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A Clinical Support System for Serious Mental Illness
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Financing Team Based Coordinated Services

Examples from First Episode Psychosis

August 27, 2020

CSS-SMI INITIATVE

The Clinical Support System for Serious Mental Illness (CSS-SMI) is a Substance Abuse and Mental Health Services Administration (SAMHSA) funded initiative implemented by the American Psychiatric Association (APA).

SAMHSA
Substance Abuse and Mental Health Services Administration

AMERICAN PSYCHIATRIC ASSOCIATION

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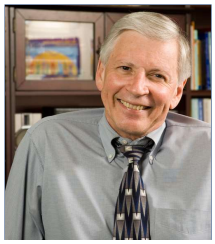

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DISCLOSURE

No relationships or conflicts of interest related to the subject matter of this presentation.

LEARNING OBJECTIVES

- Describe cost challenges associated with implementing evidence-based treatment for a serious mental illness.
- Discuss domains and dimensions of cost-effectiveness in early treatment of psychotic disorders
- Summarize limitations of current fee-for-service funding for comprehensive psychiatric treatment
- Explain payment models under consideration for comprehensive team-based care in a serious mental illness

Outcomes in Usual Care for Psychotic Disorders

- Psychotic Disorders include:
  - Schizophrenia – The focus of most studies of early intervention
  - Bipolar Disorder and Major Depressive Disorder with Psychotic Features
  - Substance-Abuse Induced Psychosis – Generally not included in early treatment trials
- Very Poor Outcome in Multiple Domains
  - Quality of life, employment, family relationships, service utilization, societal costs
- Mortality and Medical Morbidity
  - 25 years earlier mortality

Evidence-Based Treatment for First Episode Psychosis

- Early Intervention is Effective
  - Shorter Duration of Untreated Psychosis (DUP) is associated with better outcomes
    - Effectiveness of efforts to reduce DUP
- Comprehensive Psychosocial and Pharmacological Treatment is Effective
  - Coordinated Specialty Care (CSC)
  - Recovery After an Initial Schizophrenia Episode (RAISE) Clinical Trials
    - Kane, Dixon, Fusar-Poli
  - Specialized Treatment Early in Psychosis (STEP) Randomized Clinical Trial
    - Srihari
  - International Studies
    - Fusar-Poli, Correll

Coordinated Specialty Care - Components

- Team-Based Treatment
- Case Management, Care Coordination
- Supported Employment and Education (SEE)
- Psychotherapy – e.g. Cognitive-Behavioral Therapy for Psychosis (CBTp)
- Family Support and Education
- Pharmacotherapy and Primary Care Coordination

  Heinssen RK, Goldstein AB, Azrin ST, 2014
- Often Included – Peer Mentor Support

Coordinated Specialty Care -Outcomes Observed in Most Studies

Kane, Dixon, Aceitano, Srihari

- Improved educational and employment outcomes
- Reduced need for hospitalization
- Improved quality of Life
- Other
  - Reduced suicide risk
  - Improved family relationships
  - Decreased homelessness
  - Decreased substance abuse
  - Medical morbidity, earlier mortality

Domains of Cost in Serious Mental Illness

- Direct treatment costs.
- Costs to families, caregivers. Out-of-pocket, co-pays, limited deductibles, decreased work time and income.
- Costs to society other than healthcare costs – lost productivity, law enforcement and corrections, disability payments, homelessness, educational accommodations.
- Medical costs in addition to mental health care.
  - Excess morbidity and mortality for persons with SMI.

Medicaid fee for service reimbursement covers only 40% of program costs (Smith et al)

- Components of CSC not funded by insurance
  - Outreach, engagement of patients who have had an initial episode of psychosis
  - Community and referral source education
  - Supported Education and Employment
  - Peer mentor support
- Components of CSC not sufficiently funded
  - Family support, e.g., multifamily psychoeducational group
  - Team-Based care, team meetings, care coordination time and effort
  - High frequency of pharmacologic management and therapies
  - Training for evidence-based psychotherapy – Cognitive Behavioral Therapy for Psychosis

Cost-Effectiveness of Coordinated Specialty Care

- Short-term – best use of resources
  - CSC contains or decreases acute healthcare costs, e.g. hospitalization
    - Aceitano
    - Srihari
  - Quality of Life relative to cost
    - Rosenheck
- Longer term – Likely positive effects include
  - Decreased lifetime healthcare costs of psychotic disorders
  - Increased lifetime productivity

Costs and Cost Effectiveness

- Comparative Costs
  - Based on cost data from several sources, we estimate the annual cost for the program to be between $1,200 to $1,500 per client per month
  - RAISE study estimated costs at $15,200 per client per year ($1,267/month)
  - Compared to commonly reimbursed medical procedures
    - Angioplasty - $32,300
    - Knee replacement - $29,000
    - Hip replacement - $32,500
    - Cancer pharmacotherapy - $30,000 - $50,000
    - In 2012 12 of the 13 new drugs approved for cancer cost over $100,000.

Mental Health Parity

- Early psychotic disorders are:
  - a severely category of illness
  - with a treatment modality which has been shown to be effective
  - which are not covered by insurance coverage comparably to other medical illnesses.

Marginal Increases in Insurance Premium if CSC Services were Universally Available

- Based on information from Rosenheck et al's cost effectiveness study, we identified the additional cost per month to provide CSC services rather than usual treatment,
  - Using incident estimates from two recent rigorous studies – one commercial and one Medicaid population, and
    - ➢ the population structure for New York State in 2010,
      - ➢ we estimated that the additional cost to an insurance premium of $0.16 per member per month with a two-year length of stay.
- If only 75% of incident cases are served the costs drop to $0.12 per member per month or an additional premium of $1.44 per year.

Issues for consideration in funding

- Costs not typically covered by current fee-for-service insurance
- Variability among programs -
  - Variation in needed intensity
  - Variation in duration
  - Step-down with partial improvement
  - Rural populations
- Costs for a program, not attributed to specific patients
  - Education of the community – public, healthcare providers, other referral sources
    - Prevailing realities – deferred treatment, limited expectations re: outcomes
    - Subthreshold or non-acute presentations that will benefit
    - Reducing duration of untreated psychosis (DUP) – commonly 2 years
  - Training – initial and ongoing
  - Data monitoring - Continuing Quality Improvement

Medicaid Financing Strategies

- Amend the State Plan
- Use Medicaid Manage Care 'In lieu of' Provision
- Use a SMI/SED Medicaid Waiver
- Use Comprehensive Community Behavioral Health Center Financing

Amend the State Plan

To use this option states must:

- Have CMS permission to provide Home and Community Based Services (HCBS) (HCBS allows coverage of Supported Education and Supported Employment),
- Request from CMS that CSC be covered as an evidence-based service under the rehabilitation option, and
- Calculate a reimbursement rate for all clinical services that accommodates (small caseloads, team staffing, training and certification).

- ➢ Reimbursement rate is calculated by dividing program costs by anticipated number of encounters.
- ➢ Outreach and Public Education can be reimbursed through a separate contract using Medicaid Administrative funds.

Medicaid Managed Care

- For states that have Medicaid Managed Care Programs (MCOs)
  - MCOs can request from the state to cover CSC services on a cost-based basis.
  - Program costs can be fully covered as:
    - An evidence-based service.
    - Specifically tailored to persons with FEP.
    - Offered 'in lieu of' other services.
  - CSC providers can negotiate a cost-based rate with the Managed Care Company.
  - Billed on an encounter basis in the same way as the state plan modification.
  - Example from Pennsylvania.

Use of an SMI/SED Waiver

- CMS offered specific guidance to state Medicaid Directors in 2018 on the use of the 1115 waiver mechanism to finance team-based coordinated specialty care.
- Financing is cost-based.
- Requires that program be implemented that:
  - Identify and serve individuals quickly with
    - ➢ Integrated care approaches in
      - ➢ Specialty Settings.
- Outreach and Public Education can be covered with Medicaid Administrative funds.
- Example from Maine

Comprehensive Community Behavioral Health Centers (CCBHC)

- Currently a demonstration program in 10 states, or a
- SAMHSA funded grant program in other states.
- Requirements of the CCBHC nicely map CSC services,
  - e.g. Care coordination, outreach and public education, relationships with schools, patient engagement, recovery orientation, etc.
- CSC could be required by the state as an evidence-based practice.
- Addresses many of the problems CSC programs face:
  - Training, TA and program evaluation costs included.
  - Salaries are set at market rates.
  - Services can be delivered on contract to a collaborating specialty program.
- Oregon and New York sites have successfully used this mechanism.

Commercial Insurance

- Expansion of services to young adults under the Affordable Care Act.
- Typical commercial coverage doesn't include many of the services or the intensity of delivery in the CSC model.
- 42% of sites included in the national evaluation of FEP programming receive some revenue from commercial insurers for some clinical services.
- Uncovered costs of CSC programs for delivery of these EBP specialty services can be seen as a cost shift onto public payers.
- Three state examples
  - Illinois, Connecticut and Maine

Illinois

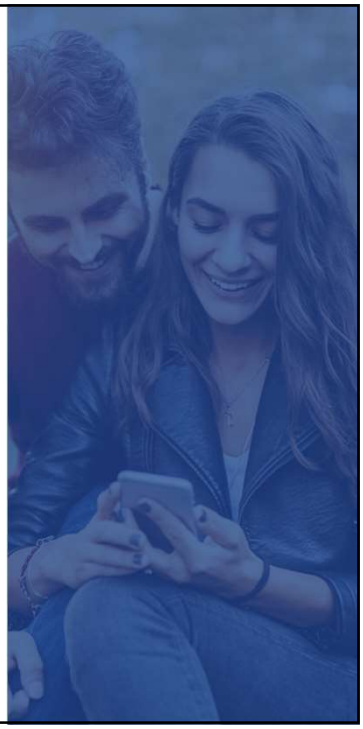
- A multi-year effort led by Thresholds in Chicago resulted in passage of the Children and Young Adult Crisis Act in 2019.
- The act addresses many treatment issues of relevance to this population and
- Included a mandate that commercial insurers cover CSC services with a cost-based rate by January 1, 2021.
  - Minus supported employment/education
- Strategy of persistent outreach and education of legislators and including insurance mandate as only one component of a more comprehensive law.

Illinois (cont.)

- The Act allows the credentialing of the entire team including peers, caser managers, BSWs, etc. under the Team Leader's credential.
- It required the Department of Insurance to convene a working group of providers and insurers to define medical necessity criteria and coding requirements.
- Currently medical necessity, continuing care and discharge criteria are being finalized.

Connecticut

- Dr. Vinod Srihari of the Yale STEP program approached Anthem Blue Cross in CT.
- They were receptive to the idea and willing to cover the costs of the program.
- Unfortunately, the CMHC did not have the infrastructure to bill commercially.
- Dr. Srihari hopes to work with a large group practice with the required infrastructure to do the billing.
- Dr. Srihari hopes to use block grant funds for outreach, public education and engagement.

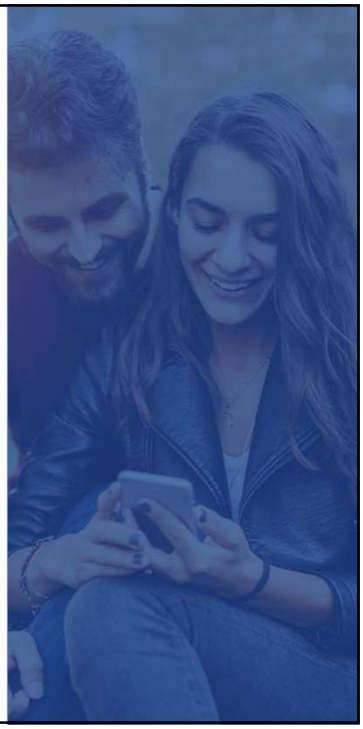


Maine

- Maine Medical Center and Maine Behavioral Health are the largest healthcare providers in the state.
- Medicaid funding of CSC supported by state legislation and Maine DHHS efforts.
  - 1115 Waiver submitted
- As part of a larger renegotiation with commercial insurers, a cost-based, bundled rate was included in contracts.
- Implementing the new service has not gone smoothly – most companies reluctant, in part owing to the Covid-19.
- Negotiations continue to develop an implementation strategy involving coding and the rate.

Fidelity Certification

- In both public and private financing, concerns with the fidelity of the CSC program are likely to be an issue.
- Some states have sponsored centers of excellence to provide support and help to assure that the programs adhere to the evidence-based practice.
- This type of certification should assuage payer's concerns.



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