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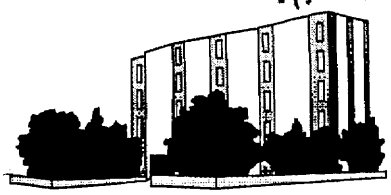

Breaking with the Past:

How New York's Private Psychiatric Hospitals Have Managed Since Managed Care

New York State Commission on Quality of Care
for the Mentally Disabled

April 1996

Breaking with the Past:

How New York's Private Psychiatric Hospitals Have Managed Since Managed Care

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April 1996

NYS Commission
on Quality of Care
for the Mentally Disabled

Executive Summary

Offering acute care services similar to inpatient psychiatric units of general hospitals, 11 for-profit psychiatric hospitals operate in the State of New York pursuant to Article 31 of the N.Y. Mental Hygiene Law (MHL). Only individuals or their closely held corporations are allowed to operate these businesses, because state law and regulation which require that individual owners be subjected to character and competence reviews effectively prohibit investor-owned corporations from obtaining operating certificates to run these facilities (MHL §31.22; 14 NYCRR 573.2, 582.4). With over 1,100 beds and serving some 14,000 patients annually, private psychiatric hospitals represent an important part of New York's inpatient psychiatric service capacity.

The 1990s have brought about significant changes in these facilities mainly as the result of managed care initiatives by private insurance carriers attempting to rein in the growing outlays for psychiatric care. The most significant influence that managed care has had over these hospitals is the role of "gatekeeper" over admissions and extended lengths of stay. Managed care firms typically require approval for non-emergency admissions and also monitor ongoing stays for medical necessity. Less expensive outpatient treatment is promoted in lieu of inpatient services. The control managed care has placed over insurance monies covering psychiatric care has clearly been effective in reducing insurance outlays to these facilities which, in turn, has resulted in increased dependency on Medicaid and Medicare revenues to keep these hospitals financially viable.

Scope of Review

Against this backdrop and as managed care moves inexorably forward, the Commission conducted this study to examine the service role of private psychiatric hospitals, their quality and cost of care, and the access to and utilization of their services particularly by individuals whose care is paid for by Medicaid or Medicare. The Commission additionally sought to evaluate the management practices and the relative competitiveness of these hospitals, especially in view of the reported abuses and profiteering in other regions of the country[1] and as the state considers greater reliance on them as an alternative to hospital stays in the shrinking state-operated psychiatric hospital system.

Moreover, with the unprecedented application of managed care techniques to mental health care, and at a time when the type and quality of care are coming under increased scrutiny, the Commission attempted to weigh the ramifications of for-profit involvement in private psychiatric hospitals as well as the safeguards that might be necessary to prevent the types of abuses found in other parts of the country as more government monies flow to these hospitals.

Study Methods

In carrying out this study the Commission looked at the programmatic and fiscal operations of New York's private psychiatric hospitals and gathered substantial amounts of financial and service utilization statistical data to enable an examination of hospital trends over a five-year period.

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[1] See, e.g., Joe Sharkey, *Bedlam*, St. Martin's Press, New York, 1994.

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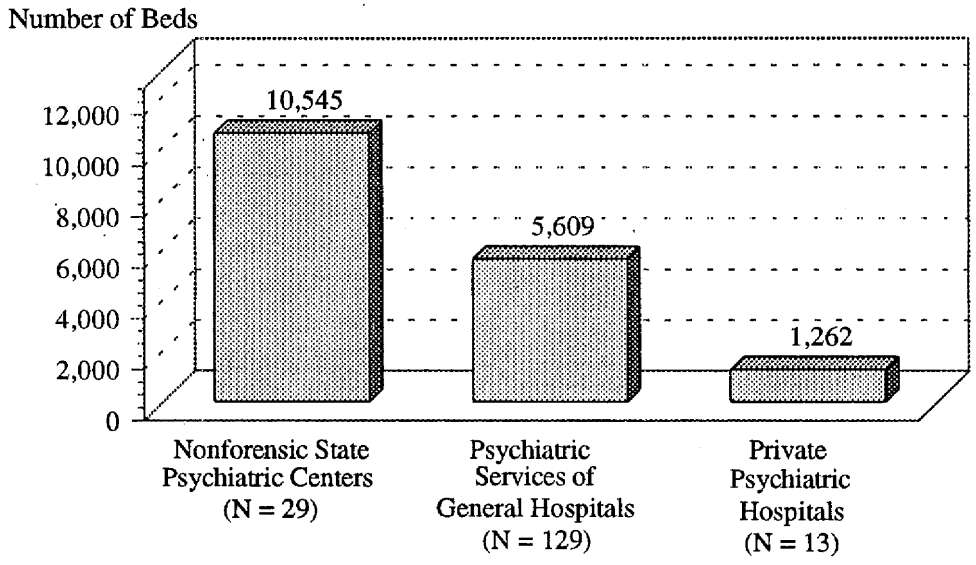
Chapter I
Introduction

Eleven private psychiatric hospitals, certified under Article 31 of the Mental Hygiene Law, currently operate in New York State.[3] Providing largely acute psychiatric inpatient care, private psychiatric hospitals offer services similar to the 129 certified psychiatric services of general hospitals in the state. Both private psychiatric hospitals and psychiatric services of general hospitals are different from New York's 29 state-operated public adult and children's psychiatric centers in that they typically do not provide intermediate and long-term inpatient care.

As shown in Figure 1, private psychiatric hospitals have a smaller inpatient psychiatric bed capacity within New York than either psychiatric services of general hospitals or state psychiatric centers. Yet, private psychiatric hospitals served more than 14,000 individual patients in 1993, reflecting a substantial part of New York's inpatient psychiatric service capacity.

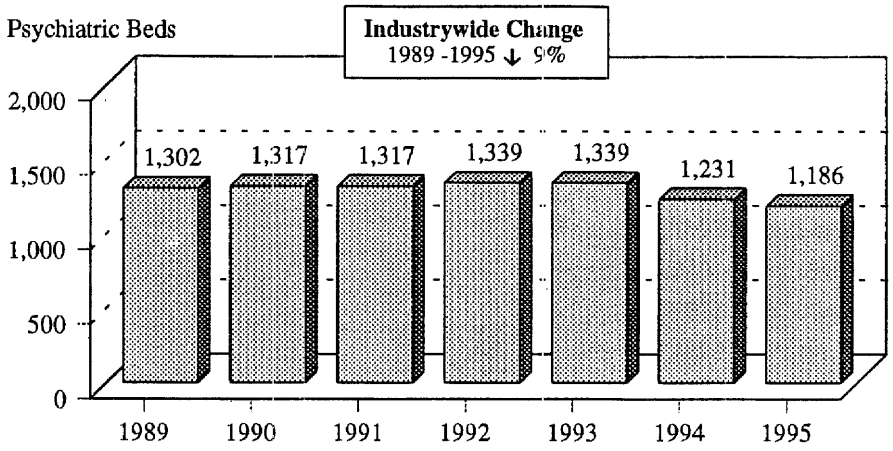
Figure 1
NYS Psychiatric Inpatient Beds* by Auspice
(March 1994)



* For psychiatric services of general hospitals and private psychiatric hospitals, the number of beds reflects official certified bed capacity. For nonforensic state psychiatric centers, which do not have an official certified capacity, the number of beds reflects patient census in mid-March 1994.

[3] At the onset of the Commission's study, 13 private psychiatric hospitals were in operation. Regent Hospital and High Point Hospital have since closed.

Figure 2
NYS Private Psychiatric Hospital Beds
(1989-1995*)



* Bed census as of December 31.

In 1993, New York's 13 private psychiatric hospitals had 1,339 certified beds. By the end of 1995, two hospitals had closed and others had taken beds out of service. Private psychiatric hospitals have reserved most of their operating beds for adult services, but all hospitals also have at least one and usually two children/adolescent units.[4]

Long Historical Roots

All but three of New York's private psychiatric hospitals have operated in the state for more than 30 years, and three have been in operation for more than 60 years. Simultaneously, while the state's private psychiatric hospital industry has not expanded as greatly over the past two decades as the industry has grown in some other parts of the country, in response to the flood of commercial insurance money for mental health, three new private psychiatric hospitals, with a total of 220 certified inpatient beds, opened in New York State since 1977—Regent (1978), Holliswood (1986), and Four Winds-Saratoga (1986). However, due to allegations of a national conspiracy to defraud the government and insurance companies, Regent Hospital, with a certified capacity of 37 beds, closed in 1994 reportedly due to actions taken by the U.S. Department of Justice against its management firm, National Medical Enterprises. In 1995, High Point Hospital, with a certified capacity of 45 beds, also closed after its owner/operator died and the attorneys handling the estate filed a Plan of Decertification with the Office of Mental Health (OMH).

Thus, as private psychiatric hospitals have closed their doors and some have downsized, the number of private psychiatric hospital beds in the state has decreased from 1,302 beds to 1,186 beds, or 9%, from 1989 to 1995 (Figure 2).

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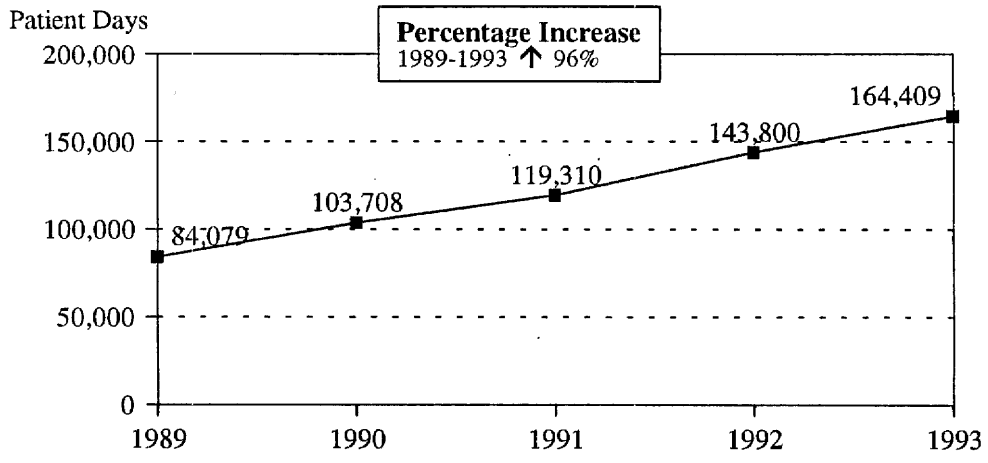
[4] As the New York State Office of Mental Health has no formal regulatory designation or standards for children and adolescent versus adult inpatient psychiatric units, these designations remain informal, and hospitals may legally serve a child or adolescent on an adult unit or vice versa.

The 1990s Brought Service Role Changes

Today, while many individuals with private insurance coverage continue to seek mental health inpatient services from private psychiatric hospitals, a combination of external forces, including fiscal necessity related to less insurance money because of managed care, and public policy decisions related to the downsizing or closure of state-operated adult and children's psychiatric centers, have encouraged private psychiatric hospitals to open their doors to a wider patient population, especially to children and adolescents eligible for Medicaid reimbursement, and elderly individuals eligible for Medicare reimbursement.[5] As shown in Figure 3, since 1989, there has been a 96% increase in the number of patient days billed to Medicaid and Medicare by private psychiatric hospitals. As private psychiatric hospitals have more substantially entered the arena of publicly supported mental health services, their importance to and influence upon the state's overall system of mental health services has grown.

In this report, the Commission takes a look inside this industry, examining the role and nature of service provision by private psychiatric hospitals; their revenues, costs, and profits; their service population; and, the quality of their services and care. There is a targeted focus on the changes which have transpired in this industry in the brief five-year period from 1989 to 1993.

Figure 3
Patient Days Reimbursed by Medicaid and Medicare
at NYS Private Psychiatric Hospitals
(1989-1993)



[5] Under the Medicare program, the federal government acts as the insurer for elderly beneficiaries. Medicare Part A, which is funded by wage taxes, is a compulsory insurance program that provides benefits for hospital and hospital-related services. Medicare Part B is a voluntary insurance program that provides coverage for physician services and is funded by premiums paid by beneficiaries and contributions from the federal government. The Medicaid program is a medical assistance program between the federal and state governments that provides benefits for the needy and the "medically needy." In New York, the program is generally funded by the federal government (50%), the state (25%), and localities (25%).

The Commission's Review

The Commission's review focused on five main areas:

- the service role of private psychiatric hospitals and specifically their service provision to persons with serious and persistent mental illness and individuals whose bills are paid by Medicaid or Medicare;
- the impact of managed care firms in altering the service utilization patterns of private psychiatric hospitals, including their admission criteria, lengths of stay, and discharge planning services;
- an assessment of the quality of the care and services provided by private psychiatric hospitals;
- an examination of the impact of managed care on the financial profile of private psychiatric hospitals, including their revenues, expenditures, and profits/losses; and,
- future policy and fiscal considerations for New York State as it considers the resources, limitations, and possible risks of greater reliance on private psychiatric hospitals for services to persons whose care is reimbursed by Medicaid and Medicare.

Methods

In addressing these issues, a number of specific research and fiscal review activities were performed.

- **On-site reviews at 8 of the 12 private psychiatric hospitals operating in New York State during 1994**

These visits, each of which spanned three days and were conducted by teams of two to three Commission staff, focused on a programmatic review of the hospitals, examining a range of issues, including treatment assessments and treatment planning, medication practices, the provision of therapies, the use of restraints and seclusion, and discharge planning. In addition, Commission staff were attentive to the basic custodial care and environmental conditions of the hospitals, their provisions for reasonable patient liberties, and the involvement of patients and, as appropriate, their families in patient care and treatment. While on-site, Commission staff also asked patients at each hospital to complete a consumer satisfaction survey.

At the end of each review, Commission staff offered hospital administrators a preliminary closing conference; formal written findings reports were also prepared and sent to each hospital reviewed. As warranted, the Commission also requested specific plans of correction from the individual hospitals.

- **Statistical reviews of service and fiscal data from 1989 through 1993 for the 12 private psychiatric hospitals in operation during 1994**

Relying on data reported on Institutional Cost Reports (mandated by the New York State Department of Health) from hospitals, service utilization and financial trends were examined. Fiscal data was analyzed over the five-year period to identify revenue, cost, and profitability patterns among the individual hospitals. Similarly, service provision data related to the number of patients served, changes in the age of the service population, length of stay, and occupancy rates allowed an empirical analysis of the service role of private psychiatric hospitals individually and industrywide over the five-year period and the relationship of these factors to hospital financial trends.

- **On-site financial reviews at six of the private psychiatric hospitals**

On-site fiscal reviews of selected private psychiatric hospitals allowed Commission staff to meet with senior management personnel to better understand the management and fiscal practices of the hospitals. By examining records and management contracts, the Commission sought to verify the accuracy and completeness of data reported on Institutional Cost Reports and to clarify hospital profitability which might have been hidden by related party transactions.

- **Interviews with representatives of two managed care firms which work closely with New York's private psychiatric hospitals**

While visiting the private psychiatric hospitals, Commission staff repeatedly heard that managed care firms were shaping the hospitals' service delivery and influencing both their clinical and fiscal decision-making and policy. Based on these reports, the Commission scheduled informal meetings and interviews with senior management staff of two managed care firms: Value Behavioral Health and Independent Health, which monitored insurance stays at New York's private psychiatric hospitals. Common issues addressed during these meetings included: criteria and recruitment of authorized providers, procedures for enrollees' referrals and access to psychiatric services, criteria and procedures used by the firms in authorizing inpatient hospitalizations and determining lengths of stay for which they will reimburse, and enrollee complaint and appeal processes.

Each meeting also included discussion of how the managed care firm negotiated contracts and per diem rates with individual private psychiatric hospitals. This subject was of special interest to the Commission as other data indicated that managed care firms' contract rates sometimes varied significantly for different hospitals and that per diem rates paid by different managed care firms at the same private hospital varied by as much as 50%.

Organization of the Report

Findings of the review are presented in four chapters.

- Chapter II provides an overview of the private psychiatric hospital industry in New York, delineating both the historical role of these hospitals in the provision of psychiatric care and the significant changes which have transpired in their services and service population in the past decade.
- Chapter III provides an overview of the quality of care and services at the eight private psychiatric hospitals visited by Commission staff.
- Chapter IV examines the impact of managed care on hospital finances and lengths of stay at private psychiatric hospitals in New York, as well as their increased dependence on Medicaid and Medicare as a revenue source over the five-year period from 1989 to 1993.
- Chapter V looks at the ownership relationships of hospitals and their impact on hospital costs/ profitability.
- Chapter VI presents the Commission's conclusions and recommendations, with a focus on the future role and public policy considerations for New York, as the role of private psychiatric hospitals in the public mental health system expands.

Chapter II
New York State's Private Psychiatric Hospital Industry

Despite their long-standing presence in New York State, private psychiatric hospitals have historically been a psychiatric treatment resource used by only a small segment of its citizens. As discussed in this chapter, the reimbursement for private psychiatric hospitals, their self-defined clinical role and specialties, and their geographical locations, had historically limited their role to the high end of the mental health and addiction market.

The 1990s have, however, brought significant changes to the state's private psychiatric hospitals which have affected their financing, the individuals they serve, and their services. Most significantly, these changes have brought the private psychiatric hospital industry more into the sphere of the publicly financed mental health system, and they have also resulted in these hospitals providing services to more individuals with serious and persistent mental illness.

The Historical Role of Private Psychiatric Hospitals

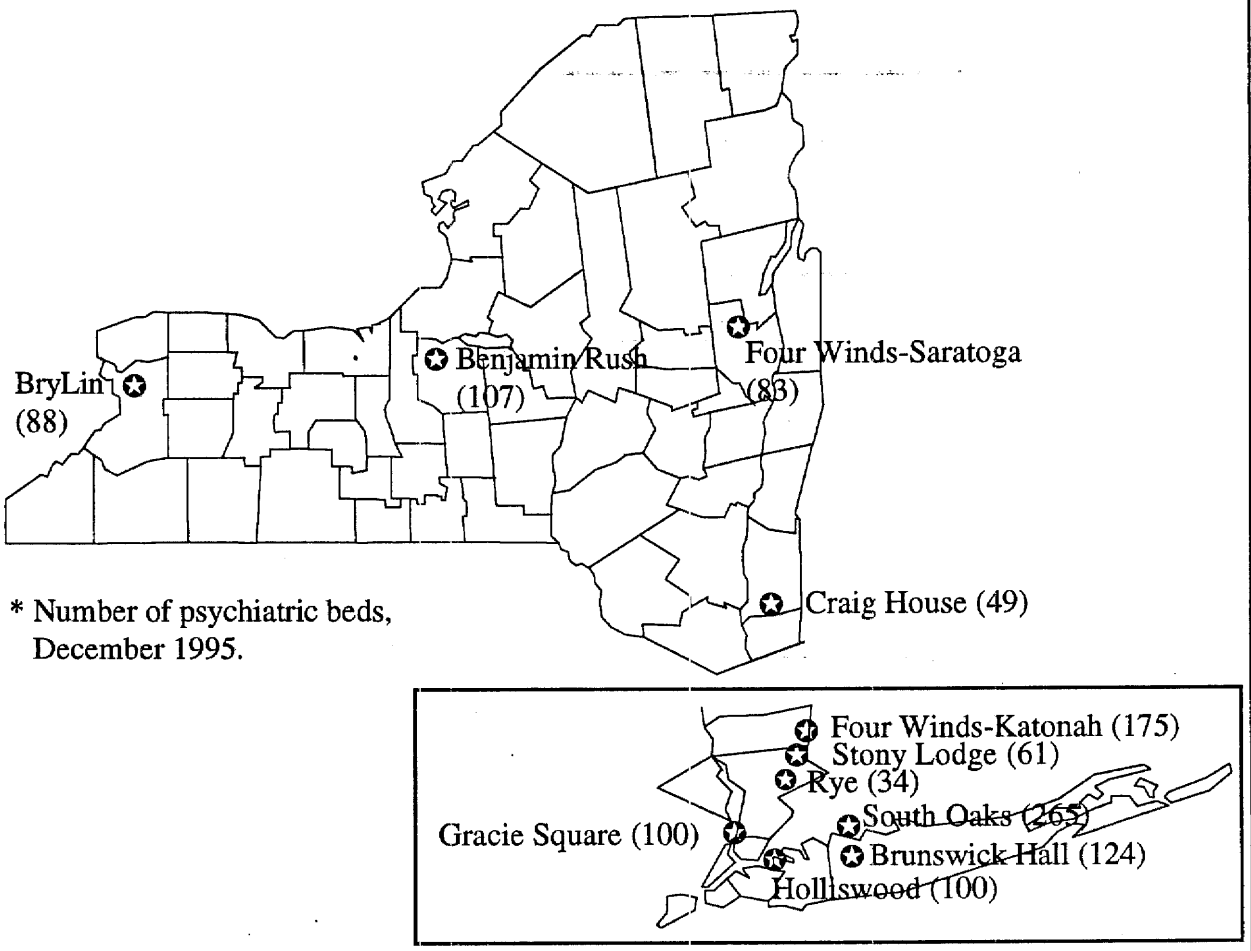
Prior to 1985, New York's private psychiatric hospitals depended almost exclusively on third-party insurers and self-paying patients for their revenues, and they generally had a reputation for being profitable institutions, largely reserved for persons in the middle and upper socioeconomic classes. Especially in the decades following World War II, many of New York's private psychiatric hospitals also acquired a reputation for the provision of "specialty" psychiatric care for individuals with eating disorders, severe and recurring depression, mental health problems complicated by drug and/or alcohol abuse, as well as for trauma survivors, and victims of sexual abuse and incest. Many private psychiatric hospitals operated specialty units for individuals with these disorders and, in some instances, patients travelled some distance to access the specialty care advertised by individual hospitals.

Although no private psychiatric hospital reported excluding admissions to individuals with serious and persistent mental illness or with severe functional impairments attributable to chronic mental illness, the prerequisite of commercial insurance coverage or ability to self-pay for services left most individuals meeting these criteria unable to access private psychiatric hospitals. Until recently, with a few exceptions, private psychiatric hospitals have also not accepted emergency involuntary admissions—which also limited the patients they admitted.

Additionally, all but four of New York's private psychiatric hospitals are located in the downstate area of Westchester County, New York City, and Long Island (Figure 4). Only 28% of the operating beds in private psychiatric hospitals are located in upstate New York. Many rural upstate communities do not, therefore, have ready access to private psychiatric hospitals.

Historically, private psychiatric hospitals, unlike state psychiatric centers or psychiatric services of general hospitals, have also largely confined their psychiatric services to inpatient

Figure 4
Location of NYS Private Psychiatric Hospitals*



* Number of psychiatric beds, December 1995.

hospitalization. Although psychiatrists affiliated with private psychiatric hospitals have frequently offered private therapy through their private practices, these hospitals have not typically operated certified mental health clinics and other mental health outpatient programs licensed by OMH. Only recently have several private psychiatric hospitals expressed an interest to OMH in becoming certified mental health outpatient providers. Three hospitals, Four Winds-Saratoga, Four Winds-Katonah, and BryLin, opened partial hospitalization programs, and another, Holliswood Hospital, was certified to provide clinic services.

Limited Regulatory Oversight

Largely due to their limited service role and population, New York's private psychiatric hospitals have also largely escaped significant oversight by OMH whose attention has been preoccupied by those parts of the service system serving more persons with serious and persistent mental illness and whose services are more often reimbursed with public funds. Although a brief section of the Codes, Rules, and Regulations of the State of New York provides basic performance standards for psychiatric hospitals [14 NYCRR 582] and another brief section pro-

vides the basis for Medicaid rate setting for private psychiatric hospitals [14 NYCRR 577], administrators of these hospitals reported that up until the past few years, they have operated (happily) with little interface with the state or local governments.

Through the present time (1995), senior officials of OMH report having no standard statewide protocol for reviewing the services of private psychiatric hospitals and confirm that certification reviews of these hospitals have been irregularly conducted in different regions of the state. Documentation sent to the Commission by OMH in May 1995 indicated that 11 of the 12 private psychiatric hospitals had not been reviewed since 1993 (Figure 5). Commission review of the two most recent available reports on the hospitals further evidenced substantial variability in the frequency, scope, and thoroughness of the state's reviews of private psychiatric hospitals. Most focused primarily on environmental conditions, with cursory reviews of treatment planning and clinical records.

Figure 5
Dates of the Two Most Recent OMH Certification Reports of Private Psychiatric Hospitals
(as of May 1995)

Hospital	Certification Dates
Benjamin Rush	2/93, 2/91
BryLin	7/93, 6/91
Brunswick Hall	4/93, 4/91
Craig House	10/93, 10/91
Gracie Square	6/93, 12/90
High Point	1/93, 11/91
Holliswood	10/93, 7/91
Four Winds-Katonah	12/93, 1/92
Rye	6/94, 3/94
Four Winds-Saratoga	5/93, 11/91
South Oaks	11/93, 10/91
Stony Lodge	7/92, 7/90

Private psychiatric hospitals have also become more involved with OMH, as they have attempted to obtain state and local government authorization to operate partial-hospitalization and clinic programs, and as they have entered into negotiations with the state to obtain and/or appeal their established Medicaid rates. Officials at OMH also report that as they have recognized the changing service role of these hospitals, more resources have been devoted to their periodic certification reviews. OMH officials have also conducted fiscal audits of two private psychiatric hospitals (Four Winds-Katonah and Four Winds-Saratoga) since 1986.

Surrogate Operators

Another interesting aspect of the operation of private psychiatric hospitals in New York State is that individuals or corporations other than the owners or operators of record on their OMH certifications actually managed the day-to-day operations of some of the hospitals. This was the case at Stony Lodge, South Oaks, Benjamin Rush, and Holliswood Hospitals, as well as at Regent Hospital which closed in 1994. In the case of Regent and Holliswood Hospitals, the owners contracted with the respective major health care management firms, National Medical Enterprise and Mediplex to run the day-to-day operations of the hospitals. In the cases of the other three hospitals, owners/operators of record spent little time at the hospital and relied on hired administrators and professional corporations to direct the day-to-day administrative and clinical operations of the hospital.

Although program review visits to each of these hospitals, except Regent Hospital (which has closed), revealed that on-site administrators were competent and diligent in their daily operating duties, the practice of "absentee" owners raised questions about the ability of OMH, through its licensing, to establish clear and im-

mediate responsibility for the operation of these hospitals. Among critical elements of the licensing process are the ability to review the character and competence of the owners and to hold them accountable with respect to standards of operation. By delegating virtually all operational duties to other individuals, "certified" owners had essentially transferred their license to others without any state regulatory review. This practice was especially questionable when the hospital's administration had been shifted to a public corporation, as the effect of state law is to prohibit publicly held corporations from holding operating certificates for private psychiatric hospitals, since the character and competence of widely held corporate ownership cannot be evaluated.

In the case of Regent Hospital, control had been shifted to National Medical Enterprises, a nationwide hospital chain that had been charged with improper practices in several states and was the subject of investigations by the U.S. Department of Justice and law enforcement authorities in several states.

Managed Care and Private Psychiatric Hospitals

Over the past five years the entry of managed care firms into psychiatry has brought major changes to private psychiatric hospitals as private health insurers have increasingly either developed their own internal managed care capacity for psychiatric services, or they have contracted for these services with specialty managed care firms established for this purpose.

Most health insurance plans now rely on these managed care firms to ensure both "precertification" for any inpatient psychiatric hospital stay for enrollees of their plans and ongoing reviews (at least every five to seven days) of the appropriateness of continued hospital stays. These managed care firms have increasingly promoted a more conservative stance toward the need for psychiatric hospitalization, often recommending outpatient mental health services in lieu of inpatient psychiatric care or as an alternative to more extended inpatient hospital stays.

Managed care firms have also shaped the way private psychiatric hospitals conduct business. They have increasingly established explicit expectations for the nature of service delivery and articulated standards for psychiatric assessments, treatment planning, psychotropic medication usage, and the regular review and documentation of patients' progress. And, unlike state governmental regulators who have tended to make considerable allowances for less-than-expected performance, managed care firms have been markedly more demanding, often simply refusing to pay for services which they have not approved or which they believe do not meet their performance expectations.

Managed care firms have also sought to influence the "pricing" of inpatient psychiatric care by negotiating directly with individual private psychiatric hospitals for per diem rates. In many instances, managed care firms have successfully negotiated substantially lower rates than hospitals' "established" per diem rates. These negotiations have been especially successful in geographic locations where there are two or more reasonably accessible private psychiatric hospitals, either within New York State or in a neighboring state. These rate agreements have decreased the revenues of private psychiatric hospitals, while driving down their cost of care.

Changes in Public Policy

Concurrent with the entry of managed care firms, other changes in public mental health policy in New York have also had a great influence on private psychiatric hospitals. Most significantly, in 1988, state policymakers developed and began implementation of plans for the most significant downsizing of state-operated psychiatric centers since the 1960s. These plans called for the state centers to reduce their role in

serving young children and to reduce their long-term patient census, which was largely comprised of older adults.

They also called for a much greater role for psychiatric services of general hospitals in acute psychiatric care, especially in serving nonelderly adults, age 21-64 years.[6] In accordance with federal law, psychiatric care for these individuals is not Medicaid-reimbursable in "Institutions for Mental Disease," including state psychiatric centers (and private psychiatric hospitals), but is Medicaid-reimbursable in psychiatric services of general hospitals. Thus, there were substantial financial advantages for the state to reduce psychiatric service provision to these individuals in state centers and to shift this service role to general hospitals.

Together, these changes in public policy, in concert with the influence of managed care firms, had the unplanned impact of defining two new service populations for private psychiatric hospitals: children whose care is reimbursed by Medicaid, and the elderly whose care is reimbursed by Medicare. Although no state plan or other document available to the Commission explicitly articulates these expectations for private psychiatric hospitals, declining occupancy rates and reduced reimbursement from third-party insurers encouraged most private hospitals to reconsider the merits of serving patients whose care would be predictably reimbursed by Medicaid and Medicare, albeit at somewhat lower per diem rates than they had historically received from insurers or private payers.

Changing Operating Practices

During visits to private psychiatric hospitals, administrators, senior clinicians, and front-line unit staff all spoke of how much things have changed in the past few years. They told how plummeting lengths of stay had changed service programs and dramatically increased the number of new admissions on their treatment units each week. Simultaneously, most staff were acutely aware that declining occupancy rates had threatened hospital revenues (and their jobs); yet, they were also concerned that changes in the population they were now beginning to serve posed new treatment challenges and the need for partnership with other service entities.

Decreasing Lengths of Stay

Administrators and senior clinicians repeatedly stated that there has been a sharp redefining of the types of psychiatric symptomatology identified as "warranting" treatment in an inpatient setting and a dramatic reduction in previously held expectations for how long most individuals *warranting* such inpatient care should stay in the hospital. The average length of inpatient stay in New York's private psychiatric hospitals had plummeted a significant 32% from an average of 37 days in 1989 to an average of 25 days in 1993. As shown in Figure 6, over this period, individual hospital data showed decreases in lengths of stay at all but three hospitals (High Point, +15%; Brunswick Hall, +27%; Rye, +184%). Of the remaining nine hospitals, six reported decreases in lengths of stay of more than 40% from 1989 through 1993.

More current data collected by the Commission at seven of the eight private psychiatric hospitals visited by its staff in the fall of 1994 further showed that lengths of stay had declined even more markedly in just the first three months of 1994.[7]

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[6] If a patient was receiving inpatient psychiatric services immediately before reaching age 21, Medicaid reimbursement can continue until the date the patient no longer requires the services on until the date the patient reaches age 22, whichever occurs first.

[7] March 1994 data were not available at one of the eight hospitals, BryLin.

Increasing Patient Admissions

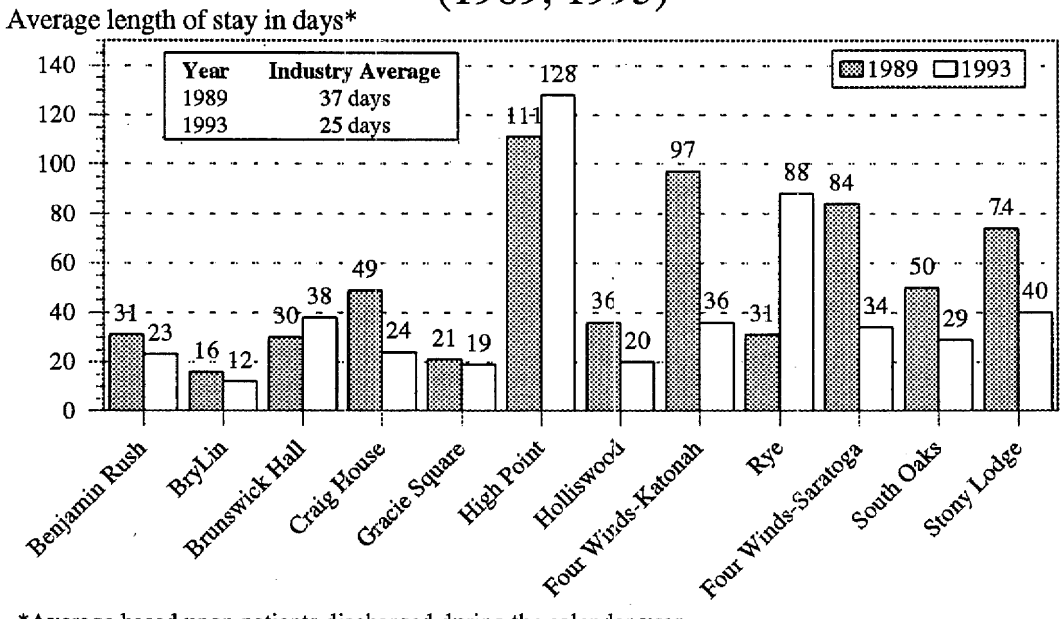
The statewide decrease in the length of hospital stays had a concomitant, but variable, impact on the number of patients individual private psychiatric hospitals served over the period. Statewide, the industry served more patients in each of the four years after 1989, with an annual increase of 4% to 14% in the total number of patients served. Overall, there was a 41% increase in the number of patients served in private psychiatric hospitals in the state in 1993 compared to the number served in 1989 (Figure 7).

For eight of the hospitals, the number of patients served increased from 25% to 219% for the period, while one hospital (Stony Lodge) reported a much smaller increase of only 8%. In contrast and contrary to the industrywide trend, at Brunswick, High Point and Rye Hospitals, the number of patients served decreased by 22%, 12% and 45%, respectively. (As noted above, these same three hospitals also had increases in their overall lengths of stay—primarily by keeping their Medicaid patients longer.)

Changes in the Population Served

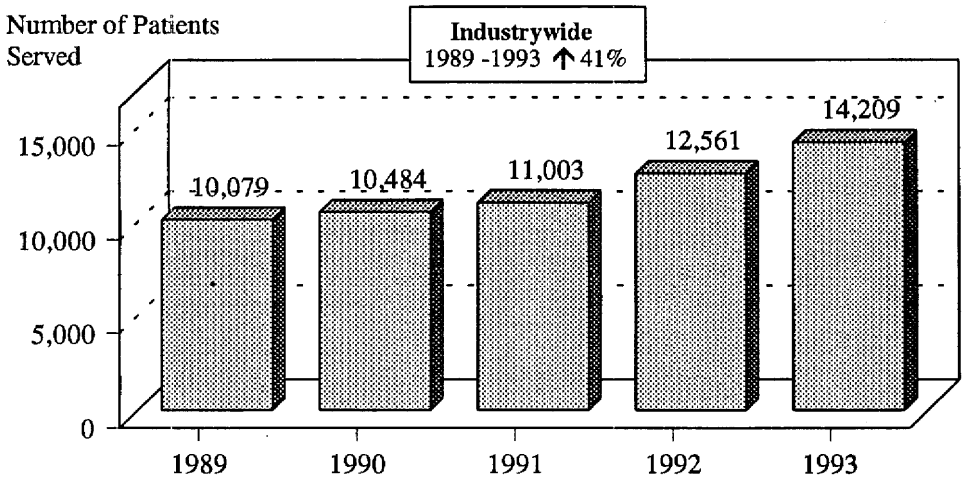
Commission visits to the private psychiatric hospitals, as well as interviews with senior staff of two managed care firms, provided further evidence that the population served by private psychiatric hospitals has changed in recent years. Perhaps the most obvious change is that most private psychiatric hospitals are dismantling their specialty service units, including special units for persons with eating disorders, trauma histories, histories of sexual abuse or incest, etc.

Figure 6
Average Length of Stay at NYS Private Psychiatric Hospitals
(1989, 1993)



*Average based upon patients discharged during the calendar year.

Figure 7
Patients Served by NYS
Private Psychiatric Hospitals
(1989-1993)



Although most private hospitals continue to assert their "special abilities" to serve individuals with these problems, their inpatient units tend to be more heterogeneous, and special services to these individuals are arranged through modifications in their treatment plans and individualized program schedules.[8]

In addition, administrators of private psychiatric hospitals reported that their patient population today tends to be more seriously ill, to have more long-standing psychiatric illnesses, and to have more significant functional impairments in daily living than the patients they served a decade ago. Several hospitals also specifically reported that managed care firms were questioning the admission of patients with specific diagnoses, including eating disorders, conduct disorders, and trauma disorders.

Across the board, administrators of private psychiatric hospitals reported to Commission staff that just having a serious mental health problem was no longer sufficient justification to a managed care firm to authorize a hospital stay. Instead, managed care firms were expecting full justification of why adequate care and treatment of the patient could not be provided through intensive outpatient services and, in some cases, they were requiring explicit evidence that without hospitalization the patient would be endangered or present a danger to himself/herself or others, which is the standard for involuntary civil commitment.

[8] The one exception to this general rule seems to be specialty service units for persons with concurrent mental health and substance abuse problems. Four of the eight private psychiatric hospitals visited by the Commission continued to operate at least one specialty unit for individuals with these concurrent problems, including two which offered specialty mental health/substance abuse units both for adults and for children and adolescents.

Services to Medicaid and Medicare Recipients

As private psychiatric hospitals have witnessed the exclusion of certain patient populations, they have simultaneously sought out new patient populations. Most obviously, private psychiatric hospitals have dramatically increased their service provision to Medicaid and Medicare recipients. As shown in Figure 8, industrywide, the number of patient bed days billed to Medicaid and Medicare increased from 84,079 days in 1989 to 164,409 in 1993, or by 96%. All but three of the hospitals (Craig House, Holliswood, and Stony Lodge) individually reported significantly increased service provision to Medicaid and Medicare recipients, and four reported an increase of more than 100% from 1989 to 1993 in the patient days reimbursed by these public programs.

From another perspective, Medicaid and Medicare reimbursed patient days accounted for only 22% of the patient days billed by private psychiatric hospitals in 1989. By 1993, patient days billed to these public programs comprised 46% of the total billed days of the 12 hospitals. At 4 of the 12 private psychiatric hospitals, Medicaid and Medicare payments reimbursed more than half of their total reimbursed days in 1993.

Staff at most private psychiatric hospitals acknowledged that increased service provision to Medicaid and Medicare recipients, who more often have few informal supports of family and friends and poorer educational and vocational backgrounds, has presented new treatment challenges. In particular, hospital staff reported that these new patient cohorts have placed increased demands on the hospitals in arranging patient discharges, as a greater percentage of these

Figure 8
Patient Days Billed to Medicaid and Medicare
by NYS Private Psychiatric Hospitals
(1989-1993)

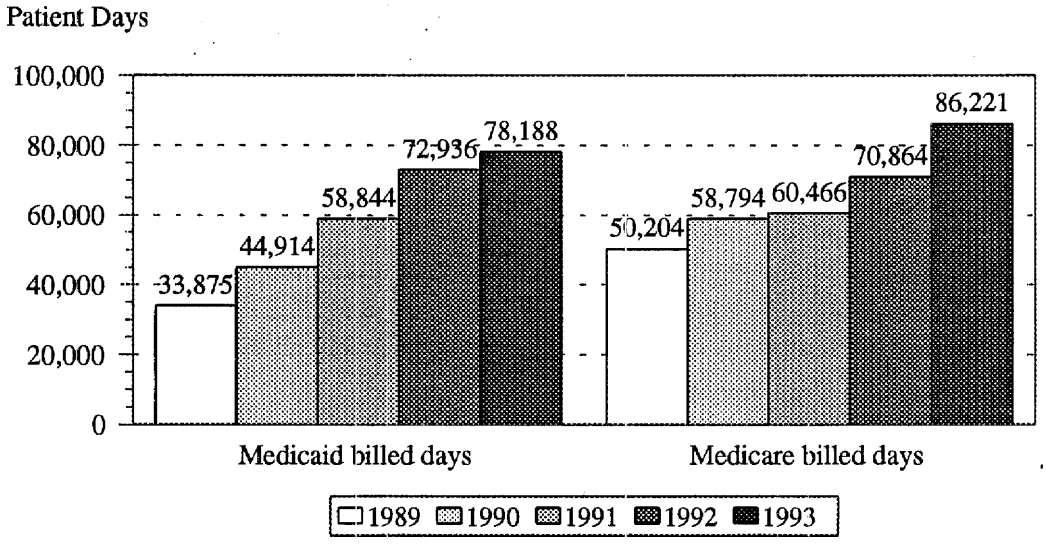
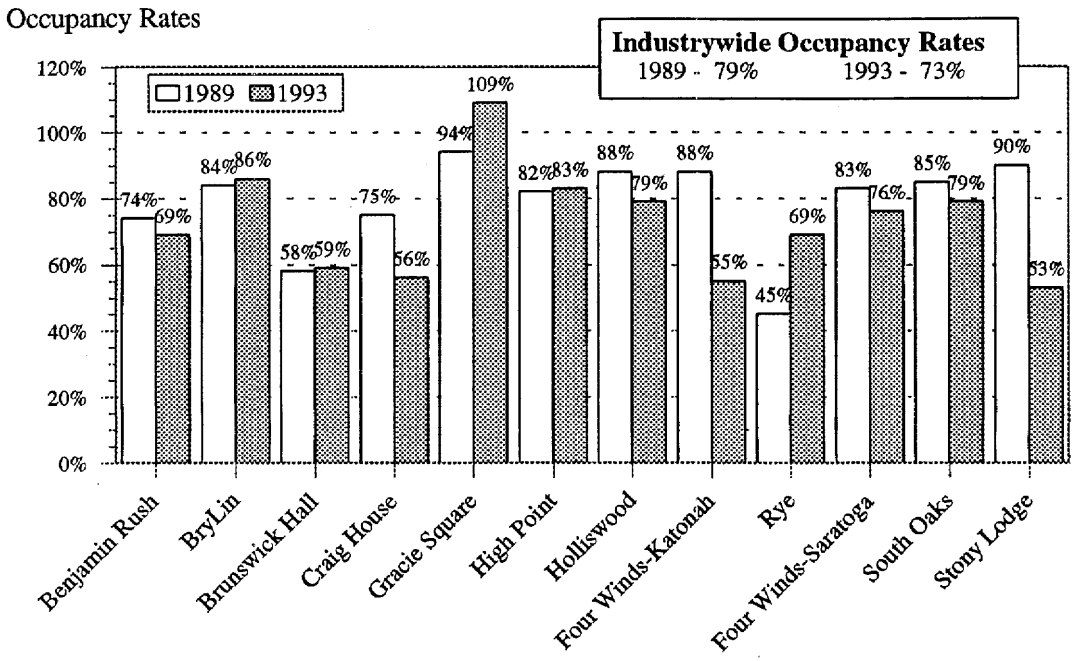


Figure 9
Occupancy Rates of NYS Private Psychiatric Hospitals (1989 vs. 1993)



patients are not able to return to their own homes or to their families. Thus, private hospitals have needed to develop stronger relationships with local social services agencies, as well as the array of housing and health-care residential facilities.

Decreasing Occupancy Rates

Notwithstanding the efforts of private psychiatric hospitals to serve more Medicaid and Medicare recipients, 7 of the 12 hospitals reported that their occupancy rates declined by at least 5 percentage points from 1989 to 1993, including three hospitals where occupancy rates decreased by at least 19 percentage points over the five-year period (Figure 9). Conversely, 3 of the 12 hospitals reported little change (0%-2%) in their occupancy rates over the period, and the 2 remaining hospitals reported occupancy rates which increased by 15 and 24 percentage points.

This mixed profile resulted in only a modest decrease in the industrywide occupancy rate from 79% in 1989 to 73% in 1993. As noted above, however, these industrywide figures masked the significant volatility of occupancy rates at most of the private psychiatric hospitals. As experienced hospital administrators can well attest, these changes in occupancy rates, especially when combined with the substantial changes in the profile of the patients served, present many complications in day-to-day hospital operations.

Conclusion

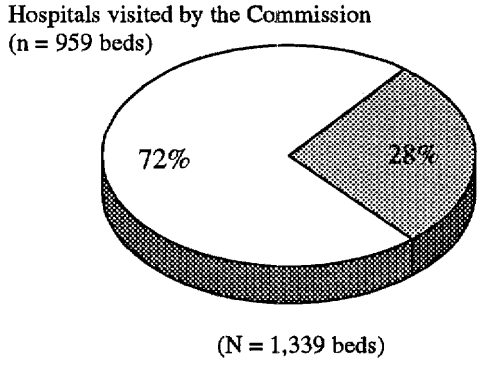
In conclusion, in the wake of managed care oversight of patient admissions and the duration of inpatient psychiatric stays and changes in state policy concerning the role of state psychiatric hospitals, most private psychiatric hospitals have found themselves serving a more seriously mentally ill population, while simultaneously facing declines in occupancy rates and revenues from patients covered by private insurance. The era of the private psychiatric hospital as an asylum for the middle and upper classes to recuperate leisurely, often over several months for specific mental health disorders or traumas, seems to have come to an end. Instead, today most private psychiatric hospitals in New York serve a considerably more heterogeneous patient population—where a significant percentage of their patients' care is reimbursed by Medicaid and Medicare.

Chapter III
Quality of Services in Private Psychiatric Hospitals

An important component of the Commission's review was to assess the quality of services provided by New York's private psychiatric hospitals. Commission staff visited 8 of New York's 12 private psychiatric hospitals (Figure 10). Together, these eight hospitals in 1993 had 959 psychiatric beds, or approximately 72% of the total private psychiatric beds in the state.

Figure 10
NYS Private Psychiatric Hospitals Reviewed by the Commission

BryLin
Benjamin Rush
Brunswick Hall
Four Winds-Katonah
Holliswood
High Point
South Oaks
Stony Lodge



Teams of two to three staff spent three full days at each hospital focusing their observations on the hospital's overall environment and administration and the clinical and custodial care services. At seven hospitals, Commission staff focused their observations on at least one adult and at least one children's unit, while at the remaining hospital (High Point), which had no adult units, two children's units were reviewed. At each hospital, with the exception of High Point, records of eight current patients, as well as at least five patients discharged in March 1994, were reviewed. In the case of High Point Hospital, only three discharged patient records were reviewed, as only three patients had been discharged in March 1994.

Many areas were assessed, including environmental safety, maintenance and attractiveness of patient living units, admission procedures and assessments, and treatment plans and reviews. Reviewers also assessed the specific therapeutic services, including individual and group therapy sessions, psychosocial and psycho-rehabilitative group activities, and psychotropic medications. Other reviewed areas included the use of restraints and seclusion, discharge planning, and aftercare services.

Interviews were conducted with senior administrative staff of the hospitals, and hospital policies were reviewed. In addition, on the units reviewed at each hospital, psychotropic medication regimes of all current patients were checked to ensure compliance with New York State Office of Mental Health Drug Guidelines, especially as related to excessive drug dosages and

polypharmacy. Patients on the units reviewed at all hospitals were afforded the opportunity to respond to a consumer satisfaction survey, and considerable unstructured observation time was spent on each unit providing opportunities for Commission staff to talk informally with patients and staff.

At the close of each hospital site visit, Commission staff provided an informal briefing to hospital administrators and senior clinicians. Subsequently, formal written reports were sent to the executive directors of each of the eight hospitals, and, as warranted, plans of correction were requested. In all cases, hospitals submitted requested corrective action plans.

Their Settings

Most private psychiatric hospitals in New York live up to their image as attractive facilities, located in picturesque settings where patients may seek solitude and retreat from the stress of their daily lives. Stony Lodge and High Point Hospitals are located on former large estates dating back to the late 1800s. South Oaks Hospital, Four Winds-Saratoga Hospital, and Four Winds-Katonah Hospital, although comprised of more modern structures, are also located on spacious campuses, with well-landscaped lawns and surrounding wooded areas. Benjamin Rush Hospital, located in downtown Syracuse, by contrast, has an urban setting, but its nicely landscaped campus, with many trees and hedges and an interior courtyard, is shielded from the city noise and traffic. To a visitor, these campuses, with their landscaped grounds and walkways, could be easily mistaken for the grounds of a college campus, a country club, or a mountain retreat.

Although three hospitals, two of them located in urban areas (BryLin in Buffalo and Holliswood in Queens) and one located on Long Island (Brunswick Hall), more closely resembled the appearance of a small general hospital, their grounds, too, were generally well-maintained and attractive. Overall, all of the private hospitals visited presented a welcoming appearance to patients and their families. And, while some had security posts at entrance gates, most were open campuses where people could come and go with some ease.

On the Inside

Inside the hospitals, Commission staff found that environmental safety and maintenance generally met high standards. Almost all treatment units and other patient areas of the eight hospitals were clean and generally well-maintained. Patient bedrooms and common areas across the eight hospitals were also adequately equipped with comfortable furnishings, and some were well-decorated. Unlike most psychiatric services of general hospitals and state hospitals, these units were usually well-supplied with relevant and appropriate reading materials, current newspapers, and games which patients could enjoy in their free time. Children's units were often especially well-stocked with these supplies.

Although most of the patient units reviewed at the hospitals were locked (67%), most of the hospitals provided opportunities for patients to go outside and/or to travel to other areas of the hospital for programs and activities each day.

Exposed overhead pipes noted at two of the hospitals (Four Winds-Katonah and Benjamin Rush) presented the only significant environmental hazard.[9] Appropriately enclosing these

[9] In the late 1980s, the Commission examined 131 inpatient suicides reported to it during the period 1980 through 1985. Eighty-four (84) of the victims (64 percent) took their lives by hanging. One of the most common structures used, accounting for 14 percent of the deaths by hanging, was exposed overhead pipes. *Preventing Inpatient Suicides: An Analysis of 84 Suicides by Hanging in New York State Psychiatric Facilities [1980–1985]* (May 1989).

overhead pipes, which were installed as a part of fire emergency sprinkler systems, presented an expensive repair for the hospitals. Notably, however, administrators of Four Winds-Katonah Hospital reported that they had ensured this correction by November 1994.

On the units, patients were in most cases appropriately dressed and groomed, and unit procedures and practices, including very flexible hours for patients to shower, free patient access to their bedrooms and personal clothing, and on-unit laundry facilities, promoted good hygiene. When warranted, attending to one's appearance and taking regular showers, etc., were also usually addressed in patients' treatment plans.

Most hospitals were also diligent in ensuring that all patients, including indigent patients, had a full supply of personal hygiene supplies and adequate personal clothing and underwear. One hospital (Holliswood), which had recently increased its services to more elderly, indigent patients from local adult homes and skilled nursing facilities, however, had some difficulties in these areas, as it had not yet established adequate procedures for elderly patients admitted with little or no extra supplies of clothing, especially underwear and socks.

Admission Practices

All hospitals had formal admission practices, which ensured an initial assessment of a patient's needs for hospitalization and, in the cases where patients were paying for their care through third-party insurance, follow-up with insurers and/or managed care firms to check the payers' concurrence with the admission. All eight hospitals also accepted Medicare patients, and six of the eight hospitals (all except Holliswood and Stony Lodge) also accepted Medicaid patients, usually children and adolescents.[10]

Although the vast majority of admissions across all eight hospitals were reportedly voluntary, all hospitals also accepted involuntarily admitted patients. Three hospitals (High Point, BryLin, and Holliswood) also accepted emergency, involuntary admissions from local emergency rooms pursuant to Section 9.39 of the Mental Hygiene Law.

All hospitals reported that they carefully screened new admissions and that only patients whose treatment needs could not be addressed in outpatient settings, including partial hospitalization programs, were hospitalized. All hospitals also reported that they served individuals with serious and persistent mental illness, including patients with many previous hospitalizations in state hospitals and concomitant drug and alcohol problems. Record reviews and on-unit observations also confirmed that most current patients at the hospitals visited suffered from a long-term mental illness.

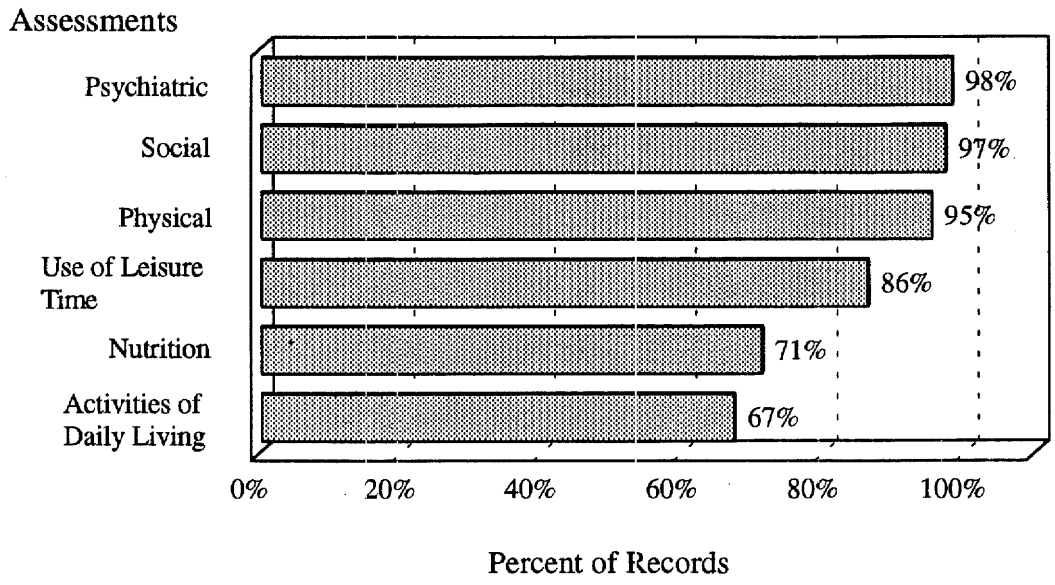
Although most of the private psychiatric hospitals acknowledged certain patient groups were excluded from admission, these were usually few in number and quite specific in nature. For example, two hospitals reported that they generally avoided admissions of children with conduct disorders; three reported that they did not accept patients who were mentally retarded; two reported that patients with recent histories of fire setting and sexual assaults would not be admitted; and, two reported that they did not accept patients with histories of very violent behavior.

Initial and Comprehensive Treatment Assessments

Across the eight hospitals, initial and comprehensive treatment assessments in the records of the current patients were generally impressive (Figure 11). Physical, psychiatric, and so-

[10] During 1995, both Holliswood and Stony Lodge Hospitals had applications pending with OMH for a Medicaid provider number.

Figure 11
Presence of Treatment Assessments
(N = 64 Records Reviewed)



cial history assessments were present in almost all records reviewed. Additionally, more than two-thirds of the records reviewed included assessments of the patient's independence in daily living skills and the patient's preferences in using his/her leisure time. When appropriate, nutritional assessments were also usually present. Assessment reports were also usually well-written and informative, and they uniformly addressed patients' strengths, as well as their needs. Despite these positive features, at several hospitals assessments only cursorily addressed patients' longer term vocational and educational needs. Problems were noted in one or both of these areas in 39 of the 64 patient records reviewed (61%), including at least half of the records reviewed at six of the eight hospitals. Of note, while two hospitals (South Oaks and Stony Lodge) reported some corrective actions to address these problems in their plans of correction, senior clinical staff at all six of these hospital also pointed out that the very short lengths of stay of most of their patients restricted meaningful attention to these areas on the inpatient unit, which partially explained the limited attention they received in inpatient assessments.

Treatment Planning

Corresponding to the high quality of the treatment assessments at the hospitals, the reviewed treatment plans across of the eight hospitals usually met all standards of OMH and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for timeliness and completeness. As illustrated in Figure 12, records of current patients indicated that: treatment plans were almost always reviewed at least monthly (89%) and often as frequently as weekly (56%); treatment goals and objectives usually were consistent with treatment assessment reports (91%); and in most cases, all acute treatment needs were addressed in the patient's plan.

Regular and detailed progress notes by nursing and psychiatric staff were also the rule across all eight hospitals. Particularly impressive—and in contrast to the practices of many psychiatric services of general hospitals and state psychiatric centers—were the frequent psychiatrist notes, which usually related directly to the patient's treatment objectives and also commented on the patient's progress as noted during individual daily sessions.

Treatment plans also consistently referenced a range of specific treatment interventions corresponding to the patient's treatment goals and objectives. As noted in greater detail below, the private hospitals reviewed also generally offered their patients many diverse treatment interventions, including psychopharmacology, daily individual therapy, many therapeutic groups, and a range of social, arts-related, and sports activities.

The only systemic treatment planning problem, noted across seven of the eight hospitals reviewed, was the absence of documentation of patient and family involvement in the treatment planning process and, specifically, in the identification of treatment objectives. As shown in Figure 13, the Commission relied on five indicators to assess patient involvement in treatment planning. In 89% of the 64 records reviewed, deficiencies were noted on at least two of these indicators, and in 47% of the records reviewed, deficiencies were noted on at least four of these indicators.

Documentation of family involvement in treatment discussions was also poor in many records, especially for adult patients (Figure 14). In total, there was documentation that the patient's treatment plan had been discussed with involved family members in 83% of the children's records reviewed and only 17% of the adult

Figure 12
Treatment Planning Indicators
(N = 64 Records Reviewed)

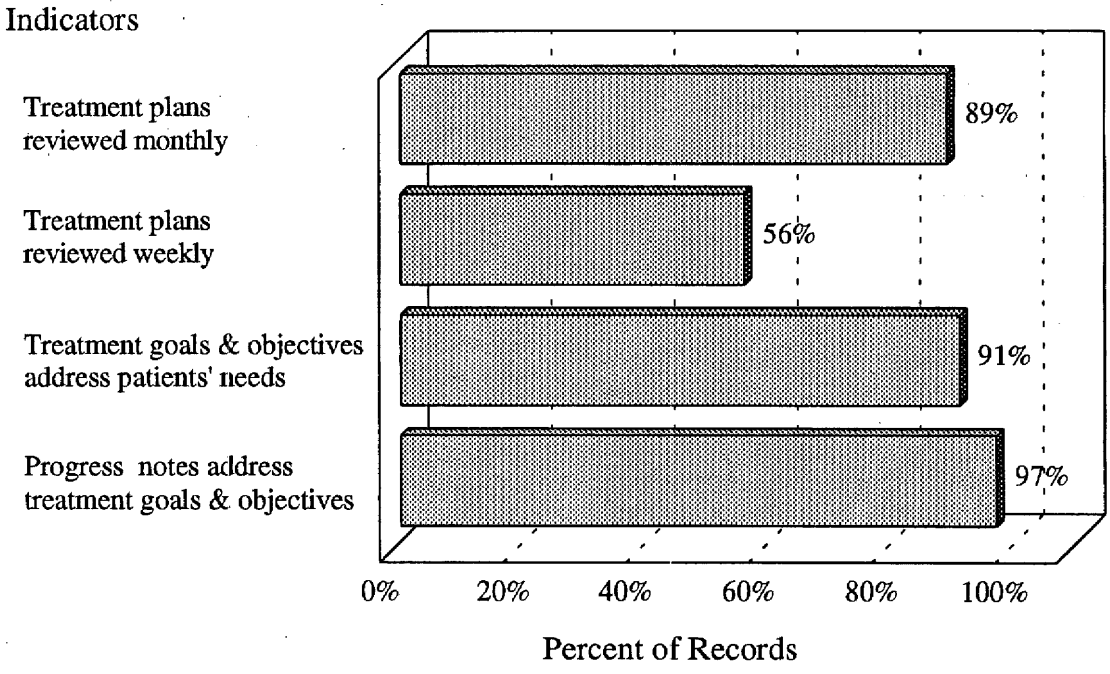
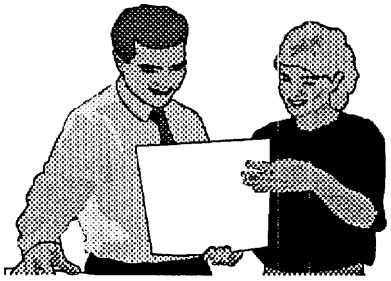


Figure 13
Five Indicators of Patient Involvement in Treatment Planning



1 – Patient participated in selecting treatment objectives.
2 – Patient was offered choices in treatment interventions.
3 – Treatment plan was discussed with the patient.
4 – Patient agreed to the treatment plan.
5 – Patient signed the treatment plan.

records reviewed. Of note, other record documentation did indicate that for over 90% of the patient records reviewed, family members had been informed of the hospitalization and had contacted (usually personally visited) the patient during his/her hospitalization.

Commission criticism for the lack of patient and family involvement, a requirement of both OMH and JCAHO, was a sore spot for many of the hospitals. While the plans of correction submitted by five hospitals indicated that patient and family involvement would be more explicitly addressed by re-educating their clinical staff to the importance of the issue and/or by revising their specific requirements (and documentation) for patient and family involvement in treatment planning, senior clinical staff at most of the hospitals (including these five) all asserted that record documentation was not a good index of the substantial patient and family involvement in treatment planning that actually occurred.

Clinicians at several hospitals also explained in closing conferences and other discussions with Commission staff that patient and family involvement in treatment planning had been severely abridged in the new era of managed care. These clinicians reported that managed care firms often require that only the most acute patient needs be addressed on inpatient settings, with mandates for very short hospital stays. Clinicians argued that, within this time frame, treatment objectives needed to be both quickly and carefully structured and triaged to meet the demands of these third-party payers—and that substantive patient involvement, which inevitably involved both time and some element of free choice, was not easily assured within these externally imposed parameters.

Other isolated treatment planning and review problems were also noted at a few of the hospitals. One hospital (Stony Lodge) essentially used boiler plate treatment plans, which

were not individualized for either its adult or child services. Additionally, on the adult units of BryLin and Four Winds-Katonah Hospitals and on the two children's units of High Point Hospital, progress notes in the records reviewed were either missing or did not adequately report on patients' progress toward their treatment goals.

Therapeutic Activities and Programs

One of the outstanding features of all of the private psychiatric hospitals was the full array of therapeutic activities and programs which they offered their patients. Most hospitals offered formal schedules for each patient listing three to five group activities which they would attend daily. Groups included psycho-rehabilitative sessions focusing on handling aggression and impulse control, relating to family and friends, and learning positive methods to be assertive and expressive of their feelings and beliefs. Other sessions focused on alcohol and drug abuse, safe sex practices, and important facts about psychotropic medications. Still other groups were oriented toward social and leisure activities, including a variety of arts and music groups.

Although patients usually had the opportunity to refuse to attend groups, during the Commission's visits, most patients attended their scheduled sessions. In informal discussions, most patients also reported that the groups were helpful and that they enjoyed them. Responses on the consumer satisfaction surveys also indicated that most patients liked the groups they were attending.

Figure 14
Family Involvement in Treatment Discussions

	Adult Patients (N = 28)	Child and Adolescent Patients (N = 36)
		
46%	Staff had regular contact with family members to discuss the patient's progress	89%
46%	Family or significant other was consulted with about treatment issues	81%
17%	The final treatment plan was discussed with the family or significant other	83%

Use of Chemical and Mechanical Restraints and Seclusion

As a general rule, the eight private psychiatric hospitals were low users of chemical and mechanical restraints and seclusion. Two of the eight hospitals reported no use of restraint during the 30 days prior to the Commission's visit on the units reviewed; and six hospitals reported no use of seclusion during this same 30-day period.

Most of the hospitals were more likely to use unscheduled doses of psychotropic medications, either with PRN or STAT orders, in addressing patients' disruptive, anxious, and/or agitated behaviors. At six of the eight hospitals, at least half of the patients on the units reviewed had received a minimum of one unscheduled psychotropic medication administration in the 30-day period reviewed. At three of the eight hospitals, more than one-third of the current patients on the units reviewed had received five or more unscheduled psychotropic medication administrations in the 30-day period.

Simultaneously, very high use of PRN and STAT medications was typically limited to a small minority of the patients. At all of the hospitals reviewed, 20% or fewer of the patients on the units visited had received 10 or more PRN or STAT administrations of psychotropic medications in the 30 days prior to the review.

Despite the hospitals' relatively low use of these interventions, review of actual episodes of their use at most of the private psychiatric hospitals suggested that better hospital oversight and monitoring of these practices was needed. As shown in Figure 16, most hospitals had problems in ensuring that these interventions were only used after less restrictive interventions had been tried and failed, that adequate physician rationales were provided for the use of these interventions, that patients needing these restrictive interventions frequently received warranted clinical reviews, and/or that periods of seclusion and "seclusion-like" interventions did not extend too long.

Behavioral Interventions with Children

With the exception of Stony Lodge and Benjamin Rush Hospitals, all of the private psychiatric hospitals reported serving more children and a more diverse group of children in recent years. This change, largely attributable to the hospitals' greater interest in serving Medicaid patients and in serving much younger children and the declining state role in serving this population, has presented new treatment challenges for many of the hospitals.

Most clinicians on children's units reported that they now served more children with serious behavioral problems, serious family dysfunction, and histories of prior hospitalizations and out-of-home placements. These problems were especially noted at three of the five hospitals (BryLin, Four Winds-Katonah, and Brunswick Hall) which had begun serving more children under 12 in the past three years.

Although recognizing these changes in their young patient cohort, none of the eight hospitals had consistently adopted guidelines that required individualized behavioral plans to assist clinicians and other direct care staff in addressing individual children's inappropriate behavior. Indeed, as a general rule, psychology services were limited at most of the hospitals, and only about half of the children reviewed (52%) had a formal psychological or behavioral assessment in their records. More commonly, hospitals had introduced new rules and practices on their children's units to address problem behaviors. In some cases, as illustrated in Figure 17, these rules seemed overly restrictive. Clinical staff at a number of the hospitals were also candid in acknowledging that the rules were not working well.

Figure 16
Problems in the Use of Seclusion, Restraint, and Unscheduled Meds

- At seven of the eight hospitals, psychiatrists and nurses usually failed to document less-restrictive attempts to calm a patient or relieve his/her anxiety or stress prior to administering an unscheduled dosage (PRN or STAT) of a psychotropic medication.
- Rationales for unscheduled administrations of psychotropic medications were not consistently documented at two hospitals, and at five hospitals, doctors' orders for PRN psychotropic orders provided vague, nonspecific indications for their administration (e.g., for anxiety).
- At two hospitals, there was no documentation that treatment plans and interventions of children receiving frequent PRN administrations of medications had been reviewed to address their increasing behavioral problems.
- At one hospital, there was often no documentation that less-restrictive interventions had been tried (or determined to be clinically inappropriate) prior to the use of restraint and seclusion. This is an explicit requirement of state law and regulation, as well as the accrediting standards of the JCAHO.
- At one hospital, seclusion orders were written for 24 hours, which is contrary to standard practices of most psychiatric inpatient settings (including all of the other private psychiatric hospitals reviewed), and patients were regularly placed in secluded but unlocked rooms in annex areas apart from the treatment unit, sometimes for several days, reportedly to ensure increased 1:1 staff supervision and isolation from other patients or staff. The hospital agreed in its plan of correction to review both practices.
- At one hospital, the seclusion room was used interchangeably for the seclusion of children and for the less-restrictive purpose of time-out as a "quiet room." As the clinical indications of the two interventions differed markedly in the hospital's policies (as do their respective state legal requirements), the Commission recommended that the hospital adapt another area, with appropriate decorations and lighting, for a quiet room and restrict the use of the seclusion room to seclusion only.
- One hospital was using an adult net restraining jacket with its youngest children (under 12) without the statutorily required formal approval from the Office of Mental Health. The hospital agreed in its plan of correction to begin using a children's size restraint jacket.

Figure 17
Overly Restrictive Practices and Rules

- At one hospital, all bathrooms and showers were kept locked on the children's unit, and children had to ask permission to use the toilet, wash their hands or face, or take a shower. At this same hospital, children were not allowed to receive telephone calls.
- At one hospital, a staff person was required to be present in the room during all visits between children and family members, except for children on the highest privilege level. There was no clinical rationale in any of the children's records for this abridgement of their privacy during visitation.
- At one hospital, one of the children's units had been "shutdown" at least six times in the 60 days prior to the Commission's visit due to disruptive behavior. "Shutdowns" often lasted more than a day and sometimes they extended to three to four days. During these periods, all children were restricted to their bedrooms, all therapeutic activities and groups were suspended, and children ate all meals in their bedrooms.
- At one hospital, only children on the highest privilege level were allowed to make telephone calls in private.
- At one hospital, children could spend time alone in their bedrooms only with a doctor's order. At this same hospital, physicians checked all incoming mail before delivering it to the children on their caseload, and there was no individualized rationale in their treatment plans documenting the need to intercept the children's mail.

Although most of these practices were modified by the hospitals when they were brought to the administrators' attention by the Commission, it was of concern that most of the practices had been long-standing and apparently had not been previously questioned by either hospital or OMH staff. As noted above, most of the hospitals also had not established a formal practice of using individualized behavioral plans, developed with the treatment team, the child, and his/her parents/guardians to address difficult and disruptive behaviors. As a result, staff were left with one set of rules or in some cases one "level system" for all children served. This approach did not allow the tailoring of more effective approaches for individual children based on their strengths and needs, or the ability of clinicians to work cooperatively with parents and children toward behavioral intervention approaches which could work upon the child's discharge home.

The usage data on unscheduled administrations of psychotropic medications also revealed that medications were frequently used to calm children whose behavior became disruptive or anxious. Across the eight hospitals, 32% of the children on the units reviewed had received at

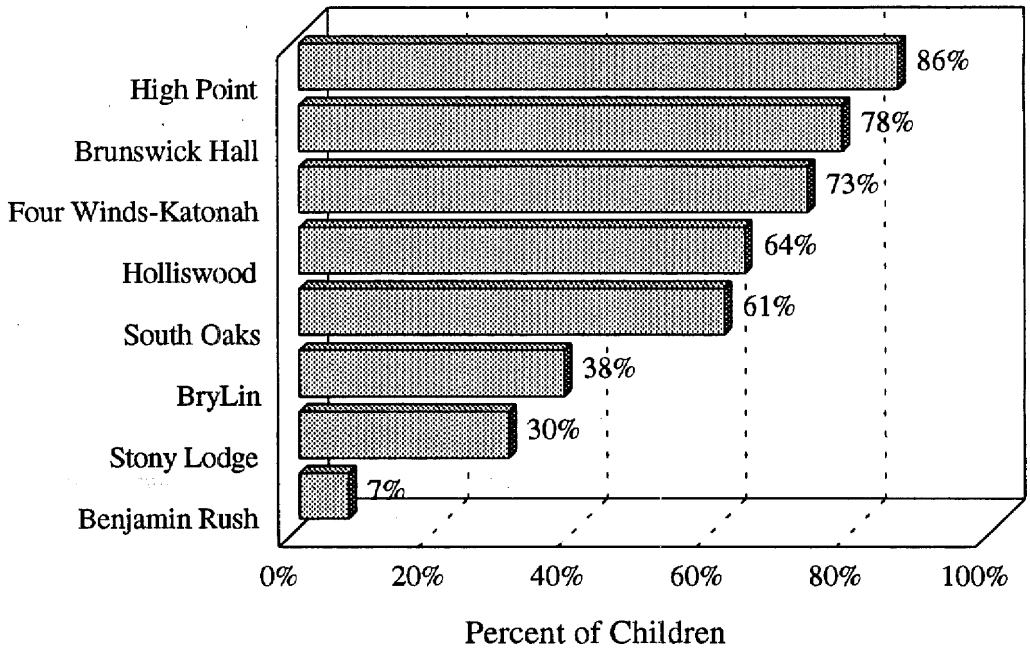
least five PRN and/or STAT administrations of medications in the 30 days prior to the Commission's visit. From another perspective, at five of the eight hospitals over 60% of the children on the units reviewed had received at least one PRN psychotropic administration in the 30 days prior to the Commission's review (Figure 18).

Many clinicians at the private psychiatric hospitals agreed that as they expanded their services to children and adolescents from many different backgrounds and experiences and with diverse psychiatric symptoms and behavioral problems, the strategies which had previously worked well on their children's units were now less effective. At most hospitals, senior administrators and clinicians reported a need for more in-service training for clinical and direct care staff in interacting with children, preventing behavioral episodes from escalating to crisis situations, and working effectively with the children's families and foster families. One hospital (South Oaks) had further resorted to building a seclusion room on its adolescent unit, after not having one for the hospital's more than 50 years of prior operation.

Discharge Planning

All of the hospitals reported that encouragement from managed care firms to keep lengths of hospital stays as brief as possible had spurred them to reconsider their discharge planning practices. The standard of starting discharge planning on the day of admission had concrete reality at all of the hospitals (documented in 95% of the current patient records reviewed), and estimates of the length of hospital stays were often listed in admission notes. Discharge crite-

Figure 18
Percent of Children by Hospital Who Received at Least One PRN Psychotropic Administration



ria for individual patients were also usually listed in the patients' charts (89%), and at most hospitals there were usually notes that these criteria had been discussed with the patient (66%).

In total, Commission staff reviewed the records of 41 former patients who had been discharged from the eight hospitals. As a general rule, most discharged patients' records (98%) provided evidence that a post-discharge residential setting and clinical therapy had been arranged for the patient prior to discharge. For most patients, these arrangements were not complicated, as patients were returning home to live with family members and to therapists with whom they were in treatment prior to their hospitalization. Three hospitals (South Oaks, Four Winds-Katonah, and Holliswood) also frequently discharged patients with referrals to come back to the hospital for a few days to two weeks, and to attend inpatient group sessions and/or to participate in the hospital's aftercare partial hospitalization program.

Another particularly positive aspect of discharge services at five of the eight hospitals was their practice to assure personal follow-up with patients after they left the hospital. Although these hospitals had different practices for follow-up—some contacted patients within a day or two of discharge, others contacted patients a week or two after discharge, and still others contacted patients two or more times after discharge—all made it a point to check on how patients were doing after they had gone home or onto another placement. Stony Lodge Hospital had also made a special effort to study patient outcomes post-discharge.

The few areas of problems with discharge planning which were common to more than one hospital centered on documentation of patient and family involvement with, and choices regarding, discharge planning (four of the eight hospitals). When these issues were discussed with hospital administrators and clinicians, they typically responded that these discussions of discharge plans did occur, but that they were not documented. Senior clinicians at several hospitals also added, however, that the issue of patient "choice" for outpatient services was considerably restricted by many managed care plans—which often required preapproval for the nature and frequency of services and which sometimes authorized services from only a narrow field of providers.

Conclusion

The Commission's review of eight private psychiatric hospitals revealed that these facilities provide high-quality services to patients with third-party insurance, as well as to a growing number of children and elderly patients who rely on government-sponsored programs to finance their mental health care. Although all the hospitals reported that they carefully screen new admissions, in large part due to increased scrutiny by managed care firms to assure that patients truly require inpatient care, once patients were admitted they received a generally high quality of custodial and clinical care services in attractive settings that were well-maintained and environmentally safe.

By reviewing records and policies, conducting unit observations and interviews with senior administrative and clinical staff, the Commission concluded that private psychiatric hospitals not only are attentive to patients' personal care needs, but also have strong treatment and discharge planning practices. These strong clinical practices included the development of comprehensive assessments that focus both on patients' strengths and needs, timely treatment plans with regular, detailed progress notes that were useful in monitoring patients' responses to treatment interventions, and discharge practices that ensured patients an arranged residential setting and scheduled therapy appointment prior to their release from the hospital.

Figure 19
Changes at BryLin Hospital

BryLin Hospital opened its child and adolescent unit in September 1992. At the time of the Commission's review, in June 1994, BryLin had experienced difficulties in the turnover of unit managers and direct care staff, as well as challenges in serving children who displayed many more behavioral problems along with their psychiatric symptomatology.

BryLin had adopted new rules and practices to address children's behavioral problems. However, these strategies had resulted in an overreliance on PRN administrations of psychotropic medications as an almost routine intervention, and utilization of restraint and seclusion. Many features of the level system, which was used to guide children's behavior on the unit, were also quite restrictive and compromised the rights of children and adolescents regarding phone usage, visitation, and access to shower facilities.

With the hospital's new venture into serving a more diverse and difficult-to-manage patient population on its child and adolescent unit, some of the practices adopted to respond to children's behavior on the unit resulted in the incorporation of restrictions on basic communication, personal hygiene, and visitation rights as "punishments" into the level system. For example, only children on the highest privilege level were able to make telephone calls in private, to sign up to take showers in the evening, or to have friends or siblings visit them in the hospital.

In its August 1994 correspondence to the hospital, the Commission suggested that BryLin staff consult with other hospitals serving children and adolescents with these diagnostic profiles to learn about other strategies that have been effective in reducing the use of restraint, seclusion, and the use of PRN administration of psychotropic medications. BryLin noted in its plan of correction that **"Several of our staff members have recently been involved in site visits to other hospitals serving children and adolescents to hopefully benefit from their efforts to resolve similar issues. We believe that our networking efforts will enable all facilities involved to benefit from the experiences and successes of the group."**

The networking that occurred between BryLin staff and the staff of other inpatient psychiatric facilities serving children led to significant changes on the child and adolescent unit at BryLin. To limit reliance on PRN psychotropic medications, the hospital negotiated with the local YMCA and community college to allow children access to their recreational facilities and increased therapeutic activities on the unit. To address children's problem behaviors, staff were offered formal training in behavior modification and the daily morning report was expanded to review children who had been in restraint or seclusion during the previous 24 hours to discuss whether all other less-restrictive clinical interventions had been tried.

The hospital also made revisions to the level system after visiting and obtaining information from three local adolescent psychiatric facilities and integrated this information into their new level system. These modifications in the level system assured that all adolescents were able to sign up for shower times both during the day and evening hours, to make telephone calls in private and to receive any visitor they liked as long as they had their parents' permission and the treatment team's approval.

In contrast to other psychiatric units of general hospitals and state psychiatric centers visited by the Commission where patients spend a great deal of idle time on the unit, private psychiatric hospitals offered patients an array of therapeutic activities and programs and required the frequent on-unit presence of psychiatrists who met with each of their patients individually several times a week. Additionally, the review showed that private psychiatric hospitals were low users of chemical and mechanical restraint and seclusion and that many hospitals conducted follow-up with patients after they were discharged, an activity rarely performed by most other inpatient psychiatric facilities.

Private psychiatric hospitals did, however, have a few areas where improvements and modifications were needed in their clinical practices. These problem areas seemed to be in direct relation to either the hospitals' reported response to managed care requirements for patients' shorter lengths of stay or to serving a more diverse group of children and adolescents who displayed more difficult and disruptive behaviors during their hospital stays.

Common among many of the hospitals was the lack of documentation of the patients' and family members' involvement in both treatment and discharge planning decisions. Clinicians reported that managed care firms' emphasis on short-term acute stays hindered their ability to have patients and families participate in these decisions due to the short time frames required to develop treatment and discharge plans.

Many hospitals also faced new treatment challenges in serving children with behavioral problems and had used PRN administrations of psychotropic medications, restrictive unit practices or restraint and seclusion to respond to children's and adolescents' disruptive behavior on the units. The Commission raised concerns about the reliance on these interventions and encouraged staff to use individualized behavior plans and other strategies that were less restrictive to address problem behaviors displayed by patients on their child and adolescent units. Networking with other hospitals which served similar child and adolescent populations on their inpatient units so senior clinical staff could learn about other techniques for addressing young patients' problem behaviors was also suggested by the Commission (Figure 19).

Although private psychiatric hospitals monitored patients for side effects of their psychotropic medications and many provided medication education groups, some medication practices required heightened efforts to ensure safeguards surrounding this treatment intervention with patients. Specifically, the Commission encouraged psychiatrists to provide written rationales for initial orders or changing orders of prescribed psychotropic medications and for multiple medication regimes. Finally, the Commission recommended that facilities make more diligent efforts to document informed parental consent for psychotropic medications prescribed to children and adolescents as required in Chapter 461 of the Laws of 1994.

Overall, the Commission's review of private psychiatric hospitals provided confirmation that these facilities offer quality services to patients. In fact, the findings from this review indicate that private psychiatric hospitals should be considered a valued component of the state's network of mental health services.

Chapter IV
An Industry in Transition

Background

The Article 31 private psychiatric hospital industry has gone through significant financial and operational changes in recent years, mainly resulting from the implementation of managed care by private health insurers. The concept of managed care entails policies such as preadmission certification, utilization review, and negotiated comprehensive reimbursement rates to control the escalating cost of psychiatric care paid by insurance companies. Additionally, the use of less expensive alternatives, like outpatient care, has been encouraged in lieu of inpatient treatment. These policies have lowered patient days and insurance revenue and, in turn, have motivated hospitals to seek a greater number of patients covered by Medicaid and Medicare. As a result of these changes, hospitals modified operating practices and cut costs to remain viable in today's more cost-conscious and competitive environment (Figure 20).

Industrywide profits for inpatient psychiatric operations have declined significantly, with individual hospitals experiencing variations as illustrated in Figure 21. In 1993, only Benjamin Rush, High Point, Four Winds-Saratoga, and South Oaks Hospitals showed a profit for their inpatient operations. When earnings from self-reported related party transactions are included, a total of five hospitals generated profits from inpatient services.[11] A review of the financial statements containing all facility operations presents a slightly better outlook with seven of the hospitals showing positive earnings.[12]

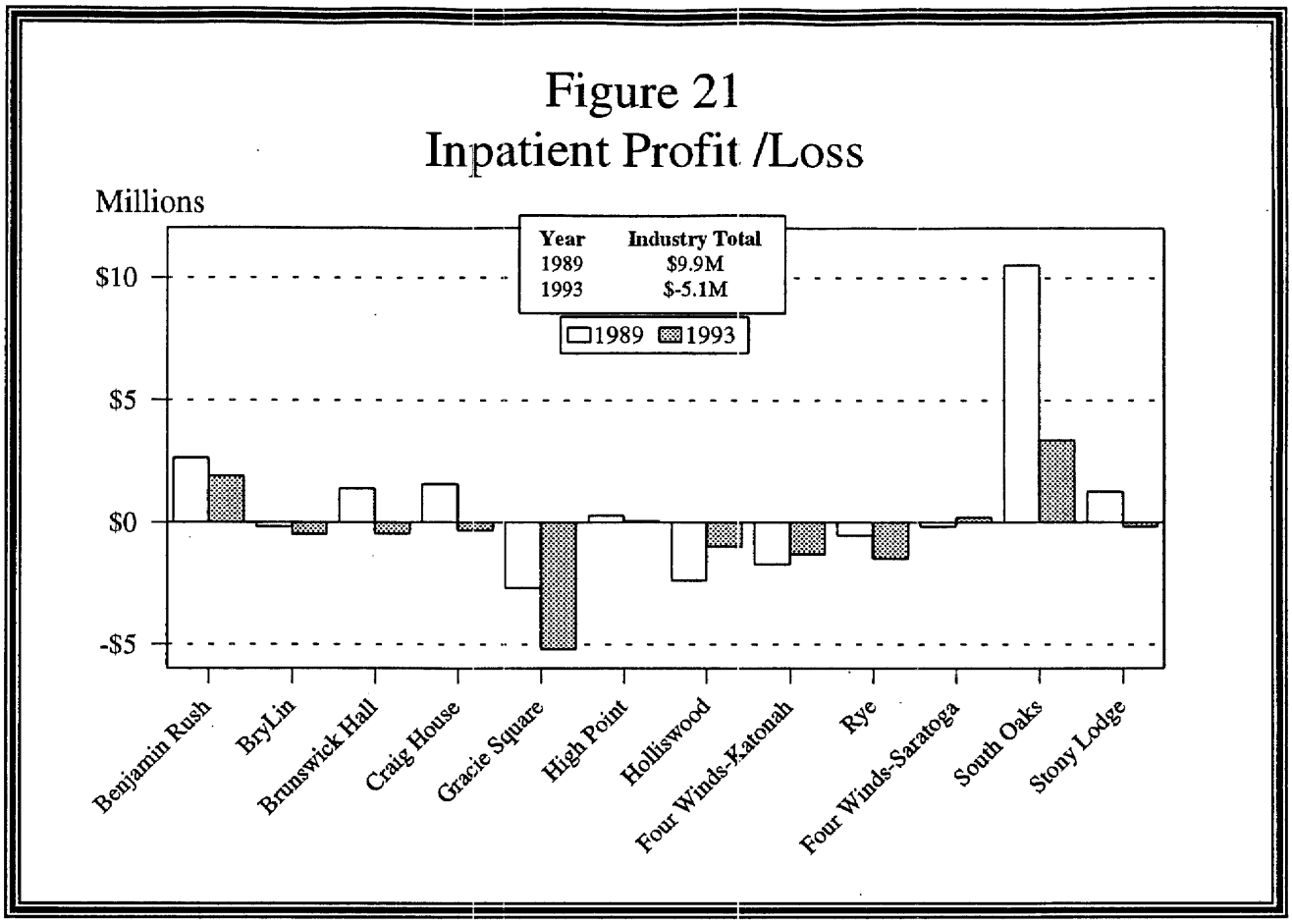
Figure 20
Impact of Managed Care

- Lower Insurance Reimbursement Rates
- Shorter Lengths of Stay for Insurance Patients
- Fewer Insurance Days
- Increase in Medicare and Medicaid Patients
- Decrease in Hospital Revenues, Expenses, and Profits

Clearly, the industry is in the midst of a turbulent period when change is occurring and hospitals have been forced to react. In 1994, Gracie Square Hospital was acquired by a cor-

[11] Holliswood Hospital showed inpatient profits when self-reported related party transactions are factored into the bottom line.

[12] Facility operations contained in the financial statements include all corporate activity such as interest income, cafeteria income and, in some cases, income from other health care programs (e.g., outpatient programs, nursing home operations, alcohol treatment programs).



poration which reduced its Article 31 bed capacity.[13] In 1995, High Point Hospital closed its 45-bed facility in the aftermath of its owner/operator's death and perhaps because of its greater value as a nonhealth facility given an oversupply of psychiatric beds in the Westchester County area. The effect on other hospitals in the wake of managed care remains to be seen.

Negotiated Insurance Rates

Prior to the implementation of managed care, insurance company payments to hospitals were customarily based upon charges established by the hospitals themselves. Hospitals routinely were reimbursed 80% to 100% of gross charges with separate billings for room and board and ancillary services such as x-rays, laboratory tests, preadmission physicals, one-to-one nursing, and other services. The Commission found instances where the charges for an inpatient psychiatric hospital stay exceeded $1,500 per day. Although a few insurance companies still pay for services based upon a percentage of the total charges, this method of reimbursement is no longer commonplace.

Today, in an effort to control costs, insurance companies contract with managed care firms to negotiate comprehensive per diem rates which

[13] Gracie Square Hospital was sold in 1994 to NYS-GSH, Inc., a not-for-profit corporation whose board is interrelated with New York Hospital. The Article 31-bed capacity of Gracie Square Hospital was reduced from 170 to 100 at the time of the sale. Much of the extra capacity (i.e., 61 beds) is temporarily being used for Article 28 psychiatric inpatients while New York Hospital undergoes renovations.

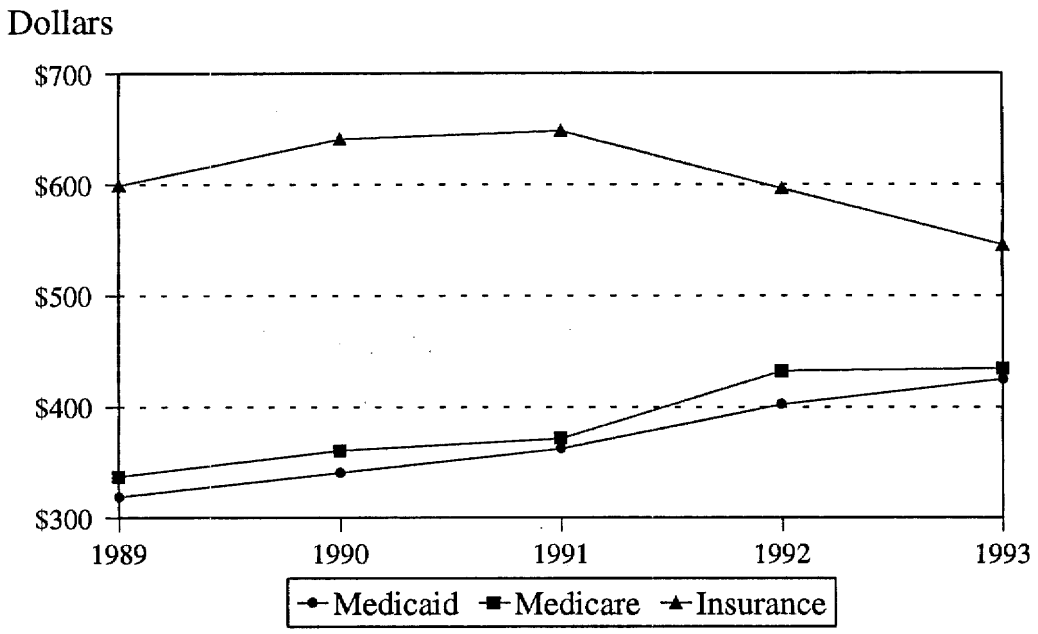
the hospitals accept as payment in full for all services provided. Managed care firms indicated that an overabundance of psychiatric beds in New York State has enabled them to reduce reimbursement rates because hospitals would rather accept a lower rate than risk the possibility of losing the managed care contract along with its patient referrals.

As a result of managed care, the average private insurance per diem reimbursement was reduced by 9% over the five-year period ending in 1993. Conversely, during this period, Medicaid and Medicare rates have been increasing, narrowing the gap between the once lucrative insurance rates and the "cost-based" Medicaid/ Medicare rates (Figure 22).

Medicaid Rates

Medicaid reimbursement rates are all inclusive per diem amounts individually set for each hospital using a cost-based system in accordance with OMH regulation 14 NYCRR 577. A hospital's rate is adjusted annually based upon patient days and allowable costs incurred by the facility two years earlier, trended forward for inflation.[14] There is no provision for profit allowed in the rates.

Figure 22
Average Daily Reimbursement



[14] There are limits on the extent to which base year inpatient and ancillary costs can be reimbursed through the Medicaid rate. For example, through rate setting, OMH places a cap on administration costs based upon 110% of the industry average and limits operating costs to prior year actual costs trended forward for inflation. Federal guidelines governing allowable costs place a limit on such items as related party charges and the salaries of certain physicians, while disallowing other costs entirely such as those pertaining to advertising hospital services.

Figure 27
Five-Year Trends
1989 to 1993

	Insurance	Medicaid	Medicare
Total Revenue	-40%	+ 200%	+118%
Factors Influencing Revenue:			
Average Length of Stay	**-49%**	-3%	-7%
# of Patients Served	+25%	**+139%**	**+ 86%**
Per Diem Reimbursement	-9%	+ 33%	+ 29%

The trends in total revenue and the factors which influence them vary significantly when comparing insurance to Medicaid/Medicare. Figure 27 presents a summary analysis showing stark differences in the trends from 1989 to 1993. Considering the three factors which influence total revenue—length of stay, the number of patients served and per diem revenue—it is evident that the Medicaid/Medicare revenue was predominantly influenced by the increase in the number of patients served, while private insurance revenue was primarily affected by the decreased average length of stay.

In short, many of the private psychiatric hospitals have tried to compensate for the decreased revenues from insurance payers by increasing services to Medicaid and Medicare patients. From an operating perspective, this change has resulted in a markedly greater proportion of patient days pertaining to children and elderly persons funded from publicly administered programs.

Medicaid Eligibility

Due to the federal requirements governing Institutions for Mental Diseases, the private psychiatric hospitals can only bill Medicaid for services provided to recipients under the age of 21 or over the age of 64.[18] Department of Social Services regulation (18 NYCRR 360–4.3) expands Medicaid eligibility for children when their care and treatment is expected to keep them away from home for more than 30 days, regardless of the parents' resources or insurance cov-

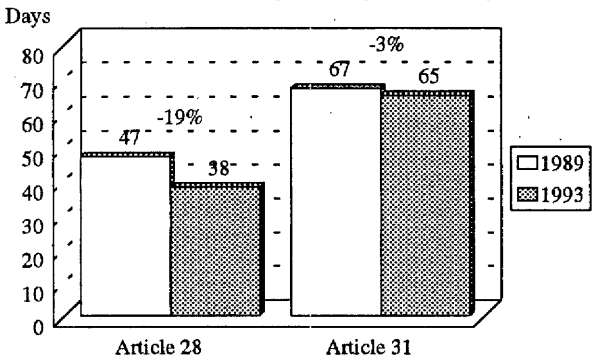
[18] *See, supra,* Footnote at p. 11.

erage. At two of the hospitals visited by the Commission, 10% to 15% of the 1993 Medicaid patient days represented children converting from private insurance to Medicaid.

Medicaid Patient Stays

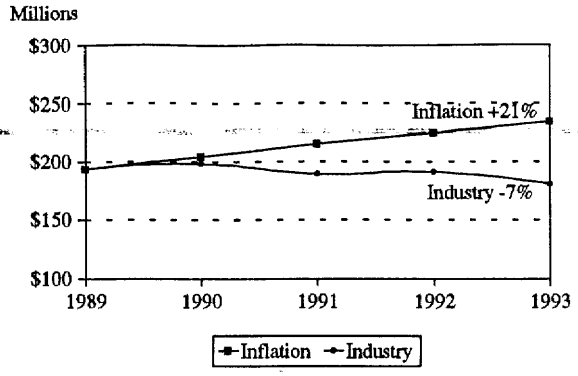
Although Medicaid patient stays were found to be longer than insurance patient stays, this was somewhat expected. Insurance patients are more likely to be healthier, connected to the workforce, and part of intact families, all of which provide sources of support that may shorten lengths of stay. Conversely, Medicaid patients often have few of these resources. Thus, the mere fact that Medicaid lengths of stay are longer does not necessarily indicate that they can be shortened. Nevertheless, comparing Medicaid length of stay figures from Article 28 general hospitals allowed the Commission to conclude that there may be room for reductions in Medicaid stays at the Article 31 psychiatric hospitals.

Figure 28
Medicaid Average Length of Stay



Based on comparable populations.

Figure 29
Industry Expenses vs. Inflation



An analysis of comparable Medicaid populations indicates that the Article 31 hospital stays are markedly longer than those of the Article 28 hospitals.[19] For 1993, the average Article 28 hospital stay was 38 days, while the Article 31 stay averaged 65 days (Figure 28). Moreover, during the five-year period ending 1993, the average stay for Medicaid patients at Article 28 hospitals declined 19%, while the average for Medicaid patients at Article 31 hospitals declined by only 3%. These figures lead to the conclusion that managed care monitoring of Medicaid patient stays at the private psychiatric hospitals could generate cost savings to the state, while providing comparable levels of service.

Hospital Expenditures

Faced with declining revenues, the private psychiatric hospital industry has been forced to reduce expenditures. Industry inpatient expenditures declined 7% over the five-year period 1989 to 1993, despite a 21% increase in the inflation trend factor, presenting not only a large constant dollar decline, but also a real dollar decline (Figure 29).[20]

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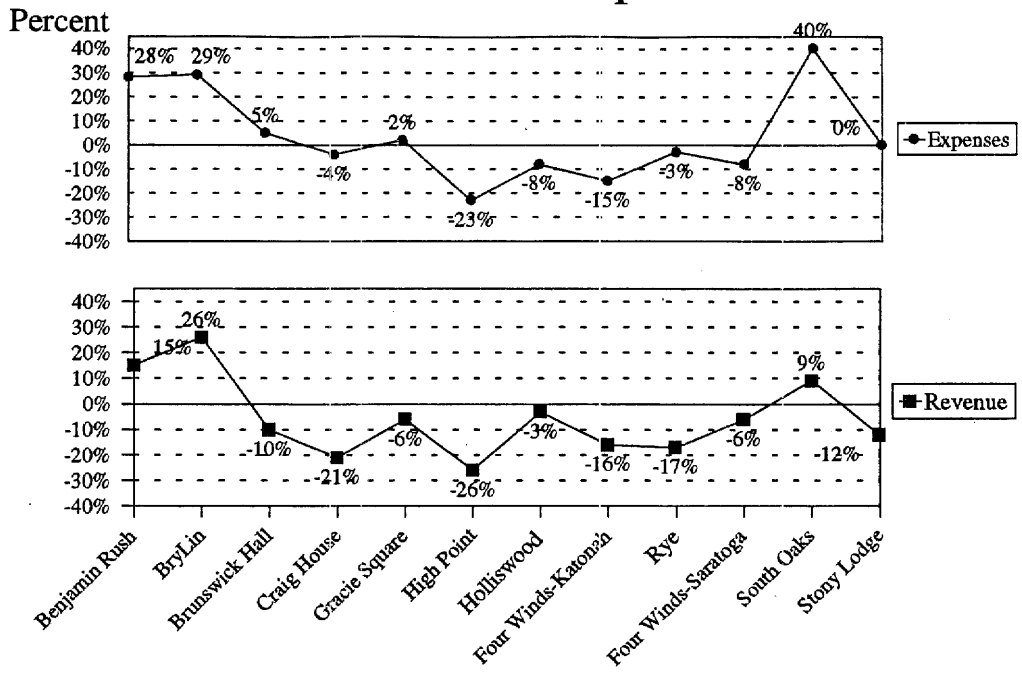
[19] Lengths of stay for Medicaid patients in the Article 28 hospitals included only those of children and elderly in order to be comparable to the Article 31 Medicaid population.

[20] Inflation is based upon the medical trend factors utilized by OMH to set the Article 31 psychiatric hospital Medicaid rates.

Figure 30
Percent Change in Per Diem Revenue and Expenses



Half of the hospitals experienced a decline in both per diem revenue and expenses. An analysis of the per diem figures shows that the fluctuation in expenses often mirrored the changes in revenue (Figure 30). It is, therefore, reasonable to conclude that many hospitals were able to economize when faced with declining revenues. Nevertheless, the decline in industry expenditures was less than the reduction in revenue. As a result, hospitals' profits from inpatient psychiatric care dropped.

Conclusion

As New York State moves toward enrolling Medicaid patients in managed care, the changes seen with insurance patients in the private psychiatric hospitals may serve as a guide for outcomes which should be anticipated. In that regard, if managed care lowers Medicaid patients' lengths of stay in a similar fashion to that already seen with insurance patients, hospital occupancy levels will drop, leading to further downsizing in an already shrinking industry. New York State should be cognizant of the potential loss of further beds in this industry when expanding Medicaid managed care, and should further consider how these hospitals might fit in the future mental hygiene system, recognizing their quality care and reasonable costs when compared to state-operated psychiatric centers.[21]

With the planned downsizing or closure of state facilities, especially children's psychiatric centers, the private hospitals could be a resource for needed short-term inpatient treatment.

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[21] The cost of freestanding state-operated children psychiatric centers was about $600 per patient day for the 1993-94 fiscal year.

Chapter V
Corporate Control and Related Party Issues

While examining the fiscal and operating practices utilized by Article 31 private psychiatric hospitals located in New York State, the Commission found management practices among certain facilities that were not specifically approved by the OMH Commissioner, namely: absentee operators and contract management through agreements with management and clinical groups, some of which involved publicly traded stock corporations.[22] These situations raise concerns over the extent to which the licensed operator is relinquishing de facto control of the hospital to outside parties.[23] Furthermore, some of these practices raise questions concerning the reliability of reported costs and profitability because certain contracts can generate higher costs to the hospital, which in reality are profits to the hospital owners or their related corporations.

Corporate Control of Hospitals

New York State has maintained a long-standing policy prohibiting ownership of hospitals by publicly traded corporations. The state's policy stems from the historical prohibition against business corporations making profits from the sick as opposed to the charitable, public-minded nature of voluntary hospitals. The restriction was relaxed in 1971 (Chapter 722) when proprietary individuals and businesses were allowed to own and operate hospitals and nursing homes, but would have to undergo the same review of public need, financial viability, and character and competence. One of the many reasons for the stockholder ownership prohibition is that the application process to obtain an operating certificate requires a character and competence review of the applicants. It would be extremely difficult, if not impossible, to assess the character and competence of the stockholders of a publicly traded corporation, particularly since another corporation may own shares of its stock.

Linked with the character and competence assessment is the desire to maintain clear and immediate responsibility for the operation of hospital health services. When ownership is far removed from service delivery, the ability of the state to hold accountable and sanction institutional owners not maintaining appropriate standards of care becomes diluted.

Another argument against publicly traded corporations is that the profit motive of its investors would take a front seat to quality of care or responsiveness to local community needs and well being. The counter to this claim is that hospitals must provide quality care and be responsive to the community needs in order to stay competitive and survive.

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[22] The operator is the holder of a hospital operating certificate and as such is the business owner of the hospital operations.

[23] New York Mental Hygiene Law §31.22(c)(1) prohibits *any* change in the person or entity that is the holder of an operating certificate absent the approval of the OMH Commissioner and a character and competence review.

Other debates reign over the effect on access to services. Some argue that investor-owned corporations have greater access to capital, thus facilitating expansion of needed services. Others claim there would be a further erosion in uncompensated care, such as services for the medically indigent. Thus, while many other states have allowed such corporate ownership for decades, the intended effect of New York State law and policy has been to preclude these investor-owned hospitals. Nevertheless, the Commission in its review found that some operators in this state have delegated control over many aspects of the hospitals' operations to publicly traded corporations, in effect, passing operational control to entities not licensed or approved to provide services.

At two of the hospitals visited, the Commission found that the operators had little or no involvement in the hospitals' management or clinical operations. This is inconsistent with the expectations that are both explicit and implicit in the existing statutory scheme that holds operators, whose character and competence was the basis for issuing the operating certificates in the first place, accountable for the hospitals' performance. In the case of one hospital (Regent), substantial problems in the operations of the hospital led to its eventual closure. In the other case (Holliswood), there was no apparent adverse effect upon patient care from these arrangements.

Regent Hospital

At Regent Hospital, the operator had entrusted virtually all control of hospital operations to National Medical Enterprises (NME), a publicly traded corporation. After Regent Hospital was granted an operating certificate by OMH, the operator reportedly removed himself from all aspects of the hospital's operations by resigning from the board of directors and entering into a contract in which NME took over the management of the facility. The remaining members of the board of directors at Regent Hospital were all high-ranking employees of NME, and they approved the non-arm's-length contract and all payments associated with it.

The Regent Hospital management contract states that NME will assume responsibility for the supervision and performance of the facility's nonclinical, administrative and business management services. Many of the activities at Regent Hospital indicate that it operated much like a subsidiary of NME. This close relationship included a cash management program run by NME in which all of Regent Hospital's cash was transferred to an NME-controlled bank account. From this bank account, NME was responsible for paying Regent Hospital's expenses. As for the clinical aspect of the hospital, the Board appointed a medical director, and the hospital contracted with a medical group as the exclusive provider of clinical services.

As noted in its August 1994 application for closure, NME had "clinical and financial responsibility for the Regent Hospital." The application listed two factors leading to the hospital's closure: (1) losses during its last three years of operation, and, (2) NME's corporate decision to cease being a provider of inpatient psychiatric services. NME's exit from the psychiatric industry in New York, as well as nationally, was the result of a settlement reached after extensive litigation and criminal investigations by the U.S. Justice Department into illegal patient recruitment, kickbacks, fraudulent billings, providing unnecessary treatment, and physical mistreatment and abuse of patients.[24]

[24] In August 1993, the FBI raided NME headquarters, regional offices, and hospitals across the country, seizing vast amounts of corporate records as part of a major health care fraud investigation. In July 1994, NME agreed to divest itself of psychiatric hospital operations and pay in excess of $360 million to settle federal criminal fraud charges. Interestingly, a few days after the Commission's fiscal investigators announced their intent to visit Regent Hospital as part of this study, the *New York Post*, on May 25-26, 1994, reported on Regent's confidential patient files overflowing from a dumpster and found blowing around on the streets of New York City. Regarding this particular occurrence, OMH did make certain inquiries; however, its scrutiny appeared focused on the discarded records and did not extend to exploring how this troubled corporation came to control Regent Hospital.

Holliswood Hospital

At Holliswood Hospital, the Commission was informed that the operator was living out of the state and rarely visited the facility. The hospital contracted with a publicly traded management company, Mediplex Inc., for daily administration. The Chairman of the Board and the majority stockholder of Mediplex Inc. was the operator of Holliswood Hospital. In June 1994, Mediplex was acquired by another publicly traded corporation, Sun Health Care Group (SHCG), Mediplex thereby becoming a wholly owned subsidiary of SHCG.

Corporate Control of Hospitals—Conclusion

Although the Commission did not intend to examine the state policy on publicly traded corporations when it began the study on the private psychiatric hospitals, the extent to which hospital control has been delegated to outside parties raises a question of whether existing public policy as reflected in statute is being adequately monitored and enforced. In the case of Regent Hospital, its operations were most clearly being controlled by a publicly traded corporation, and the dominance of NME undoubtedly played a role in the ultimate demise of this hospital. Whether or not the corporate atmosphere fosters an undesirable approach to quality service delivery is debatable, but unless the state changes its policy governing corporate control of these hospitals, more effective methods of monitoring and enforcement of the law are required, especially given the expanding role of public financing of their operations.

Related Party Costs/Hidden Profits

The Commission's examination of hospital management and clinical contracts has led to the conclusion that some hospitals may be more profitable than their financial reports would lead one to believe, particularly when related party contracts are involved. This is important to note when attempting to determine the hospital's true profitability and especially relevant for Medicaid rate-setting because cost reimbursement should be limited to the lower of the cost to a related party or the fair market value of goods or services.

Regent Hospital

Regent Hospital's financial statements indicated that its management company, NME, received incentive bonuses based upon the net income of the hospital, and transactions with NME were designed so that the hospital showed net earnings of exactly zero. In most years, the hospital's "true profits" were paid out in incentive bonuses to NME, thus increasing the reported costs and eliminating the hospital's reported profits.

The practical effect was to allow NME to surreptitiously enter the New York market, which precludes publicly traded corporations as sponsors of private psychiatric hospitals. For many years, Regent Hospital operated like a subsidiary of NME, with NME taking all the profits of the hospital and even covering its losses in the last few years of operation. Overall, this was a very lucrative arrangement for NME, with NME reaping large profits through related party charges.

Why the operator would enter into an agreement depriving him of 100 percent of all earned profits could not be determined. However, the Commission does know that NME contracted to pay him $97,000 annually as its special medical consultant. Moreover, as a consultant, the operator was reportedly given the use of a furnished office while providing a *maximum* of three hours of services per week. Under these conditions, even if he worked the maximum hours, his compensation would equate to an hourly rate of $620.

Holliswood Hospital

Holliswood Hospital's management contract with Mediplex Inc. requires specific advisory, support, and administrative services be provided to the hospital for a fee. These services include a cash management program in which all cash receipts are deposited into a Holliswood Hospital bank account which funds a Mediplex account through automatic transfers. Mediplex Inc. uses this account to pay all of Holliswood Hospital's expenses. The contract also provides that if the hospital's expenses exceed its revenues, Mediplex Inc. at its discretion may provide operating subsidies to fund the shortfall. In 1993, Holliswood Hospital paid $1.7 million to Mediplex Inc. for this management contract. Holliswood's financial statements state that fees paid to Mediplex "may not be representative of what they would have been if Holliswood had performed these services internally or had contracted for such services with unaffiliated entities," and the hospital's 1993 cost report contained a downward cost adjustment of $1.4 million to reflect such unallowable costs.

Four Winds-Katonah Hospital

A similar management contract was extensively reviewed by OMH during a Medicaid rate audit at Four Winds-Katonah Hospital. Preferred Health Care (a 68% owned subsidiary of Four Winds-Katonah) received $3.5 Million from the hospital for general advisory services, billing, and patient accounts management and financial services. This fee was based on a percentage of Four Winds Hospital's gross income plus an additional six dollars per patient bed day. Four Winds Hospital claimed that $2.1 million of these costs were allowable for reimbursement. However, OMH determined that the services provided by the management company were only worth $384,000; the remainder apparently represented profit. OMH proceeded to eliminate the reimbursement of these excessive costs from the Medicaid rate.

Highpoint Hospital

An audit of Highpoint Hospital for the years 1985 to 1989 conducted by the Special Prosecutor for Medicaid Fraud Control uncovered excessive charges and unreasonable compensation. Many of the audit findings pertained to personal expenses of the operator being reported as hospital costs. For example, the cost report contained utility charges for the operator's personal residence (e.g., electricity, gas, telephone). Additionally, certain travel and entertainment charges were personal and unrelated to the hospital's business activities.

The largest audit adjustments related to the owner's salary. The Special Prosecutor called for cost adjustments to disallow approximately three-quarters of the $325,000 to $400,000 annual salary of the operator, bringing it to a level comparable to that of an executive director at an OMH psychiatric center, a level considered by the Special Prosecutor to be reasonable in the circumstances. However, OMH has not yet developed specific guidelines for limiting Medicaid funding of operator compensation levels in the Article 31 psychiatric hospital industry.

Stony Lodge Hospital

- **Consultant Contract**

At Stony Lodge Hospital, the Commission identified a non-arm's-length contract where one of the two licensed operators agreed to be a consultant with his own hospital. The operator signed the contract on behalf of both parties — as president of the hospital and individually as its consultant. The contract provided for a constant cash payment to the consultant (operator) regardless of the hospital's profitability. This 1991 agreement called for compensation of $300,000 per year, with annual increases in accordance with the consumer price index, plus reimbursement for all travel and living expenses associated with the contract. The Stony Lodge contract stated that the owner was to determine

if and when the services were required: " ... Stony Lodge may from time to time reasonably require [general advisory and consulting services], in a manner determined by Consultant, consistent with his position and status."

- **Clinical Contract**

Stony Lodge Hospital also had a contract with Stony Lodge Medical Group (SLMG) for all clinical services performed at the hospital. SLMG is owned by the two operators of the hospital. The contract states that SLMG is solely responsible for any and all clinical operations at the hospital. The reimbursement received for this service is 100 percent of the hospital's gross clinical billings, excluding admission exams and psychiatric testing. This agreement was entered into even though the hospital never collects 100 percent of all gross billings due to negotiated rates that are below the full per diem and because of uncollectible accounts. Hospital staff are responsible for billing patients on behalf of SLMG, and for this service the hospital receives compensation equal to five percent of all SLMG's gross billings. In 1993, SLMG received over $2 million from the hospital. In addition to these payments, the hospital paid annual compensation of $632,000 for the SLMG physicians, and also paid for incidental expenses the physicians incurred. Although it appears likely that the millions of dollars in related party charges at Stony Lodge are inflated beyond their true cost, the 1993 cost report filed by the hospital did not contain any downward cost adjustments pertaining to related party contracts.

Related Party Costs—Conclusion

Fees paid to operators and related companies may not be representative of the true cost or fair market value had the hospitals not contracted with a related party. Therefore, there is no guarantee that hospital cost reports will reveal the true picture of the industry's profitability. Although the Commission believes that there have been declining profits resulting from managed care, the profitability analysis discussed in Chapter IV is only as accurate as the self-reported figures and does not necessarily present the full story.

Given that many hospitals utilize related party contracts, OMH should carefully review contractual relationships prior to the promulgation of a Medicaid rate and disallow any excess costs which in effect represent profits. OMH should also examine the extent to which owner compensation/salary is a reasonable and necessary cost so that excess payments may be disallowed for Medicaid reimbursement purposes. Audits like those performed at Four Winds and Highpoint Hospitals are the best way to ensure that the cost-based Medicaid rates are not overfunding hospital operations.

Chapter VI
Conclusions and Recommendations

Summary of Findings and Conclusions

The Commission's principal findings and conclusions are as follows:

I. Quality of Services

The Commission's review found that private psychiatric hospitals offer a high quality of care to patients with commercial insurance and to the increasing number of children and elderly who rely on government sponsored insurance programs to finance their mental health care.

From its site visits to eight hospitals, the Commission concludes that these hospitals not only are attentive to patients' personal care needs, but also have strong treatment and discharge planning practices. These strong clinical practices include the development of comprehensive assessments that focus on patients' strengths and needs, timely treatment interventions, and discharge practices that arrange residential settings and scheduled therapy appointments prior to patients' release from the hospital.

In contrast to psychiatric units of general hospitals and state psychiatric centers visited over time by the Commission, where patients spend a great deal of idle time on the unit, private psychiatric hospitals offer patients an array of therapeutic activities and programs and require frequent on-unit presence by psychiatrists who meet with each of their patients individually several times a week. Additionally, the private psychiatric hospitals were low users of chemical and mechanical restraint and seclusion, and many hospitals conducted follow-up with patients after they were discharged, an activity rarely performed by most other inpatient psychiatric facilities.

II. Lengths of Stay

Since 1989, there has been a dramatic reduction (49%) in lengths of stay brought about by managed care firms as a means of controlling and lowering costs for private insurance enrollees. Such reductions have not had any measurable adverse effect on quality of care at private psychiatric hospitals. At the same time, Medicaid and Medicare lengths of stay—free from managed care oversight—decreased only modestly (by 3% and 7%, respectively). Medicaid patients' lengths of stay at general hospitals for comparable populations were found to be 42% lower than private psychiatric hospitals.

Hospital administrators and clinical staff commented on how the advent of managed care has sharply redefined the types of psychiatric symptomatology identified as warranting treatment in inpatient settings, and a dramatic change in previously held expectations on how long inpatients should stay in the hospital. Just having a serious mental health problem, or an eating or conduct disorder are no longer accepted as sufficient justification to authorize extended hospital stays. Oftentimes, managed care firms require that only the most acute patient needs be addressed on inpatient settings and full justification is demanded on why adequate care cannot be provided through intensive outpatient services.

As private hospitals have witnessed the decline of certain patient populations, they have sought out government-insured populations. These new patients—who often have less support from family and friends, and poorer education and vocational backgrounds—have placed increased demand on the hospitals in arranging patient discharges. Thus, private hospitals have needed to develop stronger relationships with local social services agencies, as well as the array of housing and health care residential facilities.

Nevertheless, while modifying operating practices and cutting costs to remain viable in the cost-conscious managed care environment, the Commission noted that Medicaid and Medicare patients' lengths of stay have decreased only modestly, compared to lengths of stay for privately insured patients, suggesting that managed care initiatives could be successfully applied to the government insurance programs. This conclusion is especially plausible when private psychiatric hospital average stays for comparable Medicaid populations are compared to general hospitals. Since 1989, average Medicaid stays of children and elderly at private psychiatric hospitals decreased from 67 days to 65 days while similar stays at general hospitals decreased from 47 to 38 days. It appears likely that the fiscal interest in reducing the cost of care is consistent with the public policy interest of providing needed services and supports in the least restrictive environment.

III. Access to Mental Health Care by the Poor and Elderly

The Commission has found no indication that private psychiatric hospitals which historically served mostly the high end of the mental health market (i.e., patients with insurance coverage or an ability to pay) have been willing to open their doors to the uninsured. Faced with declining revenues and profits because of managed care, it is only out of necessity that the industry has been turning to providing services to the elderly and indigent mentally ill—but, only to the extent that government insurance, even at reduced "cost based" rates and without a profit add-on, is available.

The industry has responded to reductions in services to insurance clients by treating more patients covered by Medicaid and Medicare. The Commission found that the revenues from these public sources more than doubled between 1989 and 1993, rising from $28 million (or about 14% of hospital revenues) to $70 million (or 40% of hospital revenues). Due to federal requirements governing Institutions for Mental Diseases, private psychiatric hospitals can only bill Medicaid for services provided to recipients under the age of 21 or over the age of 64. Consequently, there has been a markedly greater proportion of patient days pertaining to children and elderly persons, although not sufficient to completely offset the significant reductions in private insurance revenue.

Further, while the bad debt and charity care issues for the uninsured medically indigent have been germane to general hospitals and state psychiatric centers, the Commission found no noticeable contribution by this industry to serving such populations—even in the "good times." Thus, with continued external demands to control costs and without a profit or disproportionate add-on through the Medicaid rate it is unlikely that this industry will contribute to the care of the uninsured, leaving this burden with the public/voluntary hospital system.

IV. Impact of Managed Care on Hospital Finances

When faced with declining revenues for managed care, private hospitals have been able to economize by reducing costs. The reductions in costs, however, have been less than decreases in revenues resulting in a drop in operating profits.

When faced with declining revenues because of managed care measures such as pre-admission certification, utilization review, negotiated reimbursement rates and use of less expensive outpatient services, the private psychiatric hospital industry reduced costs by 7% from 1989 to 1993, despite a 21% increase for inflation. Three-quarters of the hospitals experienced a decline in per diem revenue and most of these were able to reduce per diem expenses, but the decline in expenditures was less than the lost revenue leading to reduced profits. A precise estimate of the industry's apparently declining profitability is difficult because the Commission found numerous instances where "profits" were disguised as costs through less-than-arm's-length management contracts.

V. For-Profit Hospitals as an Alternative Treatment Source

With the downsizing or closure of state facilities, especially children's psychiatric centers, the private hospitals could help satisfy the need for placement and treatment of these individuals while at the same time helping to offset the impact of managed care on the industry. In doing so, the state will not only achieve cost savings from both managed care and state facility downsizing, but also will help further the policy goal of "privatizing."

When measured on a per diem basis, private psychiatric hospitals' $425 average Medicaid reimbursement rate compares favorably to the state's free-standing children's centers cost of $600. These same economies do not materialize for adults in state psychiatric hospitals which are able to capture Medicaid revenues for uninsured persons through disproportionate share financing or with general hospitals which qualify for Medicaid for the 21–64 population because they are not classified as Institutes for Mental Diseases.

Although Medicaid patient stays were found to be longer than insurance patient stays, this should not be surprising as insurance patients are more likely to be healthier, connected to the workforce, and part of intact families, all of which provide sources of support that may shorten lengths of stay. Nevertheless, comparing Medicaid length of stay data from general hospitals for comparable populations leads the Commission to conclude that there may be room for reductions in Medicaid stays at private psychiatric hospitals.

Based on reduced occupancy levels in this industry, there appear to be opportunities to utilize this industry to further the privatization objectives of the state, albeit their geographic concentration in a few areas of the state will limit such reliance.

VI. Public Accountability

Existing restrictions prevent investor-owned corporations from entering the New York market and operating private psychiatric hospitals. The operation of for-profit hospitals by single owner(s) has generally acted to prevent the widespread abuses associated with corporate ownership found in other states. But, if the state is to continue to prevent undesirable elements from entering New York, the Office of Mental Health must be more diligent in identifying the true owners of such facilities in light of the Commission findings that some operators had surreptitiously transferred operating responsibilities to outside individuals or corporations.

The desire to maintain clear and immediate responsibility for the operation of licensed facilities in order to hold approved identifiable individuals responsible for mental health service delivery underlies the present language and intent of Mental Hygiene Law and regulation. One concern is that ownership of a private psychiatric hospital by a national corporation, far removed from a hospital's operation, would weaken the ability of the state to hold corporate owners accountable for poor standards of care

and would pose serious problems in assessing their character and competence. Another argument is that the profit motive of investor-owned corporations would take a front seat to quality of care and to local community interests. Thus, while other states have allowed national corporate ownership of private hospitals, the effect of state law has been to preclude them as sponsors of such hospitals.

Nevertheless, the Commission has found in its review that some operators in this state have delegated control over many aspects of their hospitals' operations to outside individuals and to investor-owned corporations, in effect, passing operational control to entities not licensed or approved to provide services. While, with the notable exception of the recently closed Regent Hospital, there has been no adverse effect on patient care from these arrangements, there were many instances found by the Commission where profits have been hidden from government scrutiny in setting Medicaid rates and in evaluating the industry's financial viability.

Recommendations

1. The private psychiatric industry provides quality services at reasonable cost and is worth preserving. As the state's role in the direct provision of inpatient psychiatric hospitalization diminishes and there remains an unmet need for such services in areas of the state served by private psychiatric hospitals which are underutilized, such facilities may provide a cost-effective option for the delivery of quality services.
2. The successful techniques for reducing patient lengths of stay by managed care firms in private psychiatric hospitals should be extended to the Medicaid populations in these facilities. Using 1993 data, if Medicaid stays were reduced by 42%, bringing them in line with general hospital stays for comparable populations, there would be a potential annual savings of $13.9 million through reduced Medicaid payments (42% of $33 million Medicaid revenues in 1993).
3. To the extent that Medicaid rates continue to be based on reasonable and necessary costs, it is important that the Office of Mental Health conduct audits to help ensure that cost-based Medicaid rates are not overfunding hospital operations. Additionally, these audits would help to ensure that licensees are not transferring operational responsibility of hospitals to outside corporations or individuals.

Appendix

Response of the New York State Office of Mental Health to the Commission's Draft Report

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

James L. Stone, MSW, Commissioner

April 2, 1996

Clarence J. Sundram
Chairman
State of New York
Commission of Quality of Care for the
Mentally Disabled
99 Washington Avenue, Suite 1002
Albany, NY 12210-2895

Dear Mr. Sundram:

The Office of Mental Health (OMH) concurs with the conclusions and recommendations of the Commission in this report which reflects positively on the private psychiatric hospitals operating in New York State. OMH's response to each of the Commission's three recommendations is contained in this letter. In addition, I asked Mr. Mederic McLaughlin, OMH's Deputy Commissioner for Quality Assurance to coordinate a review of the report.

Our review of OMH quality assurance and financial data correlates with the information contained in the report.

- Certification: The hospitals have been routinely visited on the two year licensure cycle; 10 of 11 licenses are current (paperwork pending on the 11th); deficiencies focus most on environment, treatment records (particularly documentation for restraint and seclusion and medications), discharge planning and staffing.

- Audit: As noted below, OMH fiscal monitoring included the conduct of four financial/management audits at two of the private psychiatric hospitals. Many of the medicaid billing trends noted in the report were found.

- Quality Assurance: Periodic Medical Review survey data correlates well with the report in many areas. For example the report cites excellent progress notes in the private psychiatric hospitals, especially regarding their frequency and quality. OMH data show a 98 to 99 percentile scoring range for progress notes in these hospitals (and a 93 to 99 range for state psychiatric centers). OMH quality assurance staff also review complaints and incidents as they occur in these settings and conduct investigations and clinical audits as appropriate. These findings are not inconsistent with CQC data.

Recommendation:

1. The private psychiatric industry provides quality services at reasonable cost and is worth preserving. As the state's role in the direct provision of inpatient psychiatric hospitalization diminishes and there remains an unmet need for such services in areas of the state served by private psychiatric hospitals which are underutilized, such facilities may provide a cost-effective option for the delivery of quality services.

OMH Response:

OMH fully supports the investigation and utilization of cost effective high quality approaches to the delivery of mental health services. A number of alternatives including privatization and public-private joint ventures with existing inpatient providers may be considered in the future. These types of innovative solutions will hopefully become more prevalent as the state moves to adopt managed care approaches to meet the health and mental health care needs of its citizens. The Integrated Delivery System (IDS) initiative contained in the Governor's FY1996-97 budget would establish block grants to counties, enabling them to design local networks of care. Based upon the findings of the report, it appears that private psychiatric hospitals may be well positioned to compete in this environment.

Recommendation:

2. The successful techniques for reducing patient lengths of stay by managed care firms in private psychiatric hospitals should be extended to the Medicaid populations in these facilities. Using 1993 data, if Medicaid stays were reduced by 42%, bringing them in line with general hospital stays for comparable populations, there would be a potential annual savings of $13.9 million through reduced Medicaid payments (42% of $33 million Medicaid revenues in 1993).

OMH Response:

As the report notes, patients funded by the medicaid program may present additional challenges to successful treatment as compared to non-medicaid patients. Specific levels of savings, therefore, are difficult to predict even if it is assumed that the case mix of medicaid patients will remain static. In addition, dropping LOS results in limited savings if the beds remain fully utilized due to increased admissions.

As we move to implement an IDS, publicly funded patients will be enrolled by county based networks. The effect of this approach will in all likelihood change the intake referral and admission patterns existent in the private psychiatric hospitals during the time period when the study was conducted. In any case, we fully concur that the implementation of a managed care approach is necessary for publicly funded mental health services, and we are actively planning for IDS which implements this approach.

Recommendation:

3. To the extent that Medicaid rates continue to be based on reasonable and necessary costs, it is important that the Office of Mental Health conduct audits to help ensure that cost-based Medicaid rates are not overfunding hospital operations. Additionally, these audits would help to ensure that licenses are not transferring operational responsibility of hospitals to outside corporations or individuals.

OMH Response:

Currently, the Department of Social Services and the Office of Mental Health share responsibility for auditing cost reports, billing practices and issues related to operational efficiency in the private psychiatric hospitals. As the report notes, OMH has conducted four audits at two of the private hospitals over the last few years. Looking forward, under proposed IDS legislation, OMH retains authority to conduct audits of IDS networks. Counties will also monitor and audit as necessary fiscal and program data as they negotiate rates and enter into contracts with network managers or with providers.

While ownership is an area that will be focused upon through certification and fiscal audit functions, another initiative actively underway will also assist in this area. OMH's traditional Certificate of Need regulations are in revision. The new process will be designated as "Prior Approval Review (PAR)" and will incorporate provisions for prior OMH review of management contracts. Primary among the goals of this new system are to facilitate quality services and prevent abuses in the system while being responsive to new needs for flexibility within a managed care environment.

Two sets of existing CON regulations will be combined and streamlined. PAR will also decrease processing time and rely less on need methodologies and project batching, two factors that contributed to inflexible and time consuming project reviews.

I appreciate the opportunity to provide comments on this draft report.

Sincerely,

James L. Stone

James L. Stone
Commissioner

Att.

cc: Mederic McLaughlin

Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-473-7538.

The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

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