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FINAL REPORT

Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report

Executive Summary

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EXECUTIVE SUMMARY

Section 2707 of the Affordable Care Act (ACA; P.L. 111-148) required the U.S. Department of Health and Human Services (HHS) to conduct and evaluate a demonstration on the effects of providing Medicaid reimbursements to private psychiatric hospitals that treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions (EMCs).[1] The demonstration tested the extent to which reimbursing these hospitals for inpatient services needed to stabilize a psychiatric EMC, which is generally prohibited under Medicaid statute, improved access to and quality of care for beneficiaries and reduced overall Medicaid costs and utilization. This report presents the final evaluation results.

Rationale for the demonstration

Since the enactment of Medicaid in 1965, institutions for mental disease (IMDs), defined as "hospitals, nursing facilities, or other institutions primarily engaged in providing diagnosis, treatment, or care of persons with mental illness," have been prohibited by statute from receiving federal Medicaid matching funds for inpatient treatment provided to adults ages 21 to 64. Through this exclusion, Congress sought to maintain the historic responsibility of states for long-term hospitalization in large mental institutions and emphasize community-based care as an alternative. As a result of widespread "deinstitutionalization" that began in the 1950s, fewer hospital beds were needed, and over the next five decades publicly funded state IMDs closed or were downsized significantly. Individuals experiencing psychiatric emergencies were served in small psychiatric facilities or the psychiatric units of general hospitals, both of which are exempt from the IMD exclusion, or through community-based alternatives to hospitalization. During the past ten years, however, frequent boarding of psychiatric patients in general hospital emergency departments (EDs) has been reported to occur when specialized inpatient psychiatric beds are not available.

This situation is further complicated by requirements under the 1986 Emergency Medical Treatment and Labor Act that hospitals participating in Medicare examine any person who comes to the ER to determine whether he or she has an EMC. The hospital must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. An IMD that participates in Medicare and has specialized capabilities and the capacity to treat psychiatric EMCs must admit or accept transfers of patients with such conditions for stabilizing treatment, regardless of the individual's ability to pay. As a result, in states that do not cover the costs of inpatient treatment for Medicaid beneficiaries using state-only funds, IMDs excluded from Medicaid reimbursement may be required to provide uncompensated treatment to beneficiaries with psychiatric EMCs.

Implementation of the demonstration

In response to these concerns and legislative requirements, CMS implemented the Medicaid Emergency Psychiatric Services Demonstration (MEPD) and its evaluation. In August 2011, CMS solicited applications from states to participate in the demonstration and in March 2012 selected 11 states (Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North

[1] Psychiatric EMCs were deemed to be present when an individual expressed suicidal or homicidal thoughts or gestures, or was judged to be a danger to him- or herself or others.

Carolina, Rhode Island, Washington, and West Virginia) and the District of Columbia (hereafter referred to as a state) to participate; 28 private IMDs participated in the demonstration. MEPD began on July 1, 2012 and, in accordance with legislative requirements, ended three years later, on June 30, 2015.

Data submitted by participating states to CMS for payment and monitoring purposes show the following:

- MEPD funded 16,731 admissions of 11,850 Medicaid beneficiaries.
- About three-quarters of admissions were judged eligible for MEPD on the basis of suicidal thoughts or gestures; relatively few (10 percent) were based on homicidality.
- About two-thirds of beneficiaries were admitted with diagnoses of mood disorders and one-third with diagnoses of schizophrenia or other psychotic disorders.
- Of the 11,850 beneficiaries, 77 percent were admitted to a participating IMD just once during MEPD.
- The average IMD length of stay was 8.6 days. However, the distribution of length of stays was skewed, and, although the vast majority were for less than a month, some were substantially longer (with a maximum of 147 days).
- For 90 percent of admissions, beneficiaries were discharged to their homes or self-care; another 3 percent were discharged home under the care of a home health service organization. The extent to which such placements included discharge to homeless shelters, group homes or other supervised living arrangements, and the streets is unknown; follow-up care arrangements for individuals discharged to their homes or self-care were also unspecified in these data. Four percent of admissions were transferred to other institutions.
- The ACA authorized $75 million in federal funds for MEPD. Total federal and state expenditures on claims were approximately $113 million. Depending on the state, the federal share of these claims ranged from 50 to 73 percent.

Evaluation Design

The ACA directed HHS to "conduct an evaluation of the demonstration project in order to determine the impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program." The ACA required the evaluation to include the following:

A. An assessment of access to inpatient mental health services under the Medicaid program; average lengths of inpatients stays; and emergency room (ER) visits

B. An assessment of discharge planning by participating hospitals

C. An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency, and ambulatory care)[2]

[2] Note, however, that the ACA did not require CMS or states participating in MEPD to demonstrate cost neutrality.

D. An analysis of the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project, as compared to those admitted to these same facilities through other means

E. A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis

The ACA further mandated that "not later than December 31, 2013, the Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation." In September 2012, CMS awarded a contract to Mathematica Policy Research to conduct the evaluation. We prepared the Report to Congress for the secretary in the first year of the evaluation contract, and CMS posted the report to its public website in January 2014 (http://innovation.cms.gov/Files/reports/MEPD_RTC.pdf). Due to the timing of the implementation of the demonstration and the time required to plan and conduct the evaluation, HHS did not have enough data to recommend expanding the demonstration at the time the report was submitted, but recommended that the demonstration continue through the end of the current authorization to allow a fuller evaluation of its effects.

To fully assess all of the areas mandated by the ACA, as well as to meet the interests of critical stakeholders, we designed and implemented a comprehensive, mixed-methods evaluation of the MEPD. We used quantitative data on service utilization and expenditures to evaluate the MEPD's effect on inpatient admissions, length of stay, ER visits, and costs, as well as on psychiatric boarding in EDs and scatter beds. We designed a pre-post quantitative analysis: the pre-demonstration period was two years prior to the implementation of MEPD (2010–2012) and the post period was two years of demonstration experience (2012–2014). The primary quantitative data were service utilization and expenditure data drawn from Medicaid and Medicare[3] enrollment and claims files. Data on IMD admissions under the MEPD and ED boarding came directly from states, IMDs, and EDs. Where possible, we identified comparison groups and conducted difference-in-differences analyses.

To assess discharge planning by participating hospitals, as mandated by ACA evaluation area B, we collected qualitative data through site visit interviews with state project directors and IMD staff, medical record reviews, beneficiary interviews, and review of documents such as state MEPD proposals and operating plans. We also examined qualitative data on psychiatric EMC determination and stabilization review processes to better understand how states and hospitals operationalized the ACA demonstration requirements. Qualitative data also provided information on how care provided in IMDs was similar to or different than care provided in general hospital scatter beds and EDs. In addition, we supplemented quantitative data with qualitative reports regarding changes to boarding and referral process in EDs and general hospital scatter beds resulting from MEPD. Key informant interviews and an ongoing environmental scan conducted throughout MEPD also provided information about contextual events that might influence demonstration outcomes.

[3] To obtain a more accurate estimate of total costs and savings to the federal government, Medicare files were included for dual Medicare-Medicaid enrollees.

Results

Exhibit ES.1 summarizes the results of the evaluation. Overall, we found little to no evidence of MEPD effects on inpatient admissions to IMDs or general hospital scatter beds; IMD or scatter bed lengths of stays; ER visits and ED boarding; discharge planning by participating IMDs; or the Medicaid share of IMD admissions of adults with psychiatric EMCs. Federal costs for IMD admissions increased, as expected, and costs to states decreased. The extent to which these findings were driven by data limitations, were affected by external events, or reflect true effects of MEPD is difficult to determine.

Exhibit ES.1. Summary of evaluation results, by ACA area

Measure	Findings
Access to inpatient mental health services under the Medicaid program, average lengths of inpatient stays, and ER visits	
Inpatient IMD admissions[a]	The one statistically significant change that showed a decrease in IMD admissions is likely due to a data quality issue in one quarter of the pre-demonstration period. In the one state with 1.5 years of data during the MEPD, admissions increased late in the MEPD period.
General hospital scatter bed admissions	No effects (use was low but increased during MEPD in both MEPD and comparison groups)
IMD length of stay	No effects (nonsignificant trend for IMD stays to be longer than stays in general hospital psychiatric units)
General hospital scatter bed length of stay	No effects
ER visits	No effects (trend toward more ER visits during MEPD)
ED boarding time	No effects
Discharge planning by participating IMDs	
• In most states, IMDs did not change their discharge planning processes for MEPD[b] and used identical procedures for Medicaid and non-Medicaid patients. • The vast majority of beneficiaries were discharged to their homes rather than transferred to other facilities. • A third of the states implemented specific procedures to improve linkages with community-based providers for beneficiaries with EMCs. • With few exceptions, beneficiaries interviewed expressed satisfaction with the discharge planning processes at the IMDs, and 88 percent felt safe to leave the IMD when they were discharged. • IMDs appeared to provide better connection to and documentation of recommendations for aftercare than medical-surgical units in general hospitals serving beneficiaries in scatter beds. • Discharge planning was hampered by lack of available community-based care.	

Measure	Findings
Costs of the full range of mental health services (including inpatient, emergency department, and ambulatory care)[c]	
Federal Medicaid/MEPD costs for IMD inpatient stays	Costs increased
State costs for Medicaid beneficiary IMD inpatient stays	Costs decreased
IMD costs for Medicaid beneficiary IMD inpatient stays	Increased in one state, decreased in the other
Medicaid and Medicare costs for full range of mental health services[d]	Increased in two states, no effect in three
Percentage of consumers with Medicaid coverage admitted to inpatient facilities as a result of MEPD, compared to those admitted to same facilities through other means	
Proportion of admissions meeting MEPD eligibility criteria	Increase in proportion of Medicaid admissions may be due to ACA Medicaid expansion

[a] The evaluation did not separately examine MEPD's effects on readmissions.

[b] Neither the ACA nor CMS required states or IMDs to change care processes for the MEPD.

[c] Note that the ACA did not require CMS or states participating in MEPD to demonstrate cost neutrality. Not all MEPD states were included in the analyses, due to insufficient usable data.

[d] Medicare costs were included for dual Medicare-Medicaid enrollees.

Limitations. Our analytic approach and data sources presented various limitations. Data obtained directly from IMDs and EDs varied in quality and structure, and we had to make some judgements about the meaning of some of the response categories and actual responses in standardizing variables across facilities. Due to data limitations, most quantitative analyses included only a subset of participating states, and the extent to which the results would be similar for other states is unknown. For analyses relying on Medicaid data,[4] we were able to obtain only data for the first six months of MEPD for most states. As suggested by the analysis of IMD admissions in one state with 1.5 years of demonstration data, some effects might have occurred later in the demonstration; whether results would differ if data from the full MEPD time period were available is unknown. Qualitative data were biased in favor of positive results, as they relied heavily on interviews with and documents provided by state project directors and IMD staff. Beneficiary interviews were also likely subject to positive bias due to selection factors, as IMD staff obtained consents, and individuals with potentially more negative experiences (such as those with guardians who may have been involuntarily committed) and outcomes (such as those transferred to other facilities or to homeless shelters) were less likely to participate.

Most quantitative analyses did not include comparison groups for most states.[5] Pre-post analyses without comparison groups cannot determine whether changes observed over time result from MEPD or external factors. We conducted interrupted time series analyses to assess the difference in trends occurring during MEPD from trends in the pre-demonstration period, but these analyses could not establish causality regarding any differences found. Various state and hospital-level changes occurred during and independently of MEPD that could have differentially influenced outcomes for intervention and comparison groups, or overall. For example, two-thirds of participating states expanded Medicaid eligibility under the ACA during the evaluation period, which might have been responsible for an increase in the Medicaid share

[4] Medicaid data were used for analyses of IMD and scatter bed admissions and lengths of stays, ER visits, and total Medicaid and Medicare mental health costs. They were not used for analyses of ED boarding, discharge planning, costs of IMD admissions, or Medicaid share of IMD admissions (ACA area D).

[5] Exceptions included analyses of IMD length of stay and ED boarding time.

of IMD admissions in several expansion states. As a result, we cannot be certain that any effects are due to the MEPD alone. Moreover, as suggested by respondents during qualitative interviews and by observed increases in scatter bed use and ER visits in both MEPD and comparison groups, a broad increase in demand arising, in part, from the Medicaid expansions, may have masked program effects.

Implications and limitations on generalizing the results for future policy decision-making

At the time this report was written, considerable legislative and regulatory activity was taking place regarding potential full or partial elimination of the IMD exclusion. The Improving Access to Emergency Psychiatric Care Act (P.L. 114-97), enacted December 11, 2015, allows potential extension of MEPD in current states and potentially expands participation to additional states through FY2019, if HHS is able to determine and CMS can certify that a state's participation is projected not to increase net Medicaid program spending. Beyond the demonstration, on May 6, 2016, CMS released a final regulation regarding Medicaid managed care, which clarified that, in states that allow it, managed care plans can use their capitated payments to pay for IMDs as an alternative setting in lieu of state plan-covered services for enrollees over the age of 21 and under the age of 65 who stay in IMDs 15 or fewer days in a given month. Additional proposals and legislative options regarding Medicaid payment for IMD admissions are being discussed by Congress and mental health stakeholders. Therefore, it is critical to keep in mind the following limitations to the generalizability of the findings from MEPD:

- Facilities participating in MEPD were limited to private IMDs and did not include publicly-funded IMDs or residential substance abuse treatment facilities (RTFs), which are also subject to the IMD exclusion.
- The results apply only to adults with mental illnesses who are suicidal, homicidal, or otherwise judged to be dangerous to themselves or others. MEPD did not address inpatient treatment or ER visits among people with substance-related disorders or beneficiaries seeking inpatient or emergency treatment for serious psychological distress who were not judged to be dangerous to themselves or others.
- The extent to which MEPD effects generalize to a managed care environment is largely unknown.
- MEPD may underestimate the number of private IMD admissions and length of IMD stays that would be covered under Medicaid if the IMD exclusion were eliminated altogether.
- The authorizing legislation for MEPD (that is, the ACA) did not include the requirement for HHS to determine or CMS to certify that a state's participation was projected not to increase net Medicaid program spending. Therefore, states participating in MEPD were not required to offset costs of IMD admissions funded under MEPD or to demonstrate cost neutrality. We cannot determine, therefore, the effect that specific state efforts in this regard might have on costs or other evaluation outcomes.
- Due to resource limitations, outcomes examined were limited to those mandated by the ACA and for which data were readily available. Other potentially important outcomes, such as mortality from suicide and other causes, acts of violence, involvement with and costs to

the criminal justice system, homelessness, symptom remission and consumer recovery, effects on state- and county-funded community-based services, and 30-day hospital readmissions were beyond the scope and resources for this evaluation.

Conclusion

Data limitations prevent us from drawing strong conclusions about the effect of MEPD on access to inpatient care, length of stays, ER visits, and costs. Available data suggest, however, that increased access of adult Medicaid beneficiaries to IMD inpatient care would likely come at a cost to the federal government.[6] Moreover, providing access to IMD services may not be able to address the numerous reasons other than inpatient bed searches that contribute to long stays of psychiatric patients in EDs. Given the high cost of inpatient care relative to community-based care and major shortages in the availability of community-based care and psychiatric ED services across the country, future initiatives may wish to balance consideration of potential increases in funding for IMD and general hospital inpatient services within the context of a more comprehensive approach that considers distribution of new resources across all aspects of the system (inpatient, emergency, and ambulatory care).

[6] Note, however, that the ACA did not require states participating in MEPD to demonstrate cost neutrality; had this provision been included, states may have made specific efforts to offset the costs of IMD admissions through cost-savings elsewhere. We cannot determine, however, the effect such efforts might have had on costs or other evaluation outcomes.

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