Financing First Episode Psychosis Programs: Developing Medicaid and Commercial Insurance Support in Maine

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History in Maine

• 2000-2011. Treatment of Clinical High Risk for Psychosis
  – 6 sites in US.
  – Robt Wood Johnson Foundation

• 2000-2011. Home-based Assertive Community Treatment for ages 4-18, all diagnoses
  – Decreased hospitalization, incarceration, overall costs
  – Commercial insurance sought participation.

• 2015-Present. CSC for First Episode Psychosis.
  – SAMHSA support
Commercial Insurance Negotiations

1. Presented national, international data on effectiveness, cost-effectiveness, hospitalization use. RAISE, other:

2. Presented local data on disability, education and employment, and hospitalization, consistent with national data.

1. Emphasized Value Proposition: Cost of CSC vs cost of hospitalization, incarceration, and other care.

1. 9-12 month process. Seven separate contracts.
   Involved companies’ Medical Economics staff and Medical Directors, not only rate-setting staff.
Commercial Insurance Negotiations

5. CSC for FEP included in the set of services presented for renegotiation of contracts for all Behavioral Health services under MaineHealth

6. Cost-based, Bundled payment.
   - Total cost for CSC program divided by individuals served.

   a. Cost similar to ACT
   b. Insurance companies have capacity for a Day-Rate to cover total program costs. Little capacity for PMPM payment.

8. Beginning 10/1/2019
   a. Currently limited to MaineHealth contracts
   b. Quarterly and Annual review.
Data from Maine CSC

Percent of PIER Patients Employed or Enrolled in School over Time

[Graph showing the percentage of patients employed or enrolled in school over time, with lines for enrolled, employed, and enrolled or employed.

WHODAS (Disability) over Time for all Diagnostic Subgroups

[Graph showing WHODAS scores over time for different diagnostic subgroups, with lines for schizophrenia, depression, and bipolar disorder.

Maine CSC: Percent of Clients with At Least One Hospitalization in Previous Month (N=73)

[Graph showing the percentage of clients with at least one hospitalization in the previous month, divided by time intervals after intake.
Developing Medicaid (MaineCare) Support

• Emphasized to Maine DHHS the necessity for a MaineCare case rate to implement a state-wide program.
  – Little response, by the state administration at that time.

• State Legislators engaged, 2017-2018.

• Bill introduced and passed, 2019.
  – Bipartisan support
  – DHHS directed to seek Plan Amendment to allow flexibility with Medicaid. Funding debate deferred to 2020 session..
  – Favorable engagement with new state administration
State-wide program planned

• Additional sites in smaller cities

• Rural implementation
  – Consultation, direct and via Telehealth
  – Training and ongoing consultation for MultiFamily Group, Cognitive Behavioral Therapy for Psychosis
  – Develop educational and vocational support, case management

• Coordination and training through hub-and-spoke model with telehealth, periodic conferences
  – Considering Project ECHO
Key Elements in Negotiation

1. CSC for FEP identified as a critical component of a comprehensive Behavioral Health Plan for Population Health.

1. Presented local as well as national data supporting effectiveness and cost-effectiveness.

1. Emphasis on the Value Proposition. In the interest of both the population and payers.

1. Local expertise and credibility.
Key Elements in Negotiation

5. Effectiveness not over-stated.
   – Secondary Prevention, not Primary Prevention or Cure.

5. Specific evidence-based inclusion criteria, associated with effectiveness
   – Rather than conventional “Medical Necessity”.

5. All costs for an effective program included.
   – Community and referral source education
   – Outreach to engage patients, families
   – Team-based treatment

8. Anticipate challenges – Med necessity, continued care