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# MEDICARE FINANCING FOR MENTAL HEALTH CARE

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by Judith R. Lave and Howard H. Goldman

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**Prologue:** Medicare, the federal health insurance program for the nation's thirty-one million elderly, spends just 3 percent of its budget on mental health. While new provisions in the federal budget reconciliations of 1987 and 1989 have liberalized the Medicare mental health benefit, "there is some fear that this small portion reflects an underuse of mental health services by Medicare beneficiaries," write Judith Lave and Howard Goldman. They assert that increasing access to mental health services for the elderly and disabled is an important agenda item for federal health policymakers, despite the current budget pressures to control costs. In this essay, the authors offer several steps for broadening such access to mental health services. Lave is a professor of health economics at the University of Pittsburgh Graduate School of Public Health and holds a doctorate in economics from Harvard University. Prior to her current position, she has served on the faculty of Carnegie-Mellon University; has directed the Office of Economics and Quantitative Analysis, under the Deputy Assistant Secretary for Health, Department of Health and Human Services; and has directed the Office of Research at the Health Care Financing Administration. Lave has engaged in joint projects, including this paper on Medicare mental health financing, with the Johns Hopkins University–University of Maryland Center on Organization and Financing of Care for the Severely Mentally Ill. Goldman is a professor of psychiatry at the University of Maryland School of Medicine and coprincipal investigator at the Johns Hopkins–University of Maryland center. He is also director of the national evaluation of the Robert Wood Johnson Foundation Program for the Chronically Mentally Ill. He holds a joint medical degree/master of public health degree from Harvard University, as well as a doctorate in social welfare research from the Heller Graduate School at Brandeis University. Goldman's career includes three years on the faculty at the University of California, San Francisco, and several stints at the National Institute of Mental Health, including the position of assistant director.

**U**nder the federal government's Medicare program, policies regarding mental disorders differ from those for physical disorders. Coverage of mental disorders is more limited, and payment rules sometimes differ for specialty mental health providers. Some of these distinctions were built into the program from its inception, whereas others were put into effect in 1983 with the implementation of the Medicare prospective payment system (PPS).

Less than 3 percent of the Medicare dollar is spent on mental health, and there is some fear that this small proportion reflects an underuse of mental health services by Medicare beneficiaries. At the same time, however, overall Medicare expenditures were \$81.2 billion in 1987 and are expected to increase rapidly. Faced with a budget deficit and anticipated shortfalls in Medicare funding, the federal government may look to mental health for savings. In this article, we review Medicare policies with respect to financing services for people with mental disorders and present some options for change.

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### Overview Of Medicare And Mental Health Coverage

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Medicare covers all people age sixty-five and over who are eligible for Social Security, have been receiving Social Security disability payments for at least two years, or have end-stage renal disease. Eligible people are automatically enrolled in Part A (Hospital Insurance) and can enroll in Part B (Supplemental Medical Insurance, or SMI) by paying a premium that is deducted from their Social Security check. Many states will pay the SMI premium for Social Security recipients who are eligible for Medicaid, and, by 1992, all states must pay the SMI premium for Medicare recipients who are poor.

Although disabled people (under age sixty-five) account for only 9.5 percent of the overall Medicare population, they use disproportionately more mental health services. For example, approximately 11 percent of all Medicare hospital discharges were disabled, whereas about 39 percent of Medicare discharges with a mental illness diagnosis were disabled.<sup>1</sup> This occurs because mental illness is one of the most common health conditions leading to disability early in life. Approximately 22 percent of the people who leave the labor force because of disability (and who are eligible for Social Security Disability Insurance, or SSDI) are disabled as a result of mental illness.

**Covered mental health services.** Medicare coverage for mental health services is limited. Some of these limitations result from Medicare's design as a "medical insurance" program that covers the cost of acute illness and the medical management of chronic illness. Thus, coverage

excludes many of the social support services and other long-term care services needed by people who are chronically ill. Since so many Medicare beneficiaries who use services for mental disorders are chronically mentally ill and need a wide range of services, the Medicare program does not meet their needs. Furthermore, the chronically mentally ill historically have been viewed as a state or local government responsibility.

Part A imposes a lifetime limit of 190 days of paid care in freestanding psychiatric hospitals. This limit assures that Medicare will not pay for the long-term custodial support of the mentally ill. There are no special limitations on the number of days for which Medicare will pay in treating mental disorders in general hospitals. However, hospital coverage is limited to ninety days in a benefit period. The benefit period begins with the beneficiary's first day of hospitalization and ends when the beneficiary has not been in a hospital or skilled nursing facility for at least sixty consecutive days. Since many people with mental illness are frequently in and out of hospitals, they are more likely than the average Medicare beneficiary to have "uncovered" days.

Medicare Part B pays 80 percent of approved charges after a deductible is met. Medicare coverage for physician services provided in inpatient settings is the same for both mental and physical treatment. Coverage in outpatient settings, however, differs for the two kinds of illnesses.

Medicare pays for the evaluation of mental disorders as it does for the evaluation of physical disorders, but its coverage for treatment differs. Originally, Medicare paid a maximum of \$250 (50 percent of approved charges up to \$500) for the treatment of mental disorders regardless of provider. (Treatment provided by family practitioners and internists as well as psychiatrists counts toward this limit.) The first major change in this policy came in 1984, when the Department of Health and Human Services (HHS) stated that "except for psychotherapy, physician treatment services for patients with Alzheimer's disease and related disorders are not subject to the \$250 limit." Next, under the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203), Medicare expanded its mental health coverage from \$250 to \$1,100 (or from 50 percent of \$500 to 50 percent of \$2,200). In addition, the act exempted payment for the medical management involved in prescribing, monitoring, and changing prescription drugs used in the treatment of mental disorders from the special dollar limits and cost-sharing provisions. These changes brought coverage of the medical management of people with chronic mental disorders into line with that of people with chronic physical disorders. Finally, the 1989 budget reconciliation (P.L. 101-239) removed the special limits on payments for psychotherapy (although the 50 percent cost sharing was retained), and provider status was extended to

psychologists and social workers.

In 1987, a partial hospitalization benefit also was added. Historically, hospital-based partial hospitalization programs have been reimbursed by some Medicare intermediaries under Part A, while physician services were billed under Part B, subject to the special limits on the treatment for mental disorders. Freestanding partial hospital programs were often considered outpatient providers, covered only by Part B and subject to the special limits applicable to mental health.<sup>2</sup> The new statute made partial hospitalization an explicit benefit and called for regulations to be published in 1989. These regulations have yet to appear.

These recent changes have led to a significant increase in the coverage of outpatient services. The hope is that the increase will improve not only access to needed services but also the efficiency of treatment by providing alternatives to hospitalization.

**Paying for services.** Under Part A, Medicare pays differently for services provided by psychiatric hospitals and (most) psychiatric units in general hospitals than it does for services provided by general hospitals. When Medicare PPS was implemented, these psychiatric providers were exempted from the new system, because, it was argued, the diagnosis-related group (DRG) classification system was inappropriate for psychiatric cases. These providers are paid for under the Tax Equity and Fiscal Responsibility Act (TEFRA) rules, whereby a target amount per discharge is established each year. For providers that were exempted in the first year of PPS, this amount is based on the providers' 1981 costs and has been updated since 1983 by the PPS update factor. For providers that were exempted after the first year of PPS, this amount is based on their estimated costs in the year they became exempt (or, for new providers, the year they started operation). This amount also is updated by the PPS update factor. If costs are below the target cost per case, the providers keep 50 percent of the difference between the target and the actual cost per case, up to 5 percent of the target amount. If costs exceed the target, then the hospitals are paid the target cost per case. (An exceptions process allows providers to appeal the target amount. It is too early to tell how this has affected actual payments.)

Under Part B, providers are paid "customary, usual, or prevailing fees" for treating both mental and physical disorders. However, as noted above, the cost-sharing rules are different for mental health. Until 1984, patients paid 20 percent of approved charges for inpatient care and 50 percent of charges for outpatient care. Now, cost sharing for most treatment provided to patients with Alzheimer's disease and for physician services related to prescribing, monitoring, and changing prescription drugs are subject to 20 percent cost sharing.

**Data on the current system.** There are no data that show a complete picture of the use and financing of mental health services under Medicare. Since many people with mental disorders need long-term care and other services not covered by Medicare, a smaller proportion of their health care expenditures are addressed via Medicare than is true for the general Medicare population. For those services Medicare does cover, however, data are available.

Exhibit 1 provides the most recent data on Medicare expenditures for identifiable alcohol, drug, and mental health services. These numbers underestimate actual payments for such services because they do not include payments for services provided by physicians other than specialty mental health providers. These data indicate the following.

(1) In 1987, approximately 2.7 percent of Medicare payments were for

**Exhibit 1**  
**Estimated Medicare Payments, In Millions, Total For Identifiable Mental Health And Alcohol/Drug Services, Fiscal Years 1984–1987<sup>a</sup>**

Part A	FY1984		FY1985		FY1986		FY1987	
	Total <sup>b</sup>	Alcohol/drug, mental health payments	Total <sup>b</sup>	Alcohol/drug, mental health payments	Total <sup>b</sup>	Alcohol/drug, mental health payments	Total <sup>b</sup>	Alcohol/drug, mental health payments
Total	\$41,476	\$1,274	\$47,841	\$1,571	\$49,018	\$1,782	\$49,813	\$1,915
All inpatient hospital								
Total	39,080	1,031 <sup>c</sup>	45,017	1,287 <sup>c</sup>	46,042	1,473 <sup>c</sup>	46,842	1,597 <sup>c</sup>
PPS	15,515	163	35,743	387	40,885	552	41,755	362
Non-PPS	23,565	868	9,274	900	5,157	921	5,087	1,235
Alcohol/drug use, except toxic effects <sup>d</sup>	-	137	-	162	-	189	-	201
Poisoning and toxic effects of drugs <sup>e</sup>	-	106	-	122	-	120	-	117
Skilled nursing facility	535	N/A	567	N/A	568	N/A	627	N/A
Home health and hospice	1,861	N/A	2,257	N/A	2,408	N/A	2,344	N/A
<b>Part B</b>								
Total	\$19,473	\$177	\$21,808	\$187	\$25,169	\$222	\$29,937	\$253
Physician supplier <sup>f</sup>	15,915	177*	17,852	187*	20,200	222*	24,109	253*
Outpatient and home health	3,558	N/A	3,956	N/A	4,969	N/A	5,838	N/A
<b>Total</b>	<b>\$60,000</b>	<b>\$1,451</b>	<b>\$69,649</b>	<b>\$1,758</b>	<b>\$74,187</b>	<b>\$2,004</b>	<b>\$79,750</b>	<b>\$2,168</b>

Source: Unpublished Health Care Financing Administration data.

Note: Numbers may not sum due to rounding.

<sup>a</sup> Estimates of actuarial benefit payments are based on calendar year or fiscal year distributions of billed charges, depending on availability.

<sup>b</sup> Estimated benefit payments for all medical conditions.

<sup>c</sup> Represents DRGs 424–432: mental diseases and disorders, regardless of type of hospital.

<sup>d</sup> Represents DRGs 433–438: alcohol/drug use and alcohol/drug-induced organic mental disorders.

<sup>e</sup> Represents DRGs 449–451: poisoning and toxic effects of drugs.

<sup>f</sup> Includes independent lab.

\* Represents all services by psychiatrists, psychiatric osteopaths, and independent psychologists, regardless of whether they were subject to the mental health coverage limits. Does not include services by other specialties.

identifiable alcohol, drug, and mental health services. This allocation differs from private health insurance programs, for which an estimated 7 to 18 percent of expenditures are for these services.<sup>3</sup> One obvious factor contributing to this disparity is the relatively more limited coverage of mental health services under Medicare during this time period. For example, the 1987 American Psychiatric Association (APA) survey of employer health plans found that half of employer-based plans paid over 50 percent of the cost of outpatient treatment. At the same time, almost all plans had an annual maximum of cost they were willing to share. However, 60.8 percent set the maximum at over \$1,500—\$1,000 more than the Medicare maximum amount in effect that year.<sup>4</sup>

(2) In 1987, 88.3 percent of expenditures on identifiable mental health services were under Part A; 62.7 percent of overall Medicare expenditures fell under Part A. This difference is largely due to the more limited Medicare coverage of mental illness relative to other illnesses. It is interesting to note that since the implementation of PPS, the Part A share of Medicare benefits payments decreased more than five percentage points for overall Medicare expenditures, while it increased nearly one percentage point for expenditures for alcohol, drug, and mental health services. While this may be due in part to the difference in payment rules, we suspect that differences in the extent of outpatient coverage for the two kinds of illnesses play a role as well. (Mental disorders are subject to cost sharing of 20 percent for inpatient physician services and 50 percent for outpatient, whereas physical illness requires only 20 percent cost sharing in the outpatient setting.)

(3) Expenditures on identifiable mental health services have been increasing at a faster rate than overall Medicare expenditures. Some of this difference is due to the increasing numbers of people who are eligible for Medicare because they are enrolled in SSDI as a result of mental illness. The Health Care Financing Administration (HCFA) does not publish data on disabling conditions for the Medicare disabled, with the exception of end-stage renal disease. However, we can get some inkling about the increase in mental illness-related disabled in Medicare between 1984 and 1987 by noting that, between 1982 and 1985, the number of people enrolled in SSDI because of mental illness increased by 67.5 percent (from about 286,000 to 480,000). These people, if continuously enrolled in SSDI, would have become eligible for Medicare two years later. Even if only half of them were continuously enrolled, the increase in mental illness-related disabled would have been 22.7 percent, compared to an increase in the overall Medicare population of 7.9 percent. Since the rate of increase in the number of people enrolled in SSDI because of mental illness remains high (between 1985 and 1987, it was 28

percent), we would expect the number of Medicare beneficiaries whose disabling condition is mental illness to continue to increase faster than the Medicare population in general.<sup>5</sup>

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### Options For Change

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**Medicare's current philosophy.** During this era of cost containment, the government has attempted to devise rules and regulations to make the delivery of health services more efficient. In mental health, efforts have focused on reducing the fragmentation of care in the highly differentiated system of services.<sup>6</sup> This system is most troublesome for the chronically mentally ill, whose needed services are currently provided by a variety of government agencies.

The overriding question about the role of government is whether government should provide mental health services as a right or as a privilege—to fulfill a universal expectation or to be a provider of last resort. Medicare is regarded as an “earned right,” albeit to a restricted set of services. Medicaid is a means-tested program that also pays for Medicare beneficiaries who are poor. Services covered by Medicaid vary from state to state, indicating a lack of national consensus about the role of government as a provider of health care services for the poor.

In our discussion of options for change in Medicare, we accept Medicare's current philosophy; that is, it is essentially designed to pay for the evaluation and treatment of acute medical conditions and of episodic acute conditions associated with chronic physical or mental disorders. We address primarily those policies for which coverage and/or financing of mental disorders is different from those of physical disorders. To some extent, the question of parity underlies the analysis: Should the treatment of mental disorders be covered differently than the treatment of other disorders?

**Part A: the 190-day lifetime limit.** The 190-day lifetime limit on the number of covered days in freestanding psychiatric hospitals does not restrict the use of inpatient services, only the place where they are delivered. This limit is credited with encouraging the growth of inpatient psychiatric units in general hospitals, while discouraging somewhat the use of freestanding psychiatric hospitals by Medicare beneficiaries.

Since 1965, only 17,000 Medicare beneficiaries have bumped up against this limit.<sup>7</sup> However, this limit may have influenced the choice of psychiatrists or providers used by some beneficiaries. In addition, since an unlimited number of days are covered in general hospitals (subject to the constraint imposed by the benefit period), it is unlikely that the 190-day limit has had any significant effect on either access to care or the overall

number of inpatient days paid for by Medicare.

Nevertheless, the policy does have some disadvantages. First, the limit could lead to discontinuity in care; a beneficiary could be under the care of a psychiatrist who has privileges only at a freestanding hospital. Thus, beneficiaries who exceed their limit (or are close to it) and need hospitalization will need to change physicians. Second, Medicare beneficiaries who are initially enrolled in Medicare because they have been on SSDI for two years are more likely to run up against the limit, both because they are more likely to be hospitalized in any given year and because they are likely to be Medicare beneficiaries for a longer period of time. This policy then discriminates against a particular group of beneficiaries. Finally, regarding payments, the freestanding facility would receive nothing for a patient who had exceeded the limit but needed an acute hospitalization, whereas the general hospital would receive payment.

Some policy analysts have recommended that the 190-day limit be replaced with an annual limit. Sixty days, which is the limit set in the CHAMPUS program, is frequently mentioned. In 1986, 21 percent of Medicare psychiatric discharges had more than sixty days of care. Although we know that 67 percent of these beneficiaries had more than one admission and that 56 percent were on Medicare because of disability, we know little else about them.<sup>8</sup> Some of these beneficiaries may have remained in the hospital because the limited outpatient coverage that prevailed in 1986 made it difficult to receive care in ambulatory settings. However, with the coverage of partial hospitalization and the recent expansion of outpatient coverage for mental illness, incentives to keep patients in the hospital for that reason should be diminished. Some patients may be there for strictly custodial reasons, although this is counter to current Medicare policy.

Given what is known about the supply response to the setting of annual limits, we expect that the setting of a sixty-day annual limit would significantly decrease the length-of-stay of these patients.<sup>9</sup> We suspect that many patients would be forced into state hospitals or other forms of uncompensated care. These beneficiaries now are covered in general hospitals, subject only to spell-of-illness limits. If an annual limit were imposed, beneficiaries hospitalized for psychiatric disorders would be treated quite differently from those hospitalized for all other disorders.

We recommend that the 190-day lifetime limit be eliminated. This would increase patients' choice and treat the freestanding psychiatric hospitals more fairly. However, since the cost per case in freestanding hospitals is higher than in general hospitals, this policy would lead to a small increase in Medicare costs.<sup>10</sup>

**Part A: paying the hospitals.** Freestanding psychiatric hospitals and



qualified psychiatric units of general hospitals are exempted from PPS and are paid under the TEFRA rules described earlier. Introducing such a major change as DRGs into the differentiated mental health system likely would have resulted in significant cost shifting and unpredictable (and potentially adverse) consequences for Medicare beneficiaries.<sup>11</sup>

The payment limits created by the target rate constrain hospital costs and Medicare payments. Utilization rates have not risen; thus, hospitals do not appear to have responded to these constraints by significantly increasing admissions. However, four real or perceived problems exist within the current system. First, as stressed by providers, rates are “too low.” Established providers argue that the technology for treating mental disorders has changed significantly since 1981, a fact not reflected in their cost bases. Second, the cost bases of new units and new hospitals reflect the diffusion of technologies, resulting in some inequity in the treatment of “old” versus “new” providers. Third, length-of-stay and cost per case differ among excluded providers. These differences are not likely due to variation in the patient population, and the current payment system does not provide strong incentives to reduce them. Finally, hospitals bear payment risks unduly. Hospitals get only 50 percent of the savings (up to a maximum) if their costs are below the target rates, while they bear 100 percent of the losses if the rates exceed the target amounts.

We recommend that the system be rebased using more recent cost information. In addition, we recommend that peer groups be established so that the hospital’s target cost per case for subsequent years would depend not only on the politically set update factor but also on a limit tied to the mean cost of the hospitals in its peer group. These groups could be established by adjusting for a hospital’s involvement in graduate medical education, location, area wage index, DRG psychiatric case-mix, region of the country, and type of facility. If the hospital’s costs exceed the new target amount, it should receive the target amount plus some fraction of the difference between its costs and the target amount. (The limit on the government’s “cost sharing” could be set at some proportion of the target. In the first year, the hospital should be held harmless; that is, its payment should not be lower than its previous year’s costs.) If the hospital’s cost per discharge is less than the target amount, it should receive some fraction of the difference between the target amount and its costs. We note here that HCFA has contracted with the Center for Health Economics Research and Boston University to examine options for restructuring payments to exempt providers.

**Part B: the Medicare outpatient benefit package.** In 1966, most people had limited coverage for outpatient mental health benefits. Typically, an employee group policy covered 50 percent of outpatient expenditures up

to a maximum of about \$500. Outpatient mental health benefits were so limited for several reasons. The chronically mentally ill population was viewed as homogeneous and in need of primarily inpatient services. Outpatient treatments were considered discretionary and responsive to the price of care. Finally, the efficacy of certain therapies was questioned. When Medicare was established, it emulated private-sector policy in defining its outpatient mental health benefits as it did in defining its other benefits and payment policies; thus, it put in place a restrictive benefit.<sup>12</sup>

However, since Medicare's implementation, the scientific basis for psychiatric treatments has increased. The medical management of chronic mental disorders has come to resemble that of chronic health disorders.<sup>13</sup> In the private sector, the coverage of outpatient mental health services has been expanded, although it continues to be more restricted than that of other health services.

Data from the Epidemiology Catchment Areas (ECA) program, a program supported by the National Institute of Mental Health (NIMH) to use state-of-the-art approaches to estimating the prevalence of mental illness, indicate that approximately 12.3 percent of the elderly have some diagnosable mental disorder.<sup>14</sup> However, the elderly are less likely than others to seek treatment for these disorders, and much less likely to obtain care from specialty mental health providers.<sup>15</sup> Reasons for this relatively low use include the following: (1) Older people may not seek treatment for mental illness because they are unaware or deny that they are ill. Also, the stigma of mental illness may keep them from demanding mental health services. (2) Physicians may not identify the problem correctly; they may believe that the symptoms are only part of the natural aging process, or they may not want to treat them. (3) Coverage of outpatient mental health benefits under Medicare is low, thus influencing the demand for such treatment because of price.<sup>16</sup>

We conclude that use of mental health services by the elderly is currently too low, and that policymakers need to be more concerned about underuse than about overuse of these services. While use may have increased somewhat in response to OBRA 1987, we are concerned about how that legislation is being implemented. It is possible that Medicare might pay only for brief office visits and that if a physician spends more time with the patient, the additional time may be construed as providing services not related to the management of the patient's drug regimen. This fear is not groundless. Since physicians must include a diagnosis with every bill submitted, any bill with a mental disorder diagnosis may be rigorously scrutinized.

We recommend that the rules defining "medical management of psychotropic agents" be carefully monitored to ensure that they do not limit

payment to brief office visits only. We also recommend that the special cost-sharing provisions for other outpatient mental health treatments (such as psychotherapy) be dropped. Such a change may require that the limit on approved charges be reimposed as a cost-control measure. Taken together, these shifts in policy would increase access to services.

**Long-term care.** Many people with mental disorders are chronically mentally ill. They need social support services, help with daily living, and a supportive living environment. In this respect, they are similar to many other Medicare beneficiaries, although they may need a more extensive range of services than Medicare typically covers. Some Medicare recipients, those with low enough incomes to entitle them to Medicaid or who “spend down” to Medicaid, have access to a broader set of services.

The limited range of services covered by Medicare has been a concern since the inception of the program. While current policy regarding long-term care should be evaluated, consistency is needed. The long-term care benefit package should be no different for Medicare beneficiaries who are mentally ill than for others. We support increased federal involvement in the financing of long-term care for the mentally ill; however, such changes are more sweeping in nature than may be politically acceptable now, given our assumption of no fundamental change in Medicare. Thus, we do not offer detailed recommendations here.

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## Conclusion

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Most of the recommendations we have outlined above will lead to modest increases in the cost of Medicare. Some savings may result from a substitution of outpatient for inpatient services if the outpatient benefit package is enriched. There may also be some small savings from the imposition of peer group limits under the proposed change in inpatient payment policy. Under the best of circumstances, these savings will be small. Our intent, however, is to increase the welfare of Medicare beneficiaries by increasing their access to mental health care.

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## NOTES

1. The numbers are derived from data in M. Freiman, H. Goldman, and C. Taube, "Hospitalization for Psychiatric Illness under Medicare, 1985," *Hospital and Community Psychiatry* (January 1990).
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