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Rural Inpatient Psychiatric Units Improve Access to Community-Based Mental Health Services, but Medicare Payment Policy a Barrier

Overview

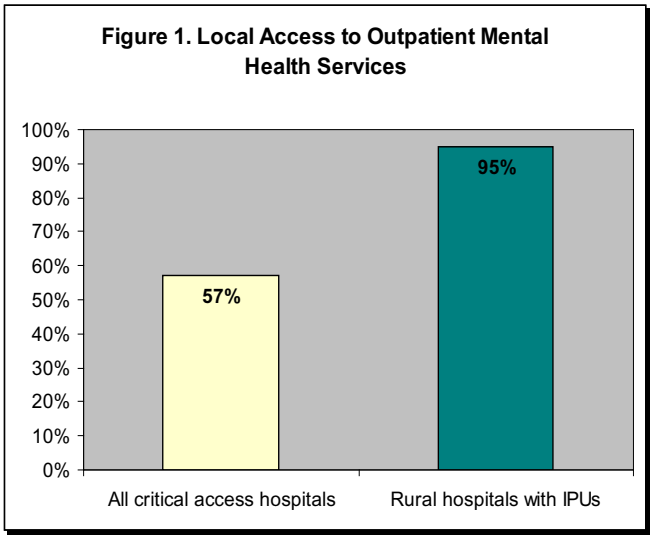
It has been well established that rural residents have poor access to mental health services.[1,2,3] Inpatient psychiatric units (IPUs) may not only be an important source of care for rural residents, but may also assist in the development of community-based services and the recruitment of mental health practitioners.

This study investigates the typical characteristics and admission processes of IPUs in rural hospitals with less than 50 beds, as well as the community-based services available to them when discharging patients. We also explore the reasons for developing these IPUs, the barriers to opening and operating a rural IPU, and factors that have led some to close.

IPUs May Improve Access to Community-based Mental Health Services

Nearly all IPUs had access to nursing homes or other long-term care, while 91% had access to community mental health centers, and 82% had access to a psychiatrist. Two thirds of these hospitals also had their own outpatient mental health services. An additional 29% of rural IPU hospitals had access to outpatient mental health services from some other community-based provider, for a total of 95% with access to some type of community-based provider (Figure 1). Unit managers reported difficulty obtaining discharge care for only five percent of their patients. At least 80 percent of psychiatrists, psychologists, and nurse practitioners working at the IPU also provided services in the local community. These findings suggest that, although a majority of these rural IPUs specialize in geriatric care, their presence in the community may increase the availability of basic outpatient mental health services. In an earlier study, we found that 43% of rural (critical access) hospital communities did not have access to any type of mental health provider.[1]

Figure 1. Local Access to Outpatient Mental Health Services



Fast Facts

- Of approximately 1500 small rural hospitals (less than 50 beds), 80 or about five percent have an inpatient psychiatric unit.
- Ninety-five percent of rural hospitals with IPUs have outpatient mental health services available locally compared with 57% in a previous survey of rural hospitals. (see Figure 1)
- Mental health practitioners who staff rural IPUs often provide outpatient services in the local community, splitting their time between staffing the hospital unit and their community practice.
- Prospective payment for inpatient psychiatric facilities is cited as a major factor in recent closures of several rural IPUs.

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Change in Medicare Reimbursement a Factor in IPU Closures

While contacting rural hospitals for this survey, we discovered that, of a total of 92 IPUs in small rural hospitals, 12 had closed, 11 within the last four years. We conducted short interviews with these hospitals to determine why they had closed. Five of the eight hospitals who participated in the interviews identified changes in Medicare reimbursement as a factor in their units closing. At the time of these closures, CMS was transitioning from a reasonable cost-based system of reimbursement to a per diem system of payment. Under this new system, the inpatient psychiatric facility prospective payment system (IPF PPS), inpatient psychiatric facilities, including units within general hospitals, would receive the national average daily routine operating, ancillary, and capital costs or federal per diem rate adjusted by a number of factors.

The new payment system is likely to result in a decrease in payment for many rural psychiatric units. For example:

- While rural facilities will receive a 17% reimbursement differential above the urban rate, for many, this will be less than they were paid under the reasonable cost method.

- CMS chose not to adjust for the size of the facility or unit stating that facilities had control over this factor and would simply decrease the size of their facilities/ units in order to obtain more favorable reimbursement.[4] However, CAHs have a limited ability to adjust their bed size with a 10 bed limit. In fact, CMS estimates show a 1.3 percent decrease in payment for psychiatric units with fewer than 12 beds.

- Many rural IPUs specialize in geriatric patients. Such units have a median length of stay of 12 days, compared to only 6 for non-geriatric units. Under the variable payment by day, reimbursement decreases to below the base rate starting at day 11. Therefore, geriatric units that may have difficulty discharging their patients in 10 days or fewer are at a significant disadvantage.

Policy Implications

To date, CMS has not conducted extensive investigations into the impact of the IPF PPS on inpatient psychiatric facilities nor determined whether the 17 percent increase in payment for rural units is adequate. Beginning in 2008, reimbursement will become 100% IPF PPS.[5] In an earlier study, we found that 43% of CAH communities did not have access to any type of mental health provider within their local community.[1] However in the current study, we found that IPU managers had access to a fairly extensive array of community-based providers. Although we cannot determine causality from this study, our findings suggest that the presence of an IPU may improve local residents' access to other mental health services. Therefore, rural IPU closures could have a significant impact on access in these communities.

Rural IPUs have begun closing even before the new payment system has been fully implemented. Further research is needed to 1) determine the financial impact of reimbursement changes on small rural IPUs, 2) determine how IPUs have adjusted their operations to deal with the new payment system, and 3) monitor future closures to identify factors contributing to their closure and the potential impact on access to community-based mental health services.

Endnotes

[1]Hartley D, Ziller E, Loux S, Gale J, Lambert D, Yousefian AE. Use of Critical Access Hospital emergency rooms by patients with mental health symptoms. J Rural Health. 2007;23:108-115.

[2]Hartley D, Bird DC, Dempsey P. Rural mental health and substance abuse. In: Ricketts TC, Ed. Rural health in the United States. New York: Oxford University Press; 1999:159-178.

[3]Lambert D, Agger MS. Access of rural AFDC Medicaid beneficiaries to mental health services. Health Care Financ Rev. 1995, September;17:133-145.

[4]Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare Program; Prospective Payment System for Inpatient Psychiatric Facilities. Final Rule. Federal Register. (2004, November 15). 42 CFR, §412 and 413.

[5] Department of Health and Human Services, Centers for Medicare and Medicaid Services. Medicare Program. Inpatient Psychiatric Facilities Prospective Payment System Payment Update for Rate Year Beginning July 1, 2007 (RY 2008). Notice. Federal Register: 2007;vol. 72:86

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