

Alternatives to Inpatient Psychiatric Services for Medicare-Medicaid Enrollees: A Case Study of Commonwealth Care Alliance

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IN BRIEF: Commonwealth Care Alliance (CCA) is one of the health plans participating in Massachusetts' One Care demonstration under the Medicare-Medicaid Financial Alignment Initiative. The One Care demonstration began serving enrollees in October 2013. Shortly after its Medicare-Medicaid Plan began operating, CCA observed unexpectedly high behavioral health needs and high use of emergency department (ED) and inpatient psychiatric facility (IPF) services among enrollees, particularly those without connections to ongoing community-based medical or behavioral health care.

To address rising costs and what CCA perceived as unnecessary IPF admissions due to a lack of appropriate and available community-based crisis stabilization settings, it built on Massachusetts' existing Medicaid behavioral health crisis stabilization services to create two new enhanced crisis stabilization units (CSUs) to: (1) provide short-term residential care for high-need patients in psychiatric crisis who could be appropriately served in a community-based setting; and (2) connect enhanced CSU patients to ongoing community-based care.

Preliminary analyses suggest that the enhanced CSUs may have contributed to decreased IPF stays, ED admissions, and per-member per-month costs. Other states developing or implementing integrated care delivery approaches for the under-65 Medicare-Medicaid population can draw upon CCA's experience to anticipate challenges they may experience and inform their own integrated program strategies.

Commonwealth Care Alliance (CCA), a not-for-profit health plan participating in Massachusetts' One Care demonstration under the Medicare-Medicaid Financial Alignment Initiative for dually eligible individuals, has created a new setting of care – an enhanced residential crisis stabilization unit (enhanced CSU) – to fill a gap in the behavioral health continuum of care available to demonstration enrollees. The goal of the enhanced CSUs is to decrease the use of high-cost Medicare inpatient psychiatric facility hospitalizations and emergency department admissions by enrollees in psychiatric crisis who could be appropriately cared for in a community-based crisis stabilization setting.

Although Massachusetts' One Care demonstration is unique in that it only includes individuals under age 65 at enrollment, all other Medicare-Medicaid Financial Alignment Initiative demonstrations (except for South Carolina) include the under-65 population as well as those 65 and older, as do most states that contract with Medicare Dual Eligible Special Needs Plans (D-SNPs).¹ Therefore, other states and health plans can look to CCA's experience and its use of the enhanced CSUs as a model for how they might address the acute clinical needs and overutilization of high-cost services that they will likely observe among their enrollees. This brief describes the development of CCA's enhanced CSUs and key features of the model. It also includes preliminary findings on the impact of the enhanced CSUs and considerations for other states or health plans that might want to develop a similar care setting.

Medicare-Medicaid Enrollees and the Financial Alignment Initiative

Individuals dually enrolled in Medicare and Medicaid (Medicare-Medicaid enrollees) are among the most costly enrollees in both programs. Many have complex care needs due to multiple co-occurring conditions. The Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO) developed the Financial Alignment Initiative in 2011 to help states create approaches to better integrate care for this population, including physical and behavioral health services and long-term services and supports (LTSS).²

Under-65 Medicare-Medicaid Enrollee Characteristics: Often-Undocumented High Needs, Utilization of Costly Services, and Poor Outcomes

In contrast to the 65-and-over Medicare-Medicaid population, under-65 enrollees are much more likely to have long-term behavioral health conditions such as anxiety disorders (21 percent, compared to 12 percent of those over 65), bipolar disorder (14 percent, compared to 3 percent), depression (31 percent, compared to 21 percent), or schizophrenia and other psychotic disorders (13 percent, compared to 7 percent).³ In CCA's experience, this population is also less connected to ongoing community-based care, and more likely to have unstable housing compared to over-65 enrollees. Because they are less often connected to care, these individuals' day-to-day behavioral health and medical needs may not be adequately addressed, leading to frequent use of costly but often unnecessary emergency room and inpatient hospital services.

CCA's Early Experience Providing Integrated Care to Dually Eligible Individuals under Age 65

CCA has a long history of providing integrated care for dually eligible individuals age 65 and older through Massachusetts' Senior Care Options program,⁴ which began in 2004. However, the One Care demonstration was CCA's first experience providing integrated care to dually eligible individuals under age 65. Almost immediately upon launching its One Care plan in 2013, CCA observed unexpectedly high behavioral health needs and high use of ED and IPF services by enrollees.^{5,6} As of late 2015, CCA reported that 22 percent of its approximately 10,000 One Care enrollees had a severe mental illness, four

"Patients' psychiatric conditions, compounded by substance abuse, homelessness, and a history of trauma impact their ability to stay connected to care. The majority do not stay connected without intervention."

– CCA Staff Member

percent had severe mental illness combined with an active substance or alcohol addiction, and approximately 49 percent had other significant behavioral health problems. Enrollees also had a high prevalence of trauma, HIV/AIDS, and homelessness, and as previously mentioned, often had no regular source of health care.

In the first 15 months of the demonstration, CCA's 10,000 members had over 900 IPF admissions, which were often preceded by an ED admission for a psychiatric crisis. Because of a lack of alternatives, individuals were often referred by EDs to the next available bed at any IPF within a 50-mile radius, presenting additional challenges for continuity of care for this population. CCA presumed that the frequent use of high-cost services was primarily due to individuals' lack of connection to ongoing, community-based care and a systemic lack of appropriate community-based alternatives to IPFs.

CCA staff reviewed the records of its members who were admitted to IPFs and found that up to 70 percent did not require such a restrictive and expensive care setting. Instead, CCA staff believed these individuals could be served in less restrictive CSUs, which are typically short-stay, six-to-eight bed, unlocked facilities that provide 24-hour care to patients in psychiatric crisis. However, existing Medicaid CSUs in Massachusetts were often full and, further, CCA felt the services provided by these “typical” CSUs were not comprehensive enough for some of its more complex enrollees, their average length of stay (LOS) was not long enough, and their model of care did not include sufficient follow-up with patients after the stay. (See Appendix 1 for a summary of CSUs in Massachusetts and how they developed.) Other existing care settings for individuals in psychiatric crisis, such as Medicare-funded partial hospitalization programs, also did not provide sufficiently intensive treatment for these individuals. (See Appendix 2 for a comparison of different care settings.) CCA saw a need for comprehensive crisis stabilization services to fill a gap in the behavioral health continuum of care and stem the rising cost of ED and IPF admissions.

Features and Key Components of CCA’s Enhanced Crisis Stabilization Units

CCA, in partnership with Bay Cove Human Services,⁷ created two enhanced CSUs in the Boston area – The Carney and Marie’s Place – that are available to its One Care members in psychiatric crisis. The Carney, opened in October 2014, is a 12-bed unit in a wing of a community hospital. Marie’s Place, a 14-bed freestanding building that CCA purchased and renovated, opened eight months after The Carney in June of 2015. (See Exhibit 1 for major features of The Carney and Marie’s Place compared to IPFs.)

Exhibit 1: Features of The Carney and Marie’s Place Enhanced CSUs Compared to IPFs

Feature	IPFs	The Carney	Marie’s Place
Facility type	Inpatient hospital	Unit of a community hospital	Freestanding home
Number of Beds	Varies; nationally over half of the nearly 500 free-standing IPFs have more than 76 beds and about 16 percent have 24 or fewer beds ⁸	12 beds	14 beds
Facility Setting	Varies; however, patients typically restricted to the inpatient unit	Residential neighborhood, walkable shops nearby	Residential neighborhood adjoining city center
Basic Unit Design	Institutional environment	Modified institutional environment may be more appropriate and comfortable for patients with more acute illnesses	Home-like environment may contribute to therapeutic nature of the unit
Public Transportation	Varies; however, patients typically restricted to the inpatient unit	Accessible public transportation	Accessible public transportation
Patient Access to the Community	None or limited; typically units are locked	Patients limited to supervised daily walks and community outings	Patients may go out “on pass” independently into the community

- **The Carney** is a single-floor unit of a community hospital. Patients who are more agitated or require more intensive monitoring tend to be referred to The Carney because the layout makes it easier for staff to monitor patients down the single sight line of the hallway, and because the wide hallways provide more room for a patient who might be agitated and blowing off steam. Staff felt that The

Carney was a better environment for patients who felt safer in the more structured-feeling hospital unit.

- **Marie’s Place** is a three-story, Victorian-style home in Brighton, MA. It is in a residential neighborhood near the city center, across from a bus stop and the local community hospital, giving patients easy access to the local community. In comparison to The Carney or to IPFs, Marie’s Place gives patients greater independence. Based on CSU staff judgment and the patient’s plan of care, CSU patients are allowed to go “out on pass” independently, for example, to get something at the local convenience store, go to church, or walk to a local Alcoholics Anonymous meeting. CCA staff feel that this relative freedom helps prepare patients for transitioning back to the community after discharge. Patients expressed appreciation for the freedom and for the respect they received from CCA staff and it seemed to motivate them to work hard and feel ownership over their recovery, and to encourage community building among the patients. The patients and staff at Marie’s Place also emphasized the contribution of the home-like environment to the therapeutic nature of the unit.

CCA designed both The Carney and Marie’s Place enhanced CSUs with a number of key components that help them to address patients’ unique needs:

- **Longer length of stay.** As previously noted, CCA’s enhanced CSUs have an average LOS of 10 days, much longer than the average 2.5 LOS for a typical CSU. (See Appendix 2 for more details on patient and facility characteristics of the enhanced CSUs compared to other care settings.)

“I use a curriculum that integrates substance abuse, trauma, and mental health, which is somewhat unique. Most groups will address substance abuse or mental health, maybe both, but integrating trauma is less common.”

– Marie’s Place Social Worker/Clinician

The longer LOS allows sufficient time to stabilize the patient in psychiatric crisis; fully assess their behavioral health, medical, and other social support needs; provide needed services while the patient is on the unit; and connect or re-connect them to primary care. In contrast,

CCA staff said that in a typical CSU, the shorter LOS makes it extremely challenging to do more than stabilize a patient before they are discharged, and staff must spend hours on the phone each day requesting service authorizations and LOS extensions. With CCA acting as both the insurer and lead clinical entity, CSU staff are empowered to make decisions about service provision and discharge dates based on their professional assessment of patient needs.

- **Staffing levels.** CCA staffs its enhanced CSUs with more masters-level clinicians compared to a typical CSU, which allows it to provide a wider range of medical services (e.g., medication-assisted detoxification) to patients while they are on the unit. Importantly, staffing levels are maintained on the weekends, which allows CCA to continue to provide one-on-one check-in meetings with patients twice per day, seven days per week, as well as support groups, and any other needed clinical or social services. CSU staff include a nurse practitioner, nurse manager, a Licensed Independent Clinical Social Worker (LICSW), and mental health workers. In comparison, typical CSU staff includes a licensed practical nurse rather than a LICSW and staffing levels may drop on the weekends.
- **Enhanced peer support.** Patients and staff at both The Carney and Marie’s Place talked about the importance of the enhanced support groups provided on the units, which address the full range of patient needs, including, mental and behavioral health, substance abuse, and trauma. They felt that the comprehensive groups were a key piece of the recovery services provided and set CCA’s CSUs apart from a typical CSU curriculum. A nurse manager at The Carney explained that in most other settings, groups are focused on a single issue – either alcohol, substance abuse, or behavioral health – and therefore do not address the complex needs of patients with multiple co-occurring conditions. CCA also incorporates peer mentors who have experienced mental health and substance abuse issues into its CSU curricula, which is a recognized promising practice for supporting recovery for adults with

serious mental illness.⁹ Peer mentors write and lead part of the curriculum, coming in to the CSUs each week to talk with patients about their personal experiences.

- **Connections to primary care and community providers.** CSU staff connect patients to a primary care provider shortly after admission. If a patient has an existing relationship with a primary care or behavioral health provider, CCA invites the provider to the unit to meet with CSU staff and the patient to help maintain or re-establish relationships prior to discharge. In contrast, CCA staff explained that care provided at IPFs tends to focus on active treatment in the facility itself, which may result in less than optimum care for those who could benefit from a connection to ongoing community-based care as well. CCA further facilitates continuity of care with outside providers by offering transportation to community medical, behavioral health, or other supportive services appointments. One patient at Marie’s Place recalled that for several months prior to coming to the CSU she had been in and out of locked IPFs and was not able to see outside providers. At Marie’s Place she was able to continue to see her community psychiatrist, which was an important part of her treatment.
- **Relationships with local EDs.** CCA’s strong relationships with local EDs provide an opportunity to “catch” individuals who previously cycled through EDs and then on to IPFs without any connection to ongoing community-based care. To encourage consideration of transfer to a CSU as an alternative to an IPF stay for patients needing continued crisis stabilization services, CCA staff attend discharge planning meetings with ED staff and remind them to consult with CCA before searching for an inpatient psychiatric bed for enrollees. To further encourage patients to consider the enhanced CSUs, CCA also meets with patients enrolled in CCA’s One Care plan while they are in the ED to educate them about the services available at The Carney and Marie’s Place. This can be especially important for patients who may be wary of CSUs based on their prior experiences. CCA also at times invites hesitant patients to visit the enhanced CSUs to persuade them to consider CSUs as an alternative to hospitalization.

“[The CSU staff] help us prepare to move on – they set me up to go to an intensive outpatient treatment center in Lowell when I’m done here. They made the appointment for me to go visit the program. They provide transportation to the doctor and back, they get you there on time and it’s all very safe.”

– Enhanced CSU patient
- **Managed care flexibilities.** Because CCA’s One Care plan operates under a capitated payment model to provide all Medicare and Medicaid services to enrollees, it has the freedom to provide services not typically covered in the fee-for-service system. For example, CCA has applied this flexibility to:
 - Enroll patients in intensive outpatient treatment programs for substance abuse and partial hospitalization programs as part of discharge plans, starting patients in the program while they are still on the unit. In the fee-for-service system these services would be non-reimbursable while patients were in a CSU.
 - Help caregivers prepare for a patient’s move back home, arranging a progressive transition, with the patient starting by spending days at home and coming back to the CSU at night, and eventually moving home, but returning to the CSU every day to participate in the curriculum with other CSU patients.
 - Provide transportation for non-medical-related purposes, such as visits to a sober home or to a court date.

Site Selection, Renovation, and Financing

When planning the enhanced CSUs, CCA looked for sites that were in a community with easy access to public transportation, close proximity to a medical facility, with a non-institutional feel, and a sustainable cost. CCA first located the residential property that would become Marie's Place. However, renovations took longer than anticipated, and, in the meantime, CCA identified, renovated, and began using The Carney, a wing in a local community hospital.

CCA determined that it needed a partner to help finance and renovate the sites that would become the CSUs. CCA chose MINCO Corporation¹⁰ for this role because it had the relevant expertise in finance, renovation, and licensing, and importantly, the capital and willingness take on the risk involved in financing a project that was the first of its kind. And MINCO had a diverse portfolio of work, which meant it was not relying on the CSUs to be extremely profitable. During the renovation of Marie's Place, MINCO staff worked closely with CCA staff, holding weekly meetings to consult on the renovation details.

The Carney required only light renovations and is currently leased from the hospital. In contrast, Marie's Place required more upfront outlays of cash for purchasing and renovations. As the developers and financiers for Marie's Place, MINCO staff felt The Carney was a more replicable model because it did not require the upfront investment of Marie's Place. However, for plans or states considering developing a care setting such as the enhanced CSUs, the long-term financial benefit of renting versus buying would depend upon a given market and its available supply of candidate housing or other types of units.

Partnerships, Staffing, and Licensing

As previously described, CCA has been serving the Medicare-Medicaid population since 2004 through Massachusetts' Senior Care Options Program. Over the years, CCA developed relationships with community organizations serving this population as well as its own community-based network of providers. CCA's leadership team brought an innovative spirit and willingness to take on the risks associated with creating a new care setting. CCA's chief of psychiatry in particular brought important expertise in emergency services and crisis stabilization services generally, risk management, and the Emergency Services Program in Massachusetts,¹¹ having overseen the first CSU in the state for several years. She also brought an expertise in training physicians and other staff in good risk management practices, which was critical for the CSUs.

While CCA had the in-house clinical expertise and vision for the enhanced CSUs, it sought a partner with experience in the administrative aspects of running a residential crisis stabilization unit. More specifically, CCA sought a partner with: (1) experience providing services to individuals with serious mental illness; (2) a good working relationship with oversight agencies such as the Massachusetts Department of Mental Health; (3) a history of creative and less risk-averse approaches to providing care; and (4) a vision and mission that was in keeping with CCA's. As previously mentioned, CCA chose to partner with Bay Cove Human Services, an organization that exceeded these criteria and had already partnered with CCA on development of Massachusetts' health homes model for behavioral health.

CCA's clinical leadership felt it was important to "keep the clinical piece in house," so the CSUs are staffed with CCA's own nurse managers, psychiatric nurse practitioners, and social workers/clinicians. The mental health workers in the CSUs come from Bay Cove. However, on the units, all CSU staff work closely together as a team.

Enhanced CSU Financing: Leveraging Medicare and Medicaid Funds to Provide Enhanced Services

States operating crisis services programs have struggled to pull together funding for crisis stabilization services from Medicaid, state general funds, SAMHSA grants, philanthropy, and the private sector.¹²

With access to both Medicaid and Medicare funding through a capitated model, Medicare-Medicaid Plans in the Financial Alignment Initiative and other integrated health plans, like D-SNPs, can add Medicare funding to the mix, providing additional resources for expanded or new services, such as enhanced CSUs, to their enrollees. Health plans that are at risk for both Medicare and Medicaid services can use the savings from reduced use of costly Medicare services like EDs and IPFs to fund lower-cost and more appropriate services for Medicare-Medicaid enrollees.

“The ultimate potential benefit is not just substituting the \$600 per day cost of a CSU for the \$1,100 per day cost of an inpatient stay, but to get enhanced engagement for the long term.”

– Bob Master, former CCA CEO

Further, once enrollees are engaged in care, health plans can: (1) conduct an initial health risk assessment to determine enrollees’ care needs; (2) provide access to needed Medicare and Medicaid services that may previously have not been available; and (3) record all of the diagnoses that are determined to be appropriate in the course of providing these services. For enrollees previously unconnected to care, this may result in assignment of more accurate Medicare risk scores, and subsequent increased capitation payments, which can help address the high costs of providing care for these enrollees. CCA is counting on long-term engagement of its members leading to better clinical outcomes and reduced use of high cost services.

Preliminary Findings on the Impact of the Enhanced CSUs

CCA is evaluating the enhanced CSUs’ impact on IPF use, LOS, and readmission rates, as well as overall costs.¹³ Following are some promising preliminary results from CCA’s analysis:

- Growth in behavioral health per member per month costs decreased from a rate of 10.7 percent per month between October 2013 and creation of the Carney CSU, to 1.5 percent per month from October 2014-June 2015.
- Costs for inpatient psychiatric admissions largely stabilized, with utilization decreasing from 9.6 admissions per 1,000 members per month in the period October 2013-September 2014, to 8.5 for the period October 2014-July 2015.
- Inpatient psychiatric days per 1,000 members per month decreased in the same period from 125 to 100.

Forthcoming analyses will examine patient satisfaction and longer-term clinical and financial impacts, including total costs across all service types, and costs for developing and operating the CSUs.

Summary of Early Lessons from CCA's Experience

Following are key lessons from CCA’s experience developing the enhanced CSUs:

- **Model of care is key.** CSUs need a comprehensive curriculum of medical and behavioral health services including comprehensive groups and peer support that address behavioral, substance abuse,

trauma, and other challenges. The LOS has to be sufficient to fully stabilize each patient and prepare them for discharge and to connect patients to community-based care during their CSU stay.

- **A clinical leadership team with strong risk management practices is essential.** Plans will need a clinical team comprised of highly skilled staff such as psychiatrists, nurse practitioners, and social workers, who are able to identify individuals who are appropriate for community-based treatment, assess and manage their symptoms effectively, and train others in these practices.
- **Plans will need experienced partners.** Plans must identify partners with experience serving the under-65 Medicare-Medicaid population, running 24-hour residences, and developing relationships with the local community. Likely partners include agencies that run housing and rehabilitation programs for individuals with psychiatric and substance abuse disorders, or housing and services programs for individuals with developmental disabilities.
- **Help with facility development may be needed.** Plans may need partners with experience purchasing or leasing, financing, renovating, and licensing properties for residential programs.
- **Small units (fewer than 20 beds) work best.** CCA staff said that a community “feel” and peer-group support would be harder to establish in larger facilities, and that a substantially larger staff would be needed.
- **Good candidate facilities.** Good candidate sites for small residential units include: unused hospital wings, large homes, small nursing facilities, facilities formerly used as group homes for individuals with serious mental illnesses or intellectual and developmental disabilities, and IPFs with 16 or fewer beds that can be funded by Medicaid.
- **Facility design matters.** Staff and patients at Marie’s Place said its home-like environment was an important contributor to the therapeutic nature of the CSU. On the other hand, staff said that the hospital environment of The Carney was more comfortable and appropriate for patients needing more intensive monitoring.

Plans that receive capitated payments to provide both Medicare and Medicaid services can use the savings generated from reduced high-cost service use to fund lower-cost and more appropriate services for Medicare-Medicaid enrollees. Capitated payments can be enhanced by properly documenting the care that is provided to patients using crisis stabilization services, especially care for previously unmet needs.

CCA has found that short-term residential crisis stabilization services can be a more appropriate alternative to Medicare IPF in many cases, if the services are properly designed, staffed, and managed. The enhanced CSU model may be a good addition to integrated care programs in states that provide crisis stabilization services similar to those in Massachusetts, and especially those states that provide those services through a managed care arrangement. The enhanced CSU model may also work in states that provide Medicaid-funded short-term crisis residential services and crisis stabilization through fee-for-service arrangements. (See Appendix 1 for details on varying state approaches to providing behavioral health crisis services.) Integrated health plans in these states may be in a particularly good position to consider building upon existing services to create enhanced CSUs for enrollees with high behavioral health needs.

Appendix 1: The Context of Care: Crisis Stabilization Services in Massachusetts and Nationally

Crisis Stabilization Services in Massachusetts. CSUs in Massachusetts were established in their current form in 2009 as part of a redesign of the state's Emergency Services Program (ESP). The ESP is administered by the Massachusetts Behavioral Health Partnership, which is run by a private entity, Beacon Health Options. The Massachusetts Behavioral Health Partnership is responsible for managing Medicaid behavioral health services in the state. The purpose of the ESP is to provide 24-hour access to behavioral health crisis assessment, intervention, and stabilization in the community, and to provide a community-based alternative to ED admissions when possible. Community crisis stabilization services, including CSUs, are one component of the crisis stabilization services available through the ESPs. Other services include a community-based location to coordinate the operation of and provide access to services, and mobile crisis intervention to provide on-site face-to-face assessment and treatment for youth and adults in crisis.

Crisis Stabilization Services Nationally. A recent SAMHSA-funded environmental scan of state behavioral health crisis services nationally suggested that seven other states provide crisis stabilization services similar to those in Massachusetts: Illinois, Maine, Michigan, Missouri, Tennessee, Texas, and Wisconsin.¹⁴ Two of those states (Michigan and Tennessee) provide those services through a managed care arrangement similar to the Massachusetts Behavioral Health Partnership. The scan also identified a number of other states that provide Medicaid-funded short-term crisis residential services and crisis stabilization through fee-for-service arrangements with community mental health centers and other providers, including California, Hawaii, Minnesota, Mississippi, New Mexico, and Oregon. Integrated Medicare-Medicaid plans in these states may be in a particularly good position to consider building upon existing services to create enhanced CSUs for enrollees with high behavioral health needs.

Appendix 2: CCA's Enhanced Crisis Stabilization Units Compared to Other Treatment Options

	Medicare Inpatient Psychiatric Facilities	Medicare Partial Hospitalization Benefit	Typical Medicaid CSU	CCA's Enhanced CSUs
General Characteristics	24-hour - Inpatient hospital -Typically locked setting	Day program -Unlocked setting	24-hour residential community-based facility -Unlocked setting	Same as typical CSU -Unlocked setting
Average Length of Stay	13 days	11-12 days	2.5 days	10 days
Average Daily Cost*	\$1,100	\$240	\$585	\$680
Clinical and Social Needs of Patients	-Requires active treatment of an intensity that can only be provided in an inpatient hospital setting or a DSM-V principal diagnosis -Patients must have co-morbid physical health conditions in addition to a psychiatric diagnosis	-Requires active intensive treatment of condition to maintain functional level and prevent relapse or hospitalization -Does not require 24-hour supervision -Must have an adequate support system and must not be an imminent danger to themselves or others -Commonly have acute onset or decompensation of a covered DSM-IV Axis I mental disorder or a DSM-V diagnosis	-Does not require the intensive clinical treatment provided in an inpatient psychiatric setting -Requires 24-hour care; in psychiatric crisis with active symptomology consistent with a DSM-V diagnosis -May benefit from a short-term, structured stabilization setting -Does not have immediate need for hospital-based diagnostic tests or general medical treatment	-Same as typical CSUs, generally *Patients may have higher needs than in a typical CSU, for example, they may require medication-assisted detoxification services, which are typically not provided in CSUs
Services Provided	-Physician-led treatment, which may include: psychotherapy, drug therapy, electroconvulsive therapy, occupational, recreational, and milieu therapy	-Individual or group psychotherapy -Other services may include: occupational therapy, services of other staff (social workers and others) trained to work with psychiatric patients, drugs and biologicals that cannot be self-administered, family counseling, patient training and education, medically necessary diagnostic services related to mental health treatment	-Crisis stabilization, including initial and continuing bio-psychosocial assessment, care management, medication management, mobilization of family/guardian/natural supports and community resources	-Same as typical CSUs *Additional Services: -Medication-assisted substance abuse detox -Enhanced group, medical, and addiction support. -Emphasis on connection to primary care medical team and other providers, transportation to appointments

* Costs reflect CCA and Massachusetts costs reported by CCA staff. Costs in other states will likely vary, based on regional adjustments to Medicare payment rates, and state Medicaid program and reimbursement features. For more information on national average Medicare payments per day for IPFs in 2012 and other characteristics of Medicare IPFs, see MedPAC. "A Data Book: Health Care Spending and the Medicare Program," Charts 6-29 to 6-33, pp. 86-90. June 2015. Available at: <http://www.medpac.gov/documents/data-book/june-2015-databook-health-care-spending-and-the-medicare-program.pdf?sfvrsn=0>.

	Medicare Inpatient Psychiatric Facilities	Medicare Partial Hospitalization Benefit	Typical Medicaid CSU	CCA's Enhanced CSUs
Staffing	<ul style="list-style-type: none"> -Services must be under the supervision of a clinical director, services chief, or equivalent -Director of psychiatric nursing services with a master's degree in psychiatric mental health nursing, or its equivalent -Registered Nurse (RN) available 24 hours per day -Adequate number of doctors of medicine and osteopathy to provide essential psychiatric services -Adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide care included in each patient's treatment program and to maintain progress notes on each inpatient -Adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning 	<ul style="list-style-type: none"> -Physician-led treatment -Multidisciplinary team provided care 	<ul style="list-style-type: none"> -Supervising Psychiatrist -Nurse manager (RN) -Master's level clinician -LPNs -Bachelor's level milieu staff and mental health workers 	<ul style="list-style-type: none"> -Supervising Psychiatrist -Psychiatric Nurse Practitioner (RN) -Nurse Manager (RN) -Licensed Independent Clinical Social Workers -Mental Health workers

SOURCES: CCA program staff descriptions; Community Crisis Stabilization Performance Specifications. Accessed on 11/24/15 at: <https://www.masspartnership.com/pdf/CCSFINALJul2014.pdf>; Medicare Benefits Policy Manual, Chapter 2: Inpatient Psychiatric Hospital Services, and Chapter 6: Hospital Services Covered under Part B, accessed on 2/11/16 at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-loms-Items/Cms012673.html>

Endnotes

¹ D-SNPs are a type of Medicare Advantage plan that serve beneficiaries dually enrolled in Medicare and Medicaid. To operate in a state, D-SNPs must have a contract with the state to facilitate coordination of Medicare and Medicaid services for enrollees, although states are not required to enter into such contracts.

² For more information about the Financial Alignment Initiative see: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>.

³ Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. Data book: Beneficiaries Dually Eligible for Medicare and Medicaid. Exhibit 8, p. 35. January 2016.

⁴ The Senior Care Options (SCO) program provides all services reimbursable under Medicare and Medicaid through companion Medicaid managed care organizations and Medicare Advantage dual eligible special needs plans and their provider networks. It provides coordinated care, geriatric support services, and social support services.

⁵ Note that the “institutions for mental diseases” (IMD) exclusion that prohibits federal Medicaid payment for services for those between the ages of 21 and 65 in IPFs with more than 16 beds does not apply to Medicare-funded services.

⁶ Medicare IPFs are the major alternative to CSUs for crisis services for enrollees in integrated Medicare-Medicaid plans. There are about 50 Medicare IPFs in Massachusetts and over 1,500 nationwide. In 2012, Medicare paid an average of \$819 per day for IPF services nationally, and the average length of stay was 12.8 days. For more information see: MedPAC. “A Data Book: Health Care Spending and the Medicare Program.” June 2015; “Inpatient Psychiatric Facilities Prospective Payment System Update for FY 2016,” *Federal Register*, Vol. 80, No. 150, August 5, 2015, pp. 46723-46724; Mathematica Policy Research. “Development of Quality Measures for Inpatient Psychiatric Facilities.” Prepared for ASPE, February 2015, Table V.8, pp. 63-64.

⁷ Bay Cove provides services to over 20,000 individuals and families with developmental disabilities, mental illness, and drug and alcohol addiction at over 160 sites in Massachusetts annually, including through its Boston Medical Center-affiliated CSU.

⁸ “Inpatient Psychiatric Facilities Prospective Payment System Update for FY 2016, *Federal Register*, Vol. 80, No. 150, August 5, 2015, p. 46724. Psychiatric units in general hospitals are smaller, with nearly 60 percent of the 1100 facilities having units of 24 beds or fewer.

⁹ Purington, Kitty. Using Peers to Support Physical and Mental Health Integration for Adults with Serious Mental Illness. National Academy for State Health Policy. January 2016. Accessed on 1/26/16 at <http://nashp.org/wp-content/uploads/2016/01/Peer-Supports.pdf>.

¹⁰ MINCO is an appraisal, brokerage, and development company with experience building group residences for individuals with developmental disabilities and mixed-use and affordable housing developments.

¹¹ See Appendix 1 for more information about the Emergency Service Program in Massachusetts, and crisis stabilization services in Massachusetts, and nationally.

¹² Truven Health Analytics. *Crisis Services: Effectiveness, Cost Effectiveness, and Funding Strategies*. Prepared for the Substance Abuse and Mental Health Services Administration, 2014. Available at: <https://store.samhsa.gov/shin/content/SMA14-4848/SMA14-4848.pdf>.

¹³ CCS Evaluation. Internal Preliminary Results Presentation. 7/14/15.

¹⁴ Truven Health Analytics, op cit.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The **Integrated Care Resource Center** is a national technical assistance initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the **Integrated Care Resource Center** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

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