

**TRENDS IN MEDICARE INPATIENT
GEROPSYCHIATRIC CARE
(Non-Dementia Psychiatric Illness)**

**DR Hoover, A Akincigil, E Kalay, JA Lucas,
J Walkup, JD Prince, S Crystal**

Rutgers University

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BACKGROUND

NON-DEMENTIA PSYCHIATRIC ILLNESS

Psychiatric Illness:

- **Dementias** – Diminished Cognitive Function
 - Alzheimer's Disease, etc.
- **Non-Dementias** – Other than Diminished Cognitive Function
 - Depression, Bipolar Disorder, Schizophrenia, Substance Abuse, Other

This Talk is on

Non-Dementia Psychiatric Illness

Which we abbreviate as NDPI

NDPI, the Elderly (65+) and MEDICARE

- NDPI Prevalent in Elderly (Bartels 2003)
 - But NDPI under-diagnosed & under-treated in the elderly (Crystal 2003)
- Medicare is primary payer for the Elderly

NDPI INPATIENT CARE FACILITY TYPES

General Treatment Facilities

1. General Hospital (Scatter) Beds
2. Skilled Nursing Facilities (SNF)

Specialized to Psychiatric Care

3. Psychiatric Acute Care Units
4. Long Stay Psychiatric Hospitals

MEDICARE PART-A REIMBURSEMENT OF NDPI INPATIENT CARE

- Restrictive Guidelines That Change Over Time
- Guidelines Differ by Facility Type
 - Prospective Payment Systems for General Hospitals (1983) and SNFs (1997)
 - 30 Day Annual & 190 Day Lifetime Cap for Long-Stay Hospitals and SNFs

Factors Influencing Inpatient NDPI Treatment

- Managed Care (late 1980s on)
 - “Spillover effect” into patients not on managed care (Baker, 2003)
- SSRI Antidepressants (1990s on)
 - Reduces Number and Duration of Inpatient Stays for Some NDPI?

Recent Declines in Inpatient Care Days & Costs Observed for Many Illnesses

- Attributed to Managed Care (Lave 2003)
- From 1990 to 2000 mean hospital days for NDPI & Dementias combined fell from 25.6 to 10.0 (NAPHS 2002)

OBJECTIVES OF THIS TALK

Evaluate Recent **Medicare Part A** Expenditures and Covered Days for **Elderly** NDPI Inpatient Care

- Focus on **NDPI** which have different etiologies and MEDICARE reimbursement guidelines than do Dementias

METHODS

Study Population

- Elderly (65+) Medicare Beneficiaries
 - in 1992 & 2002 Medicare Provider Analysis and Review (MEDPAR) files
 - covered w/o HMO full year
- Unit of Observation is Inpatient Stay
 - Some Persons have multiple NDPI stays

NDPI Diagnoses for Stays

- From ICD-9 CM Codes & Classified into
 - Depression
 - Bipolar Illness
 - Schizophrenia
 - Substance Abuse
 - Other NDPI
- Only Stays With **NDPI as the Primary Diagnosis** Used

Facility Characteristics of Interest

- Facility Type
 - Gen Hosp, SNF, Psych Unit, Long Stay
- Facility Ownership
 - Non-Profit, Profit, Government

Economic Outcomes of Interest

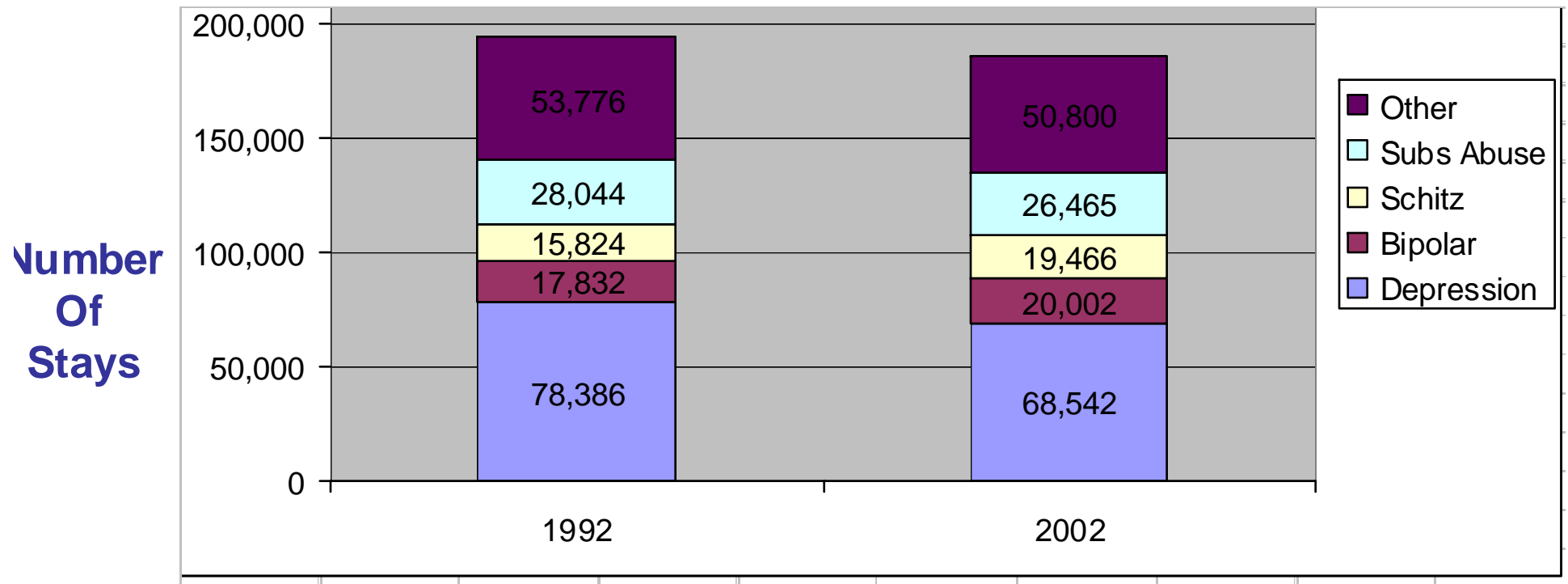
- Medicare Covered Days Per Stay
- Dollars Billed to Medicare Part A Per Stay
 - Interim, including Pass-Through
 - 1992 dollars adjusted to 2002 dollars

RESULTS

Numbers of Beneficiaries & NDPI Inpatient Stays

	1992	2002
Eligible Elderly Beneficiaries	27,733,310	28,510,520
NDPI Inpatient Stays	193,962	183,505
NDPI Inpatient Stays per Beneficiary	699 / 100,000	644 / 100,000

Stays by Primary NDPI Diagnosis

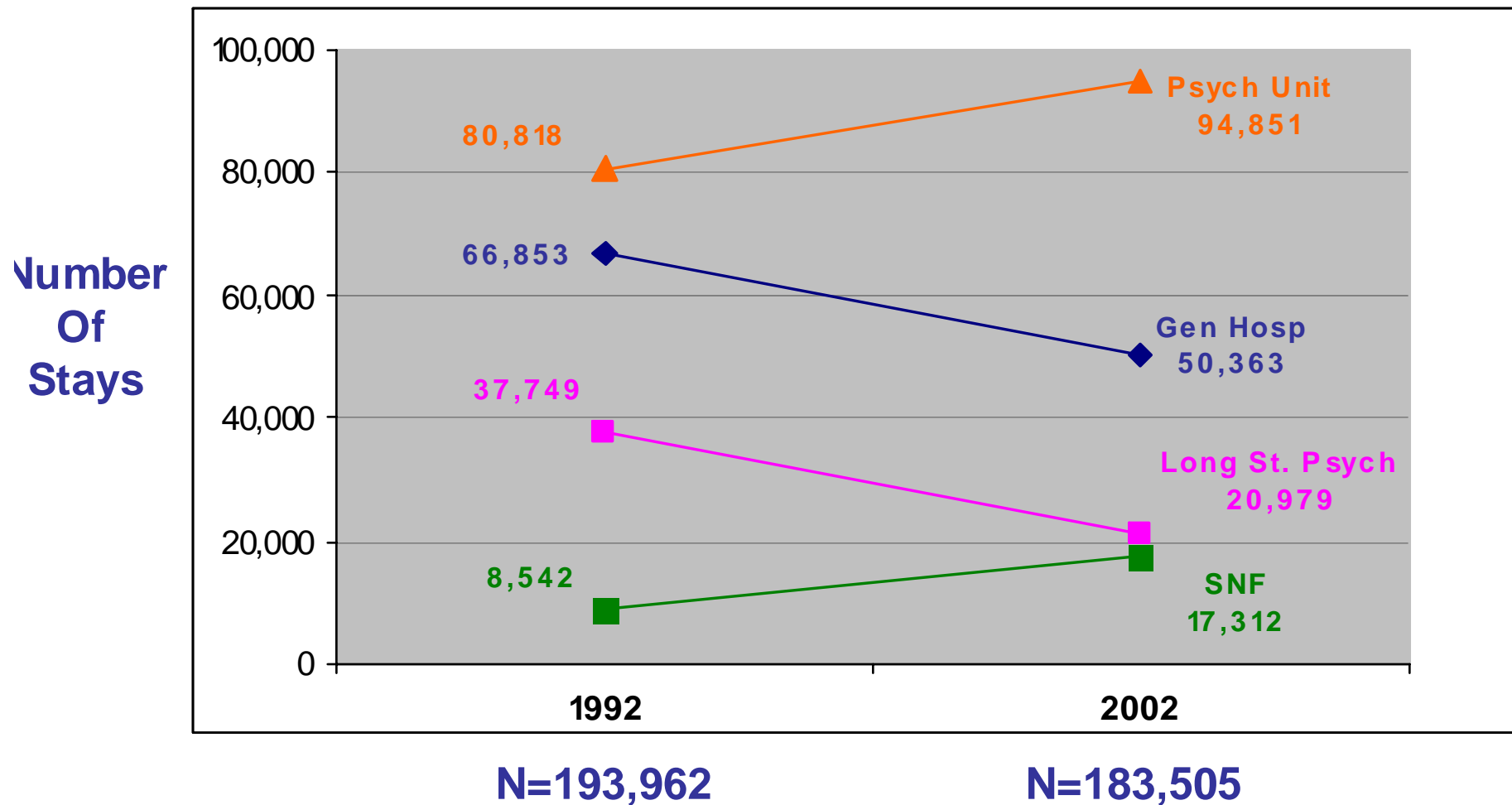


N=193,962

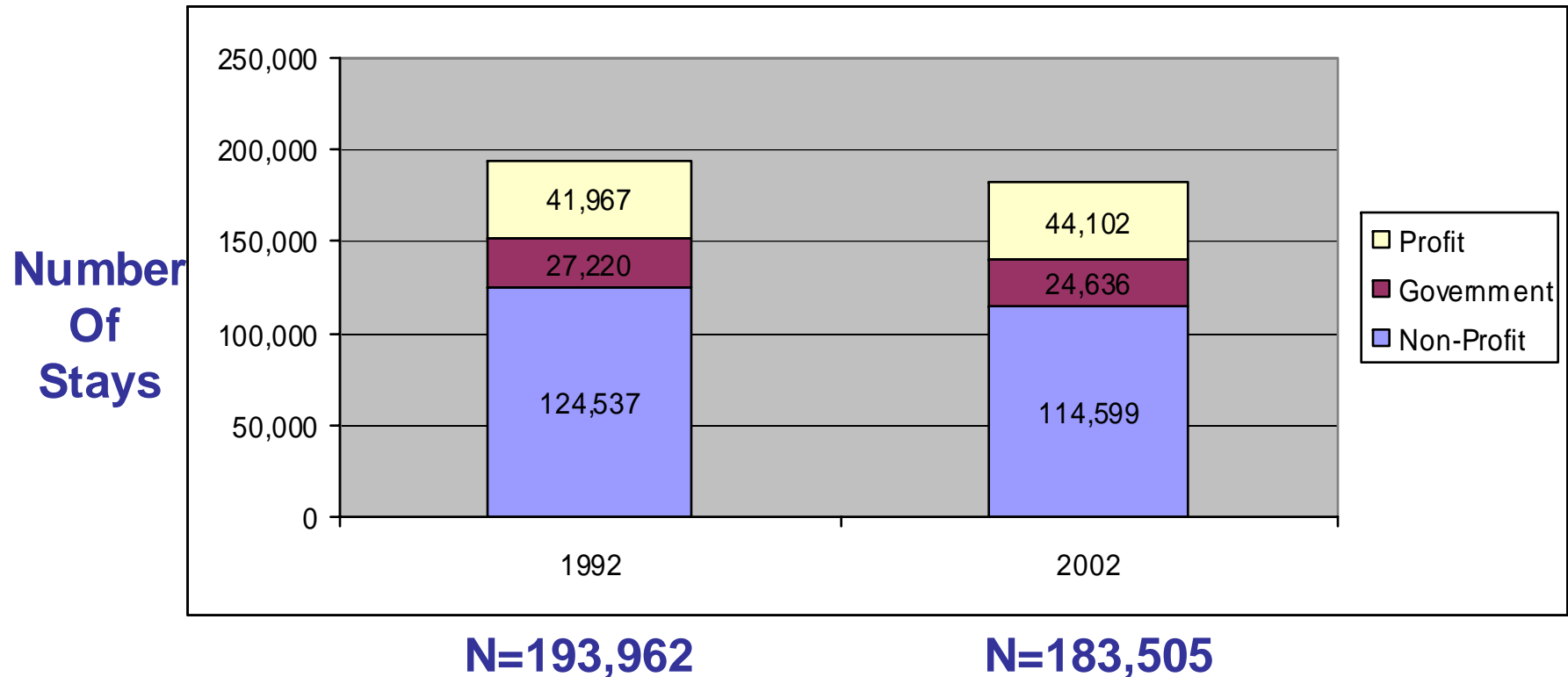
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NDPI Stays By Facility Type & Ownership

NDPI Stays by Facility Type

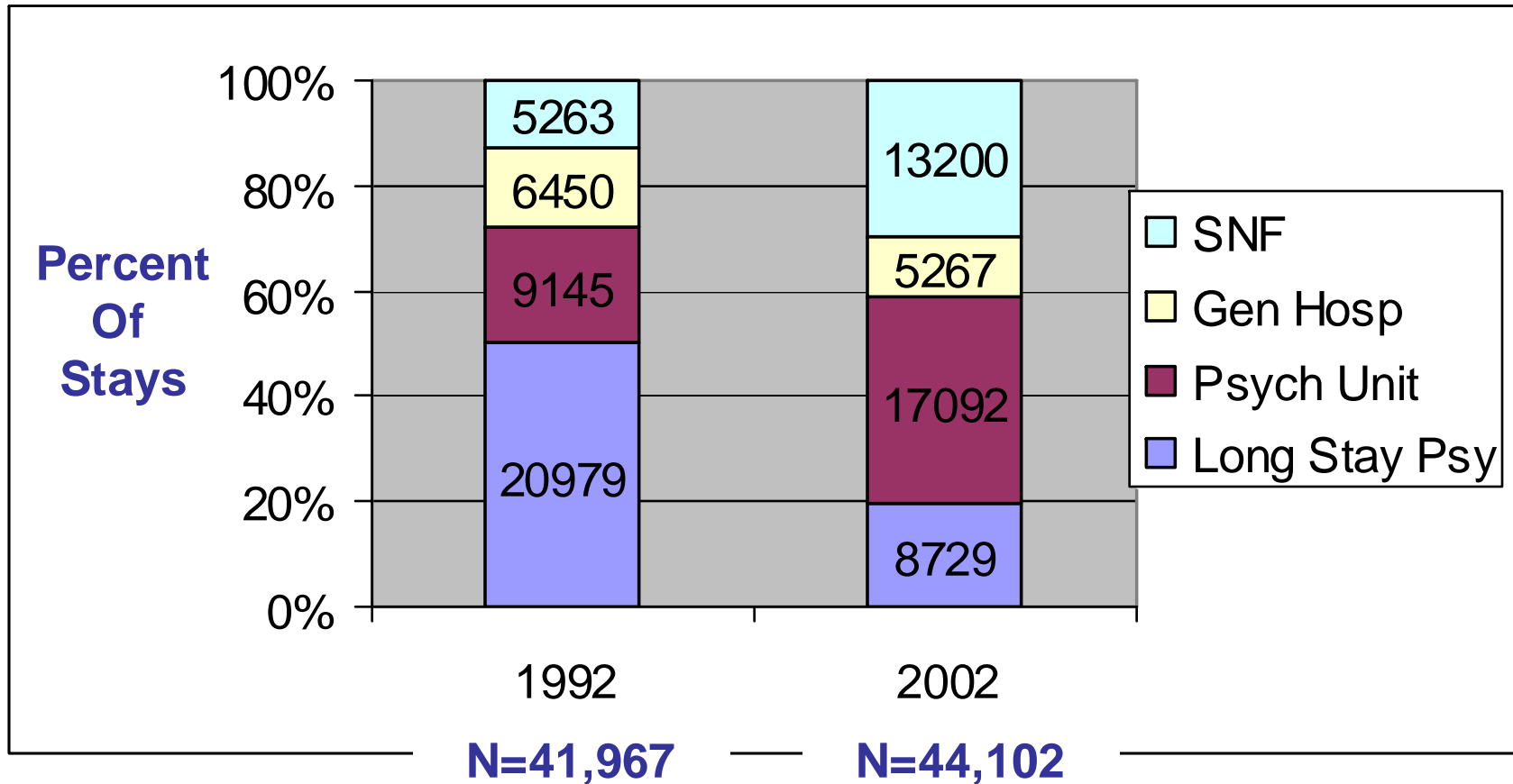


NDPI Stays by Facility Ownership



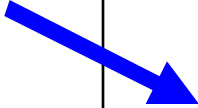
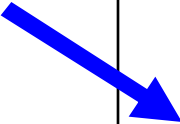
OVERALL – Little Change in Ownership Distribution From 1992 to 2002

Stays In For- Profit Institutions by Facility Type

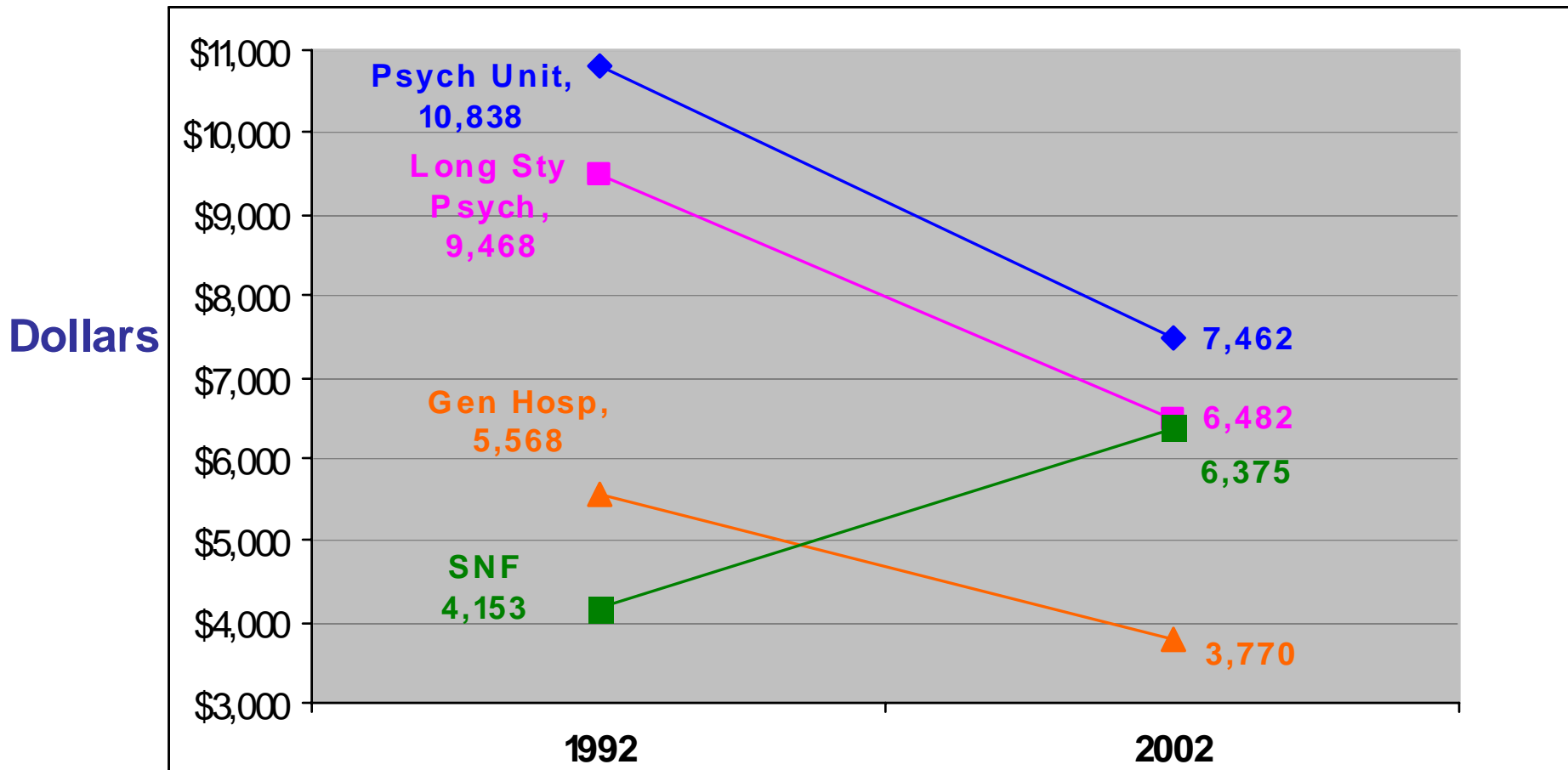


Mean Medicare Expenditures & Days Per Stay

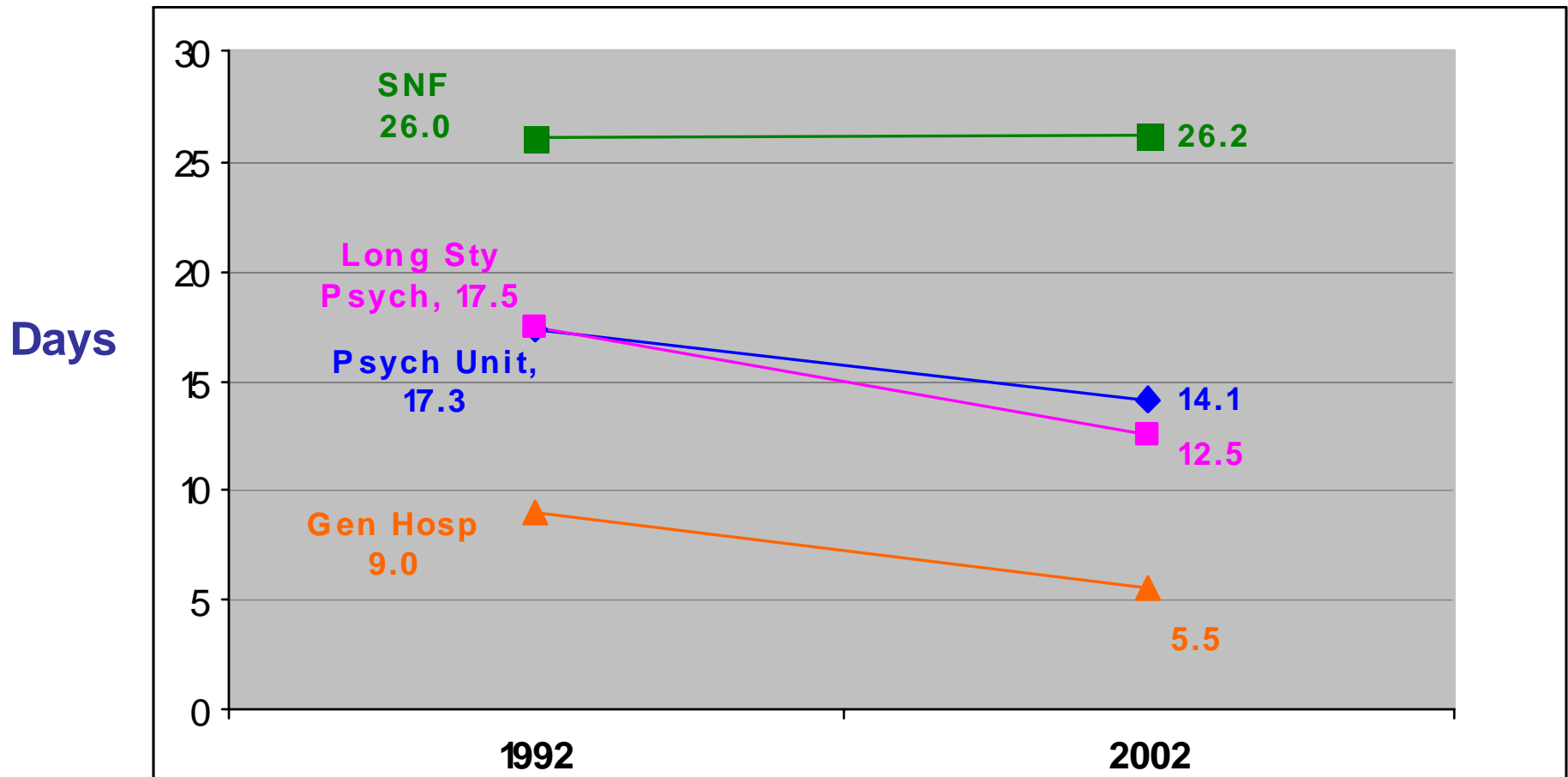
Overall Mean Medicare Payment & Covered Days Per Stay

	1992	2002
Mean Expenditures	\$8,461 	\$6,207
Mean Days	14.9 	12.1

Mean Medicare Payment per Stay by Facility Type



Mean Medicare Covered Days by Facility Type



DISCUSSION

FACILITY TYPE USAGE FOR ELDERLY NDPI CARE CHANGED FROM 1992 TO 2002

- General Hospital Bed and Long Stay Hospital Use **Declined**
- Psychiatric Unit and SNF Use **Increased**
 - Despite regulations that restrict SNF use
- These Shifts Occurred Mostly in the For Profit Sector

MEDICARE COSTS & DAYS **DECLINED** FROM 1992 to 2002

- Mean days per Stay declined by 2.8
- Mean expenditures declined by \$2,254
- Declines occurred for all demographic subgroups and NDPI Diagnoses (Data Not Shown)
- Declines occurred for all facility types **except SNFs** which had expenditure increases

Implications

- Diminishing NDPI stays & costs suggest cost-cutting strategies & shifts to outpatient settings
- Besides facility based reimbursement guidelines market factors may influence elderly NDPI inpatient care
- The patterns seen here may also reflect what is happening in non-elderly NDPI Inpatient care