Acute inpatient psychiatric service provided to individuals with intellectual disability is a specialized field that has yet to attain support on a national basis. Articles have been prepared that detail the unique operations of the specialty units and clearly describe their positive clinical outcomes. However, the literature has very little data that supports the fact that a specialized approach is better than a generalized approach. The reports that do exist focus more on long-term care settings and not on acute hospital placement. Without a data driven road map to guide them, most social planners, medical economists, directors of state and local service delivery organizations, parents and advocates have chosen not to become involved in planning for acute inpatient psychiatric care for individuals with intellectual disability. They have left it up to the hospitals to do what they believe they should or can do and to the insurers who assume that, like any of their other acutely ill populations, individuals with intellectual disability can be managed as a population of general psychiatrically ill individuals and not as a population of psychiatrically ill individuals who also have intellectual disability and unique treatment needs.

Specialized inpatient psychiatric services is defined as a “unique inpatient service designed solely to meet the psychiatric treatment needs of individuals with intellectual disability.” The term specialized, then, requires a more extensive discussion since within the term there are levels of service intensity. Some specialized services are simply adaptive milieus with traditional diagnostic and treatment approaches while others are more multi-modal in approach, reviewing medical, behavioral, psychological and psychiatric issues before developing coordinated interventions.

Generally, there are no specialized standards of care for psychiatric individuals with intellectual disability, regardless of the location of their treatment (long term or short term). In Massachusetts three specialty units have been created (two in private hospitals and one in an academic medical center—The UMass Memorial Medical Center (UMMMC) and because of this, Massachusetts has offered a bit more focus on this population than has been available in most other states. However, in spite of this focus, only one insurer, the Massachusetts Behavioral Health Partnership (one of the Behavioral Health Managed Care Organizations for Medicaid), has created standards of care for the services they purchase on these units.

Although those standards set only the minimums of care, it is the first time the issue is being addressed. Unfortunately, any performance standards for specialized programming will only impact the small number of programs contracted as specialized programs (Medicare supports but does not recognize specialized programming of this nature). The standards do not impact the other non-specialized units that provide the bulk of the service to individuals with intellectual
disability where no specialized needs are planned or acknowledged. There are no standards for the insurer to require providers of general psychiatry to address the issue of provider competency in intellectual disability before they refer a individual for inpatient care.

On the specialized unit at UMMC, approximately 30% of admissions are supported by Medicaid as primary insurer, 63% by Medicare as primary and 7% by private insurers and other state payment sources. In 1999 in the United States 61% of the population was insured by private insurance, 10% by Medicaid, 13% by Medicare and 16% was uninsured. The private insurers spent only 32% of the total dollars spent on health care although their covered lives were practically double. The publicly assisted individual proportionally uses more health care resources than the privately insured individual. It is our experience that in the field of intellectual disability, the predominant insurance for individuals with intellectual disabilities and mental illness and who require psychiatric hospitalization is public and overwhelmingly Medicare.

Most behavioral health payers now acknowledge that they have a responsibility to provide acute inpatient psychiatric care to individuals with intellectual disability. However, at UMMC we are still required to handle several calls a year from small managed-care organizations who are attempting to deny access to an acute psychiatric admission for a individual with intellectual disability based solely on their diagnosis of intellectual disability, and not because of the psychiatric acuity of the accompanying psychiatric illness.

Insurers, providers and state authorities and regulators have not aggressively sought to define the nature of the ideal delivery system for inpatient psychiatric care for individuals with intellectual disability. For the public insurer there could be the legitimate fear of inordinate cost shifting to the acute insurance dollar of service costs already assumed elsewhere in a state’s budget. For the private payers the need is not defined as significant enough to address on a systemic basis, particularly if the insurer has few enrollees with intellectual disability and has small market share in multiple markets. On the provider side the ability to be creative is limited by the reimbursement formulas with even the most progressive administrators stating “No Margin No Mission.”

The lack of involvement of the state departments and authorities is clearly remarkable and potentially relates to the lack of an understanding of what force their voice would have if it were well articulated to the insurers. In addition, the lack of a “road map” with directions on what path to take makes the process more risky. Regardless of the indecision of the stakeholders as contributing to the lack of focus on this population, it is also important to note the changes in the past fifteen years in the service delivery system and the impact these changes also had.

Changing Demands on the System of Care

People with intellectual disability have a higher rate of mental illness. Given the necessity to treat certain psychiatric presentations with inpatient hospitalization, it is reasonable to assume that individuals with intellectual disabilities will be psychiatrically hospitalized at a rate at least equal to the population at large. Because of the dramatic successes in deinstitutionalization of individuals with intellectual disabilities and their movement to community based settings, the problems in developing effective acute inpatient psychiatric services for this population may be viewed as a fairly new development.

Between 1988 and 1994 the general discharges from general, acute inpatient psychiatric units increased by 35% in spite of the development of managed care approaches by many of the insurers. At the same time, overall hospital discharges increased less than 2%. In part this can be explained by an increase in the population of service user’s overall and community service provision. When individuals were housed in “total institutions,” their periodic need for acute intervention was most often managed by the institution. With deinstitutionalization and the move to community placements, more individuals were treated in the community. This, along with improvements in access to medical care and advances in medical technology, allows our communities to work with older individuals with additional illnesses that are associated with advanced life stages and with other medical conditions. Many of these individuals are new to the insurance rolls, new to the providers and in many ways new to the state.
authorities empowered to direct their community care since the care has been moved to the community and away from the institutions.

**Payment and Management Changes**

Managed-care entered into the general psychiatric service delivery systems in the late 1980s and early 1990s. The entry was prompted by dramatic cost increases in behavioral health expenses—both actual dollars and as a percent of overall medical costs. It also occurred simultaneously to the deinstitutionalization of individuals with intellectual disability, individuals with serious mental illness and individuals with a variety of co-occurring disorders. Community service delivery systems were forced to struggle to meet the needs of new populations with little or no preparation.

While the demand for more comprehensive community based services increased, the entry for managed care was not easy either. Managed care was quite controversial, often pitting physician against physician and insurance plan administrator against hospital administrator. Clinicians and service providers complained endlessly of unnecessary supervisory oversight of what previously had been an unmanaged experience. Physicians were used to providing care based on their own diagnoses and providing treatment based on their own assessment and timetable. They quickly became pitted against companies attempting to their decrease behavioral health expenditures by creating alternatives to high priced inpatient care to include a decrease in the length of inpatient treatment. During a ten year period ending in the late 1990s, the average length of stay for acute inpatient psychiatry dropped from over thirty days to less than ten days.

Most primary insurers did not have the internal expertise to create the systems to decrease behavioral health costs. Insurance companies were pushed to contract with private Behavioral Health Management Care Organizations (BHMCOs), whose sole corporate focus was managing behavioral health providers in their networks and the services that those organizations provided. Many of these new companies were either owned or managed by senior clinicians (including psychiatrists) who had experience on the delivery side and who assumed they could create savings through competitive contracting and creating efficiencies within existing systems.

The move to third-party behavioral health managers occurred in both the public and private sector. Of the major medical insurance providers, only Medicare remained solely responsible for the care their providers offered, and they continued to reimburse for this care through a long-standing prospective payment system that required only individual acuity and provider performance.

Other major payers moved aggressively into managed care practice. In many states Medicaid, the second largest public payer for behavioral health services behind Medicare, moved into managed care quite quickly. States sought and received federal waivers to allow the Medicaid dollar to be managed. Most states felt they did not have the expertise or the infrastructure to adequately manage care by using existing departments. They sought out BHMCOs who competitively responded for each contract that was released for bid. Private insurers were also aggressive in their move to managed care and many primary insurers developed relationships with BHMCOs to actually manage the care for their members. Some BHMCOs were hired to provide administrative services only (ASO), while others were contracted to go at risk for the costs of providing the services. This form of “carving out” the benefit to an at-risk entity is unique to behavioral health.

In the early 1990s, the fear of managed care was great. Many outpatient clinicians developed strategies to avoid managed care with outpatient clinicians relying on “cash only practices” to eliminate the oversight of a financial third party. A separate tier of outpatient care was created. Since inpatient care is significantly more expensive than outpatient care, with the exception of a comparatively small number of private pay inpatient units, most inpatient units either complied with managed care or became financially not viable.

In spite of the fears expressed in the 1990s, the actual experience of managed care has been easier to accept than most had anticipated. On a systemic level, the interventions that were implemented never created the catastrophes that anti-managed-care forces were sure would occur. While many argue that the present lengths of stay are a bit too short and the rates for payment much too low, most believe the development of community programming to support front door
diversions and inpatient step-down services actually improved care for many.

Most administrators of inpatient psychiatric programming would wish to have less oversight, but they recognize that the profession did not manage its own resources, and that the third party involvement has produced positive financial results for the insurers and the entity purchasing the insurance (employer and enrollee). In general, hospital administrators would say that over time, they have even developed reasonable working relationships with most of the BHMCOS.

Hospital trade organizations have also become effective in bringing BHMCOS to the table to look at service delivery issues, and the nature of most discussions are generally not adversarial. Among the issues the trades organizations in Massachusetts have successfully influenced have been clinical oversight processes, claims payment and appeal processes, admission access and credentialing issues.

**Dual Diagnosis (ID/MH) and Managed Care**

The past fifteen years of managed care have been filled with huge changes in the overall delivery system, and many of the changes have been created by or tempered by what feels to many providers as endless participation in work groups, task forces and advisory committees. With all this effort to develop systems and to positively impact the care provided to the general psychiatric population, little or no discussion occurred relating to psychiatric care for individuals with intellectual disability. This is surprising since the intellectual disability population is well insured, generally more service available than other mental health populations and frequently care managed by at least one organization.

While planning and policy discussion did not occur for delivery systems involving individuals with intellectual disability, individuals with intellectual disability did repeatedly surface. Intellectual disability becomes an issue when reports are drawn on: (1) acute access and individuals stuck in emergency departments awaiting acute psychiatric placement, (2) acute access and individuals stuck on medical surgical units awaiting acute psychiatric placement, (3) individuals and violent incidents (perpetrator and victim), (4) individuals stuck on inpatient psychiatric units with no community placement available, (5) individuals with multiple re-

admissions, especially to multiple hospitals, and (6) individuals on multiple psychiatric medications.

As was mentioned earlier, public policy initiatives including those associated with managed care, seek to be data driven. The dearth of available data with regard to the psychiatric inpatient service needs of individuals with intellectual disabilities has become increasingly problematic as the system has moved forward to contain costs. While data is needed, feedback from clinical and social advocates is also required. Unfortunately, in today's system, access to care is so difficult that advocates do not want to make demands on a system out of concern that future access could be compromised.

Managed care has not resisted improving the overall care delivery system for individuals with intellectual disability nor has it championed the cause. The primary insurers, be they public or private, have not extended the task to their BHMCO. State authorities and departments have been reluctant to push for improved care because in addition to not having a road map, they are concerned about potential cost shifts back to their limited service dollars that are already allocated and desperately needed. The true senior clinical leadership from the provider side is fully engaged in delivery issues and functions more as over taxed firefighters and not as social planners.

The voice of the intellectually disabled and psychiatrically impaired individuals is not being heard because it is not being brought to the table. Our lesson from managed care for general populations is that the BHMCOS can be engaged and influenced with solid thinking, organizational collations and provider responsiveness. Over the years there have been tremendously successful lobbying efforts to BHMCOS conducted by hospitals, professional trade organizations, individuals rights organizations and family organizations for general psychiatric populations but unfortunately no consolidated approach for individuals with intellectual disability.

**The Future**

During the past two years the largest singular change in the financial support mechanisms for general inpatient care since the introduction of managed care has been implemented by Medicare. The change was required by the Balanced Budget Refinement Act of 1999\(^1\) and was implemented January 1, 2005, following
several drafts that were circulated for comment. Medicare had been reimbursing on a cost based system with no case mix adjustment. The new change has established a national per diem reimbursement with adjustments. Some adjustments include psychiatric and medical co-morbidities; length of stay, medical education costs, emergency evaluation costs, electroconvulsive therapy (ECT) and certain individual demographics such as age.

This change is not designed to increase or decrease the national expenditure but was designed to more closely associate reimbursements to actual individual care costs. This change has gone into effect virtually without any comment from intellectual disability advocacy groups, mental retardation commissioners or legal advocates. Comments were requested but few occurred. While it is unclear how the new Medicare reimbursements will impact each hospital, (there is a gradual four-year phase in period) with the enormously high penetration of Medicare individuals on units specializing in intellectual disability, the impact will be significant and potentially of concern. The Medicare changes have specific targets and many believe some of these targets could have a negative impact on the inpatient treatment for individuals with intellectual disability. Physicians and hospitals must adapt the care they provide to meet the mandates of the payers in order to stay financially viable.

The list of adjustments/incentives/disincentives is extensive, and it is too early to determine what aspects of the physician’s care will be influenced by these changes. However, two important issues that must be addressed are the length of stay adjustments and the revised cost reimbursement protocols.

LENGTH OF STAY ADJUSTMENTS FOR LONGER LENGTHS OF STAY

Medicare did a thorough review of hospitals’ Medicare Cost Reports, looking at all Medicare admissions and determined that initial days in care are more costly. While this may be true with the general populations based on a review of the specialty unit at UMMC, it does not appear true on our intellectual disability specialty unit.

It is UMMC’s experience that the costs are evenly distributed throughout the entire length of stay. This fact is true, when we look at the aggregate of all admissions as well as when we look at cohorts of individuals by 10 day length of stay increments (i.e., individuals discharged on days 1 to 10, 11 to 20, 21 to 30 and 31 and up).

In the cohort review there was less than a 2% variation between the average daily costs for individuals discharged in any of the studied 10 day cohorts. This minor increase in cost does not easily compare to the front end loading of the initial days of treatment that are included in the new Medicare formula. Of interesting note is the actual distribution of the length of stay by individual. On general psychiatry units at UMMC, 74% of all individuals are discharged within the first ten days while the specialty unit discharges only 44.5% during the same time period.

Another concern is the notion that all individuals with intellectual disability can be treated within length of stay assumptions that are derived from general psychiatric populations. The Specialty Unit at UMMC had a length of stay that in 2006 was almost twice as long as the length of stay of the other 51 psychiatric beds (17.9 days on the specialty unit vs. 8.6 days on the general psychiatry units). The lengths of stay on the Specialty Unit have increased as the unit has become a New England resource and the acuity of the individuals has increased. The average length of stay for out of state individuals is longer than the in-state average.

It is also interesting to look closer at the actual distribution or clustering of the discharges. Figure 1 displays data drawn from discharge billings for the specialty intellectual disability unit at UMMC for the fiscal year 2006 (October 2005 through September 2006). The intellectual disability unit had only a few discharges (2.3%) from day one and two while the general units discharged 15.6% by day two. The intellectual disability unit discharged only 9% of by day six while the general units discharged 58.7% by the sixth day. The intellectual disability unit discharged 44.4% by day ten while the general units discharged 73.7% by the tenth day. On the other end of the length of stay continuum, the intellectual disability unit discharged 26% after the twentieth day and 9.1% after the fortieth day while the general units discharged 8% after the twentieth day and only 2.7% after the fortieth day.

In intellectual disability specialty care, few individuals stay for a short period of time and many stay for longer periods of time. It was felt that the few early discharges were most likely
transfers to medical floors because of acute medical issues and needed treatments while the short term discharges from the general units reflected clinical step-downs. It is also felt that the general units’ average length of stay includes a large number of days (potentially over 1,000 for the 51 beds) of individuals awaiting placement in long term care placements while the intellectual disability unit’s days reflect almost only acute days. UMMMC figures are drawn off billed days and include denied days and Administrative Necessary Days (ANDs).

An attempt to uniformly decrease the length of stay could prove to be clinically detrimental to individuals with intellectual disability. That is not to say that the intention of the Medicare reimbursement change is to decrease the length of stay for any particular individual with intellectual disability. But if a unit chooses to specialize in the treatment of persons with intellectual disability, and they have longer lengths of stay, Medicare reimbursements will probably not address the additional costs of providing the service for the specialty unit. To meet the financial requirements, treating physicians may choose to singularly focus their interventions on several identified symptoms and decrease the comprehensive evaluations/

Interventions that have become sought after by care managers. The potential for an unintended consequence is significant.

**Costs Reimbursement**

Under the new Medicare formula, the cost of providing inpatient care to individuals with intellectual disability is established by diagnostic categories and not functional categories. If the individual is integrated into a general psychiatric unit and treated in a general manner with the average amount of clinical acuity, the cost can be seen as relating to the norm and this is supported by the Medicare analysis. However, if the admission is to be viewed as more comprehensive, if the individual’s clinical situation is more complex with behavioral, medical, psychiatric and neurological complications, and if the individual is treated in a specialty unit, the costs will increase—not just every once in a while but in almost every case. The cost increase is driven by many factors including an increased need for multi-disciplinary diagnostic assessment and the associated treatments, higher numbers of staff trained in specialized behavioral interventions and an enormous amount of collateral work.¹,⁸

The unit at UMMMC admits a disproportionately larger number of individuals
with moderate to severe intellectual disability with individuals in the mild range more frequently being referred to general units. Virtually every individual admitted to the specialty unit has an active community provider, a family system or an assigned/inolved guardian, a community psychiatrist and a care manager from one of the assigned state agencies.

By reviewing cost data at UMMMC it is possible to begin to differentiate between the costs associated with the specialty population because analysis is of services within the same system of care. As was mentioned earlier, UMMMC operates three units, one that serves individuals with more severe/chronic mental illness including aggression, one that deals with a homogeneous population with the capacity to manage considerable medical acuities and the specialty, intellectual disability unit. The unit that specializes in the severely mentally ill is licensed as an acute unit but operates within a less expensive long-term care hospital. The other two units operate on the Medical Center campus and under the Medical Center’s license in expensive medical surgical space. The findings indicate that the utilized day cost of the intellectual disability unit is 55% higher than the general psychiatry units. All three units achieve occupancy targets of over 90% so reviewing by utilized day is a consistent variable. Within the per diem cost, the proportion of indirect costs are approximately 16% with direct costs of approximately 84% for all units. Therefore, the majority of the additional costs for the specialty unit are driven by direct costs with direct costs (staffing and other costs that directly interact with/touch the individual).

Medicare’s intention is/was not to negatively impact specialty units; however, clearly there will be an impact. Costs cannot be maintained if reimbursements do not support them. Given what we have learned from the UMMMC experience, the new Medicare reimbursement guidelines, should they remain unchecked, will dramatically reduce the resources necessary to provide effective inpatient services to individuals with intellectual disability.

In one of the more odd paradoxes, BHMCOs (managed care) who utilize specialty units like the UMMMC unit, do so with reimbursements at cost. Their penetration of enrollees with intellectual disability is low, and they are willing to pay above the “general market” and at cost to address periodic problems. Medicare, historically the only major payer who focused on reimbursing costs, is potentially moving away from doing this for specialized programs for individuals with intellectual disability.

**Conclusion**

Clinical and administrative leaders in the field of intellectual disability need to create a focus on inpatient psychiatric care for individuals with intellectual disability. They need to determine what it is that they believe the standard of care should be, and that access to care should be universally available. Once the field leadership identifies the best practice, we need to immediately develop dialogue with the payers. Managed care in the 1990s was successfully tempered by dialogue and lobbying. To best care for persons with intellectual disability, we need to establish this dialogue before unintended consequences change the system in a non-thoughtful manner.

While it would be wonderful to have data to drive this process, in the real field (where services are provided) we have professionals, we have families and we have guardians who have their experiences to guide their recommendations. These experiences could certainly inform planning, and although not quantitative in nature, the qualitative information will be moving and informative. Qualitative analysis of the service experiences of stakeholders is not an uncommon pathway to the development and improvement in social policy. More needs to be done to elicit an active dialogue between stakeholders, including service recipients and insurers. It is certainly clear that the new Medicare reimbursement system will not require improvements in the psychiatric care of individuals with intellectual disabilities. It is even uncertain that the changes will support the minor improvements that have been accomplished in the past decade. Advocates, administrators, clinicians, family members and concerned others must monitor the quality of care that hospitals are allowed to offer and enter into dialog with state officials, insurers and the hospitals to demand improvements where improved care is needed.

**References**


**Correspondence:** William H. O’Brien, MSW, Instructor in Psychiatry, Executive Director, UMass Memorial Behavioral Health System, Department of Psychiatry, 55 Lake Avenue North, Worcester, MA 01655; email: obrienw@ummc.org.