Case report

Serving people with severe mental illness who are dually eligible for Medicare and Medicaid

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Implementation lessons

1. Capitated payments enable flexible spending across medical, behavioral health, and social domains, allowing for member-tailored fully integrated care teams, investment in special care delivery innovations, and partnerships with community-based behavioral health organizations.

2. Innovations such as Enhanced Crisis Stabilization Units and a Mobile Integrated Health program can be used to address the shortage of crisis stabilization beds and high utilization of acute services.

3. Stratification models can be used to optimize the intensity and type of care provided, meet members’ diverse and evolving needs, and make efficient use of the scarce pool of behavioral health and other clinicians.

4. Organizations can collaborate with community partner organizations such as behavioral health provider organizations who already have relationships with members.

1. Background

Of the 10.7 million individuals in the United States who are dually eligible for Medicare and Medicaid,\textsuperscript{1} one third of those under the age of 65 and 10% of those over the age of 65 have severe mental illness (SMI)\textsuperscript{2} (defined here as schizophrenia, schizoaffective disorder, bipolar disorder, or major depression). Dually eligible individuals with SMI, in particular, have complex care needs—in addition to severe mental health diagnoses, many dually eligible individuals have concurrent serious chronic illness.\textsuperscript{3} Care is further complicated by a high prevalence of substance use disorders,\textsuperscript{4} physical disability,\textsuperscript{5} social factors such as homelessness and poverty,\textsuperscript{6} and average annual spending on care for dually eligible individuals with mental illness is nearly two times higher than spending for those without.\textsuperscript{6,7}

Nationally, efforts to address the needs of dually eligible individuals with SMI have been stymied by silos between medical, behavioral health, and social care systems. It is well documented that people with SMI have poor access to primary care, poor coordination between psychiatry and primary care, and limited assistance with the social aspects of their well-being such as housing and connectedness.\textsuperscript{3,8} The scarcity of behavioral health specialists further exacerbates issues with timely access to appropriate mental health care.\textsuperscript{9}

This case study highlights the efforts of Commonwealth Care Alliance to meet the needs of its growing number of patients with SMI. Commonwealth Care Alliance is an integrated payer-provider for dually eligible individuals in Massachusetts. The model leverages capitated blended payments from the federal and state government to use dollars flexibly across medical, social, and behavioral domains.

2. Organizational context

Commonwealth Care Alliance is a nonprofit healthcare organization that is presently serving more than 20,000 members dually eligible for Medicare and Medicaid across Massachusetts. Commonwealth Care Alliance receives monthly risk-adjusted, fully capitated blended payments from Medicare and Medicaid, made available through the CMS Medicare Medicaid Coordination Office. Commonwealth Care Alliance has two products: One Care, the Massachusetts CMS Financial Alignment Demonstration project for Medicare-Medicaid dually eligible individuals under 65, and Senior Care Options, a Special Needs Plan for individuals aged 65+ who are either dually eligible or eligible for Medicaid (MassHealth) only. Commonwealth Care Alliance bears financial risk for the healthcare spending of its members, which it manages through intensive care models aiming to reduce unnecessary acute care utilization.

3. Problem

In mid-2013, senior leaders at Commonwealth Care Alliance committed themselves to developing new systems to meet the needs of the growing number of members with SMI. At that time, Commonwealth...
Care Alliance had just over 5000 members who were 65 or older, of whom approximately 42% had SMI. The number of members, however, was set to grow to 20,000 by 2017 through Commonwealth Care Alliance’s entry into the new One Care program for individuals aged under 65. The prevalence of SMI, particularly schizophrenia, schizo-affective disorder, and bipolar disorder, was expected to be much higher in this younger dually eligible population. Upon internal review, Commonwealth Care Alliance found that there was a scarcity of mental health, addiction, and primary care clinicians across Massachusetts, as well as a scarcity of crisis stabilization beds. There was high utilization of acute services and costs for members with SMI were significantly higher than for those without major mental illness. The confluence of poor social determinants of health (including housing, food insecurity, and social isolation), a high prevalence of trauma, high baseline costs of care, and the scarcity of clinical providers equipped to care for this cohort of patients meant that new innovations were needed to ensure success in caring for Commonwealth Care Alliance’s growing number of members with SMI.

By January 2017, Commonwealth Care Alliance had expanded its program to more than 20,000 members, of whom 61% were in the One Care Program (under age 65, dually eligible beneficiaries) and 39% were in the Senior Care Options program (dually eligible or Medicaid-only beneficiaries aged 65+). The number of members with SMI had gone up from just over 3000 in Fall 2013 to 12,200 in January 2017. The prevalence of SMI was 59% overall, with 13% of members with diagnoses of schizophrenia and schizoaffective disorder, 14% with bipolar disorder, and 55% with major depression. As expected, the prevalence of SMI was higher among One Care members (under 65) than Senior Care members (aged 65+). Seventeen percent of members with SMI had a history of opioid misuse, with a prevalence of up to 29% among those with bipolar disorder. Overall, 59% of members with SMI were female and 41% were male. The mean age of the members with SMI was 57.

The key problem Commonwealth Care Alliance sought to address was how to provide care to a growing number of members with SMI that addressed their heterogeneous behavioral health, medical, and social needs while also reducing acute mental health and emergency department utilization and associated spending.

4. Solution

In order to successfully serve this growing group of members, Commonwealth Care Alliance carried out the following strategies:

1) Commonwealth Care Alliance built out core model components including enhanced Crisis Stabilization Units and a Mobile Integrated Health program to address the shortage of crisis stabilization beds and the high utilization of acute services; and
2) Commonwealth Care Alliance refined its stratification model so that it can optimize the intensity and type of care with members’ diverse and evolving needs, and make efficient use of the scarce pool of behavioral health resources. This included expanding the role that clinicians play in care coordination and establishing care management partnerships with behavioral health community provider organizations.

Part 1: Core components of the care approach

The following components of Commonwealth Care Alliance’s approach to care are consistent across all members:

Risk assessment and care planning

Care for a new member with SMI, as for any member, starts with a full standardized assessment of medical, behavioral health, and social needs (the One Care and SCO Minimum Data Sets). Based on this assessment, members are assigned a care partner, whose licensure and skill set are tailored to the patient’s needs. In partnership with the member, a care plan is developed, which is designed to be executed by the member, the care partner, and an integrated interprofessional team.

Interprofessional care team

Members of the interprofessional care team can include behavioral health specialists (all of whom are cross-trained in addiction care), primary care nurses, physicians and other clinicians, a psychiatry specialist, a health outreach worker, a long-term supports and services coordinator (who assesses and coordinates members’ in-home and community-based service needs), and other providers as needed. The care partner coordinates care with team members inside and outside of Commonwealth Care Alliance, using team meetings, electronic medical records (where possible), joint visits, and frequent ad hoc communication. Since 2013, Commonwealth Care Alliance has grown the role that clinicians other than nurses play in care coordination, particularly behavioral health clinicians and health outreach workers.

Enhanced crisis stabilization units

In 2013–2014, Commonwealth Care Alliance built two enhanced Crisis Stabilization Units (CSUs). The goal of the enhanced CSUs is to reduce the use of high-cost inpatient psychiatric facility hospitalizations of enrollees who would be more appropriately cared for in a community-based crisis stabilization setting, and to address the scarcity of crisis stabilization unit beds in the state. Commonwealth Care Alliance’s enhanced CSUs allow for a longer length of stay than classic crisis stabilization units to enable clinical improvement and therapeutic relationships. Enhanced CSUs help reinforce internal coping skills and external supports and promote continuity of care and post-discharge follow-up. They are staffed by medically and psychiatrically trained clinicians with the ability to manage a wide array of complex medical and psychiatric diseases including detoxifications of members with addiction. A stay in an enhanced CSU is typically less costly than a mental health inpatient stay ($600 vs. $1100 per day). More than 80% of CSU stays are reported to be diversionary for acute mental health stays.

Integrated Mobile Health

Commonwealth Care Alliance developed other diversionary services for members to avoid acute utilization. For example, it developed an Integrated Mobile Health program that provides members with in-home services by paramedics, thereby avoiding unnecessary emergency department visits. These can be particularly useful for members with SMI who frequently use the emergency department for mental health issues that could be managed at home, such as anxiety. Unlike Visiting Nurse Association services, where individuals receive services on a fixed schedule, the purpose of the Integrated Mobile Health program is to address members’ acute needs when they arise.

Addressing social determinants of health and long-term supports and services

Commonwealth Care Alliance members have access to additional services that may not be reimbursable by standard Medicaid and Medicare coverage, but are critical to improving the overall health and wellbeing of patients with SMI. For example, health outreach workers partner with members to help them apply for housing, as housing instability is a key issue for members with SMI and may indirectly impact their ability to stay healthy. Commonwealth Care Alliance can also pay for services such as transportation to a court hearing, to reduce the likelihood of incarceration that may also impact members’ health. Unlike many Accountable Care Organizations, Commonwealth Care Alliance has no carve-out for its long-term services and support (LTSS) costs. As a result, Commonwealth Care Alliance is incentivized to integrate medical and behavioral health with social services in the form of LTSS. Commonwealth Care Alliance integrates the LTSS coordinator into the core care team, which helps members access services from community-based organizations such as food delivery services and personal care assistants. Members with SMI may use LTSS support to help with medication adherence as well.

Engagement: meeting members where they are

A core tenet of Commonwealth Care Alliance’s approach to care is the ability to meet members in their home or community—in spaces
where they feel comfortable and are likely to engage more meaningfully in relationships. Commonwealth Care Alliance has a dedicated team of community health workers focused on finding and engaging hard-to-reach members, linking with them wherever they access healthcare, such as in inpatient and crisis stabilization units, or finding them in the community. Many clinical visits also take place in the home or wherever the member is most comfortable. This is particularly important for members with SMI, who often face multiple barriers to accessing care and who may choose to avoid contact with a healthcare system that has in many cases been a source of trauma, mistrust, and fragmentation.

**Part 2: tailored components of the care approach**

Commonwealth Care Alliance refined its stratification system to assign members to care team structures according to their physical, behavioral, and social needs (see Fig. 1). The stratification system is designed to optimize the balance of behavioral, medical, and social care, and the intensity of intervention to meet heterogeneous needs with efficient use of resources. The stratification model also takes into consideration members’ existing relationships with partner organizations, which is particularly important for members with SMI who often have experienced disrupted engagement with providers. Risk stratification occurs during the first 90 days of member enrollment, and includes a comprehensive assessment that takes into consideration the type of needs (medical, behavioral, and social), not just the intensity of needs. Members may be transferred between different levels of care as needed. Commonwealth Care Alliance reassesses all patients on an annual basis, or more frequently if there are changes in a member’s circumstances.

Fig. 1 highlights the levels of care and varying team structures that members with SMI can be stratified into at Commonwealth Care Alliance.

**Levels of care for members with severe mental illness**

**Extreme complexity**

**Group 1: Behavioral Intensive**

**Example patient:**

James is a man in his late 20s who is living with polysubstance dependence, ADHD, and bipolar disorder. He also has hypertension, but is otherwise healthy. His behavioral health symptoms such as suicidal ideation and significant psychosocial issues such as homelessness have resulted in repeated emergency department presentations. He is currently at risk for eviction from his home.

**Needs:**

Commonwealth Care Alliance's priority is to maximize medical and behavioral health treatment for members with existing providers and/or to assist members to negotiate the range of psychosocial stressors that often contribute to the member's inability to maintain community tenure. Without intensive support and/or treatment for members without providers, these members are at high risk of frequent readmissions to inpatient settings because of overwhelming psychosocial situations or because of being at high risk of harm to self or others.

**Approach:**

All members are assigned a behavioral health specialist as their care partner who works in close partnership with the interprofessional care team to address their behavioral, social, and medical needs. The behavioral health offerings for this group may include any of the services...
previously described. For example, a psychiatric clinical nurse specialist might provide bridge visits for management of medications, a service that is frequently necessary due to access issues to prescribers for a range of reasons. Members are diverted from acute mental health inpatient stays to enhanced Crisis Stabilization Units whenever appropriate.

**Group 2: Medical and Behavioral Intensive**

*Example patient:*

John is a man in his mid-thirties with a devastating spinal injury resulting in quadriplegia, a deep vein thrombosis and multiple amputations. He has bipolar disorder and has attempted suicide in the past. He has a history of frequently missing medical appointments.

*Needs:*

These members have both SMI and physical disabilities with limited mobility and typically need assistance with many activities of daily living.

*Approach:*

These members are referred to a unique in-house healthcare clinic, Commonwealth Community Care. This in-house clinic team is experienced in care for people with severe physical disabilities as well as severe mental illness. Most of the care is provided in the home, given the barriers these patients often have with going into a clinic due to their limited mobility. The Commonwealth Community Care partner is generally an advanced primary care practitioner (NP/PA). To meet members’ behavioral and social needs, the Commonwealth Community Care partner coordinates an integrated care team of behavioral health clinicians as well as works with a long-term services coordinator and health outreach worker. The full range of behavioral health clinicians may provide in-home direct care to the members as well as provide consultation to other team members so as to clarify members’ behavioral health needs and how to manage those needs.

**Moderate-high complexity**

*Group 3: In-home care coordination*

*Example patient:*

Alice is a woman in her mid-twenties with depression, panic disorder, opioid use disorder, hepatitis C, fibromyalgia, seizure disorder, and migraines. She recently experienced a near fatal overdose from heroin. She has a prior history of homelessness, but now has stable housing. She has a difficult relationship with an abusive partner and also has pending criminal trials.

*Needs:*

These members need intensive coordinated care in the home. In addition, these members may need help with substance use disorder and may have complicated social issues, such as legal matters pending.

*Approach:*

These members receive home visits from their care partner. Whether the member is assigned to a behavioral health or primary care advanced practitioner is based on which need is most salient. The behavioral health specialists or psychiatric nurse specialists may provide additional support and/or treatment as an adjunct to existing treatment particularly when members are in crisis. The aim of going to the home is to better understand the member’s social and physical environment and to forge trust. New members assigned to this group can continue seeking care with their previous PCP, psychiatrist and/or therapists, if they have a good relationship with them. Commonwealth Care Alliance has a large network of providers it contracts with and if the providers are outside Commonwealth Care Alliance’s network it works to contract with those providers whenever possible. The Care Partner coordinates care with other members of the care team regardless of whether they are in-house or external.

**Low-moderate complexity**

*Group 4: Phone care coordination*

*Example patient:*

Maria is a woman in her 50s with uncontrolled type II diabetes, bipolar disorder, and severe personality disorder. She maintains monthly visits to her PCP, as well as frequent follow-up with a variety of specialists, including weekly chiropractor treatments and twice-weekly therapy appointments. She has limited utilization of acute services; however, she has several strained relationships with her family, friends, and partner stemming from violence and mistrust.

*Needs:*

These members require coordinated care through phone visits. They are often relatively stable, so do not require as intensive support, or they prefer communicating via phone. These patients will have regular outpatient psychiatrist and therapist appointments as well as close follow-up with their primary care provider.

*Approach:*

The care model is exactly like the care received by Group 3 members, except the care management is provided by phone. As with the Group 3 members, the care partner can be a behavioral health or primary care clinician and they can work with providers inside or outside of Commonwealth Care Alliance. The mental health inpatient and CSU rates are lowest in this group.

**Group 5: Care Coordination Outsourced**

*Example patient:*

Tanya is a woman in her 40s with depression and borderline personality disorder, who often presents to emergency departments complaining of suicidal ideation and/or frequent non-epileptic seizures. She receives a range of services including community-based flexible support services through one of Commonwealth Care Alliance’s community partner organizations with whom she has a long-standing relationship. The member has lived previously in staffed residential settings but is now living independently with case management support. She has limited support from friends and family.

*Needs:*

These members have significant community-based behavioral health needs and have existing relationships with one of Commonwealth Care Alliance’s community partner organizations.

*Approach:*

Trusting, longitudinal relationships are central to complex care and particularly critical for people with SMI. Because many community organizations already provide high-quality services in the community, Commonwealth Care Alliance has established deeply integrated, collaborative care management partnerships with a few key community partner organizations, such as community health centers and behavioral health provider organizations, to provide high-quality care coordination according to the Commonwealth Care Alliance approach, for Commonwealth Care Alliance members with whom these organizations have an existing relationship (e.g., via a staffed residential facility, outpatient mental health services, or primary care). Members are assigned to care partners at these organizations who provide a mix of in-person and telephonic care management, depending on need. Commonwealth Care Alliance provides access to extra services working as part of the partner organization’s interprofessional team. There is a range of need among these members.
Least complex and unengaged

Group 6: Least Complex

As part of Commonwealth Care Alliance’s strategy to diversify the care team, Commonwealth Care Alliance will shortly begin enrolling some members with the least medical and behavioral health complexity in care models with non-licensed care partners. These care partners will have behavioral health support and utilize motivational interviewing and other strategies for engagement and promoting lifestyle changes.

5. Lessons for the field and unresolved questions

5.1. Knowledge of what is best for dually eligible individuals with SMI is limited. Commonwealth Care Alliance’s payment model of monthly fully capitated blended payments allows for innovation and creativity to develop new approaches, such as the enhanced CSU by allowing for flexible spending across medical, behavioral health, and social domains. Scalability would require Medicaid to allow for this approach on a much broader scale. The Medicaid Accountable Care Organizations presently being tested in Massachusetts represent an example of this flexible payment model being tested more broadly.

5.2. Commonwealth Care Alliance approach to care is designed to maximize impact given a scarcity of mental health, addiction, and primary care providers across Massachusetts. By tailoring the balance and intensity of medical, behavioral and social care provided to the member and leveraging existing services in the community, Commonwealth Care Alliance aims to meet members’ needs in a timely and targeted fashion. Commonwealth Care Alliance continues to work to increase the number of trained clinicians both within its organization and across the state.

5.3. There continues to be a need to develop risk-adjustment methodologies that give more meaningful consideration to social determinants of health, in order to ensure more appropriate payment allocation. Commonwealth Care Alliance’s capitated payment model, based on MassHealth rating categories and Medicare risk scores, does not keep pace with expenses for members who have significant social complexity. For example, many homeless members have elevated inpatient, emergency department, and medical expense rates, and Commonwealth Care Alliance’s care teams often use extra resources trying to find and engage these members. It is widely known that most conventional risk adjustment methodologies “break” at the upper margins of complexity and cost.11–13 Since many dually eligible individuals fall within those margins, the limitations of these methodologies have a profound impact on the ability to provide financially viable care to these complex populations.

5.4. Strong, trusting therapeutic relationships between patients and providers are a fundamental underpinning for improving health and outcomes, particularly for members with SMI. Because of this, if a member has an existing relationship with one of Commonwealth Care Alliance’s key community partner organizations, the member can be assigned to a care partner and team at that organization for care management. Meanwhile, the Medicaid Accountable Care Organizations being developed in Massachusetts will expand this model of contracted community partnerships for care management.

References

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