CHAPTER 13

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

RECOMMENDATION

13 The Congress should eliminate both:

- the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities; and
- the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 13

Eliminating Medicare's coverage limits on stays in freestanding inpatient psychiatric facilities

Chapter summary

In Medicare, coverage of treatment in freestanding inpatient psychiatric facilities (IPFs) is subject to limitations—a 190-day lifetime limit on days in IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in freestanding IPFs on their first day of Medicare entitlement. (Under Part A, a beneficiary's initial Medicare benefit period can span 150 days: 60 full-benefit days, 30 days with Part A coinsurance, and 60 lifetime reserve days.) These provisions were established in 1965 (with the implementation of Medicare), when most inpatient psychiatric care took place in state- and locally run freestanding facilities. However, the landscape has changed substantially in the last 60 years, and the provision of inpatient psychiatric services has shifted away from longer-term custodial-type care in government-run facilities to acute psychiatric care in privately owned facilities. In 2023, only 4 percent of Medicare-covered IPF days were in government-run freestanding IPFs, while 35 percent were in privately owned freestanding IPFs. The remaining 60 percent of Medicare inpatient psychiatric days took place in hospital-based IPFs, which are not subject to these limitations.

A small but highly vulnerable group of beneficiaries is affected by Medicare's coverage limits on freestanding IPFs. As of January 2024, since

In this chapter

their initial enrollment in Medicare, about 40,000 Medicare beneficiaries had exhausted their coverage in freestanding IPFs. An additional 10,000 Medicare beneficiaries were within 15 days of the 190-day limit. In 2023, among the Medicare beneficiaries who were near or at the 190-day limit, over 70 percent were under 65 (disabled) and 84 percent had low incomes. Eighty percent of fee-for-service (FFS) Medicare beneficiaries near or at the limit had a diagnosis of schizophrenia in the prior year. These beneficiaries also were more likely than other IPF users to have "dual" diagnoses of schizophrenia or depressive disorder and substance use disorders. Although Medicaid or Medicare Advantage (MA) plans with supplemental IPF benefits could serve as alternative sources of coverage for beneficiaries affected by the 190-day limit, Medicaid funding restrictions and low MA enrollment by these beneficiaries limit their use.

Medicare beneficiaries reaching the limit may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, be disruptive to care, and potentially be a less appropriate setting for the beneficiary. We compared beneficiaries who were near or at the 190-day limit with a group of beneficiaries who were further away from the limit but had a similar history of previous freestanding IPF use. We found that beneficiaries affected by the limit had an average of 2.4 covered days in a freestanding IPF compared with 7.6 covered days for the comparison group, suggesting that freestanding IPF days could increase by about 5 days on average if the limit were removed. However, beneficiaries affected by the limit had 5.0 covered days in a hospital-based IPF compared with 2.8 days for those in the comparison group, indicating that some substitution away from hospital-based IPFs would occur in the absence of the limit. Similarly, beneficiaries affected by the limit had more covered psychiatric days in general acute care hospitals compared with those not affected by the limit (2.0 days vs. 1.3 days). Beneficiaries affected by the limit had an average of 2.2 fewer days of covered inpatient psychiatric care than beneficiaries in the comparison group, indicating that overall covered days for inpatient psychiatric services would likely increase if the limit were removed.

We multiply the estimated changes in the number of inpatient psychiatric days between beneficiaries affected and not affected by the 190-day limit and the average Medicare per diem spending on the various types of inpatient psychiatric care. This yielded an estimated $40 million increase in FFS Medicare program spending from eliminating the limit in 2023. The amount could be higher or lower depending on a variety of other factors we did not

account for, including spending on other types of Medicare services and changes in behavior by IPFs that could result from the limit being removed. Removing the limit would also increase Medicare spending for MA enrollees because MA plans would be required to expand coverage days for beneficiaries using freestanding IPFs.

The Commission recommends that the Congress eliminate the 190-day lifetime limit on covered days in freestanding IPFs and the reduction in the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding IPF on and in the 150 days prior to their date of Medicare entitlement. Eliminating the limits on psychiatric services in freestanding IPFs would improve access to inpatient psychiatric care for some of the most vulnerable Medicare beneficiaries and would better align Medicare's coverage of inpatient psychiatric services with coverage for other types of medical care. Aside from the elimination of these limits, the Medicare benefit structure related to IPF coverage would not change: Eligibility requirements for IPF admission, such as patients requiring "active" treatment, would still apply. In addition, beneficiaries would still be subject to the spell-of-illness rule under Part A, which specifies the length and frequency of Medicare-covered benefit periods.

Eliminating these coverage limits is just one step in addressing the unmet needs of beneficiaries suffering from serious behavioral health conditions. Continued work to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are transitioned appropriately to the community upon discharge is critically important. The Commission will continue to monitor access and quality of care for beneficiaries who use IPF services. ■

When Medicare was implemented in 1965, the legislation specified limited coverage of stays in freestanding inpatient psychiatric facilities (IPFs), which were the predominant form of psychiatric hospital at the time. The limitation was intended to restrict Medicare's coverage to the "active phase" of psychiatric treatment and curb the federal government's financial responsibility for long-term custodial care (Frank 2000).

Medicare imposed both lifetime limits and higher cost sharing for ambulatory behavioral health services than for other medical services, both of which were common practice among commercial insurers at the time. Over time, changes in Medicare legislation eliminated the differential cost sharing for ambulatory behavioral health services, but two limits on inpatient psychiatric hospitalizations persist: a 190-day lifetime limit on days in freestanding IPFs and a reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are in a freestanding IPF on their first day of Medicare entitlement.

In January 2022, the chair 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, including the impact of the 190-day lifetime limit on freestanding IPF use. In response, the Commission reported in June 2023 on 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 the impact of the 190-day limit (Medicare Payment Advisory Commission 2023). Since then, the Commission has continued to examine the impact of the 190-day limit—and of a required reduction to IPF users' initial benefit period based on prior IPF use—on the highly vulnerable beneficiaries who need IPF care.

In this chapter, we discuss changes in the provision of inpatient psychiatric care since Medicare's inception and the impact of the IPF coverage limitations on beneficiaries' access to care. We describe the beneficiaries who are affected by these limits and review the options available to them when they have exhausted their Medicare coverage. Finally, we recommend the removal of these limits on Medicare coverage of care in freestanding IPFs and discuss the implications of this recommendation.

Background

Medicare beneficiaries experiencing an urgent, acute mental health or substance use disorder–related crisis may be treated in specialty IPFs that provide 24-hour care in a structured, intensive, and secure setting. IPFs can be freestanding hospitals or specialized units within general acute care hospitals. Patients who need inpatient behavioral health 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 IPF care is to stabilize the individual's condition and enable a safe return to the community.

Medicare's coverage limits on care in freestanding IPFs

As is the case for general acute care hospital stays, IPF stays are covered under Medicare Part A. Each stay is subject to the Part A deductible ($1,676 in 2025) and coinsurance (none for Days 1–60; $419 per day for Days 61–90). After the 90th day, beneficiaries can draw from up to 60 lifetime reserve days (with a coinsurance amount of $838 per day).[1,2]

Uniquely in Medicare, coverage of treatment in psychiatric hospitals under Part A is subject to additional limits:

- ***A 190-day lifetime limit on days in freestanding IPFs:*** Medicare coverage of treatment in freestanding IPFs is subject to a lifetime limit of 190 days. Inpatient psychiatric days in hospital-based IPFs or general acute care hospitals do not count toward this limit (Centers for Medicare & Medicaid Services 2017).

- ***A reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are receiving inpatient psychiatric care from a freestanding IPF participating in Medicare as of their first day of Medicare entitlement:***[3] For these beneficiaries, the length of the initial Part A benefit period is dependent upon IPF days used during a pre-entitlement look-back period—any days of freestanding IPF care in the 150 days preceding Medicare entitlement are subtracted from the initial benefit period. The reduction applies to all inpatient psychiatric hospitalizations (including in hospital-based IPFs and general acute care hospitals) occurring during the initial benefit period, but not nonpsychiatric general hospital stays.[4] Subsequent benefit periods are not affected by this reduction (Centers for Medicare & Medicaid Services 2017).[5]

These provisions were established in 1965 (with the implementation of Medicare)—when the majority of inpatient psychiatric care was provided by freestanding facilities run by state and local governments—to ensure that states, rather than the federal government, continued paying for inpatient psychiatric services.

Since Medicare's inception, the provision of inpatient psychiatric services has shifted away from state and local government–run facilities

The psychiatric hospital sector has undergone dramatic changes since Medicare's implementation in 1965. At that time, state and local psychiatric hospitals were the predominant providers of inpatient psychiatric services (Lave and Goldman 1990). The "deinstitutionalization" movement that began in the 1960s was partly in response to concerns about the inhumane treatment of long-term patients in some public psychiatric hospitals. The movement resulted in a push for community-based treatment (Fuller et al. 2016, Mechanic 2014, Salinsky and Loftis 2007, Sisti et al. 2015). This policy shift led to the downsizing and closure of many state- and county-owned psychiatric hospitals and a significant decrease in the total number of inpatient psychiatric beds, while also shifting capacity to the private (nongovernment) sector (Salinsky and Loftis 2007). From 1970 to the early 2000s, the share of nationwide psychiatric beds at state and county psychiatric hospitals declined from 80 percent to 30 percent, and overall inpatient psychiatric hospital capacity fell substantially from over 427,000 beds to 86,000 (Hutchins et al. 2011, Salinsky and Loftis 2007). The total number of residents in state psychiatric hospitals declined by 87 percent over the same time (Lutterman 2022). The closures particularly affected elderly residents at state psychiatric hospitals; the total number of elderly residents in these hospitals declined by 96 percent (Lutterman 2022).

The number of private hospital–based and freestanding IPFs grew dramatically 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). In fact, currently, most Medicare beneficiaries who receive inpatient psychiatric services obtain them from private entities. In 2023, only 4 percent of Medicare beneficiaries' inpatient psychiatric days were in freestanding government IPFs. An additional 12 percent received services from hospital-based government IPFs. The remaining 84 percent of fee-for-service (FFS) Medicare beneficiaries' inpatient psychiatric days were at nongovernment hospitals (including both hospital-based and freestanding facilities).

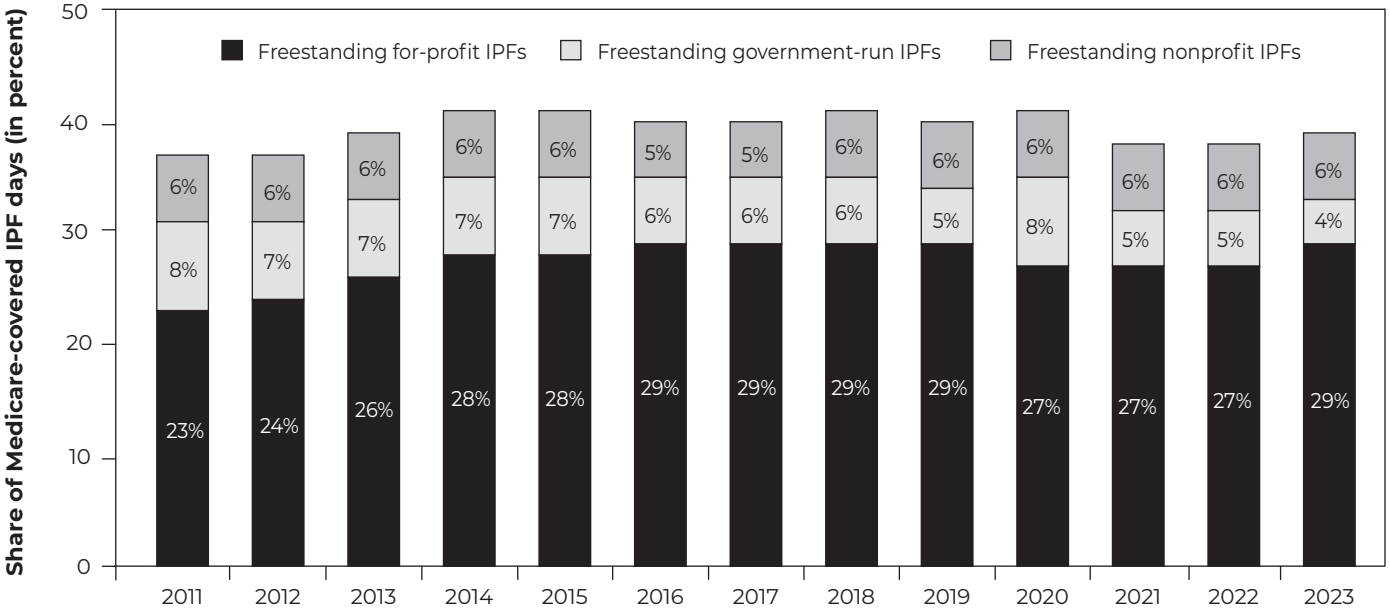
A small but highly vulnerable group of beneficiaries is affected by Medicare's limits on psychiatric hospitalizations

In 2023, about 40 percent of all Medicare IPF days were in freestanding IPFs and therefore subject to the 190-day limit (Figure 13-1). The share of Medicare days in freestanding for-profit IPFs has increased since 2011 from 23 percent to 29 percent, while the share of government days declined from 8 percent to 4 percent during the same period. About 6 percent of Medicare IPF days were in freestanding nonprofit IPFs, an amount that has been consistent since 2011 (Figure 13-1).

As of January 2024, 813,970 Medicare beneficiaries had used at least one day in a freestanding IPF since their initial enrollment in Medicare (Table 13-1, p. 460). Of these, 39,170 Medicare beneficiaries had exhausted their coverage in freestanding IPFs; another 10,100 were approaching the 190-day limit. Sixty-three

FIGURE 13–1

Share of Medicare beneficiaries' days in freestanding inpatient psychiatric facilities, by ownership, 2011–2023



Note: IPF (inpatient psychiatric facility). "Medicare-covered days" includes both fee-for-service and Medicare Advantage IPF days. The remaining (unshown) share of Medicare-covered IPF days are in hospital-based IPFs.

Source: MedPAC analysis of Medicare cost reports from CMS.

percent of beneficiaries near or at the limit as of 2023 were FFS beneficiaries, and the remaining 37 percent were Medicare Advantage (MA) enrollees. In 2023, about 1,300 beneficiaries newly exhausted the 190-day limit (data not shown).

Beneficiaries affected by the reduction in available inpatient psychiatric benefit days in their initial benefit period are more difficult to identify. We have neither data on the use of IPFs in the period before Medicare eligibility nor data on how the first benefit period after entitlement is affected by prior IPF use. To estimate the number of Medicare beneficiaries who may have been affected by prior IPF use in 2023, we counted the number of beneficiaries with a freestanding IPF stay that occurred in the same month as their Medicare entitlement. In 2023, we found that fewer than 100 beneficiaries had any IPF stays that occurred in the month of Medicare entitlement. However, not all these beneficiaries would have had any freestanding IPF days in the 150 days prior to Medicare entitlement, and so not all of them would have had their first benefit period reduced. Further, not all of them would have had inpatient psychiatric stays in the first benefit period that were long enough to be affected by any reduction by prior use. On the other hand, this amount does not capture the individuals who may have had no covered inpatient psychiatric days during their entire initial benefit period because they had used 150 days of freestanding IPF care in the period immediately preceding Medicare entitlement. Overall, we estimate that the restriction on the initial benefit period likely applies to very few beneficiaries each year. Moreover, the beneficiaries to whom it does apply would not continue to be affected past the initial benefit period (since the limitation reduces only the initial benefit period). Due to the uncertainty about who is affected and the fact that only beneficiaries' first benefit periods would be affected, we do not assess the impact of the initial benefit reduction.

TABLE 13–1

Number of Medicare beneficiaries who neared or reached the 190-day limit as of January 2024

	Number of beneficiaries		
	Any freestanding IPF days since Medicare enrollment	Reached 190-day limit	Within 15 days of 190-day limit
FFS	456,630	25,310	5,900
MA	357,340	13,860	4,190
Total	813,970	39,170	10,100

Note: IPF (inpatient psychiatric facility), FFS (fee-for-service), MA (Medicare Advantage). Table figures include Medicare beneficiaries who were enrolled in FFS Medicare or MA in 2023 and had at least one day in a freestanding psychiatric hospital as of January 2024. Components may not sum to totals due to rounding.

Source: Medicare enrollment data from CMS.

Beneficiaries near or at the 190-day limit are highly vulnerable

Medicare beneficiaries (whether enrolled in FFS or MA) who used IPF care are far more likely to be disabled and have low incomes compared with other beneficiaries who did not have any covered days in freestanding IPFs since their enrollment in Medicare (Table 13-2). They were also more likely to be Black. In comparison with beneficiaries who had a history of using freestanding IPFs but were not near the 190-day limit, the beneficiaries who were near or at the 190-day limit in 2023 were more likely to be disabled (75 percent vs. 61 percent), male (61 percent vs. 50 percent), Black (26 percent vs. 18 percent), and have low incomes (84 percent vs. 69 percent).

Using data on chronic conditions in 2022, we found that FFS Medicare beneficiaries near or at the limit were more likely to have schizophrenia compared with other FFS IPF users—80 percent compared with 58 percent among those who used freestanding IPFs but were not near the limit (Table 13-3, p 462).[6] Beneficiaries near or at the limit were less likely to have depressive disorders (54 percent vs. 61 percent) but more likely to have a substance use disorder (34 percent vs. 27 percent).[7] FFS beneficiaries near or at the limit were also more likely to have "dual" diagnoses (schizophrenia or depressive disorder and a substance use disorder) (Table 13-3, p. 462).

Other coverage options for beneficiaries who reach the 190-day limit

Some Medicare beneficiaries may have other sources of health care coverage to assist with the costs of IPF days past the 190-day limit. In 2023, about 9 percent of MA plans provided additional IPF days as a supplemental benefit. For full-benefit dually eligible Medicare beneficiaries, Medicaid may provide additional coverage.[8] In fact, in some states, Medicaid has more generous behavioral health coverage than Medicare (Medicare Payment Advisory Commission 2023). However, in the 1965 implementation of Medicaid, the Congress also limited the federal government's involvement in long-term psychiatric care by prohibiting federal matching funds for Medicaid beneficiaries in hospitals that have 16 or more beds and primarily treat mental health or substance use disorders—called the "institutions for mental diseases" (IMD) exclusion (see text box on p. 464). The IMD exclusion applies to care that adults under age 65 receive in these facilities, though many states receive waivers. Federal funding is available in most states for individuals 21 or younger and for those 65 and over.

TABLE 13–2

Medicare beneficiaries near or at the 190-day limit were more likely to be disabled, have low incomes, and be Black, 2023

Characteristic	Medicare beneficiaries		
	Near or at the limit of covered freestanding IPF days	With a history of freestanding IPF use but not near the coverage limit	All other (no freestanding IPF use since enrollment in Medicare)
Current eligibility status and demographics			
Aged	25%	39%	89%
Disabled	75	61	11
Female	39	50	54
Male	61	50	46
<45	20	19	2
45–64	53	41	8
65–79	22	32	67
80+	5	8	23
Non-Hispanic White	63	69	73
Black	26	18	11
Asian/Pacific Islander	2	1	4
Hispanic	7	8	9
American Indian/Alaska native	1	1	<1
Other or unknown	1	2	4
Geography			
Metropolitan	87	83	83
Micropolitan	9	11	10
Other rural	4	6	7
Dually eligible for Medicaid or receiving LIS during the year			
No	16	31	78
Yes	84	69	22

Note: IPF (inpatient psychiatric facility), LIS (low-income subsidy). "Near or at the limit of covered freestanding IPF days" includes fee-for-service (FFS) and Medicare Advantage (MA) beneficiaries who were within 15 days of exhausting the 190-day lifetime limit on covered days in freestanding IPFs or who had already exhausted the limit. "With a history of freestanding IPF use but not near the coverage limit" includes FFS and MA beneficiaries who had between 16 days and 189 days remaining (i.e., these beneficiaries had at least one day in a freestanding IPF since Medicare enrollment). "All other (no freestanding IPF use since enrollment in Medicare)" includes beneficiaries who had not used any days in a freestanding IPF since Medicare enrollment (but might have used a hospital-based IPF or psychiatric services in a general acute care hospital). "Dually eligible for Medicaid or receiving LIS during the year" includes beneficiaries who had full or partial dual eligibility for Medicare and Medicaid or were enrolled in the Part D low-income subsidy in the year; these statuses serve as proxies for low-income status. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare enrollment data from CMS.

As shown in Figure 13-2 (p. 463), 20 percent of Medicare beneficiaries near or at the 190-day limit are either enrolled in an MA plan with supplemental IPF benefits or are dually eligible for full-benefit Medicaid and are 65 years or older. The remaining 80 percent are dually eligible for Medicaid but are under age 65 and thus

TABLE 13–3

FFS Medicare beneficiaries near or at the 190-day limit were more likely to have schizophrenia and substance use disorders, 2022

Behavioral health condition	Share of FFS Medicare beneficiaries: Near or at the limit of covered freestanding IPF days	With a history of freestanding IPF use but not near the coverage limit	All other (no freestanding IPF use since enrollment in Medicare)
Schizophrenia	80%	58%	4%
Depressive disorders	54	61	20
Substance use disorders	34	27	4
Schizophrenia or depressive disorders and substance use disorders (dual diagnoses)	33	25	2

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility). "Near or at the limit of covered freestanding IPF days" includes FFS Medicare and Medicare Advantage (MA) beneficiaries who were within 15 days of exhausting the 190-day lifetime limit on covered days in freestanding IPFs or who had already exhausted the limit. "With a history of freestanding IPF use but not near the coverage limit" includes FFS and MA beneficiaries who had between 16 days and 189 days remaining (i.e., these beneficiaries had at least one day in a freestanding IPF since Medicare enrollment). "All other (no freestanding IPF use since enrollment in Medicare)" includes beneficiaries who had not used any days in a freestanding IPF since Medicare enrollment (but might have used a hospital-based IPF or psychiatric services in a general acute care hospital). "Schizophrenia" includes schizophrenia and other psychotic disorders, bipolar disorder, and personality disorders. "Depressive disorders" includes major depressive affective disorder, anxiety disorders, and post-traumatic stress disorder. "Substance use disorders" includes alcohol use disorders, drug use disorders, and opioid use disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see https://www2.ccwdata.org/web/guest/condition-categories-other). Table includes beneficiaries enrolled in FFS Medicare in 2023 with chronic condition data available in 2022.

Source: MedPAC analysis of Chronic Condition Warehouse data from CMS.

may be subject to the IMD exclusion (depending on whether their state has a waiver) or are not covered by Medicaid.[9]

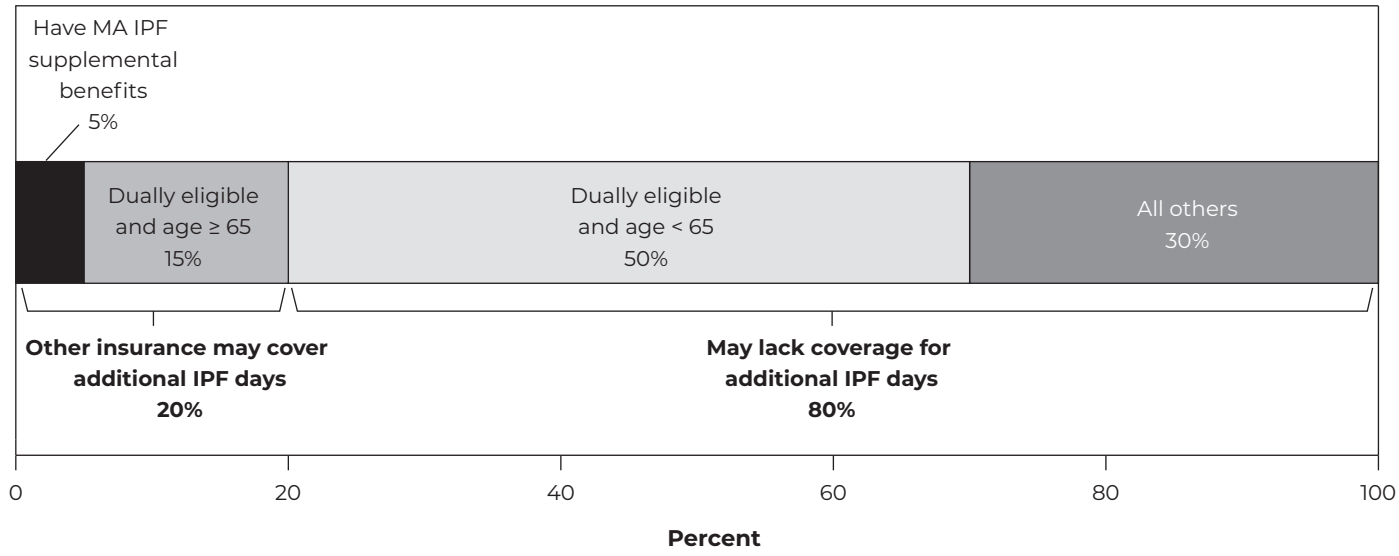
The 190-day limit creates access issues for some beneficiaries with chronic and severe behavioral health conditions

Researchers, policy analysts, and providers generally agree that demand for inpatient care for people with the most difficult-to-treat behavioral health conditions far outstrips supply, in large part because community-based treatment for such people is often inadequate (Fuller et al. 2016, Lamb and Weinberger 2014, McBain et al. 2022a, Mechanic 2014, Sharfstein and Dickerson 2009, Sisti et al. 2015). Lack of capacity to serve patients with serious behavioral health conditions has also contributed to a substantial burden on the criminal justice system (Lamb and Weinberger 2014, Lamb et al. 2004, Lurigio and Harris 2022, Lutterman 2022, McBain et al. 2022b, Sisti et al. 2015). For example, McBain and colleagues noted that, in one state, the shortage of psychiatric beds resulted in over 1,000 individuals being housed in county jails despite being deemed mentally incompetent to stand trial (McBain et al. 2022b).

As the number of public IPFs has declined, private IPFs have become the predominant site of care for Medicare beneficiaries needing acute inpatient psychiatric care (with freestanding private IPFs serving a large share of FFS Medicare beneficiaries using IPFs (Figure 13-1, p. 459)). However, freestanding private IPFs are likely less willing and able to take patients who have reached or are close to Medicare's 190-day lifetime limit. In interviews conducted with a small set of IPFs, some interviewees stated that the 190-day limit can present significant issues for patients who need longer-term care or those who have multiple periodic inpatient stays because of chronic serious behavioral health conditions such as schizophrenia (L & M Policy

FIGURE 13–2

Many Medicare beneficiaries near or at the 190-day limit may have lacked additional coverage, 2023



Note: MA (Medicare Advantage), IPF (inpatient psychiatric facility). Medicare beneficiaries who are full-benefit dually eligible and age 65 or older may have Medicaid coverage of additional IPF days beyond the 190-day limit. Dually eligible beneficiaries between ages 18 and 64 may be subject to the "institutions for mental diseases" exclusion and have limited coverage through Medicaid beyond the 190-day limit. "All others" includes non–full-benefit dually eligible Medicare beneficiaries and non–dually eligible Medicare beneficiaries who are not enrolled in an MA plan with IPF supplemental benefits. These beneficiaries may also have limited coverage beyond the 190-day limit.

Source: MedPAC analysis of Medicare enrollment data and MA plan benefit package data from CMS.

Research 2023, Medicare Payment Advisory Commission 2023).[10] A few of the IPF interviewees reported that after a patient passes the 190-day limit, IPFs provide uncompensated care and help the patient obtain Medicaid coverage. One noted that they try to get patients who meet the 190-day limit into hospital-based IPFs so that they can receive Medicare-covered care there. Most IPFs considered the 190 days to be insufficient coverage, especially for patients with chronic behavioral health conditions, and stated that the limit increased the difficulty of finding suitable postdischarge placement options.

Although some beneficiaries who reach the 190-day limit can be transferred to hospital-based facilities, changing hospitals during a stay or course of care can be disruptive and result in fragmented care. Moreover, the number of hospital-based IPFs has declined in recent years, exacerbating difficulties in finding alternative placement for patients nearing their 190-day limit (we previously reported that from 2017 to 2021, the number of hospital-based IPFs declined by 4 percent annually (Medicare Payment Advisory Commission 2023)). In addition, some IPF interviewees discussed how higher-needs and older patients (who are more likely to be frail and have more medical comorbidities) tend to be placed in "geriatric units" that occupy only a subset of beds within the IPF due to the greater resources required (such as higher staff-to-patient ratios and longer lengths of stay) (L & M Policy Research 2023).

Beneficiaries may also receive inpatient psychiatric services from general acute care hospitals (referred to as "scatter-bed" stays). Our analyses have found that scatter-bed stays compose about a third of all Medicare inpatient psychiatric stays, and thus they meaningfully supplement the number of IPF beds (Medicare Payment

Medicaid's "institutions for mental diseases" exclusion

Medicaid is a joint federal and state program that covers medical costs for individuals with limited income and resources. Each state implements its own Medicaid program subject to certain federal rules and regulations, and the federal government shares in a portion of the costs. Under a policy known as the institutions for mental diseases (IMD) exclusion, the federal government does not make matching payments to states for services to Medicaid enrollees ages 21 to 64 in IMDs. An IMD is defined in the Medicaid program as a "hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (Social Security Act Sec. 1905(i)).

Like the limits on inpatient psychiatric coverage, the IMD exclusion was intended to ensure that states, rather than the federal government, continued paying for inpatient psychiatric services since state- and locally run psychiatric hospitals were the predominant form of psychiatric hospital in 1965 (Medicaid and CHIP Payment and Access Commission 2019, National Association of Medicaid Directors 2022). States can still pay for these services without federal matching funds and, in recent years, almost all states have made use of available exceptions to obtain federal funds for Medicaid enrollees receiving inpatient psychiatric services from IMDs. Such exceptions include Section 1115 demonstration waivers, disproportionate-share-hospital payments, a state-plan option for services for substance use disorders, and managed care "in lieu of" arrangements (Congressional Budget Office 2023).[11] Although these exceptions promote access for inpatient psychiatric services in participating states, they are subject to restrictions, for example, on the type of services covered or length of stay. The Congressional Budget Office estimated that if the IMD exclusion were eliminated, federal spending would increase by $38.4 billion from 2024 to 2033, even after accounting for spending on exceptions and waivers currently used by states (Congressional Budget Office 2023). ■

Advisory Commission 2024). However, we found that the types of beneficiaries who use scatter-bed stays differ from those who use IPFs: Scatter-bed users tended to be older, with more medical comorbidities (Medicare Payment Advisory Commission 2024). Moreover, prior research found fewer psychiatric visits and shorter lengths of stay among scatter-bed stays compared with IPF stays, calling into question whether scatter beds are an appropriate setting of care for individuals with severe behavioral health conditions (Mechanic and Davis 1990).

To understand how the 190-day coverage limit might affect access to care, we compared utilization of inpatient psychiatric services by beneficiaries "affected by the limit" (proxied by beneficiaries who reached the limit or were within 15 days of reaching the limit in 2023 and had had at least one freestanding IPF stay in the previous five years) with a comparison group of similar beneficiaries not affected by the limit in 2023. We constructed the comparison group as beneficiaries who in 2023 had 16 days to 90 days remaining before reaching the limit and who also had had at least one freestanding IPF stay in the previous five years.[12] The goal was to identify comparison beneficiaries who were likely to have similar propensities for using inpatient psychiatric care as beneficiaries affected by the limit, but who were not (or were less) influenced by the 190-day limit itself.

Our analysis suggests that beneficiaries who were affected by the 190-day limit substituted freestanding IPF care with inpatient psychiatric services in hospital-based units and in scatter beds of general acute care hospitals. As shown in Table 13-4, in 2023, beneficiaries affected by the limit had an average of 2.4 covered days

TABLE 13–4

Setting of FFS Medicare–covered inpatient psychiatric care differed for beneficiaries affected by the limit compared with similar beneficiaries not affected by the limit, 2023

	Mean covered days per FFS Medicare beneficiary		Difference between the comparison group and those affected by the limit
	Affected by the 190-day limit (*N* = 14,590)	Comparison group (*N* = 17,770)	
Freestanding IPF	2.4	7.6	5.2
Hospital-based IPF	5.0	2.8	–2.2
Psychiatric stay in a general ACH	2.0	1.3	–0.8
All inpatient psychiatric stays in 2023	9.4	11.7	2.2

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility), ACH (acute care hospital). "Affected by the 190-day limit" includes FFS beneficiaries who had exhausted or were within 15 days of exhausting the 190-day limit and had at least one freestanding IPF stay between 2018 and 2022. "Comparison group" is composed of FFS Medicare beneficiaries who were within 16 days to 90 days of meeting the 190-day limit and had at least one freestanding IPF stay between 2018 and 2022. All differences were statistically significant at the 1 percent level.

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

in a freestanding IPF compared with 7.6 covered days for the comparison group. By contrast, beneficiaries affected by the limit had 5.0 covered days in hospital-based IPFs compared with 2.8 days for those not affected by the limit. Similarly, beneficiaries affected by the limit had more covered psychiatric days in general acute care hospitals compared with those not affected by the limit (2.0 days vs. 1.3 days).

As shown in Table 13-4, in 2023 beneficiaries affected by the 190-day limit had an average of 2.2 fewer days of total covered inpatient psychiatric care than beneficiaries in the comparison group, which could suggest that beneficiaries affected by the 190-day limit face constraints on their use of services.

Illustrative effect on use and spending if the coverage limit on care in freestanding IPFs were removed

Over the years, stakeholders have called for the Medicare program to eliminate the 190-day limit on coverage of treatment in freestanding IPFs and legislative attempts have been made (AARP 2024, Commonwealth Fund 2023). Stakeholders point out inequities with the limit. For instance, beneficiaries with chronic behavioral health conditions, particularly younger individuals who are eligible for Medicare due to disability, are more likely to reach the limit during their lifetime and face barriers to IPF care (Commonwealth Fund 2023).

As an illustrative example of how Medicare spending could change if the 190-day limit were removed, we calculated the change in Medicare spending in 2023 associated with the differences in psychiatric hospital use discussed above. As shown in Table 13-4, we found that freestanding IPF days could increase if the limit were removed and that, although use of hospital-based IPFs and scatter-bed stays could decrease, the overall number of covered days for inpatient psychiatric services could increase if the limit were removed. We multiplied these estimated differences by the average per diem Medicare payment in 2023 for comparison-group beneficiaries who were not affected by the limit (Table 13-5, p. 466). By totaling those amounts, we estimate that Medicare would spend an additional $1,260 per beneficiary currently affected by the 190-day limit if the limit were removed. That is, if beneficiaries affected by the limit were to change their psychiatric

TABLE 13–5

Illustrative change in per beneficiary FFS Medicare spending on inpatient psychiatric services if the 190-day limit were eliminated, 2023

	Change in number of covered days per beneficiary	Per diem average FFS Medicare payment	Increase in FFS Medicare payments per beneficiary
Freestanding IPF	5.2	$800	$4,200
Hospital-based IPF	–2.2	$900	–$2,000
General acute care hospital	–0.8	$1,200	–$930
Total FFS Medicare spending per beneficiary	2.2	—	$1,260

Note: FFS (fee-for-service), IPF (inpatient psychiatric facility). "Change in number of covered days per beneficiary" was estimated by comparing FFS Medicare beneficiaries affected by the 190-day limit with a group of similar beneficiaries who were between 16 days and 90 days away from the limit (see Table 13-4, p. 465). "Per diem average FFS Medicare payment" was the average Medicare payment per day for beneficiaries in the comparison group. "Increase in FFS Medicare payments per beneficiary" was calculated by multiplying the preceding two columns. Services provided by freestanding IPFs and hospital-based IPFs are paid under the IPF prospective payment system; Inpatient psychiatric services provided in general acute care hospitals are paid under the inpatient prospective payment system. Components may not sum to totals due to rounding.

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

hospital use to be the same as similar beneficiaries not affected by the limit, Medicare would spend an additional $1,260 for each beneficiary.

To estimate the total impact, we multiplied the increase in FFS spending per beneficiary ($1,260) by the number of FFS beneficiaries near or at the limit in 2023 (31,210, shown in Table 13-1 (p. 460)). We estimate that eliminating the 190-day coverage limit would have increased FFS Medicare spending by approximately $40 million in 2023.[13]

Actual changes in Medicare spending could be higher or lower depending on a variety of considerations. Not all beneficiaries at or near the 190-day coverage limit would change their use of psychiatric services (some beneficiaries may no longer need inpatient psychiatric services or may have established alternative, long-term care). The comparison group of beneficiaries we defined as "not affected by the limit" might also change their use of inpatient psychiatric services in response to removing the limit (as may providers). Medicare spending on other services such as Part D prescription drugs and Part B clinician services might be affected as well, though the direction of effects is unclear.[14] Finally, freestanding IPFs (including government-run IPFs) might change their behavior by accepting more Medicare patients and keeping them for longer periods if the limit were removed; such a change would increase spending relative to our estimate (but, importantly, may also increase needed access).

We previously found that IPF occupancy rates declined from 76 percent to 70 percent between 2017 and 2021, indicating that, overall, IPFs could accommodate additional use if the limit were removed (Medicare Payment Advisory Commission 2023). However, we noted that occupancy rates varied significantly across IPFs and that some of the interviewees in the small set of IPFs we interviewed indicated difficulty in staffing all licensed beds; thus, occupancy rates measured from cost reports may be underestimated (L & M Policy Research 2023, Medicare Payment Advisory Commission 2023). It would be important to continue to monitor IPF use and access.

Implications for Medicaid

Eliminating the 190-day limit would decrease Medicaid spending (as well as federal Medicaid matching payments) for dually eligible beneficiaries who currently have exceeded the 190-day limit and now

receive coverage through Medicaid. Because of the IMD exclusion (see text box on the exclusion, p. 464), this decrease in spending would be more limited in states that do not have an exception to the IMD exclusion. Medicaid spending reductions would be greater in states that do have an exception.

Removing the coverage limits on care in freestanding IPFs

Beneficiaries who reach the 190-day lifetime limit on covered days in freestanding IPFs may still obtain psychiatric care from hospital-based IPFs or general acute care hospitals, but an alternative setting may be difficult to find, disruptive to care, and potentially a less appropriate setting for the beneficiary. Eliminating the 190-day lifetime limit, as well as the reduction of inpatient psychiatric benefit days available in the initial benefit period for beneficiaries who are receiving inpatient psychiatric care on their first day of Medicare entitlement, would improve access to IPFs for some of the most vulnerable Medicare beneficiaries. While removing the limit will likely lead to increased use of (and Medicare spending on) freestanding IPF services, use of other types of inpatient psychiatric care, to the extent that they substitute for care in freestanding IPFs, would decrease.

Existing relevant aspects of the Medicare benefit would remain the same if the 190-day limit were eliminated. These features include:

- Active treatment criteria for eligibility for IPF care: Medicare patients must still meet eligibility criteria to be admitted to any IPF. Criteria specify that IPFs can 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 (Centers for Medicare & Medicaid Services 2018).
- Spell of illness: Each Part A Medicare benefit period or spell of illness begins at admission to an inpatient facility and is limited to 90 days (with deductible and copayment) and 60 nonrenewable lifetime reserve days (which have higher beneficiary cost sharing). A new benefit period starts only when the beneficiary has been discharged for at least 60 days. Thus, even with the 190-day limit eliminated, beneficiaries using IPFs would still be subject to Medicare's benefit period structure and total lifetime reserve days.

RECOMMENDATION 13

The Congress should eliminate both:

- **the 190-day lifetime limit on covered days in freestanding inpatient psychiatric facilities; and**
- **the reduction of the number of covered inpatient psychiatric days available during the initial benefit period for new Medicare beneficiaries who received care from a freestanding inpatient psychiatric facility on and in the 150 days prior to their date of Medicare entitlement.**

RATIONALE 13

The limitations on Medicare coverage of care in freestanding IPFs were implemented in 1965 when public hospitals were the primary providers of inpatient psychiatric care. Nearly 60 years later, a substantial share of inpatient psychiatric care is provided at private freestanding psychiatric hospitals, which may be less willing and able to treat beneficiaries who have exceeded the 190-day limit and have exhausted their Medicare Part A coverage. Alternative insurance options such as certain MA plans and Medicaid may cover additional days, but our analysis found that only about 20 percent of beneficiaries who were near or at the limit in 2023 would have had this additional coverage (this is likely higher if accounting for waivers of the IMD exclusion among many states). Beneficiaries affected by this limit are among the most vulnerable; the majority are disabled and have low incomes and severe chronic behavioral health conditions. Beneficiaries reaching the limit may obtain care from hospital-based IPFs—and our analysis finds that they do—which are not subject to these limitations. However, the declining number of hospital-based IPFs may diminish these facilities' ability to serve as a substitute setting for beneficiaries who need inpatient psychiatric care and have exceeded the 190-day limit. Moreover, shifting care settings in response to the limit may lead to fragmented or less appropriate care. Eliminating the limits on psychiatric services in freestanding IPFs would promote access to inpatient psychiatric services and better align the

coverage of inpatient psychiatric services with the coverage of other types of medical care. Aside from the elimination of these limits, the Medicare benefit structure related to IPF coverage would not change: Eligibility requirements for IPF admission, such as patients requiring "active" treatment, would still apply. In addition, beneficiaries would still be subject to the spell-of-illness rule under Part A, which specifies the length and frequency of Medicare-covered benefit periods.

IMPLICATIONS 13

Spending

- Relative to current law, we expect that this recommendation would increase federal spending by less than $50 million in one year and by less than $1 billion over five years.

Beneficiary and provider

- We expect that this recommendation will increase Medicare beneficiaries' access to inpatient psychiatric care at freestanding IPFs by increasing freestanding IPFs' willingness to treat beneficiaries with chronic and severe behavioral health conditions.

Importance of continued work to address the needs of Medicare beneficiaries with severe behavioral health conditions

Eliminating the 190-day limit would improve access to IPFs for some of the most vulnerable Medicare beneficiaries. However, removing Medicare limitations on inpatient psychiatric hospitalizations is just one step in addressing the unmet needs of beneficiaries suffering from serious behavioral health conditions. Continued work is needed to ensure that Medicare beneficiaries are receiving high-quality inpatient psychiatric care and are appropriately transitioned out of the hospital. Per requirements set forth in the Consolidated Appropriations Act (CAA), 2023, CMS is planning to collect more information on the services provided by IPFs and the patients who use them. It will be important to continue to monitor access, quality of care, and payments to IPFs for Medicare beneficiaries.

Concerns about care provided in certain freestanding IPFs

IPFs serve vulnerable patients with complex needs, and the type and quality of care these patients receive in some psychiatric hospitals has been a longstanding concern (Fuller et al. 2016, Mechanic 2014, Salinsky and Loftis 2007, Sisti et al. 2015). More recently, two large IPF chains (together accounting for 250 freestanding psychiatric hospitals) were investigated by the Department of Justice for practices at some of their facilities (Department of Justice 2024, Department of Justice 2020). Allegations included improper detainment of patients who were not eligible for inpatient care; inadequate staffing, training, and supervision of staff; improper use of restraints and seclusion; and billing for services not provided. Greater transparency in the services provided at IPFs, how they vary based on patient characteristics, and the quality of the care provided is critical for this population.

In our June 2023 report to the Congress, we discussed concerning trends in the data provided by freestanding for-profit IPFs (Medicare Payment Advisory Commission 2023). These IPFs tended to have lower costs per stay than other types of IPFs, but they also had low use rates or missing information on ancillary services (such as the use of prescription drugs, laboratory services, and medical supplies), making it difficult to know whether patients were receiving these services (as well as hampering the ability of the payment system to align payments to the costs of care). For example, while nearly all FFS Medicare beneficiaries treated in hospital-based IPFs had some amount of drugs and laboratory services on the claim, only 40 percent of freestanding for-profit IPF stays had any ancillary services on the claim (Medicare Payment Advisory Commission 2023). It is not clear why certain IPFs fail to report ancillary charges, and CMS has attempted to address the poor reporting over the years, most recently in the fiscal year 2025 final rule, in which CMS said that Medicare administrative contractors would be instructed to reject cost reports that do not include information on ancillary services (with exceptions granted to government-owned or tribally owned IPFs only) starting on October 1, 2024 (Centers for Medicare & Medicaid Services 2024). We will continue to track ancillary services provided to Medicare beneficiaries by IPFs.

In addition, there is little information on the mix (and amount) of staff employed by IPFs and how staff spend their time across various IPF tasks (such as inpatient assessment, counseling, drug management, nursing care, and behavioral monitoring). IPF staffing data could provide useful insights into the variation in costs and quality of care across providers, enabling CMS and Medicare beneficiaries to better understand the services that they are purchasing and using. There is a precedent for regularly collecting staffing information: Skilled nursing facilities (SNFs) are required to submit detailed staffing data through the Payroll-Based Journal. Payroll data are considered the gold standard for measuring staffing; the data are submitted electronically and can be audited by other data sources (Centers for Medicare & Medicaid Services 2023). Researchers have found the SNF payroll data to be consistent and accurate; the data serve as an important tool for policymakers and researchers to assess staffing and its relationship to patient outcomes (Geng et al. 2019, Zheng et al. 2022).

Challenges in transitioning from IPFs to the community

Transitioning from the psychiatric hospital back to the community can be particularly challenging. Studies have found that during the period immediately following IPF discharge, individuals are highly vulnerable and at risk for poor outcomes, leading to a "revolving door" of hospital readmissions (Bravo et al. 2022, Fonseca Barbosa and Gama Marques 2023, Tyler et al. 2019). We previously reported on the substantial use of emergency departments (EDs) and hospital visits in the period after IPF discharge: Using claims data from 2018, we found that 29 percent of FFS Medicare beneficiaries discharged from an IPF had an ED visit or hospital admission (including IPF readmission) within 30 days (Medicare Payment Advisory Commission 2023). This figure rose to 47 percent in the 90 days following IPF discharge. In interviews conducted with a small set of IPFs in 2022 and 2023, interviewees noted persistent challenges in finding discharge placement options, which lengthened stays and resulted in discharging some patients with long-term behavioral health conditions back into the community despite significant social, behavioral, and medical needs and inadequate support (L & M Policy Research 2023). Many of these patients were eventually readmitted.

Care coordination with outpatient providers is vital to improve the transition from an IPF: Communication between inpatient and outpatient behavioral health providers during an inpatient psychiatric stay has been associated with increased odds of attending timely outpatient behavioral health appointments (Smith et al. 2020). Continuation of care and follow-up after discharge is especially important for IPF patients discharged to their homes, the most common setting to which IPF patients are discharged (Assistant Secretary for Planning and Evaluation 2019). Indeed, our prior analyses using 2018 data found that only 15 percent of beneficiaries had ambulatory visits with behavioral health practitioners within seven days of IPF discharge (and only 30 percent within a month of discharge) (Medicare Payment Advisory Commission 2023). IPF interviewees also noted difficulty in obtaining appropriate follow-up care for their IPF patients after discharge, particularly with psychiatrists (L & M Policy Research 2023). 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.*

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 suggest that many of these patients do not receive effective, well-coordinated behavioral health care.[15] Starting in 2027, CMS will begin reporting a new risk-standardized claims-based measure on ED visits occurring in the 30 days following discharge (Centers for Medicare & Medicaid Services 2024). We will continue to track transitions from the IPF to the community and the use of post-IPF follow-up care.

Ongoing monitoring of the FFS Medicare IPF payment system and quality of care is needed

In our June 2023 report to the Congress, we noted that more information is needed to improve the accuracy of payments under the IPF prospective payment system. Notably, our analysis of IPFs' costs and margins suggested that Medicare payments were not well-aligned to costs of efficient care delivery. The available

data used to develop the payment system do not enable policymakers to adequately capture variation in patient severity and resource use to accurately set payments. Moreover, as discussed above, we found that many IPFs were not reporting ancillary services provided to patients, information that is needed to accurately calculate costs from the Medicare cost reports to set payments appropriately.

CMS continues to address these shortcomings. More recently, per the CAA, 2023, CMS will begin to collect data in the following areas: resource use and the need for patient 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). A standardized tool will be used to collect patient assessment data, beginning by 2028.

CMS requires IPFs to report quality measures through a pay-for-reporting program and has recently made several improvements to the reporting program. Starting in 2026, patient-experience survey data must be reported. CMS is also developing several claims-based outcome measures: a measure of 30-day all-cause ED visits following an IPF discharge and 30-day all-cause mortality rate following discharge. Many of the measures in the reporting program are based on chart-abstracted data, meaning that facilities calculate the measure based on their own medical records and report the results in aggregate without validation of the underlying patient-level data. Starting in 2024, CMS requires submission of patient-level data for chart-abstracted measures. These changes align with the Commission's principles 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). We will continue to monitor updates to the IPF payment system and quality reporting program. ■

Endnotes

1 Patients must also pay any Part B cost sharing for services from physicians and other clinicians received during the stay.

2 Days in inpatient facilities, including IPFs, count toward a beneficiary's use of lifetime reserve days (if the beneficiary is in the inpatient facility for more than 90 days during a benefit period). Lifetime reserve days are nonrenewable.

3 Only beneficiaries receiving psychiatric treatment from a Medicare-certified freestanding IPF on the day of entitlement are subject to a reduction in the length of this initial benefit period. Inpatient psychiatric use of hospital-based IPFs or general acute care hospitals on the day of entitlement would not trigger a reduction to the initial benefit period.

4 For example, if an individual spent 150 days in a Medicare-certified freestanding IPF ending on the first day of Medicare entitlement, Medicare would not cover any inpatient psychiatric days during the beneficiary's initial benefit period. However, Medicare would cover nonpsychiatric medical services received at general acute care hospitals up to the full initial benefit period.

5 Use of freestanding IPFs during the pre-entitlement period does not count toward the 190-day life limit. Medicare-covered days of freestanding IPF use during the initial benefit period would count toward the beneficiary's 190-day limit.

6 "Schizophrenia" includes schizophrenia and other psychotic disorders, bipolar disorder, and personality disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see https://www2.ccwdata.org/web/guest/condition-categories-other).

7 "Depressive disorders" includes major depressive affective disorder, anxiety disorders, and post-traumatic stress disorder. "Substance use disorder" includes alcohol use disorders, drug use disorders, and opioid use disorders. Conditions were defined by the presence of a diagnosis as of the end of 2022 (using, generally, a two-year look-back period; see https://www2.ccwdata.org/web/guest/condition-categories-other).

8 Full-benefit dually eligible beneficiaries include those with a status of "qualified Medicare beneficiaries," "specified low-income Medicare beneficiaries," and other types of full-benefit Medicaid coverage who meet eligibility criteria under the state plan. Other dually eligible beneficiaries receive partial benefits, in which Medicaid covers varying portions of Medicare Part A and Part B premiums and cost sharing (see https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office/downloads/medicaremedicaidenrolleecategories.pdf).

9 Our understanding is that Medigap does not provide coverage beyond the 190-day limit. We note that for about 5 percent of beneficiaries at or near the limit, Medicare is not the primary insurer; thus, additional IPF coverage from those beneficiaries' primary insurance is a possibility.

10 The Commission hired a contractor to conduct telephone interviews with officials at 10 IPFs between November 2022 and February 2023 to better understand services provided, patient mix, and challenges facing IPFs.

11 States with Medicaid managed care plans can pay for treatment in IMDs as an in-lieu-of service, which is a service that is not included under the state plan but is a clinically appropriate, cost-effective substitute for a similar, covered service. Under that authority, federal matching funds are available for the monthly payments to managed care plans for enrollees ages 21 to 64 who have an IMD stay if certain criteria are met (Congressional Budget Office 2023).

12 FFS Medicare beneficiaries affected by the limit and the comparison group of FFS Medicare beneficiaries were relatively similar on key characteristics such as the percent disabled (82 percent vs. 78 percent), percent under age 65 (81 percent vs. 77 percent), and percent with low-income status (89 percent vs. 86 percent).

13 When FFS spending increases, payments to MA plans also increase (reflecting the additional care that plans would be required to cover for their enrollees). The amount of increase depends on how much plans' bids increase in relation to the benchmark, their rebate percentage, and the share of MA beneficiaries in the county, among other factors.

14 Any increase in IPF stays would also increase Part B clinician services provided during the stay (for example, psychiatrist visits during the IPF would be billed under Part B). However, associated Part B services would decrease to the extent that there would be fewer stays in hospital-based IPFs or general acute care hospitals. Part D prescription drugs may also be affected: FFS Medicare

payments to IPFs and acute care hospitals include medications. Thus, to the extent that Medicare-covered inpatient days increase with the elimination of the 190-day limit, Part D drug spending could decrease.

15 Recent legislation though the CAA, 2023, sought to increase the supply of behavioral health practitioners by allowing services by licensed marriage and family therapists and licensed professional counselors to be covered by Medicare.

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