New England (HHS Region 1)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Implementing Real-World, Evidence Based Early Services for Early Psychosis and Signs of Risk Online Discussion Series Session 1:

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

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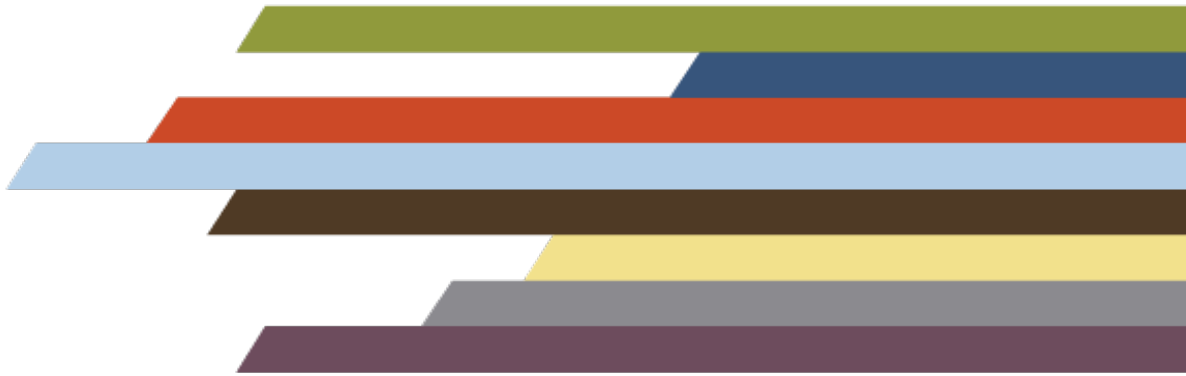


Opportunity:
Population Health Improvement by Scaling up Evidence-Based Treatment for Severe Mental Illness

- A proven intervention can improve life for thousands of severely mentally ill people.

- It will decrease costs for healthcare.
  - Short-term – through decreased ED, Crisis, and Hospitalization costs
  - Long-term – decreased costs in multiple domains for those with Severe Mental Illness

Challenge:

- Major barrier to expanding access –

  Absence of sustainable funding through insurance.

Challenge: We need to change the paradigm about mental health treatment

- Current assumptions
  - Pessimism that we can improve treatment for SPMI
  - Skepticism that increased investment will result in change. Limited Return on Investment
  - Current treatment has limited effectiveness.
    - Improvement possible only with further research, e.g. Bio-Markers.
  - We should do what we can because it is humane and ethical
    but with low expectations of changing outcomes and costs.
  - Effect - Resources are disproportionately used for severe illness, older patients.

- Investment in earlier stages is limited.

New Paradigm

- Early identification and evidence-based treatment is good public policy - a critically needed investment in the health of the population.
- With currently available treatments, we can markedly improve outcomes for individuals and decrease the burden of SPMI on healthcare resources and society.
- We already know how to identify earlier many individuals who have, or are at markedly increased risk for, severe mental illness.

Context:

Value-Based Health Care

Value = Benefits / Costs Michael Porter, et. al.

Implementation Gap in Healthcare Innovation

Demonstrated efficacy to implementation = 17 years

Webinar Overview – Steps towards insurance funding

1. Educate all stakeholders
    1. Early treatment works.
    2. Early treatment is cost-effective.
2. Define costs, cost-effectiveness, and return on investment
3. Define Funding models
4. Developing Medicaid coverage
5. Developing commercial insurance coverage

Educate Whom?

- Public – Families, Schools, Primary Care, Law Enforcement, Employers – all those who deal with adolescents and young adults.
- Healthcare providers – Our own organizations and leadership, Colleagues
- Payers – Insurance companies, state Medicaid leaders, Employers and benefits managers

Education: Coordinated Specialty Care

- Recovery After an Initial Schizophrenia Episode (RAISE) studies.
  - Heinssen R, et.al., 2017, Kane JM, et.al., 2016, Dixon LB, et.al., 2018, Srihari V, et.al., 2015)

- Components:
  - Team-Based Care – vs fragmented services
  - Case Management/ Care Coordination
  - Recovery-based Psychotherapy
  - Family Education and Support
  - Pharmacotherapy and Primary Care Coordination
  - Supported Employment and Education
  - Peer Support and Mentoring
  - Community Education
  - Outreach to engage patients and families

Education: Early Treatment Works.

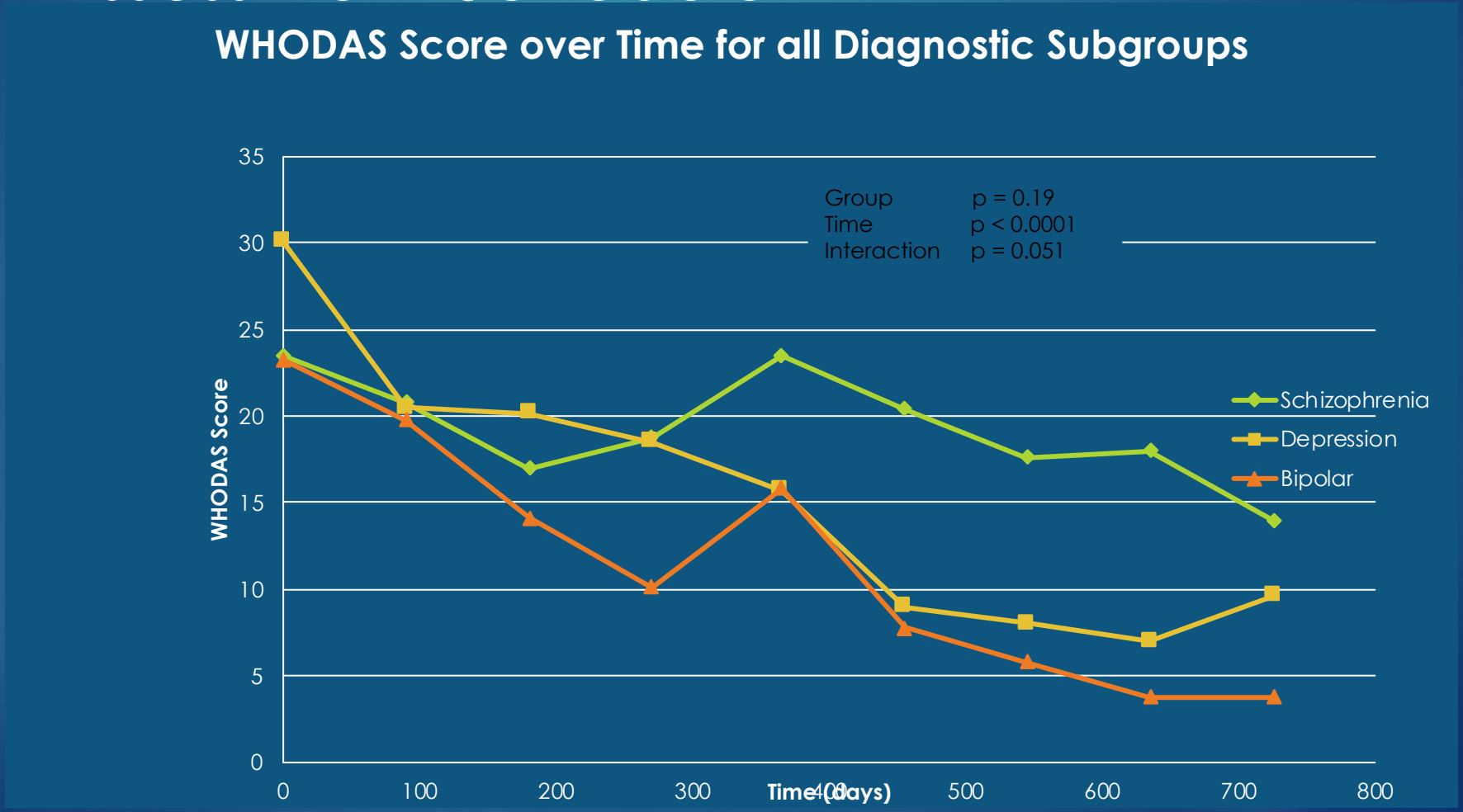
Dixon LB, Goldman HH, Srihari VH, Kane JM, 2018.

- Improved participation in employment and education
- Decreased hospitalization and overall healthcare costs
- Decreased involvement/costs with law enforcement and Corrections
- Improved Quality of Life
- Improved relationships with family, housing, medical care
- Outcomes better with lower Duration of Untreated Psychosis (DUP).

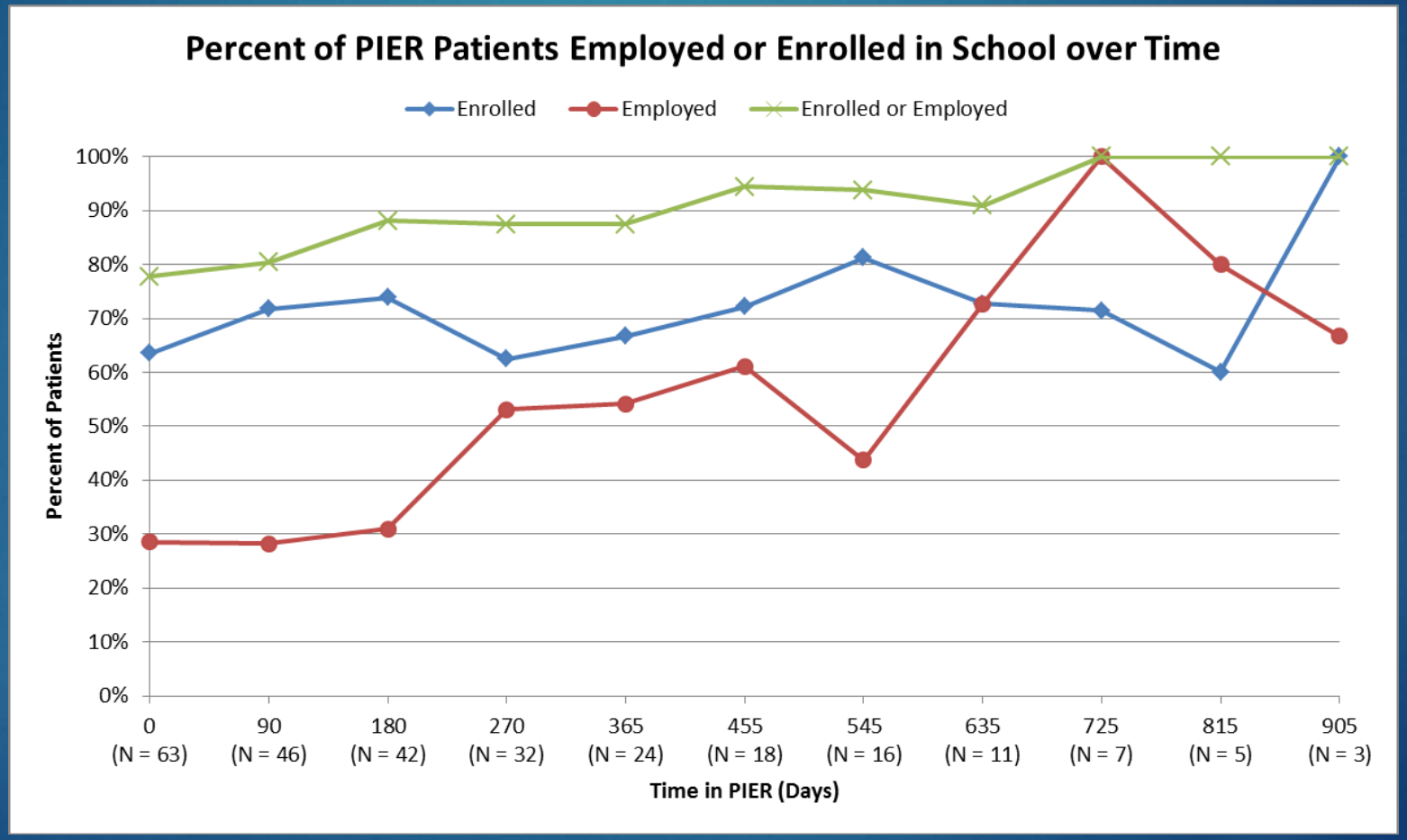
Education: Early Treatment Works. Local Outcomes – Maine

- Decreased disability - World Health Organization Disability Assessment Scale (WHODAS)
- Increased participation in Education and Employment
- Decreased Hospitalization

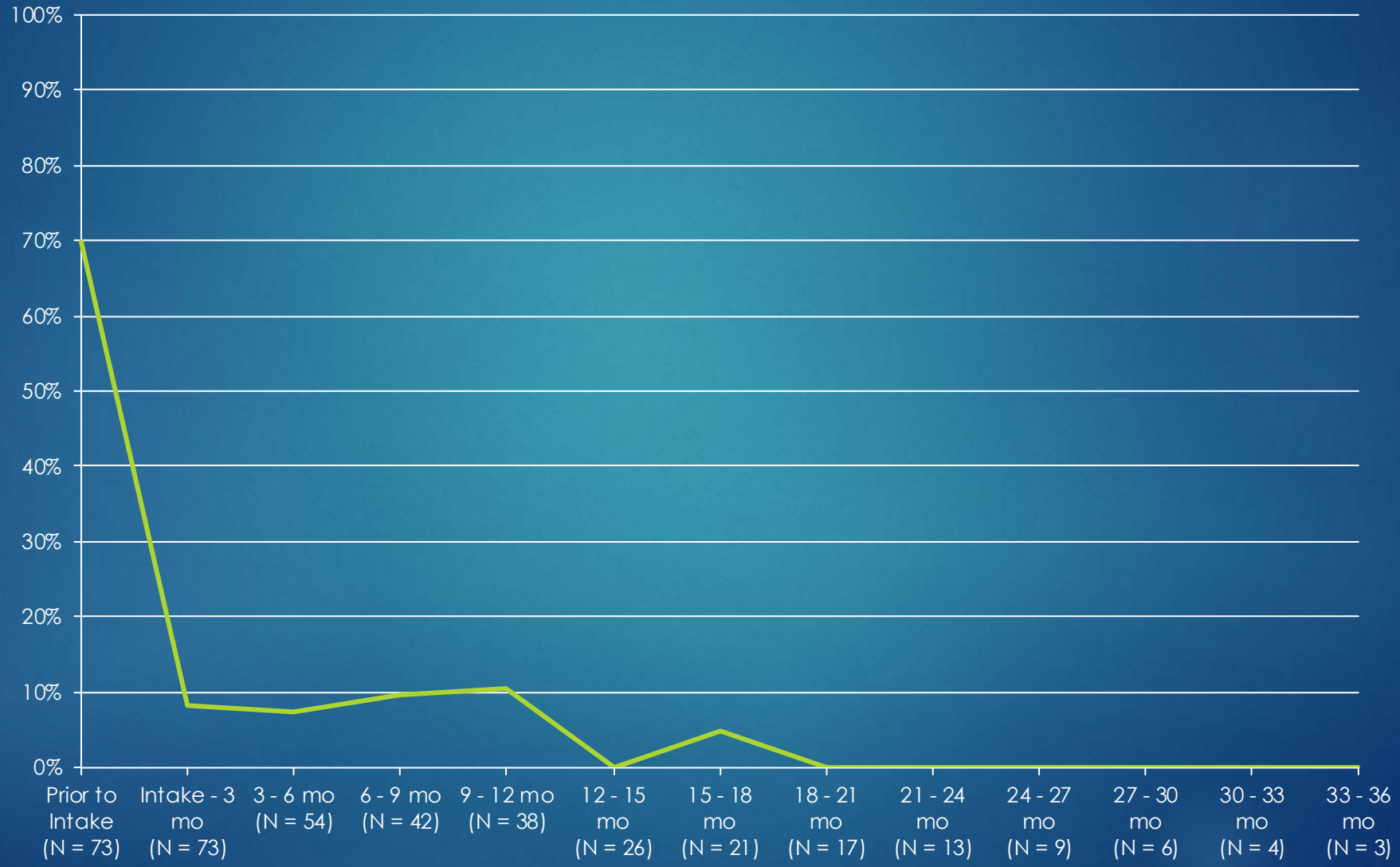
Maine CSC – Outcomes - World Health Organization Disability Assessment Schedule



Maine - Coordinated Specialty Care for First Episode Psychosis



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



Education: CSC Cost-Effectiveness

US - Randomized controlled trial (Srihari V, et.al., 2015, Murphy SM, et.al., 2018)

- Half as many hospitalizations in first year
  - Coordinated Specialty Care - 23% hospitalized
  - Usual Care - 44% hospitalized
- Hospital Bed-days/year with
  - Coordinated Specialty Care - 5.34
  - Usual Care - 11.51
  - Savings per patient: 6 hospital days /year @ $2200/day = $13,200
- Cost of CSC =$1984/patient.
- Net benefit of $2991 at 12 months.

UK – large three year community mental health study (Tsiachristus A, et.al. 2016)

- Decreased hospitalization costs - $5175. (US $)
- Increased community mental health costs - $823
- Annual savings per patient of $5119

Education: Cost-effectiveness- continued

- RAISE study, U.S. (Rosenheck R, et. al., 2016, Schizophrenia Bulletin)
  - Incremental Cost Effectiveness Ratio indicated cost-effectiveness for Coordinated Specialty Care vs. Usual Care.
  - Cost per Quality Adjusted Life Year comparable to costs typically paid for other medical care.
    - Use of statins for hyperlipidemia
    - Chemotherapy for cancer
    - Care for diabetes, coronary artery disease
- International review, 16 studies. (Aceituno D., et.al. 2019)
  - Consistent cost-effectiveness for Early Intervention in First-Episode Psychosis and in Clinical High-Risk for Psychosis.

CSC is Not Fully Covered by Current Insurance

- Components – Funded by Health Insurance / Not funded
  - Team-Based Care
  - Case Management
  - Recovery-based Psychotherapy – e.g. CBT-Psychosis
  - Family Education and Support – Family Therapy, Multifamily Group Psychoeducation
  - Pharmacotherapy and Primary Care Coordination
  - Supported Employment and Education
  - Peer Support and Mentoring
  - Community Education
  - Outreach to engage patients and families

Current insurance funding for covered services

- Revenue from billed services = 15-25% of cost of program.
  - Optimal billing, with Medicaid waiver for home- and community-based services (OnTrackNY) = 48% of costs (Smith TE etal, 2019)
- Commercial insurance – 20% to 50% of patients
  - Persons up to age 26 on parents' health insurance
- Medicaid – 50% to 80%
  - Higher in suburban and economically-stable urban areas

Current programs depend on Federal or state funding. Not Sustainable.

- Community Mental Health Block Grant – 10% Set-Aside
  - "States shall expend at least ten* percent of the amount each receives…to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset." (* 2014 5%, since 2016 10%)
  - Insufficient to cover cost of all services for a region or state
  - May support some functions - community education, provider training, outcome data monitoring and analysis

Education: Costs of implementing CSC

- Reported costs vary:
  - $1200-2200 per patient per month
  - 14,4000-26,400 annually

- Sources of variability in included components:
  - Education to public and healthcare providers
  - Outreach to referral sources, patients, families – prior to registration as patients
  - Training and supervision in evidence-based interventions
  - Extent of family education, psychotherapy, groups, support
  - Outcome and fidelity data monitoring
  - Peer Support

- Other costs:
  - Overhead – space, admin support, patient accounts
  - Margin added in anticipation of insurance coverage denials, other.

Education: Other costs to society – not covered by medical insurance

- Relevant for support from families, other professional organizations, employment benefits managers

- Families' out-of-pocket costs
  - High deductible policies, increasing co-pays
- Patients' and caregivers' lost productivity
- Education systems
- Law enforcement, Corrections
- Welfare
  - Homelessness
  - Foster care for offspring of mentally ill and substance-abusing adults

Rationale for payers to cover CSC

- Quadruple aim (Bodenheimer T, Sinsky C. 2014)
  1. Improve Population Health
  2. Reduce Costs
  3. Enhance Patient Experience
  4. Improve work life for Providers

- Value-Based Health Care – Accountability and Efficiency (Porter M, 2006, 2020)

- Reduce the Population Cost burden of Severe and Persistent Mental Illness
  - ED, Crisis services – Within the first year
  - Psychiatric hospitalization – Within the first year
    - Note separate "Silos" for accounting for inpatient vs. Outpatient costs
  - Decrease medical morbidity – (25 years' earlier mortality in SPMI)
  - Improve primary care and other sectors' efficiency, costs, provider burden

Funding Models

- Bundled Payment or Case Rate
  - Costs of all components included in a single charge. Per day, per month.
  - Efficiency. One charge, one payment rather than multiple.
  - Accountability. Outcomes can be monitored. Reimbursement can be aligned with outcomes
  - Including services currently covered by CPT codes

- Conventional billing (CPT codes) for currently covered services, plus alternative payment for the rest.
  - Limited Bundle
  - Healthcare Common Procedure Coding System (HCPCS, or "Hixpix")
    - E.g. HCPCS T1024 - *Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children, per encounter* or just "***Team evaluation & management***"
    - Suggested by Meadows Healthcare Policy Institute

Models

- Meadows Mental Health Institute:
  - Recommends Healthcare Common Procedure Coding System (HCPCS) coding – single code for all components of the CSC model.
    - Comparable to accepted billing for Assertive Community Treatment (ACT) and Multi-Systemic Therapy (MST)
    - Flexibility – two structures based on intensity of service.
      - Monthly Case Rate for the full CSC model
      - Encounter rate for less intensive service
- Washington (R. Daughtry, 2020)
  - Stage 1. Billing for covered services, with balance paid for by Mental Health Block Grant Set-Aside. Study total costs to create a Case Rate (Bundled Rate)
  - Stage 2. Case Rate.
    - Pilot with state employees' health plan
    - Medicaid and commercial insurance
- Illinois – Medicaid coverage phased in over 4 years. Working Group on rates.

Developing Medicaid Coverage

- States with negotiated coverage
  - Oregon
  - Pennsylvania
- Legislation to require Medicaid coverage
  - Illinois – passed in 2019
  - Washington
  - Maine – Passed in House. Pending in Senate

Steps in developing Medicaid coverage

- Need to define:
  - Numbers served. Eligible population, number likely engaged.
  - Percentage on Medicaid
  - Cost per patient (PMPM)
  - Federal match – reducing costs to state
    - Waivers, e.g. #1115
    - State Plan Amendment
- Negotiation with state governments – Challenges
- Pros and Cons of a Legislative mandate

- See Humensky J.L., Dixon L.B., & Essock S.M., (2013). An interactive tool to estimate costs and resources for a first-episode psychosis initiative in New York State. *Psychiatric Services*, *64*, 832-834.

Commercial Insurance Coverage

- No current successful implementation
  - Innovative funding models in cardiovascular disease and cancer, not in mental health
    - Stigma ?
    - Pessimism about investing in mental health services. Educate re: past vs current data on effectiveness.
    - Severe mental illness perceived to be a small population and cost relative to major medical disease categories (MI, Stroke, Cancer)
  - Note: Schizophrenia total costs in US = $1,557,000,000 (Cloutier M, 2013); Bipolar Disorder costs $85,611,000,000 (Kleinman L, et.al., 2003)
- Maine
  - Agreement by one of five major payers. Ongoing negotiation.
    - Accepted Case Rate or Bundled Funding model
    - Implementation dependent on logistical factors, including coding
- Connecticut, others – ongoing negotiation
- Note: some states are including mandated commercial insurance coverage in legislation.

Issues to be addressed in engaging commercial payers in funding CSC

- First - Engage your Healthcare Provider Systems in support for early intervention in psychotic disorders
  - Define how it is in their interest. ED, Hospital use and costs
  - Population Health perspective. Quadruple Aim.
  - Value-Based perspective in healthcare resources.
  - Clear costs and net cost savings due to reduced inpatient costs.
  - Efficiency of all medical staff, primary care and other. Time engaged in treatment of SPMI.

- Develop support beyond specific provider organizations
  - Coalitions of stakeholders
    - Employers – Benefits managers
    - Payers
    - Providers

Commercial insurance issues – contd.

- Eligibility criteria - define
  - Note: Difference from conventional Medical Necessity
    - Individuals not (yet) severely disabled, high-utilizers of services.
- Duration of CSC – most programs expect approx. 2 years.
  - Define Stepdown, Continuing effective components for the individual.
  - Payment approaches to stepdown
- Define CSC clearly
  - Refer to literature on outcomes, reduced hospital utilization. RAISE and other
  - National credentialing organization?
  - Staff credentials, activities
  - Compare to Assertive Community Treatment (ACT) fidelity scales

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Implementing Real-World, Evidence Based Early Services for Early Psychosis and Signs of Risk Online Discussion Series

Upcoming sessions:

Date/ time	Presenter /Lead Discussant
2/26/20 2-3PM	Douglas R. Robbins, M.D., Financing First Episode Psychosis Programs: Developing Medicaid and Commercial Insurance Support in Maine
3/11/20 2-3PM	Reid Plimpton, MPH, Project Manager for Northeast Telehealth Resource Center, Medical Care Development & Terry Rabinowitz, MD, DDS, NETRC Principle Investigator Medical Director, Telemedicine, University of Vermont Medical Center
4/29/20 2-3PM	Melissa Rowan, MSW, MBA, Senior Vice President for Policy Implementation at Meadows Mental Health Policy Institute on the workgroup to propose uniform coding and payment strategies for commercial insurers, Medicare, and Medicaid
5/6/20 2-3PM	Ian Lang, MBA, Executive Director of the Brookline Center for Community Mental Health, Former Executive Director Continuum Behavioral Health (Rhode Island)
TBD	Margaret Guyer, Ph.D., Director of Workforce Development at Department of Mental Health of Massachusetts