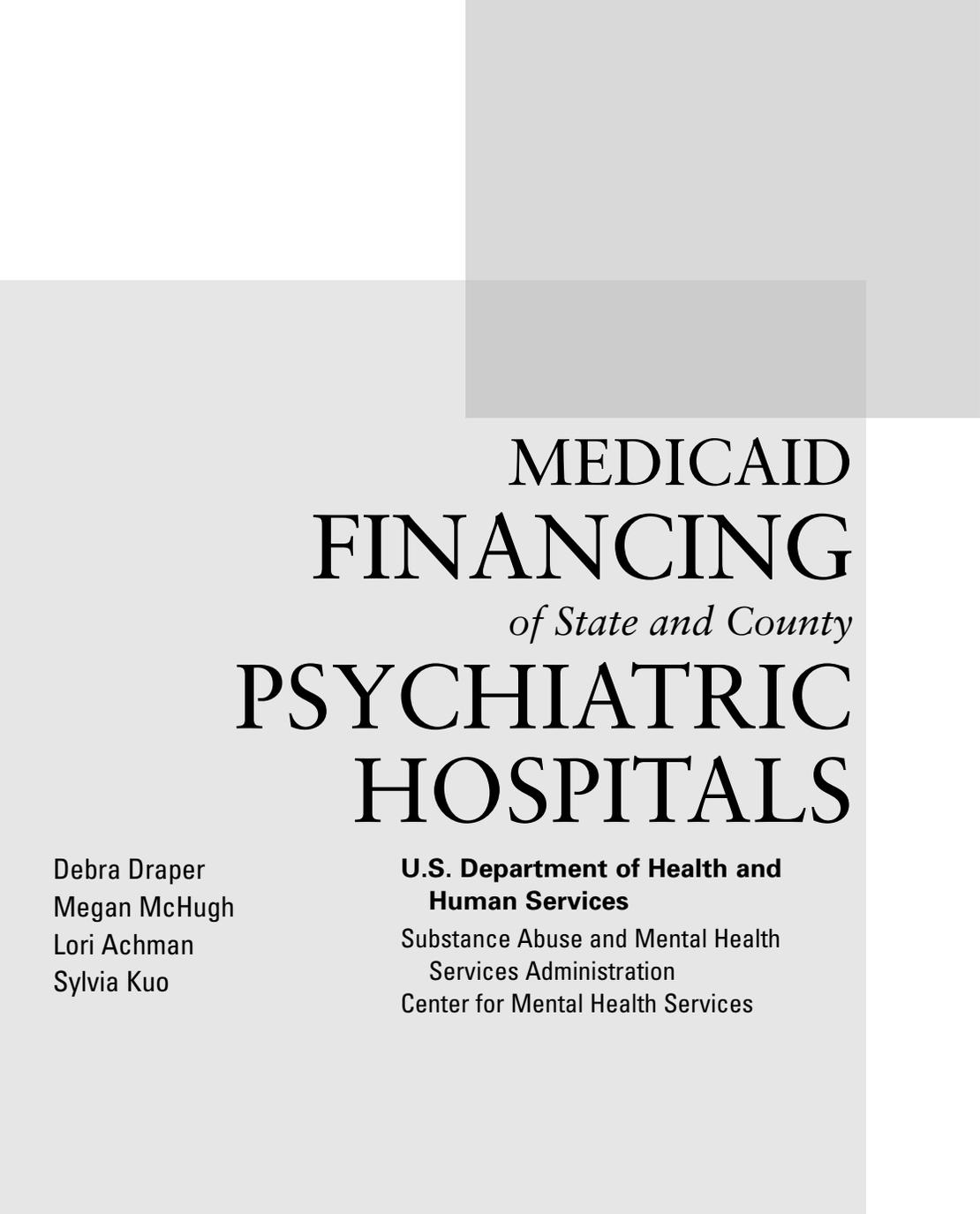


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# Executive Summary

A common perception is that public psychiatric hospitals receive little or no Medicaid funds because of the Institutions for Mental Diseases (IMD) exclusion. This policy prohibits Medicaid reimbursement for care provided to individuals older than 21 years or younger than 65 years if the care is delivered in psychiatric institutions. Nevertheless, while States continue to provide substantial support to public psychiatric hospitals, in recent years Medicaid has funded an increasing share of the operations of these facilities. This study was undertaken to address the lack of comprehensive information regarding the nature and scope of such Medicaid support. The study identifies potential sources of Medicaid funds paid on behalf of public psychiatric hospitals and provides an estimate of the amount of such funds in 2001. The Medicaid funding experiences of public psychiatric hospitals in five States—Arkansas, California, Iowa, Maryland, and New Jersey—were examined in depth for the study.

## *Major findings:*

- In 2001, an estimated \$2.6 billion in Medicaid funds were paid on behalf of public psychiatric hospitals in the United States. This represents approximately one-third of total operating costs for these institutions.
- Medicaid funding for State and county psychiatric hospitals can be derived from several sources:
  - IMD Optional Services: States may choose to provide coverage for inpatient services in an IMD for Medicaid-eligible individuals age 65 and over or under age 21, as well as for nursing facility services in an IMD for persons age 65 and over.
  - Medicaid Managed Care: States can obtain IMD expenditure authority through a 1115 Medicaid waiver; pay for IMD services with savings from Medicaid managed care programs; or indirectly pay for IMD services if IMDs participate in the provider networks of behavioral health organizations (BHOs) that contract with the State's Medicaid program.
  - Disproportionate Share Hospital (DSH): The Medicaid program provides supplemental payments to hospitals, including IMDs, that render a large volume of care to indigent patients.
  - Administrative payments: IMD residents' Medicaid eligibility allows

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payment for administrative services provided to them, such as administrative case management.

- Of these sources, DSH payments currently represent the overwhelming majority of Medicaid funds paid to State and county psychiatric facilities.
- The pursuit of each of these funding sources varies considerably from State to State, as dictated by local circumstances. Even among States that avail themselves

of the same sources of Medicaid funds, methods and amounts differ significantly.

The role of public psychiatric hospitals is changing constantly. States have worked since the 1960s to move large numbers of patients out of these facilities into community-based treatment settings. The challenges faced by State and county psychiatric hospitals are substantial and are likely to affect future Medicaid financing strategies pursued by the hospitals themselves or on their behalf.



# Introduction

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**W**hile States enjoy significant flexibility in the design and operation of their Medicaid programs, they nonetheless rely heavily on financial support from the Federal Government. The Medicaid financing process is highly complex, and more so in many ways for State and county psychiatric hospitals than for other facilities and services. Much of the complexity is rooted in the Federal Government's longstanding policy that long-term psychiatric care—primarily for adults—is the responsibility of the States. Consequently, Federal law does not generally allow Medicaid reimbursement for care provided to individuals older than 21 years or younger than 65 years if the care is delivered in institutions for mental diseases (IMDs) (Geller 2000; National Association of State Mental Health Program Directors 2001a).<sup>1</sup> Dramatic shifts in mental health care delivery also have added to the complexity surrounding Medicaid financing of State and county psychiatric hospital services. In a trend commonly referred to as deinstitutionalization, sites of care have moved rapidly from inpatient to outpatient facilities and from institutions to community-based treatment programs (Geller 2000).

Even though the IMD exclusion and changes in mental health care delivery generally have limited Medicaid reimbursement for services in State and county psychiatric hospitals, these hospitals potentially may avail themselves of other sources of

Medicaid funds. For example, Federal assistance in the form of disproportionate share hospital (DSH) payments is available to State and county psychiatric facilities serving a disproportionate number of low-income patients. However, Federal laws enacted

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<sup>1</sup> An IMD is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services” (U.S. Department of Health and Human Services (USDHHS) 1992, 1994). Further, “[a]n institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases” (USDHHS 1994). When Congress created the Medicaid program in 1965 and subsequently amended it in 1972, it relaxed the IMD rule. The rule allowed funding for inpatient psychiatric care rendered in general hospitals as well as certain services for IMD residents age 65 years and older and persons under age 21 (USDHHS 1992). Medicaid reimbursement for inpatient psychiatric care provided by IMDs is available for individuals under age 21 and for individuals age 65 years and older if the State elects these optional services under its Medicaid State plan.

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during the 1990s set limits on payment amounts.<sup>2</sup> Congress also imposed significant restrictions, to be phased in over time, on the use of DSH monies to finance IMD services (National Association of Public Hospitals and Health Systems 2001a; National Association of State Mental Health Program Directors 2001b, 2001c; U.S. General Accounting Office (USGAO) 2000). Although many public psychiatric hospitals have benefited from the availability of Medicaid supplemental funds such as DSH, the continued availability of the funds, at least at recent levels, may be less certain in the future.

Thus, the overarching question is, “What share of State and county psychiatric hospital operations does Medicaid finance?” While existing evidence is limited and dated, it does suggest that Medicaid has been financing an increasing share of public psychiatric hospital operations. One estimate suggested that Medicaid represented approximately 10 percent of State and county psychiatric hospital revenues in 1990; a more recent estimate suggested that it accounted for 18 percent in 1994 (Manderscheid et al. 2001). However, given the extensive variation in State Medicaid programs as well as in States’ approaches to the use of Medicaid financing, the experiences of individual States may differ dramatically from these national estimates. Further, much has happened since the mid-1990s that could affect trends both nationally and in individual States, including the proliferation of the

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<sup>2</sup> Among these laws are the Omnibus Budget Reconciliation Act of 1993 (OBRA) and the Balanced Budget Act of 1997 (BBA) (National Association of Public Hospitals and Health Systems 2001a; National Association of State Mental Health Program Directors 2001b, 2001c; USGAO 2000).

DSH program and of Medicaid managed care programs.

## **A. Historical Context of Public Psychiatric Hospitals**

Medicaid’s role in funding services for patients in public psychiatric hospitals has been influenced greatly by the IMD exclusion and deinstitutionalization.

### *1. IMD Exclusion*

Although the roots of the IMD exclusion predate the Medicaid program, the rule continues to confound today’s financing relationship between Medicaid and State and county psychiatric hospitals. The 1950 amendments to the Social Security Act established the prohibition of Federal assistance for IMD residents as well as for patients diagnosed with a psychosis found in other medical institutions (USDHHS 1992). When the Medicaid program was established in 1965, it created the State option that, for the first time, allowed Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to IMD residents age 65 years and older. Further amendments in 1972 allowed for optional coverage, under certain circumstances, for IMD residents under age 21 or, in some cases, under age 22. Thus, the IMD exclusion generally prohibits Medicaid reimbursement for services obtained in IMDs by Medicaid-eligible adults age 22 to 64 years of age (Office of the Inspector General (OIG) 2001a, 2001b, 2001c).<sup>3</sup> However, the IMD exclusion does not bar Medicaid reimburse-

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<sup>3</sup> Some States, such as Iowa, specify that IMD residents can be covered through age 22 if they are hospitalized in an IMD before their 21st birthday (Center for Health Services Research and Policy 2001; OIG 2001b).

ment for inpatient psychiatric services per se, only services provided in specific types of facilities.<sup>4</sup> Medicaid funds may be available for the same services rendered in a non-IMD environment.

An IMD is defined as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services” (USDHHS 1992, 1994). Further, “[a]n institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases” (DHHS 1994).<sup>5</sup> Both Federal and State governments generally concur that State and county psychiatric hospitals qualify as IMDs. In fact, the literature often uses the

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<sup>4</sup> According to the *State Medicaid Manual*, the key criteria for a facility to be designated as an IMD include the following: has more than 16 beds; specializes in the treatment of persons with mental illness; the current need for institutionalization for at least 50 percent of the residents results from mental diseases; is licensed and/or accredited as a psychiatric facility; and operates under the jurisdiction of a State mental health authority. The manual further specifies guidelines in the event of ambiguity about a particular facility—for example, whether a general hospital psychiatric ward is considered a component of the hospital or an independent institution (USDHHS 1994).

<sup>5</sup> Over the years, there has been considerable debate about what other facilities fit the IMD definition. For example, some of that debate has focused on whether nursing homes can be designated as IMDs. According to a 1995 Supreme Court ruling, they can be if they meet the criteria (USDHHS 1992). The IMD exclusion has led to the growth of non-IMD facilities such as psychiatric facilities with 16 or fewer beds and psychiatric hospitals that have become affiliated with a general hospital to bypass the 50 percent rule, and to the shifting of persons with mental illness into non-IMD nursing homes (Administration for Children and Families 1999; OIG 2000).

terms “IMD” and “public psychiatric hospital” interchangeably. While the Centers for Medicare and Medicaid Services (CMS) has Federal regulatory authority over IMDs, it does not maintain a comprehensive list of existing IMDs but instead expects States to be self-policing in this area (personal communication, 12/11/01, M. Mullen at Center for Medicaid and State Operations (CMSO)). Consequently, the nationwide number of IMDs beyond those that are public psychiatric hospitals remains unknown.

## 2. *Deinstitutionalization and Public Psychiatric Hospitals*

Since the late 1960s, the Nation has seen a dramatic shift in the settings of care for persons with mental illness. Much of the shift resulted from a change in Federal policy during the mid-1960s, when policymakers were intent on moving people out of State psychiatric hospitals and into community-based programs. Important factors contributing to deinstitutionalization included the promotion of community care settings that developed with the passage of the Community Mental Health Centers Act of 1963; the creation of the Medicaid and Medicare programs in 1965, which provided funding for community-based mental health services; the introduction of psychotropic medications during the 1960s; and the growing patient-rights movement, including the development of patient-focused mental health law (Grob 2001; Gronfein 1985; Mechanic 1969). More recently, managed care has continued the move toward community-based treatment settings for persons with mental illness, as have legal rulings such as the Supreme Court decision *Olmstead v. L.C.* (Hogan

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1999; Perlin 2000; Ray and Oss 1993; White House 2002).<sup>6</sup>

The impact of these forces on public psychiatric hospitals over the years is striking. The number of public psychiatric hospitals declined by 26 percent between 1970 and 1998 (see Figure I.1). Despite substantial growth in the number of private psychiatric hospitals early in the same period, by 1992 these hospitals' numbers likewise began to decline. Between 1992 and 1998, the number of private facilities decreased by 27 percent. At least through 1998, however, the number of psychiatric units in general hospitals continued to grow, although at a much more moderate pace in recent years.

While the trends in the number of psychiatric hospitals by ownership type generally reflect the impact of shifts in mental health care settings, the effects are more dramatic in terms of changes in bed capacity (see Figure I.2). In 1970, the Nation counted more than 400,000 public psychiatric hospital beds, but by 1998, the number had decreased to just over 63,000, an 85 percent decline. During the same period, the number of private psychiatric hospital beds increased more than twofold, from just over 14,000 to more than 33,000. In addition, the number of psychiatric beds in general hospitals more than doubled, increasing from approximately 22,000 in 1970 to just over 54,000 by 1998.

In sum, public psychiatric hospitals represented the overwhelming majority of psychiatric hospital beds in 1970, but the picture

changed dramatically by 1998. The loss of nearly 350,000 public psychiatric hospital beds during this period was only partially offset by the combined increase in the number of private and general hospital psychiatric beds (approximately 50,000).

According to the National Association of State Mental Health Program Directors Research Institute (2000), the shrinkage in State psychiatric hospital capacity led to an escalation in the number of closures and consolidations of State psychiatric hospitals over the past decade.

## **B. Focus of This Report**

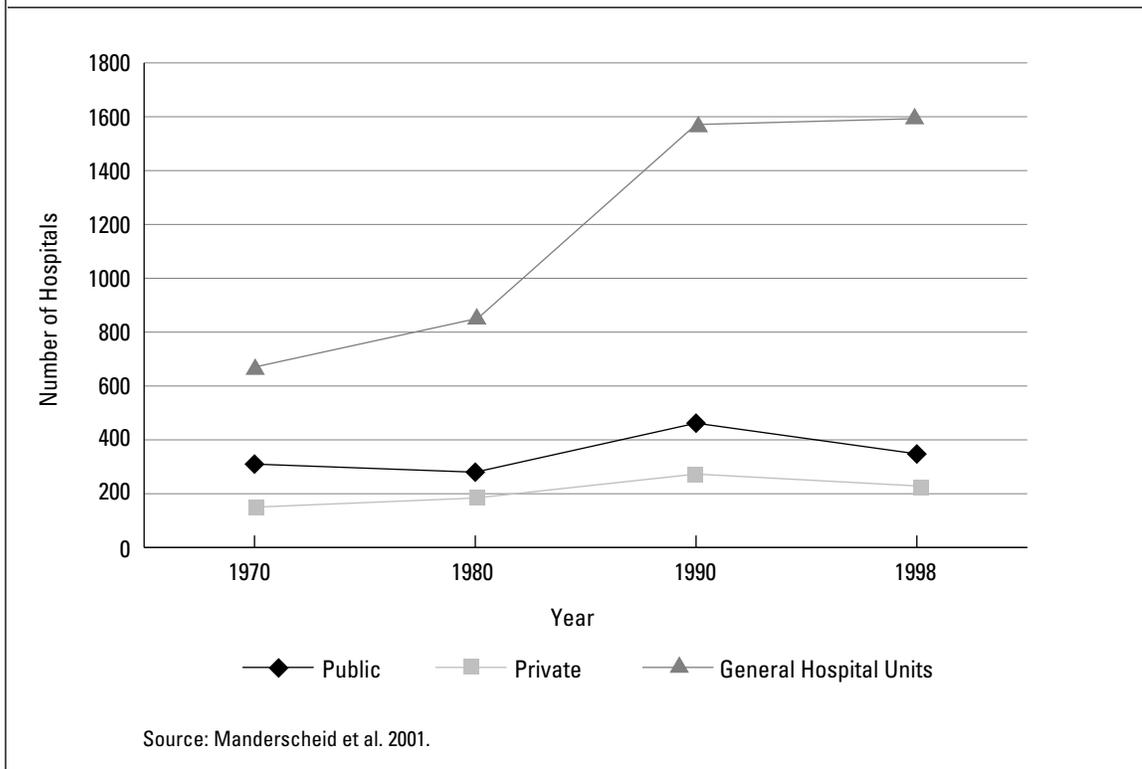
As the role of State and county psychiatric hospitals in public mental health systems has evolved, many people believe, incorrectly, that these institutions receive few, if any, Medicaid funds. This misperception may be bolstered by a general lack of information and data bearing on the issue. Although some research, for example, has looked at DSH payments to public psychiatric hospitals, the information on the overall share of facility funding represented by Medicaid is limited at best. Further, the available information is dated and does not reflect changes in Medicaid financing policies over the past 10 years.

The purpose of this report is to identify the sources of Medicaid funds that State and county psychiatric hospitals receive, changes in these sources over time, and the pressures and local circumstances that influence the Medicaid financing strategies that States pursue on behalf of these public institutions. In addition, the report updates previous estimates of the share of public psychiatric hospital operations financed by Medicaid. This information will help to gauge more accurately the effect of changes in Medicaid

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<sup>6</sup> The court ruled on the case in June 1999. It held that "in appropriate circumstances, the ADA [Americans with Disabilities Act] requires the placement of persons with disabilities in a community-integrated setting whenever possible" (White House 2002).

**Figure I.1: Number of Psychiatric Hospitals by Ownership Type, 1970–1998**



financing policies on these public institutions and the persons they serve.

### C. Study Methods

This report draws from a multifaceted study of State and county psychiatric hospitals. Specifically, information was collected from four sources:

- *Review of the literature.* The review focused on articles and other information discussing sources of and changes in Medicaid funds available to public psychiatric hospitals and the factors that have shaped the role of Medicaid involvement with these institutions.
- *Expert advisory panel.* The panel providing guidance to the project included representatives from State mental health authorities, State Medicaid agencies, mental health

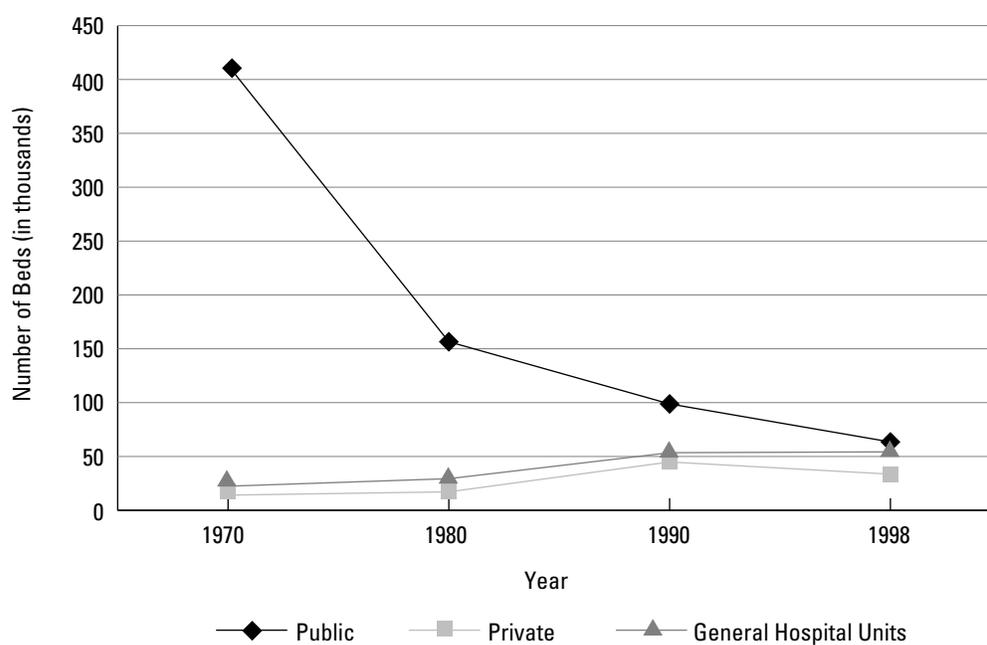
researchers, relevant national trade organizations, public consulting, and CMS.<sup>7</sup>

- *Case studies of five States.* The study team conducted site visits to five States: Arkansas, California, Iowa, Maryland, and New Jersey, selected for their broad range of demographic characteristics and Medicaid funding experiences.<sup>8</sup>

<sup>7</sup> Appendix A presents a list of the expert panel members.

<sup>8</sup> The characteristics considered in selecting States for inclusion in the case studies were (1) geographic location; (2) population size; (3) number of State psychiatric hospitals; (4) existence of county psychiatric hospitals; (5) IMD participation in the DSH program; (6) IMD optional services for the population under age 21 and/or the population age 65 and over; (7) Medicaid waivers with provisions for IMDs such as IMD expenditure authority; and (8) inclusion of public psychiatric hospitals in Medicaid managed care organizations' provider networks.

**Figure I.2: Number of Psychiatric Hospital Beds by Ownership Type, 1970–1998**



Source: Manderscheid et al. 2001.

- *Interviews with CMS regional office staff.*<sup>9</sup> Conducted by telephone, the interviews solicited the insights and perspectives of CMS regional office staff on the process of adding, terminating, or altering Medicaid financing strategy for a State’s public psychiatric hospitals.

#### **D. Organization of the Report**

The balance of this report examines the above issues more fully. Chapter II identifies and describes the sources of Medicaid funds that may be available to State and county

psychiatric hospitals. Chapter III examines the specific Medicaid funding experiences of these institutions in the five case study States and the local circumstances that may affect Medicaid financing strategies pursued by each State. Chapter IV reconciles earlier estimates of Medicaid’s contribution to the overall funding of public psychiatric hospitals with today’s situation. Finally, Chapter V draws overall conclusions and discusses pressures—such as States’ budget crises—that may affect future Medicaid financing of public psychiatric hospitals.

<sup>9</sup> CMS regional office staff who participated in interviews were those who work directly with the five case study States.



# Sources of Medicaid Funds for State and County Psychiatric Hospitals

Identifying and understanding Medicaid funding sources for public psychiatric hospitals is difficult because information about them is limited and because funds are used in complex ways. Although some sources of Medicaid funds have been available to State and county psychiatric hospitals under the State option for some time, the past decade has seen these facilities tap into new Medicaid funding streams, such as DSH payments. This chapter examines the different Medicaid funding streams available to State and county psychiatric hospitals.

## A. IMD Optional Services

Federal law requires that States provide certain basic services that are deemed medically necessary to Medicaid recipients. In addition, States may choose to provide certain optional services under their Medicaid plan as allowed by Federal regulations. Optional services must be offered consistently within a State without discrimination based on disease category or geographic location (Johns Hopkins AIDS Service 2003).

For IMDs such as State and county psychiatric hospitals to receive Medicaid reimbursement for inpatient services provided to persons under 21 years of age and/or to persons age 65 years and older, the State must choose specifically to cover these optional services under the State Medicaid plan. States, however, are not required to choose any of the IMD optional services, although most have

opted for them (see Table II.1).<sup>10</sup> Specifically, States may choose to provide the following:

- Coverage of inpatient hospital services under the direction of a physician for Medicaid-eligible individuals aged 65 and over in an IMD. Forty States and the District of Columbia cover this optional service.
- Nursing facility services for Medicaid-eligible individuals aged 65 and over in

<sup>10</sup> Whether services received by IMD residents outside the IMD are Medicaid-reimbursable has been the subject of considerable discussion between the States and the Federal government. The Federal Government recently conducted a series of audits through the Office of the Inspector General in which it found States improperly claiming Medicaid reimbursement for adult and child IMD residents temporarily released to receive care in acute care hospitals (OIG 1995, 2001a, 2001b, 2001c); however, some States have resisted such an interpretation.

Table II.1: IMD Optional Services by State

State	<i>Under 21<sup>a</sup></i>			<i>65 Years and Older</i>			State	<i>Under 21<sup>a</sup></i>			<i>65 Years and Older</i>		
	<i>Inpatient Psychiatric</i>	<i>Inpatient Hospital</i>	<i>Nursing Services</i>	<i>Inpatient Psychiatric</i>	<i>Inpatient Hospital</i>	<i>Nursing Services</i>		<i>Inpatient Psychiatric</i>	<i>Inpatient Hospital</i>	<i>Nursing Services</i>	<i>Inpatient Psychiatric</i>	<i>Inpatient Hospital</i>	<i>Nursing Services</i>
Alabama	X	X	X				Missouri	X	X				
Alaska	X	X					Montana	X	X			X	
Arizona	X	X	X				Nebraska	X	X			X	
Arkansas	X						Nevada	X	X			X	
California	X	X	X				New Hampshire	X	X			X	
Colorado	X	X	X				New Jersey	X	X			X	
Connecticut	X	X	X				New Mexico					X	
Delaware		X	X				New York	X	X				
District of Columbia	X	X	X				North Carolina	X	X			X	
Florida		X					North Dakota	X	X				
Georgia							Ohio	X	X			X	
Hawaii							Oklahoma	X	X				
Idaho	X		X				Oregon	X	X				
Illinois	X	X	X				Pennsylvania	X	X			X	
Indiana	X	X					Rhode Island	X	X			X	
Iowa	X	X	X				South Carolina					X	
Kansas	X	X	X				South Dakota					X	
Kentucky	X	X	X				Tennessee	X	X			X	
Louisiana	X	X					Texas						
Maine	X	X					Utah	X	X			X	
Maryland	X	X	X				Vermont	X	X			X	
Massachusetts	X	X	X				Virginia		X			X	
Michigan	X	X	X				Washington	X	X			X	
Minnesota	X	X	X				West Virginia						
Mississippi	X						Wisconsin	X	X			X	
							Wyoming		X				

Source: Medicaid State Plan Summaries (Commerce Clearing House, Inc. 2001).

Notes: The number of States and the District of Columbia choosing IMD optional coverage for the under-21 population = 40; the number of States and the District of Columbia choosing optional coverage for inpatient hospital services for IMD residents 65 years and older = 41; and the number of States and the District of Columbia choosing optional coverage for nursing facility services for IMD residents 65 years and older = 34.

<sup>a</sup>The definition of the "under-21" group varies slightly by State; some States cover those through age 21, others cover those strictly under the age of 21, and still others cover those aged 22 if they are hospitalized on their 21st birthday (Center for Health Services Research and Policy 2001).

an IMD. This option includes nursing services provided in nursing homes that meet IMD requirements. Nursing services must be needed on a daily basis and be provided on an inpatient basis. Thirty-three States and the District of Columbia cover this optional service.

- Coverage of inpatient psychiatric care only for Medicaid-eligible IMD residents under age 21. In order to qualify for Medicaid reimbursement, the inpatient psychiatric services must be provided under the direction of a physician and also must be pro-

vided in a psychiatric hospital, inpatient psychiatric program in a hospital, or other psychiatric facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or another accrediting organization. Thirty-nine States and the District of Columbia cover this optional service (CMS 2002b).

## B. Medicaid Managed Care

The advent of Medicaid managed care has led to the creation of new funding opportunities for IMD services. States may request a

waiver from the Federal Government in order to operate a specific kind of program (CMS 2002a). Medicaid waivers often are used to authorize managed care or alternative delivery or reimbursement systems. States may obtain two distinct types of Medicaid waivers to implement managed care in their Medicaid programs. Both types—Section 1915(b) and Section 1115—fall under the purview of Title XIX of the Social Security Act.

More recently, the Balanced Budget Act of 1997 gave States the option of amending their State plans to require Medicaid beneficiaries' enrollment in managed care. This option allows States to forgo the waiver as long as certain exempted populations, such as supplemental security income (SSI) populations and children with special health care needs, are not required to enroll. If there is mandatory enrollment for exempted populations, a waiver is still required (*Federal Register* 2001c).

There are three ways in which States can use managed care programs to pay for IMD services. First, States can pay for IMD services with savings generated from Medicaid managed care programs. Second, States can indirectly pay for IMD services in State and county psychiatric hospitals if those hospitals participate in the provider networks of BHOs that contract with the State's Medicaid program. Third, States can obtain IMD expenditure authority through an 1115 Medicaid waiver.

### 1. *Paying for IMD Services Through Savings*

Section 1915(b) waivers, known also as freedom-of-choice waivers, permit States to bypass certain provisions of the Medicaid law and require beneficiaries to enroll in managed care. CMS requires that 1915(b) waiver programs cannot negatively affect beneficiary

access or quality of care of services, and cannot cost more than what the Medicaid program would have cost without the waiver. The waiver programs are approved for 2 years and may be renewed if the State applies (CMS 2002a). The 1915(b) waiver permits States to use cost savings to provide additional services to existing Medicaid-eligible beneficiaries. This waiver does not grant "IMD expenditure authority." That is, it does not give States the authority to reimburse IMDs directly for inpatient services provided to adults (CMS 2002a; personal communication, 11/14/01, R. Rhodes at CMSO). However, given that States are allowed to use any savings generated from managed care to provide additional services to Medicaid beneficiaries, States technically can use the savings to pay for inpatient services provided to adults in IMDs.

### 2. *Inclusion of Public Psychiatric Hospitals in BHO Provider Networks*

Medicaid dollars may filter through to IMDs indirectly if the facilities participate in the provider networks of behavioral health organizations (BHOs) that contract with a State's Medicaid program. The inclusion of State and county psychiatric hospitals in such a network may be a State requirement, as in Hawaii and Iowa (see Table II.2); however, these hospitals may also be included at the discretion of the BHOs themselves.<sup>11</sup>

<sup>11</sup> Members of the expert panel confirmed that if inpatient hospital services are included in the State's capitation payment to BHOs, then these organizations could potentially purchase services from public facilities such as State and county psychiatric hospitals.

### 3. Section 1115 Waiver IMD Expenditure Authority

Section 1115 waivers, also referred to as research and demonstration waivers, allow States to carry out experiments to test new approaches to benefit design, service organization, delivery, and financing as well as eligibility. In fact, States often use the waivers to expand coverage to the uninsured (Health Care Financing Administration (HCFA) 1997; Physician Payment Review Commission 1995, 1996; Rotwein et al. 1995). Section 1115 waiver projects are typically approved to operate for a 5-year period and must be budget

neutral over the life of the project (CMS 2003). The flexibility of the waivers has encouraged some States to incorporate IMD services into their Medicaid managed care programs by obtaining IMD expenditure authority (see Table II.2). Eight States currently have 1115 waivers with IMD expenditure authority.

Depending on the State, the IMD expenditure authority may not extend to all IMDs in the State but rather to a designated group, such as private freestanding psychiatric hospitals. In other words, just because a State has IMD expenditure authority does not necessarily mean that such authority

**Table II.2: 1915(b) and 1115 Waiver Provisions Affecting IMDs**

<i>State</i>	<i>Type of Waiver</i>	<i>Description of IMD Provisions</i>
Arizona	1115	Medicaid coverage of all Medicaid-eligible adults at all IMDs; coverage up to 30 days per episode; aggregate annual limit of 60 days
Delaware	1115	Medicaid coverage of all Medicaid-eligible adults at all IMDs; coverage up to 30 days per episode; aggregate annual limit of 60 days
Hawaii	1915(b)	Mandates State psychiatric hospital inclusion in Medicaid managed care networks
Iowa	1915(b)	Mandates State psychiatric hospital inclusion in Medicaid managed care networks
Maryland	1115	Medicaid coverage of only Temporary Cash Assistance (TCA) adults at all IMDs <sup>a</sup> ; coverage up to 30 days per episode; aggregate annual limit of 60 days
Massachusetts	1115	Medicaid coverage of all Medicaid-eligible adults at all IMDs; coverage up to 30 days per episode; aggregate annual limit of 60 days
Oregon	1115	Medicaid coverage of all Medicaid-eligible adults only at Eastern Oregon Psychiatric Center (a private facility); coverage up to 30 days per episode; aggregate annual limit of 60 days
Rhode Island	1115	Medicaid coverage of all Medicaid-eligible adults only at Butler Hospital (a private facility); no limits
Tennessee	1115	Medicaid coverage of all Medicaid-eligible adults at all IMDs; coverage up to 30 days per episode; aggregate annual limit of 60 days
Vermont	1115	Medicaid coverage of all Medicaid-eligible adults at all IMDs; coverage up to 30 days per episode; aggregate annual limit of 60 days

Source: Compiled from the Center for Health Services Research and Policy (2001) and information from various State project officers in the Division of Integrated Health Systems, Family and Children's Health Program Group, CMSO.

<sup>a</sup>The Temporary Assistance for Needy Families (TANF) program in Maryland is known as Temporary Cash Assistance (TCA).

applies to State and county psychiatric hospitals. Furthermore, all IMD expenditure authority States except Rhode Island impose a 30-day limit per episode and a 60-day annual limit for inpatient mental health services; the coverage is intended to treat IMDs as acute care facilities for new admissions rather than as long-term care facilities (Center for Health Services Research and Policy 2001; personal communications, 11/19/01, various State project officers at CMSO).

States have not actively pursued Section 1115 waivers as a vehicle for receiving IMD expenditure authority. In fact, most of the existing waivers were approved during the mid-1990s, and States have demonstrated little activity recently in the pursuit of these waivers (personal communication, 11/19/02, M. Fiori at CMSO). **CMS reports that as the Section 1115 waivers with IMD expenditure authority expire, this authority will not be renewed (Peltz 2002).**

### **C. Disproportionate Share Hospital Payments**

For many State and county psychiatric hospitals, Medicaid's DSH program is a major funding source. The intent of the DSH program is to provide supplemental payments to hospitals that render care to a large volume of indigent patients; these facilities are often unable to generate revenues sufficient to cover their uncompensated care costs because they do not serve enough privately insured patients and because Medicaid reimbursement is low (Coughlin and Liska 1997). Subject to some minimal Federal requirements, the States have substantial discretion in setting the criteria for hospitals' eligibility for DSH payments, and the criteria almost always encompass both public and

private psychiatric hospitals.<sup>12</sup> Over a short period, the size of the DSH program increased dramatically, rising from a total of \$1.4 billion in payments with 6 participating States in 1990 to \$17.5 billion with 39 participating States by 1992 (Coughlin and Liska 1997). In 2001, the size of the DSH program was reportedly \$15.9 billion, with 47 States and the District of Columbia participating (CMS-64 Files 1991–2001).

Most State and county psychiatric hospitals far exceed minimum requirements for DSH payments to hospitals. In the early 1990s, amid State budget shortfalls and expansions in Medicaid eligibility, States began using DSH for their IMDs (Coughlin and Liska 1997; Coughlin et al. 1994).<sup>13</sup> The DSH program gave States the opportunity to obtain additional Federal dollars, subject to the Federal match.<sup>14</sup> Yet, owing to Federal restrictions on the use of DSH monies, many States turned to intergovernmental transfers (IGTs)—monetary transfers within or across different levels of government—to revert DSH funds back to State general treasuries

<sup>12</sup> According to the U.S. General Accounting Office (1998), “[H]ospitals must receive DSH payments if their Medicaid utilization rate is at least one standard deviation greater than the average for hospitals participating in Medicaid or if their low-income utilization exceeds 25 percent...[and] [s]tates may designate other hospitals to receive DSH funding if the hospital’s Medicaid utilization rate is at least 1 percent of its total bed days.”

<sup>13</sup> The Federal Government consistently has used the term “IMD” in relation to DSH program participation; however, evidence indicates that the “IMDs” participating in the DSH appear to be only psychiatric hospitals under State, county, and/or private ownership (CMS Medicaid DSH Files 1998–2000; Coughlin, Ku, and Kim 2000).

<sup>14</sup> The Federal match applies to qualified State Medicaid expenditures, with the current matching rates ranging from 50 percent for the “richest” States up to 76 percent for the “poorest” States (*Federal Register* 2000a).

or to fund other, sometimes non-Medicaid, services (Coughlin and Liska 1997; OIG 2001d; USGAO 1994, 1998, 2000, 2001). An expanded discussion of how IGTs are used within a DSH program can be found in Appendix B.

Typically, data do not break down Medicaid funding source by type of provider. The one exception, is DSH receipts, which offer data on the extent of DSH funds paid on behalf of public psychiatric hospitals in 1998 (see Table II.3). Nonetheless, the data

**Table II.3: State DSH Allocations by Psychiatric Hospital Ownership, FY 1998**

State	Total DSH for State	Percent DSH to IMDs	IMD DSH	Ownership Type	
				Private	Public
Alabama <sup>a</sup>	\$394,719,037	1.4	\$5,445,255	\$ —	\$5,445,255
Alaska	12,688,347	100.0	12,688,347	—	12,688,347
Arizona	122,347,000	—	—	—	—
Arkansas	1,656,113	28.2	466,593	466,593	—
California	442,104,105	0.5	2,155,189	—	2,155,189
Connecticut	370,130,366	27.9	103,267,503	103,267,503	—
Delaware	3,534,500	100.0	3,534,500	—	3,534,500
District of Columbia	32,857,143	—	—	—	—
Florida <sup>a</sup>	370,754,045	26.8	99,347,719	34,958	99,312,761
Idaho	1,436,990	—	—	—	—
Indiana	116,439,213	64.5	75,117,785	—	75,117,785
Iowa	19,837,652	93.5	18,540,540	1,817	18,538,723
Kansas	43,392,800	86.2	37,406,858	—	37,406,858
Kentucky	194,685,251	—	—	—	—
Louisiana <sup>a</sup>	734,339,152	0.1	452,364	452,364	—
Maryland	143,283,966	70.8	101,452,469	—	101,452,469
Massachusetts	548,500,577	18.9	103,700,000	—	103,700,000
Maine <sup>a</sup>	71,392,621	—	—	—	—
Minnesota <sup>a</sup>	56,382,060	17.5	9,885,420	—	9,885,420
Missouri	666,056,964	1.3	8,989,089	8,333,767	655,322
Montana	220,052	—	—	—	—
Nevada	73,560,000	—	—	—	—
New Hampshire <sup>a</sup>	103,411,171	—	—	—	—
New Mexico	6,886,109	0.9	60,914	60,914	—
North Carolina	338,800,136	49.1	166,276,389	42,336	166,234,053
North Dakota	1,194,829	83.6	998,478	—	998,478
Oklahoma	22,691,824	14.2	3,221,641	311,823	2,909,818
Oregon	28,234,851	66.9	18,889,988	—	18,889,988
Pennsylvania	40,955,369	—	—	—	—
Rhode Island	55,985,977	0.1	38,558	38,558	—
South Carolina	433,786,686	8.5	36,981,675	868,472	36,113,203
Utah	72,810,270	12.9	9,363,448	—	9,363,448
Vermont	29,071,994	31.1	9,039,342	—	9,039,342
Virginia	160,677,775	—	—	—	—
Washington <sup>a</sup>	330,274,439	31.7	104,656,857	30,355	104,626,502
West Virginia	82,222,530	21.5	17,704,657	—	17,704,657
Wisconsin	11,177,730	24.8	2,775,257	88,076	2,687,181
Wyoming	67,001	—	—	—	—

Source: Compiled from CMS Medicaid DSH files by state, the Knowledge Exchange Network (KEN), NASMHPD State psychiatric hospital database, and various Web sites.

Notes: California, Indiana and Louisiana use State fiscal year 1998; Minnesota uses calendar year 1997. States not included in the list are “no report.” Some of these States have no State DSH payments, while others are still reconciling their accounts. The information reflects combined Federal and State DSH payments.

<sup>a</sup> These States did not identify hospital type and/or ownership. In this case, KEN was used to identify psychiatric hospitals, while the NASMHPD database and various hospital or State Web sites were used to derive ownership. If ownership was still unclear, then private ownership was assumed.

do not indicate which States are using IGTs or, for those that do use IGTs, the uses to which the States allocate the funds.<sup>15</sup>

Federal concerns about the dramatic rise in DSH spending prompted Congress to pass a statute designed to curb DSH expenditure growth. Legislation enacted during the early 1990s created State-specific Medicaid DSH allocations that limited expenditures to 1992 levels for “high-DSH” States and allowed

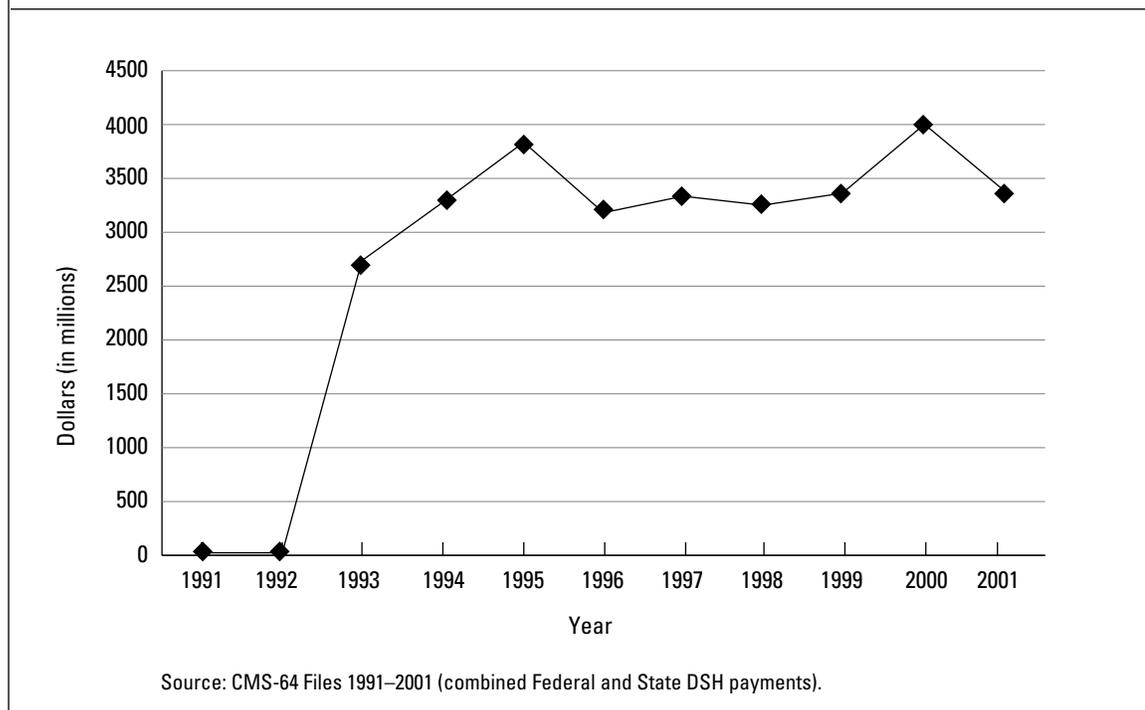
growth in proportion to State Medicaid spending based on 1992 levels for “low-DSH” States.<sup>16</sup> The Omnibus Budget Reconciliation Act of 1993 (OBRA) introduced further restrictions that created facility-specific caps, under which total DSH payments to a provider could be no more than the total non-reimbursed costs of providing inpatient care to Medicaid and uninsured patients (Coughlin and Liska 1997; National Association of Public Hospitals and Health Systems 2001a).

More recent legislation has curtailed overall State DSH spending still further by specifically focusing on IMD DSH in light of the rapid escalation in payments during the early to mid-1990s (see Figure II.1). The Balanced Budget Act of 1997 (BBA) specified State-

<sup>15</sup> Coughlin et al. (2000) attempt to estimate where DSH funds end up by using State surveys on revenue and expenditures for their DSH programs overall. Across the 40 responding States, the researchers found that the total gain to States and hospitals through the DSH program was \$8 billion, \$2 billion of which went to State hospitals, \$1.2 billion of which States retained in residual funds, and the remainder of which went to non-State hospitals. However, the estimates aggregate both psychiatric and acute care hospitals and cannot distinguish whether the \$2 billion to State hospitals funded services or was offset by lower appropriations from the State budget.

<sup>16</sup> “High-DSH” States were those whose DSH payments exceeded 12 percent or more of their total Medicaid expenditures; “low-DSH” States were those with less than 12 percent (Coughlin and Liska 1997).

**Figure II.1: Total IMD DSH (including public and private IMD payments), 1991–2000**



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by-State allocations for fiscal years 1998 through 2002 in which the amounts were to remain fixed or to decrease over the period. For IMDs, each State could spend no more on DSH for these facilities than it did in fiscal year 1995, either in absolute dollars or as a percentage of total State DSH spending.

The BBA placed specific restrictions on those States that spent more than half of their DSH allocation on IMDs, limiting future IMD DSH expenditures as a percentage of total DSH to 50 percent in fiscal year 2001, 40 percent in fiscal year 2002, and 33 percent thereafter (HCFA 1997; National Association of Public Hospitals and Health Systems 2001a; National Association of State Mental Health Program Directors 2001b, 2001c). Temporary relief came from the Beneficiary Improvement and Protection Act of 2000 (BIPA), which allowed State DSH allocations to increase by the Consumer Price Index for fiscal years 2001 and 2002. Consequently, IMD DSH payments were not subject to the 50 percent limit imposed by the BBA for 2001 and continued to represent a substantial portion of the total DSH payments in many States in that year (see Table II.4). In fiscal year 2003, however, the allocations reverted to the level specified in the BBA (HCFA 2001; NAPH 2001a). Using 2001 data on DSH, it appears the BBA's 33 percent IMD cap affects 15 States in 2003.<sup>17</sup>

Florida is one of the States affected by the BBA IMD caps. A 2000 audit report by the Florida Office of Program Policy Analysis and Government Accountability anticipated that the State would lose \$29.6 million, or

almost 11 percent of the State's budget for mental health institutions, as a result of IMD caps in the DSH program. To offset the loss, the State chose to close down a State mental hospital by moving patients to other hospitals or into community treatment settings. All patient transfers were completed for this hospital on February 8, 2002 (Florida Department of Children and Families 2003).

While the BBA has placed limits on the amount of DSH paid on behalf of IMDs, this source of funds is likely to continue to contribute a significant portion of the overall Medicaid funding that States receive. It is expected that States pursuing this funding strategy will continue to seek DSH funds on behalf of their public psychiatric hospitals to the extent possible under the law.

#### **D. Administrative Payments**

While Federal regulations allow States to be reimbursed for the costs necessary to administer their Medicaid programs, the intent of the regulations becomes less clear when administrative costs are associated with IMD residents. The reason stems largely from the IMD exclusion that prohibits Medicaid reimbursement for most IMD services. Given, however, that the IMD exclusion applies only to services, it does not preclude the use of Medicaid funds for administrative costs related to Medicaid-eligible IMD residents (USDHHS 1992). A 1992 USDHHS Report to Congress clarified that IMD residents' Medicaid eligibility allows them to receive applicable administrative services, even though no Federal financial participation is available for treatment services.

Several different types of Medicaid administrative services are eligible for Federal financial participation (FFP). FFP is available for direct program management; costs incurred

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<sup>17</sup>The 15 States, according to Table II.4, are Alaska, Delaware, Florida, Kansas, Maine, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oregon, Pennsylvania, South Dakota, and Washington.

**Table II.4: IMD DSH Payments by State (including public and private IMD Payments),<sup>a</sup> 2001**

<b>State</b>	<b>Mental Health DSH Payments</b>	<b>Mental Health DSH Payments as % of Total DSH Payments</b>
Alabama	\$3,301,620	0.9
Alaska	9,086,653	65.0
Arizona	28,474,900	27.7
Arkansas	862,932	3.8
California	0	0.0
Colorado	23,144	0.0
Connecticut	9,499,186	4.5
Delaware	4,140,000	100.0
District of Columbia	3,845,809	4.7
Florida	149,714,986	44.2
Georgia	0	0.0
Hawaii	0	— <sup>b</sup>
Idaho	0	— <sup>b</sup>
Illinois	114,957,399	30.3
Indiana	141,698,773	21.6
Iowa	0	0.0
Kansas	36,315,789	77.3
Kentucky	36,470,274	19.1
Louisiana	77,400,268	8.9
Maine	49,160,020	100.0
Maryland	31,443,762	50.1
Massachusetts	102,999,998	21.2
Michigan	214,684,937	49.7
Minnesota	2,806,270	4.4
Mississippi	0	0.0
Missouri	176,489,923	38.8
Montana	0	0.0
Nebraska	0	0.0
Nevada	0	0.0
New Hampshire	27,631,468	17.5
New Jersey	412,820,368	36.5
New Mexico	229,258	1.5
New York	574,400,000	23.4
North Carolina	174,935,077	42.1
North Dakota	601,485	56.7
Ohio	93,432,758	14.7
Oklahoma	1,320,022	5.8
Oregon	17,242,348	56.5
Pennsylvania	399,730,333	52.5
Rhode Island	1,576,714	2.0
South Carolina	51,251,895	13.8
South Dakota	751,298	70.0
Tennessee	0	— <sup>b</sup>
Texas	234,740,519	17.4
Utah	181,503	25.0
Vermont	0	0
Virginia	1,752,745	0.7
Washington	115,310,820	35.2
West Virginia	23,300,694	22.8
Wisconsin	3,341,469	28.2
Wyoming	0	0

Source: CMS-64 Files 1991–2001 (Combined Federal and State DSH payments).

<sup>a</sup>Includes all Mental Health DSH payments, not just payments to State and county psychiatric hospitals. The data do not provide this level of specificity.

<sup>b</sup>No DSH payments to the State.

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in the design, maintenance, and operation of automated systems; and the processing of Medicaid applications, appeals, and general information to the public about the program. In addition to services eligible for FFP, Federal policy defines other IMD services that can be claimed as necessary to manage a State's Medicaid program. Those services include monitoring of certain medications and administrative case management (including assessment, care planning, and referrals and linkages to other programs and providers).

Currently, only a few States receive administrative payments on behalf of IMD residents. In one State, for example, the State Medicaid Authority, as the lead agency responsible for the largest percentage of IMD facilities, claims activities and costs associated with the administration of the Medicaid hospital and nursing home system. This State does not segregate the IMD facilities from its total claim. In two other States, the State Mental Health Authority claims the Federal match for the costs of administrative services related to maintaining Medicaid eligibility, conducting disability assessments, and preparing predischarge benefits applications for IMD residents. Although the staff doing the reimbursable work is located in the State's public hospitals, it is actually assigned to a central administrative unit within the Mental Health Authority. Also, since the staff conducting the work performs these adminis-

trative tasks exclusively, cost identification and claiming are rather straightforward. These indirect costs are separated out from the facilities' cost reports.

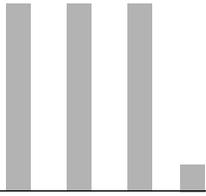
## **E. Conclusion**

Several sources of Medicaid funds—including those from DSH payments, IMD optional services, Medicaid managed care, and administrative payments—are available to State and county psychiatric hospitals.<sup>18</sup> However, the pursuit of each of these funding sources varies considerably from State to State as dictated by local circumstances. Even among States that avail themselves of the same sources of Medicaid funds, methods and amounts differ significantly. A good example is the disparate approaches to the use of DSH payments for IMDs.

The existing information is suggestive but insufficient to provide an understanding of the overall financial impact of Medicaid funding on State and county psychiatric hospitals, both in individual States and nationally. In addition, it offers little insight into why States vary in their pursuit of funding sources for their public psychiatric hospitals or into the factors that influence their decisions. Through case studies, the next chapter examines the Medicaid funding experiences of public psychiatric hospitals in five States—Arkansas, California, Iowa, Maryland, and New Jersey—and begins to piece together some of the missing information.

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<sup>18</sup>The use of enhanced payment programs for public psychiatric hospitals was also explored. Although some of the States have used upper payment limit arrangements for general hospitals and/or nursing homes, none were found to be using these arrangements for their public psychiatric hospitals.



# Medicaid Funding of State and County Psychiatric Hospitals in Five States

**W**hile States may take advantage of several Medicaid funding strategies to help support their public psychiatric hospitals, they nonetheless face unique local circumstances that dictate variation in the Medicaid policies they follow. This review of five case study States—Arkansas, California, Iowa, Maryland, and New Jersey—reveals which Medicaid strategies are most common and significant and examines the role of public psychiatric hospitals in the five States and the funding strategies used to support such hospitals.<sup>19</sup>

## **A. The Role of Public Psychiatric Hospitals in States' Public Mental Health Systems**

The public mental health system, including the availability of and State preference for treatment settings, differs among the five case study States. The role and place of public psychiatric hospitals in a State's continuum of mental health care influence the Medicaid financing strategies States pursue on behalf of these facilities. In some States, State psychiatric hospitals, operating largely outside the overall treatment continuum, serve limited

niche populations: the hardest to serve, most chronically ill patients. In other States, these public hospitals are a major component of the overall public mental health care system, serving both short- and long-term patients.

### *1. Arkansas*

In contrast to the other four States, Arkansas operates only one public psychiatric hospital. With several hospital closures in recent years, the number of beds in the private sector, including both freestanding psychiatric hospitals and psychiatric units within general hospitals, has decreased sharply. Consequently, demand for the State psychiatric hospital's services from both the forensic and civil populations has escalated. The lack of alternative treatment settings has created a 100-person waiting list for forensic beds and a 40-person waiting list for civil beds.

<sup>19</sup> Appendix C contains profiles of the public psychiatric hospitals in the case study States, including the role played within the public mental health system, the hospital admission process, operational changes in recent years, and expected changes at the time of the site visits.

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## 2. *California*

In California, the State's 58 counties are responsible for public mental health services, including services for Medicaid-eligibles. The counties are at risk for mental health services for their residents, and they control how mental health dollars are spent. When a county needs to place a resident in a State facility, it pays a predetermined per diem rate. Counties use the State psychiatric hospitals only as a last resort, mostly to treat the hardest to serve, most chronically ill civil patients. This is due to the high cost of State facilities, their long distance from many communities, and the fact that the State hospitals primarily serve forensic patients. California's State psychiatric hospitals receive a small share of their operating budgets from Medicaid, with those Medicaid dollars generally intended for civilly committed patients 65 years and older and 21 years and younger, both noticeably small groups.

California's system of psychiatric health facilities (PHFs) (both publicly and privately owned), along with psychiatric units in general hospitals and freestanding psychiatric hospitals, serve local needs for acute inpatient psychiatric treatment. The length of stay in PHFs is typically short—5 to 7 days. Most PHFs can collect Medicaid reimbursement for persons from 22 to 64 years of age because the hospitals are small enough—16 beds or fewer—to avoid the IMD exclusion. PHFs often receive more Medicaid dollars for services, as a percentage of total budgets, than do the State hospitals.

## 3. *Iowa*

Iowa's four State psychiatric hospitals, an integral part of the State's public mental health system, primarily serve short-term patients (shorter than 30-day stays). Among

the five case study States, Iowa's State psychiatric hospitals are the only ones that admit voluntary patients; patients do not have to meet the more rigorous commitment requirements of posing an imminent danger to themselves or others.

Medicaid-eligible, voluntarily admitted adults and all Medicaid-eligible child patients receive services through the State's Medicaid managed behavioral health care plan, known as the Iowa Plan.<sup>20</sup> Given that the State hospitals accommodate voluntary patients for short stays, the State requires the behavioral health organization that holds its Medicaid contract to include these hospitals in its provider network, thereby allowing the hospitals to secure some Medicaid funding for patients between the ages of 22 and 64 years. For patients in that age range who are involuntarily committed, the State and counties share the costs of care in the State hospitals, with the State paying 80 percent of the per diem and the county of residence paying the remaining 20 percent plus any costs of care beyond that covered by the per diem rate. If county residency is not established, the State pays 100 percent of costs.<sup>21</sup> In addition, once a Medicaid-eligible child's commitment is decertified by the State's managed behavioral health care plan, the State is responsible for 100 percent of costs.

## 4. *Maryland*

Maryland has a Section 1115 waiver that grants the State IMD expenditure authority; however, the State excludes State psychiatric

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<sup>20</sup> Services for children admitted through the criminal justice system are not reimbursed through Medicaid.

<sup>21</sup> The State is responsible when the patient cannot establish "legal settlement" in a county. Legal settlement is established when a resident has lived in a county for 12 or more months.

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hospitals from the IMD waiver provision. It prefers to have short-term patients (those with 30-day or shorter stays) served in private facilities so that the State psychiatric hospitals can remain the treatment setting of last resort. As a consequence, State psychiatric hospitals forgo some Medicaid funds that they might otherwise receive. Like many other States, Maryland has focused on reducing its State psychiatric hospital population and redirecting patients to community-based programs.

### 5. *New Jersey*

New Jersey also has a policy to reserve its State and county psychiatric hospitals for longer-term patients. However, instead of using a Section 1115 waiver as Maryland does, New Jersey set up a system of short-term-care facilities, which are psychiatric units within general hospitals, for stays of up to 2 weeks. The short-term-care facilities are not State or county owned but instead are private facilities which the State formally designates and to which it provides some financial support.

New Jersey has also set up a statewide structured admissions process under which all individuals admitted to a public psychiatric hospital or a short-term-care facility must undergo evaluation by a county screening center. The centers, funded through the State's Division of Mental Health Services (DMHS), try to place individuals meeting the involuntary admission criteria in the least restrictive setting, preferably the local short-term-care facility. The direction of patients into short-term-care facilities allows Medicaid reimbursement for psychiatric services because the facilities do not meet the criteria that make them subject to the IMD exclusion. Persons needing longer-term care are transferred to State or county psychiatric hospitals.

The county hospitals serve essentially the same clientele as the State hospitals in terms of length of stay and patient characteristics. However, county facilities serve mostly county residents, whereas the geographic service area of the State psychiatric hospitals is much broader. Another difference is that the State hospitals have a larger forensic population.<sup>22</sup> The State psychiatric hospitals also operate some specialized programs that are not available at county facilities, including programs for children and the dually diagnosed (persons with developmental disabilities and mental illness). Both the short-term-care facilities and county hospitals alleviate some of the capacity pressure faced by the State psychiatric hospitals.

### **B. States as Primary Funders of State and County Psychiatric Hospitals**

Public psychiatric hospitals in the five case study States rely on State or county general funds as their main source of funding. State hospitals in three of the States—Iowa, Maryland, and New Jersey—are 100 percent State-appropriated; that is, the hospitals' entire operating budget comes from a State appropriation. All revenue collected from patients or insurers (including Medicaid) is turned over to the State general fund. One respondent suggested that in States where hospitals are 100 percent State-appropriated, an individual hospital might be relatively insulated from budget swings resulting from changes in revenue sources.

In California, the State and the counties together fund the State psychiatric hospitals: a State appropriation covers forensic patients, while counties, using funds they receive from

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<sup>22</sup> Only one of the county psychiatric hospitals accepts forensic patients.

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the State, pay a per diem rate for civilly committed patients.<sup>23</sup> Any revenues collected from private or public insurance for civilly committed patients are deposited into a fund that is used periodically to adjust (e.g., lower) the per diem rate that counties are charged. However, in California, State psychiatric hospitals receive little Medicaid funding because of the high proportion of forensic patients in the State system.

In Arkansas, the situation is different. A State appropriation covers about 90 percent of the single State hospital's operation, with the hospital at risk for funding the remainder of the budget. For example, the hospital's operating budget in the fiscal year beginning July 2001 is \$23.5 million. The State appropriation totaled \$21 million, meaning that the hospital is responsible for collecting the remaining \$2.5 million. In accordance with a sliding-fee scale, the hospital bills all patients, regardless of ability to pay, to cover its costs beyond the State appropriation.<sup>24</sup> If the hospital fails to collect from Medicaid or other payers, the State does not reimburse it for the lost collections.

Appropriations for State psychiatric hospitals in all five case study States have held steady or declined slightly in recent years. However, all five States were facing budget deficits at the time of the case study site visits, and, as a result, their public psychiatric hospitals were likewise in the throes of fiscal

challenges. In Arkansas, the State usually appropriates enough money to fund annual payroll increases, but there was no increase in fiscal year 2001. At the time of the case study site visit, the hospital was considering either closing its 16-bed adolescent unit or changing the intensity of the unit to a subacute level, a move that might open up new funding opportunities. Respondents in California did not believe that the State budget shortfalls would affect the State psychiatric hospitals; given that the hospitals treat primarily forensic patients, their capacity is a public safety priority. In Iowa, the budgets of the four State psychiatric hospitals had remained steady over the past 5 years but had seen some recent declines in response to the statewide budget shortfall. In Maryland, recent budget declines for the State psychiatric hospitals have led to delays in purchases, in hiring, and in the initiation of capital projects. Respondents in New Jersey were hopeful that, despite the State's budget deficit, the impact on its public psychiatric hospitals would not be significant.

California and New Jersey also operate county-owned psychiatric hospitals. Ten county-owned psychiatric units or hospital facilities in California provide 24-hour inpatient care.<sup>25</sup> PHFs, which have a special licensure and receive county appropriations, provide service intensity similar to acute psychiatric hospitals, but they lack an emergency room and other onsite ancillary services, such as laboratories. Because only two PHFs have more than 16 beds, most are not subject to the IMD exclusion. In New Jersey, the six county-operated psychiatric units or hospitals participate in a "90/10 program" for uninsured patients whereby the State pays 90 per-

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<sup>23</sup> Every county receives "realignment funds" from the State sales tax and vehicle license fee. It uses the funds to lease beds from the State psychiatric hospitals on an annual basis per expected need. If one of the county's beds is not needed, the county may sublease it to another county.

<sup>24</sup> The hospital is legally obligated to bill all patients, but few patients actually pay. The hospital does not use a collection agency, but the billing department performs a State income tax intercept in cases where the patient clearly has the ability to pay.

<sup>25</sup> The State also has six privately owned PHFs.

cent of the cost of care and the county pays 10 percent; if the patient is not a resident of any county, the State pays 100 percent. The “90/10 program” also applies to State psychiatric hospitals, in that counties support 10 percent of the costs in those hospitals for county residents.

### C. Sources of Medicaid Funds

Reliance on Medicaid revenues to fund State psychiatric hospital operations varies across the five States (see Table III.1).

#### 1. IMD Optional Services

**Persons under the age of 21.** Every case study State covers inpatient psychiatric services for persons under the age of 21, but not all public psychiatric hospitals accept patients in this age group. Most of the public psychiatric hospitals in the case study States no longer offer inpatient services to

children under 12; however, they do have some capacity to serve adolescents. Public psychiatric hospitals in Maryland stopped admitting children 5 or 6 years ago, and only two of them currently serve adolescents. The State directs children in need of inpatient psychiatric services—a covered group under Medicaid—to private hospitals. California and New Jersey each have one State psychiatric hospital serving children. In Arkansas, the State psychiatric hospital does not treat children but has 16 beds for adolescents and an additional 16 beds for juvenile sex offenders. In Iowa, two of the four State psychiatric hospitals specialize in treating children, although service capacity for children has recently shrunk.

Overall, children and adolescents make up a small share of the State psychiatric hospitals’ patient load (see Table III.2). Consequently, the amount of Medicaid funds collected for the population under age 21 is small.

**Table III.1. Revenues of State-Owned Psychiatric Hospitals by Source and Percentage of Total (in millions of dollars)**

State	Total Funding Amount	State Funding		Non-DSH Federal Medicaid Share		DSH Federal Medicaid Share		Medicare		Other Funding	
		Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total	Amount	Percentage of Total
Arkansas	\$ 23.5	\$ 20.8	88.5	\$ 0.5	2.1	\$ 0	0	\$ 0.8	3.4	\$ 1.4	6.0
California	575.0	555.0 <sup>a</sup>	96.6	7.5	1.3	0	0	12.2	2.1	0.3 <sup>b</sup>	0.0
Iowa	47.7	28.8	60.3	9.0	18.9	0	0	NA <sup>c</sup>	NA	9.9 <sup>c</sup>	20.8
Maryland	200.9	132.2	65.8	5.9	2.9	57.4	28.6	2.2	1.1	3.2	1.6
New Jersey	230.5	44.1	19.1	10.2	3.9	140.7	61.0	6.5	2.8	29.0	12.6

Source: Analysis of data collected from State mental health agencies during case study site visits.

Notes: Other funding includes revenue from self-pay patients, other insurers, counties, and leasing arrangements. Arkansas and Iowa data cover State fiscal year 2001; California data cover calendar year 2001; Maryland data cover State fiscal year 2001; and New Jersey data are projected for State fiscal year 2003. With recent funding relatively stable, the different time periods should not materially affect the comparability of the data.

<sup>a</sup>Represents State funding and “other payers” aside from Medicaid, Medicare, and third parties.

<sup>b</sup>Represents third-party revenues.

<sup>c</sup>NA: Not available separately. “Other Funding” includes Medicare revenue.

**Table III.2: Number and Percentage of Children/Adolescent and Geriatric Beds in the State Psychiatric Hospital Systems**

<i>State</i>	<i>Total Number of Beds in the State</i>	<i>Total Number of Beds for Children and Adolescents</i>	<i>Percentage of Beds for Children and Adolescents</i>	<i>Total Number of Geriatric Beds</i>	<i>Percentage of Beds for Geriatric Care</i>
Arkansas	202 <sup>a</sup>	32—all adolescent	15.8	NA	NA
California	4,984 <sup>b</sup>	140	2.8	NA	NA
Iowa	436 <sup>a</sup>	47	10.8	60	13.8
Maryland	1,319 <sup>a</sup>	30—all adolescent	2.3	42	3.2
New Jersey	2,080 <sup>a</sup>	50	2.4	323	15.5

Source: Interviews with representatives from mental health service authorities in the five case study States. Geriatric beds are psychiatric beds specifically designated for persons age 65 years and older.

NA: Not available indicates that the State does not operate a special program for geriatrics and therefore does not designate a certain number of civilly committed beds for such patients. In all States, some of the general population adult beds may also be used by persons 65 years and over.

<sup>a</sup> Number of staffed beds (number of beds that are operational).

<sup>b</sup> Number of licensed beds (number of beds the State has been granted the authority to operate, which may be higher than the actual number of staffed beds).

**Persons age 65 and older.** Four of the five case study States cover inpatient psychiatric services provided to patients 65 years and older as a Medicaid optional service. The exception is Arkansas. Representatives from the mental health division in Arkansas have initiated discussions with the Medicaid division about amending its State plan by 2004 to include individuals age 65 and over, but, at the time of the site visit, no final decision had been reached. Unlike the case with children, most State psychiatric hospitals do not restrict services for those over age 64. In fact, many offer a specialty in geriatric care. However, evidence from the case study site visits suggests that beds specifically designated for the elderly, like those for children, represent a relatively small share of State psychiatric hospitals' overall capacity (Table III.2). Providing further evidence, California's Department of Mental Health reported that as of June 30, 2001, 146 of the total 4,377 clients in the State hospitals, or 3.3 percent, were over 64 years of age (California Department of Mental Health 2002). Of those 146, only 36 were reported

as "county-billable," meaning even potentially Medicaid-eligible.

## 2. *Medicaid Managed Care*

Two States, Iowa and Maryland, use Federal waivers to obtain Medicaid funding for the nonelderly adult population that is typically disqualified from Medicaid reimbursement for certain services under the IMD exclusion. Iowa's Section 1915(b) waiver, known as the Iowa Plan, allows the State to take the savings generated from the use of managed care to provide services not otherwise covered under the State Medicaid plan, including inpatient services in State psychiatric hospitals. Medicaid largely funds the Iowa Plan for services provided to Medicaid-eligible persons. SAMHSA block grants and public health funds provide additional support for services provided to the indigent through the Iowa Plan.

Under the Iowa Plan, the State psychiatric hospitals become, by contract, part of the provider network of Medicaid's behavioral health care vendor, Magellan Behavioral Care of Iowa (formerly Merit). As long as

Magellan approves admissions and lengths of stay, the State psychiatric hospitals may be reimbursed for services provided to the voluntary (noncommitted) Medicaid-eligible adult population over 21 years of age and under 65 years of age and to Medicaid-eligible children, whether voluntary or involuntary.

According to a Magellan representative, in 2001, the State psychiatric hospitals received \$4.3 million through this arrangement.

Maryland has a Section 1115 waiver that carves out mental health services for all Medicaid-eligible persons, including children with severe emotional disturbance (SED) and adults with serious and persistent mental illness (SPMI). Under this waiver, which grants the State IMD expenditure authority, private psychiatric hospitals receive payment for 30 days per episode, up to 60 days per year, and 120 days in a lifetime for adult patients (ages 22 to 64). However, because the State hospitals are excluded from the waiver, they receive no Medicaid funds via the waiver program. The State psychiatric hospitals will admit patients when their Medicaid funding ends. Due to CMS's decision to eliminate IMD expenditure authority waivers, Maryland's IMD waiver program will likely end when it comes up for renewal. This change could potentially shift significant capacity pressure from the private psychiatric hospitals back onto the State hospitals, which already maintain waiting lists.

### *3. Disproportionate Share Hospital Payments*

Public psychiatric hospitals participate in DSH in three States—Arkansas, Maryland, and New Jersey. In Arkansas, the DSH funds are deposited into the hospital's account with the Department of Human Services for hospital-designated use. Because State psychiatric

hospitals in Maryland and New Jersey are 100 percent State appropriated, DSH funds are deposited directly into the State general fund. In Maryland, the State psychiatric hospitals receive a notification letter stating that the hospital has been "credited" with DSH funding, but it is unclear whether those DSH funds returned to the Maryland State treasury are set aside for a particular purpose. When DSH funding is returned to the State of New Jersey, the money is earmarked for a charity care fund and a hospital relief fund, a small portion (reportedly 10 percent) of which is set aside for psychiatric hospitals and allocated through the Division of Mental Health Services. In Maryland and New Jersey, the State appropriation is considered the State match for DSH. In Arkansas, the State psychiatric hospital funds the match.

**DSH payments to public psychiatric hospitals.** The amount of DSH funding public psychiatric hospitals receive varies considerably with the different DSH systems in each State, reflecting States' localized health systems and funding priorities.<sup>26</sup> For example, as part of an overall DSH funding increase for the State, the Arkansas State Hospital received DSH funds for the first time in fiscal year 2002. The Balanced Budget Act (BBA) of 1997 replaced the statutory formula for DSH with specified DSH amounts by State; Arkansas's share was \$2.7 million. In 2000, the Federal Benefits Improvement and Protection Act (BIPA) helped low-DSH States, such as Arkansas, by setting the minimum State DSH payment equal to 1 percent

<sup>26</sup>The amount of DSH funding public psychiatric hospitals receive also reflects, to some degree, the length of time the facilities have been participating in their State's DSH program. For example, public psychiatric hospitals in New Jersey have participated in the State's DSH program for many years.

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of total Medicaid expenditures (HCFA 2001; National Association of Public Hospitals and Health Systems 2001a). Arkansas's DSH funding rose to approximately \$21 million in 2002, and the State psychiatric hospital benefited.

Maryland has a unique system in which all insurers (Medicare, Medicaid, and private) pay the same amount for the same treatment at general hospitals. A commission sets rates so that payment for uninsured patients (charity care) is included. The general hospitals are then ineligible to participate in the DSH program because their rates already cover the costs of caring for indigent persons. As a result, only the public and private psychiatric hospitals, two chronic hospitals, and three specialty hospitals are eligible to participate in the State's DSH program. With so few hospitals eligible, Maryland has not been able to collect its full DSH share since 1999; however, the State always collects the maximum amount of funding available under the IMD DSH caps. In 2001, Maryland collected \$40 million in retroactive DSH payments. The State realized that it had been using an incorrect rate and was not collecting all of the funding for which it was eligible. Using the correct rates, the State will receive an additional \$14 million annually in DSH.

New Jersey has a minimum requirement—essentially a 1 percent Medicaid utilization rate—for hospitals to qualify for DSH. All State and county psychiatric hospitals are eligible to participate in DSH, and the maximum funds allowed under the IMD DSH cap are received on their behalf. The State claims DSH for all DSH-eligible expenditures in the county psychiatric hospitals; that revenue is also deposited into the State general fund.

One of the results of California's creation of a county-based public mental health system is that State psychiatric hospitals are not eligible to participate in the State DSH program. Given that the counties are responsible for indigent care—medical and mental health—the State has essentially passed the DSH program on to the counties. Counties and individual hospitals decide whether to claim DSH payments, and hospitals are eligible as long as they meet the State's minimum requirements. County-owned PHFs are potentially eligible to receive DSH funding, and a few have received minimal payments in the past. As one respondent noted, however, counties are more likely to spend DSH funds on general medical care. According to the California Department of Health Services, one publicly owned PHF received DSH payments totaling \$276,360 for fiscal year 1999–2000. Another county-owned PHF was eligible but did not receive any payments. In fiscal year 1998–1999, two county-owned PHFs received DSH payments totaling \$141,414 (California Department of Health Services 2000).

Public psychiatric hospitals in Iowa do not participate in DSH. In Iowa, DSH payments are made to general hospitals only—not to IMDs. The largest share of DSH funding (more than 60 percent) goes to the University of Iowa, and IGTs are reportedly used to move these funds from the university back to the State.

**IMD DSH caps.** Recent reductions in the IMD DSH caps will affect both Maryland and New Jersey over the next year. One Maryland respondent fears that, if the reductions lead to lower State appropriations, the quality of care provided by the State psychiatric hospitals may be jeopardized. Other respondents were not sure how, if

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at all, the new DSH caps would affect the hospitals. One New Jersey respondent did not expect the lower DSH caps to affect the State psychiatric hospitals because the facilities receive a State appropriation to cover all operating costs. For 2002, the Arkansas State psychiatric hospital received approximately half the IMD DSH cap for the State. Given that private freestanding psychiatric hospitals in Arkansas participate in the DSH program, they are also funded within the IMD DSH cap constraints.

**Relationship between DSH funds and State appropriations.** In Arkansas and Maryland, respondents suggested that there does not appear to be a direct relationship between the State appropriation and DSH collections. As one Maryland respondent notes, DSH historically has not affected State hospital appropriations. Another respondent agreed, noting that, while the State appropriation has decreased in each of the past 2 years, the decline is attributable to a statewide budget shortfall rather than to lower DSH revenues.

In contrast, New Jersey respondents say that there is a connection between DSH funds and the State appropriation. When the Department of Human Services (Division of Mental Health Services) submits a budget to the legislature, the department makes sure that legislators understand that the State will receive some DSH funds to offset the full 100 percent State appropriation. Respondents believe that the New Jersey legislature understands that if it cuts funding to the State psychiatric hospitals or the hospitals become decertified, the State will no longer have access to Federal DSH funds, at least not at the same level. The respondent says that in the early 1990s some county psychiatric hospitals sued the State for the

DSH money that the State claimed on their behalf. The court ruled that use of the money was at the discretion of the State legislature.

#### 4. *Administrative Payments*

None of the five States collect Medicaid funds related to administrative services provided on behalf of public psychiatric hospital patients. Most were not aware that these payments could be claimed.

#### **D. Conclusion**

While States fund a substantial portion of public psychiatric hospital operations, Medicaid also plays an important role. States tend to favor funding strategies related to DSH programs, IMD optional services, and Medicaid managed care rather than strategies involving reimbursement for administrative services.

Some of the case study States have pursued similar Medicaid funding strategies, but the effects of those strategies vary with the specifics of each State's public mental health care system. For example, all five States cover optional services for children under the age of 21, but most States divert children to private hospitals or primarily serve children from the juvenile justice system; in the latter case, sources other than Medicaid fund services.

The specific Medicaid funding streams pursued by a State depend on several factors. Not all States may be eligible for, nor may all States want to pursue, every funding opportunity. The sources of funding a State pursues for its public psychiatric hospitals are closely linked to the mental health and Medicaid systems' views of the hospitals, the populations served by the hospitals (forensic versus civil commitments), and length of

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stay (long, intermediate, or short term). Furthermore, the role of public psychiatric hospitals in the States is constantly changing; States have worked since the 1960s to move large numbers of patients out of these facilities into community-based treatment settings.

Many hospitals are trying to supplement their decreasing budgets by pursuing alternative sources of funding, such as leasing or selling land and building space or serving the expanding forensic population. As Medicaid funding sources become subject to more restrictions, such as DSH payment limits, and as the IMD expenditure authority under managed care waivers is phased out, the level of Medicaid funding likely will decline.

# IV. National Estimate of Medicaid Funding

**A**lthough it is clear that public psychiatric hospitals receive Medicaid funds, the share of total funding represented by such funds remains less clear. This chapter attempts to clarify the issue by creating a national estimate of the amount of funding that public psychiatric hospitals receive from Medicaid. This estimate is derived from available DSH data as well as from the Medicaid funding experiences of the five case study States.

## A. Previous Estimates of Medicaid Funding

The most recent estimate of Medicaid funding, based on 1994 data, suggests that Medicaid funds account for approximately 18 percent of State and county psychiatric hospital revenues (Manderscheid et al. 2001).<sup>27</sup> Since 1994, however, several notable developments have affected Medicaid funding for public psychiatric hospitals.

- States increasingly have included their public psychiatric hospitals in DSH programs, although not all of the DSH monies actually stay with these facilities but often are retained by or returned to the State for use at the State's discretion (Coughlin and Liska 1997; Coughlin et al. 1994).
- The role of public psychiatric hospitals continues to evolve as the facilities assume dual responsibility as the (1) provider of last resort for persons, primarily adults,

<sup>27</sup>This compares to an earlier estimate of 10 percent based on 1990 data (Manderscheid et al. 2001) Note: The 1990 estimate is from the same source as the 1994 estimate.

with severe and chronic mental illness who do not have the resources to seek care elsewhere and (2) protector of the public safety in providing care for a forensic population with mental illness (National Association of State Mental Health Program Directors Research Institute 2002).

- Since the mid-1990s, States have expanded their use of Medicaid managed care—an arrangement that often makes special provisions for mental health services (HCFA 1997; Physician Payment Review Commission 1995, 1996; Rotwein et al. 1995).

With these developments in mind, the following section discusses a more current estimate of the Medicaid-funded share of public psychiatric hospital operations.

## B. National Estimate of Medicaid Funding of Public Psychiatric Hospitals

To develop an overall national estimate of the amount of Medicaid funds supporting public psychiatric hospitals, estimates of two components are required: (1) DSH funding

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and (2) non-DSH funding. An estimate of total operating costs for public psychiatric hospitals is also required. The most recent figure available is for fiscal year 2001, when State mental health authorities reported spending \$7.4 billion on inpatient services in State psychiatric hospitals (personal communication, 3/19/2003, T. Lutterman at the National Association of State Mental Health Program Directors Research Institute).<sup>28</sup>

### 1. *DSH Medicaid Funding Estimate*

As previously noted, DSH funding represents the largest share of Medicaid funding for State and county psychiatric hospitals. The only year for which data are available on IMD DSH spending, which separate it by public and private hospitals, is 1998 (Table II.3). That evidence is limited, however, as only 37 States and the District of Columbia reported the information in this fashion. For those States reporting, DSH allocations for public psychiatric hospitals were \$838 million of \$6 billion in total DSH allocations, or 14 percent.<sup>29</sup>

To estimate the amount of DSH allocations made on behalf of public psychiatric hospitals, the 14 percent figure from the preceding paragraph is used as the basis for the calculation. In 2001, total DSH spending for all States was \$15.9 billion (CMS-64 Files 1991–2001). Applying the 14 percent to this \$15.9 billion

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<sup>28</sup> Although the \$7.4 billion estimate pertains to State psychiatric hospitals only, it is assumed that because so few county psychiatric hospitals exist, as noted earlier in this report, it provides a reasonable base on which to develop the national estimate of Medicaid funding for public psychiatric hospitals overall—State and county facilities.

<sup>29</sup> These totals are derived from Table II.3, which is based on various data, including CMS Medicaid DSH files and reflect combined Federal and State DSH payments. Appendix D details data sources and limitations.

figure results in a DSH estimate for public psychiatric hospitals of \$2.2 billion for 2001, or 29 percent of the \$7.4 billion operating costs.

### 2. *Non-DSH Medicaid Funding Estimate*

The non-DSH Medicaid funding estimate is developed based on the experience of the five case study States. Given, however, that the information from the States reported only the Federal share of Medicaid, not their own share, the latter had to be calculated to determine the total amount of non-DSH Medicaid funding. To do so, the Federal medical assistance percentage (FMAP) was used. However, the calculation is more complex than it appears because the FMAP is based on the Federal fiscal year (October 1 to September 30), whereas the State data are based on either the State fiscal year (July 1 to June 30) or the calendar year (January 1 to December 31), as noted in Table IV.1. Consequently, the FMAP was converted to the period comparable to that covered by the State data (see Table IV.1).

Using the converted FMAP, the percentage of the overall operating costs for the State psychiatric hospitals in the five case study States represented by non-DSH Medicaid funds was calculated (see Table IV.2). This calculation resulted in an estimate of 6 percent. Applying the 6 percent to the \$7.4 billion estimate of 2001 spending on inpatient public psychiatric hospital services results in a non-DSH Medicaid funding estimate for public psychiatric hospitals of \$0.4 billion for 2001.

### 3. *Overall National Estimate of Total Medicaid Funding*

It is estimated that Medicaid provided \$2.6 billion in funding on behalf of public psychiatric hospitals in 2001 (Table IV.3). This includes an estimated \$2.2 billion in

<b>Table IV.1: Conversion of Federal Medical Assistance Percentage (FMAP) to Available State Financial Information</b>			
<b>State Fiscal Year 2001 Data</b>			
	2000 FMAP (applies to one-quarter of State fiscal year)	2001 FMAP (applies to three-quarters of State fiscal year)	State Fiscal Year 2001 FMAP
Arkansas	72.85	73.02	72.98
Iowa	63.06	62.67	62.77
<b>Calendar Year 2001 Data</b>			
	2001 FMAP (applies to three-quarters of State fiscal year)	2002 FMAP (applies to one-quarter of State fiscal year)	Calendar Year 2001 FMAP
California	51.25	51.40	51.29
<b>State Fiscal Year 2000 Data</b>			
	1999 FMAP (applies to one-quarter of State fiscal year)	2000 FMAP (applies to three-quarters of State fiscal year)	State Fiscal Year 2001 FMAP
Maryland	50.00	50.00	50.00
<b>State Fiscal Year 2003 Data<sup>a</sup></b>			
	2002 FMAP (applies to one-quarter of State fiscal year)	2003 FMAP (applies to three-quarters of State fiscal year)	State Fiscal Year 2001 FMAP
New Jersey	50.00	50.00 <sup>b</sup>	50.00

Source: *Federal Register* 1999, 2000a, 2000b.

Notes: Different years' FMAPs were used because States reported data from different time periods. Arkansas and Iowa data cover State fiscal year 2001; California data cover calendar year 2001; Maryland data cover State fiscal year 2001; and New Jersey data are projected for State fiscal year 2003. With recent funding relatively stable, the different time periods should not materially affect the comparability of the data.

<sup>a</sup>Projected data.

<sup>b</sup>Projected FMAP for 2003.

<b>Table IV.2: Total Medicaid Funding of State Psychiatric Hospitals in Five Case Study States (in millions of dollars)</b>					
<b>State</b>	<b>Total Funding</b>	<b>Medicaid Non-DSH Funds</b>			<b>Medicaid Non-DSH as Percentage of Total Funding</b>
		<b>Federal Share</b>	<b>State Share</b>	<b>Total</b>	
Arkansas	\$ 23.5	\$ 0.5	\$ 0.2	\$ 0.7	3
California	575.0	7.5	7.1	14.6	3
Iowa	47.7	9.0	5.3	14.3	30
Maryland	200.9	5.9	5.9	11.8	6
New Jersey	230.5	10.2	10.2	20.4	9
<b>Total</b>	<b>\$ 1,077.6</b>	<b>\$ 33.1</b>	<b>\$ 28.7</b>	<b>\$ 61.8</b>	<b>6</b>

Source: Analysis of data collected from State mental health agencies during site visits to case study States.

Notes: Arkansas and Iowa data cover State fiscal year 2001; California data cover calendar year 2001; Maryland data cover State fiscal year 2000; and New Jersey data are projected data for State fiscal year 2003.

**Table IV.3: Total Estimate of Medicaid Funding of State and County Psychiatric Hospitals: 2001 (in billions of dollars)**

<i>State</i>	<i>Total Operating Costs</i>	<i>Medicaid DSH Funding</i>	<i>Medicaid Non-DSH Funding</i>	<i>Total Medicaid Funding</i>	<i>Medicaid as Percentage of Total Funding</i>
Totals	\$7.4	\$2.2	\$0.4	\$2.6	35

Source: Total operating costs for fiscal year 2001 from personal communication, 3/19/03, with T. Lutterman at the National Association of State Mental Health Program Directors Research Institute. "Medicaid non-DSH" based on estimate of five case study States. "Medicaid DSH" from 2001 CMS-64 files. Medicaid amounts include both State and Federal Shares.

Medicaid DSH funding and nearly \$0.4 billion in Medicaid non-DSH funding. This represents approximately one-third of public psychiatric hospitals' total operating costs in 2001. However, various caveats and limitations, detailed in the next section, may have a substantial impact on the accuracy of the estimate.

### **C. Assumptions and Limitations of the National Estimate**

The estimate should be interpreted cautiously in light of the following assumptions and limitations associated with its development.

- Significant State-to-State variability exists in terms of Medicaid funding. Therefore, it is difficult to determine the true "national representativeness" of the estimate, since it was based in part on five States' experiences.
- The widest variation in Medicaid funding of public psychiatric hospitals among the States is in DSH funding. The estimate does not attest to the amount of these funds that actually remain with the hospitals versus the amount retained by or returned to the State for State-designated use.

- The estimate is a "snapshot" in time. Consequently, it may not reflect future changes in local circumstances and Federal policies related to Medicaid.

### **D. Conclusion**

In sum, the evidence suggests that the amount of Medicaid funds paid on behalf of public psychiatric hospitals is increasing. For 2001, Medicaid provided an estimated \$2.6 billion in funding on behalf of these facilities, which represents approximately one-third of total operating costs. This compares to previous Medicaid funding estimates of 18 percent in 1994 and 10 percent in 1990. DSH monies comprised the largest share of the \$2.6 billion—nearly 85 percent. However, various caveats and limitations may affect the accuracy of the estimate, including the extensive State-to-State variability and the fact that the estimate represents a snapshot in time and may not hold true for other years. In addition, the estimate makes no assumptions as to the amount of Medicaid funds that stay with these public facilities, as opposed to being retained by or returned to the State for use at the discretion of the State.

**D**espite the perception that few people are served by public psychiatric hospitals, these facilities continue to hold a critical place in the continuum of care for persons with mental illness. It is true that the capacity of these institutions has diminished significantly as a result of deinstitutionalization—a trend in which the traditional site of care has moved from inpatient to outpatient facilities and from institutions to community-based treatment programs. However, many public psychiatric hospitals continue to play an essential role, serving persons, primarily adults, with severe and chronic mental illness who do not have the resources to seek care elsewhere, and a forensic population with mental illness.

Another common, but inaccurate, perception is that public psychiatric hospitals receive few or no Medicaid funds because of the Federal Government's long-standing policy, known as the IMD exclusion, that long-term psychiatric care is the responsibility of the States. Evidence does suggest, however, that Medicaid is funding an increasing share of public psychiatric hospital operations. This chapter provides a number of overall conclusions about this evidence, as well as a brief discussion of pressures that may affect future Medicaid funding of public psychiatric hospitals.

## **A. Medicaid Funding and Public Psychiatric Hospitals**

Although States avail themselves of various sources of Medicaid funds for their public psychiatric hospitals, there is substantial State-to-State variability as to the specific sources and amounts pursued. The most

significant sources of Medicaid funds paid on behalf of public psychiatric hospitals are those from IMD optional services, Medicaid managed care, and DSH payments. Of these sources, DSH payments represent the overwhelming majority of Medicaid funds pertaining to these facilities.

It is estimated that in 2001, \$2.6 billion in Medicaid funds were paid on behalf of public psychiatric hospitals, including \$2.2 billion in DSH funds and \$0.4 billion in non-DSH funds. Medicaid represented approximately 35 percent of these public facilities' operating costs during that year. This estimate is higher than previous estimates of 18 percent from 1994 and 10 percent from 1990 (Manderscheid et al. 2001). It was derived using available Medicaid data, as well as from the experiences of the five States included in this study—Arkansas, California, Iowa, Maryland, and New Jersey. It is important to note,

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however, that the extensive State-to-State variation that exists with regard to Medicaid funding may limit the accuracy of the estimate when extrapolating to a national basis. Also, because the estimate is based on data from a limited time period, it may not be applicable to other time periods. In addition, the estimate makes no assumptions as to the amount of Medicaid funds that actually remains with these public facilities versus being returned to States' treasuries.

## **B. Pressures Affecting Future Medicaid Funding**

The challenges faced by State and county psychiatric hospitals are both substantial and likely to affect the Medicaid financing strategies pursued by the hospitals themselves or on their behalf. Beyond the specific challenges brought about by changes in Medicaid funding—such as the recent establishment of DSH caps or the future disallowance of IMD expenditure authority under Section 1115 waivers—the following broader environmental pressures may also influence funding strategies:

- ***Fiscal crises in the States.*** Nearly all States are facing budget shortfalls for which higher spending in Medicaid programs is at least partially responsible (National Governors Association 2002; Smith et al. 2002).
- ***Continuing deinstitutionalization.*** Federal policy that continues to emphasize community-based rather than institutional care has been reinforced by the U.S. Supreme Court's decision in *Olmstead vs. L.C.* (White House 2002).

- ***Reconfiguring and redefining roles.*** As public safety at the community level becomes more and more important, the demand on public psychiatric hospitals for forensic services is likely to grow, perhaps affecting hospitals' capacity to serve other populations (Daigneau 2002; National Association of State Mental Health Program Directors Research Institute 2000). Forensic patients typically are not funded by Medicaid, but instead are funded through States' correctional budgets.
- ***Mental health parity.*** An absence of parity in insurance coverage for mental health and substance abuse raises the pressure on the public mental health system, including State and county psychiatric hospitals. These facilities act as the safety net not only for indigent and low-income individuals but also for persons who have exhausted their insurance benefits (National Mental Health Association 2002). Efforts that establish parity could significantly change this situation.

In terms of Medicaid financing strategies for State and county psychiatric hospitals, the States themselves and others assisting them will need to consider a wealth of factors. In addition to the environmental pressures mentioned here, there is extensive State-to-State variation in the level of Medicaid support as well as continuing change in local circumstances and, at the Federal level, changes in Medicaid financing policies. Consequently, what holds true today may not hold true in the future. Therefore, it is necessary to monitor continuously the shifts in these factors and the various approaches to Medicaid financing of public psychiatric hospitals.

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# Appendix A.

# Expert Advisory

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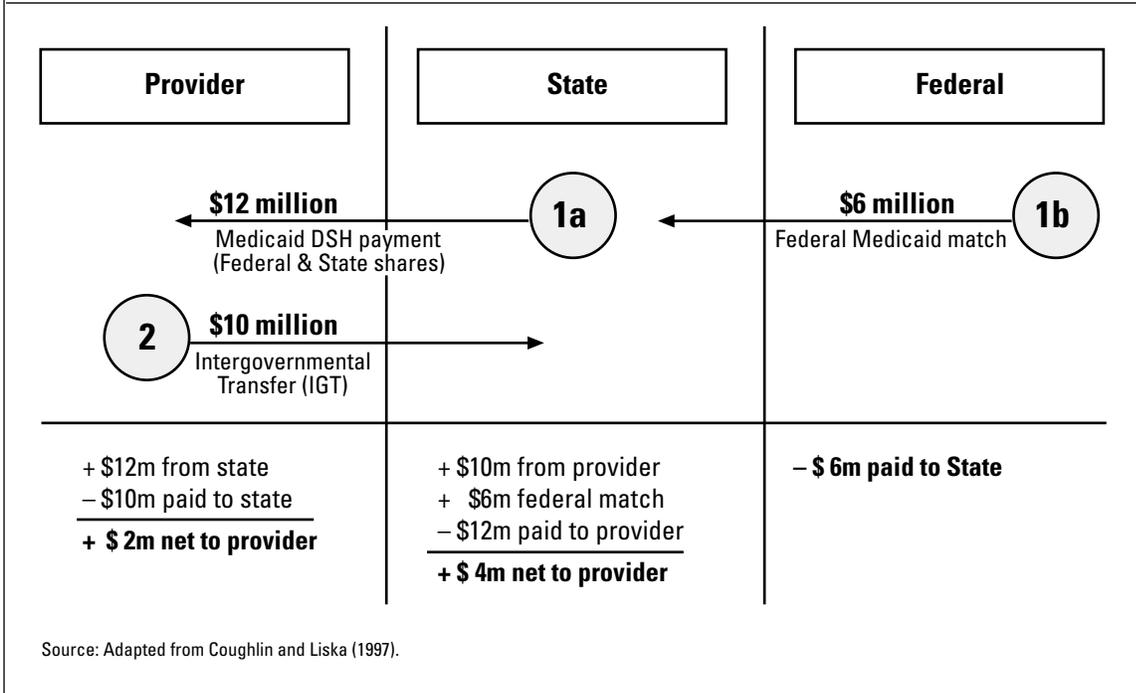
# Appendix B. The Use of Intergovernmental Transfers in the Disproportionate Share Hospital Payment Program

**S**ome observers believe that States' inclusion of Institution for Mental Diseases exclusions (IMDs) in their disproportionate hospital share (DSH) programs is closely tied to the use of intergovernmental transfers (IGTs).

A hypothetical example, adapted from Coughlin and Liska (1997), illustrates how the IGT process works (see Figure B.1). Consider a hospital with \$2 million in uncompensated care. If the hospital were located in a State where the Federal match was 50 percent, the State would reimburse the hospital \$2 million in DSH payments by funding \$1 million itself and receiving the additional \$1 million from the Federal Government as a result of the match. With an IGT, the process might change. For example, the State may pay the hospital \$12 million in DSH monies, well above the actual cost of \$2 million (1a). The Federal Government would match half of that payment, or \$6 million (1b). If the hospital were publicly owned, the State could institute an IGT and transfer \$10 million back from the

hospital (2). In the end, the hospital would be just as well off; it would be reimbursed for its uncompensated care cost of \$2 million, the State would receive a net of \$4 million in additional monies (spending \$6 million and taking back \$10 million), and the Federal Government would pay out \$6 million. The net of \$4 million received by the State could then be applied to other operations, such as funding other mental health services, offsetting any State appropriations made to the hospitals, or just reverting to the State general fund for State-designated use (Coughlin and Liska 1997). Given this context, Coughlin and Liska (1998) have hypothesized two reasons why States decided to incorporate IMDs into their DSH programs. First, given that many IMDs are publicly owned, States may take back the

Figure B.1: Hypothetical Example of a State Medicaid Financing Strategy



money through IGTs. Second, the use of IMDs makes it easier to spread DSH payments over more hospitals and thus

spend down the entire State DSH allotments, since facility-based caps limit the allotment that can go to individual facilities.

# Appendix C. Profiles of Public Psychiatric Hospitals in the Five Case Study States

## Profile of Public Psychiatric Hospitals in Arkansas

### *Public Psychiatric Hospitals as a Component of the State's Public Mental Health System*

Arkansas has one State psychiatric hospital, which serves adults and adolescents. It is also the provider of last resort. Most patients there are seriously and chronically mentally ill and have little or no insurance and few assets. At the time of our visit, the State had five freestanding private psychiatric hospitals.

The State hospital recently formalized its admission priorities as follows:

- **First Priority.** Adults and adolescents with the greatest need for treatment (homicidal and suicidal) and no financial resources or treatment alternatives

- **Second Priority.** Adults and adolescents with severe mental illness who have family support
- **Third Priority.** Adults and adolescents with severe mental illness who reside in a correctional facility
- **Fourth Priority.** Adults and adolescents with mental illness who are either uninsured or whose insurance carrier has denied further treatment, and who are already receiving care in other hospitals

Children (defined as youth under the age of 12) needing inpatient psychiatric services are treated in private hospitals.

### *Hospital Admission Process*

The Arkansas State Hospital has a single-point-of-entry system. All patients, including court-ordered individuals or those requesting

Figure C.1: State Psychiatric Hospitals in Arkansas

<i>Hospital Name</i>	<i>Number of Beds<sup>a</sup></i>	<i>Facility Characteristics</i>	<i>Average Length of Stay (Days)</i>
Arkansas State Hospital	202	Adult civilly committed (90 beds) Adult forensic (80 beds) Adolescent (16 beds) Juvenile sex offenders (16 beds)	Adult civilly committed (< 30) Adult forensic (long term) Adolescent (90) Juvenile sex offenders (400)

Source: Interviews with representatives from the Division of Mental Health.

<sup>a</sup>The number of licensed beds is 315. Occupancy runs approximately 95 percent of staffed beds.

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transfer from a private hospital, must be evaluated by one of 15 community mental health centers (CMHCs) located throughout the State. As part of this admission evaluation, CMHCs try to find a community placement, which is a local hospital if inpatient services are deemed necessary. The goal is to use the State psychiatric hospital only as a last resort.

Although all CMHCs receive State funds to finance “alternatives to State hospitalization,” they vary in their use of these funds. Some use them to pay for local psychiatric beds, while others use them for support services, such as assisting patients with their medications, in order to lessen the need for hospitalization. Because of mounting fiscal pressure, CMHCs have recently begun to seek local hospitalization less frequently, thus raising the demand for State psychiatric hospital beds. At the same time, the demand for forensic beds has also been increasing. As a result, there are now wait lists at the State hospital. At the time of the site visit, there was a 100-person wait list for adult forensic beds and a 40-person list for adult civil beds.

### *Major Operational Changes*

The existing adult forensic unit opened during the early 1990s. It was originally housed in a separate building, but the State’s loss of a 1988 class action lawsuit alleging mistreatment of patients in this unit forced the State to move the unit into the main hospital building. With this change, the number of forensic beds fell from 120 to 80. The 16-bed juvenile sex offender unit, a relatively recent addition to the hospital, opened during the past 10 years.

State fiscal year 2002 was the first year that the Arkansas State Hospital partici-

pated in the State’s DSH program. This opportunity came as a result of and to protect an overall increase in DSH funding for the State. In 2000, the Federal Benefits Improvement and Protection Act (BIPA) helped low-DSH States such as Arkansas by setting a floor on DSH payments equal to 1 percent of total Medicaid expenditures. Arkansas’ DSH funding rose to approximately \$21 million in 2001, up from \$2.7 million in previous years.

### *Anticipated Operational Changes*

Over the next several years, Arkansas expects that several operational changes will affect the State psychiatric hospital. First, the State is contemplating either closing or reconfiguring the adolescent unit because of funding cuts. In conjunction with this, the State is reportedly exploring the possibility of refocusing the care delivered in the adolescent unit from an acute to a subacute level, as demand for the latter appears to be higher. Although Medicaid reimbursement is lower for the subacute level of care, some believe that the higher demand for these services will more than offset the rate differential.

Second, the State expects changes as a result of having recently lost a lawsuit filed by the American Civil Liberties Union on behalf of inmates waiting for a bed in the State psychiatric hospital. A Federal judge ruled that the State was in error in denying inpatient psychiatric services to prisoners because there were no available forensic beds. At the time of the site visit, the State was awaiting the judge’s ruling on what remedial actions would be required. Some believe that the State will be required to increase the number of

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forensic beds to accommodate inmates in need of services.

Third, there is some concern that an Arkansas law, Act 911, may raise legal challenges on behalf of individuals needing civil commitment beds. According to this statute, people who are acquitted of a crime because of mental incompetence, after they serve their sentence, are not required to receive inpatient treatment following their release from jail, but they can be placed in a group home, a State psychiatric hospital, or another appropriate setting for a minimum of 5 years. Act 911 patients in the community who violate the terms of their release are immediately sent to the State psychiatric hospital. Because this has happened in so many cases, the State has had to place many Act 911 patients in civil commitment beds, thus reducing its capacity to serve civilly committed patients. Respondents fear that this shift in capacity may spawn legal challenges brought on behalf of individuals who need civil commitment beds.

A final change that may take place relates to IMD optional services. Arkansas State Hospital does not currently receive Medicaid funding for patients over the age of 64 because the State has not elected this optional IMD service. Some discussion is taking place between the mental health and the Medicaid divisions about moving forward with a State plan amendment that would allow Medicaid to fund services for the 65 and older population receiving services in the State psychiatric hospital. At the time of the site visit, however, no final decision had been made.

At the time of the site visit, the retirement of the director of the mental health division was imminent. A permanent replacement had not yet been named.

## **Profile of Public Psychiatric Hospitals in California**

### *Public Psychiatric Hospitals as a Component of the State's Public Mental Health System*

The responsibility for administering and managing mental health services in California is delegated to the State's 58 counties. Each county's mental health department provides care for Medicaid-eligible and uninsured patients using (1) earmarked funds from a portion of the State sales tax and the vehicle licensing fee, and (2) a distribution of funds from the State for Medicaid mental health services. Most inpatient psychiatric services are provided by psychiatric units of general hospitals, private psychiatric hospitals, and skilled nursing facility IMDs.

In addition to these facilities, California has 16 psychiatric health facilities (PHFs), 10 of which are county owned. PHFs are essentially the equivalent of freestanding acute care psychiatric hospitals, although licensing requirements differ from those of a psychiatric hospital. (For instance, the scope of ancillary services required to be on site is smaller for PHFs.) PHFs are primarily used for short-term stays (5 to 7 days), usually for crisis stabilization. Most PHFs have 16 or fewer beds and may be eligible for Medicaid reimbursement, as they do not meet the criteria for an IMD. A few of the PHFs are larger but are not eligible for Medicaid funds for 22- to 64-year-olds under the IMD exclusion.<sup>30</sup>

California's four State psychiatric hospitals represent a specific niche in the public mental health system. These facilities serve

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<sup>30</sup> California has selected optional IMD services for both the under-21 population and the 65 and older population.

Figure C.2: State and County Psychiatric Hospitals in California

<i>Hospital Name</i>	<i>Number of Beds<sup>a</sup></i>	<i>Facility Characteristics</i>	<i>Average Length of Stay (Days)<sup>b</sup></i>
<b>State Psychiatric Hospitals</b>			
Atascadero State Hospital	1,145	Maximum-security forensic	348.0
Metropolitan State Hospital	1,184	140-bed children's unit, minimum-security forensic, and adult civil commitments	276.0
Napa State Hospital	1,362	Low- to moderate-security forensic and adult civil commitments	440.0
Patton State Hospital	1,293	Maximum-security forensic	284.0
<b>Psychiatric Health Facilities (County Owned)</b>			
Butte County Mental Health	16	Adults	3.8
El Dorado County Mental Health	15	Adults	6.4
Fresno County PHF	16	Adults	7.9
Marie Green Psychiatric Center	16	Adults and children	5.6
Sacramento County Mental Health Treatment Center	100	Adults and children	19.7
San Joaquin County Mental Health Service	40	Adults	9.2
Santa Barbara County PHF	16	Adults	5.3
Sempervirens PHF	16	Adults	7.3
Shasta County Mental Health Services	15	Adults and children	5.3
Sutter-Yuba PHF	16	Adults	10.9

<sup>a</sup> Licensed bed information from California Office of Statewide Health Planning and Development's Hospital Quarterly Financial Reports, Second Quarter of 2002. Accessed at [www.oshpd.state.ca.us/HQAD/HIRC/hospital/finance/quarterly\\_data/index.htm](http://www.oshpd.state.ca.us/HQAD/HIRC/hospital/finance/quarterly_data/index.htm).

<sup>b</sup> State hospital information from Department of Mental Health (2001, November) "State Hospital Benchmark Reports FY00-01," available at [www.dmh.cahwnet.gov/SADA/default.asp](http://www.dmh.cahwnet.gov/SADA/default.asp). PHF information from Office of Statewide Health Planning and Development's Hospital Quarterly Financial Reports.

a predominantly forensic population. Only two of the four State hospitals—Napa and Metropolitan—accept civil patients (i.e., long-term, chronic patients who have no alternative community treatment options because of the severity of their illness and because they are a threat to public safety). All civil patients in the State psychiatric hospital system must meet civil commitment requirements (i.e., be a danger to themselves or others). To accommodate residents in

need of State psychiatric hospital beds, counties lease beds annually from the State at a per diem rate.

#### *Hospital Admission Process*

State hospitals often represent “the end of the road” for civilly committed patients. The patients are typically transferred from other treatment settings in which they could not be cared for appropriately. All civilly committed patients must meet the involuntary commit-

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ment requirements and are hospitalized through the courts. Forensic patients are hospitalized for a number of different reasons, including being found guilty by reason of insanity, being incompetent to stand trial, and committing sexually violent predatory behaviors.

In sharp contrast to the State psychiatric hospitals, the PHFs provide short-term care, often in the form of emergency crisis stabilization. While PHFs accept both voluntary and involuntary patients, their target population is individuals who meet medical necessity criteria for acute psychiatric care. For instance, Fresno County's PHF defines its target population as "those with a suspected or established mental disorder diagnosis or who may pose a danger to themselves and/or others, have impaired judgment or are exhibiting uncooperative behavior to the extent that they cannot reasonably be assured a lower level of care or cannot provide the basic necessities of living such as food, clothing or shelter."<sup>31</sup>

### *Major Operational Changes*

In 1991, California went through what it calls "realignment." The major operational change during this time was the designation of portions of the sales tax and vehicle license fees to counties specifically for the provision of mental health services, including inpatient psychiatric care at the State hospitals. Realignment essentially shifted the responsibility for public mental health services to the counties. The realignment funds were intended to serve what the State identified as the target populations: seriously and persistently mentally ill (SPMI) adults and

seriously emotionally disturbed (SED) children. For patients receiving Medicaid, the county became responsible for funding the State match.

Four years later, in 1995, the State added to the counties' mental health responsibilities under a plan called the Medi-Cal specialty mental health services consolidation. At the time, Medi-Cal, the State's Medicaid program, was moving toward a managed care model, and there was concern in the State, particularly among the advocacy community, that this model of care would not be appropriate for the financing and delivery of mental health services. Consequently, the State redirected the money that had historically been spent on Medi-Cal "specialty mental health services" directly to the counties. Respondents defined specialty mental health services as any mental health service not provided by a primary care doctor. Phase One of the Medi-Cal specialty mental health consolidation, which occurred in 1995, involved transferring the responsibility for all inpatient mental health services to the counties. Previously, counties were responsible for inpatient services under realignment only for SPMI adults and SED children. The Medi-Cal consolidation added to the county responsibility for services to Medi-Cal-eligible individuals outside this target population. Phase Two of the Medi-Cal specialty mental health consolidation in 1997–98 involved the transfer of outpatient services to the counties. For all Medi-Cal services, the counties now fund the State match out of their realignment and mental health consolidation funds.

The county-level assumption of responsibility for inpatient mental health services prompted a dramatic shift in civil commitments from the State hospitals to what counties perceived as a more cost-effective

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<sup>31</sup> Fresno County Human Services System Web site: [www.fresnohumanservices.org/adultservices/psychiatrichealthfacility/targetpopulation.htm](http://www.fresnohumanservices.org/adultservices/psychiatrichealthfacility/targetpopulation.htm). Accessed November 17, 2002.

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setting—local providers. In turn, the State hospitals shifted their focus from a civilly committed population to a forensic population. Before realignment, the State psychiatric hospitals housed approximately 70 percent civil commitments and 30 percent forensic patients. Now, the reverse is true.

Care for forensic patients is funded through State appropriations based on the established per diem rate. The payments go to the State Department of Mental Health.

### *Anticipated Operational Changes*

The trend toward treating primarily forensic patients in California's State hospitals is expected to continue. In fall 2001, California's Department of Mental Health began construction on its fifth State hospital, Coalinga State Hospital. This facility is slated to have 1,500 beds and serve only sexual offenders. Construction is expected to be completed in fall 2004. In addition, construction recently was completed on a 64-bed inpatient mental health treatment center inside Salinas Valley State Prison. The California Department of Corrections and the Department of Mental Health will operate the Salinas Valley Psychiatric Program jointly. The two departments currently run a similar program at Vacaville State Prison.

## **Profile of Public Psychiatric Hospitals in Iowa**

### *Public Psychiatric Hospitals as a Component of the State's Public Mental Health System*

Each quadrant in Iowa is served by one of four State psychiatric hospitals known as mental health institutes (MHIs). Each MHI also provides specialty services that cut across the entire State. For example, Clarinda MHI (in the southwest) draws from

the entire State for its geropsychiatric program; Mt. Pleasant MHI (in the southeast) does the same for dual diagnoses and substance abuse care. Two facilities specialize in psychiatric care for children and adolescents—one in the eastern part of the State (Independence MHI) and the other in the west (Cherokee MHI). Independence MHI also has a Psychiatric Medical Institute for Children (PMIC), which is a stepdown unit from acute care but provides a higher level of service than residential treatment.

There are no private freestanding psychiatric hospitals in Iowa, which limits the alternatives for patients needing inpatient services. As a consequence, the MHIs are responsible for a large segment of the treatment continuum, from acute to long-term care. However, most MHI patients are short-term cases (length of stay fewer than 30 days). The MHIs admit voluntary patients, meaning that patients do not necessarily have to meet the more rigorous commitment requirements of being a danger to themselves or others. Another attribute unique to the public health system in Iowa is that the MHIs are included in the Medicaid managed behavioral health care network.

Under Iowa law, the State pays for 20 percent of the per diem in MHIs, while the county of legal responsibility pays the remaining 80 percent and any costs of care beyond those covered by the per diem rate. Counties reportedly view the MHIs as a good buy, since they deliver relatively inexpensive care and generally do a "good job" of filling a need.

### *Major Operational Changes*

The past 10 years have ushered in a greater emphasis on specialization among the four MHIs. As mentioned, each hospital has a specialty and draws patients from across the

**Figure C.3: State and County Psychiatric Hospitals in Iowa**

<i>Hospital Name</i>	<i>Number of Beds<sup>a</sup></i>	<i>Facility Characteristics</i>	<i>Average Length of Stay (Days)</i>
Independence Mental Health Institute	170	Adult Adolescent Children PMIC <sup>b</sup>	Adult (53) Adolescent (79) Children (89) Child/Adolescent (121)
Clarinda Mental Health Institute	80	Adult Geriatric	Adult (20) Geriatric (1,178)
Mount Pleasant Mental Health Institute	89	Adult Substance abuse Dual diagnosis	Adult (40) Substance abuse (27) Dual diagnosis (26)
Cherokee Mental Health Institute	97	Adult Adolescent Children	Adult (29) Adolescent (74) Children (60)

Source: Iowa Council on Human Services Budget Recommendation for fiscal year 2003.

<sup>a</sup>Number of staffed beds.

<sup>b</sup>Beds in the Psychiatric Medical Institute for Children are not acute and are not included in the total bed count.

State in that specialty area. The State has also stepped up efforts to avoid institutionalization when possible and to reduce the length of stay. With regard to deinstitutionalization, MHIs have been more or less successful, depending on the other providers and community resources in their area. In terms of their mission, MHIs are trying to make the transition to becoming short-term facilities that focus on acute psychiatric care.

Until recently, lengths of stay in the MHIs were becoming shorter, but they are now on the upswing. For example, at the Clarinda facility, stays are becoming longer because of the difficulty of returning patients to the community for continued care. Eighteen months before the site visit, the average length of stay for adults was 8 days; 4 months later it was 12 days, and at the time of the site visit in April 2002, it had risen to 20 days.

The pattern is similar for the average daily census (at least at one of the hospitals), initially on the decline but now beginning to rise again. From 1985 through 1995, the average daily census at the Independence

facility was 170 patients. Beginning in 1995 and continuing through the late 1990s, the average daily census began to fall, hitting a low of 113 in 1998. Much of this decline was a function of the introduction of Medicaid managed care, which emphasizes less restrictive treatment settings, and the advent of new psychotropic drugs, which made it increasingly possible for patients to be maintained outside of an institutional setting. However, patients who once responded well to psychotropic medications are reportedly relapsing with greater frequency and returning to the MHI. Respondents also said that many of these individuals have not been able to be maintained appropriately in the community.

The MHIs' organizational relationships within Iowa's Department of Human Services (DHS) have changed in several ways in recent years. Four years ago, the MHIs were part of the Mental Health Developmental Disabilities Division, but the Administrator of that division did not report directly to the director of DHS. The MHIs are now under the Operations Division, whose deputy director reports

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directly to the director of DHS. Respondents believe that the change has made the MHIs more accountable to DHS.

Over the past 10 years, the MHIs have been exploring opportunities to reduce administrative costs by sharing services with other organizations. For instance, the Clarinda and Mount Pleasant facilities co-located with a State prison. The Independence MHI shares its campus with a private adolescent center, and the Clarinda facility does the same with a private academy for nonviolent delinquent youth.

Iowa has a very large managed behavioral care carve-out contract with Magellan (formerly Merit). Under this contract, launched in 1995 and known as the Iowa Plan, all four State psychiatric hospitals contract with Merit to be network providers. The carve-out covers both the voluntary (noncommitted) adult population over 21 and under 65 who are Medicaid eligible and Medicaid-eligible children, whether voluntary or involuntary.

### *Anticipated Operational Changes*

Net budgeting was recently introduced as a new accounting method in the State. The PMIC at the Independence MHI is piloting the new methodology. Previously, the PMIC used the same accounting system as the State psychiatric hospitals; operations were 100 percent State appropriated, and any payments received from third parties were deposited to the State general fund to offset the appropriation. Under net budgeting, the PMIC receives a State appropriation for the total operational budget less anticipated collections/receipts. The facility, in turn, keeps all collections from third-party payers and others. Because net budgeting is a change only in accounting technique, it does not affect billing or admission processes.

Several respondents believe that the State eventually may close one or more of the MHIs. Historically, local politicians have reportedly fought against this because these facilities employ many people in rural areas where the employment base is relatively small. However, the inpatient psychiatric hospital operations on the Clarinda and Mount Pleasant campuses are now smaller and co-located with much larger correctional facilities. Consequently, the psychiatric hospitals no longer employ as many people as they once did.

### **Profile of Public Psychiatric Hospitals in Maryland**

#### *Public Psychiatric Hospitals as a Component of the State's Public Mental Health System*

Maryland has eight State psychiatric hospitals, most of which serve a mix of patients: acute, long-term, and forensic. However, the Carter Center serves only acute care patients, and the Perkins Hospital serves only forensic patients. Five years ago, the State hospitals stopped admitting children under the age of 12. They are treated instead in private hospitals or in one of the three State-run residential institutes for children and adolescents (RICAs). Only two State psychiatric hospitals accept adolescent patients.

The hospitals have specific catchment areas, but in recent years, when the hospitals have been operating at full capacity, new admissions sometimes have been sent to any hospital that has an open bed. The State, which views the hospitals as providers of last resort, attempts to place patients with insurance in private facilities first. However, long-term patients, even if insured, typically end up in one of the State psychiatric facilities

**Figure C.4: State and County Psychiatric Hospitals in Maryland**

<i>Hospital Name</i>	<i>Number of Beds<sup>a</sup></i>	<i>Patient Characteristics</i>
Crownsville Hospital	204	Civil, forensic, adult geriatric, adolescent
Eastern Shore Hospital	80	Civil, forensic
Springfield Hospital	325	Civil, forensic, deaf
Spring Grove Hospital	285	Civil, forensic
Perkins Hospital	220	Forensic
Finan Hospital	114	Forensic, civil, geriatric, adolescent
Upper Shore Hospital	40	Civil, forensic
Carter Center	51	Civil, forensic

Source: Interviews with representatives from the Mental Hygiene Administration and calls to the hospitals.

<sup>a</sup>The number of staffed beds.

when the insurance is exhausted or no longer covers treatment.

Lengths of stay vary as follows: about one-third of patients are discharged in fewer than 30 days, one-third are discharged in 31 to 90 days, and one-third are discharged after 90 days or longer. The length of stay has risen in recent years because of an increase in the severity of illness and in the number of forensic patients. At the time of the site visit, 100 patients in the State psychiatric hospital system were reportedly ready to be discharged to another setting, but an appropriate community placement was not available. Respondents say that the dually diagnosed (persons with a developmental disability and mental illness) are the most difficult to place.

#### *Hospital Admission Process*

Patients must be referred by some other facility or organization. Referrals come primarily from emergency rooms (60 percent), courts (14 percent), jails (11 percent), acute care hospitals (7 percent), and other facilities (primarily adolescent patients). The State psychiatric hospitals do not admit walk-ins,

but they do accept voluntary admissions.

At the time of the site visit, 82 people were waiting to be admitted to a State psychiatric hospital bed; 55 of those waiting were in other hospitals.

#### *Major Operational Changes*

Maryland has a Section 1115 waiver that carves out mental health services for Medicaid eligibles. The waiver gives the State IMD expenditure authority, which is primarily used for services rendered in private psychiatric hospitals. Under the waiver, these hospitals receive payment for 30 days per episode, up to 60 days per year and 120 days in a lifetime for adult Medicaid patients (age 22 through 64). This policy relieves some pressure on the State psychiatric hospitals and reinforces their role as safety net providers. The State hospitals admit patients from private hospitals when the patients exhaust their Medicaid coverage.

The number of patients served by the State psychiatric hospitals has declined steadily over the past 10 years. For example, Springfield Hospital had 900 patients in

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1990, 400 in 2000, and 325 at the time of the site visit. One respondent said that the downsizing stems from several changes that began about 10 years ago. First, a State recession forced facilities to downsize due to budget constraints. Second, there was a concurrent push toward the use of community-based services. And last, a gubernatorial commission recommended the closure of one of the three largest State psychiatric hospitals in central Maryland. To comply, however, the State needed to increase funding for community-based services while continuing to operate the State psychiatric hospital that was scheduled for closure. But because the State did not have the money to fund this dual system of care, it developed a 5-year plan to reduce the patient load to 1,150 individuals Statewide. The plan called for the State psychiatric hospitals to be streamlined and remodeled to run more efficiently. Although three facilities have reduced the number of beds and remodeled, the State has not yet met this patient load goal.

During the same 10-year period, there was a dramatic shift in the types of patients served by the State psychiatric hospitals. While the total number of forensic patients remained relatively steady, the number of civilly committed patients fell. At the time of the site visit, only 500 of the approximately 1,400 beds in the State were for nonforensic patients. This disproportionate shift in patient mix towards the longer-term forensic patient has increased the length of stay across the State psychiatric facilities.

Hospital downsizing prompted the Mental Hygiene Administration to look at ways to use patient buildings for other purposes. For example, some facilities have leased the space to compatible community

services, such as substance abuse treatment facilities or office space for State agencies, such as the Mental Hygiene Administration. The Eastern Shore Hospital sold a large parcel of land to Hyatt Hotels, and the State used the proceeds to build a new Eastern Shore Hospital, reducing the number of beds from 300 to 80.

### *Anticipated Operational Changes*

Many respondents said that Maryland's current fiscal crisis has fueled the debate about whether the State should close one of the three largest State psychiatric hospitals, as recommended by a gubernatorial commission several years ago. To date, political pressure has prevented closure, and unions representing State employees have opposed such a move. Still, one of the goals of the current administration reportedly is to reduce the size of the hospitals such that none serves more than 250 patients.

Another option, according to one respondent, would be for the State to run more specialized rather than "generic" psychiatric hospitals. Under such a system, one large hospital would serve as the core facility, providing general services. This "nucleus" would be surrounded by a number of specialty hospitals, each providing a distinct set of services geared, for example, toward children, adolescents, or geriatric patients. Although some are concerned that such a system would create a hardship for families in terms of travel, others believe that Maryland's relatively small size makes travel a "nonissue."

In addition to raising the possibility of closing or restructuring State psychiatric hospitals, the State fiscal crisis has prompted other changes that are likely to affect hospital operations. For instance,

the State Senate recently passed a bill calling for the elimination of 3 to 8 percent of personnel in all State agencies and departments. For the State psychiatric hospitals, this translates into 210 to 290 positions. One respondent noted that the hospitals could adjust staffing by approximately 100 positions, but cuts beyond this would require an overall reconfiguration of the hospitals. Another respondent said that Mental Hygiene Administration staff would have to absorb the remaining cuts. A final decision on how to respond to the budget cuts had not been made at the time of the site visit.

Under the present public mental health system, the State pays community mental health centers, or core services agencies, through a fee-for-service system for care to uninsured, or “gray zone” patients. At the time of the site visit, there was language in the budget bill that would change the funding for these patients such that they would be covered by a grant, and providers would limit services to the amount of the grant. As a result, gray zone patients would not be able to receive outpatient services on demand if the grant funding was depleted. Restrictions in such services might, in turn, raise demand for inpatient services from the State psychiatric hospitals. Furthermore, if the State also decides to limit pharmacy services as part of the new arrangement, the provision will apply only to new patients; current patients will be grandfathered in.

The final change observed at the time of the site visit was that the longstanding director of the Mental Hygiene Administration was in the process of leaving his position. A permanent replacement had not yet been named.

## **Profile of Public Psychiatric Hospitals in New Jersey**

### *Public Psychiatric Hospitals as a Component of the State’s Public Mental Health System*

In New Jersey, the State and county psychiatric hospitals serve primarily as intermediate- and long-term care facilities. Short-term care is provided through a State-designated system of short-term care facilities (STCFs), which comprise psychiatric units in general hospitals. The State psychiatric hospitals primarily serve their regional catchment areas, although specialty units (such as Ancora’s dual diagnosis unit for individuals with a mental illness and a developmental disability) sometimes serve the entire State. Brisbane Child Treatment Center is the only State hospital for children, so it draws from the entire State. The six county hospitals/units serve essentially the same population as the State hospitals, although their catchment area is generally limited to the county in which they are located. Although these hospitals report directly to their respective county boards of freeholders, who are elected officials, they must submit a business plan every year to the State Division of Mental Health Services for review and approval.

Patients in the State and county psychiatric hospitals are primarily indigent persons with serious and chronic mental illness. All must meet the involuntary admission criteria—that they pose a threat to themselves or others. According to one State respondent, about 73 percent of the patients in State psychiatric hospitals are discharged within 6 months of admission, while the remaining 27 percent require longer-term care.

The State psychiatric hospitals are gross budgeted through the State’s regular appropriations process, meaning that their

Figure C.5: State and County Psychiatric Hospitals in New Jersey

<i>Hospital Name</i>	<i>Number of Beds<sup>b</sup></i>	<i>Facility Characteristics</i>	<i>Average Length of Stay (Days)</i>
<b>State Psychiatric Hospitals<sup>a</sup></b>			
Ancora Psychiatric Hospital	726	Adults and 33 developmentally disabled/mentally ill; 135 geriatric and 116 forensic beds	1,224
Brisbane Child Treatment Center	50	Children 11–18 years old	118
Hagedorn Psychiatric Hospital	288	Adults and 188 geriatric beds	576 general population 513 geropsychiatric
Greystone Park Psychiatric Hospital	538	Adults	566
Trenton Psychiatric Hospital	478	Adults	477
<b>County-Owned Psychiatric Hospitals</b>			
Bergen Regional Medical Center	307 <sup>c</sup>	Adults, 120 geriatric, 8 forensic	Intermediate care <sup>d</sup>
Buttonwood Hospital <sup>e</sup>	30	Adults	28
Camden County Health Services Center	158	Adults	Usually 30 days or less
Essex County Hospital Center	400	Adults	Intermediate care
Meadowview Hospital	84	Adults	Intermediate care
Runnells Hospital <sup>e</sup>	44	Adults	Intermediate care

Sources: Information provided by staff from the Department of Mental Health Services and Buttonwood Hospital during study team site visit.

<sup>a</sup> The Division of Mental Health Services also runs the Ann Klein Forensic Center, a 200-bed inpatient psychiatric unit within a State prison.

<sup>b</sup> Staffed beds.

<sup>c</sup> 100 beds are classified as IMD, the remaining 207 beds are not. The psychiatric hospital is part of a larger 1,185-bed surgical/acute care facility.

<sup>d</sup> Intermediate care generally refers to lengths of stay of more than 30 days but less than 6 months.

<sup>e</sup> Not an IMD. Part of a larger, long-term care facility.

entire budget is funded by the State. All hospital revenues, including Medicaid funds for services and DSH payments, go directly to the State treasury to offset the State appropriation. Counties are responsible for funding a portion of the cost for county residents in State and county psychiatric hospitals. County payments are also sent to the treasury to offset the State appropriation.

New Jersey's 90/10 State Aid program reimburses counties for the services provided

to indigent persons in county hospitals. For county residents, the State pays 90 percent of the per diem, and the county picks up the remaining 10 percent.<sup>32</sup> For individuals not meeting the county residency criteria, the State pays the full 100 percent. If a patient is Medicaid eligible, the county psychiatric hospital must accept the Medicaid rate as

<sup>32</sup> County residency is established by residing in the county for at least 5 years.

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payment in full even if it is less than the rate for indigent persons.<sup>33</sup> Approximately 87 percent of patients in the county hospitals are covered through the State Aid program.

### *Hospital Admission Process*

All individuals receiving inpatient psychiatric services in a public psychiatric hospital must be admitted through a State-certified screening center.<sup>34</sup> There are 23 such centers (one in each county other than Essex County, which has three). Individuals can be assessed at the screening center or by a screener who travels to where the individual is located. The screeners evaluate potential admissions based on the involuntary commitment criteria. If the screener recommends admission, a psychiatrist must personally evaluate the patient and must approve the admission. The screening process focuses on placing individuals in the least restrictive treatment setting, which is often an STCF. New Jersey has approximately 300 STCF beds in approximately 15 facilities throughout the State. These STCFs primarily serve patients with stays shorter than 2 weeks. If an STCF bed is not available, or if the screener knows the patient's history and believes a longer-term placement is necessary, the screener may refer the patient to a State or county psychiatric hospital.

Individuals needing longer-term treatment are typically transferred to a State or county psychiatric hospital. The majority of State and county psychiatric hospital admissions are transfers from STCFs. The State facilities have no licensed bed capacity *per se* and

must accept all patients admitted through the screening centers. There is little movement of patients between State and county psychiatric hospitals, since the latter are intended to serve their respective counties exclusively. Residents of counties with a county psychiatric hospital would normally go to a State psychiatric hospital only if they met the admission criteria for one of the special treatment programs (e.g., having a dual diagnosis) or if the county facility was full.

While all patients in the public psychiatric hospital system must initially meet the involuntary admission criteria, they may change to a voluntary status following admission.

### *Major Operational Changes*

In 1987–88, New Jersey changed its policy such that the preferred place of treatment for individuals with acute psychiatric problems was no longer a public psychiatric hospital, but a community-based setting.<sup>35</sup> The STCF system was developed in response to this policy change. As mentioned, STCFs are intended to serve patients needing short-term care, provide services closer to the patient's homes, and to reserve the State and county hospitals for intermediate and long-term patients. As originally developed, STCFs served patients needing stays of up to 28 days. The average length of stay is now 10 to 11 days.

In 1995, New Jersey launched the Redirection plan, the purpose of which was to close a State-owned facility, Marlboro Psychiatric Hospital, and redirect all of the \$65 million used to operate that facility to community-based services. This operational change was the largest in the State inpatient mental health system in the past 10 years.

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<sup>33</sup> According to respondents, the per diem rate is currently higher than the Medicaid rate of reimbursement.

<sup>34</sup> The screening centers are always located in a general hospital.

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<sup>35</sup> Acute is defined as requiring 30 days of treatment or less.

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At its peak in 1994, Marlboro had 780 beds. Resources from its closure were used to finance 480 community placements (including approximately 388 community residential beds) and approximately 280 additional inpatient beds at the remaining State psychiatric hospitals. Marlboro officially closed in June 1998, after which time the Statewide admissions dropped by over 30 percent and overall State hospital census fell, although it has begun to rise slightly in recent years.

### *Anticipated Operational Changes*

New Jersey is in the early stages of the Redirection II program, under which the State plans to construct a smaller replacement facility for Greystone Park Psychiatric Hospital. Greystone's replacement facility will initially have 400 beds, a reduction of 138 beds from its current capacity, although there will be the potential for expanding by an additional 50 beds.

Under this plan and with additional State appropriations, the State plans to expand community-based mental health services, including supportive housing placements,

which are expected to relieve some of the pressure on discharge planning at the State psychiatric hospitals. At present, the State estimates that nearly 400 patients in the entire State psychiatric hospital population are appropriate for discharge to another treatment setting, but the absence of placement options essentially keeps them in the State psychiatric hospital system. The State has committed to funding both the inpatient and outpatient components of the Redirection initiative so that the expansion in the community-based infrastructure takes place before patients are discharged.

As the hospital census declines, the State does not intend to reduce overall hospital staffing so as to improve the staff-to-patient ratio and improve staff recruitment and retention at all of the State hospitals. A major component of the Redirection II Plan is to improve statewide quality of care in both community and hospital services.

Despite New Jersey's current budget problems, funding to initiate this plan was provided in State fiscal year 2003 and additional funding is anticipated for fiscal year 2004.

# Appendix D.

## Data Limitations

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**T**he financing role that Medicaid assumes with regard to State and county psychiatric hospitals is highly complex, and is made more so because of severe data limitations. Despite the existence of several publicly available national datasets on Medicaid, mental health, and psychiatric hospitals, each has limitations that may conceal the “true” magnitude of Medicaid funds received by public psychiatric hospitals (see Table D.1).

First, the data tend to express Medicaid expenditures in the aggregate, making it impossible to identify funds apportioned specifically to public psychiatric hospitals. The exception is in the accounting for DSH spending through the Medicaid DSH files, but those data are available only for 1998. In accounting for Medicaid reimbursements, HCFA-64 reports “mental health” (non-DSH) expenditures, but the data cover all providers within States, not just public psychiatric hospitals.

Second, even if it were possible to “back out” expenditures on public psychiatric hospitals, the existence of IGTs complicates the determination of the amount of Medicaid dollars that remain with these facilities. No information exists on the extent of funds flowing through IGTs, which States use IGTs, or the purposes for which States use the funds (e.g., other mental health services, offsets of State appropriations made to the hospitals, or other State-designated use).

In addition, States vary substantially in their portfolio of Medicaid funding sources and the extent of their use. For example,

Wisconsin does not use IGTs in its DSH program for public psychiatric hospitals (personal communication, 11/12/01, D. Zimmerman at the Wisconsin Department of Health and Family Services; Coughlin and Liska 1998) but is heavily involved in enhanced payments to county nursing facilities (GAO 2001; personal communication, 11/12/01, D. Zimmerman at the Wisconsin Department of Health and Family Services). Delaware, on the other hand, runs all its DSH funds through one State psychiatric hospital.

Finally, CMS cannot verify the use of upper-payment limit strategies for IMDs or for county-owned psychiatric hospitals in particular. State plan amendments altering payment methodologies to take advantage of enhanced payment strategies are too general to reveal whether the payments apply to IMDs (personal communication, 11/14/01, L. Reed at CMSO). Further, it is difficult to identify county-owned psychiatric hospitals along with the set of States in which they are located. Overall, data limitations have exacerbated a thin knowledge base on Medicaid financing of State and county psychiatric hospitals.

**Table D.1: Descriptions and Limitations of Currently Available Data on Medicaid Financing of Public Psychiatric Hospitals**

<b>Dataset</b>	<b>Source</b>	<b>Purpose/Description</b>	<b>Relevant Aspects</b>	<b>Limitations</b>
HCFA-64	CMS	Actual Medicaid expenditures incurred by States, broken into 24 statutorily defined categories, filed for the purposes of obtaining the Medicaid Federal match	Two categories <ul style="list-style-type: none"> <li>Mental health</li> <li>Mental health DSH, by State, 1994–1999</li> </ul>	<ul style="list-style-type: none"> <li>Categories are total expenditures not broken out by provider type</li> <li>Does not include revenues (i.e., impact of IGTs)</li> </ul>
Medicaid DSH files	CMS	DSH expenditures by hospital, categorized as public, private, psychiatric, acute, and child, filed with CMS to verify DSH caps	<ul style="list-style-type: none"> <li>Identifies all psychiatric hospitals that receive DSH, the amount, and whether public or private</li> <li>By hospital, by State, 1998–2000</li> </ul>	<ul style="list-style-type: none"> <li>Collection began only in fiscal year 1998</li> <li>Does not identify ownership beyond “public,” i.e., State- versus county-owned</li> <li>Not all States have reported; there are State-by-State variations in reporting</li> <li>Inconsistencies with HCFA-64 “mental health DSH”</li> <li>Does not include revenues (i.e., impact of IGTs)</li> </ul>
Inventory of Mental Health Organizations and General Hospital Mental Health Services (IMHO)	Center for Mental Health Services (CMHS)	Inventory of all specialty mental health organizations and separate psychiatric services of non-Federal general hospitals; collects funding source, expenditures, patients served, and so forth for research and policymaking	Identifies State and county psychiatric hospitals, shows Medicaid funding, 1994	<ul style="list-style-type: none"> <li>Data from 1994; collection also for 1998 and 2001, but only for sample (not complete inventory)</li> <li>Sources of funding are broad categories: Medicaid, client fees, Federal block grants, and so forth</li> <li>Does not include revenues (i.e., impact of IGTs)</li> </ul>
State Mental Health Agency Revenues and Expenditures Study	NRI, NASMHPD	Funding sources and expenditures of State mental health agencies (SMHA)	Funding from SMHA to State psychiatric hospitals, 1997	<ul style="list-style-type: none"> <li>Funding from SMHA to State mental hospitals not broken out by hospital or funding type (DSH versus other things)</li> <li>Does not include revenues (i.e., impact of IGTs)</li> </ul>
Mental Health Facilities 2000	Knowledge Exchange Network (KEN) at CMHS	Database with all mental health service organizations by facility type and address; provides consumer information about where to seek psychiatric services	Identifies psychiatric facilities by State and type of organization (i.e., “psychiatric hospital”), 2000	<ul style="list-style-type: none"> <li>Does not identify ownership (private/State/local)</li> <li>No expenditure/revenue information</li> </ul>
Directory of State Psychiatric Hospitals	NASMHPD	Database of all State psychiatric hospitals in the county, by State, and with address; consumer information	Identifies all State psychiatric hospitals, 1998	<ul style="list-style-type: none"> <li>Does not include county psychiatric hospitals</li> <li>No expenditure/revenue information</li> </ul>

Source: Assessment of noted databases.





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