

## **The Psychiatric Bed Crisis in the US:**

Understanding the Problem and Moving Toward Solutions

### **Section 3**

## **Financing of Psychiatric Beds**

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## A. Introduction

This section summarizes some of the major sources of funding for psychiatric beds and changes in funding over time. This section is divided into background, current status (adult and child/adolescent services), sustainability of funding sources, barriers/problems with the current model, policy recommendations, a review of the impact on medical inpatient and ambulatory care, and a brief consideration of the impact of disasters and pandemics.

## B. Background

**Pre-1960s:** Patients were in separate institutions (asylums) funded by the state or (less frequently) in private institutions funded by families or philanthropy. Adoption of insurance coverage began in the post-World War II environment.

**1960-1980s:** Medicaid provided federal matching funds to the states for the health care of individuals at or close to public assistance. In order for states to receive federal funds, they could not reduce their health expenditures, most of which went to state psychiatric hospitals.

At the time Medicare and Medicaid were enacted, Medicare limited psychiatric inpatient care to 190 lifetime days in both state and free-standing private institutions but not general hospitals, attempting to maintain dedicated state funds. Medicaid coverage to “institutions for mental diseases” (IMD; i.e., institutions where more than 50% of the discharges are psychiatric) was limited to persons under 21 and 65 years of age or older, again limiting federal support and encouraging continued direct state expenditures.

By 1974, most health insurance plans provided some coverage for hospital care of mental illnesses. General hospitals increasingly replaced public mental hospitals as the primary institutions for care.

Diagnosis-related groups (DRGs) were included in the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA). Congress exempted psychiatric hospitals from this Prospective Payment System (PPS) for distinct part psychiatric units in general hospitals. The allowable cost protocols in place made psychiatric units and hospitals relatively more profitable in the early years of DRGs.

In the 1980s, for-profit managed behavioral health companies (MBHC) began contracting for oversight and utilization management of psychiatric benefits. Hospitals frequently accepted rates below their costs, because not getting a contract might eliminate patient access or loss of marginal bed capacity and contribution margin associated with psychiatric inpatient services.



**1990s-2007:** In the 1990s, state Medicaid programs also began to contract with MBHCs to manage their psychiatric benefits under [Section 1915b](#) or [Section 1115 Medicaid](#). TEFRA was modified by the Balanced Budget Act (BBA) of 1997 with payment limits, frequent rate reductions, and reduced GME payments in psychiatry.

The Balanced Budget Refinement Act of 1999 replaced cost-based Medicare reimbursement with the Inpatient Prospective Payment System (IPPS) for psychiatric hospitals and exempt general hospital units. However, the IPPS does not fully account for costs of those patients cared for in general hospitals who have significant medical comorbidities or problems with activities of daily living (Drozd et al., 2006). Since the development of the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) in 2004 there has been a relative growth in for-profit free-standing psychiatric hospitals and a decline in general hospital bed capacity (MEDPAC, 2010).

More people with serious mental illness became justice-involved and incarcerated in jails and prisons during this period, with most expenses being absorbed as part of the county (jail), state (prison), or federal (Federal Bureau of Prisons) budgets. Staff salaries and pharmacy budgets for psychiatry expanded dramatically.

**2008-2010:** The Mental Health Parity Addiction Equity Act (MHPAEA) mandated that coverage for mental health and substance use disorders be comparable to the insurance coverage for medical/surgical care if that coverage included mental health and substance use disorder benefits. Parity protections apply to Medicaid benefits, once a beneficiary is enrolled in a managed care organization (including any services delivered through another managed care plan or by fee for services). MHPAEA applies to a very small portion of Medicare Advantage plans (Medicare Advantage coverage that is issued through a group plan offered by an employer). These plans — Employer Group Waiver Plans (EGWPs) — are offered by employers or unions to their retirees.

**2010-present:** Among Medicare, Medicaid, and dually eligible populations, a majority of adults treated for a behavioral health disorder in general hospital psychiatric units had multiple co-occurring physical conditions (Thorpe, 2017), increasing the uncompensated cost of care.

In 2015, Medicare payments to inpatient psychiatric facilities, both freestanding hospitals and specialized hospital-based units, totaled approximately \$4.5 billion (MEDPAC, 2017). These payments are determined by adjusting a daily base rate (\$771 per day for 2018) based on geographic and facility-specific differences (MEDPAC, 2017). The included Inpatient Psychiatric Facility Quality Reporting (IPFQR) program carries a 2% reduction in reimbursement for failure to report specified data or to meet expected standards. In addition, Medicare pays for approximately 250,000 psychiatric discharges per year on medical services (“scatter beds”) under the IPPS (MEDPAC, 2010). State psychiatric hospital systems vary greatly in terms of funding strategies and amount per capita.



## C. Current Status

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Overall expenditure on mental health has steadily increased in recent decades from \$32 billion in 1986 to \$186 billion in 2014. The percentage of mental healthcare dollars spent on inpatient care, however, decreased from 42% in 1986 to 27% in 2014. (Summergrad et al., in press; SAMHSA, 2016). A further look at the sources of revenue for different types of hospitals provides additional information on trends. For private psychiatric hospitals, between 1990 and 2002 the proportion of total revenue that came from patient fees, including private health insurance, decreased from 61.3% to 42.7%. For general hospitals during this same time period, the decrease was from 36.5% to 31.5%. During the same time period, the proportion of private psychiatric hospitals' total revenue from Medicaid and Medicare increased significantly (from 9.4% to 25.9% for Medicaid and from 10.8% to 18.2% for Medicare). For general hospitals from 1990 to 2002, Medicaid revenue was essentially unchanged (24.2% to 24.0%) and Medicare revenue increased from 24.2% to 36.9% (Summergrad et al., in press).

### 1. Current Adult Financing Systems

- **Medicaid**

Medicaid and Medicare are the major sources of public funding for inpatient psychiatric care. The Medicaid IMD exclusion prohibits the use of federal Medicaid financing for care provided to patients aged 21-64 years old in inpatient mental health and substance use disorder treatment facilities with greater than 16 beds. A facility is designated as an IMD if it is licensed or accredited as a psychiatric facility, is under the jurisdiction of the state's mental health authority, specializes in providing mental healthcare, or more than 50% of its patients require admission due to a mental health condition.

The IMD exclusion is the only section of federal Medicaid law that prohibits federal payment for medically necessary care because of the type of illness being treated. States can request modifications to traditional Medicaid payments (e.g., ability to admit patients of all ages to IMDs including private psychiatric hospitals, payments for residential or nonhospital emergency or community-based care). However, waivers vary among state programs, depending on the organization of the state mental health systems, and can be based on regional, county, or statewide programs. Additionally, as of October 2018, states can receive federal payment under Medicaid for services provided to pregnant and postpartum women diagnosed with substance use disorders at IMDs. There is further inconsistency in Medicaid access, given that Medicaid expansion via the ACA has been inconsistently utilized across states.

As a result of the IMD exclusion, patients covered by Medicaid who experience acute psychiatric crises often end up in unsafe or ineffective settings including emergency rooms, jails, prisons,



homelessness services, and forensic psychiatry beds. This results in worse medical outcomes for individuals with mental illness and higher costs to county, state, and federal governments (Summergrad et al., in press).

- **Medicare**

Medicare makes payments for psychiatric services to inpatient psychiatric hospitals and certified inpatient psychiatric units in acute care and critical access hospitals, collectively known as inpatient psychiatric facilities (IPFs). Medicare calculates a per diem payment amount using the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS). This per diem base rate includes all costs for a patient in the IPF, including inpatient operating and capital-related costs (routine and ancillary services). It generally excludes pass-through costs, such as bad debts and graduate medical education. The per diem base rate is then adjusted for specific facility and patient characteristics.

Facility-based adjustments include:

- (1) Adjustment to the labor portion of the per diem amount based on geographic differences using an IPF wage index.
- (2) 17% adjustment for location in a rural area.
- (3) 12% higher payment adjustment for the first day of a stay in IPFs with a qualifying emergency department.
- (4) Adjustment for teaching hospitals for indirect medical education costs.
- (5) Adjustment to the nonlabor portion based on higher cost of living specifically in Hawaii and Alaska.

Patient-based adjustments include:

- (1) Adjustment based on principal psychiatric diagnosis known as the Medicare Severity-Diagnosis Related Group.
- (2) Age.
- (3) Presence of certain specific active comorbidities.
- (4) Length of stay.

IPFs get additional payments for electroconvulsive therapy (ECT) treatments and outlier cases, which are defined as cases with extraordinarily high costs (Centers for Medicare and Medicaid Services, 2019).

- **Other State and Federal Funding Sources**

Other state and federal funding sources include the Veterans Affairs, Department of Defense, Substance Abuse and Mental Health Services Administration, and the Indian Health Service.

- **Private Health Insurance and Managed Behavioral Health Care**

In contrast to Medicare's cost-containment approach, HMOs and private health insurance companies turned to specialized managed behavioral health companies (MBHC) for oversight and management of their psychiatric benefits starting in the 1980s. These companies are often referred to as *carve-outs*. The carve-out companies developed programs of preadmission



review and continued-care certification to control the use of psychiatric services, particularly on inpatient units (Kihlstrom, 1997). In addition to reviewing admissions and continued care, these carve-out companies would often negotiate reduced rates with individual hospitals.

Unlike Medicare, which has contracts with every hospital, often standardized by region, prevailing wage, and employment costs, these private for-profit companies chose which hospitals could have their contracts. As small carve-outs consolidated or were bought up by larger ones, these companies developed significant purchasing power. In many markets, their consolidated purchasing power approached monopsony, allowing them to dictate rates to hospitals. Hospitals frequently accepted rates below their costs, because not getting a contract would mean a loss of so much volume that the unit would have to be downsized or closed. Patient and provider dissatisfaction with these programs generated many complaints to state insurance regulators and legislators. In response, a portion of the 2008 Mental Health Parity Addiction Equity Act (MHPAEA) mandates that the Department of Labor oversees insurance plans offered by employers to mitigate these practices (Summergrad et al., in press).

- **State Systems (Including Forensic Beds)**

Because of the unique responsibilities that states bear for the direct provision of psychiatric services, the organization, budgeting, and interrelationship of state mental health systems with Medicaid and Medicare are unique components of hospital psychiatry. States have often modified their state-run systems in coordination with Medicaid waivers (often Medicaid Section 1115) and have used state and federal funding streams from both Medicare and Medicaid programs to create more comprehensive systems of care.

Nationally, 46% of beds within state and county psychiatric hospitals are occupied by forensic patients (NASMHPD, 2014).

- **Funding for Psychiatric Care in Correctional Systems**

While a person is incarcerated in the United States, Medicaid and Medicare generally cannot be billed for health care services. The one exception to this rule has historically been overnight stays in a community hospital other than emergency department visits and observation stays. Even with this opportunity for federal matching funds to pay (typically) 50% of the eligible expenses, many states have not chosen to exercise this option due to the complexity of the billing process on a per-inmate basis and the need to coordinate closely with the state Medicaid authority (Trestman, 2015).

The Patient Protection and Affordable Care Act (ACA) offers an increase in Medicaid coverage to two subsets of inmates. First, it allows pre-trial jail inmates the opportunity to initiate or maintain Medicaid enrollment (Blair et al., 2011). This does not allow for billing; however, it eases access to entitlements following release (Minton, 2010). The one exception to Medicaid billing remains overnight community hospital stays, with federal reimbursement at 90% of allowable charges. Additionally, the ACA requires coverage for children up to the age of 26 by a parent's health care plan. This may allow for billing and cost recovery for off-site specialty care or overnight hospitalizations of inmates in this category (Blair et al, 2011; PPACA, 2010).



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Because Medicare and Medicaid funds are not available for the majority of inmates, prison health care is funded almost exclusively with state resources. State departments of correction typically receive between 2.5% and 2.9% of the entire state budget and correctional healthcare consumes between 9% and 25% of states' total correctional budget (Schaenman et al., 2013; Trestman, 2015). The average per inmate per year medical cost in American prisons in 2010 was just over \$6,000 (Kyckelhahn, 2012). Of that total, approximately one quarter (\$1,500) is spent on mental health services.

Jails are typically funded by the county they serve. Each of America's 3,283 jails has a constitutionally mandated responsibility for health care (Stephan and Walsh, 2006). The system for health care delivery typically varies by size of the facility: small, medium, or large jails, with respective bed capacities of 50 or fewer, 1,000 or fewer, and over 1,000. Most small (50 or fewer beds) to medium (51-1,000 beds) facilities contract out care on a fee-for-service or hourly basis for nursing, mental health, and medical staff. Most connect closely with a local hospital for emergency, psychiatric, and medical care when needed. Large jails (>1,000 beds) often have an internal health care system more closely resembling a prison than a small jail, with substantial on-site staff and capacity for sub-acute care (Trestman, 2015).

## **2. Current Child and Adolescent Funding**

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The funding for child and adolescent psychiatric beds comes from multiple sources including Medicaid, private insurance, private pay, child welfare, juvenile justice, intellectual and developmental disabilities programs, substance use disorder programs, and schools. (See Section 7.) These funding sources can also be blended to support the inpatient stay with schools paying for the educational needs of the child and insurance or a state agency paying for the clinical and 'bed costs' associated with the stay. DRGs are only relevant for the minority of children who are deemed 'dual eligible' for both Medicaid and Medicare, typically by meeting a qualifying condition for Medicare such as a developmental disorder. The Children's Health Insurance Program (CHIP) is a state and federal combined health insurance program for children in families who earn too much to qualify for Medicaid but not enough to buy private health insurance. CHIP provides free or low-cost health





coverage and goes by different names in every state. The majority of inpatient services are funded on a fee-for-service basis in the private sector (non-profit and for-profit organizations). Rates are negotiated with each payer and utilization management varies from payer to payer. Some rates are inclusive of professional fees, others separate. Some plans have pay for performance, which includes differential rates based on historical lengths of stay (LOS) and readmission rates.

An intermediate care level for children and adolescents is a psychiatric residential treatment facility (PRTF). As noted by Medicaid (CMS, 2020):

“A PRTF provides comprehensive mental health treatment to children and adolescents (youth) who, due to mental illness, substance abuse, or severe emotional disturbance, need treatment that can most effectively be provided in a residential treatment facility. All other ambulatory care resources available in the community must have been identified, and if not accessed, determined to not meet the immediate treatment needs of the youth.”

The settings of inpatient treatment for children and adolescents also differ from adult settings with an increasing number of community-based settings providing these services, particularly for younger children. These beds are variably called community-based acute treatment (CBAT) or acute residential treatment (ART). Their funding is similar to more traditional, hospital-based inpatient facilities although the per diem costs are significantly less and the settings are much less medically oriented. Many of these programs are based in residential facilities that lack laboratory testing capacity or other medical specialists but will have on-site or contracted psychiatric treatment providers who oversee the child’s treatment program. The lengths of stay in these community-based programs tends to be longer than for hospital-based care.

Longer-term out-of-home treatment for children and adolescents is increasingly being provided in private, non-, and for-profit residential settings as states have increasingly been closing their state hospitals for children. Funding for these placements also comes from a variety of sources but is more likely to come from public state agencies (child welfare, juvenile justice, intellectual/development disability, schools) than from either public or private insurance although states may bill Medicaid for some of the services provided.

Per the July 2018 *Faces of Medicaid Data Series* (by the Center for Healthcare Strategies) there was an increase in the percentage of children enrolled in Medicaid hospitalized psychiatrically from 3.2% in 2008 to 5.2% in 2011 (Pires et al., 2018). At the same time, the mean expense per hospitalization decreased from \$11,803 to \$4,840 (a drop of 144%). Per the authors of the study, this may suggest lower average lengths of stay due to more children being enrolled in Medicaid managed care, children leaving inpatient treatment and moving to residential treatment (which has remained fee for service in many states), or states using alternatives (such as wraparound, respite, multisystemic therapy, or MST). There is also a crisis in terms of bed capacity in the U.S. Carubia et al. (2016) found that between 2009 and 2012, the number of general inpatient psychiatric beds declined by 3,000, and the average wait time for an appointment with a child and adolescent psychiatrist was estimated to be nearly eight weeks. This crisis has led to children often having to ‘board’ on pediatric units while awaiting an inpatient bed to become available. It is not uncommon for these



'boarders' to stay a week or longer, often receiving little in terms of child psychiatric treatment other than consultation and in some cases, being discharged to home rather than ultimately being admitted for treatment in an inpatient facility as they may no longer meet medical necessity criteria.

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#### **D. Sustainability of Current Financing Models**

For more than 20 years while psychiatric units were exempted from DRGs, they also did not receive adjustments to their rates reflecting increased labor, GME and IME costs, rural adjustments or patient-based adjustments while medical/surgical services received regular increases. The additional regulatory and legal environment applicable to psychiatry required additional and uncompensated support from the hospital. Psychiatry reimbursement went from favorable to unfavorable relative to medical and surgical services. Acute care hospitals found that the narrow and often negative margins for their psychiatric services were no longer favorable compared to services such as orthopedics, transplant and intensive care. In that context, psychiatric units were often closed or repurposed. The recent focus on ligature by CMS and the Joint Commission often required extensive and costly renovations which made psychiatric units even more disadvantaged and accelerated downsizing and closures.

It will only be through substantial increases in reimbursement that acute care hospitals will once again consider increases to inpatient psychiatric services. In addition, physician and other clinician and network investments by hospitals and health systems are often predicated on the profitability of inpatient or ambulatory procedural care. In general, given the competition for physicians overall and especially the current demand for psychiatrists, hospitals and health care systems will not be willing to invest limited capital for psychiatric beds, integrated electronic records or psychiatrists unless the overall hospital payment model for inpatient psychiatry is reformulated.

#### **E. Barriers/ Problems with the Current System**

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Providing psychiatric inpatient care to patients with acute psychiatric symptoms proves challenging given limited hospital beds and the availability of community services. Many communities across the United States lack a comprehensive continuum of care that includes



treatment services shown to improve outcomes for diverse populations. Reduced access is reflected in emergency department overcrowding and waiting lists for acute care. There are many barriers to providing care for patients in inpatient psychiatric settings such as the paucity of reimbursement for patients' care, lack of insurance coverage, prior authorization requirements, utilization review techniques, and lack of clinically appropriate level of care criteria. These barriers often result in delayed care, patients not being admitted, or being discharged too early.

As hospital costs continue to rise and as health care inflation exceeds the general rate of inflation, reimbursement in psychiatric inpatient units typically cover only half of the total costs of care. As long as the units cover their direct costs and make some incremental contribution to the margin, there is some economic basis for their retention. But as hospitals' overall economic situation deteriorates, units that do not come close to covering their full cost allocations look like prime targets for replacement by more profitable services (Applebaum, 2003).

Consequently, the number of acute psychiatric inpatient beds has decreased steadily over the past decade. If reimbursement rates for psychiatric hospitalizations do not cover the cost to deliver care, this treatment option may cease to be available, and a less appropriate setting, such as correctional facilities, may become the alternative "treatment setting" for individuals with severe mental illness.

The process of requiring prior authorization by third-party insurance plans or other entities is detrimental to patient care. This process often results in delays for patients in receiving life-sustaining treatment, and for psychiatrists, it typically results in an extensive amount of required paperwork to be submitted, multiple phone calls back-and-forth to insurance companies, and significant wait times for approval, resulting in delayed or disrupted medical care for patients. This also burdens emergency room departments that are struggling with boarding. In a survey conducted of American College of Emergency Physicians members, 48% of respondents said that psychiatric patients are boarded one or more times a day in their emergency department. When asked how long the longest patient waiting in the emergency department for an inpatient bed was boarded, nearly 38% of respondents said 1 to 5 days (American College of Emergency Physicians, 2016).

While length of stay for inpatient services varies by state and county, the median length of stay for inpatient psychiatric care has declined from 42 days in 1980 to about seven days in 2014. (Lutterman et al., 2017) This decrease is due, in part, to more effective treatments becoming available, along with greater recognition of patient preferences for outpatient services and involvement of patients and families in treatment/discharge planning activities. At the same time, both public and commercial payers have contributed to these trends via reduced payments to hospitals and the use of stringent utilization review practices to restrict inpatient services. Requiring prior authorization and concurrent review for inpatient psychiatric services as well as application of medical necessity criteria to determine whether care is approved or



denied has enabled managed care organizations to tightly control access to and duration of inpatient psychiatric care.

Utilization review practices used by managed care organizations may unreasonably limit inpatient care and put patients at risk for poor outcomes when they are experiencing a crisis. Studies have shown the period immediately following discharge from inpatient psychiatric care carries substantial risks for serious and even life-threatening events. Utilization review criteria that limit inpatient length of stay to the minimum “medically necessary” can lead to premature discharge and adverse outcomes including relapse and hospital readmission, homelessness, violent behavior, criminal justice involvement, and all-cause mortality including suicide (Compton et al, 2006; Olfson et al., 2010; Lin and Lee, 2008). These risks are especially concerning given the high rates of failed transitions from inpatient to outpatient mental health care: 42%-51% of adults and 31%-45% of youth do not receive any outpatient mental health treatment for their disorder within 30 days of inpatient discharge (Nelson et al., 2000).

The long-standing Conditions of Participation (COP) in CMS are required for an organization to bill to, and be reimbursed by, Medicare and Medicaid (Code of Federal Regulations, 42 CFR 482 Subpart E). These requirements include substantial administrative burdens that date back to the 1970s and are no longer relevant. One such example is the obligatory and time-consuming treatment plans, which are not required of any discipline other than psychiatry. They may have had relevance at a time when the average length of stay was measured in months but are no longer applicable.

The lack of clinically appropriate level of care criteria has resulted in reduced patient access to necessary services and has negatively affected clinical status and outcomes. Patient outcomes may further be negatively impacted by not focusing on social determinants of health, which are nonclinical factors influencing health, such as socioeconomic status and employment. These are rarely if ever considered in utilization criteria.

## F. Recommendations for Policy Changes <sup>1</sup>

- Reduce regulatory burden that drives up costs without commensurate benefit: Eliminate 42 CFR part 482 Subpart E COPs (e.g., Subpart E, 482.60; 482.61 (medical record requirements: treatment plans); 482.62 (staff requirements)).
- Develop a modified per diem rate based on actual audited costs by type of facility and geography with compensation for complexity; severity; and additional tests/treatment clinically indicated to achieve a realistic operating margin of at least 10%.
- Rebase payment system to allow the marginal value of approximate equivalence to a market basket of all medical-surgical services over 3-5 years. This would require re-basing procedural margins for inpatient and outpatient care at the hospital level.

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<sup>1</sup> Note: These recommendations were based on the deliberation and extensive experience of authors of this Section and do not represent APA policy from the APA Board of Trustees.



- Provide adequate funding for a continuum of care inclusive of community and residential options.
- Make parity with general medical services outcomes-based, rather than merely equivalent length of stay based. This applies also to housing/boarding in the emergency department.
- Evaluate the impact of eliminating the IMD exclusion on state, for-profit, and not-for-profit facilities: concerns include commoditizing services, increased health inequity and access, decreased general hospital investment in beds, and state reduction in investments in beds.
- Evaluate elimination of the 190-day lifetime limit for psychiatric hospitals: concerns include commoditizing services, increased health inequity and access, decreased general hospital investment in beds, and state reduction in investments in beds.
- Ensure effective enforcement of the Emergency Medical Treatment and Labor Act to reduce inappropriate manipulation of the system.

## G. Impact on Medical Inpatient and Ambulatory Care

While modeling of these impacts has not been done reliably, the relative costs of psychiatric care are enormous. Those with serious mental illness as a group have high rates of comorbidity that lead to decreased life expectancy, higher medical costs, more frequent medical hospital readmissions, and longer medical lengths of stay (Rivelli and Shirey, 2014). The opportunity for integrated care to reduce the costs and burden of comorbid disease is substantial and complex (Roehrig, 2016; Anfang and Liptzin, 2014). Model programs have demonstrated the financial viability of integrating psychiatric care into primary medical care (e.g., Reiss-Brennan et al., 2010).

## H. Disaster/ Epidemic Planning

The experience gained during the current COVID-19 pandemic suggests opportunities for building resilience into the system. Such approaches include prospective multi-month all-payer global budgets based on prior claims (e.g., Vermont's ACO model) or variations of Maryland's Health Services Cost Review Commission (Murphy et al., 2020).

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