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Issue Brief

Financing Coordinated Specialty Care for First Episode Psychosis:

A Clinician/Advocate's Guide

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July 2020

Funding for this initiative was made possible (in part) by Grant No. 1H79SM080818-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Executive Summary

This issue brief provides a conceptual overview of strategies that can be employed to fully cover the costs of Coordinated Specialty Care (CSC) for persons with first episode psychosis (FEP). It is written for clinicians and advocates so that they can understand the issues involved in achieving cost-based reimbursement for CSC. Our goal is to inform clinicians of the funding challenges and options to address those challenges so that they can effectively discuss them with administrators and policy staff and pursue options that lead to a financially sustainable program.

CSC is an evidence-based practice that is effective in treating persons experiencing a first episode of psychosis. It involves a multidisciplinary team providing a full range of client centered services. It also includes a public education and outreach function that is intended to hasten the identification and rapid referral of persons with FEP. Several of the service components that are included in CSC are difficult to cover using conventional Medicaid or commercial insurance. A recent study indicated that only about 50% of the costs of CSC programs can be compensated with Medicaid payments. Currently these gaps in reimbursement are covered by either state general funds or federal block grant funds that are not sufficient to serve everyone with a first episode. If these programs are to become sustainable and their long-term promise of reducing disability for persons with psychosis are to be achieved, a cost-based reimbursement rate must be provided through insurance including both commercial and public payers.

In this issue brief we outline several strategies that may be used to achieve a cost-based rate for CSC services. We present four examples for persons who are enrolled in or eligible for Medicaid including:

- Modification of an existing state plan for states that have permission from the Centers for Medicaid and Medicare Services (CMS) to provide home and community-based services.
- For states with Medicaid Managed Care the ‘in lieu of’ provision can be used to fund CSC.
- Special CMS Waivers may be used to provide team-based services for persons with severe mental illness.
- For states that have Certified Community Behavioral Health Clinics, CSC services can be fully covered.

We then discuss three different strategies that are being employed to establish cost-based reimbursement with commercial insurers. These include:

- Illinois' recently passed legislation that mandates commercial coverage for CSC services.
- A major service provider in Maine that has included a cost-based reimbursement for CSC in a re-negotiated contract with commercial insurers.
- A Connecticut effort to work with a large practice plan to provide the infrastructure to bill a large commercial payer.

Finally, we address the costs and cost effectiveness of CSC services. Here we demonstrate that the cost of CSC services are substantially less than the costs of many regularly reimbursed medical procedures and that a cost effectiveness analysis indicates that the small increase in costs for CSC services relative to ordinary community treatment are well worth the improved outcomes achieved by a CSC program. When the costs of CSC are distributed over an insured population, we present some estimates that they would add less than two dollars to an annual insurance premium.

Early intervention in psychosis holds the promise for reversing the lifelong disability that often accompanies psychosis. If this promise is to be realized, everyone who develops psychosis should have access to effective, evidence-based care. An insurance benefit that covers the cost of this care is essential if we are to realize the promise of early intervention.

Acknowledgements

I received help from several individuals in preparing this issue brief. Brenda Jackson, MPP was especially generous with her time in reviewing Medicaid strategies that can be used for cost-based reimbursement. Melisa Rowan, MSW, MBA, from the Meadows Research Institute; Jen Snow, MPA, Brandon Graham, BA, and Ken Duckworth, MD, from NAMI; Tom Schulpin, MA, from Virginia; Marc Fagan, PsyD, and Heather O'Donnell, JD, from Thresholds in Chicago; Vinod Srihari, MD, from Yale; Doug Robbins, MD, from Maine Behavioral Health; Jessica Pollard, PhD, from Maine Department of Health and Human Services, Jill Stemple from Pennsylvania Department of Human Services; and Amy Cohen, PhD, and Tristan Gorrindo, MD, from the American Psychiatric Association all provided great guidance and editorial suggestions that were much appreciated. While I profited from their guidance and input, the content of this brief is my sole responsibility and not that of these individuals who kindly helped with the project.

Introduction

Coordinated Specialty Care (CSC) is an evidence-based, team delivered service that has been shown to be effective for treating persons who are experiencing a first episode of psychosis (FEP).[1] Given its team-based nature as well as its range and intensity of services, it cannot be easily financed by the existing range of fee for services insurance reimbursements – even in a well-designed Medicaid program with a wide range of service options.[2] Insurance coverage is focused on traditional office-based services while CSC programs blend a multi-disciplinary team-based intervention and some core services that are not included in typical fee for service benefit packages (e.g., outreach, public education, often supported employment and education). The services that are included may not adequately cover their costs owing to the intensity of services and coordination among team members. Researchers and policy staff in collaboration with colleagues at the Meadows Mental Health Policy Institute in Texas have examined various mechanisms for funding CSC services and concluded that the best financing method is a cost-based rate that covers the CSC service package and that allows the flexibility to individually tailor services to program participants.[3] Additionally, they identified an existing billing code that can be used to bill for these services.[4] We therefore will address funding strategies that produce a cost-based rate that adequately covers the CSC evidence-based practice in order to assure the sustainability of the program.

If we are to develop the capacity to meet the needs of persons with FEP, it is imperative that we develop a financing strategy that is adequate to address the new cases that emerge each year. Current financing strategies involve the funding from insurance that is augmented with state general funds and/or funds from the federal Mental Health Block Grant (MHBG). These resources are not adequate to meet the need nationally and state and federal grant funds are subject to rescission at any time. An insurance mechanism that includes both commercial payers and Medicaid with an accessible benefit package that covers the full cost of the program is therefore essential.

In this brief we are going to discuss some of the strategies and options that are available to provide appropriate reimbursement for CSC from insurance payments – both commercial insurance and Medicaid. Our goal is to inform clinicians of the funding challenges and options to address those challenges so that they can effectively discuss with administrators and policy staff and pursue options that lead to a financially sustainable program. The discussion will be conceptual rather than delving into the technical details of financing. We will organize the paper into three sections. The first will address Medicaid funding strategies, the second will consider issues with commercial insurance and the third will include information on estimating the cost of the services and making the case for cost effectiveness. Where appropriate, we will present examples to illustrate how others are addressing these issues in order to provide you with strategies that you may explore.

Medicaid Financing

Medicaid is the public insurance program that is jointly financed by the federal and state governments. It is designed to assist low-income individuals and individuals with disabilities. Unquestionably, Medicaid is the best insurance program for persons with serious mental health conditions since it often covers a wide range of services that are needed by persons who are dealing with serious life challenges related to their mental health. It includes treatment as well as rehabilitative services. Under the Affordable Care Act Medicaid services were expanded to include persons who earned up to 138% of the federal poverty level. This is a very important provision since it enabled states that expanded Medicaid (fourteen states chose not to expand) to serve individuals who had not developed illness related disability. This included many low-income young adults who were experiencing the onset of illness but who had not yet met disability criteria. This provided them with an insurance benefit that they could use to treat their illness and hopefully avoid becoming disabled.

One of the challenges with Medicaid is that each state has a different Medicaid plan that is negotiated with the federal Centers for Medicare and Medicaid services (CMS). The services that may be available in New York, for example, could differ substantially from those in Florida. Also, Medicaid has grown to be a substantial part of each state's budget and so there is pressure to help contain Medicaid costs. Among the most common ways to control costs is to cap the overall budget of the Medicaid program and have an intermediary organization (like a managed care company) agree to provide services to a designated population for a specified amount. In either case where Medicaid is directly paying for services or paying through an intermediary, various mechanisms will be used to contain costs. Fortunately, some of the cost control mechanisms can be used to the advantage of CSC cost-based bundled rate.

There are at least three strategies for fully covering CSC services for people on Medicaid. The first involves amending the state plan to include all the services in CSC and that accounts for the intensity of CSC services. For states that have Medicaid managed care arrangements the "in lieu of" provision can be used to fund CSC. The third strategy is to apply for a specific waiver from CMS that will allow for cost-based coverage.

Amend the State Medicaid Plan. The first strategy is to request that CSC be covered as an evidence-based service under what is called the 'rehabilitation option'. States that have this option in their state Medicaid plan can cover many but not all of the services included in CSC. The state must also have permission from CMS to provide home and community-based services (HCBS). HCBS allows coverage of supported education and employment and some other CSC services that are not included in the rehabilitation option. By combining these two approaches a reimbursement rate can be calculated which accommodates the small caseloads, team staffing, training and certification costs and other CSC unique attributes. This rate can be billed for each encounter with a CSC client. All program costs (except one

I'll discuss in a minute) for the CSC will be divided by the anticipated number of encounters to calculate the CSC encounter rate.

Amending the state plan works for getting a rate for all of the clinical services in CSC. It, however, doesn't cover the costs for outreach and public education which are a key component of CSC. These costs can be reimbursed through a separate contract to provide outreach and public education using funds that are available for the administration of the Medicaid program. In some cases, a center of excellence can be established to provide outreach and public education with the costs of training and fidelity assessment also included.

Medicaid Managed Care. For states that have Medicaid managed care, CSC service costs can be fully covered by classifying them as a cost-effective alternative service offered 'in lieu of' other currently offered services. 'In lieu of' services are tailored to the specific needs of first episode clients. CSC providers can negotiate a comprehensive reimbursement rate with the managed care company that includes all of the components of the evidence-based CSC service. The costs of the CSC program are divided into the number of anticipated encounters and paid on a daily or monthly basis following contact with client. Outreach and public education as well as training and fidelity assessment are funded through a separate contract using Medicaid administration funds.

Pennsylvania operates a Medicaid managed care program. Based on the 'in lieu' rationale a managed care company providing services in Philadelphia requested that the state allow it to pay a bundled, cost-based rate to a CSC program. The Pennsylvania Office of Mental Health and Substance Abuse Services subsequently contracted with an actuary to certify that the CSC program was cost-effective, conformed to the model recommended by the National Institute of Mental Health (NIMH) and was consistent with a joint letter from CMS, the NIMH and the Substance Abuse and Mental Health Services Administration (SAMHSA) regarding funding for CSC programs.[5] The actuary recommended that the CSC services could serve as 'in lieu of' other services in the state plan since CSC was deemed to be medically appropriate for this service population and to be cost effective. The Philadelphia CSC program then negotiated a monthly cost-based rate for the services with the managed care vendor. Unfortunately, the supported education and supported employment (SEE) benefit was not included in the rate and had to be separately reimbursed because Pennsylvania does not have the HCBS funding authority for mental health. This strategy therefore can work in states that have a managed care plan, which is quite common. You might pursue this option with your managed care vendor and/or state office of behavioral health.

Use of the SMI/SED Waiver. CMS offered specific guidance to state Medicaid directors in 2018 that the use of the 1115 Waiver mechanism was appropriate for implementing programs that address the needs of persons with serious mental illness or serious emotional disturbance. The guidance specifically required that programs implement strategies for identifying and serving individuals quickly, with integrated care approaches in specialty settings. CSC

services qualify for these requirements. Using this mechanism states can fully cover the costs of CSC services. As in the other examples, Medicaid administrative funds can be used for general outreach, public education, training and fidelity assessment.

Researchers and practitioners in Maine have been involved in early intervention research in psychosis for several years. They have developed one of the national models that has been promulgated to sites across the country.[6] Their national leadership and commitment to disseminating their technology was part of the reason that the Health and Human Services Committee of the Maine legislature asked the Department of Health and Human Services to investigate what would be required to construct a financing mechanism that could sustainably support CSC type services. Since Medicaid is a prominent payer for CSC services in Maine, state staff began by investigating the possibility of using it to fund the full cost of the program. Initially, they investigated the use of a modification to their state plan. However, use of that mechanism would not permit the inclusion of SEE. Maine does not have managed care and therefore couldn't use the in lieu of approach that was successful in Pennsylvania. They therefore are exploring the possibility of using an 1115 waiver mechanism that would permit the inclusion of SEE and all of the other CSC services. An 1115 waiver permits the state Medicaid program to use Medicaid funds in ways that ordinarily would not be permitted by the program so long as they are for a project that is likely to serve the objectives of the Medicaid program. The waivers can be tailored to the needs of specific populations. CMS has also provided specific guidance to state Medicaid directors that the 1115 mechanism is an appropriate mechanism to fund services like CSC.[7] Although it isn't a legal requirement, these waivers should not increase costs to the Federal government. This would be a state concern as well. Using the 1115 mechanism will permit funding for the full costs of the CSC model. If able to proceed from a budgetary perspective, Maine is exploring development of a rate that would be paid on a per member per month basis, giving programs the flexibility to tailor the program to a client's needs and goals. Ideally, payment would be linked to performance outcomes. As in Pennsylvania and other states, Maine is planning to partner with a university-based program to help with centralized functions like training and fidelity assessment.

Therefore, these are three examples of approaches that your state might consider in obtaining cost-based CSC services for Medicaid enrollees that would help to assure the sustainability of your CSC program. As you've probably guessed, there are many technical details that must be addressed in these strategies but those are for your business manager to address.

Certified Community Behavioral Health Clinic (CCBHC). In addition to the use of these three options, another mechanism for funding the full cost of the program is the use of the CCBHC mechanism. Although it is only a demonstration program in 10 states right now or a special grant program from SAMHSA with about 180 grant recipients around the county, many hope that the program will ultimately be expanded nationally. The logic of the program and many of the required service components nicely map onto the CSC model. The program

requires, for example, care coordination, outreach, education and engagement, patient centered treatment planning among other services that are compatible with the CSC model. It takes a wellness and recovery orientation and is designed to fully serve individuals with complex mental health and substance use disorders. CCBHCs also emphasize the delivery of evidence-based care. In the demonstration states CSC could be required by the state as an evidence-based practice. This would allow for the full costs of this service be covered. In the expansion grant sites CSC services could be covered for the under or uninsured. Other financing aspects of the CCBHC also address some of the chronic problems that CSCs have in supporting their program. Training and technical assistance costs may be included. Salaries are set at market levels meaning that programs may offer competitive salaries. CCBHCs are required to have partnerships with schools which are key to both early identification and supported education services. Importantly, CCBHCs don't have to directly deliver the services. They can contract with designated collaborating organizations for the provision of highly specialized services such as CSC. Anyone who qualifies to receive services must be served. Therefore, individuals who do not have Medicaid or other insurance must have access to the program. CCBHCs can include the costs of enrollment specialists to help individuals obtain Medicaid or other benefits as well as participate in the state insurance exchanges.

In the 10 demonstration states, the state mental health authority along with the Medicaid authority must approve the inclusion of CSC services for a cost-based payment. For the recipients of the CCBHC expansion grants from SAMHSA the grantees would have to demonstrate the need for the service in their area and build CSC into their grant application in order to use the grant funds to cover the full cost of the program. However, given the range of required services for the CCBHC, many of the difficult to fund components of the model – like outreach and engagement – are included. In response to the Covid-19 pandemic, the recently passed CARES Act included 250 million dollars to expand the availability of CCBHCs using the expansion grant mechanism at SAMHSA.

A full list of the 165 new CCBHCs is available at https://www.samhsa.gov/grants/awards/2020/SM-20-012.

A full list of the original expansion grant grantees is available at https://www.samhsa.gov/grants/awards/2018/SM-18-019.

A list of the states that were initially included in the national demonstrations can be found at https://www.samhsa.gov/grants/awards/2018/SM-18-019.

You can review these lists to see if there is a CCBHC in your area. If one is in your community, you could pursue them to include your program as a designated collaborating organization to provide CSC to their enrollees. However, both the CCBHC expansion grants and the mental health block grant are subject to annual appropriations and therefore vulnerable. If the CCBHC Medicaid demonstration becomes available nationally, it can provide a viable mechanism for fully covering the cost of the CSC program.

BestSelf in Buffalo and PEACE Health in Oregon both participated in the CCBHC demonstration. While the PEACE program hit an administrative barrier recently to their CCBHC financing, both programs were enthusiastic proponents of the model. It fully covers the cost of the program and supports the ancillary supports like training and program evaluation.

Commercial Insurance

With the passage of the Affordable Care Act in 2010, young adults through age 26 can be covered on their parent's insurance. Since adolescence through young adulthood are the ages of greatest risk for developing psychosis, many individuals with private insurance can be found in CSC programs. In the 36 programs that were studied in the national evaluation of the CSC programs, 15 programs (42%) reported receiving revenue from private payers in the second year of the evaluation.[8] While most Medicaid programs include many of the services that comprise the CSC program, commercial insurance programs generally cover only inpatient and emergency care, psychotherapy and medication. Additionally, many have co-pays that can represent a significant cost to individuals or families – especially given the frequency of CSC contacts. For CSC programs that bill private insurance companies, these revenues are typically a small portion of their overall budget. Given limited billings and the difficulties involved in getting onto insurance panels, many CSC programs choose not to pursue private payments.

However, using state general funds or block grant monies to serve people with commercial insurance is essentially providing a subsidy to the private insurance company for several key components of the CSC model and represents a cost shift from the private insurer onto public funds. As such, it further limits access to this EBP since it uses funds that could otherwise be used to expand services.

With the provision in the ACA to expand coverage to young adults, the evidence base regarding the effectiveness of CSC services, and the levels of unmet need for these programs, we think that commercial insurers should reimburse CSC services in much the same way they do other services that require coordinated, multi-intervention components.

Several groups have made progress in approaching commercial payers for reimbursement of CSC services. Here we present three state illustrations of how they have approached the problem.

Illinois. Thresholds in Chicago worked for several years to convince commercial insurers to cover CSC. This effort entailed developing the case for improved outcomes and reduced costs. However, this approach was not successful.

The commercial insurance lobby indicated that there was no demand for the service – that they had heard no request from businesses that their employees needed this as a covered benefit. This is one of the problems with approaching insurers directly since they typically only cover services that their customers (often business) want and/or that are mandated by the state.

Another challenge with convincing commercial insurers to cover CSC is that most of the population with serious mental illnesses drop out of commercial insurance as they become sick and disabled. The issue is not that this population is costing plans a lot of money because most of the population with psychosis moves to Medicaid or the public sector. The insurers have little incentive to change this trajectory.

After experiencing no success by directly approaching the insurers, Thresholds developed and led a statewide coalition of providers and advocates in a broader legislative attempt to improve the mental health system for children and young adults with serious mental illness. A great deal of time (over a period of two years) was spent educating legislators regarding the need for early treatment.

After unsuccessfully proposing a bill that contained only an insurance mandate for CSC and Assertive Community Treatment (ACT), the legislative strategy shifted to develop a bill that focused on multiple issues aimed at addressing the state's mental health crisis for young people. This effort resulted in the passage of the Children & Young Adult Mental Health Crisis Act (PA 101-0461)[9] which included a mandate that requires coverage of CSC and ACT for youth under age 26, beginning on January 1, 2021. (PA 101-0461, Sec. 30). The bill also addressed preventive mental health services for youth through the Medicaid program, and a redesign of one of the state's primary programs for youth with serious mental illnesses, as well as certain educational materials the state must develop to help educate parents on what behavioral health services are available for children and youth through the public sector.

With respect to the commercial insurance mandate, both CSC and ACT must be covered through a bundled payment. The Act also allows the credentialing of the entire treatment team, including peers, case managers and bachelor level social workers, by having the team leader's credentialing qualify all team members to be credentialled with the insurer. The Illinois Department of Insurance is required to convene a working group of providers and insurers to define the medical necessity criteria, coding for a bundled payment and the practicalities on credentialing. At this writing draft medical necessity criteria, continuing care and discharge criteria have been developed and discussions are ongoing in the workgroup regarding selection of the code and determination of the rate as well as credentialing requirements.

While supported employment and education were excluded from commercial coverage of CSC, the Act requires providers to adhere to fidelity. Block grant or other dollars will be used to support the SEE component of the model. The bill also addresses adherence by reference to the clinical model used in the NIMH RAISE demonstration. Adherence will be assured by limiting the groups that can bill for this service to those contracted and certified by the state as Illinois First programs that must comply with the CSC model.

The bill requires that after five years, dependent upon the request of the insurer, an independent evaluation be conducted to determine the impact of the program on insurance premiums in Illinois. If premiums are found to increase more than one percent solely due to this program, it will no longer be required.

Connecticut. In contrast to the experience in Illinois, Dr. Vinod Srihari from the Yale STEP program and the Connecticut Mental Health Center (MHC), approached Anthem/Blue Cross about paying for CSC services from his STEP program and found them to be receptive to the idea. Unfortunately, the Connecticut MHC didn't have the infrastructure to bill a commercial payer. Subsequently, Dr. Srihari began working with an academic group practice that has the needed infrastructure to bill commercial insurers. They are developing an alternative payment strategy that may be used in upcoming negotiations with commercial payers. He is also exploring using the block grant funds that STEP receives to fund the outreach, engagement and public education functions which can be difficult to support from insurance payments.

Maine. Practitioners and researchers in Maine have a long history of innovative, team-based care for early intervention in severe mental illness. Dr. Doug Robbins from Maine Behavioral Health Care developed an intensive home- and community-based outpatient program in 2000 for children and adolescents at risk for hospitalization and other out-of-home placement due to early serious mental illness. The program demonstrated marked positive effects on clinical function and healthcare costs and was approached by Anthem Blue Cross and Aetna for inclusion in their benefit packages. The initiative coincided with the Implementation of the Affordable Care Act and did not move forward due to uncertainty in insurance markets. Dr. Bill McFarlane from Maine Medical Center, developed the Portland Identification and Early Referral (PIER) Program in 2001 for intervention with adolescents and young adults who were at Clinical High Risk for Psychosis (CHR-P). Based in part on positive outcomes from the PIER program, Dr. Robbins and colleagues in collaboration with the with Maine Department of Health and Human Services (DHHS) developed a SAMHSA-funded program for First Episode Psychosis, which now includes CHR-P. The program in Maine, implementing CSC, has demonstrated improvements in functional outcome and decreased need for hospitalization comparable to those observed in the NIMH RAISE study.

A key barrier to developing an ongoing, multisite program for early intervention in psychotic disorders, in Maine as well as nationally, is the absence of sustainable funding through insurance – both Medicaid (MaineCare) and commercial. Dr. Robbins and others have worked

with the Maine Legislature and Maine DHHS on developing cost-based Medicaid coverage, which they hope will become final this year.

Maine Health, which includes Maine Medical Center, is the largest healthcare provider network in Maine and a leading provider in northern New Hampshire. Last year, the behavioral health practice renegotiated their relationship with all the commercial payers in their region. Supported by the CEO of Maine Behavioral Health, Dr. Robbins proposed including a mechanism to develop a bundled, cost-based payment into the contracts that have now been successfully executed with each of the payers. He is now trying to move forward with each of the payers individually to get the billing mechanics in place. Unfortunately, the process has not been going smoothly. In part because of the Covid-19 pandemic and continuing uncertainty in the insurance markets, most of the insurers, have been reluctant to work on the details about operationalizing the requirement. Work continues with commercial insurance companies to make clear both the short-term cost advantages, through reduced psychiatric hospitalization, as well as long-term positive effects on clinical outcomes, costs, and burden on families, with the goal of ongoing commercial coverage for CSC for early intervention in psychotic disorders.

Fidelity/Program Certification. Several generic issues are likely to arise in discussions with commercial insurers. Some of these were mentioned in the Illinois example such as credentialing and medical necessity criteria. Others that we have identified in conversations with Dr. Ken Duckworth who is the Medical Director at the National Alliance on Mental Illness and has commercial insurance experience. In addition to having a code that can be billed, Dr. Duckworth noted that insurers would like to be assured that the service they are purchasing has fidelity to the CSC model. He suggested that a state or national certification procedure would help address these concerns.

Another strategy that has been used by several states involves establishing a center of excellence that helps to assure fidelity to the program model. Two outstanding examples are the OnTrack program in New York and the EASA program in Oregon. In both instances, the state has designated these entities to work with local programs to assure that they are complying with the model as well as to do ongoing training and support. In both, a common data platform is used by all of the clinics which can provide ongoing monitoring and benchmarks for program performance and improvement. EASA supports some discipline specific groups across their programs that meet regularly to provide support and consultation regarding clinical or other issues that may have emerged. California, Ohio and Pennsylvania have similar centers of excellence. Maine is considering establishing one. As we mentioned earlier, Medicaid administrative funds can be used for these purposes since most clinics will serve Medicaid clients. The centers of excellence can also do public education and outreach activities to build the needed referral network.

Additionally, there are several organizations that nationally disseminate variations of the CSC model. In addition to OnTrack and EASA, the NAVIGATE program that was used in the RAISE

demonstration trains teams nationally and internationally. The PIER program in Maine has also trained programs throughout the U.S. Having this standardization in models which can be accompanied by ongoing training and support should help to assure the integrity of the CSC program to insurers.

Summary. Several groups have made progress in approaching commercial payers for reimbursement of CSC services but there is a considerable amount of work to be done to provide and sustain this evidence-based practice in treatment of early psychosis to patients across the country. This article summarized three examples of approaches to commercial payers for CSC services. One involves statutory language mandating a cost base, bundled rate (minus SEE), a second in which the insurer expressed a willingness to pay but the agency lacked the infrastructure to bill commercially and a third where a mandate was built into a larger contract that is now struggling with implementation. It seems clear from these case studies that there will be variability among the states in the receptivity of commercial payers to fund CSC services and that the logistics of billing will be an important consideration.

Costs and Cost Effectiveness

In a resource constrained system, the cost of services is an important consideration – especially in relation to their clinical effectiveness. Services like CSC that are flexible, intensive, outreach oriented and relatively comprehensive of client needs, are thought of as expensive. Traditionally, these services have been difficult to reimburse since they weren't seen as conforming to more standard, facility-based care like inpatient or outpatient treatment and involved a range of rehabilitative and support services in addition to traditional clinical care. In this section of the issue brief, we examine the cost of services and estimates of their cost effectiveness and contrast them with some the costs of some other medical procedures.

Costs. Dr. Tom Smith and colleagues from the New York Office of Mental Health conducted a rigorous study to determine the costs of CSC services.[10] They selected a stratified random sample of FEP clients and had their teams document all of their activities conducted for these clients over a two-week period – including case conferences, supervision and other administrative activities. The researchers then estimated the overall costs of implementing the CSC model as well as the revenue that could be collected within the New York State Medicaid program, which has a relatively comprehensive benefit. Their research demonstrated that they could collect about 48% of the needed revenue from Medicaid billings. The total cost of care for each of the selected clients was about $1,400 per client per month or about $16,800 dollars per year.

This figure is remarkably similar to one derived from an actuarial study of an Oregon program which found the cost of a CSC program to be approximately $1,400 per member per month

(pmpm). In an earlier publication by Gonzales and colleagues,[11] they interviewed an administrator from a Virginia program who estimated that their total cost of services per member per month was about $1,200. In a cost effectiveness study to be discussed below, Rosenheck and colleagues[12] estimate the costs for the CSC program used in the RAISE study at about $1,300 per person per month. Cost-based rates in Pennsylvania are also in this range from $1,200 to $1,500 pmpm. All of these programs conformed to the CSC model that Heinssen et al summarize[13] regarding staffing and case load considerations.

Cost Effectiveness. Using data collected from the RAISE study, Rosenheck and colleagues investigated the cost effectiveness of the NAVIGATE CSC model relative to the comparison condition of standard care.[14] While the details of the study are quite complex, the ultimate conclusion they reached was that the CSC model was cost effective. While it did cost more than ordinary community behavioral health treatment, it achieved greater benefits and the relative improvement in client outcomes was worth the additional cost when compared to the norms generally used in this type of analysis. Additionally, an important component of the cost for the CSC program was greater use of an on patent antipsychotic medication in the CSC program as contrasted with the comparison sites. Since some of these medications have now become generic, the cost differences between the CSC and comparison sites would be reduced. Another important finding from the study was that the cost effectiveness of CSC was much greater for individuals with a shorter duration of untreated psychosis, further underscoring the importance of rapid identification and engagement of clients in this program.

Comparative Costs with Other Medical Procedures. The annual cost of services per person in the RAISE demonstration was about $15,200. In comparison to other medical costs, services researchers at the MD Anderson Cancer Center report that, in 2005 the cost of cancer pharmacotherapy was between "$30,000 to $50,000 … In 2012, 12 of the 13 new drugs approved for cancer indications were priced above $100,000 per year of therapy." [15] Using 2017 data the International Federation of Health Plans contrasted the cost of services across several nations.[16] In the U.S. the average hospital admission price for an angioplasty was $32,300, a knee replacement $29,000 and a hip replacement $32,500 as contrasted with a yearly cost for CSC services at around $15,000. The point being that CSC's intensive services are often considered costly while they are modest compared with prices routinely charged for other medical interventions.

Average Increases in Insurance Premiums for CSC. Earlier, we presented cost data for several programs that ranged in the $1,200 to $1,500 per member per month range, as well as information documenting the cost effectiveness of CSC services. If we were to identify every person with first episode psychosis and treat them, how much would that increase insurance rates? We did some 'back of the envelope' calculations using Rosenheck et al's cost data and New York State population data from 2010. If we look at the additional cost of treating persons with a first episode and use an incidence rate of new cases based upon two recent, rigorous studies,[17] we estimate that it would increase insurance premiums by about

$0.08 per enrollee per month or $0.96 per year if we enrolled all of the new cases. If we assume a two-year length of stay the premium increase would be $0.16 per enrollee per month. If we only could enroll ¾ of new cases, the additional premium drops to about $0.06 per member per month. We've further described our calculation methods and assumptions below for those interested.[18] The service seems very affordable when the cost is spread over an entire population to be insured. Therefore, CSC services have been shown in a rigorous trial to be cost effective and we would argue very affordable when part of a general population insurance program. We know these programs are the most appropriate treatment for people with early psychosis and should be widely available to ensure treatment is available early and health outcomes are achieved. While more longitudinal research is required, we also believe that CSC programs will result in lower lifetime disability and greater productivity. The minimal increase in insurance premiums should be more than offset by savings in disability and treatment expenses as well as the increased productivity of persons who otherwise would likely be unemployed and receiving disability insurance payments.

In Conclusion

In this paper we have argued that in order to sustain CSC programming in the long term, we must develop insurance mechanisms that fit the program model and fully support its operation with fidelity. Traditional insurance mechanisms, including Medicaid, are not adequate and require supplemental funding generally from state general funds or federal block grant dollars. We have presented several strategies that may be used with Medicaid enrollees to fully cover the cost of the program. This is particularly important given the expansion of Medicaid in 36 states to cover low-income young adults who are not likely to meet disability criteria. We also argued that a good number of enrollees in these programs have commercial insurance that can cover some of the components of CSC but not the full model and that commercial insurance is not always utilized. We presented three examples of states that are attempting to secure payment from commercial insurers with the Illinois effort likely to be the most successful – perhaps providing a precedent and strategy that may be used elsewhere. Finally, we presented estimates of the program's cost from several programs that converge at around $1,400 per month as well as a rigorous cost effectiveness analysis that demonstrated that CSC services are worth the small increase in cost that they incur. When these costs are spread across an insured population, they are likely to add less than two dollars per year to the insurance premium. This small increase in cost will be more than offset by the likely increased rates of employment among persons with FEP as well as their decreased reliance of public disability benefits.

Armed with this information, you may wish to begin discussions with your program leadership about pursuing cost-based funding as your program matures. Doing so will free block grant funds that can be used to expand programs in your state. If we are to realize the promise of

early intervention, we need to provide access to CSC services to everyone developing a psychotic illness and deliver the program model with fidelity. These financing strategies should help underwrite this vision.

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[14] Rosenheck op. cit.

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[18] If we calculate the difference between the NAVIGATE group cost and the comparison condition that can be an estimate of the additional cost to implement the CSC model. That is about $180 more per month for NAVIGATE over standard care using generic drug costs. How many new cases would we expect in a year? Two recent studies have used rigorous methods to investigate this question and have estimated rates of new cases (incidence rate) that are much higher than have traditionally been used. One looked at a large, commercially insured population and the other a Medicaid group. As you might expect they came up with different rates with the commercially insured estimated at about 86 new cases each year per 100,000 population aged 15-29 and the Medicaid population at 287 per 100,000 for people aged 15 to 25. For our purposes here, we averaged the two rates and used about 186 per 100,000 as the incidence rate. We then looked at the 2010 census information for New York's population and used the population estimate for ages 15-29 to calculate the number of expected persons with FEP. When we multiply the estimated number of new cases by the additional cost per case to get a total new cost. We then divide this number by the non-elderly population of New York to estimate the addition to the insurance premium.

This clearly is a back of the envelope calculation since it assumes that everyone in the population is insured, doesn't adjust for Medicaid versus commercially insured rates in the population, restricts the estimate to the 15-29 age group when many programs serve wider age ranges, etc. It does provide a rough estimate of the increase in premium. Even if we are underestimating by 100% the pmpm increase is quite small.