Report to Congress on the Evaluation of the Medicaid Emergency Psychiatric Demonstration

December 1, 2013

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REPORT TO CONGRESS ON THE EVALUATION OF THE MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION

Section 2707 of the Affordable Care Act (P.L. 111-148) requires the Department of Health and Human Services to conduct and evaluate a demonstration to provide Medicaid reimbursements to private psychiatric institutions, which are referred to in Medicaid as "institutions for mental disease" (IMDs), that treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions (EMCs). The Affordable Care Act mandates the secretary to submit to Congress and make available to the public a report on the findings of the evaluation no later than December 31, 2013.

This report presents the initial steps taken to implement the demonstration and early evaluation results. It is based on limited preliminary information provided by participating states and IMDs, including (1) a review of state demonstration applications, operational plans, and quarterly reports, (2) information obtained through initial conversations with state demonstration and IMD staff, and (3) payment and monitoring data submitted by states during the first year of implementation. The legislation further mandates that the evaluation include a recommendation regarding whether the demonstration should be continued after December 31, 2013, and expanded on a national basis. Due to the timing of the implementation of the demonstration and the time required to plan and conduct the evaluation, we do not have enough data to recommend expanding the demonstration at this time; given the limited data, however, we recommend that the demonstration continue through the end of the current authorization, December 31, 2015, to allow a fuller evaluation of its effects.

Background

Since the enactment of Medicaid in 1965, IMDs have been prohibited by statute from receiving federal Medicaid matching funds for inpatient treatment provided to adults ages 21 to 64. This prohibition was rooted in the historic responsibility of states for long-term hospitalization in large mental institutions and the desirability of 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 downsized significantly. Increasingly, individuals experiencing psychiatric emergencies have been served in small psychiatric facilities or the psychiatric units of general hospitals, both of which are exempt from the Medicaid IMD exclusion, or through community-based alternatives. During the past ten years, however, frequent boarding of psychiatric patients in emergency rooms (ERs) and nonpsychiatric beds of general hospitals (referred to as scatter beds) has been reported to occur when specialized inpatient psychiatric beds are not available.

Under the 1986 Emergency Medical Treatment and Labor Act, hospitals participating in Medicare are required to examine any person who comes to the Emergency Room (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 in private IMDs using non-Medicaid funds, private IMDs may be required to provide uncompensated treatment to Medicaid beneficiaries with psychiatric EMCs.

The Medicaid Emergency Psychiatric Demonstration (MEPD) is testing whether the expansion of Medicaid coverage to include services provided by private IMDs to treat psychiatric EMCs improves access to and quality of medically necessary care, discharge planning by participating IMDs, and the impact on Medicaid costs and utilization. The demonstration will also explore a potential remedy to alleviate burdens related to psychiatric boarding in ERs and general hospital scatter beds. For the purposes of the demonstration, the Affordable Care Act defines psychiatric EMCs, with respect to an individual, as one who expresses suicidal or homicidal thoughts or gestures, if judged to be dangerous to him- or herself or others.[1] Before the third day of the hospital stay, participating IMDs must determine whether or not EMCs among demonstration participants have been stabilized; a patient is considered stable when the EMC no longer exists and the individual is no longer dangerous to him- or herself or others.

As depicted in Exhibit 1 and 2, the demonstration is aimed at reducing a number of undesirable aspects of the current system of care for psychiatric EMCs by increasing the use of private IMDs.

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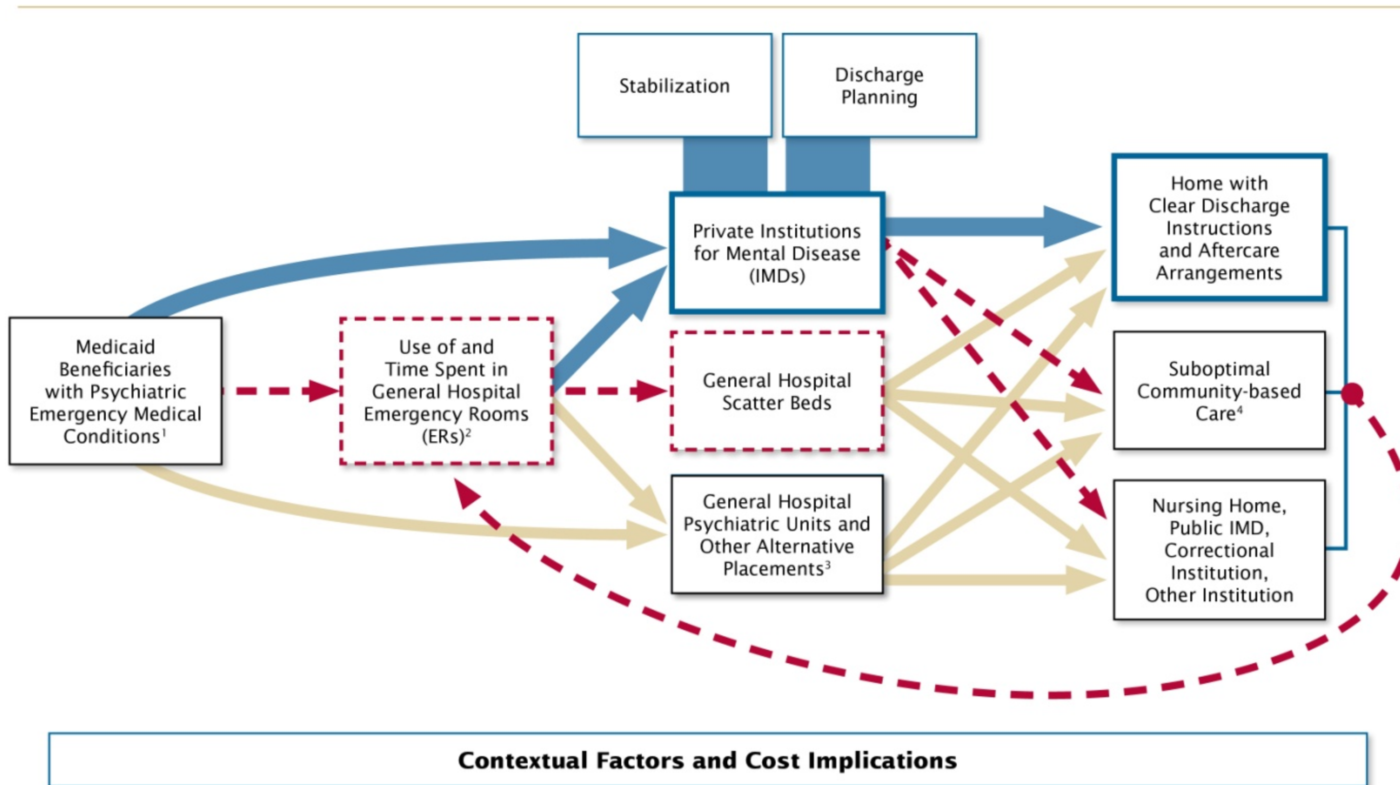
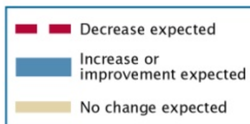
[1]In October 2012, CMS notified participating states that it had expanded the eligibility criteria to also include beneficiaries who may not express suicidal or homicidal thoughts or gestures but are nevertheless judged to be dangerous to themselves or others.

Exhibit 1. Anticipated MEPD Effects on Flow of Medicaid Beneficiaries with Psychiatric EMCs Through the Health Care System





[1]By definition, a psychiatric emergency medical condition exists when an individual expresses suicidal or homicidal thoughts or gestures or is determined to be a danger to oneself or others.
[2]Individuals may skip admission to the general hospital emergency room through utilization of mobile crisis teams or crisis centers, or through direct admission to stabilization facilities.
[3]Alternative placements include public IMDs and community alternatives (e.g., non-IMD residential rehabilitation facilities or crisis centers).
[4]Suboptimal community-based care would include discharges to homeless shelters or no identified residence, and discharges to home without clear and specific follow-up care plans.

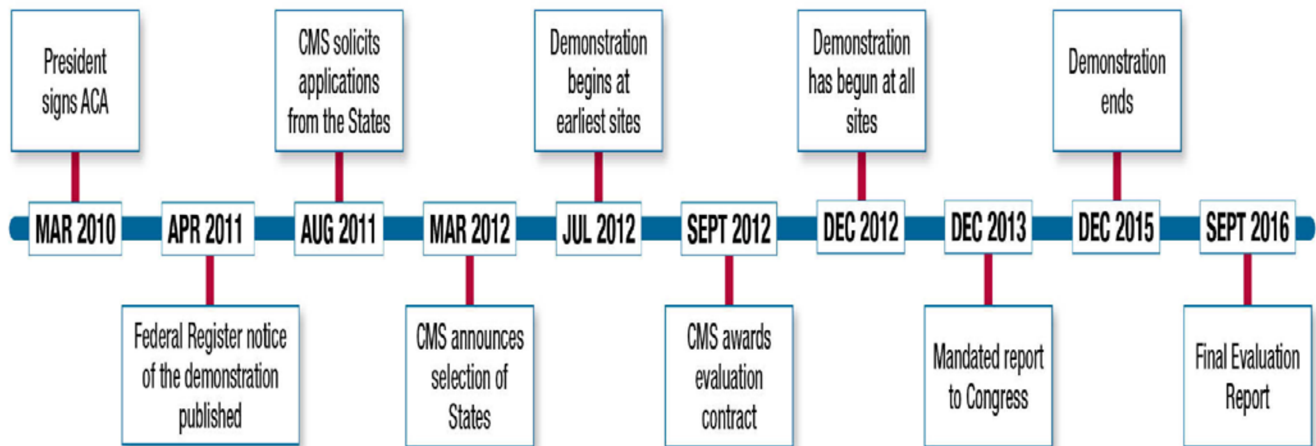
Exhibit 2. Anticipated and Potential Outcomes Associated with the MEPD

Expected Change	No Expected Change
Increased use of private IMDs	Placement in general hospital psychiatric units, public IMDs, and community alternatives
Reduced psychiatric boarding in ERs	Quality of discharge planning in general hospitals, public IMDs, and community alternatives
Fewer placements in general hospital scatter beds	Aftercare following discharge from general hospitals, public IMDs, and community alternatives
Shorter time to stabilization, resulting in lower costs	
Improved discharge planning in participating IMDs, resulting in better aftercare following discharge	
Fewer readmissions to ERs	

Implementation Progress

CMS is implementing the 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 Carolina, Rhode Island, Washington, and West Virginia) and the District of Columbia (hereafter referred to as a state) to participate. The demonstration began on July 1, 2012, and on September 3, 2012, CMS awarded a contract to Mathematica Policy Research to conduct the evaluation (Exhibit 3).

Exhibit 3. Timeline for Demonstration Implementation and Evaluation



State Mental Health Service System Context

The mental health systems in participating states vary in number, size, and type of inpatient psychiatric facilities, as well as in the availability of community-based services. In line with the national deinstitutionalization trend, all of the states participating in the demonstration indicated that they had shifted their focus from inpatient treatment to community based-services over the past few decades. The states vary widely in per capita spending for mental health services and the relative proportion of funds spent on hospitals and community-based programs (Exhibit 4).

Exhibit 4. State Mental Health Agency (SMHA) Expenditures and Services Availability

	SMHA Expenditures, 2010[1]			% of SMHA Clients Receiving Services, 2011[2]	
State	Per Capita, Adults ($)	Percent of All Expenditures on State Hospitals[d]	Percent of All Expenditures on Community-Based Programs[d]	Percent of Assertive Community Treatment (ACT)	Percent of Supported Housing
Alabama	35.37	43	54	1.6	0.4
California	138.41[a]	20	79	1.2	0.3
Connecticut	227.12[a,b]	30	63	0.7	2.4
District of Columbia	328.72	46	40	8.8	3.7
Illinois	78.88	27	71	0.9	1.0
Maine	249.91[a]	13	84	7.6	12.0
Maryland	131.89[a]	24	73	4.5	15.3
Missouri	98.29	48	49	0.9	-
North Carolina	116.08[a]	19	80	4.0	-
Rhode Island	112.36	30[c]	68[c]	8.4	2.4
Washington	94.64	29	69	1.5	3.1
West Virginia	56.68[b]	38[c]	61[c]	1.0	0.4

Sources: [1]National Association of State Mental Health Program Directors Research Institute, 2011 Revenue and Expenditures Study. Available at [http://www.nri-inc.org/projects/Profiles/Prior_RE.cfm]. Accessed May 10, 2013.

[2]Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services Uniform Reporting System Output Tables. Available at [http://www.samhsa.gov/dataoutcomes/urs/urs2011.aspx]. Accessed May 10, 2013.

[a]SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

[b]Medicaid Revenues for Community Programs are not included in SMHA-Controlled Expenditures.

[c]Children's Mental Health Expenditures are not included in SMHA-Controlled Expenditures.

[d]Totals do not add to 100 percent. Expenditures were also used for prevention, research, training, and administration.

Across the 12 states, 27 private IMDs are participating in the demonstration (Exhibit 5). Because the IMDs serve a variety of clients, some of whom are not eligible for the demonstration, only a portion of the total number of IMD beds are available for demonstration participants.

Exhibit 5. Private IMDs Participating in MEPD

State	Name and Location of Participating IMDs	Total Number of IMD Beds[a]	Number of Beds Potentially Available for Beneficiaries Enrolled in Demonstration
Alabama	BayPointe Hospital, Mobile County[b]	24 for adults in psychiatric crisis	24
	EastPointe Hospital, Mobile County	66 for adults in psychiatric crisis	66
	Hill Crest Behavioral Health Services, Birmingham	94 for adults, adolescents, and children	53
	Mountain View Hospital, 56 miles northeast of Birmingham	68 child and adult	18 on adult unit, with additional 10 possible from swing unit
California	John Muir Behavioral Health Facility, Contra Costa County	73 (37 adult)	37
	Heritage Oaks Hospital, Sacramento	125 (106 adult)	106
	Sierra Vista Hospital, Sacramento	107 (83 adult)	83
	Sutter Center for Psychiatry, Sacramento	73 (43 adult)	43
Connecticut	Natchaug Hospital, Tolland County, in the northeastern region of state	57 (33 adult)	33
District of Columbia	Psychiatric Institute of Washington	124 beds for children, adolescents, adults, and senior adults with mental health and addictive illnesses	45 (35 admissions allowed per month)
Illinois	Chicago Lakeshore Hospital, Chicago, Cook County	146 for children, adolescents, and adults with acute mental illness	28, with an additional 28-bed unit available if capacity reached
	Riveredge Hospital, Chicago, Cook County	210 for children, adolescents, and adults	210 (10 admissions allowed per month)
Maine	Acadia Hospital, Bangor (urban)	100 (68 staffed, 36 adult)	36
	Spring Harbor Hospital, Westbrook (rural)	100 (88 staffed, 48 adult)	48
Maryland	Adventist Behavioral Health, Rockville (Washington, DC area)	106 (79 adult)	79
	Brook Lane Health Services, western urban area	42	20
	Sheppard Pratt Health System, Baltimore region	414 (336 staffed)	225
Missouri	Royal Oaks Hospital, Windsor, a small rural community in the central part of the state	41 (40 staffed)	8
	St. Louis Regional Psychiatric Stabilization Center, St. Louis	25	25
	Two Rivers Behavioral Health System, Kansas City	105	85

Exhibit 5 (continued)

State	Name and Location of Participating IMDs	Total Number of IMD Beds[a]	Number of Beds Potentially Available for Beneficiaries Enrolled in Demonstration
North Carolina	Holly Hill Hospital, Wake County	168 (108 adult)	108
Rhode Island	Butler Hospital, Providence	117 licensed (78 short-term and intensive adult psychiatric), plus 20 under a state Department of Mental Health waiver	78, plus 20 waiver beds
Washington	Fairfax Hospital, King County, which includes Seattle	133 licensed (101 set up, 21 of which are for adolescents)	80
	Lourdes Counseling Center, Richland, a large rural area	32 (22 staffed, all for adults)	22
	Navos Mental Health Solutions, King County, which includes Seattle	72 (32 residential treatment, 40 hospital), primarily for involuntary commitment	40
West Virginia	Highland Hospital, Charleston, Kanawha County, in the southwestern portion of the state	80	34
	River Park Hospital, Huntington, Cabell County, in the southwestern portion of the state	102	28

[a]Numbers may include beds for children and adolescents, older adults, and other individuals not eligible for the demonstration.

[b]On December 20, 2012, we were informed that BayPointe Hospital had shifted its adult population to EastPointe Hospital and that, unless the EastPointe unit reaches capacity, the BayPointe adult unit will not be reopened.

In seven of the participating states, private IMDs were uncompensated for inpatient treatment provided to Medicaid beneficiaries before the demonstration. In four of these seven states, however, IMDs receive disproportionate share hospital payments from the state, which provide financial assistance to hospitals that serve a large number of low-income patients, including Medicaid beneficiaries (Exhibit 6). The five remaining states used state or county funds to reimburse Medicaid stays at IMDs before the demonstration.

Exhibit 6. Funding for Inpatient Stays in Private IMDs for Adult Medicaid Beneficiaries Before the Demonstration

State	Private IMD Funding for Adult Medicaid Patients Before MEPD
Alabama	Uncompensated
California	In 1991, California shifted responsibility for mental health services from the state to the county level. Sacramento and Contra Costa Counties, the two counties participating in the demonstration, used county funds to reimburse IMDs.
Connecticut	Connecticut reimbursed inpatient stays at IMDs for individuals enrolled in the Medicaid program for low-income adults (known as Husky D).
District of Columbia	Uncompensated; IMDs participating in the demonstration received Medicaid disproportionate share hospital (DSH) payments from the state
Illinois	Uncompensated
Maine	Uncompensated
Maryland	Maryland used state-only dollars to reimburse private IMDs for 84 percent of per diem charges for inpatient psychiatric services.
Missouri	Uncompensated; IMDs participating in the demonstration received Medicaid DSH payments from the state
North Carolina	Uncompensated; IMDs participating in the demonstration received Medicaid DSH payments from the state
Rhode Island	Uncompensated; IMDs participating in the demonstration received Medicaid DSH payments from the state
Washington	Washington provided reimbursement to IMDs under a Medicaid managed care waiver covering community and inpatient mental health services.
West Virginia	West Virginia used state-only dollars to reimburse IMDs for involuntary commitments when beds were unavailable in other facilities.

Source: State demonstration proposals and interviews with state demonstration staff.

Note: DSH payments provide financial assistance to hospitals that serve a large number of low-income patients, including Medicaid beneficiaries.

In addition to the private IMDs participating in the demonstration, a variety of other types of facilities also offer inpatient psychiatric services in the participating states, including non-participating private IMDs, state- and county-funded IMDs, general medical facilities with psychiatric units, and smaller facilities exempted from the IMD exclusion. Community-based services to prevent or serve as alternatives to hospitalization are also available in most states.

States differ in eligibility requirements for the demonstration in terms of the inclusion or exclusion of managed care enrollees. In eight, managed care enrollees are excluded from the demonstration, managed care is not available for behavioral health services, or mental health services are carved out of managed care. Given the movement of Medicaid toward managed care, this restricted eligibility may limit the extent to which the evaluation results can be generalized to other state systems.

Initial Results

Initial implementation results are based on data submitted by participating states to CMS for payment and monitoring purposes during the first year of implementation (July 2012 through June 2013). These data include information regarding number of inpatient admissions to the IMDs, characteristics of beneficiaries served, length of stay, discharge status, and expenditures. These data show the following:

- Participating IMDs in the 12 states submitted claims for 3,458 admissions of 2,791 Medicaid beneficiaries (Exhibit 7). With the exception of North Carolina, enrollment rates were lower than might be expected based on estimates provided by the states, possibly due to slow startup and narrower eligibility criteria at the beginning of the demonstration.
- The vast majority of beneficiaries were determined eligible to participate in the demonstration as a result of suicidal thoughts or gestures (Exhibit 8).
- Sixty percent of beneficiaries were admitted to the IMDs with diagnoses of depressive disorders, bipolar disorders, or other mood disorders, and 33 percent were admitted with diagnoses of schizophrenia or other psychotic disorders (Exhibit 8).
- Of the 2,791 beneficiaries, 84 percent had just one admission during the first year of the demonstration (Exhibit 8).
- The average inpatient length of stay was just over one week. For 88 percent of admissions, beneficiaries were discharged to their homes or self-care. (Exhibit 9)
- The Affordable Care Act authorized $75 million in federal funds to be spent over three years for the demonstration. Through June 2013, total federal and state expenditures on claims were approximately $22 million (Exhibit 10). Depending on the state, the federal share of these claims ranged from 50 to 73 percent. Therefore, Federal expenditures on MEPD in the first year were substantially less than one might expect. Differences in expenditures across states can largely be explained by variations in numbers of admissions, which reflect, in part, slower startup in some states.

Exhibit 7. Inpatient Admissions to IMDs Under the MEPD

State	Date of First Enrollment	Number of Unique Participants Through 6/30/2013	Number of Admissions Through 6/30/2013	Average Number of Admissions per Month[a]	State Estimates of Patients Expected to Enroll in the Demonstration[b]
Alabama	7/3/2012	207	262	23	Year 1—7,867[c], Year 2—10,156[c], Year 3—10,156[c]
California	7/1/2012	447	632	56	Contra Costa: 144 over three years Sacramento: 2,876 over three years[d]
Connecticut	7/2/2012	167	196	17	250 per year
District of Columbia	7/2/2012	176	220	19	400 per year[d]
Illinois	12/19/2012	71	85	16	200 per year
Maine	7/27/2012	127	144	14	700 per year
Maryland	7/1/2012	809	1013	85	1,400 per year in 2012 and 2013; >1,400 in 2014
Missouri	7/7/2012	274	326	30	1557 over three years
North Carolina	12/18/2012	80	90	16	153 over three years
Rhode Island	9/26/2012	15	22	3	120 to 150 per year
Washington	7/24/2012	172	193	18	1,063 per year
West Virginia	8/1/2012	246	275	27	1,230 per year
Total		**2791**	**3458**	**304**[e]	

[a]Average number of admissions was calculated by dividing the total number of admissions through May 31, 2013 by the number of months in the demonstration until that date. The number of months that the demonstration was operating in a state was calculated as the number of days from the date of first enrollment through May 31, 2013, divided by 30. Because states began on different dates, the number of months included in the calculations varies by state. We did not include June admissions in the calculations (the last date for which we have data) because the number of admissions in the June data was much lower than the number of admissions in the previous months, leading us to believe that the June data were incomplete.

[b]Planned enrollment estimates are based on information provided in the states' demonstration applications, operational plans, and quarterly demonstration monitoring reports, and through follow-up conversations of the evaluation contractor with state demonstration staff from November 2012 to March 2013.

[c]Number of patient days, not number of patients.

[d]Number of admissions, not number of unique patients.

[e]The total average number of admissions per month is calculated by dividing the total number of admissions in all 11 states and the District of Columbia through May 31, 2013 and dividing by 11 months. June 2013 data were not used in the calculation because we suspect that these data were incomplete; we expect to receive additional claims for this month in the future.

Exhibit 8. Characteristics of Medicaid Beneficiaries Admitted to IMDs in the First Year of the MEPD

	Number	Average/Percent[a]
Age at Admission[b]	**3456**	**38**
EMC (admitted before Oct 1)[c]	**714**	.
Suicidal thoughts or gestures	519	73
Homicidal thoughts or gestures	126	18
Both suicidal and homicidal thoughts or gestures	55	8
Determined a danger to self or others by means other than suicidal or homicidal[d]	14	2
EMC (admitted on or after Oct 1)[c]	**2744**	.
Suicidal thoughts or gestures	1775	65
Homicidal thoughts or gestures	180	7
Both suicidal and homicidal thoughts or gestures	197	7
Determined a danger to self or others by means other than suicidal or homicidal	592	22
Admitting Diagnosis	**3458**	.
Schizophrenia spectrum disorders	913	26
Depressive disorders	875	25
Bipolar disorders	871	25
Other mood disorders	357	10
Other psychotic disorders	241	7
Anxiety disorders	62	2
Substance-related disorders	49	1
Other mental health diagnoses	86	2
Other non-mental health diagnoses	4	0
Primary Discharge Diagnosis Differs from Admitting Diagnosis	**801**	**23**
Demonstration Participants with One or More Admission During First Year	**2791**	.
One admission	2350	84
Two admissions	316	11
Three admissions	73	3
Four admissions	25	1
Five admissions	17	1
Six admissions	5	0
Seven admissions	3	0
Ten admissions	1	0
Eleven admissions	1	0

[a]Categories may not sum to 100 due to rounding.

[b]Two records had invalid dates of birth and were excluded from any analysis of age.

[c]The categories of eligibility changed on October 1, 2012 to include "determined to be a danger to self or others by means other than suicidal or homicidal."

[d]All patients that were admitted before October 1, 2012 and had an EMC of "determined to be a danger to self or others by means other than suicidal or homicidal" were discharged after October 1, 2012.

Exhibit 9. Characteristics of IMD Admissions in the First Year of MEPD

	Number	Percent/Average
Length of Stay	**3458**	**8.2 days**
Discharge Status	**3458**	
Discharged to home or self-care	3027	88
Discharged/transferred to another facility[a]	198	6
Discharged/transferred to home under care of organized home health service organization	117	3
Other/not available	56	2
Still a patient	43	1
Left against medical advice	15	0
Hospice (home or medical facility)	2	0

[a]Includes discharge/transfer to another short-term general hospital, skilled nursing facility (SNF), intermediate care facility (ICF), federal health care facility, or another type of institution, as well as discharge to hospital-based swing bed care, inpatient rehabilitation, long-term care hospital, nursing facility, psychiatric hospital, or critical access hospital.

Exhibit 10. MEPD Expenditures for IMD Inpatient Admissions

State	Number of Admissions Through 6/30/2013	Total Amount Claimed Through 6/30/2013 (in dollars)	Average Amount Claimed per Admission (in dollars)
Alabama	262	1,398,600	5,338
California	632	4,097,210	6,483
Connecticut	196	1,082,670	5,524
District of Columbia	220	1,147,560	5,216
Illinois	85	492,678	5,796
Maine	144	558,062	3,875
Maryland	1,013	8,155,192	8,051
Missouri	326	1,426,021	4,374
North Carolina	90	433,422	4,816
Rhode Island	22	133,125	6,051
Washington	193	1,431,000	7,415
West Virginia	275	1,698,047	6,175
Total	**3,458**	**22,053,588**	**6,378**

Evaluation Design and Considerations

As mandated by the Affordable Care Act, the evaluation of the demonstration shall include assessment of (1) access to inpatient services under the Medicaid program, average lengths of inpatient stays, and ER visits; (2) discharge planning by participating hospitals; (3) the impact of the demonstration on costs of the full range of mental health services (including inpatient, emergency, and ambulatory care); and (4) the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration compared to the percentage admitted to the same facilities through other means.

Mathematica will conduct a comprehensive, "mixed-methods" evaluation that integrates quantitative and qualitative data to address each mandated evaluation area. The way in which each research question will be investigated will vary by state, based upon available data and the identification of appropriate comparison groups. The primary quantitative data will be service utilization and expenditure data drawn from Medicaid and Medicare enrollment and claims files (pertaining to dually entitled beneficiaries). Data on IMD admissions under the MEPD will come from claims submitted to CMS on a quarterly basis for demonstration payment and monitoring purposes. Data on IMD admissions before the demonstration and in comparison facilities must be obtained directly from states and facilities, as these data are not included in Medicaid files because of the IMD exclusion.

Mathematica will gather qualitative data during two rounds of site visits in 2014 and 2015. During each round, they will visit each participating IMD and, for each IMD, one ER that refers patients to that IMD and one general hospital that admits patients with psychiatric EMCs to general medical units when no psychiatric bed is available. They will interview facility staff and review medical records regarding criticial processes of care, including procedures for psychiatric EMC determination, inpatient admission, stabilization assessment, stabilization, and discharge planning. After each visit, they will conduct telephone interviews with five beneficiaries from each participating IMD who received inpatient treatment through the demonstration and were recently discharged. These interviews will be essential to understanding beneficiaries' experiences with the admission and discharge processes and to obtaining their viewpoints on whether and how quality of care improves as a result of the demonstration.

The demonstration design presents a number of challenges for clearly demonstrating effects that can be attributed to the MEPD. Variations among the states in available data, comparison groups, program design, and contextual factors will necessitate analyzing results separately for each state and synthesizing information across states, if possible (Exhibit 11). Although Mathematica will thoroughly explore the suitability of nonparticipating private and public IMDs and general hospital psychiatric units as comparison facilities for quantitative data analyses, they may not be able to identify credible comparisons or obtain needed data in some states. Qualitative data regarding contextual factors surrounding the demonstration will provide rich contextual detail to aid in interpreting the quantitative results and identifying possible alternative explanations. Without adequate comparison facilities, however, they will still not be able to attribute results to the demonstration with confidence. In addition, few if any data are available to address the effect of the demonstration on psychiatric boarding times in ERs. Medicaid and Medicare claims report number of ER visits and, possibly, number of days in the ER, but they do not provide information about the number of hours spent in the ER during the visit. Mathematica

will explore the possibility of collecting patient-level data on hours spent in the ER directly from a subset of ERs participating in site visits, but obtaining these data may not be feasible.

The comprehensive evaluation will provide important information regarding expected effects of the demonstration on beneficiaries, IMDs, ERs, and Medicaid and Medicare (for dual eligible beneficiary) costs. A complete report of the results of the evaluation will available in 2016.

Conclusions

When considering the implications of the demonstration for future policy, one must keep in mind several limitations to the generalizability of the results:

- First, facilities participating in the demonstration are limited to private IMDs, which provide only a subset of the inpatient psychiatric beds available in the participating states. Given the differences in patient populations served, the results may not apply to public IMDs. The demonstration also does not address inpatient treatment provided in general hospital psychiatric units or psychiatric facilities with fewer than 17 beds or community-based acute care alternatives to hospitalization, all of which are exempt from the IMD exclusion.
- Second, most of the participating states restrict demonstration eligibility to beneficiaries whose Medicaid service costs are reimbursed on a fee-for-service basis. Capitated Medicaid managed care plans, established through waivers that allow exemption from the IMD exclusion, may include coverage of inpatient treatment provided in IMDs. To avoid duplication of payments, however, the four states that have included managed care enrollees in the demonstration have taken steps to ensure inpatient IMD treatment covered under the demonstration is otherwise excluded from federal matching funds under the managed care plans of demonstration participants. The demonstration, therefore, will not provide information about treatment provided by IMDs through managed care plans.
- Third, the demonstration population represents only a portion of all inpatient admissions following ER visits due to psychiatric conditions. Because they are exempt from the IMD exclusion, the demonstration does not address psychiatric boarding in ERs or inpatient treatment of children under 21 (for whom concerns about psychiatric boarding have also been raised) or adults age 65 or older. The demonstration also does not address inpatient treatment for substance-related disorders, although such treatment is subject to the IMD exclusion, and problems of boarding in ERs have also been reported for this group. The results apply only to adults with mental illnesses who are suicidal, homicidal, or otherwise judged to be dangerous to themselves or others. Consistent with these eligibility criteria, demonstration participants were about twice as likely to be suicidal as subjects of previous reports of people receiving inpatient care after seeking help for psychiatric conditions in ERs as reported in previous research (Weiss et al. 2012). Results of the demonstration will not apply to beneficiaries seeking inpatient treatment for serious psychological distress who are not judged to be dangerous to themselves or others.

State demonstration applications and operational plans indicate few intentions to change specific aspects of care (such as EMC determination and admissions, stabilization assessment, or discharge planning procedures). The evaluation will systematically solicit information about any such changes that are occurring from key informants. In the absence of planned changes, the program theory underlying the demonstration legislation relies on the following expectations:

- As a result of provision of federal matching funds for inpatient treatment, private IMDs will increase the number of inpatient beds, resulting in increased access to care for Medicaid beneficiaries. In addition, states that previously reimbursed private IMDs out of state-only funds will reallocate savings toward the improvement of community-based services, resulting in decreased need for inpatient services.
- Increased access to private IMDs will reduce psychiatric boarding in ERs and general hospital scatter beds.
- Because stabilization and discharge planning provided by private IMDs is of higher quality, it will be more effective than inpatient treatment provided to beneficiaries in scatter beds, resulting in decreased readmissions.
- Decreases in overall Medicaid costs will result from decreased use of ER services and decreased readmissions, producing savings for Medicaid and Medicare that exceed the costs of IMD inpatient treatment provided under the demonstration.

Each of these expectations has been cited by stakeholder groups advocating for the elimination of the IMD exclusion. The MEPD and its evaluation provide a unique opportunity to assess systematically the extent to which such results occur when federal Medicaid matching funds for inpatient treatment in private IMDs are provided for adults with psychiatric EMCs.

Exhibit 11. Availability of State Data Regarding IMD Admissions for Adult Medicaid Beneficiaries in MEPD States

State	Number of Participating IMDs	State Has Pre-Demonstration Data from Participating IMDs	Eligible Non-Participating Private IMDs	State Has Pre-Post Data from Non-Participating Private IMDs	State Has Pre-Post Data from Public IMDs	Post-Demonstration Descriptive Analysis Possible[a]	Trend Analysis Possible[b]	IMD Comparison Group Analysis Possible[c]	General Hospital Psychiatric Unit Comparison Groups Possible[c]
Alabama	4					✓	Maybe	No	Unknown
California	4	✓[d]	✓	✓[d]	✓	✓	Maybe	Maybe	Contra Costa Cty: Unknown Sacramento: No
Connecticut	1	✓				✓	Partial	No	Yes
District of Columbia	1				✓	✓	Maybe	Maybe	Yes
Illinois	2		✓			✓	Maybe	No	Yes
Maine	2	✓			✓	✓	✓	Maybe	Yes
Maryland	3	✓			✓	✓	✓	Maybe	Yes
Missouri	3		✓			✓	Maybe	No	Yes
North Carolina	1		✓			✓	Maybe	No	Yes
Rhode Island	1				✓	✓	Maybe	Maybe	Yes
Washington	3	✓			✓	✓	✓	Maybe	Yes
West Virginia	2				✓	✓	Maybe	Maybe	Yes

[a]Descriptive analysis alone cannot determine whether inpatient admissions, lengths of stay, and costs changed after the demonstration was implemented.

[b]Trend analyses will allow determination of the extent to which inpatient admissions, lengths of stay, and costs change after implementation of the demonstration. Trend analysis alone, however, will not allow us to rule out alternative explanations for the changes based on factors extraneous to the demonstration. In other words, we will not be able to say with confidence that any changes that occurred were due to the demonstration rather than something else.

[c]Analyses using comparison groups will generate the strongest estimates of the extent to which inpatient admissions, lengths of stay, and costs change after the demonstration and allow us to rule out many alternative explanations for the changes based on factors extraneous to the demonstration. Different types of comparison groups may be able to rule out some possible alternative explanations, but not others. We are carefully considering the suitability of nonparticipating IMDs and general hospital psychiatric units for comparison purposes.

[d]In California, data are available from counties rather than the state. Once potential comparison facilities are identified, We will determine whether data from those facilities are available at the county level.