

CHAPTER

6

**Congressional request:
Behavioral health services in
the Medicare program**

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Chapter summary

Medicare covers a range of behavioral health services, from screening, assessment, and evaluation to therapy, counseling, and inpatient psychiatric hospitalizations. In January 2022, the Chairman of the House Committee on Ways and Means requested that the Commission conduct an analysis of behavioral health services in the Medicare program. In response, this chapter explores two main topics: (1) utilization and spending by the traditional fee-for-service (FFS) beneficiary population for clinician and outpatient behavioral health services and (2) trends and issues in inpatient psychiatric care for beneficiaries, including discussion of Medicare's inpatient psychiatric facility (IPF) prospective payment system (PPS) and indicators of payment adequacy. Our work is supported by interviews conducted with IPFs on their provision of services and how these services differ by patient characteristics and facility types. Where possible, we include data on Medicare Advantage (MA) enrollees.

Clinician and outpatient behavioral health services

Clinician and outpatient provision of behavioral health services, such as psychiatric evaluations, psychotherapy, opioid treatment programs, and behavioral health integration, are covered by Medicare Part B for FFS beneficiaries. In 2021, spending for these behavioral health services and conditions was \$4.8 billion. In that year, 4.9 million Medicare FFS

In this chapter

- Medicare coverage of behavioral health services
- Clinician and outpatient behavioral health services
- Trends and issues in inpatient psychiatric care

beneficiaries (16 percent) received these services. Beneficiaries who used Part B behavioral health services were more likely to be disabled, low income, and younger than other FFS Medicare beneficiaries. They also incurred nearly twice the spending on overall health care (including prescription medications) as all FFS beneficiaries. In 2021, the top three behavioral health conditions were depression, anxiety, and substance use disorders (SUDs). Between 2019 and 2021, opioid use disorders (OUDs) among Medicare FFS beneficiaries increased annually by 7 percent. In 2020, Medicare began an opioid treatment program (OTP) benefit, which was used by nearly 40,000 FFS beneficiaries in 2021, representing a 27 percent increase from the prior year.

In 2022, behavioral health clinicians accounted for 40 percent of clinicians who opted out of Medicare, a higher rate than for other types of clinicians. Indeed, psychiatrists have the highest opt-out rate of all physician specialties. We found large shifts over time in the behavioral health workforce that provides services to Medicare beneficiaries; between 2016 and 2021, substantial growth in behavioral health services provided by nurse practitioners occurred while volume by psychiatrists declined. The pandemic exacerbated perceived shortages of behavioral health clinicians, but the rapid take-up of telehealth has helped to meet current needs. Telehealth for behavioral health services continued to grow in 2021, even as use of other telehealth services declined from their high in 2020. Among behavioral health services, telehealth was most used for psychotherapy services. Beneficiaries using telehealth for behavioral health visits filled more Part D prescription medications, despite spending less on overall Medicare Part A and Part B services, compared with their in-person-visit counterparts. Notably, some behavioral health clinicians provided only telehealth in 2021 (i.e., provided no in-person health services in that year)—a trend that should continue to be monitored.

Trends and issues in inpatient psychiatric care

Medicare beneficiaries experiencing an acute behavioral health crisis can be treated in general acute care hospitals or in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting. Medicare reimburses specialty IPFs for care provided to FFS beneficiaries through the IPF PPS. In FY 2021, 157,500 Medicare FFS beneficiaries had 230,500 stays at one of 1,480 hospital-based or freestanding IPFs and incurred \$3.0 billion in spending on IPF care (including both Medicare program costs and beneficiary cost sharing).

Medicare beneficiaries using IPF services are among the most vulnerable. Compared with the rest of the FFS Medicare population, they are much more

likely to be disabled and low income, have more chronic conditions (such as hypertension, kidney disease, and dementia), consume more health care services, and are costlier to Medicare. In 2021, Medicare Part A and Part B spending per beneficiary for those with an IPF stay was nearly four times higher than for all FFS beneficiaries. Medicare Part D prescription drug spending for beneficiaries who had an IPF stay was nearly twice as much as for other FFS beneficiaries. As of January 2023, nearly 50,000 Medicare beneficiaries had reached or were within 15 days of reaching the 190-day lifetime limit on freestanding IPF days. These beneficiaries were more likely to be disabled, younger, low income, and Black compared with other beneficiaries who had an IPF stay in 2021.

Using data from 2018, we found a high rate of emergency department visits and acute care hospital admissions before and after an IPF admission, and a relatively low rate of visits with behavioral health clinicians, suggesting that many of these beneficiaries were not receiving effective, well-coordinated outpatient behavioral health care.

Our indicators of Medicare payment adequacy for IPFs revealed some concerning trends and identified gaps where additional information is needed to assess the accuracy of payments and the quality of IPF care.

Beneficiaries' access to care—We examined trends in IPF supply and the volume of services as indicators of beneficiaries' access to IPFs.

- **Capacity and supply of providers**—While the number of IPFs has declined since 2017, the number of psychiatric beds has grown, fueled by growth in the number of beds at for-profit IPFs. In 2021, aggregate occupancy rates, based on Medicare cost reports, decreased to 70 percent (from 76 percent in 2017), suggesting availability of IPF beds. However, IPF interviewees agreed that labor shortages limited the number of staffed beds available, a situation that is not fully captured by cost reports. Moreover, higher occupancy rates at government IPFs—which frequently function as providers of last resort—also indicate insufficient supply for persistently mentally ill beneficiaries.
- **Volume of services**—Overall Medicare FFS volume at IPFs has been declining for several years, with commensurate decreases in aggregate Medicare FFS spending on IPF services. The decline in utilization between 2019 and 2021 was particularly steep, likely related to avoidance or deferral of inpatient

stays in response to the spread of COVID-19 and to IPFs' limited treatment capacity due to staffing shortages.

Quality of care—Data on the quality of care provided by IPFs are currently too limited to meaningfully assess and compare quality across facilities. As IPFs begin to report patient-level quality results, CMS and others will be able to better assess the quality of care provided by IPFs. Incorporation of more outcomes and patient experience measures into the IPF quality reporting program would also improve policymakers' ability to assess quality.

Providers' access to capital—Access to capital appears to be strong among IPFs. Almost two-thirds of IPF providers are hospital-based units that would access any necessary capital through their parent institutions. Overall, acute care hospitals maintained strong access to capital in 2021. Freestanding IPFs also had access to capital; the largest owner of freestanding IPFs expanded between 2019 and 2022, with plans for new facilities between 2023 and 2025.

Medicare payments and providers' costs—In 2021, the overall aggregate margin for IPFs was -9.4 percent, though margins varied substantially across IPFs. The variation tracked with differences in costs by IPF type, with freestanding for-profit IPFs having lower costs (and higher margins, 15.0 percent) and hospital-based IPFs having higher costs (and lower margins, -28.3 percent). This pattern is likely due in part to differences in scale (for-profit IPFs tend to be larger). It is not clear whether differences in the mix of patients served or the quality of care provided also plays a role. To properly assess whether the IPF payment system is accurately capturing costs and classifying patients, policymakers need more information on patient severity and resource use, including use of ancillary services. Some ancillary services, such as prescription drugs, are expected to be widely used by IPF patients. However, we found that a number of IPFs (over 50 percent of freestanding for-profit IPFs) do not report ancillary services or have changed their cost-reporting designations to “all-inclusive-rate” hospitals, such that they are not required to separately report ancillary services. Some of these issues may be resolved when CMS collects more information on IPFs' resource use and patient characteristics, as required by the Consolidated Appropriations Act, 2023. ■

Introduction

Behavioral health refers to the promotion of mental health and overall wellbeing, including the treatment of substance use disorders (SUDs). Behavioral health conditions include depression, anxiety, substance use, schizophrenia spectrum, bipolar, and other disorders. In 2021, the prevalence of behavioral health conditions among adults in the U.S. was over 30 percent (Substance Abuse and Mental Health Services Administration 2022). Older adults are particularly at risk for behavioral health problems: Functional decline, increased comorbidities, pain, and loss of social support during the aging process can trigger or exacerbate anxiety, depression, and SUDs (Fleet et al. 2022, Koenig et al. 1994). The prevalence of these conditions among older adults has been growing (Substance Abuse and Mental Health Services Administration 2017).

Services to diagnose and treat behavioral health conditions are provided in various settings, such as clinicians' offices, hospital outpatient departments, clinics, emergency departments, inpatient hospital settings, and more recently through telehealth in the patient's home. Clinicians who provide these services also vary widely, including psychiatrists, psychologists, social workers, general and family practitioners, nurse practitioners, and physician assistants. The coronavirus pandemic—and consequent disrupted medical care, increased social isolation, and loss of loved ones—further heightened the risk of behavioral health problems among older adults (Busch et al. 2022a, Friedman 2022, Government Accountability Office 2021a, Yang et al. 2022). Long-standing concerns about access to behavioral health services have also been exacerbated by the coronavirus pandemic (Government Accountability Office 2022a).

In January 2022, the Chairman of the House Committee on Ways and Means requested that the Commission conduct an analysis on the utilization and availability of behavioral health services for Medicare beneficiaries, as follows:

- Describe the utilization of outpatient behavioral health services, including telehealth for behavioral health services, and characteristics of beneficiaries using these services.

- Examine trends and issues in inpatient psychiatric facility (IPF) care for beneficiaries, including examining the adequacy of Medicare's payment to IPFs, quality of IPF care, and information on beneficiaries reaching the 190-day lifetime limit on freestanding psychiatric hospital days.
- To the extent possible, describe use of behavioral health services by beneficiaries enrolled in Medicare Advantage (MA).

In response, we examined Medicare's coverage of behavioral health services; Medicare beneficiaries' use of, and spending on, behavioral health services provided by clinicians and outpatient facilities; and trends and issues in IPF services provided to Medicare beneficiaries, including findings from interviews conducted with IPF officials on the provision of services and how they differ by patient characteristics and facility types.

Our analyses on utilization and spending rely upon Medicare fee-for-service (FFS) claims data. Where possible, we use MA encounter data to examine utilization among MA enrollees. We use diagnosis codes and procedure codes to identify beneficiaries using behavioral health services. To the extent that behavioral health codes are not used, our results undercount utilization and spending. Studies have found underuse of behavioral health services to affect older adults in particular for several reasons, including lack of knowledge of the availability of services, lack of perceived need for care, and stigma (Crabb and Hunsley 2006, Garrido et al. 2011, Sorkin et al. 2016).

Medicare coverage of behavioral health services

Medicare covers a range of behavioral health services, from annual screening, evaluation, and counseling to inpatient psychiatric hospitalizations in a variety of settings, including clinicians' offices, clinics, hospital outpatient and inpatient facilities, and via telehealth (Table 6-1, p. 232). Coverage includes integration of behavioral and physical health services as well as early detection and interventions for SUDs. Behavioral health services covered under Medicare Part B require patient cost sharing through a deductible and 20 percent

**TABLE
6-1**

Medicare coverage of behavioral health services

	Types of services	Location(s)	Beneficiary costs
Screening	<ul style="list-style-type: none"> • Welcome to Medicare • Wellness visit • Depression • Alcohol misuse 	<ul style="list-style-type: none"> • Some services require an outpatient setting that can provide follow-up treatment 	<ul style="list-style-type: none"> • No cost sharing
Counseling	<ul style="list-style-type: none"> • Psychiatric evaluation • Individual or group psychotherapy • Family counseling • Alcohol counseling 	<ul style="list-style-type: none"> • Any setting 	<ul style="list-style-type: none"> • Part B deductible + 20% coinsurance
Behavioral and physical health integration	<ul style="list-style-type: none"> • Behavioral health integration services • Health behavior assessment and intervention 	<ul style="list-style-type: none"> • Any setting 	<ul style="list-style-type: none"> • Part B deductible + 20% coinsurance
Early intervention for nondependent substance use (SBIRT)	<ul style="list-style-type: none"> • Screening for risk of a substance use disorder • Brief intervention • Referral for additional treatment 	<ul style="list-style-type: none"> • Clinician office or hospital outpatient 	<ul style="list-style-type: none"> • Part B deductible + 20% coinsurance, though some services are considered preventive and have no cost sharing
Opioid use disorder (OUD) treatment	<ul style="list-style-type: none"> • Medications for OUD • Substance use counseling • Individual or group therapy • Testing and assessments 	<ul style="list-style-type: none"> • Accredited and certified OTP provider • Clinician office and hospital outpatient can bill some services 	<ul style="list-style-type: none"> • OTPs: Part B deductible only • Non-OTPs: Part B deductible + 20% coinsurance
Partial hospitalization	<ul style="list-style-type: none"> • Intensive outpatient care • Therapy, counseling • Minimum of 20 hours per week 	<ul style="list-style-type: none"> • Hospital outpatient, community mental health centers 	<ul style="list-style-type: none"> • Part B deductible + 20% coinsurance
Inpatient psychiatric hospitalization (IPF or general acute care hospital)	<ul style="list-style-type: none"> • 24-hour care in hospital • Therapy, counseling, rehabilitation, medication management 	<ul style="list-style-type: none"> • Hospital inpatient 	<ul style="list-style-type: none"> • Part A deductible + copay for hospital stay • Part B deductible + 20% coinsurance for clinician services
Prescription drugs	<ul style="list-style-type: none"> • Pharmacy fills for self-administered drugs • Clinician administered in an outpatient setting • Administered in an inpatient setting 	<ul style="list-style-type: none"> • Any setting, but coverage differs by type of drug (self-administered or not) and setting 	<ul style="list-style-type: none"> • Part A when received in hospital or SNF • Clinician administered: Part B deductible + 20% coinsurance • Self-administered: Part D

Note: SBIRT (screening, brief intervention, and referral to treatment), OTP (opioid treatment program), OUD (opioid use disorder), IPF (inpatient psychiatric facility), SNF (skilled nursing facility). This table does not include additional benefits specified by the Consolidated Appropriations Act, 2023.

coinsurance, though cost sharing is waived for certain types of services (such as screening and preventive care). In 2020, Medicare Part B began to cover episodes of care for treating opioid addiction, consisting of counseling, therapy, and medication-assisted treatment (including methadone) from certified opioid treatment providers (Centers for Medicare & Medicaid Services 2021c).

For beneficiaries needing more intensive behavioral health interventions, Medicare covers partial hospitalization, which includes an intensive psychiatric outpatient treatment. Partial hospitalization can provide a “step-down” alternative following an inpatient hospitalization or may be used instead of inpatient care for patients who need more services than can be provided on an outpatient basis but who are not so ill that they need 24-hour care and supervision.¹ Partial hospitalization programs (PHPs) offer a combination of individual, group, family, occupational, and activity therapies and are administered by hospital outpatient departments or community mental health centers (CMHCs). Use of PHPs diminished substantially in the last two decades after findings of fraud, waste, and abuse among CMHCs.² The Consolidated Appropriations Act (CAA), 2023, limits PHPs to beneficiaries requiring a minimum of 20 hours of these services per week while adding a new “intensive outpatient services” benefit for beneficiaries needing a minimum of 9 hours of services per week (effective January 1, 2024). The text box (p. 234) summarizes recent legislation related to Medicare behavioral health services.

Beneficiaries experiencing an acute mental health or SUD-related crisis requiring hospitalization can be treated by specialty IPFs, which are freestanding hospitals or specialized units within acute care general hospitals. Beneficiaries may also receive care for a psychiatric or SUD condition in a general acute care bed (referred to as “scatter beds”). These services are covered under Medicare Part A, which requires patient cost sharing, including a deductible and copayments depending on the length of the stay. Under Medicare Part A, the limit to the total lifetime number of days in freestanding IPFs is 190 days. Services from physicians and other clinicians during hospitalization are covered by Medicare Part B (and subject to Part B cost-sharing requirements).

Finally, a significant component of Medicare’s coverage for treatment and management of behavioral health conditions is coverage of pharmaceuticals. Medicare Part B covers drugs provided incident to clinician services that are not generally self-administered (e.g., long-acting injectable medications that must be administered by a health care professional). Part D, Medicare’s outpatient prescription drug benefit, requires drug plans to cover all drugs in the following classes (with limited exceptions): antidepressant, anticonvulsant, and antipsychotic medications. CMS reviews formularies to ensure that Part D plans are not discriminating against beneficiaries with certain conditions (such as beneficiaries with SUDs). During an inpatient hospital stay, all prescription medications are covered as part of the Medicare Part A–covered inpatient stay.

Medicaid is the largest payer for behavioral health services in the U.S., and some state Medicaid programs offer additional behavioral health services not covered by Medicare (see text box on Medicaid and behavioral health services, p. 235). Nearly 20 percent of beneficiaries in Medicare’s traditional FFS program were dually eligible for Medicaid at some point in 2021 (this was nearly 40 percent among beneficiaries using Part B behavioral health services) and could be eligible for additional Medicaid behavioral health services, depending on their state.

Clinician and outpatient behavioral health services

Our work examines utilization and spending on outpatient–provided and clinician–provided behavioral health services. We identified the characteristics of beneficiaries using these services and the types of practitioners providing them. Notably, we observed a substantial shift from in-person visits to telehealth visits that occurred with the onset of COVID-19.

Medicare’s payment for Part B behavioral health services

Our work focused on Medicare payment of Part B behavioral health services such as psychiatric evaluations, psychotherapy, opioid treatment programs, and behavioral health integration, among

Recent behavioral health legislation

The Consolidated Appropriations Act (CAA) of 2021 and the CAA, 2023, included several Medicare provisions related to behavioral health, including expansion of the behavioral health workforce, making the tele-behavioral health expansion permanent, adding Medicare coverage for intensive outpatient psychiatric services, and requiring the collection of more information related to inpatient psychiatric facilities to refine the payment system and better track quality of care.

Adding marriage and family therapists and mental health counselors to the behavioral health workforce

Effective January 1, 2024, per the CAA, 2023, Medicare will cover and reimburse licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs). Prior to this date, LMFTs and LPCs were able to bill for care provided to Medicare beneficiaries only when performed under the supervision of physicians or non-physician practitioners. Medicare will reimburse these clinicians at 75 percent of the payment for psychologists, comparable to the payment rate for clinical social workers.

Permanent expansion of tele-behavioral health

The CAA, 2021, removed the geographic restrictions on tele-behavioral health provision and added the patient's home as an originating site for telehealth services that are used to diagnose, evaluate, or treat a behavioral health disorder. Per the CAA, 2023, starting in 2025, an in-person visit must be provided by the clinician furnishing tele-behavioral health services within six months prior to the initial telehealth visit and annually thereafter; however, the policy does not apply if the practitioner and patient agree that the benefits of an in-person service are outweighed by the risks and burdens associated

with an in-person service. CMS will also pay for tele-behavioral services provided in an audio-only interaction if the clinician has the capability to use an interactive telecommunications system that includes video and the beneficiary is unable to use the video component or does not consent to video use.

New intensive outpatient services benefit

Effective January 1, 2024, per the CAA, 2023, Medicare will cover an “intensive outpatient services” benefit for beneficiaries needing a minimum of nine hours of intensive behavioral health services per week. This differs from the existing partial hospitalization benefit, which is available to Medicare beneficiaries needing at least 20 hours of services per week. Intensive outpatient services may be provided in federally qualified health centers, rural health clinics, and community mental health centers.

Inpatient psychiatric facility data collection

The CAA, 2023, requires CMS to collect additional information to refine payments under Medicare's inpatient psychiatric facility payment system. Starting in October 2023, CMS is required to collect additional data on ancillary service provision (e.g., prescription medications, laboratory services), resource use, and need for monitoring (e.g., violent behavior, physical restraint) and interventions (e.g., detoxification services, dependence on a respirator) through cost reports, claims, or another source. CMS also is required to collect information on patient characteristics (e.g., functional status, cognitive function, comorbidities, and impairments) using a standardized patient assessment instrument beginning in 2028. Last, CMS is required to develop a measure of patients' perspectives on care and add the measure to the quality reporting program by 2031. ■

others (see text box on our methods for identifying behavioral health services, p. 238). We included services for which the diagnosis on the claim indicated a behavioral health condition or for which the place

of service was a behavioral health-related location (e.g., psychiatric treatment facility). From the Part B practitioner (or carrier) claims file, we included Part B behavioral health clinician services performed under

Medicaid and behavioral health services

Federal law mandates that Medicaid cover certain medically necessary behavioral health services, but states can offer other optional services that are important to beneficiaries with behavioral health conditions. States may also participate in demonstrations or waiver programs that provide additional services or test alternative approaches to delivering behavioral health services. Below, we highlight a few notable behavioral health benefits that are unique to Medicaid (i.e., not covered by Medicare). This is not an exhaustive list of additional Medicaid behavioral health benefits.

- **Rehabilitation services option:** States can offer recovery-oriented behavioral health services to beneficiaries. These include some of the same services that are covered by Medicare (such as counseling, therapy, and partial hospitalizations) as well as services Medicare does not cover. For example, as of 2015, over 45 states offer community psychiatric support services or assertive community treatment. Other common services provided by states include employment supports, home-based services, round-the-clock services, and caregiver support services (Medicaid and CHIP Payment and Access Commission 2015).
- **Certified Community Behavioral Health Clinics (CCBHCs):** CCBHCs are specialty clinics that provide comprehensive and coordinated behavioral health care that addresses both physical and behavioral health conditions, including 24/7 mobile crisis support, outpatient mental health and substance use counseling and treatment, and primary care screening. CCBHCs began as a Medicaid demonstration program in 2016 with eight states, and the program has since received over \$300 million in planning grant funds from the federal Substance Abuse and Mental Health Services Administration to expand nationwide (Department of Health and Human Services 2022, Government Accountability Office 2021b).
- **Housing-related supports:** Several state Medicaid programs have seen success in providing and expanding housing-related services for individuals with substance use disorders who are at risk of or experiencing homelessness (Department of Health and Human Services 2020). These include strategies to support transition to housing, housing and tenancy sustaining services, and state-level housing-related collaborative activities.
- **Services from licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs):** LMFTs and LPCs are considered eligible providers by most Medicaid plans, while currently they can only practice incident to a physician or other eligible practitioner under Medicare (Schoebel et al. 2022). Under the CAA, 2023, LMFTs and LPCs will be eligible to bill Medicare starting January 1, 2024 (see text box on recent behavioral health legislation, p. 234).
- **Mental health parity:** Medicaid managed care organization (MCO) plans must abide by federal behavioral health parity rules that require that health plans have the same coverage for behavioral health services as for medical/surgical services in terms of financial requirements (e.g., cost sharing) and treatment limits (e.g., prior authorizations).³ States are encouraged to apply parity rules more broadly than to only MCO enrollees. Parity rules do not apply to Medicare or Medicare Advantage plans. For example, some stakeholders have asserted that Medicare's limit on the number of days in freestanding inpatient psychiatric facilities would not meet parity standards (Government Accountability Office 2022b). ■

the physician fee schedule (PFS). From the outpatient claims file, we also included Part B behavioral health services provided by hospital outpatient departments, CMHCs, skilled nursing facilities (SNFs), critical

access hospitals (CAHs), rural health clinics (RHCs), and federally qualified health centers (FQHCs). We calculated total Part B spending as all Medicare

**TABLE
6-2**

Medicare FFS beneficiaries using Part B behavioral health services, 2017–2021

	FFS beneficiaries using behavioral health services (millions)	Share of FFS beneficiaries	Part B spending for behavioral health services			
			PFS allowed charges (billions)	Other total payments (billions)	Total spending (billions)	Total spending per beneficiary
2017	5.3	16%	\$3.4	\$1.1	\$4.5	\$846
2018	5.4	16	3.5	1.1	4.6	860
2019	5.4	16	3.6	1.2	4.7	876
2020	5.0	16	3.5	0.9	4.5	885
2021	4.9	16	3.8	1.0	4.8	981

Note: FFS (fee-for-service), PFS (physician fee schedule). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. “Total spending” represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing. “Other total payments” includes Part B payments for services provided in hospital outpatient departments, community mental health centers, skilled nursing facilities, critical access hospitals, rural health clinics, and federally qualified health centers. Components may not sum to totals due to rounding.

Source: MedPAC analysis of carrier and outpatient FFS claims and Medicare enrollment data from CMS.

program payments made to the provider of the service, including beneficiary cost sharing.

In 2021, total spending for Part B behavioral health services was \$4.8 billion (up from \$4.5 billion in 2017) (Table 6-2). Most of this spending was for PFS-covered services (\$3.8 billion, or 80 percent of the total). Between 2017 and 2020, per beneficiary total behavioral health spending was steady, with an annual growth rate of 1 percent. However, between 2020 and 2021, spending per beneficiary grew by 11 percent (from \$885 to \$981). This growth was likely related to increases in the reimbursement of evaluation and management (E&M) services that went into effect January 1, 2021 (Centers for Medicare & Medicaid Services 2020a).

Characteristics of Medicare beneficiaries using Part B-covered behavioral health services

Approximately 16 percent of Medicare FFS beneficiaries use Part B behavioral health services each year (Table 6-2). (See text box, p. 238, for a discussion of the methods we used to identify Part B behavioral health services.) From 2019 to 2021, with the onset of the pandemic (and growth in MA enrollment), the

number of FFS beneficiaries using Part B behavioral health services declined from 5.4 million to 4.9 million; however, this figure continued to represent about 16 percent of the FFS population. In 2021, total spending on Part B behavioral health services was \$4.8 billion; spending per beneficiary was \$981.

FFS beneficiaries using behavioral health services were more likely to be disabled, low income, and have higher Medicare overall spending

In 2021, Medicare beneficiaries using Part B behavioral health services were more likely to be disabled, female, young, low income, and have a higher CMS hierarchical condition category (HCC) risk score (meaning poorer health status) compared with other FFS beneficiaries (Table 6-3). Beneficiaries using Part B behavioral health services were slightly more likely to be located in an urban metropolitan area compared with other FFS beneficiaries (81 percent vs. 79 percent).⁴ Beneficiaries using Part B behavioral health services were less likely to be located in a health professional shortage area (HPSA) (26 percent vs. 29 percent for other FFS beneficiaries).⁵ Total Medicare Part A and Part B spending for

**TABLE
6-3**

Characteristics of Medicare FFS beneficiaries using Part B behavioral health services, 2021

Current eligibility status and demographics (in percent)	Beneficiaries using behavioral health services	All other FFS
Aged	71	90
Disabled	29	10
ESRD	0.2	0.3
Female	62	53
Male	38	47
<45	10	3
45-64	23	14
65-79	50	63
80+	17	20
Non-Hispanic White	80	78
Black	9	9
Asian/Pacific Islander	2	3
Hispanic	6	6
American Indian/Alaska Native	0.6	0.5
Other or unknown	3	3
Metropolitan	81	79
Micropolitan	11	12
Rural (adjacent)	5	6
Rural (nonadjacent)	3	4
Frontier		
No	99	99
Yes	1	1
Mental health HPSA		
No	74	71
Yes	26	29
Dual eligible or LIS during year		
No	58	82
Yes	42	18
HCC risk score	1.40	0.98
Medicare Part A and Part B spending (per capita)	\$19,481	\$7,896
Medicare Part D (per capita)*		
Gross spending**	\$7,085	\$3,926
Fills	74	47

Note: FFS (fee-for-service), ESRD (end-stage renal disease), HPSA (health professional shortage area), LIS (low-income subsidy), HCC (hierarchical condition category). Beneficiaries using behavioral health services include those with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. Geographic categories are based on the beneficiary's county of residence, mapped using the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes.

*Includes only those beneficiaries enrolled in Part D.

**Reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies.

Source: MedPAC analysis of FFS standard analytic files, Medicare enrollment, HCC risk score, and Part D prescription drug event data from CMS.

Identifying Part B behavioral health services

We created an analytic file consisting of Part B behavioral health services by applying the following criteria to select Medicare fee-for-service (FFS) carrier and hospital outpatient claims line-item records from 100 percent of Medicare FFS standard analytic claims files:⁶

- *Select behavioral health conditions:* records with mental health or substance use disorder–related diagnosis codes specified using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (Table 6-4), or
- *Select behavioral health visits:* records for the following services:
 - psychiatric evaluation: 90791, 90792, 90885, 90887, 90889, 90899
 - psychotherapy visits: 90832–90838, 90839–90840, 90845–90848, 90849, 90853, 90863, 90875–90876, 90880
 - behavioral health integration services: 99492, 99493, 99494, G2214, 99484
 - behavior assessment and intervention: 96150–96159
 - partial hospitalization: G0177, H0035, S0201
 - screening, brief intervention, referral to treatment: G2011, G0396, G0397
 - opioid treatment program: G1028, G2067–G2080, G2215, G2216, G2086–G2088, or
- *Select behavioral health place of service:* records where the place of service is related to behavioral health care:
 - inpatient psychiatric facility
 - residential and nonresidential substance abuse treatment facility
 - psychiatric residential treatment facility
 - opioid treatment facility
 - community mental health center (CMHC) or partial hospitalization in a hospital outpatient department

We include outpatient claims for Part B behavioral health services if they occurred in hospital outpatient departments, CMHCs, skilled nursing facilities, critical access hospitals, rural health clinics, or federally qualified health centers. We summed total payments for these services with allowed charges from the physician fee schedule to obtain total spending for Part B behavioral health services. Total spending represents all payments made to the provider for the service, including beneficiary cost sharing. Unless indicated otherwise, our spending and utilization figures refer to total spending for these Part B behavioral health services rather than all Medicare services. We exclude clinical laboratory claims and claims for Part B drugs

(continued next page)

beneficiaries using behavioral health services in 2021 was two and half times that of other FFS beneficiaries, and their Medicare Part D spending was nearly twice that of other FFS beneficiaries. Medicare spending on Part B behavioral health services represented less than 4 percent of total Part A and Part B spending

for beneficiaries who used Part B behavioral health services in 2021 (data not shown).

In 2021, the two most common behavioral health conditions diagnosed among beneficiaries using Part B behavioral health services were depressive disorders (5.8 percent of FFS beneficiaries, with \$1.4 billion of

Identifying Part B behavioral health services (cont.)

**TABLE
6-4**

Clinical Classifications Software Refined categories for mental, behavioral, and neurodevelopmental disorders

CCSR category	Description
MBD001	Schizophrenia spectrum and other psychotic disorders
MBD002	Depressive disorders
MBD003	Bipolar and related disorders
MBD004	Other specified and unspecified mood disorders
MBD005	Anxiety and fear-related disorders
MBD006	Obsessive-compulsive and related disorders
MBD007	Trauma- and stressor-related disorders
MBD008	Disruptive, impulse-control, and conduct disorders
MBD009	Personality disorders
MBD010	Feeding and eating disorders
MBD011	Somatic disorders
MBD012	Suicidal ideation/attempt/intentional self-harm
MBD013	Miscellaneous mental and behavioral disorders/conditions
MBD014	Neurodevelopmental disorders
MBD017	Alcohol-related disorders
MBD018	Opioid-related disorders
MBD019	Cannabis-related disorders
MBD020	Sedative-related disorders
MBD021	Stimulant-related disorders
MBD022	Hallucinogen-related disorders
MBD023	Inhalant-related disorders
MBD024	Tobacco-related disorders
MBD025	Other specified substance-related disorders
MBD026	Mental and substance use disorders in remission
MBD027	Suicide attempt/intentional self-harm; subsequent encounter
MBD034	Mental and substance use disorders; sequela

Note: MBD (mental, behavioral, and neurodevelopmental), CCSR (Clinical Classifications Software Refined).

Source: CCSR from the Agency for Healthcare Research and Quality.

(reported separately). We refer to these behavioral health services as “Part B behavioral health services” and the beneficiaries who use these services as “beneficiaries using Part B behavioral health services.”

For analyses of the type of behavioral health services that beneficiaries received, we include the types of visits listed above as well as evaluation and management visits and emergency department visits when either type of visit had an accompanying behavioral health diagnosis code. ■

**TABLE
6-5**

Depressive and anxiety disorders were the most common behavioral health conditions among FFS beneficiaries using Part B behavioral health services, 2021

	Number of beneficiaries (thousands)	Share of beneficiaries	Total spending for behavioral health condition (millions)
Depressive disorders	1,784	5.8%	\$1,443
Anxiety and fear-related disorders	1,550	5.0	702
Substance use disorders	704	2.3	541
Trauma-related and stressor-related disorders	664	2.1	511
Schizophrenia spectrum and other psychotic disorders	519	1.7	662
Bipolar and related disorders	416	1.3	425
Neurodevelopmental disorders	217	0.7	100
Disruptive, impulse-control, and conduct disorders	80	0.3	39
Suicide attempt/intentional self-harm	78	0.3	71
Other behavioral health conditions	466	1.5	207

Note: FFS (fee-for-service). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who had carrier or outpatient FFS claims with behavioral health diagnosis codes. Total spending represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing. Diagnoses were grouped using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp). Excluded from this table are behavioral health services for which there was not an associated behavioral health diagnosis code (approximately \$95 million in spending).

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

associated spending) and anxiety and fear-related disorders (5.0 percent, with \$702 million in spending) (Table 6-5). About 2 percent of FFS beneficiaries had an

SUD, associated with \$541 million in Part B behavioral health spending. The true number of beneficiaries with SUDs is likely higher: A recent study reported

**TABLE
6-6**

Part B behavioral health spending was disproportionately higher for FFS beneficiaries with certain dual diagnosis categories, 2021

	Share of beneficiaries using behavioral health services	Share of total spending on behavioral health services
Depression/anxiety/trauma only	60%	49%
Schizophrenia/bipolar only	11	13
Substance use disorder only	10	7
More than one of the above categories	10	27
All other behavioral health conditions	10	4

Note: FFS (fee-for-service). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who had carrier or outpatient FFS claims with behavioral health diagnosis codes. Total spending represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing. Diagnoses were grouped using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp) and categorized as shown. Excluded from this table are behavioral health services for which there was not an associated behavioral health diagnosis code (approximately \$95 million in spending).

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

Accountable care organizations and behavioral health care

Medicare accountable care organizations (ACOs) were designed to promote care coordination and improve quality and delivery of care through shared-savings financial incentives. ACOs should thus be incentivized to address the needs of beneficiaries with behavioral health conditions, given these beneficiaries' high associated spending and the proven effectiveness of coordinated behavioral and physical care (Busch et al. 2017, Figueroa et al. 2022, National Association of State Mental Health Program Directors 2016). However, evidence to date has found that many ACOs have not made the necessary investments to integrate behavioral health into primary care (Busch et al. 2022b). One study found that only 14 percent of ACO respondents to a 2017–2018 national survey reported including a specialty behavioral health

provider in their ACO network (Newton et al. 2022). Moreover, studies to date have found little or no impacts of ACOs on quality of care and spending related to behavioral health (Acevedo et al. 2021, Busch et al. 2017, Busch et al. 2016, Figueroa et al. 2022).

Although ACOs remain interested in addressing behavioral health, and some progress has been made by Medicaid ACOs, studies have reported several barriers to progress. These include the limited behavioral health workforce, slow adoption of the necessary health information technology (to facilitate information exchange across providers), and limited behavioral health-specific quality incentives (Beil et al. 2019, Fullerton et al. 2016, Minkoff 2016). ■

that older adults are at higher risk of undiagnosed and untreated SUD since they are less likely to be screened, assessed, and treated compared with younger adults (Dufort and Samaan 2021). This may be due to greater difficulty in screening because of cognitive impairment, misattributing of symptoms of SUD to the aging process, stigma, and a misconception that substance use is less likely among older adults (Dufort and Samaan 2021).

Beneficiaries with co-occurring behavioral health conditions, or dual diagnoses (particularly with SUDs), are at greater risk of poor outcomes, including arrests, homelessness, increased medical problems, and higher costs of care (Dixon 1999, Pew Research Center 2023, Substance Abuse and Mental Health Services Administration 2023). We defined behavioral health dual diagnoses as having diagnoses in more than one of the following categories: (1) depressive, anxiety and fear-related, or trauma- and stressor-related disorders; (2) schizophrenia or bipolar disorders; and (3) SUDs. We found that beneficiaries with dual diagnoses incurred disproportionately more spending on Part B behavioral

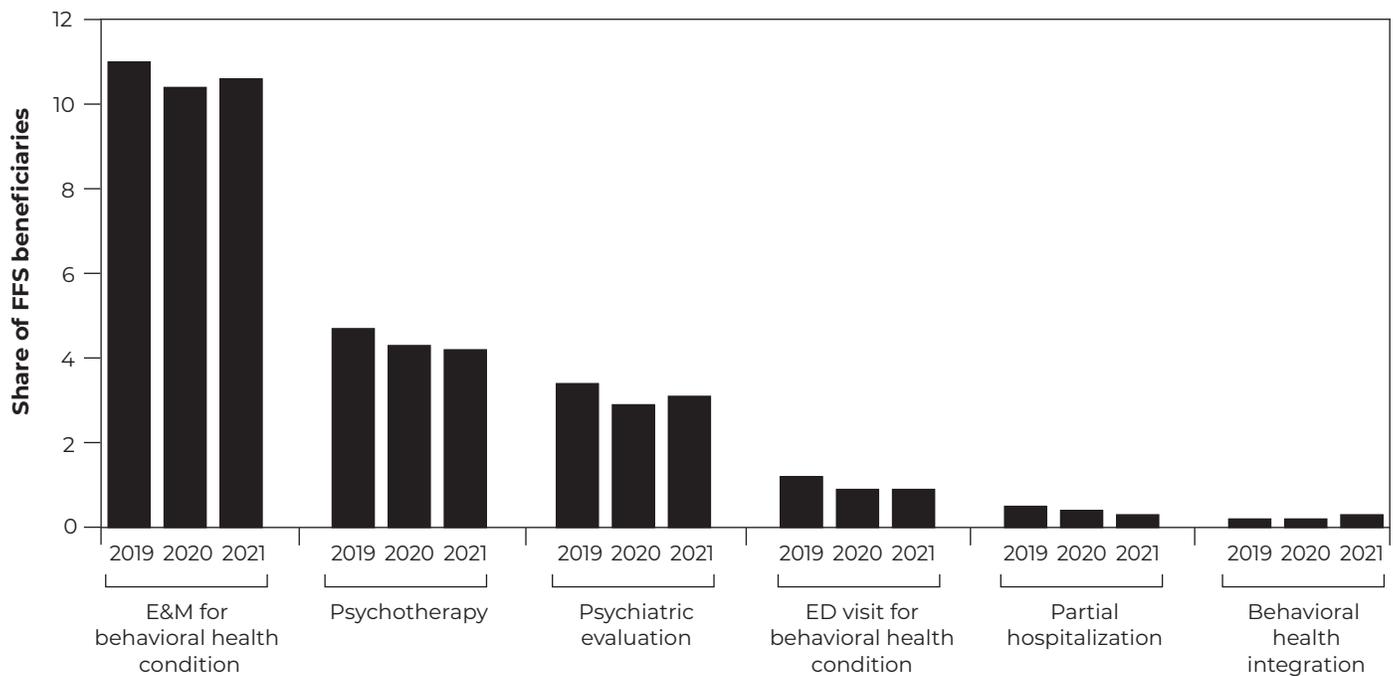
health services compared with others without dual diagnoses in 2021 (Table 6-6). In addition, in the same year, Medicare spent nearly \$30,000 per capita on Part A and Part B services for beneficiaries with dual diagnoses, which was 1.5 times the per capita amount spent for all beneficiaries using behavioral health services (data not shown).

Utilization of Part B behavioral health services

We identified the provision of Part B behavioral health services based on the presence of certain Healthcare Common Procedure Coding System (HCPCS) codes, diagnosis codes, and places of services (see text box on the methodology for defining Part B behavioral health services, pp. 238–239). We identified the following behavioral health service types: psychotherapy, psychiatric evaluation, evaluation & management (E&M) visits for a behavioral health diagnosis, emergency department (ED) visits for behavioral health diagnosis, partial hospitalizations, and behavioral health integration services.

FIGURE 6-1

Share of FFS beneficiaries using behavioral health services, 2019–2021



Note: FFS (fee-for-service), E&M (evaluation and management), ED (emergency department). Figures represent the share of all FFS beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services. Behavioral health conditions were defined using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp).

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

E&M visits for a behavioral health diagnosis were the most common type of behavioral health service among beneficiaries using Part B behavioral health services. In 2021, 11 percent of FFS beneficiaries had this type of visit (Figure 6-1). The next most common behavioral health visits were for psychotherapy and psychiatric evaluations. About 1 percent of the FFS population had an ED visit for a behavioral health condition. Only 0.3 percent of Medicare FFS beneficiaries received partial hospitalization services. For most of these services, utilization dipped in 2020 (with the onset of COVID-19) but increased in 2021, nearing 2019 levels.

Less than 1 percent of beneficiaries received behavioral health integration services, though this share slightly increased between 2019 and 2021 (Figure 6-1). Clinicians

can bill for behavioral health integration services if they implement a multidisciplinary team-based approach to primary care, which is based on the Psychiatric Collaborative Care Model (Centers for Medicare & Medicaid Services 2022a). Versions of the collaborative care model have been shown to be effective through multiple studies over the past few decades (Kroenke and Unutzer 2017, Raney 2015, Reed et al. 2016, Vohs et al. 2022). Integration of primary and behavioral health care is a key component of Health and Human Services' strategy to address the mental health crisis (Assistant Secretary for Planning and Evaluation 2022). Accountable care organizations (ACOs) may also be well placed to promote integrated behavioral health care, though there has been little progress to date (see text box, p. 241).

**TABLE
6-7**

Volume and spending by FFS beneficiaries for selected behavioral health services (physician fee schedule services only), 2021

	Number of unique beneficiaries (millions)	Volume of services (millions)	Average volume per beneficiary using service	Aggregate allowed charges (millions)	Allowed charges per beneficiary using service
E&M visit for behavioral health conditions	3.1	13.3	4.2	\$1,270	\$410
Psychotherapy	1.2	14.8	11.9	1,450	1,170
Psychiatric evaluation	0.9	1.2	1.3	190	210
Behavioral health integration	0.1	0.3	4.0	20	230

Note: FFS (fee-for-service), E&M (evaluation and management). Includes FFS beneficiaries with at least one month of Part B enrollment in the year who used physician fee schedule behavioral health services (see text box on pp. 238–239 for definition of each visit type and list of E&M codes). Table includes only physician fee schedule services. Behavioral health conditions were defined using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp). Volume is measured as the number of services received. Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of carrier standard analytic files and Medicare enrollment data from CMS.

In 2021, E&M services for a behavioral health condition and psychotherapy were the most commonly received behavioral health services. The greatest volume of services was for psychotherapy (Table 6-7). In 2021, 1.2 million FFS beneficiaries had a psychotherapy visit, aggregate spending on the service was nearly \$1.5 billion, and volume of services was 14.8 million. Beneficiaries receiving psychotherapy had, on average, 11.9 encounters and incurred \$1,170 in spending per beneficiary.⁷ In contrast, more beneficiaries had an E&M visit for a behavioral condition (3.1 million), though average per beneficiary volume for those receiving this service was only 4.2 and spending was \$410 per beneficiary.

We found that over 30 percent of beneficiaries using behavioral health services received only one behavioral health visit, and the median number of visits was three (data not shown).⁸ However, the number of visits varied by type of service—over 80 percent of beneficiaries using psychotherapy had two or more visits in a year.

Behavioral health services received by MA enrollees are shown in the text box on pp. 244–246.

Growth in the treatment of substance use disorders

For each year from 2017 to 2021, slightly over 100 per 10,000 FFS beneficiaries received treatment for

alcohol-related, opioid-related, and other substance use disorders (SUDs).⁹ However, the number of beneficiaries treated for an opioid use disorder (OUD) has grown while treatment of alcohol use disorders and other SUDs has declined (Figure 6-3, p. 247).¹⁰ OUDs grew more rapidly in recent years; from 2019 to 2021, they grew by 7 percent annually (from 40 beneficiaries to 44 beneficiaries per 10,000 FFS beneficiaries) compared with 3 percent (from 38 beneficiaries to 40 beneficiaries per 10,000 FFS beneficiaries) from 2017 to 2019 (Figure 6-3). Before 2019, the numbers of beneficiaries treated for alcohol disorders and for other SUDs were steady, but from 2019 to 2021, these declined annually by 5 percent and 8 percent, respectively.¹¹

Growth in the treatment of OUDs was driven by urban areas; the level was steady in rural areas (Figure 6-4, p. 248). This may be related to reported undertreatment of OUDs in rural areas (Andrilla et al. 2019). Several recent studies have found poorer access to OUD treatment centers and providers in rural areas compared with urban areas (Amiri et al. 2021).

Medicare covers early-intervention SUD services for beneficiaries with nondependent substance use, referred to as screening, brief intervention, and referral

Medicare Advantage and clinician- and outpatient-provided behavioral health services

Currently, nearly half of Medicare beneficiaries are enrolled in Medicare Advantage (MA) (Medicare Payment Advisory Commission 2022a). MA plans must cover Medicare Part A and Part B services (except graduate medical education, hospice, and acquisition costs for kidney transplants) and often offer supplemental benefits, such as lower cost sharing or non-Medicare benefits. Plans may limit enrollees' choice of providers, subject to federal and state network adequacy rules that require sufficient providers for "reasonable and timely access to care" (Assistant Secretary for Planning and Evaluation 2021). However, there have been reports of lacking in-network access to behavioral health providers among MA plans, resulting in frequent use of higher-cost out-of-network behavioral health providers (Larson 2022, McGinty 2020). Indeed, behavioral health providers were found to be among the least likely to be included in any MA network (Meyers et al. 2022).

To assess utilization of behavioral health services among MA enrollees, we applied an algorithm similar to our fee-for-service (FFS) analyses using 2019 outpatient and physician/professional MA encounter data. Based on the submitted encounter data, we found that 16 percent of MA beneficiaries used behavioral health services, the same percentage as for FFS beneficiaries (data not shown). Characteristics of beneficiaries using outpatient

behavioral health services are shown in Table 6-8. Differences between FFS and MA beneficiaries using behavioral health services generally followed overall differences between FFS and MA beneficiaries. However, MA enrollees using behavioral health services were less likely to be age 80 or older compared with FFS counterparts (Table 6-8).

Utilization by the type of behavioral health visit was also generally similar among MA and FFS beneficiaries (Figure 6-2, p. 246). However, MA plans have a financial incentive to record all possible diagnoses, while FFS providers do not (Medicare Payment Advisory Commission 2022b). Thus, differential coding practices may lead to higher rates of behavioral health conditions among MA enrollees compared with FFS beneficiaries, all else equal. The differential may be reflected in the higher percentage of evaluation and management services for behavioral health conditions among MA enrollees and may have also affected the share of MA beneficiaries using emergency departments for behavioral health conditions.¹²

In 2019, we concluded that the accuracy of the encounter data was not yet sufficient for use in comparing MA and FFS utilization; this limitation still exists today (Medicare Payment Advisory Commission 2019). While we cannot with certainty make comparisons of the volume of behavioral

(continued next page)

to treatment (SBIRT) services (Centers for Medicare & Medicaid Services 2022d). From 2019 to 2021, use of SBIRT services increased by 6.7 percent annually, from 9.4 to 10.7 per 10,000 FFS beneficiaries.¹³ As of January 1, 2020, Medicare Part B began covering a new benefit for treating OUDs when provided by accredited and certified entities.¹⁴ These entities include hospital outpatient departments, substance use treatment facilities, and health care clinics, among others.¹⁵ The

opioid treatment programs (OTPs) provide Medicare beneficiaries with medications for OUDs, substance use counseling, individual and group therapy, testing, and assessments. OTP providers receive payment for a bundle of services provided during an episode of care, depending on whether medications (which can include take-home medications) were needed. Between 2020 and 2021, use of OTPs increased by 27 percent, from 10 beneficiaries to 13 beneficiaries per 10,000

Medicare Advantage and clinician- and outpatient-provided behavioral health services (cont.)

**TABLE
6-8**

Characteristics of FFS beneficiaries and MA enrollees using behavioral health services, 2019

	Beneficiaries using behavioral health services		All other beneficiaries	
	FFS	MA	FFS	MA
Aged	68%	70%	90%	91%
Disabled	32	30	10	9
Female	59	63	53	55
Male	37	37	47	45
<45	9	5	2	1
45-64	22	24	8	8
65-79	46	52	64	66
80+	24	18	26	25
Non-Hispanic White	77	67	79	68
Black	9	13	9	13
Asian/Pacific Islander	1	2	3	4
Hispanic	5	15	6	12
American Indian/Alaska Native	1	0	1	0
Other or unknown	6	2	3	3
Urban	80	89	78	87
Rural	20	11	22	13
Average HCC risk score	1.48	1.55	1.04	1.14
Dual eligible or LIS during year				
No	56	55	82	78
Yes	44	45	18	22
Medicare Part D (per capita)*				
Gross spending**	\$6,482	\$5,547	\$3,685	\$3,212
Fills	75	74	50	50

Note: FFS (fee-for-service), MA (Medicare Advantage), HCC (hierarchical condition category), LIS (low-income subsidy). FFS beneficiaries include those with at least one month of Part B enrollment in the year who used Part B behavioral health services. MA beneficiaries include those enrolled in a health maintenance organization (HMO) or preferred provider organization (PPO) plan who used similarly defined behavioral health services. All other FFS beneficiaries include those with Part A and Part B coverage at the midpoint of the year. All other MA beneficiaries include MA beneficiaries enrolled in HMO or PPO plans at the midpoint of the year. HCC risk scores do not account for unaddressed coding intensity.

*Includes only those beneficiaries enrolled in Part D. **Reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies.

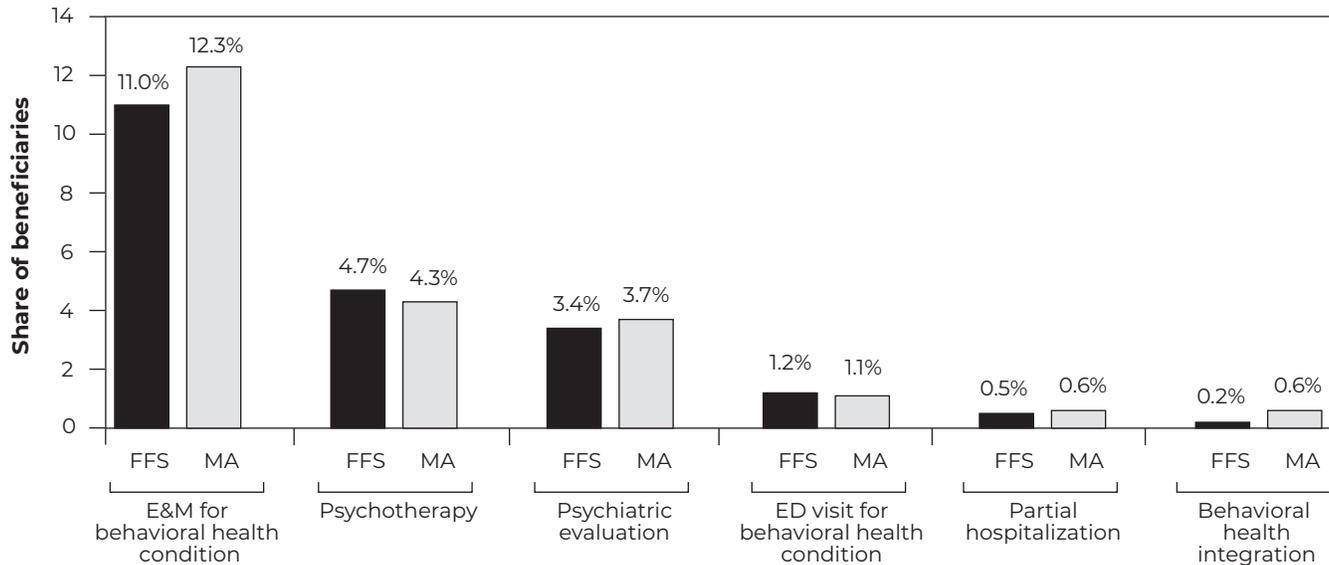
Source: MedPAC analysis of Medicare Provider Analysis and Review, MA encounter, Medicare enrollment, HCC risk score, and Part D prescription drug event data from CMS.

(continued next page)

Medicare Advantage and clinician- and outpatient-provided behavioral health services (cont.)

FIGURE 6-2

Based on submitted encounter data, we find similar use of behavioral health services among FFS and MA beneficiaries, 2019



Note: FFS (fee-for-service), MA (Medicare Advantage), E&M (evaluation and management), ED (emergency department). FFS beneficiaries include those with at least one month of Part B enrollment in the year who used Part B behavioral health services. MA beneficiaries include those enrolled in an HMO or preferred provider organization plan who used similarly defined behavioral health services. Behavioral health conditions were defined using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp).

Source: MedPAC analysis of FFS claims, MA encounter, and Medicare enrollment data from CMS.

health service use between MA and FFS, we maintain that the incentives for MA plans to code diagnoses that contribute to the calculation of an enrollee's

hierarchical condition category risk score allow us to identify MA enrollees who received any (at least one) of a given type of service. ■

FFS beneficiaries (Table 6-9, p. 247). Spending for OTP services was \$250 million, or \$6,440 per beneficiary receiving OTP services, in 2021.

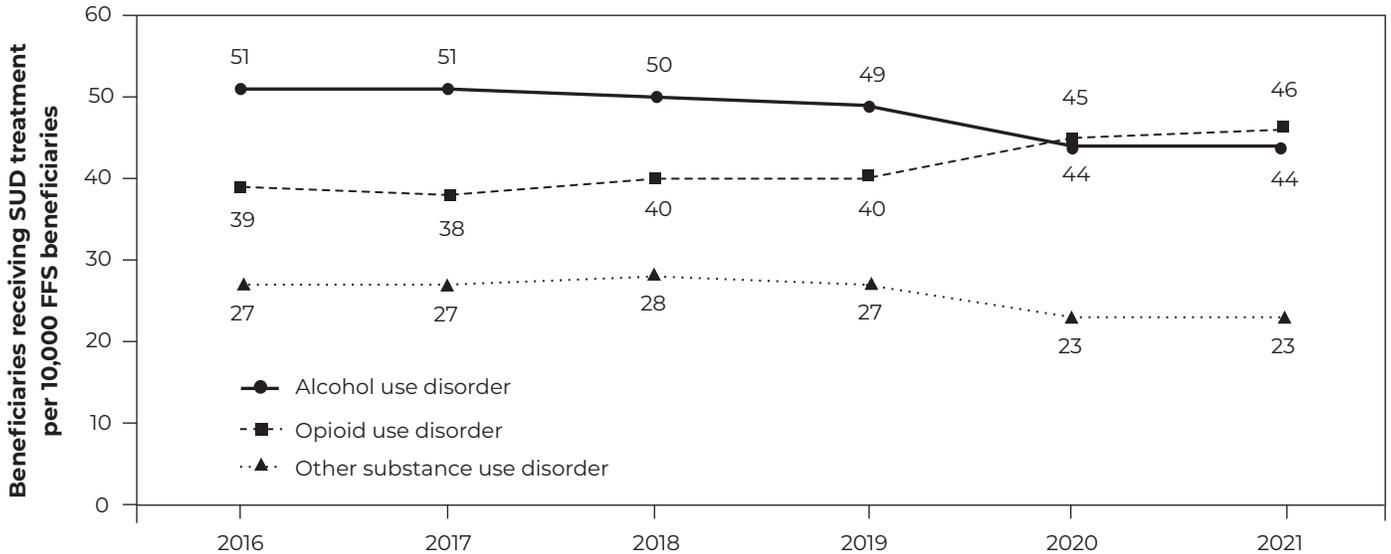
Use of prescription medications

In 2021, Part D gross spending on psychotropic medications for beneficiaries using Part B behavioral health services was nearly \$6 billion (Table 6-10, p. 248).¹⁶ The costliest psychotropic medications were

antipsychotics: Gross spending was nearly \$4 billion for 1.1 million beneficiaries (\$3,420 per beneficiary). Among the costliest antipsychotic medications was paliperidone (brand name Invega), a treatment for schizophrenia and schizoaffective disorders, used by 62,000 beneficiaries. In 2021, spending was \$1.2 billion, or \$19,600 per beneficiary (\$1,900 per 30-day fill) who used this medication (data not shown).

FIGURE 6-3

The number of FFS beneficiaries receiving treatment for opioid use disorders grew while number of those receiving treatment for substance use disorders declined, 2016–2021



Note: FFS (fee-for-service), SUD (substance use disorder). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who had carrier or outpatient FFS claims with substance use disorder diagnosis codes excluding tobacco use disorders (see text box on identifying Part B behavioral health services, pp. 238–239, for list of behavioral health conditions). Diagnoses were grouped using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp).

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

In 2021, Medicare paid roughly \$40 million for (clinician-administered) Part B drugs for behavioral health conditions (i.e., claim for a Part B drug with an associated behavioral health diagnosis) by 43,000

beneficiaries (\$910 per beneficiary) (data not shown). Nearly half the spending was on extended-release paliperidone injection (Invega), which was also among the costliest Part D psychotropic medications.

TABLE 6-9

Medicare implemented an opioid treatment program benefit in 2020

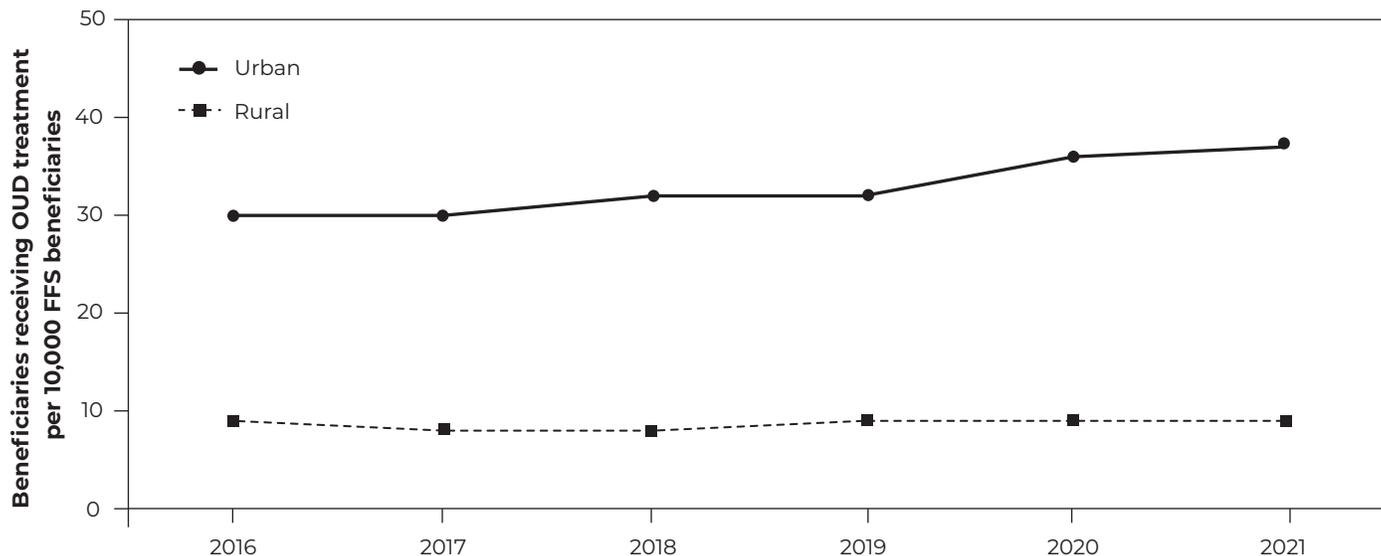
	2020	2021
FFS beneficiaries receiving OTP services	32,150	39,120
Per 10,000 FFS beneficiaries	10	13
Total spending on OTP services (in millions)	\$190	\$250
Total OTP spending per beneficiary receiving OTP services	\$5,930	\$6,440

Note: FFS (fee-for-service), OTP (opioid treatment program). "Total spending" represents all payments made to the provider, including beneficiary cost sharing, and is calculated by summing allowed charges from the Part B carrier claims and total payments from the outpatient claims. Numbers may not calculate to total due to rounding.

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

**FIGURE
6-4**

Growth in the number of FFS beneficiaries receiving treatment for opioid use disorders driven by urban areas, 2016-2021



Note: FFS (fee-for-service), OUD (opioid use disorder). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who had carrier or outpatient FFS claims with opioid use disorder diagnosis codes. Diagnoses were grouped using the Healthcare Cost and Utilization Project Clinical Classifications Software Refined categories for the mental, behavioral, and neurodevelopmental body system (https://www.hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp). "Urban" indicates beneficiaries living in metropolitan statistical areas (MSAs) as indicated by core-based statistical areas. "Rural" indicates beneficiaries living outside MSAs, which includes both micropolitan statistical areas and rural areas as indicated by core-based statistical areas.

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

**TABLE
6-10**

Medicare Part D psychotropic medication use and spending by FFS beneficiaries who used Part B behavioral health services, 2021

	Beneficiaries (millions)	Gross spending (billions)	Average spending per beneficiary using specified type of medication
Any psychotropics	3.4	\$5.8	\$1,710
Antidepressants	2.7	0.8	310
Anticonvulsants	1.7	1.0	620
Antianxiety	1.4	0.1	100
Antipsychotics	1.1	3.8	3,420
Bipolar disorder medications	0.1	0.01	120

Note: FFS (fee-for-service). Includes Medicare beneficiaries enrolled in Part D with at least one month of Part B enrollment in the year and who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. "Gross spending" reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not already reflected in prices at the pharmacies. Numbers may not calculate to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data from CMS and the First Databank Enhanced Therapeutic Classification System.

**TABLE
6-11**

Volume of services provided to FFS beneficiaries by behavioral health specialists, 2021

	Number of clinicians	Average Medicare allowed charges per clinician	Beneficiaries per clinician	Total beneficiaries (thousands)
Licensed clinical social worker	28,800	\$19,800	21	600
Psychiatrist	23,300	44,400	87	2,030
Psychologist	19,300	38,600	39	760
Addiction medicine	320	35,300	67	20

Note: FFS (fee-for-service). Includes clinicians who served at least five Medicare beneficiaries with at least one month of Part B enrollment in the year. Numbers may not sum to total due to rounding.

Source: MedPAC analysis Medicare fee-for-service carrier claims from CMS.

Fewer psychiatrists, more nurse practitioners and licensed clinical social workers provide behavioral health services to Medicare FFS beneficiaries

Medicare behavioral health specialties include psychiatry, licensed clinical social work, clinical psychology, and addiction medicine.¹⁷ In 2021, 28,800 LCSWs, 23,300 psychiatrists, and 19,300 psychologists billed Medicare (Table 6-11).¹⁸ Psychiatrists served the most FFS beneficiaries, both in aggregate (over 2 million) and per provider (87 FFS beneficiaries per psychiatrist, on average).

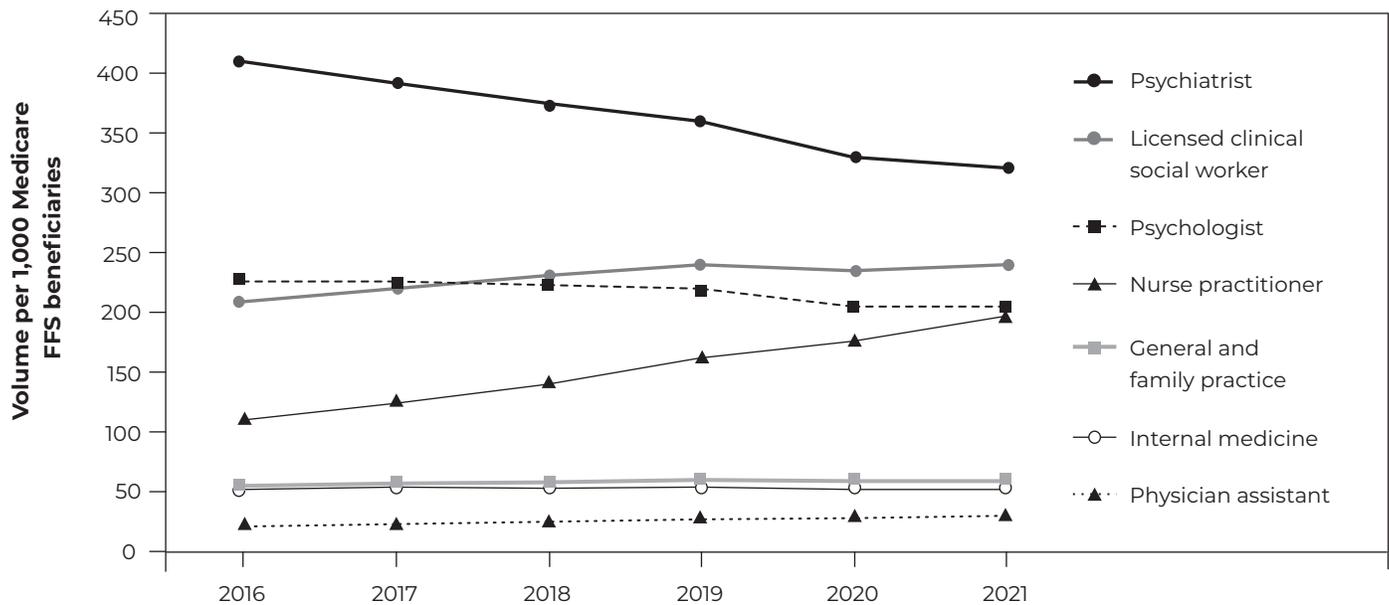
The 23,300 psychiatrists who billed for a Medicare service represented about 60 percent of total licensed psychiatrists in the U.S. (Association of American Medical Colleges 2019). Behavioral health specialists are disproportionately likely to opt out of participating in the Medicare program. Opting out entails contractually agreeing to not receive any payment from Medicare, directly or indirectly, for any Medicare beneficiary. As of October 2022, 29,000 physicians and other health professionals have actively opted out of Medicare (they have current opt-out affidavits on record). Of these 29,000 clinicians, behavioral health providers make up over 40 percent: 17 percent are clinical psychologists, 15 percent are psychiatrists, and 11 percent are LCSWs (Centers for Medicare & Medicaid Services 2022c). Among psychiatrists, the opt-out rate is 7.2 percent, which is the highest across physician specialties (Ochieng et al. 2020).

A study examining the characteristics of psychiatrists opting out of Medicare found that opt-outs were more likely to be older, female, graduates of top-20 medical schools, and practicing in areas with fewer psychiatrists per Medicare beneficiary compared with psychiatrists who did not opt out of Medicare (Yu et al. 2019). This last finding implies that when there is more competition for patients, providers are motivated to accept Medicare, which presumably reimburses less than private-pay rates. However, psychiatrists opt out of the private insurance market as well. One study found that even if psychiatrists accept insurance, they appear to limit the number of insured patients they serve in a year (Benson et al. 2020).

Behavioral health specialists are not the only clinicians who provide behavioral health services. The pandemic exacerbated shortages of behavioral health clinicians (Health Resources & Services Administration 2022, Lopes et al. 2022, Terlizzi and Schiller 2022), but shifts in the provision of these services were occurring prior to the pandemic. In 2021, 61 percent of the beneficiaries who used Part B behavioral health services received them from a behavioral health specialist (down from 69 percent in 2016) (data not shown). We found shifts over time in the specialty of the clinicians who provide Part B behavioral health services. Most notably, between 2016 and 2021, the volume of these services provided by psychiatrists declined (5 percent average annual decrease) and rose for nurse practitioners (12 percent average annual increase) (Figure 6-5, p. 250). Medicare

**FIGURE
6-5**

Shifts in the types of clinicians treating beneficiaries with behavioral health conditions, 2016-2021



Note: FFS (fee-for-service). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a physician fee schedule claim with a behavioral health diagnosis code. Volume was calculated by summing the number of services on the claim line item and dividing by the total number of FFS beneficiaries multiplied by 1,000.

Source: MedPAC analysis of FFS carrier claims and Medicare enrollment data from CMS.

does not collect information on the specialties of nurse practitioners, though one study estimated that between 2011 and 2019, the supply of psychiatric nurse practitioners increased by 162 percent (Cai et al. 2022). Volume by psychologists has slightly fallen since 2016 (2 percent annual decline) while volume by LCSWs and by physician assistants has increased (3 percent and 7 percent annual increase, respectively).¹⁹

The literature has discussed the growing role of primary care practitioners in providing behavioral health. One study found that from 2006 to 2018, the prevalence of mental health concerns addressed during primary care visits increased by nearly 50 percent (Rotenstein et al. 2023). The authors found substantial variation by race and ethnicity, with Black and Hispanic patients disproportionately less likely to have mental health concerns addressed by primary care physicians. Behavioral health conditions may be underdiagnosed by primary care practitioners due to those practitioners' high volume of patients (affecting

the amount of time with each patient), confidence in appropriately treating patients with behavioral health conditions, and concerns about confidentiality and stigmatizing the patient (Beck et al. 2019, Kessler et al. 2003, Pincus et al. 2003).

Recent policy to expand the capacity of the behavioral health workforce

The 2023 final rule for Medicare's physician fee schedule expanded the behavioral health workforce by enabling licensed marriage and family therapists (LMFTs) and licensed professional counselors (LPCs) to practice under the general supervision of a physician or nonphysician practitioner (NPP) instead of under direct supervision (Centers for Medicare & Medicaid Services 2022b). General supervision requires that the service be provided under the overall direction and control of a supervising physician or NPP, but the supervising clinician does not have to be present in the office suite while the service is delivered. Under direct supervision,

**TABLE
6-12**

Substantial shift from office-based to tele-behavioral health visits between 2019 and 2021

Place of service	2019		2021	
	Total spending for Part B behavioral health services (millions)	Percent of total	Total spending for Part B behavioral health services (millions)	Percent of total
All locations	\$4,750	100%	\$4,800	100%
Office	1,920	40	1,080	23
Hospital outpatient	590	12	420	9
Skilled nursing facility or nursing facility	500	11	430	9
Inpatient hospital	330	7	250	5
Emergency room	300	6	230	5
Telehealth	40	1	1,340	28
Nonresidential opioid treatment facility*	—	—	240	5
Other place of service	1,070	23	810	17

Note: Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. Total spending represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing. Numbers may not sum to the total due to rounding.

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

by contrast, the supervising physician or NPP must be physically present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. LMFTs and LPCs cannot currently bill Medicare directly, but supervising clinicians are allowed to bill for services they provide to established patients in nonfacility settings under “incident to” billing rules. However, effective January 1, 2024, the CAA, 2023, enables LMFTs and LPCs to bill Medicare directly without supervision of physicians or NPPs (see text box on recent Medicare behavioral health legislation, p. 234).

Since 2019, delivery of behavioral health services substantially shifted from in-person visits to telehealth visits

Medicare covers many behavioral health services when provided by live, two-way video. Before 2018, beneficiaries had to receive behavioral health services using telehealth at an originating site (e.g., a clinician’s office or a hospital) in a rural area, with the clinician at a distant site (U.S. House of Representatives 2016). In 2018, the Congress permanently removed the

geographic restrictions and added the patient’s home as an originating site for telehealth treatment of an SUD or a co-occurring mental health disorder.

The CAA, 2021, permanently removed the geographic restrictions and added the patient’s home as an originating site for telehealth services used to diagnose, evaluate, or treat a behavioral health disorder (independent of a substance use disorder). After the public health emergency ends, the CAA, 2021, requires that the clinician furnishing telehealth services provide an in-person visit within six months prior to the initial telehealth visit.²⁰ For subsequent telehealth services, the Secretary implemented an annual in-person visit requirement; however, the policy does not apply if the practitioner and patient agree that the benefits of an in-person service are outweighed by the risks and burdens associated with an in-person service. The CAA, 2023, delayed these in-person requirements until after December 31, 2024. CMS will also pay for telehealth services provided by an audio-only interaction if the clinician has the capability to use an interactive telecommunications system that includes video and the

**TABLE
6-13**

FFS beneficiaries receiving Part B behavioral health services differed by use of in-person versus tele-behavioral health, 2021 (cont. next page)

	In-person behavioral health only	In-person and tele-behavioral health	Tele-behavioral health only
Share of all FFS beneficiaries receiving behavioral health services	63%	22%	15%
Current eligibility status and demographics			
Aged	78%	55%	64%
Disabled	22	45	35
ESRD	0.2	0.2	0.2
Female	61	63	65
Male	39	37	35
<45	7	17	12
45-64	19	31	27
65-79	53	42	49
80+	21	10	11
Non-Hispanic White	81	80	78
Black	9	9	9
Asian/Pacific Islander	2	2	2
Hispanic	5	6	7
American Indian/Alaska Native	0.6	0.6	0.5
Other or unknown	2	3	3
Metropolitan	80	82	86
Micropolitan	12	11	9
Rural (adjacent)	5	4	4
Rural (nonadjacent)	3	3	2
Frontier			
No	99	99	99
Yes	1	1	1
Mental health HPSA			
No	72	76	80
Yes	28	24	20

beneficiary is unable to use the video component or does not consent to video use.

In 2019, 40 percent of total spending for Part B behavioral health services was for care provided in a clinician's office; by 2021, this percentage fell to 23 percent (Table 6-12, p. 251). During the same time,

telehealth for behavioral health services grew from 1 percent to 28 percent of total behavioral health spending. The availability of telehealth during this period could also be related to lower spending on in-person behavioral health services taking place in hospital outpatient departments, nursing facilities, and other places of service.

**TABLE
6-13**

FFS beneficiaries receiving Part B behavioral health services differed by use of in-person versus tele-behavioral health, 2021 (cont.)

	In-person behavioral health only	In-person and tele-behavioral health	Tele-behavioral health only
Dual eligible or LIS during year			
No	62	46	58
Yes	38	54	42
HCC risk score	1.43	1.40	1.24
Total Medicare Part A and Part B spending	\$21,700	\$18,600	\$11,600
Medicare Part D gross spending*	\$6,100	\$9,300	\$7,700
Any Part D fills	70	84	72
Antidepressants	8	12	10
Anticonvulsants	4	7	5
Antipsychotics	2	7	4
Antianxieties	2	4	3
Bipolar disorder medications	0.1	0.4	0.2

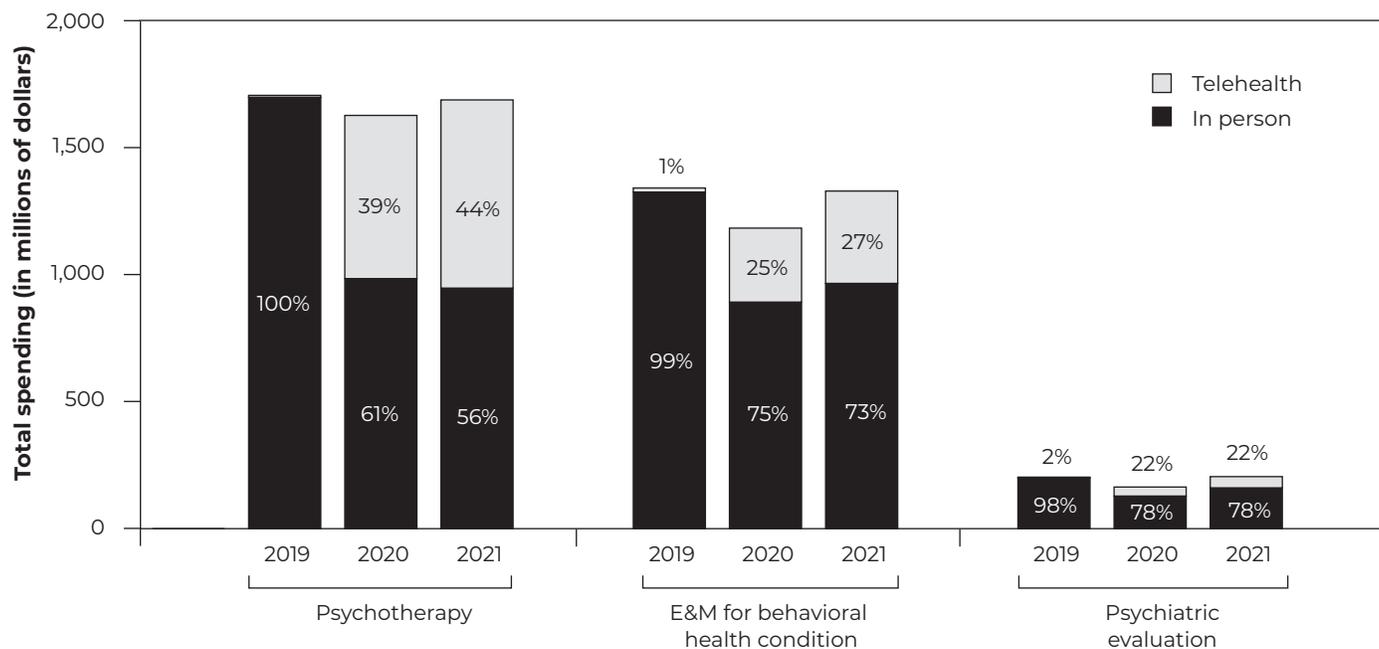
Note: FFS (fee-for-service), ESRD (end-stage renal disease), HPSA (health professional shortage area), LIS (low-income subsidy), HCC (hierarchical condition category). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. Geographic categories are based on the beneficiary's county of residence, mapped using the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes.
*Includes only beneficiaries enrolled in Medicare Part D. "Gross spending" reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not already reflected in prices at the pharmacies.

Source: MedPAC analysis of FFS standard analytic files, Medicare enrollment, HCC risk score, and Part D prescription drug event data from CMS.

Overall telehealth use rose sharply in 2020 but declined in 2021, though it was still higher than pre-pandemic levels. In contrast, between 2020 and 2021, telehealth for behavioral health services continued to grow—from 25 percent to 28 percent of total behavioral health service spending. Indeed, telehealth played an important role in maintaining access to behavioral health during the pandemic. For example, one study found that availability of telehealth for behavioral health services substantially improved wait times at an academic medical center (McMahan et al. 2022), and another found increased patient and provider satisfaction and reduced no-show rates for patients of an FQHC (Lombardi et al. 2022).

Characteristics of beneficiaries receiving behavioral health services through telehealth

Among beneficiaries using Part B behavioral health services in 2021, 63 percent used only in-person behavioral health services, 22 percent used both in-person and telehealth delivery, and 15 percent used telehealth only (that is, most beneficiaries using behavioral health services through telehealth also received in-person behavioral health services) (Table 6-13).²¹ Our study of beneficiary characteristics across the three groups using behavioral health services found that beneficiaries who used at least some telehealth tended to be younger, disabled, female, located in an urban area, and low income; had lower HCC risk scores; and incurred lower total Medicare Part A and

FIGURE 6-6**Shift to telehealth visits for behavioral health services began in 2020 and continued in 2021**

Note: E&M (evaluation and management). Includes fee-for-service beneficiaries with at least one month of Part B enrollment in the year who had behavioral health visits. Total spending represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing.

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS

Part B spending compared with beneficiaries who had in-person visits only (Table 6-13, p. 253). Beneficiaries using only telehealth (no in-person visits) for behavioral services incurred the lowest total Medicare Part A and Part B spending—\$11,600, compared with \$21,700 for those using in-person behavioral health services only and \$18,600 for those using both in-person and telehealth for behavioral health services. Beneficiaries who had both in-person and telehealth visits had the highest gross Part D prescription drug spending (\$9,300, compared with \$6,100 for in-person-only users and \$7,700 for telehealth-only users) and more fills of psychotropic drugs. The availability of telehealth may be a more convenient mechanism to obtain prescriptions. Future work could assess new prescriptions and refills via telehealth and whether this differs for beneficiaries who received only telehealth for behavioral health services.

Psychotherapy accounted for largest share of telehealth spending for behavioral services

Among behavioral health services, psychotherapy had the highest share of spending for telehealth: In 2021, telehealth accounted for 44 percent of spending for psychotherapy services, compared with 39 percent in 2020 and virtually none in 2019 (Figure 6-6). Other types of behavioral health visits followed a similar pattern.

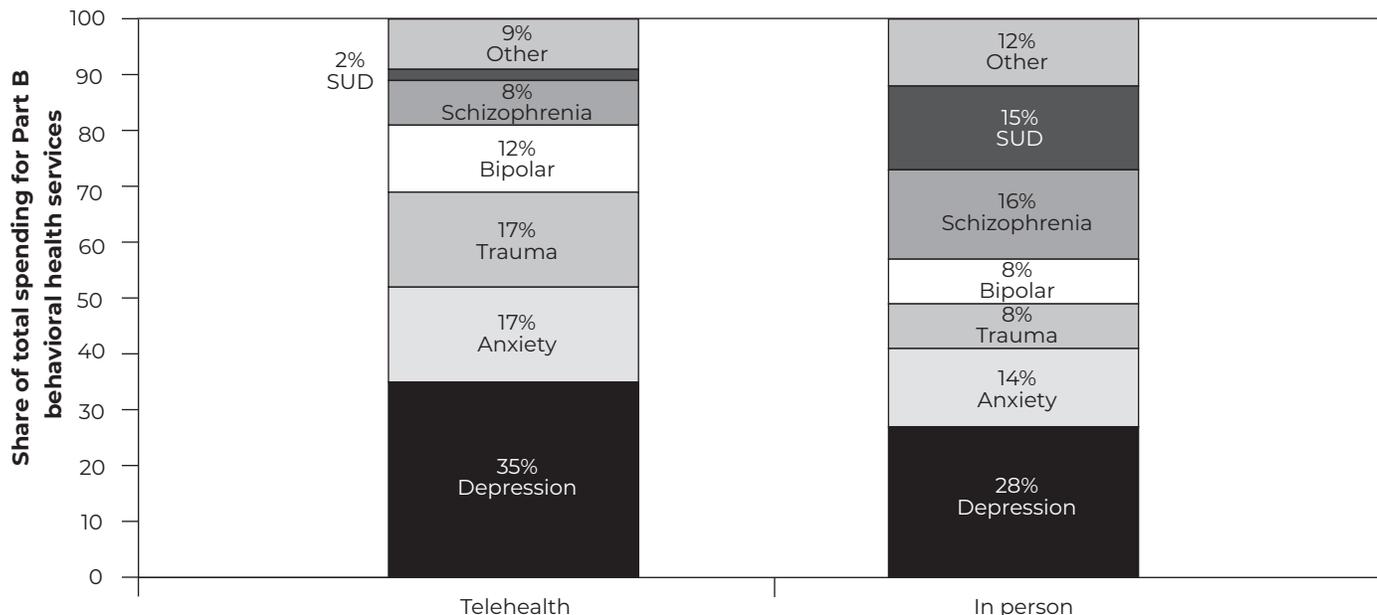
Likewise, in 2021, the majority of telehealth spending for behavioral health services was for psychotherapy (56 percent) (data not shown). In contrast, spending for in-person psychotherapy was 27 percent.

Patients with depressive and anxiety disorders had the highest share of telehealth spending

In 2021, the largest shares of telehealth spending for behavioral services were for treating depressive

FIGURE 6-7

Higher shares of telehealth spending for behavioral services were for depressive and anxiety disorders, 2021



Note: SUD (substance use disorder). Includes Medicare beneficiaries with at least one month of Part B enrollment in the year who used Part B behavioral health services or had a Part B claim with a behavioral health diagnosis code. "Total spending" represents all Part B behavioral health payments made to the provider, including beneficiary cost sharing.

Source: MedPAC analysis of carrier and outpatient standard analytic files and Medicare enrollment data from CMS.

disorders (35 percent), anxiety (17 percent), and trauma conditions (17 percent) (Figure 6-7). Schizophrenia and SUDs accounted for relatively small shares of telehealth spending (8 percent and 2 percent, respectively). In contrast, 16 percent of in-person behavioral health spending was used to treat schizophrenia and 15 percent was used for SUDs.

Clinicians providing telehealth for behavioral health services

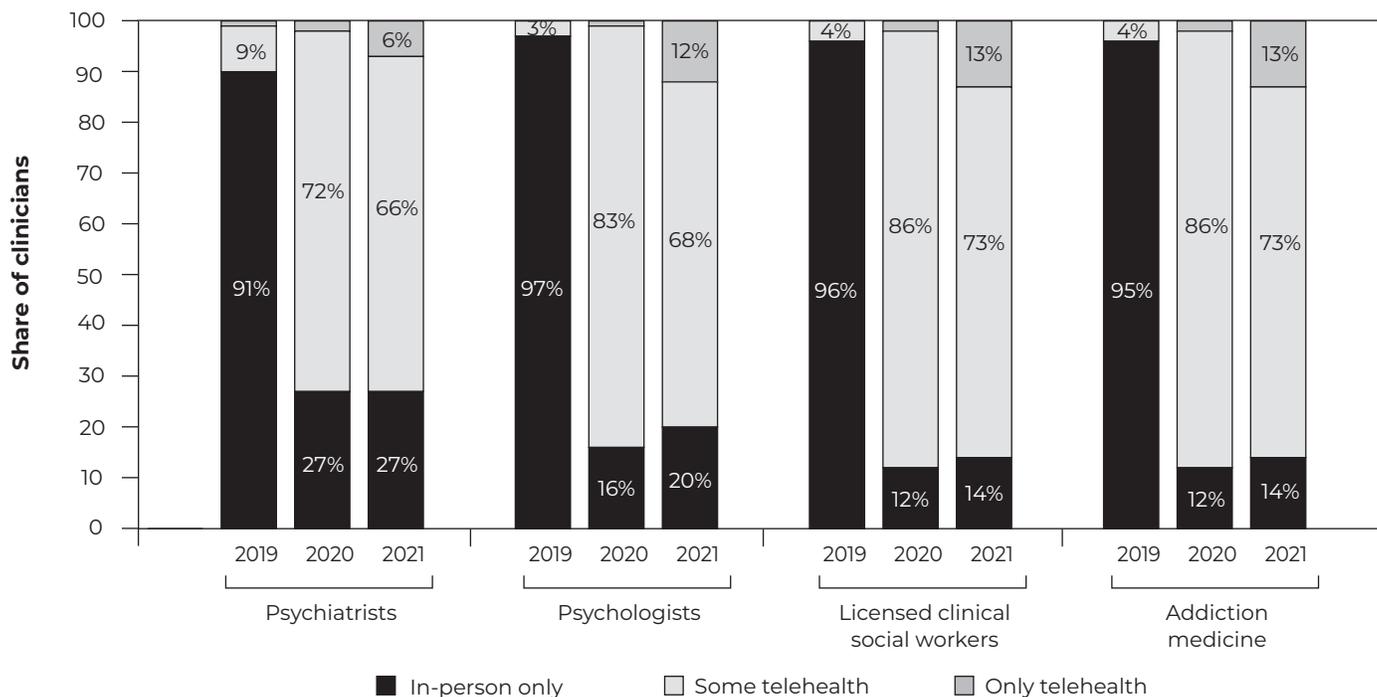
Prior to the pandemic, more widespread availability of telehealth for behavioral health services was already seen as a potential strategy to enhance access to behavioral health care (Dormond et al. 2017). In 2019, 10 percent of psychiatrists and from 3 percent to 4 percent of other behavioral health clinicians provided at least some telehealth (Figure 6-8, p. 256). In 2020,

telehealth rapidly expanded; over 70 percent of psychiatrists and over 80 percent of other behavioral health specialists provided at least some telehealth.

In 2021, not only did substantial provision of telehealth continue, but the share of behavioral health clinicians who provided *only* telehealth also grew (that is, all services billed by the practitioner were provided by telehealth). In 2021, 6 percent of psychiatrists and from 12 percent to 13 percent of other behavioral health clinicians provided only telehealth services (Figure 6-8, p. 256). Growth in the share of behavioral health clinicians who provide telehealth services only could impact access to in-person behavioral health services, and it will be important to monitor as another aspect of assessing access to care in future work.

FIGURE 6-8

Growth in share of behavioral health clinicians providing any telehealth to Medicare beneficiaries, 2019–2021



Note: Includes behavioral health clinicians who had visits with at least five Medicare beneficiaries with one month or more of Part B enrollment in the year. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of fee-for-service carrier claims and Medicare enrollment data from CMS.

Trends and issues in inpatient psychiatric care

With regard to inpatient psychiatric care, we examined the adequacy of Medicare payments to IPFs under the prospective payment system (PPS). We used the Commission’s payment adequacy indicators to assess beneficiaries’ access to IPF care, quality of IPF care, access to capital, and the relationship between Medicare payments and IPFs’ costs. We also reviewed the impact on care of the 190-day lifetime limit on days spent in freestanding psychiatric hospitals. Interviews with officials of IPFs conducted by L&M Policy Research from late 2022 to early 2023 informed our findings (see text box).

Introduction to IPFs

Medicare beneficiaries experiencing an urgent, acute mental health or SUD-related crisis may be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting.²² IPFs can be freestanding hospitals or specialized units within acute care general hospitals. Patients who need inpatient care can be admitted to an IPF where they may receive individual and group therapy, psychosocial rehabilitation, illness management training, family therapy, electroconvulsive therapy, and other treatments. In addition, a majority of IPF patients receive drug therapy in the form of antipsychotics, mood stabilizers, antidepressants, and anticonvulsants. Patients can also receive care for medical comorbidities such as diabetes, infectious disease, wounds, and cardiac conditions. The goal of

Interviews conducted with IPFs

To better understand services provided, patient mix, and challenges facing inpatient psychiatric facilities (IPFs), the Commission contracted with L&M Policy Research to conduct telephone interviews with officials at these facilities. L&M conducted semi-structured interviews with 10 IPFs between November 2022 and February 2023. IPFs were selected to represent various provider types and their characteristics:

- IPF type, ownership, and affiliation
- geographic location
- size

- designation of all-inclusive rate and reporting of ancillary services

Interviews were typically conducted with the IPFs' chief medical officers and chief financial officers. L&M developed an interview guide, including topics related to types of services provided to Medicare beneficiaries (and whether these differ by type of IPF), how services differ by patient characteristics, changes over time, provision and reporting of ancillary services, and general perceptions related to Medicare payment.

L&M's full report can be found on our website at www.medpac.gov. ■

IPF care is to stabilize the individual's condition and enable safe return to the community.

As is the case for general acute care hospital stays, IPF stays are covered under Medicare Part A. Thus, each stay is subject to the Part A deductible (\$1,600 in 2023) and coinsurance (none for days 1–60; \$400 per day for days 61–90). After day 90, the daily coinsurance rate increases (to \$800), and each day counts toward the beneficiary's inpatient lifetime reserve days (which total 60 days).²³ Patients must also pay any Part B cost sharing for services from physicians and other clinicians received during the stay. Beneficiaries are also subject to a 190-day lifetime maximum on the number of days in freestanding psychiatric hospitals.

Medicare requirements for IPFs

To be certified as an IPF eligible for Medicare payment under the IPF prospective payment system (PPS), facilities must meet Medicare conditions of participation for acute care hospitals. They must also meet the following criteria:^{24,25}

- be primarily engaged in providing, by or under the supervision of a psychiatrist, psychiatric services

for the diagnosis and treatment of mentally ill persons;

- admit only patients with a psychiatric principal diagnosis who require active treatment of an intensity that can be provided appropriately only in an inpatient hospital setting;
- furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities;
- maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals; and
- meet special staff requirements regarding adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written individualized, comprehensive treatment plans, provide active treatment measures, and engage in discharge planning. This includes availability of a registered nurse 24 hours each day.

Medicare's IPF prospective payment system

Under the IPF PPS, Medicare pays predetermined per diem rates based primarily on the patient's condition

(age, diagnosis, comorbidities) and length of stay, and the location of the IPF. Medicare's payment rates are intended to cover all routine, ancillary, and capital costs that efficient providers are expected to incur in furnishing inpatient psychiatric care. Payments to IPFs are determined by adjusting a daily base payment rate for geographic differences in labor costs and for differences in the costs of care related to specified patient and facility characteristics that can be identified using administrative data (Medicare Payment Advisory Commission 2021). The base payment rate for each patient day in an IPF is calculated using the national average daily routine operating, ancillary, and capital costs in IPFs in 2002, updated for inflation. The IPF base payment rate in fiscal year 2023—\$865.63 per day—is adjusted for differences in labor costs by multiplying the labor-related portion of the base payment amount—77.4 percent—by an area wage index. This wage-adjusted base rate is further adjusted for the following patient-specific and facility-specific characteristics:

- Age—In general, payment increases with increasing patient age over 45.
- Diagnosis—Patients are assigned to one of 17 psychiatric Medicare severity–diagnosis related groups (MS–DRGs), such as psychoses, depressive neuroses, and degenerative nervous system disorders. Medicare assigns a weight to each of the MS–DRGs reflecting the average costliness of stays in that group compared with that for the most frequently reported psychiatric diagnosis in fiscal year 2002 (MS–DRG 885, psychosis).
- Comorbidities—This adjustment recognizes the increased costs associated with 17 specific patient conditions—such as renal failure, diabetes, and cardiac conditions—that are secondary to the patient's principal diagnosis and that require treatment during the stay.
- Length of stay—Per diem payments decrease as patient length of stay increases.²⁶
- Cost of living adjustment—IPFs in Alaska and Hawaii are paid up to 25 percent more than IPFs located in other areas, reflecting their disproportionately higher costs. This add-on is applied to the nonlabor portion of the base rate only.
- Rural location adjustment—IPFs in rural areas are paid 17 percent more than urban IPFs.
- Teaching adjustment—Teaching hospitals have an adjustment based on the ratio of interns and residents to average daily census.
- Emergency department adjustment—IPFs with qualifying emergency departments are paid about 10 percent more for their patients' first day of the stay.
- Electroconvulsive therapy (ECT)—IPFs receive an additional payment for each ECT treatment furnished to a patient. In fiscal year 2023, the ECT payment is \$372.67.

The IPF PPS has an outlier policy for stays that have extraordinarily high costs, drawn from an outlier pool of 2 percent of total payments. Medicare makes outlier payments when an IPF's estimated total costs for a case exceed the total payment amount for the case plus a fixed loss amount (\$24,630 in fiscal year 2023, adjusted by the wage index and the facility-specific characteristics outlined above). Medicare will cover 80 percent of the costs above this threshold for days 1 through 9 and 60 percent of the costs above the threshold amount for the remaining days.

Under the CAA, 2023, CMS can begin to collect additional information to refine payments under the IPF PPS. This includes data on resource use, need for monitoring, interventions, and patient characteristics such as functional status, cognitive function, and comorbidities and impairments. Collection of additional data using claims or cost reports will begin by October 2023, and collection of patient assessment data using a standardized tool will begin by 2028.

FFS beneficiaries using IPF services were more likely to be disabled, low income, and have higher Medicare overall spending

In 2021, beneficiaries who used IPFs were substantially more likely than other FFS beneficiaries to be disabled (54 percent vs. 12 percent of other FFS beneficiaries), young (26 percent were under age 45 vs. 3 percent of other FFS beneficiaries), Black (16 percent vs. 8 percent of other FFS beneficiaries), and to have low incomes (64 percent were eligible for the Part D low-income subsidy or for Medicaid benefits (“dual eligible”) vs. 19 percent of other FFS beneficiaries) (Table 6-14).

**TABLE
6-14**

Medicare FFS beneficiaries using IPFs tended to be disabled, under age 65, Black, and low income, 2021

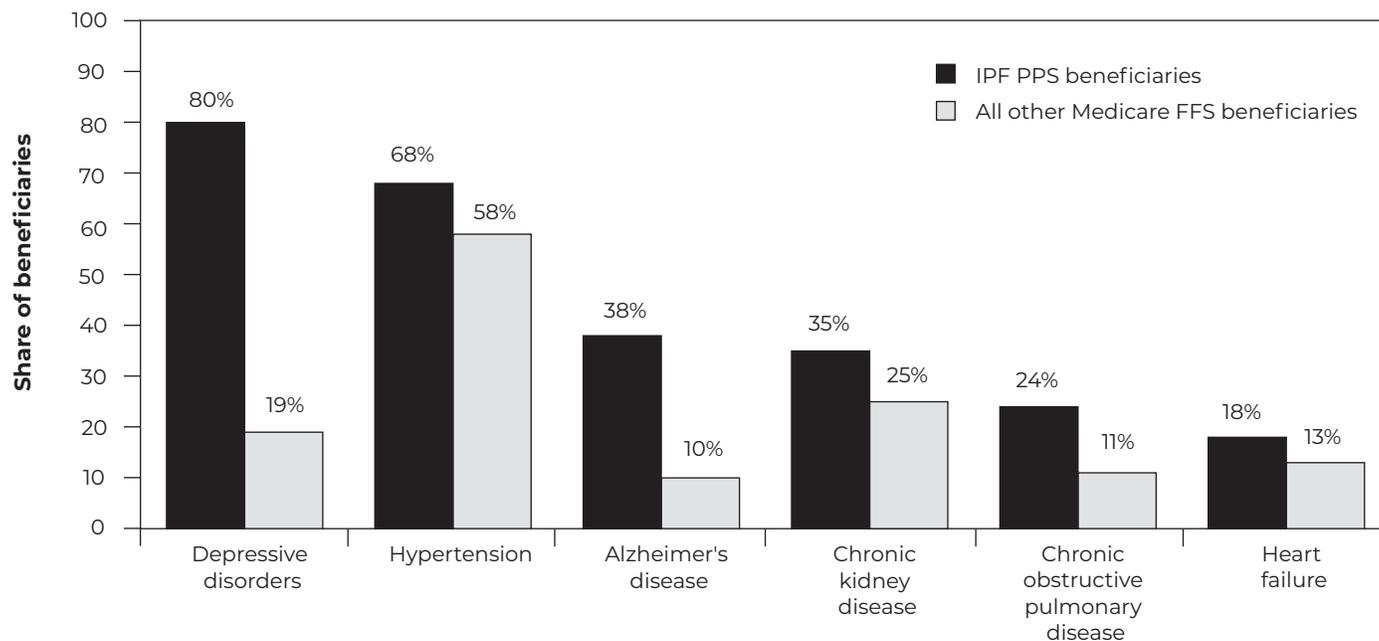
	All IPF users	IPF users with more than one stay in 2021	All other FFS beneficiaries
All	100%	26%	—
Current eligibility status and demographics			
Aged	46	32	88
Disabled	54	68	12
Female	49	46	55
Male	51	54	45
<45	26	36	3
45–64	30	34	12
65–79	31	24	64
80+	12	6	20
Non-Hispanic White	72	68	80
Black	16	19	8
Asian/Pacific Islander	2	2	3
Hispanic	6	7	6
American Indian/Alaska Native	1	1	1
Other or unknown	3	4	3
Metropolitan	80	83	79
Micropolitan	12	11	12
Rural (adjacent)	5	4	6
Rural (nonadjacent)	3	2	4
Dual eligible or LIS during year			
No	36%	25%	81%
Yes	64	75	19
HCC risk score	1.41	1.44	1.01
Medicare Part A and Part B spending (per capita)	\$40,800	\$57,500	\$9,500
Medicare Part D (per capita)*			
Gross spending**	\$7,700	\$8,200	\$4,500
Fills	70	68	51

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), LIS (low-income subsidy), HCC (hierarchical condition category). Components may not sum to totals due to rounding. "All IPF users" represents beneficiaries with an IPF stay ending in 2021. "All other FFS beneficiaries" represents those with Part A and Part B coverage at the midpoint of 2021 and excludes IPF beneficiaries. Geographic categories are based on the beneficiary's county of residence, mapped using the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes.

*Includes only those beneficiaries enrolled in Part D.

**Reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

**FIGURE
6-9****Beneficiaries using IPFs have more chronic conditions than other FFS beneficiaries, 2019**

Note: IPF (inpatient psychiatric facility), FFS (fee-for-service), PPS (prospective payment system). "IPF FFS beneficiaries" represents FFS beneficiaries with an IPF stay ending in 2019. "All other Medicare FFS beneficiaries" represents FFS beneficiaries with Part A and Part B coverage at the midpoint of 2019, excluding beneficiaries using IPFs in the year.

Source: MedPAC analysis of Medicare Provider Analysis and Review, enrollment data, and the Chronic Care Warehouse chronic condition data from CMS.

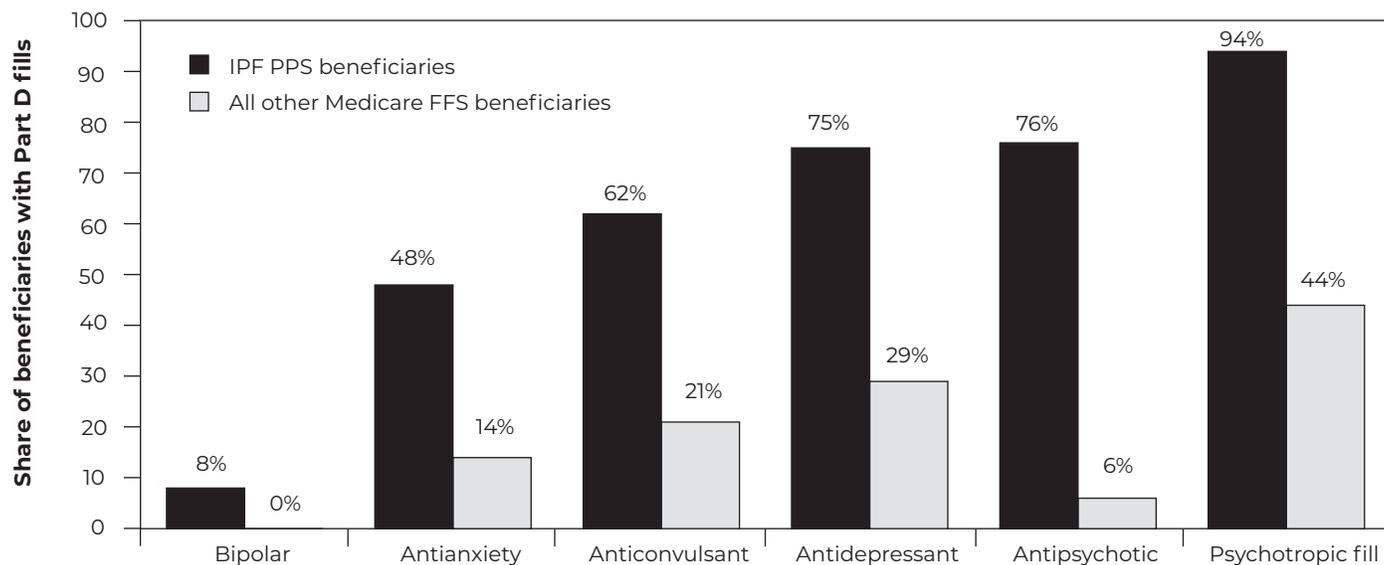
Beneficiaries with multiple IPF stays in a year were even more likely to be disabled, younger than 65, Black, and low income.

Compared with other FFS beneficiaries, those using IPFs incurred higher overall Medicare spending during the year of their IPF stay (Table 6-14, p. 259). On average, in 2021, Medicare Part A and Part B spending for beneficiaries using IPFs was \$40,800 compared with \$9,500 for the other FFS beneficiaries with Part A and Part B coverage. Average Medicare Part D spending (for those enrolled in Part D) was \$7,700 (with 70 prescription fills) for beneficiaries using IPFs compared with \$4,500 (and 51 prescriptions filled) for the other FFS beneficiaries with Part D. Beneficiaries using IPFs also had a higher average HCC risk score (1.41 versus 1.01 for all other FFS beneficiaries).

Not surprisingly, in 2019, beneficiaries using IPFs were much more likely to have a diagnosis of depressive

mood disorders (80 percent) compared with other FFS beneficiaries (19 percent) (Figure 6-9).²⁷ In the same year, compared with other FFS beneficiaries, they were also more likely to have hypertension (68 percent vs. 58 percent), Alzheimer's disease (38 percent vs. 10 percent), chronic kidney disease (35 percent vs. 25 percent), and chronic obstructive pulmonary disease (24 percent vs. 11 percent).

In 2021, 94 percent of IPF PPS beneficiaries with Part D filled prescriptions for psychotropic medications compared with 44 percent of other FFS beneficiaries enrolled in Part D (Figure 6-10). Beneficiaries who had IPF stays used more of each type of psychotropic medication: 76 percent filled antipsychotic medication prescriptions (compared with 6 percent of other FFS beneficiaries) and 75 percent filled prescriptions for antidepressants (compared with 29 percent of other FFS beneficiaries). (Since any medications used during an IPF stay are provided by the hospital and paid under the

FIGURE 6-10**Type of psychotropic medications filled by FFS beneficiaries using IPFs, 2021**

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility). "IPF PPS beneficiaries" represents FFS beneficiaries with an IPF stay ending in 2021. "All other FFS beneficiaries" represents FFS beneficiaries with Part A and Part B coverage at the midpoint of 2021, excluding beneficiaries using IPFs in the year. All populations are limited to Medicare FFS beneficiaries enrolled in Part D in 2021.

Source: MedPAC analysis of Part D prescription drug event data from CMS and the First Databank Enhanced Therapeutic Classification System.

IPF PPS, these would be prescription fills that occurred before or after the IPF stay.)

Medicare FFS patients in IPFs are assigned to 1 of 17 psychiatric Medicare severity–diagnosis related groups (MS–DRGs). However, the MS–DRG system does not differentiate well among Medicare beneficiaries in IPFs; in 2021, 96 percent of stays were assigned to seven MS–DRGs (data not shown) and nearly 75 percent of stays were assigned to the psychosis MS–DRG (Table 6-15, p. 262). The psychosis MS–DRG is a broad category that includes patients with principal diagnoses of mood disorders (such as bipolar disorder and major depression) and non-mood psychotic disorders (such as schizophrenia). From 2019 to 2021, the share of patients with non-mood psychotic disorders (such as schizophrenia) increased by 3 percent annually. In contrast, during that period, the share of patients with mood disorders decreased by 1.5 percent. The text box on pp. 264–265 identifies characteristics of MA enrollees who had an IPF stay in 2019.

When asked about the characteristics of patients treated in their facilities, many IPF interviewees said they tended to screen out patients with comorbidities or other needs that require more medically complex care or specialized equipment, such as intravenous therapy, telemetry, feeding tubes, tracheotomy, or oxygen. They explained that their facilities do not have the equipment or resources necessary to treat these conditions on site, emphasizing that these interventions present ligature and other risks for patients. Many interviewees stated that patients are first medically cleared in the emergency room before being admitted to the IPF to address their behavioral health. However, IPF interviewees also reported that the patients they saw had increasingly more severe mental illness, aggression, more medical comorbidities and secondary SUD diagnoses, as well as greater unmet social needs. Interviewees noted that some patients delay treatment, leading to more severe conditions that take longer to stabilize.

**TABLE
6-15**

Growing share of Medicare FFS beneficiaries' stays at IPFs were for schizophrenia, 2019–2021

Psychiatric MS–DRG grouping	2019	2020	2021	Average annual change 2019–2021
Psychosis	73.4%	74.4%	74.8%	0.6%
Mood disorders	38.6	37.5	36.9	–1.5
Schizophrenia	34.8	36.9	37.9	3.0
Organic disturbances	7.0	6.9	6.8	–1.1
Alcohol/drug dependency	6.4	6.2	6.2	–1.1
Neurosis	4.5	4.2	3.9	–4.4
Nervous system disorder	5.9	5.4	5.3	–3.2
Other psychiatric	1.8	1.9	2.0	3.7
Other nonpsychiatric	1.0	1.0	1.0	0.6
Total	100.0	100.0	100.0	

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), MS–DRG (Medicare severity–diagnosis related group). Totals may not sum to 100 percent due to rounding. Data represent FFS beneficiaries with an IPF stay ending in each fiscal year. Psychiatric MS–DRG groupings are categorized as the following: mood disorders (885 and International Classification of Diseases, 10th Revision (ICD–10) diagnosis codes F30–F39); schizophrenia, schizotypal, delusion, and other non–mood psychotic disorders (885 and ICD–10 diagnosis codes F20–F29); organic disturbances and mental retardation (884); alcohol/drug abuse or dependency with and without rehabilitation and with and without MCC (894, 895, 896, 897); neurosis with and without depressive (881, 882); degenerative nervous system disorders with and without major complication or comorbidity (056, 057); other psychiatric MS–DRGs (880, 883, 896, 876, 887); other nonpsychiatric MS–DRGs (all others).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

Beneficiaries' access to IPF care

We examined trends in IPF supply and the volume of services as indicators of beneficiaries' access to IPFs. While the number of IPFs decreased by 2 percent annually between 2017 and 2021, the number of psychiatric beds grew slightly during this time, fueled by growth in the number of beds at for-profit IPFs. The mix of IPFs has changed, trending toward for-profit freestanding hospitals, while the number of hospital-based IPFs has declined, and beneficiary characteristics appeared to differ by facility type and ownership. Overall Medicare FFS volume at IPFs has decreased over time, with commensurate decreases in aggregate Medicare FFS payments to IPFs. The decline in utilization between 2019 and 2021 was particularly steep, likely related to avoidance or deferral of inpatient stays in response to the spread of COVID-19. Higher occupancy rates at government IPFs—which frequently function as providers of last resort, serving patients with severe and persistent mental illness who

are difficult to place in other facilities—could indicate insufficient supply for severely mentally ill beneficiaries whose conditions are more difficult to treat. Moreover, IPF interviewees noted that, more recently, staffing shortages (which may not be reflected in occupancy rates based on cost reports) decreased the availability of staffed beds.

Trends in the supply of IPFs

The psychiatric hospital sector has undergone dramatic changes over the last 60 years. Beginning in the 1960s, the downsizing and closure of many state-owned and county-owned psychiatric hospitals resulted in a large drop in the total number of inpatient psychiatric beds and shifted capacity to the private (nongovernment) sector (Salinsky and Loftis 2007). The “deinstitutionalization” movement was partly in response to concern about the inhumane treatment of long-term patients in public psychiatric hospitals, which resulted in a push for community-based

**TABLE
6-16**

Overall number of Medicare-certified IPFs declined while the number of freestanding for-profit facilities increased, 2017–2021

	2017	2018	2019	2020	2021	Average annual change 2017–2021
All IPFs	1,609	1,582	1,542	1,532	1,482	-2.0%
Rural	331	323	300	298	276	-4.4
Urban	1,258	1,238	1,221	1,212	1,186	-1.5
Hospital unit	1,088	1,057	1,008	987	927	-3.9
Nonprofit	663	645	614	599	571	-3.7
For profit	236	228	213	210	196	-4.5
Government	189	184	181	178	160	-4.1
Freestanding	521	525	534	545	555	1.6
Nonprofit	75	77	73	73	70	-1.7
For profit	288	295	313	316	328	3.3
Government	158	153	148	156	157	-0.2
Nonteaching	1,353	1,309	1,272	1,261	1,213	-2.7
Teaching	256	273	270	271	269	1.2
Bed size 1–24	701	685	644	617	580	-4.6
Bed size 25–49	353	335	328	317	311	-3.1
Bed size 50–99	292	296	305	313	309	1.4
Bed size ≥100	251	250	257	269	273	2.1

Note: IPF (inpatient psychiatric facility).

Source: MedPAC analysis of cost report data from CMS.

treatment (Fuller et al. 2016, Mechanic 2014, Salinsky and Loftis 2007, Sisti et al. 2015).

Overall inpatient capacity fell from over 427,000 beds in the 1970s to 86,000 in 2005 (Hutchins et al. 2011), even as the number of private hospital-based and freestanding IPFs increased substantially in the 1980s and early 1990s (encouraged by the cost-based payment method Medicare used to pay for IPF services at that time) (Salinsky and Loftis 2007). Today, researchers, policy analysts, and providers generally agree that demand for public psychiatric hospitals—which historically have cared for patients who have conditions that are the most difficult to treat—far outstrips supply, in large part because community-based treatment for the seriously mentally ill is often inadequate or nonexistent (Fuller et al. 2016, Lamb and

Weinberger 2014, McBain et al. 2022b, Mechanic 2014, Sharfstein and Dickerson 2009, Sisti et al. 2015). Lack of capacity to serve the most seriously mentally ill patients has placed substantial burden on the criminal justice system (Lamb and Weinberger 2014, Lamb et al. 2004, Lurigio and Harris 2022, Sisti et al. 2015).²⁸

IPFs can be freestanding hospitals or specialized units within acute care general hospitals, and within each type, ownership can vary between for profit, nonprofit, and government run. Between 2017 and 2021, the number of hospital-based units declined 3.9 percent per year (Table 6-16). As the number of hospital-based IPF units has fallen, freestanding for-profit IPFs have grown by 3.3 percent per year. Over the same time, freestanding and hospital-based government-run IPFs

Medicare Advantage enrollees using IPFs

We combined Medicare hospital claims data and Medicare Advantage (MA) encounter data to identify MA enrollees who had an inpatient stay in an inpatient psychiatric facility (IPF) in 2019. We identified approximately 120,000 MA enrollees with an IPF stay during the year (Table 6-17). This number represented 0.5 percent of all MA enrollees in 2019.²⁹ In comparison, 0.7 percent of fee-for-service (FFS) beneficiaries had an IPF stay in the same year. We found that the characteristics of MA enrollees who used IPFs were generally similar to those of FFS IPF users, with some demographic differences mirroring the differences in the overall

FFS and MA populations. For example, MA enrollees who used IPFs appeared to be sicker, with an average risk score (1.70) that was about 8 percent higher than that of FFS IPF users (1.57). However, that difference in risk scores is similar to the difference in average risk scores between the MA and FFS populations as a whole (9 percent). The higher risk scores among MA enrollees could be a result of differential incentives for coding between MA and FFS programs (Medicare Payment Advisory Commission 2022c). We also found that MA enrollees who used IPFs had a higher rate of mood disorders than FFS IPF users (50 percent versus 44 percent) and a lower rate of schizophrenia (30

(continued next page)

**TABLE
6-17**

Beneficiary characteristics of MA and FFS enrollees using IPF services, 2019 (cont. next page)

	IPF		Population	
	FFS	MA	FFS	MA
Current eligibility status and demographics				
Aged	45%	47%	86%	88%
Disabled	55	53	14	12
Female	51	54	55	57
Male	49	46	45	43
<45	22	16	3	2
45-64	32	37	10	10
65-79	30	34	61	64
80+	15	13	25	24
Non-Hispanic White	73	67	79	68
Black	16	19	9	13
Asian/Pacific Islander	1	1	3	4
Hispanic	6	11	6	12
American Indian/Alaska Native	1	0	1	0
Other or unknown	2	2	3	3
Rural	20	12	21	12
Urban	80	88	79	88
Average HCC risk score	1.57	1.70	1.11	1.21
Dual eligible or LIS during year				
No	32	35	78	74
Yes	68	65	22	26

Medicare Advantage (MA) enrollees using IPFs (cont.)

percent versus 34 percent). MA IPF beneficiaries had slightly higher rates of antianxiety and antidepressant Part D prescription fills than FFS IPF beneficiaries.

IPF interviewees did not note any differences between MA and FFS patients, but some interviewees reported that they were in the process of appealing MA plan denials for patients they felt needed a longer stay.

We note that using encounter data to identify MA enrollees who use IPF services could undercount

the true number of MA beneficiaries admitted to psychiatric hospitals. We were unable to identify 7 percent of the IPFs used by FFS beneficiaries in the encounter data (i.e., MA enrollees did not have stays with those IPFs or those IPFs were not properly identified). In addition, we were unable to validate whether we have accurately identified all MA enrollees using IPFs since the Medicare Provider Analysis and Review claims for MA enrollees who use IPFs appear to be underreported for IPFs. ■

**TABLE
6-17**

Beneficiary characteristics of MA and FFS enrollees using IPF services, 2019 (cont.)

	IPF		Population	
	FFS	MA	FFS	MA
Psychiatric MS-DRG*				
Mood disorders	44	50	-	-
Schizophrenia	34	30	-	-
Organic disturbances	9	8	-	-
Alcohol/drug dependency	8	8	-	-
Neurosis	6	6	-	-
Nervous system disorder	8	6	-	-
Other psychiatric	3	2	-	-
Had Part D psychotropic drug fills				
Antianxiety	48	50	15	13
Antidepressant	76	80	31	28
Anticonvulsant	64	64	22	21
Antipsychotic	75	73	7	5
Bipolar disorder medications	9	8	0	0

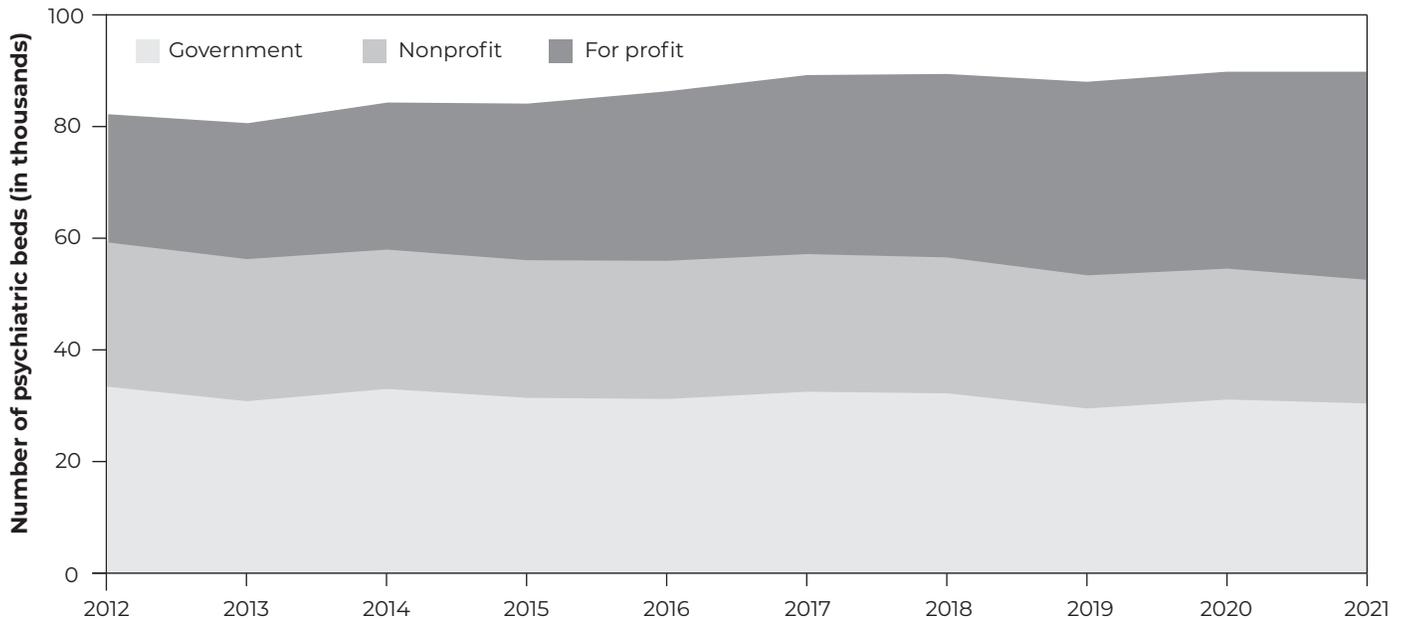
Note: MA (Medicare Advantage), FFS (fee-for-service), IPF (inpatient psychiatric facility), HCC (hierarchical condition category), LIS (low-income subsidy), MS-DRG (Medicare severity–diagnosis related group). The IPF columns represent shares of beneficiaries with at least one IPF stay in the year. FFS columns include those with Part A and Part B coverage at the start of the stay for the IPF column or at the midpoint of the year for the population. MA columns include only those MA beneficiaries enrolled in health maintenance organizations or preferred provider organizations at the start of the stay for the IPF column or at the midpoint of the year for the population. MA IPF beneficiaries were identified as those with at least one IPF stay in the year using the MA encounter data and the Medicare Provider Analysis and Review data. HCC risk scores do not account for unaddressed coding intensity.

*Share of beneficiaries with any stays in year indicating a psychiatric MS-DRG principal diagnosis: mood disorders (885 and International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes F30–F39); schizophrenia, schizotypal, delusion, and other non-mood psychotic disorders (885 and ICD-10 diagnosis codes F20–F29); organic disturbances and mental retardation (884); alcohol/drug abuse or dependency with and without rehabilitation and with and without major complication or comorbidity (MCC) (894, 895, 896, 897); neurosis with and without depressive (881, 882); degenerative nervous system disorders with and without MCC (056, 057); other psychiatric MS-DRGs (880, 883, 896, 876, 887); other nonpsychiatric MS-DRGs (all others).

Source: MedPAC analysis of Medicare Provider Analysis and Review, MA encounter, Medicare enrollment, HCC risk score, and Part D prescription drug event data from CMS. The First Databank Enhanced Therapeutic Classification System was used to identify psychotropic drugs.

**FIGURE
6-11**

Growth in inpatient psychiatric beds at for-profit IPFs, 2012–2021



Note: IPF (inpatient psychiatric facility).

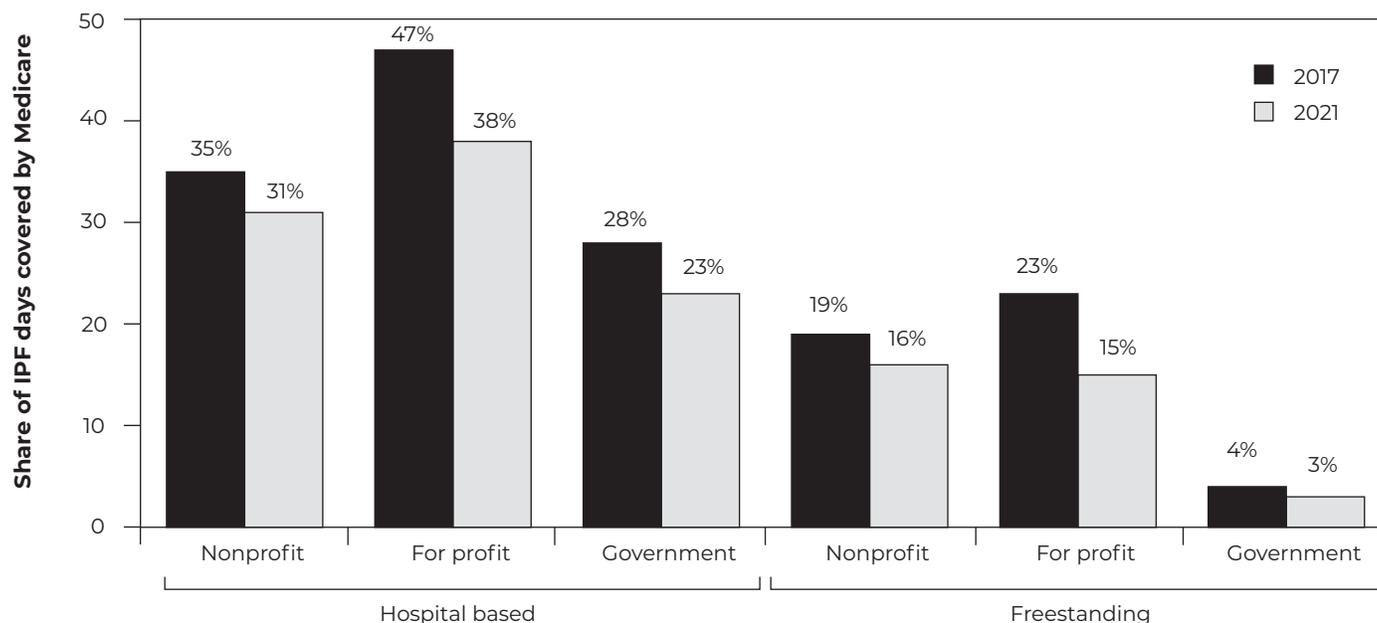
Source: MedPAC analysis of cost report data from CMS.

declined by 0.2 percent and 4.1 percent, respectively. Overall, the number of IPFs fell by 2.0 percent annually from 2017 to 2021 (Table 6-16, p. 263).

Since the 1970s, the nation's capacity of psychiatric beds has dramatically decreased and shifted toward freestanding for-profit IPFs; in 1970, 80 percent of psychiatric beds were at state and county psychiatric hospitals, but by 2002, only 30 percent of beds were in government IPFs (Salinsky and Loftis 2007). More recently, between 2012 and 2021, the number of beds in for-profit IPFs increased by 5.6 percent annually, while the number of beds at nonprofit and government-owned IPFs fell annually by 1.7 and 1.0 percent, respectively (Figure 6-11). As a result, in 2021, for-profit entities accounted for 41 percent of Medicare-certified psychiatric beds, up from 28 percent in 2012. In 2021, government IPFs accounted for 34 percent of psychiatric beds and nonprofit IPFs accounted for 25 percent of psychiatric beds. Overall, between 2012 and

2021, the total number of IPF beds increased by about 1 percent annually.

Although the total number of IPF beds has been stable in recent years, there are reports of shortages and waitlists for IPF beds that have been exacerbated by COVID-19 (McBain et al. 2022a, Pinals and Fuller 2020). Deinstitutionalization was predicated on the idea that stronger, more humane and effective community and outpatient supports would decrease the need for inpatient psychiatric care, but some have asserted that community-based infrastructure is lacking and more inpatient psychiatric beds are needed (McBain et al. 2022a, Pinals and Fuller 2020). IPF interviewees also frequently noted that geriatric units comprised only a subset of beds within the IPF. Although Medicare beneficiaries can use beds in other units, depending on patients' medical needs and functional health status, older age was a limiting factor in admitting patients for some IPFs. Thus, not all beds in IPFs are available to over-65 Medicare beneficiaries.

FIGURE 6-12**Medicare share of total IPF days decreased between 2017 and 2021 across all IPF types**

Note: IPF (inpatient psychiatric facility). Medicare-covered days include both fee-for-service and Medicare Advantage enrollees.

Source: MedPAC analysis of cost report data from CMS.

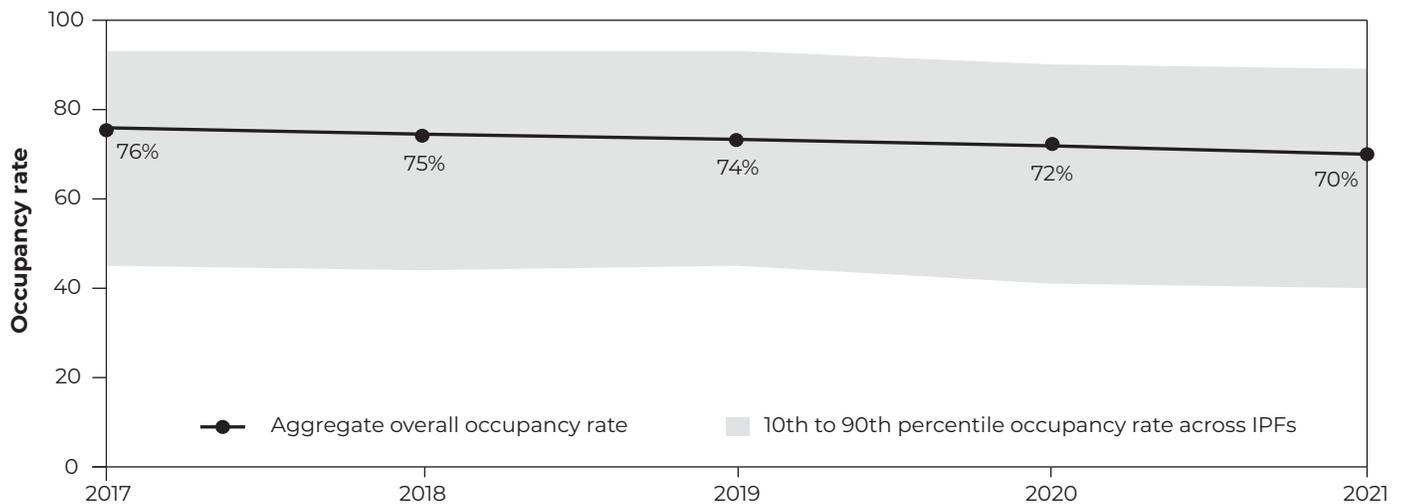
In 2021, Medicare beneficiaries (FFS and MA) represented 16 percent of total IPF days, with the remainder of payers composed of Medicaid, commercial, and other payers (or self-pay), down from 21 percent in 2017. In 2021, the share of Medicare beneficiaries' IPF days of IPFs' total days varied by IPF type, from 3 percent for freestanding government-run IPF days to 38 percent for hospital-based for-profit IPF days (Figure 6-12). The Medicare share of IPFs' days has fallen over time across all IPF types (Figure 6-12). The total number of IPF days has remained relatively stable over the last five years (data not shown), and thus the lower shares of Medicare-covered days appear to represent declines in utilization by Medicare beneficiaries.

From 2017 to 2021, overall occupancy rates (calculated as total occupied bed days divided by total bed days available) declined from 76 percent to 70 percent, though there was substantial variation across IPFs (Figure 6-13, p. 268). Occupancy rates in freestanding

government-owned IPFs—which frequently function as providers of last resort—were among the highest, with more than half of these IPFs having occupancy rates over 80 percent in recent years. This finding suggests that access to services for the sickest beneficiaries is inadequate in some areas. Occupancy rates tended to be higher in urban than in rural areas and in the Northeast and West census regions compared with others (data not shown). As a point of comparison, in 2021, the occupancy rate across short-term acute care hospitals was 65 percent (Medicare Payment Advisory Commission 2023). However, occupancy rates based on Medicare cost reports (as in Figure 6-13) do not account for beds that are temporarily unavailable due to staffing shortages or the need to convert semiprivate rooms to private rooms to isolate a psychiatric patient (for COVID-19 or other reasons). Almost all of the IPF interviewees noted difficulty in staffing all licensed beds. Thus, occupancy rates, as measured from cost reports, are likely underestimated.

**FIGURE
6-13**

Declining occupancy rates overall, though substantial variation across IPFs, 2017–2021



Note: IPF (inpatient psychiatric facility). Aggregate occupancy rates are calculated as the total used bed days divided by total bed days available.

Source: MedPAC analysis of cost report data from CMS.

The characteristics of Medicare FFS beneficiaries using IPFs differed by whether the facility was hospital based or freestanding and by ownership (Table 6-18). These differences have implications for Medicare beneficiaries needing IPF services, especially as hospital-based IPF beds decline and freestanding for-profit IPF beds grow. In summary, we found:

- Freestanding IPFs tended to serve more beneficiaries who were disabled compared with hospital-based units (ranging from 63 percent to 82 percent vs. from 49 percent to 56 percent) and beneficiaries who were younger than 45 years (ranging from 32 percent to 47 percent vs. from 20 percent to 26 percent).
- Freestanding nongovernment IPFs served more patients with a principal diagnosis of mood disorder (ranging from 44 percent to 46 percent vs. from 38 percent to 39 percent among hospital-based nongovernment IPFs).
- Freestanding IPFs served more beneficiaries with a principal diagnosis of alcohol or drug dependency compared with hospital-based IPFs (ranging from 8 percent to 11 percent vs. 4 percent).
- Hospital-based IPFs had higher rates of beneficiaries with principal diagnoses of organic disturbances (ranging from 9 percent to 11 percent vs. from 3 percent to 5 percent) or nervous system disorders (ranging from 8 percent to 9 percent vs. from 2 percent to 4 percent).
- Beneficiaries at hospital-based IPFs tended to have higher risk scores than those at freestanding IPFs (ranging from 1.53 to 1.71 vs. from 1.16 to 1.43).
- Freestanding government IPFs served beneficiaries who were very different from those at other IPFs and composed only 4 percent of Medicare FFS IPF stays. Patients at freestanding government IPFs had longer median lengths of stay (18 days compared with 8 to 11 days among other types of IPFs), had high rates of beneficiaries who were disabled (82 percent vs. from 49 percent to 63 percent), young (47 percent under age 45 vs. from 20 percent to 32 percent), low income (80 percent vs. from 64 percent to 70 percent), and diagnosed

**TABLE
6-18**

Beneficiary characteristics vary by IPF type, FY 2021

	Hospital based			Freestanding		
	Non-profit	For profit	Government	Non-profit	For profit	Government
Share of IPF beneficiaries*	36	16	11	7	37	4
Current eligibility status and demographics						
Aged	49	51	44	37	37	18
Disabled	50	49	56	63	63	82
Female	52	49	48	50	46	40
Male	48	51	52	50	54	60
<45	22	20	26	32	32	47
45-64	29	29	30	32	32	34
65-79	34	35	30	28	27	16
80+	16	16	14	8	9	3
Non-Hispanic White	75	72	67	74	69	67
Black	15	16	21	13	17	18
Asian/Pacific Islander	1	2	2	2	1	2
Hispanic	5	7	6	7	8	6
American Indian/Alaska Native	1	0	1	1	1	2
Other or unknown	3	2	3	4	3	5
Rural	21	18	24	13	17	30
Urban	79	82	76	87	83	70
Average HCC risk score	1.57	1.71	1.53	1.38	1.43	1.16
Dual eligible or LIS during year						
No	36	35	30	33	32	20
Yes	64	65	70	67	68	80
Median length of stay	9	10	10	8	11	18
Psychiatric MS-DRG**						
Mood disorders	39	38	31	44	46	25
Schizophrenia	34	37	42	33	37	53
Organic disturbances	10	11	9	3	5	4
Alcohol/drug dependency	4	4	4	10	11	8
Neurosis	6	4	6	6	3	7
Nervous system disorder	8	8	9	3	4	2
Other psychiatric	3	2	3	2	2	4
Other nonpsychiatric	2	1	2	1	0	2
Had ECT during year						
No	97	99	98	97	99	99
Yes	3	1	2	3	1	1

Note: IPF (inpatient psychiatric facility), FY (fiscal year), HCC (hierarchical condition category), LIS (low-income subsidy), MS-DRG (Medicare severity-diagnosis related group), ECT (electroconvulsive therapy). Data represent fee-for-service beneficiaries with an IPF stay ending in FY 2021. Percentages may not sum to 100 due to rounding.

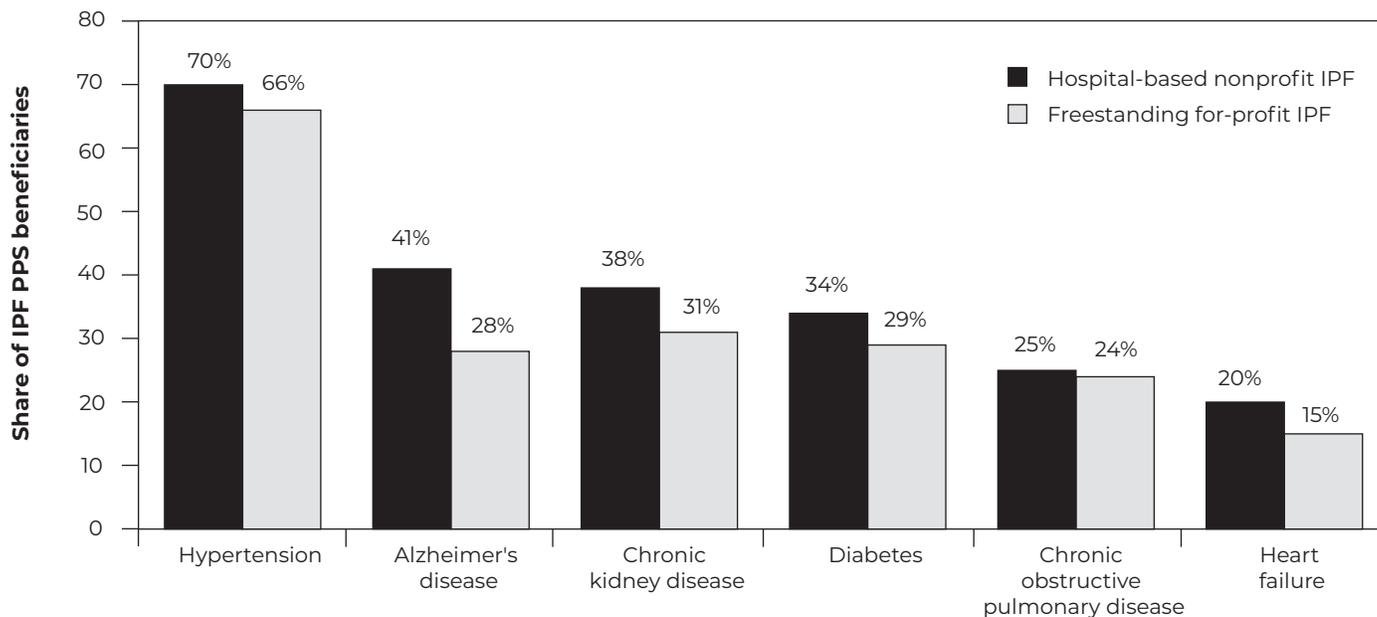
*Percent adds up to greater than 100 percent across IPF types because some beneficiaries have stays with more than one IPF type.

**Percent of beneficiaries with any stays in year indicating a psychiatric MS-DRG principal diagnosis: mood disorders (885 and International Classification of Diseases, 10th Revision (ICD-10) diagnosis codes F30-F39); schizophrenia, schizotypal, delusion, and other non-mood psychotic disorders (885 and ICD-10 diagnosis codes F20-F29); organic disturbances and mental retardation (884); alcohol/drug abuse or dependency with and without rehabilitation and with and without major complication or comorbidity (MCC) (894, 895, 896, 897); neurosis with and without depressive (881, 882); degenerative nervous system disorders with and without MCC (056, 057); other psychiatric MS-DRGs (880, 883, 896, 876, 887); other nonpsychiatric MS-DRGs (all others).

Source: MedPAC analysis of Medicare Provider Analysis and Review data, cost report data, Medicare enrollment, and HCC risk score data from CMS.

**FIGURE
6-14**

Higher rate of certain chronic conditions among FFS beneficiaries using hospital-based nonprofit IPFs compared with freestanding for-profit IPFs, 2019



Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), PPS (prospective payment system).

Source: MedPAC analysis of Medicare Provider Analysis and Review, enrollment data, and Chronic Care Warehouse chronic condition data from CMS.

with schizophrenia (53 percent vs. 33 percent to 42 percent).

- Government IPFs (hospital based and freestanding) served higher rates of rural beneficiaries (ranging from 24 percent to 30 percent vs. from 13 percent to 21 percent among other IPFs).

Note that some (though not all) of the beneficiary characteristics listed in Table 6-18 (p. 269) are also used to adjust payments in the IPF PPS (e.g., advanced age, rural location).

Using data from 2019, we examined the frequency of selected chronic conditions of IPF PPS beneficiaries by IPF type. Focusing on hospital-based nonprofit and freestanding for-profit IPFs, which account for over 70 percent of Medicare IPF PPS beneficiaries, we found that hospital-based nonprofit IPFs tended to serve greater shares of beneficiaries with Alzheimer's disease,

chronic kidney disease, and diabetes than freestanding for-profit IPFs (Figure 6-14).

These findings were generally supported by IPF interviewees—freestanding (nongovernment) IPF interviewees tended to report more restrictive admission criteria than hospital-based IPFs. Patients admitted to freestanding IPFs with medical comorbidities generally had conditions that were well controlled or stable. However, there was some variation in freestanding IPFs' approach toward more medically challenging patients. For example, one freestanding facility reported having internal medicine or family medicine practitioners involved on a regular basis and could take patients with more medical severity.

Trends in the use of IPF services

In 2021, 157,500 Medicare FFS beneficiaries had 230,500 IPF stays (Table 6-19).³⁰ (About 120,000 MA enrollees

**TABLE
6-19**

IPF PPS stays declined while length of stay increased, 2017–2021

	2017	2018	2019	2020	2021	Average annual change*	
						2017–2019	2019–2021
IPF stays	395,100	371,000	345,900	283,000	230,500	–6.4%	–18.4%
Stays per 1,000 FFS beneficiaries	11.9	11.2	10.5	8.8	7.5	–5.7	–15.4
Unique beneficiaries	263,400	248,200	230,700	189,400	157,500	–6.4	–17.4
Multiple users	73,200	68,500	63,400	51,200	41,300	–6.9	–19.3
Length of stay (in days)							
Nongovernment IPFs	12.2	12.3	12.4	12.8	13.1	0.8	3.1
Government IPFs	21.1	23.9	22.7	24.0	27.2	3.7	9.6
Spending (in billions)	\$4.3	\$4.2	\$3.9	\$3.4	\$3.0	–4.4	–12.2
Spending per FFS beneficiary	\$129	\$126	\$120	\$107	\$99	–3.6	–9.1
Payment per IPF beneficiary	\$16,400	\$16,800	\$17,100	\$18,100	\$19,300	2.2	6.2
Payment per covered day	\$880	\$890	\$910	\$940	\$990	1.4	4.6
Payment per stay	\$10,900	\$11,200	\$11,400	\$12,100	\$13,200	2.2	7.5

Note: IPF (inpatient psychiatric facility), PPS (prospective payment system), FFS (fee-for-service). Data exclude scatter beds (beds used in acute care hospitals to treat patients with psychiatric or alcohol- and drug-related conditions).
*Based on unrounded figures.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

were admitted to an IPF in 2019.) Controlling for the number of beneficiaries enrolled in Medicare FFS, IPF stays declined 5.7 percent per year, on average, between 2017 and 2019, possibly reflecting an overall decline in all hospital stays. Between 2019 and 2021, the number of IPF stays per 1,000 FFS beneficiaries fell by 15.4 percent annually. This large decrease could be partially explained by avoidance or deferral of inpatient stays in response to the spread of COVID-19; between 2019 and 2020, general acute care hospital stays fell 12 percent (Medicare Payment Advisory Commission 2023).³¹ However, in 2021, IPF stays declined substantially, while the decline in acute care inpatient hospital stays from the prior year was less than 2 percent.³² IPF interviewees frequently noted their inability to use all licensed beds because of challenges in hiring staff (IPFs possibly face greater difficulty in recruiting staff compared with acute care hospitals), as well as the common use of semiprivate rooms (such

that beds need to be taken offline to accommodate patients needing a single room).

Average lengths of stay have increased over time, particularly between 2019 and 2021 (Table 6-19). For nongovernment IPFs, the average length of stay rose 3.1 percent annually over this time to 13.1 days (by comparison, between 2017 and 2019, the average length of stay rose by less than 1 percent annually). Length of stay tends to be longer for government-run facilities—27.2 days per stay in 2021—and has increased by 9.6 percent annually since 2019. Longer stays led to higher payment per IPF stay, which increased by 7.5 percent annually (last row of Table 6-19).

Reduced overall utilization and longer stays indicate potential changes in the mix of Medicare beneficiaries who use psychiatric hospitals. Several IPF interviewees discussed observing general increases in patients’ aggression and severity over time. Almost all IPF

**TABLE
6-20**

Medicare beneficiaries and the 190-day limit on freestanding psychiatric hospital coverage, 2023

	Any days in freestanding IPF		Reached limit	Within 15 days of reaching limit
	Number	Share of population		
Medicare beneficiaries	847,200	1.5%	38,900	10,400
Fee-for-service	537,900	1.8	27,300	6,800
Medicare Advantage	309,400	1.1	11,500	3,600

Note: IPF (inpatient psychiatric facility). Table figures include the count of Medicare beneficiaries who were enrolled in Medicare fee-for-service or Medicare Advantage in 2021 and had at least one day in a freestanding psychiatric hospital as of January 2023. Percentages represent the share of the relevant population.

Source: MedPAC analysis of enrollment data from CMS.

interviewees discussed challenges with identifying safe and supportive discharge options for patients, resulting in prolonged lengths of stay. As one interviewee stated, “We have a lot of challenges in getting patients to that next step.” Interviewees indicated that referring organizations, such as skilled nursing and assisted living facilities, do not want to readmit patients who require a high level of care and supervision. In some cases, discharge locations such as group homes have beds available but do not have the available or appropriate staff to accommodate admissions from IPFs. Other interviewees noted that closure of government-run psychiatric hospitals in their state, which typically take higher-needs patients, has made it harder to discharge patients who are awaiting placement, resulting in longer stays.

Medicare’s 190-day lifetime limit on treatment in freestanding psychiatric hospitals could affect use of services

Uniquely in Medicare, coverage of treatment in freestanding psychiatric hospitals is subject to a lifetime limit of 190 days. This provision was established in 1965 (with the implementation of Medicare) when the majority of inpatient psychiatric care was in government-run freestanding facilities. The 190-day limit does not apply to hospital-based units (currently 60 percent of IPF stays) and therefore affects the type

of facilities from which some beneficiaries seek care. When beneficiaries reach the limit during an IPF stay, patient care may be disrupted.

Our analyses of lifetime psychiatric hospital days showed that (as of January 2023) for all individuals enrolled in Medicare FFS or MA at some point in 2021, 847,200 beneficiaries had at least one day in a freestanding psychiatric hospital. Among these beneficiaries, 38,900 exhausted all 190 days and 10,400 beneficiaries were within 15 days of reaching the limit. The breakdown by FFS and MA enrollees is shown in Table 6-20. A disproportionate share (70 percent) of beneficiaries reaching the 190-day limit were covered by FFS (the overall share of FFS Medicare beneficiaries in 2021 was 53 percent).³³ It is not clear whether the greater FFS share was due to differences in the type of care needed by the FFS and MA populations or to how well freestanding psychiatric facility days are recorded for MA enrollees. It is also unknown whether some MA plans provide additional coverage of freestanding psychiatric hospital days past the 190-day limit (though no IPF interviewees indicated that this was the case).

The majority of Medicare FFS beneficiaries who had reached the 190-day limit or were near reaching the limit were disabled (75 percent) and low income (85 percent) (Table 6-21).³⁴ Most were male (60 percent) and nearly a quarter were Black. Compared with other

**TABLE
6-21**

Characteristics of Medicare FFS beneficiaries who have reached or are close to reaching the 190-day limit on freestanding IPF days as of January 2023

Characteristic in 2021	FFS beneficiaries reaching or near 190-day limit	All other FFS beneficiaries with an IPF stay in 2021
Current eligibility status and demographics		
Aged	25%	48%
Disabled	75	52
Female	40	50
Male	60	50
<45	22	26
45-64	56	29
65-79	18	32
80+	5	13
Non-Hispanic White	66	73
Black	24	15
Asian/Pacific Islander	2	2
Hispanic	6	6
American Indian/Alaska Native	1	1
Other or unknown	1	3
Urban	84	80
Rural	16	20
Dual eligible or LIS during year		
No	15%	38%
Yes	85	62
HCC risk score	1.48	1.39
Medicare Part A and Part B spending (per capita) ^a	\$22,700	\$40,200
Medicare Part D (per capita) ^b		
Gross spending ^c	\$12,200	\$4,200
Fills	83	52

Note: FFS (fee-for-service), LIS (low-income subsidy), HCC (hierarchical condition category). Beneficiaries at or reaching the 190-day limit include FFS beneficiaries who were enrolled in Medicare in 2021 and had exhausted or were within 15 days of exhausting the 190-day limit in freestanding psychiatric hospitals by January 2023.

^aIncludes Medicare payment of covered services only.

^bIncludes only those beneficiaries enrolled in Part D.

^cReflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not already reflected in prices at the pharmacies.

Source: MedPAC analysis of FFS standard analytic files, Medicare enrollment, and Part D prescription drug event data from CMS.

Medicare FFS beneficiaries who had an IPF stay in 2021, the beneficiaries at or nearing the 190-day lifetime limit had higher risk scores and higher Part D prescription drug spending but lower per capita Medicare Part

A and Part B spending (\$22,700 compared with \$40,200). Lower spending among this group could be related to reaching coverage limits on inpatient stays.³⁵ In fact, we found that nearly half (47 percent)

**TABLE
6-22**

High use of ED and inpatient hospital services before and after an IPF stay, 2018

Type of service	Days before IPF admission			Days after IPF discharge		
	≤90	≤30	≤7	≤7	≤30	≤90
Any ED or inpatient admission	54%	36%	19%	14%	29%	47%
Emergency department only*	42	24	8	9	21	38
Acute care hospital admission**	24	16	11	5	10	19
Inpatient psychiatric hospital admission	30	18	7	7	18	31
Partial hospitalization	8	5	3	6	9	12

Note: ED (emergency department), IPF (inpatient psychiatric facility).

*Includes only ED visits that did not have a subsequent inpatient admission (including IPF admission) within three days.

**Does not include IPF admissions.

Source: MedPAC analysis of the Medicare Provider Analysis and Review (MedPAR), Medicare FFS claims, and Medicare enrollment data from CMS.

of FFS beneficiaries at or near reaching the 190-day freestanding psychiatric hospital day limit had fewer than 60 lifetime reserve days remaining, and that 20 percent had no lifetime reserve days remaining (data not shown). Medicaid may also cover additional care for these beneficiaries that is not captured in Medicare claims data.

Some IPF interviewees discussed the implications of the 190-day limit. They stated that the limit can present significant issues for patients who need longer-term care or those who have multiple periodic inpatient stays, often because of chronic serious mental illness, such as schizophrenia. A couple of the IPF interviewees reported that after surpassing the 190-day limit, IPFs provide uncompensated care and help the patients obtain Medicaid coverage. One noted that they try to get patients who meet the 190-day limit into acute care hospitals (or hospital-based IPFs) so that they can have Medicare coverage. Most IPFs considered the 190-day limit insufficient, especially for patients with chronic mental illnesses, and stated that it increased the difficulty of finding suitable postdischarge placement options.

In future work, we will continue to track beneficiaries who reach the 190-day lifetime limit on freestanding IPF care and determine the types of care these patients receive when reaching the limit.

Health care utilization before and after an IPF stay

Beneficiaries are admitted to IPFs for acute psychiatric episodes requiring 24-hour intensive care. They are expected to have received other medical services prior to the IPF stay and require substantial follow-up care after the IPF stay. Our report on the utilization of certain health care services before and after an inpatient psychiatric hospitalization uses IPF stays that began and ended in 2018. We included only IPF stays for which the beneficiary was alive at the end of 2019. We searched Medicare claims for services that occurred in several time frames before the IPF admission and after the IPF discharge.

Our sample consisted of 259,000 IPF stays for 169,000 beneficiaries. We report on the use of certain types of health care in the 7, 30, and 90 days prior to and following the IPF stay. The percentages shown in the tables and figures that follow are cumulative: If an emergency department (ED) visit occurred in the 7 days prior to IPF admission, it would also have occurred in the 30 and 90 days prior to admission.

Most patients using IPFs are admitted through an ED—over 70 percent of IPF stays in 2021 had an ED visit in the week prior to admission to the IPF (data not shown). IPF interviewees confirmed that IPFs admit most of their patients from the ED, where they are

**TABLE
6-23**

Less than a third of IPF stays had behavioral health practitioner visits occurring before or after the stay, 2018

Type of service*	Days before IPF admission			Days after IPF discharge		
	≤90	≤30	≤7	≤7	≤30	≤90
Any visit with behavioral health practitioner	36%	25%	13%	15%	30%	42%
E&M visit with nonbehavioral health practitioner	66	46	22	25	50	68

Note: IPF (inpatient psychiatric facility), E&M (evaluation and management).

*To avoid double counting with other types of services, we exclude visits with practitioners that occurred in the emergency room, inpatient hospital (including a psychiatric facility), or during a partial hospitalization.

Source: MedPAC analysis of the Medicare Provider Analysis and Review (MedPAR), Medicare FFS claims, and Medicare enrollment data from CMS.

screened to ensure that IPFs admit patients who are medically stable. To better understand the separate encounters with the health care system prior to the IPF stay, we broke down “ED or hospitalizations” into ED-only visits, with no acute care or IPF admission in the following three days; acute care inpatient hospital stays (not including IPF stays); and IPF stays. That is, ED visits that resulted in an acute hospital or IPF stay were counted in these latter categories rather than as an ED visit.

We found that in the seven days prior to IPF admission, 8 percent of beneficiaries had an ED-only visit, 11 percent had an acute care inpatient hospital stay, and 7 percent had a prior IPF stay (Table 6-22). The share of stays for which any of these events occurred in the 30 days before an IPF admission was 36 percent (54 percent in the 90 days prior to the IPF stay). We also found high ED use and hospitalizations in the period following IPF discharge. In the month after IPF discharge, 29 percent of beneficiaries had an ED-only visit, were admitted to an acute care inpatient hospital, or were readmitted to an IPF (Table 6-22). Use of partial hospitalizations was relatively low before and after an IPF stay, with only 12 percent of IPF stays having a partial hospitalization in the following 90 days.

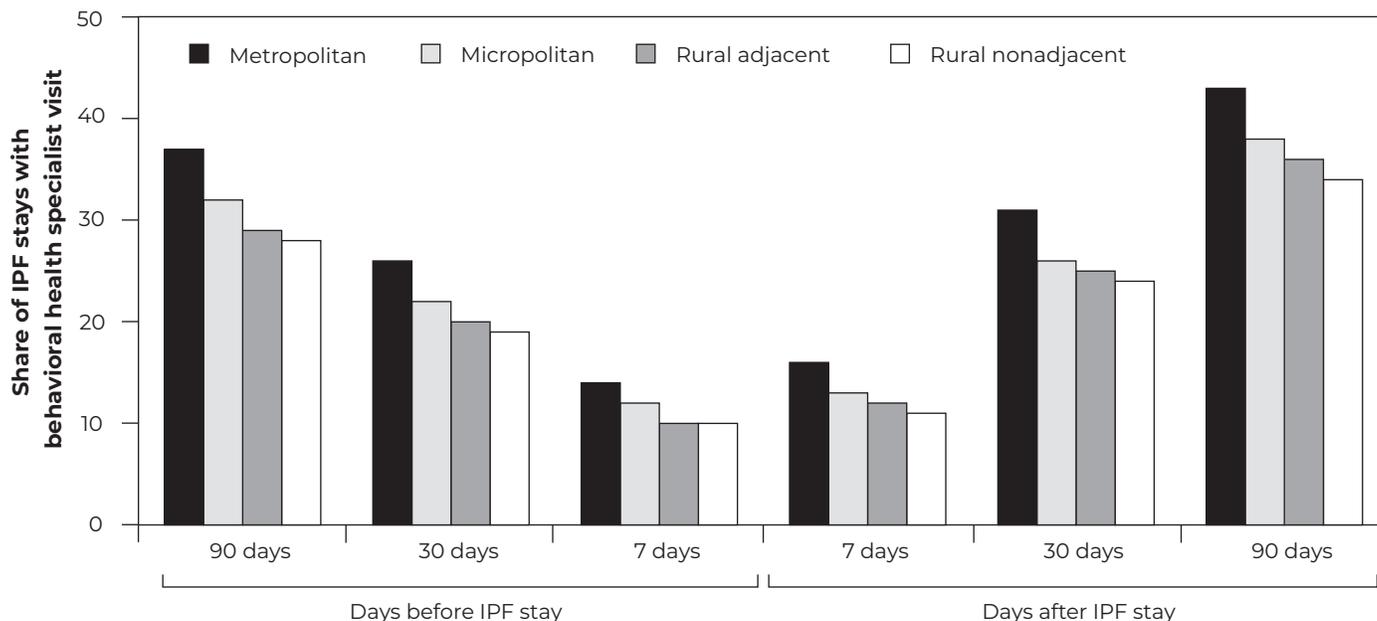
Only 13 percent of beneficiaries had ambulatory visits with a behavioral health practitioner (psychiatrist, psychologist, licensed clinical social worker, or addiction medicine physician) in the week before

IPF admission (Table 6-23). More beneficiaries—22 percent—had an evaluation and management visit with a nonbehavioral health practitioner in the week prior to IPF admission, increasing to 66 percent in the 90 days prior to the IPF stay. Only 15 percent of beneficiaries had a visit with a behavioral health practitioner in the week following discharge, increasing to 42 percent in the 90 days following discharge.³⁶ IPF interviewees discussed difficulty in obtaining appropriate follow-up care for their IPF patients after discharge, particularly with psychiatrists. One stated:

We'll refer them to see a therapist, and they might have to see them two or three times before they can get in with a psychiatrist. It could be two or three months to actually see the psychiatrist because they have to see the therapist so many times—that's how much there is a shortage of psychiatrists. The need is just growing and growing.

Moreover, IPF interviewees noted that the lack of discharge placement options not only lengthens stays but has also resulted in releasing more long-term mentally ill patients back into the community despite significant social, behavioral, and medical needs and inadequate support. Many of these patients are eventually readmitted.

We examined whether these patterns differed depending on the geographic characteristics of the beneficiary's location (Figure 6-15, p. 276, and Figure 6-16, p. 277). The geographic breakdown in our

FIGURE 6-15**Compared with beneficiaries in metropolitan areas, beneficiaries in rural areas were less likely to have a behavioral health specialist visit before or after the IPF stay, 2018**

Note: IPF (inpatient psychiatric facility). Includes Medicare fee-for-service (FFS) beneficiaries admitted to and discharged from an IPF during calendar year 2018. Geographic categories are based on the beneficiary's county of residence, mapped using the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes. Behavioral health specialists include psychiatrists, psychologists, licensed clinical social workers, and addiction medicine specialists.

Source: MedPAC analysis of the Medicare Provider Analysis and Review (MedPAR), Medicare FFS claims, and Medicare enrollment data from CMS.

sample was as follows: 81 percent of IPF stays were for beneficiaries in urban (metropolitan) counties, 11 percent in rural (micropolitan) counties, 5 percent in rural counties adjacent to an urban area, and 3 percent located in rural (nonadjacent) counties.³⁷

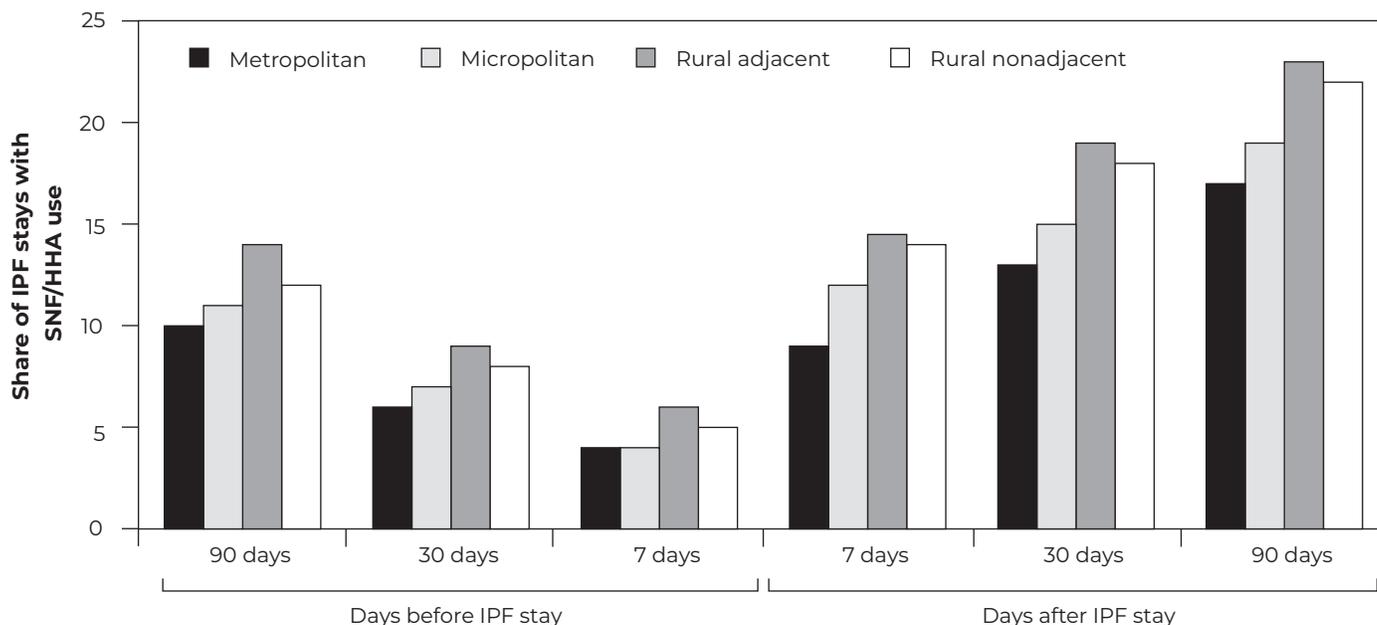
We found fewer hospitalizations, ED visits, and physician visits for rural beneficiaries admitted to IPFs across almost all pre-IPF and post-IPF stay time frames compared with urban beneficiaries. Figure 6-15 shows that 16 percent of urban beneficiaries had a visit with a behavioral health specialist in the seven days following IPF discharge, compared with 11 percent among rural nonadjacent beneficiaries. We found a similar pattern for the other time frames before and after an IPF stay. We did not include rural health clinics (RHCs) or federally qualified health centers (FQHCs) in this analysis, and our counts of visits to behavioral health specialists in rural areas would likely be higher if we included these facilities.³⁸

Compared with urban beneficiaries, beneficiaries in rural areas used post-acute care (SNF and home health care) more before and after the IPF stay. In the seven days following IPF discharge, 9 percent of beneficiaries with an IPF stay in urban areas were admitted to a SNF or home health agency compared with 14 percent of IPF users in rural (adjacent) and rural (nonadjacent) areas (Figure 6-16).

The high rate of ED visits and acute care hospital admissions before and after IPF admission, and the relatively low rate of visits with behavioral health clinicians, suggests that many of these patients do not receive effective, well-coordinated behavioral health care. We did not assess whether the health care received before and after an IPF stay was clinically appropriate. We also did not exhaustively include all available services (for example, we did not include visits with RHCs and FQHCs). Future analyses could include other Medicare services or add stratifications (e.g.,

**FIGURE
6-16**

Beneficiaries in rural areas were more likely than beneficiaries in metropolitan areas to be admitted to SNFs and HHAs before and after the IPF stay, 2018



Note: SNF (skilled nursing facility), HHA (home health agency), IPF (inpatient psychiatric facility). Includes Medicare FFS beneficiaries admitted to and discharged from an IPF during calendar year 2018. Geographic categories are based on the beneficiary's county of residence, mapped using the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes.

Source: MedPAC analysis of the Medicare Provider Analysis and Review, Medicare FFS claims, and Medicare enrollment data from CMS.

beneficiary characteristics such as age, low income, and race/ethnicity).

IPFs' quality of care

The Chairman of the House Committee on Ways and Means requested that the Commission describe quality-of-care measures for IPFs and, to the extent feasible, analyze how such quality varies for Medicare beneficiaries across facilities. In summary, data on the quality of care provided by IPFs is currently limited. The Medicare program currently has an IPF pay-for-reporting quality program that focuses predominantly on process measures that are reported in aggregate by providers. As IPFs begin to report patient-level quality results, CMS and others will be able to better assess the quality of care provided by IPFs. Beyond improving the validity of IPF-reported quality data, the Commission also encourages CMS to develop and implement

additional quality measures tied to clinical outcomes and patient experience.

IPF quality reporting program

Pursuant to the Affordable Care Act of 2010, CMS implemented the IPF quality reporting (IPFQR) program October 1, 2012. The IPFQR program is a pay-for-reporting program intended to encourage IPFs and clinicians to improve the quality of care provided to beneficiaries. The program collects facility-level quality results and publicly reports them.³⁹

Under the IPFQR program, IPFs must report a numerator and a denominator value for all quality measures based on data in their own administrative and chart records, as well as formally acknowledge the data's accuracy and completeness. CMS has noted that aggregate data reported by IPFs do not allow for comprehensive data validation, thereby diminishing

CMS's ability to detect any errors in chart-abstracted measures that IPFs report. CMS recently finalized a policy to require IPFs to submit patient-level data for select chart-abstracted measures starting from the summer of 2023 onward (Centers for Medicare & Medicaid Services 2021a). IPFs had the option to begin submitting patient-level data to CMS in 2022 on a voluntary basis. Patient-level reporting, or reporting on each patient-abstracted measure, and indicating whether the patient was included in each numerator and denominator of the measure, may address data validation concerns.

Eligible IPFs that do not participate in the IPFQR program or meet all data reporting requirements in a given fiscal year will receive a 2 percent reduction of their annual update to their standard federal rate for the applicable fiscal year.⁴⁰ Since the program's inception, the vast majority of participating IPFs satisfactorily met the IPFQR program requirements and received the full annual update. In fiscal year 2023, 98 percent of the IPFs eligible to participate in the IPFQR program met all requirements and did not experience a reduction in their annual payment update. One percent of eligible IPFs participated in the program but failed to meet all requirements and thus received a 2 percent reduction to their annual update. Another 1 percent of eligible IPFs that chose not to participate in the program also received a 2 percent reduction in their annual update.

IPFQR program measures

For fiscal year 2014, the first IPFQR program year, IPFs were required to report data for six quality measures to meet the program requirements. The program has grown to include 14 measures for fiscal year 2024 (Table 6-24). These measures cover a range of processes the IPFs can implement to maintain or improve the health of their patients during the stay and discharge. The IPFQR program includes one outcome measure—a 30-day all-cause unplanned readmission following psychiatric hospitalization—that measures the impact an IPF has on care during the stay and at discharge to prevent patients from returning to a hospital.

The IPFQR program measures are based on three data sources: chart abstracted, claims based, and the Centers for Disease Control and Prevention's National Healthcare Safety Network (CDC NHSN). The majority of measures for fiscal year 2024 are based on chart-

abstracted data, which IPFs or their vendors calculate based on their own records and then report as aggregate results to CMS (Table 6-24).⁴¹ Claims-based measures are calculated by CMS using Medicare FFS claims data. Finally, the recently adopted COVID-19 health care personnel vaccination measure requires IPFs to submit data to the CDC NHSN, a public health registry.

The Commission encourages CMS to develop and implement additional quality measures tied to clinical outcomes and patient experience. CMS has signaled a move in this direction, as it is currently developing two measures tied to clinical outcomes that may be included in future IPFQR program measure sets: improvement in depression symptoms during the IPF stay (chart abstracted) and 30-day risk-standardized all-cause mortality following IPF discharge (claims based). CMS has also noted that it plans to develop and implement patient experience surveys for IPFs in the future.

IPF quality measure performance

Overall, due to data limitations, it is difficult to interpret IPF quality measure performance. In 2021, the IPFQR program included 15 quality measures (19 indicators, since some measures have multiple rates). Fifteen of these indicators are based on chart-abstracted data, meaning that facilities calculate the measure based on their own medical records and report the results (i.e., numerators and denominators) in aggregate. Without patient-level data, CMS has not been able to assess the accuracy of the chart-abstracted measures that IPFs report.

In 2021, average performance across all IPFs on chart-abstracted quality measures varied widely (Table 6-25, p. 280). For example, for the measure of tobacco use treatment provided at discharge, the lowest mean rate was 21 percent, while the highest mean rate for the measure screening for metabolic disorders was 80 percent. Also, some performance across IPFs on quality measures varied more than others. For example, the IPF at the 75th percentile for tobacco use treatment provided during the stay had a rate that was 4.1 times that of the IPF at the 25th percentile, while the IPF at the 75th percentile for medication continuation following discharge had a rate that was 1.2 times that of the IPF at the 25th percentile. These large ranges and variation in performance suggest opportunities for improvement.

**TABLE
6-24**

IPFQR program quality measures for FY 2024

Measure name	Measure description
Patient safety	
Hours of physical restraint use	Hours that patients spent in physical restraints for every 1,000 hours of care
Hours of seclusion use	Hours that patients spent in seclusion for every 1,000 hours of care
Preventive care and screening	
Screening for metabolic disorders	Patients discharged on antipsychotic medications who had metabolic disorder screenings in the past year
Influenza immunization	Patients assessed and given influenza vaccination
COVID-19 health care personnel vaccination*	COVID-19 vaccination among health care personnel
Substance use treatment	
Alcohol use brief intervention during the stay	Patients with alcohol abuse who received or refused a brief intervention during their stay
Alcohol and other drug use disorder treatment at discharge	Patients who screened positive for alcohol or drug use who, at discharge, received or refused a prescription to treat that disorder or a referral for addiction treatment
Tobacco use treatment during the stay	Patients who use tobacco and received or refused counseling and medication to quit during their stay
Tobacco use treatment at discharge	Patients who use tobacco and who, at discharge, received or refused a referral for outpatient counseling and received or refused a prescription to help them quit
Follow-up care	
Patients discharged on multiple antipsychotic medications with appropriate justification	Patients discharged on two or more clinically appropriate antipsychotic medications
Transition record received by discharged patients	Patients who received a care record and follow-up plans at discharge
Medication continuation following discharge**	Patients who filled at least one prescription within 30 days of discharge
Follow-up after psychiatric hospitalization**	Patients who received follow-up care from an outpatient mental health care provider after discharge: within 30 days and within 7 days
Outcome	
30-day all-cause unplanned readmission following psychiatric hospitalization**	Patients readmitted to any hospital within 30 days of discharge

Note: IPFQR (IPF quality reporting), FY (fiscal year). Unless noted, quality measures are based on chart-abstracted data, meaning IPFs or their vendors calculate values based on their own medical records and report aggregate results to CMS.

*Denotes a measure based on results that an IPF reports to the CDC National Healthcare Safety Network.

**Denotes a claims-based measure calculated by CMS, as opposed to chart-abstracted measures calculated by the IPF.

Source: Final rules for inpatient psychiatric facility prospective payment system.

**TABLE
6-25**

Quality measure performance across IPFs, 2021

Measure	Mean	25th	50th	75th	75th to 25th percentile ratio
Hours of physical restraint use	0.52	0	0.05	0.22	–
Hours of seclusion use	0.37	0	0.02	0.18	–
Screening for metabolic disorders	80%	74%	90%	97%	1.3
Influenza immunization	78	69	88	97	1.4
Alcohol use brief intervention during the stay					
Provided or offered	67	47	78	93	2.0
Provided	73	58	81	95	1.6
Alcohol and other drug use disorder treatment at discharge					
Provided or offered	72	55	80	95	1.6
Provided	59	35	61	88	2.5
Tobacco use treatment during the stay					
Provided or offered	72	59	79	93	1.6
Provided	45	17	47	70	4.1
Tobacco use treatment at discharge					
Provided or offered	57	28	65	88	3.2
Provided	21	0	4	30	–
Patients discharged on multiple antipsychotic medications with appropriate justification	62	37	70	91	2.5
Transition record received by discharged patients	67	43	83	96	2.22
Timely transmission of transition record	59	27	71	90	3.3
Medication continuation following discharge*	73	68	74	79	1.2
Follow-up after psychiatric hospitalization					
Within 30 days*	53	44	53	62	1.4
Within 7 days *	29	21	28	36	1.7
30-day all-cause unplanned readmission following psychiatric hospitalization*	20	18	20	22	1.2

Note: IPF (inpatient psychiatric facility). The analysis includes 1,524 IPFs. A small number of IPFs were excluded from the analysis because of missing results or characteristic information. Not all IPFs had enough cases to report every measure or none of the IPF's cases met the measure criteria. "Hours of physical restraint use and seclusion" are hours for every 1,000 hours of patient care. The table shows unweighted averages.

“–” denotes that a ratio could not be calculated with a zero divisor.

*Denotes a claims-based measure.

Source: MedPAC analysis of IPF quality public use files, January and April 2023.

**TABLE
6-26**

IPF quality measure performance, 2017–2021

Measure description	2017	2018	2019	2020	2021	Percentage point change, 2017–2021
Hours of physical restraint use	0.57	0.49	0.47	0.44	0.52	–0.05
Hours of seclusion use	0.28	0.28	0.30	0.34	0.37	0.09
Influenza immunization	84%	84%	83%	81%	78%	–6
Tobacco use treatment during the stay						
Provided or offered	79	80	81	79	72	–7
Provided	45	46	47	46	45	0
Tobacco use treatment at discharge						
Provided or offered	54	56	58	59	57	3
Provided	16	18	21	22	21	5
Patients discharged on multiple antipsychotic medications with appropriate justification	63	63	63	63	62	–1

Note: IPF (inpatient psychiatric facility). The analysis included about 1,500 IPFs with some variation year to year because of differences in the number of IPFs with complete results and characteristic information. The table includes only measures that are part of the IPF quality reporting program over all five years and that did not have significant changes to the measure specifications. “Hours of physical restraint use” and “seclusion” are hours for every 1,000 hours of patient care.

Source: MedPAC analysis of IPF quality public use files, 2018–2022.

In 2021, average IPF performance on the 30-day all-cause unplanned readmission (claims-based outcome) measure was 20 percent, which suggests that facilities have substantial opportunities to reduce readmissions after psychiatric hospitalizations.⁴² The IPF at the 75th percentile of performance had a rate that was 0.8 times that of the IPF at the 25th percentile of performance.

We also compared rates of 30-day all-cause readmission following psychiatric hospitalization by various IPF provider characteristics. The magnitude of the differences across readmission rates is small, but the variation in readmission rates between groups of IPFs could indicate variation in quality among the different IPF types (data not shown). Urban IPFs had slightly better performance than their rural counterparts. Freestanding facilities had better performance than hospital-based units. When compared by ownership, government IPFs had the best performance, followed by nonprofit facilities and then for-profit facilities. IPFs with the highest share of low-income beneficiaries had the best performance,

compared with facilities with low and medium shares of low-income beneficiaries.

Between 2017 and 2021, some IPFQR program quality measure results improved, while others declined or stayed the same (Table 6-26).⁴³ For example, hours of physical restraint use decreased slightly (lower values are better). Tobacco use treatment provided at discharge improved from 16 percent to 21 percent. Contrastingly, the rate of providing or offering tobacco use treatment during the stay declined from 79 percent to 72 percent. Although we are unsure of the accuracy of the results for these chart-abstracted measures, they could indicate marginal changes in IPF quality results over time.

IPFs’ access to capital

Access to capital, which allows IPFs to maintain, modernize, and expand their facilities, is another of the Commission’s payment adequacy indicators. Almost two-thirds of IPF providers are hospital-based

**TABLE
6-27**

Wide variation in Medicare margin by type of IPF, FY 2018–2021

	Share of Medicare FFS stays		Aggregate Medicare margins			
	2018	2021	2018	2019	2020	2021
All IPFs	100%	100%	-2.1%	-4.0%	-8.7%	-9.4%
Hospital-based unit	58	56	-19.1	-21.3	-28.2	-28.3
Nonprofit	34	32	-23.9	-26.0	-34.2	-34.8
For profit	15	15	-8.0	-10.5	-14.8	-13.0
Government	10	10	-	-	-	-
Freestanding	42	44	20.6	18.3	16.9	15.0
Nonprofit	6	6	-10.9	-10.0	-19.2	-21.6
For profit	32	35	26.7	23.7	24.1	21.7
Government	3	3	-	-	-	-
Teaching	19	20	-21.1	-21.6	-26.8	-24.6
Nonteaching	81	80	1.6	-0.6	-5.0	-6.2
Urban	86	87	-1.8	-3.8	-8.9	-9.2
Rural	13	12	-3.5	-5.1	-7.2	-11.0
<25 beds	26	25	-18.8	-19.5	-26.7	-27.2
25–49 beds	22	21	-12.1	-15.9	-21.8	-20.5
50–99 beds	26	28	5.4	1.8	-0.7	-2.7
≥100 beds	25	26	17.9	16.4	12.3	12.7

Note: IPF (inpatient psychiatric facility), FY (fiscal year), FFS (fee-for-service). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. They are not included in margin percentages but are included in share of Medicare FFS stays. "Medicare margin" is calculated as aggregate Medicare payments for IPF PPS services minus aggregate allowable Medicare costs for Medicare FFS beneficiaries, divided by aggregate payments for IPF PPS services. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of cost report and Medicare Provider Analysis and Review (MedPAR) data from CMS.

units that would access any necessary capital through their parent institutions. Therefore, in assessing access to capital for hospital-based IPFs, we look at the availability of capital for acute care hospitals. Overall, as detailed in our March 2023 report to the Congress (Medicare Payment Advisory Commission 2023), general acute care hospitals' access to capital strengthened in 2021, with the all-payer operating margin among hospitals paid under the inpatient PPS reaching a record high despite a decline in federal relief funds. Additionally, hospitals maintained strong access to bond markets. While the effect of the coronavirus pandemic on hospitals' finances varied substantially

across hospitals, we have no evidence that it has had a negative effect on hospitals' long-term access to the capital markets.⁴⁴

To assess freestanding IPFs' access to capital, we look at the availability of capital for publicly traded IPFs. Market analysts indicate that the IPF industry's largest chain, Universal Health Services (UHS)—which owned over 20 percent of freestanding IPFs and accounted for about 12 percent of Medicare IPF stays in 2021—has good access to capital. This assessment is reflected in the chain's continued expansion before and through the pandemic. Between 2019 and 2022, the company

opened six new facilities and added almost 600 acute psychiatric beds in new and existing facilities. Between 2023 and 2025, the company plans to open at least three new facilities.⁴⁵ However, despite continued growth and expansion, UHS cited the shortage of nurses and other clinical staff as a significant operating issue. The staffing shortage has required UHS to hire expensive temporary staff or enhance wages and benefits to recruit and retain health care providers. In some cases, they have been unable to fill vacant positions and, as a result, have been required to limit patient volumes.⁴⁶

IPFs' access to capital depends in large part on their total (all-payer) profitability. In 2021, the all-payer total margins for freestanding IPFs increased from 0.6 percent in the previous year to an aggregate margin of 3.2 percent.⁴⁷ However, all-payer profitability varied substantially for freestanding IPFs by ownership. In 2021, for-profit freestanding IPFs had an all-payer total margin of about 12.5 percent (up from 10.4 percent in 2019) compared with 4.4 percent (down 0.09 percent from 2019) for nonprofit freestanding IPFs. Data were not available to calculate total all-payer margins for hospital-based IPFs separately from the parent hospital.

Medicare payments and IPFs' costs

We calculated IPF Medicare margins by comparing payments made under the IPF PPS to providers' costs for their Medicare FFS patients using Medicare cost reports. IPF PPS margins have decreased over time (Table 6-27). From 2018 to 2021, the aggregate Medicare margin for IPF PPS services among all IPFs fell from -2.1 percent to -9.4 percent. However, financial performance under the IPF PPS varied widely. In 2021, the aggregate Medicare margin for IPF PPS services among freestanding IPFs was 15.0 percent, compared with -28.3 percent in hospital-based IPFs. The high aggregate margin of freestanding IPFs was driven by for-profit facilities. In 2021, freestanding IPFs that were for profit had an aggregate Medicare margin of 21.7 percent for IPF PPS services. Government-owned IPFs are not included in the aggregate margins reported in Table 6-27.

When we include the COVID-19 public health emergency (PHE) provider relief funds available starting in 2020, the margins improved; aggregate margins including the funds improved by 5.9 percentage points

(from -8.7 percent to -2.8 percent) in 2020 and by 2.6 percentage points (from -9.4 percent to -6.8 percent) in 2021 (data not shown). Aggregate margins improved for rural IPFs from -11.0 percent to -5.1 percent with relief funds.

The variation in margins appears to be driven by differences in costs among IPFs. As shown in Table 6-28 (p. 284), costs varied widely with regard to IPF type, ownership, and bed size. Costs per day were lowest among freestanding for-profit IPFs with 100 or more beds (\$650 per day) and were highest among freestanding government facilities with 100 or more beds (\$2,270). We expected size to have an inverse relationship with costs per day because larger facilities can spread costs over more beds. This relationship was apparent among the for-profit IPFs (both hospital based and freestanding) but did not always hold among nonprofit and government IPFs. Costs per day were higher among hospital-based units compared with freestanding IPFs (\$1,330 vs. \$930 per day). For-profit IPFs had lower costs than nonprofit and government facilities among both freestanding and hospital-based IPFs.

As learned from the IPF interviews, freestanding IPFs tended to have more restrictive admission criteria related to patients' medical conditions. Given that patients with more medically complex conditions or lower functional status require more staff time as well as more specialized equipment, this was likely a factor driving lower costs (and higher margins) among these IPFs. Indeed, one IPF interviewee noted that taking more complicated cases would increase the costs of maintaining a facility that could accommodate these services and questioned whether payments would cover these additional costs:

It's partly a financial consideration. . . . It's cheaper to build a freestanding hospital without all the [medical infrastructure]. And then there's the question of whether or not you're going to be reimbursed for having a medically complicated patient.

Concerning trends among freestanding for-profit IPFs

IPFs' costs for caring for Medicare beneficiaries consist of routine and ancillary costs, which must be reported annually to CMS.⁴⁸ Routine costs include nursing services and room and board, which are typically provided to all patients in a facility. Ancillary costs are

**TABLE
6-28**

Differences in costs by IPF type and size, FY 2021

	Bed size	Number of IPFs	Cost per day	Payment per day
Freestanding		555	\$930	\$890
Nonprofit		70	1,190	980
	1-24	22	1,310	1,060
	25-49	6	1,260	1,050
	50-99	21	1,140	1,030
	≥100	21	1,190	940
For profit		328	690	880
	1-24	38	870	900
	25-49	41	820	930
	50-99	118	650	850
	≥100	131	650	880
Government		157	2,000	860
	1-24	21	1,810	920
	25-49	12	1,550	940
	50-99	37	1,400	1,000
	≥100	87	2,270	800
Hospital-based unit		927	1,330	1,030
Nonprofit		571	1,590	1,010
	1-24	313	1,370	1,010
	25-49	172	1,380	1,010
	50-99	75	1,370	990
	≥100	11	1,270	1,090
For profit		196	1,080	950
	1-24	109	1,180	970
	25-49	53	1,100	980
	50-99	27	1,010	940
	≥100	7	790	830
Government		160	1,560	1,210
	1-24	86	1,220	950
	25-49	27	1,560	1,130
	50-99	31	1,800	1,310
	≥100	16	1,710	1,450

Note: IPF (inpatient psychiatric facility), FY (fiscal year). "Cost per day" includes IPFs' costs for Medicare fee-for-service (FFS) beneficiaries divided by the number of Medicare FFS beneficiary days. Payment per day is calculated as total IPF PPS payments to IPFs divided by the number of Medicare FFS beneficiary days.

Source: MedPAC analysis of cost report data from CMS.

for specific services (e.g., laboratory, radiology, drugs, therapy). Ancillary services vary by patient, and for most IPFs (those not using an "all-inclusive rate"), the charges for ancillary services are to be recorded on each IPF claim for a stay. Ancillary costs per stay can

then be calculated by applying cost-to-charge ratios from the corresponding ancillary cost center on the cost reports to the charges on the claim. Routine costs compose the majority (over 85 percent) of costs for a patient at an IPF (Garrett et al. 2009, RTI International

**TABLE
6-29**

Billing for ancillary services varies by IPF type, FY 2021

Ancillary service	Share of FFS stays with ancillary charges						
	All	Hospital based			Freestanding		
		Non-profit	For profit	Government	Non-profit	For profit	Government
Non-all-inclusive-rate IPFs (180,400 stays at 1,184 IPFs)							
Drugs	83%	97%	99%	99%	78%	40%	88%
Laboratory	80	96	96	97	78	31	72
Radiology—diagnostic	20	25	29	31	4	5	7
Physical therapy	16	21	26	18	6	3	3
Occupational therapy	15	17	18	19	1	2	3
Medical supplies	12	12	17	20	2	19	2
CT scan	10	15	14	16	1	0	1

Note: IPF (inpatient psychiatric facility), FY (fiscal year), CT (computed tomography).

Source: MedPAC analysis of Medicare Provider Analysis and Review (MedPAR) data from CMS.

2005), though most or all IPF patients are expected to incur some ancillary costs. We found similar proportions of routine versus ancillary costs using more recent data.

Hospitals must apportion allowable costs between Medicare and non-Medicare patients to each ancillary department unless they have an all-inclusive rate or no charge structure. An “all-inclusive” rate means that one charge covers all services. CMS allows hospitals without charge structures for individual services rendered to use alternative methods of apportionment. For these hospitals, ancillary services are not commonly or reliably reported separately for each service. Instead, we would expect that the costs of ancillary services would be combined with routine costs into one facility-level amount.

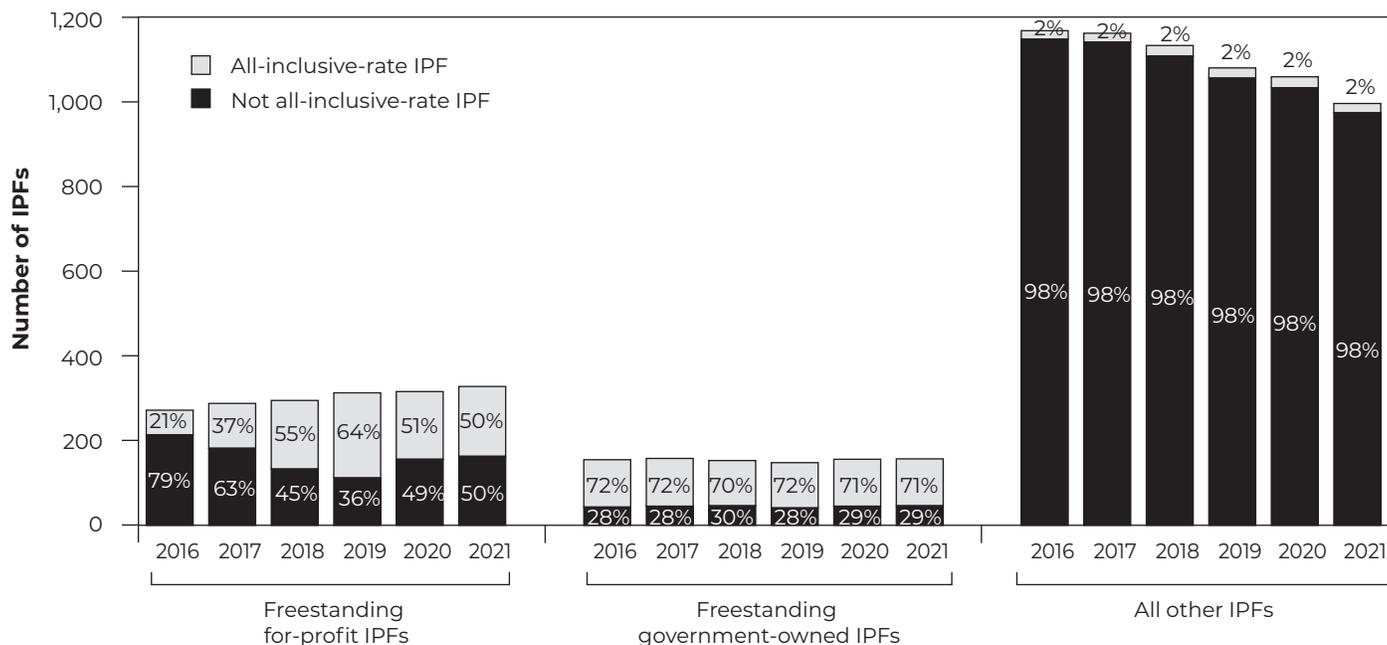
CMS has repeatedly expressed concern over the number of claims that contain no ancillary charges when “most patients requiring hospitalization for active psychiatric treatment will need drugs and laboratory [ancillary] services” (Centers for Medicare & Medicaid

Services 2021b). In 2017 and 2018, CMS issued several transmittals explicitly specifying that cost reports from psychiatric hospitals without ancillary costs would be rejected unless the hospital was an all-inclusive-rate facility (Centers for Medicare & Medicaid Services 2018b, Centers for Medicare & Medicaid Services 2018c, Centers for Medicare & Medicaid Services 2017).

Table 6-29 shows that among IPFs that were not all-inclusive-rate hospitals (and therefore were required to apportion costs to each ancillary department), 83 percent of stays contained ancillary charges for drugs and 80 percent contained ancillary charges for laboratory services. However, reporting of ancillary costs differed across IPF types. Among hospital-based IPFs, nearly all stays had ancillary charges for drugs and laboratory service charges. The percentages were substantially lower among freestanding IPFs, particularly freestanding for-profit IPFs. For these IPFs, only 40 percent and 31 percent of stays, respectively, contained charges for drugs and laboratory services (Table 6-29).

FIGURE 6-17

Many freestanding for-profit IPFs have changed to an all-inclusive-rate status, FY 2016–2021



Note: IPF (inpatient psychiatric facility), FY (fiscal year).

Source: MedPAC analysis of cost report data from CMS.

In our review of charges for ancillary services for drugs at the IPF level, we found that IPFs tended to report charges on the claim for all or almost all of their stays or none of their stays. That is, reporting of ancillary charges for drugs appeared to be an accounting rather than clinical decision. For example, in 2021, among freestanding for-profit IPFs without the all-inclusive rate, 53 percent (86 of 163 IPFs) reported no ancillary drug charges for any stays. However, for the IPFs that reported ancillary drug charges, on average, 90 percent of the IPFs’ stays indicated some ancillary charges for drugs.

Lacking ancillary costs has been further exacerbated by the growing number of facilities designated as all-inclusive-rate providers. Between 2016 and 2021, the number of all-inclusive-rate hospitals, as designated on their cost reports, increased from 190 to 298 (with a high of 332 IPFs in 2019), driven almost exclusively by freestanding for-profit IPFs (Figure 6-17). From

2016 to 2019, the share of freestanding for-profit IPFs designating as all-inclusive-rate providers grew from 21 percent to 64 percent. In 2020 and 2021, this percentage fell to around 50 percent. Over 70 percent of freestanding government IPFs have an all-inclusive-rate status, but this percentage has not changed over time.

One large owner of freestanding for-profit psychiatric hospitals throughout the country has been responsible for much of the shift toward all-inclusive-rate status. In 2016, just 16 percent of this owner’s IPFs were all-inclusive-rate facilities, though 92 percent of its claims had no reported ancillary charges (Table 6-30). Possibly in response to CMS’s 2017 and 2018 transmittals requiring ancillary charges for providers without the all-inclusive rate, this owner’s IPFs began shifting to all-inclusive-rate status; by 2019, 91 percent were all-inclusive-rate providers. The process for converting from a facility for which a cost structure is in place to

**TABLE
6-30****One large chain converted almost all its IPFs to all-inclusive-rate facilities, FY 2017-2021**

	Number of IPFs	Share of IPFs with all-inclusive rates	Share of stays with no ancillary drug charges
2016	115	16%	92%
2017	116	53	93
2018	117	85	94
2019	118	91	94
2020	117	91	94
2021	116	91	92

Note: IPF (inpatient psychiatric facility), FY (fiscal year). Includes IPFs affiliated with one large owner of freestanding for-profit IPFs.

Source: MedPAC analysis of cost report and Medicare Provider Analysis and Review (MedPAR) data from CMS.

charge for individual services to an all-inclusive-rate facility is not clear. Medicare cost report instructions indicate that all-inclusive-rate hospitals can select from alternative methods of apportionment (A, B, C, D, and E, in declining order of sophistication in terms of ability to calculate and apportion costs), but once a method of higher sophistication is selected, a hospital cannot elect to change to a lower method of sophistication in subsequent reporting periods (Centers for Medicare & Medicaid Services 2020b). It is not clear whether a similar requirement applies to changing a facility's overall designation to an all-inclusive-rate hospital.

Since costs incurred for ancillary services would not be separately reported for each service after converting to an all-inclusive-rate facility, we would expect higher routine costs (which would be aggregated with costs incurred for ancillary services), all else equal. To examine this, we identified 59 IPFs that converted to an all-inclusive-rate structure in 2017 and 2018 and served Medicare FFS IPF beneficiaries for all years between 2016 and 2019. For these IPFs, we compared average routine costs per day and the share of stays for which any drug or laboratory services were reported for each year on the claims or cost reports (Table 6-31, p. 288). We found that even before the hospital converted to an all-inclusive-rate structure, only 12 percent of claims had drug or laboratory ancillary charges (see the 2016

row of Table 6-31). This percentage fell to 5 percent in the year after conversion. In 2017, immediately prior to the conversion to an all-inclusive rate, 42 percent of these IPFs reported some drug or laboratory ancillary costs on their cost reports; this fell to 4 percent in 2018 after conversion. Average routine costs per day increased slightly after 2017, from \$530 to \$590 per day in 2019, but this increase is too small to be explained by changes in the allocation of ancillary costs.

These findings show that, despite CMS's efforts to encourage accurate reporting of ancillary services, many IPFs continue to report no ancillary services. One reason for the recent growth in conversions to all-inclusive-rate hospitals could be that IPFs wished to avoid rejection of their cost reports due to the lack of documented ancillary service costs.

IPF interviewees confirmed that almost all patients receive some ancillary services, especially drugs and laboratory services, though they noted that ancillary services were generally a small portion of overall costs. While IPF interviewees internally tracked some ancillary services, very few perceived financial benefits to reporting comprehensive ancillary charges, nor any repercussions for failing to provide the information. Interviewees tended to conflate the "all-inclusive" designation with per diem reimbursement from payers,⁴⁹ stating that they were an all-inclusive-rate

**TABLE
6-31**

**IPFs switching to an all-inclusive rate between FY 2017 and 2018
already had low reporting of ancillary services**

	Not all-inclusive IPFs	All-inclusive IPFs	IPF stays	Share of stays with drug or laboratory ancillary charges on claim	Share of IPFs with drug or laboratory costs on cost report	Average routine cost per day from cost report
2016	59	0	27,800	12%	15%	\$520
2017	59	0	26,650	8	42	530
2018	0	59	24,620	5	4	560
2019	0	59	23,220	5	1	590

Note: IPF (inpatient psychiatric facility), FY (fiscal year). Routine costs per day were calculated by obtaining total inpatient routine service costs from Worksheet D-1, Part II, and subtracting pass-through costs from Worksheet E-3, Part II.

Source: MedPAC analysis of cost report data and Medicare Provider Analysis and Review (MedPAR) data from CMS.

hospital despite not being designated as such on their costs reports.

Some freestanding IPF interviewees that were part of proprietary chains indicated that corporate policies determined whether they reported separate ancillary services. One freestanding IPF that was part of a chain reported separate ancillary services and stated that they did so because the state Medicaid program required that level of detail for payment. This interviewee noted that other IPFs in the same chain that were in other parts of the country typically do not report ancillary charges. One IPF interviewee indicated that they would need a new electronic medical record system to capture charges for each ancillary service.

More information is needed to assess payment accuracy and quality of care

More information is needed to assess the accuracy of payments—that is, the ability of the payment system to accurately capture costs and classify patients—and the quality of care that beneficiaries receive in IPFs. As for payment accuracy, we found substantial variation in IPFs’ Medicare margins by facility type. The variation tracked with differences in costs by IPF type, with freestanding for-profit IPFs having lower costs (and higher margins) and hospital-based IPFs having higher costs (and lower margins). This pattern may be due to differences in scale (for-profit IPFs tend to be larger), but also to differences in the mix of patients served

and the quality of care provided. As for quality, data measuring IPFs’ quality of care are scant.

Payment accuracy

As with any payment system, Medicare’s payments for IPF services need to be well calibrated to patients’ costliness so as not to create incentives for providers to admit certain types of patients and avoid others. However, analysis of IPF costs and margins suggests that Medicare payments may not track as closely to costs as they should. The per diem payment structure under the IPF PPS helps to mitigate some of the difficulty in tracking payment to costs. Per diem payment systems do not need to account for costs associated with length of stay (except to appropriately adjust for diminishing per diem costs for longer stays), while a stay- or episode-level payment system needs to account for both length of stay and daily intensity of care. Indeed, CMS selected a per diem payment structure for the IPF PPS because of the difficulty in predicting costs with administrative data (Cotterill and Thomas 2004). However, under the per diem rate payment system, IPFs nevertheless need to track per diem costs appropriately.⁵⁰ To the extent that per diem costs vary and patient characteristics affecting those costs are not adequately captured by the payment system, the IPF PPS pays too much for some patients and too little for others. To properly assess the IPF payment system, policymakers need more information

on patient severity and resource use, including use of ancillary services.

Unmeasured patient severity

Early work conducted during the design of the IPF PPS recognized the limitations of using administrative data to capture variation in IPF patients' costs (Lave 2003). For example, a pre-IPF PPS study found that diagnoses could account for only 2 percent or 3 percent of the variation in daily IPF costs at the time (Lave 2003). Indeed, currently, nearly three-quarters of IPF patients fall within the same psychiatric DRG and over 70 percent of stays have no qualifying comorbidity adjustment (The Bizzell Group 2022).

One of the earlier studies conducted to support IPF PPS design collected data directly from IPFs to measure how daily resource use varied by patient characteristics, including characteristics not present in claims data (RTI International 2005). The study found activity of daily living (ADL) deficits and "serious danger to self or others" to be important cost drivers that were not available on administrative data. They found other factors that had minor effects once more important factors were taken into account; these included cognitive impairment, global assessment of function (GAF) score (a scoring system used to assess the severity of mental illness), and history of falls. Another study using data from a German psychiatric hospital found that GAF, danger to self, involuntary admission, and ADL deficits affected per diem hospital costs when used in conjunction with other elements available on administrative data (Wolff et al. 2016).

IPF interviewees emphasized that diagnoses, age, and ancillary charges alone are not indicative of a patient's costliness. Rather, interviewees said that looking at the resources needed to appropriately care for a patient, given their combination of diagnoses, cognitive and functional capacity, and mental condition, provides a more accurate picture of composite cost. Interviewees generally cited three sources of cost that distinguish high-resource-consuming patients:

- staffing intensity, based on a combination of individual patient variables, to include diagnoses, comorbidities, cognitive and functional impairment, history of aggressive behavior, and whether the patient is in the custody or legal hold of law enforcement;

- semiprivate rooms that must be converted to private rooms for patient safety, thus taking one or more staffed beds offline, as well as other required specialized equipment; and
- long lengths of stay with declining per diem payment rates and patients who exceed the 190-day benefit cap on freestanding IPF stays.

The IPF PPS's current lack of information on the types of services that IPF patients receive and how staff spend their time—such as inpatient assessment, counseling, drug management, nursing care, and behavioral monitoring—is a significant shortcoming. Including other elements that significantly affect routine nursing and staff time in the IPF PPS could improve the accuracy of Medicare's payments, but doing so would require IPFs to submit additional information about their patients.⁵¹ Under the CAA, 2023, CMS can begin to collect additional information to refine payments under the IPF PPS. This includes data on resource use and need for monitoring (e.g., violent behavior, physical restraint), interventions (e.g., detoxification services, respirator), and patient characteristics (e.g., functional status, cognitive function, comorbidities and impairments). Collection of additional data through claims or cost reports is to begin by October 2023, and collection of patient assessment data using a standardized tool is to begin by 2028. We will continue to monitor refinements to the IPF payment system as additional data are available.

Inconsistencies in reporting of ancillary service use

IPFs' provision of ancillary services is collected at the stay level, providing a source of patient-level variation in costs that can be used to improve payment accuracy. In contrast, routine costs (which include nurse and staff time) are aggregated at the facility level. However, data quality on ancillary services is hampered by two concerning issues. First, hospitals that are not designated as all-inclusive-rate facilities are required to report this information, but many do not report any ancillary services, even prescription drugs, which are widely regarded as necessary for almost all IPF patients (and, according to IPF interviewees, can be very costly, depending on the type). This lack of information appears to be an issue of accounting and not related to the clinical needs of patients, since nonreporting IPFs tend to not report ancillary services for any of

their patients. Second, in recent years, the number of freestanding for-profit IPFs converting to an all-inclusive designation has grown. Our analyses of the data show that when some of these IPFs converted to obtain all-inclusive-rate designations, there was no commensurate increase in routine costs (which should have happened once ancillary costs became aggregated with routine costs). In fact, many of the IPFs that newly converted to the all-inclusive designation in recent years had already been failing to report ancillary charges prior to the conversion.

IPF interviewees confirmed that reporting ancillary services does not factor prominently, since they are not reimbursed for them and since these represent a modest portion of overall expenses in comparison with labor costs. This may also explain the recent conversions to all-inclusive-rate designations when CMS announced enforcement of the requirement to report ancillary charges on cost reports for non-all-inclusive-rate hospitals. More transparency is needed in the process of converting to an all-inclusive-rate facility and how approval occurs.

CMS recently commissioned a study to use more recent claims and cost report data to assess and update the IPF PPS adjustments. The authors addressed the lack of ancillary charge data for some facilities by reweighting the data by type of IPF (The Bizzell Group 2022). This reweighting presumes that ancillary charges were “missing” data and gives greater weight to the data from providers who report ancillary charges to counterbalance the missing data. No distinction was made for all-inclusive-rate hospitals, for which, in principle, ancillary costs are aggregated into routine costs and are not missing. Estimates of costs would be biased if data were inappropriately treated as missing (or as zero). Our interview findings show that many facilities aggregate their costs rather than

report them separately by ancillary service and that more information on resource use would be needed to appropriately update IPF PPS adjustments. The forthcoming IPF data collections specified by the CAA, 2023, have the potential to capture the necessary information to improve the accuracy of payments.

Quality of IPF care

Data on the quality of care provided by IPFs are limited. Medicare currently has an IPF pay-for-reporting quality program that mainly includes provider-reported aggregate results. This level of data reporting does not allow for comprehensive data validation, thereby diminishing CMS’s ability to detect any errors in chart-abstracted measures that IPFs report. Beginning in mid-2023, IPFs will be required to submit patient-level data for select chart-abstracted measures. Once the data are available, policymakers will be able to better assess the quality of care provided by IPFs.

The measures currently used by CMS are predominantly process measures. One of the Commission’s principles for measuring quality is that Medicare’s quality payment programs should include a small set of performance measures tied to clinical outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018). Process measures can play a role in provider-level quality improvement programs, and they can be valuable for public reporting of quality to consumers. Broader outcomes and patient experience measures that matter to patients and translate to better health are also needed and are especially crucial given the vulnerability and high risk of IPF patients. CMS is currently developing some new measures tied to clinical outcomes for potential inclusion in the IPFQR program and has noted plans to develop and implement IPF patient experience surveys. ■

Endnotes

- 1 To qualify for partial hospitalization services, beneficiaries must have behavioral health disorders that severely interfere with multiple areas of their daily lives, but they must be able to cognitively participate in a program of therapy. A physician must certify that the beneficiary would otherwise need inpatient treatment or has been recently discharged from inpatient care and needs partial hospitalization to avoid a relapse or rehospitalization and that less-intensive treatment options would be inadequate. In addition, a physician must develop a partial hospitalization treatment plan, including the type, amount, duration, and frequency of services to be received, as well as the goals of treatment. Participating beneficiaries must have a plan of treatment that includes a minimum of 20 hours of services per week for an unlimited length of time. A physician is required to recertify the beneficiary's need for services 18 days after admission and at least every 30 days thereafter.
- 2 A focused effort to crack down on fraud in CMHCs resulted in a substantial decline in the number of CMHC PHPs. The Office of Inspector General of the Department of Health and Human Services reported that Medicare paid \$218.6 million for PHP services in 206 CMHCs in 2010; by 2012, Medicare spending for CMHC PHPs had fallen to \$31 million (Office of Inspector General 2013).
- 3 Parity rules do not apply to Medicare benefits provided by Medicaid MCOs to dual-eligible beneficiaries, nor do they apply to Medicaid FFS enrollees (Musumeci 2015).
- 4 We used geographic categorizations from the Office of Management and Budget and U.S. Department of Agriculture's Urban Influence Codes: urban/metropolitan counties (containing an urban cluster of 50,000 or more people); rural/micropolitan counties (containing a cluster of 10,000 to 50,000 people); rural/adjacent (adjacent to urban areas and do not have a city with at least 10,000 people); rural/nonadjacent (not adjacent to an urban area and do not have a city with at least 10,000 people). A rural county is defined as adjacent to an urban area if it physically adjoins one or more metropolitan areas and has at least 2 percent of its employed labor force commuting to central metropolitan counties. "Frontier" is defined as counties with six or fewer people per square mile (Office of Management and Budget and USDA's Urban Influence Codes).
- 5 HPSAs are designated by the Health Resources and Services Administration. CMS pays a 10 percent quarterly bonus to psychiatrists when they deliver services in mental health HPSAs.
- 6 Behavioral health services in this chapter are defined differently than in the chapter on telehealth in this report.
- 7 In Table 6-7, p. 243, we use only physician fee schedule claims (and not hospital outpatient claims) to avoid double-counting volume. Volume is measured as the number of services received.
- 8 These numbers include volume of services only from physician fee schedule claims (and not outpatient claims).
- 9 Other SUDs include disorders related to cannabis, sedatives, stimulants, hallucinogens, inhalants, and other substances and exclude tobacco-related disorders.
- 10 These numbers include only FFS beneficiaries with an OUD diagnosis indicated on a Part B carrier or outpatient claim. A study by the Office of Inspector General using all claims (and encounter data) found that 1 million Medicare (FFS and MA) beneficiaries had an OUD diagnosis in 2021 (Office of Inspector General 2022).
- 11 We identify SUDs using the diagnosis codes present on claims; to the extent that beneficiaries with multiple SUDs, including OUDs, are coded only with "OUD," we may undercount the presence of other SUDs.
- 12 In addition, MA encounter data contain only claim-level diagnoses, while FFS claims have line-level diagnoses for each procedure/service included on the claim. Thus, if an MA encounter claim had a behavioral health diagnosis listed (in any position), all line items affiliated with that claim were included in our analysis. This likely resulted in the identification of more services for behavioral health conditions among MA enrollees than for FFS enrollees.
- 13 Claims records for SBIRT services were included in our Part B behavioral health services file only if the record also included a behavioral health condition diagnosis code or occurred in a behavioral health location (see text box, pp. 238-239).
- 14 The Substance Abuse and Mental Health Services Administration (SAMHSA) certifies opioid treatment programs.
- 15 SAMHSA maintains a directory of OTP providers: <https://dpt2.samhsa.gov/treatment/directory.aspx>.
- 16 "Gross spending" reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and

- manufacturers that are not already reflected in prices at the pharmacies.
- 17 Psychiatry includes geriatric psychiatry and neuropsychiatry.
 - 18 We excluded clinicians who served very few FFS beneficiaries in the year (fewer than five). Clinician counts were sensitive to the threshold used. For example, 50,850 LCSWs billed for at least one service in the year (56 percent of these LCSWs served at least five beneficiaries). Of the total clinicians counted, 84 percent were psychiatrists, 65 percent were psychologists, and 77 percent were addiction medicine professionals.
 - 19 Figure 6-5 (p. 250) is based on the specialty of the billing clinician, and we cannot determine whether “incident to” billing occurred. Under incident to billing, a practitioner such as a nurse practitioner or physician assistant provides the service to the patient under the supervision of a physician or other practitioner, whose name is on the bill.
 - 20 This requirement does not apply to telehealth services used to treat SUDs or a co-occurring mental health disorder.
 - 21 It is possible that beneficiaries using only in-person behavioral health services used telehealth for other, nonbehavioral health medical care.
 - 22 Psychiatric or substance use-related care may also be delivered in general acute care hospitals, reimbursed by the inpatient PPS or on a cost basis when provided in critical access hospitals. While the focus of this chapter is on care provided under the IPF PPS, the use of these “scatter beds” is not uncommon: In 2021, there were about 159,000 such stays at acute care hospitals.
 - 23 The deductible and coinsurance apply to a benefit period. The benefit period begins the day a beneficiary is admitted as an inpatient to a hospital or skilled nursing facility (SNF) and ends when the beneficiary is not an inpatient of a hospital or SNF for 60 consecutive days. If a beneficiary is admitted as an inpatient after the 60 consecutive days, a new benefit period begins. Thus, a beneficiary may have multiple stays in an IPF within the same benefit period.
 - 24 See 42 CFR §412.23. Also see Centers for Medicare & Medicaid Services (2018a).
 - 25 CMS enacted numerous blanket waivers to increase Medicare beneficiaries’ access to medical services during the public health emergency. For IPFs, these included allowing IPF beds to be used for acute care services and provision of IPF PPS stays in acute care beds; see more at <https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf>.
 - 26 Patients who are readmitted to the IPF within three days of discharge are considered to have an interrupted stay. In such cases, Medicare treats the readmission as a continuation of the original stay, with length of stay adjustments applied accordingly.
 - 27 We use 2019 data because 2021 Chronic Care Warehouse chronic condition data were not yet available and 2020 information would be affected by the start of the coronavirus pandemic.
 - 28 According to the Bureau of Justice Statistics, 14 percent of state and federal prisoners and 26 percent of jail inmates reported experiences that met the threshold for serious psychological distress in the 30 days prior to incident, according to a survey that was conducted between February 2011 and May 2012. More than one-third of prisoners and 44 percent of jail inmates had been told in the past by a mental health professional that they had a mental disorder (Bronson and Berzofsky 2017).
 - 29 Beneficiaries who had an inpatient stay at an IPF for a nonpsychiatric diagnosis were excluded from this analysis. This exclusion eliminated 1 percent of IPF FFS records and about 5 percent of IPF MA records.
 - 30 Beneficiaries can also be treated for psychiatric or alcohol- and drug-related conditions on an inpatient basis in scatter beds—regular beds in acute care hospitals. Medicare pays for scatter beds on a per discharge basis under the acute care hospital inpatient PPS or, for critical access hospitals, on reported costs. In 2021, there were about 159,000 such stays at acute care hospitals, with over 20 percent of these stays having a substance use-related psychiatric DRG.
 - 31 General acute care hospital stays here refer to stays at a hospital paid under the inpatient PPS.
 - 32 Between 2019 and 2021, scatter bed stays declined by 6 percent annually, conditional on the FFS population size. Between 2017 and 2019, scatter bed stays declined by 1 percent, conditional on the FFS population size.
 - 33 Given data limitations, we were unable to determine the type of coverage the beneficiary had when the 190 days were exhausted.
 - 34 Over 85 percent of beneficiaries who were designated as low income based on the Part D low-income subsidy had full or partial dual eligibility for Medicare and Medicaid.
 - 35 Medicare covers up to 90 days of inpatient hospital and SNF days during a benefit period, with an additional 60 lifetime reserve days available. A benefit period begins on the first day a patient is admitted to an inpatient hospital or SNF and ends 60 days after the patient leaves the inpatient hospital or SNF.

- A beneficiary who has been in an inpatient hospital for 120 days uses 30 lifetime reserve days. The beneficiary can use another 90 days in a subsequent benefit period but has only 30 remaining lifetime reserve days.
- 36 CMS calculates a “follow-up after psychiatric hospitalization” using claims data under the IPF quality reporting program. The measure calculates the percent of IPF patients receiving intensive outpatient services from mental health providers in the 7 days and 30 days following discharge; the rates for this measure in 2019 were 27 percent and 50 percent, respectively. These values differ from those reported in Table 6-22 (p. 274) and Table 6-23 (p. 275) because the CMS measure uses a broader definition (e.g., services by nurse practitioners and certified clinical nurse specialists are included in the numerator).
 - 37 A rural county is defined as adjacent to an urban area if it physically adjoins one or more metropolitan areas and has at least 2 percent of its employed labor force commuting to central metropolitan counties.
 - 38 RHC and FQHC clinician services would (generally) be bundled in an outpatient claim and would not have a separate clinician bill.
 - 39 IPF quality measure results are posted on CMS’s Care Compare website.
 - 40 Eligible IPFs include psychiatric units within acute care or critical access hospitals and freestanding psychiatric hospitals.
 - 41 Providers report results based on their full patient population or a sample of all patients (including non-Medicare FFS patients).
 - 42 We did not update the readmissions analysis because CMS identified an error with its calculations of the 2021 measure rates. The corrected readmissions measure data will be available with the April 2023 Care Compare refresh, and we will update results at that time.
 - 43 We present measures that were in the IPFQR program for each of the five years and did not have significant changes to the measure specifications. We plan to incorporate the *30-day all-cause unplanned readmission following psychiatric hospitalization* measure when we have readmission results for 2021, in April 2023. From 2017 to 2019, the measure rate stayed relatively constant with around 20 percent of patients readmitted.
 - 44 Hospital cost reports do not require hospitals to report an all-payer margin specifically for their IPF or other hospital-based units.
 - 45 UHS annual financial reports for 2019–2021 can be found at <https://ir.uhsinc.com/financial-information/annual-reports>.
 - 46 UHS SEC filing February 27, 2023, annual report can be found at <https://ir.uhs.com/static-files/2c25ee00-c815-4405-aa52-4b1e94bd8a8c>.
 - 47 IPFs’ margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments. All-payer total margin includes payments from all payers as well as investments.
 - 48 All Medicare-certified institutional providers are required to submit annual reports on each facility’s characteristics, utilization, costs, and charges in total and for Medicare. Data are made available from the Healthcare Cost Report Information System: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports>.
 - 49 IPF interviewees indicated that they generally received per diem reimbursement from all payers (not just under the IPF PPS).
 - 50 The literature is somewhat mixed on the extent of variation in per diem costs among IPFs. On the one hand, a review of literature on cost drivers of inpatient psychiatric care in the U.S., Australia, Canada, Japan, New Zealand, and Spain reported that per diem costs tend to be relatively homogenous even before patient classification (Wolff et al. 2015). On the other hand, the study by Cromwell (which was also reviewed by Wolff et al. (2015)) concluded that there was wide variation in the day-to-day intensity of IPF care (RTI International 2005). Furthermore, the authors estimated that up to 60 percent of the variation could potentially be explained by patient characteristics and therefore it was worth the effort to identify explanatory patient characteristics (RTI International 2005).
 - 51 When the Congress mandated implementation of a per diem PPS for IPFs in 1999, CMS began to pursue the development of an assessment instrument that would yield a richer source of data. However, time limitations led CMS to move forward without an assessment tool (Centers for Medicare & Medicaid Services 2004).

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