



Coordinated Specialty Care for First Episode Psychosis: Costs and Financing Strategies



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Executive Summary

Coordinated Specialty Care (CSC) is a multi-component, evidence-based, early intervention service for individuals experiencing a first episode of psychosis (FEP) that can improve their quality of life and social and clinical outcomes. Financing these important team-based services can be a challenge. Several core service components as well as the costs of training and coordinating teams with small caseloads, which are all essential for the effective delivery of CSC, can be difficult to cover through fee-for-service billing and other existing financing mechanisms. Many states rely on federal Mental Health Block Grant (MHBG) funds, which have been set aside for FEP services since 2014, to cover their CSC team and service costs. The MHBG is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), which is committed to improving equity in access to CSC and other behavioral health services. However, MHBG funds are not a sufficient source of support. Taking advantage of a wider array of financing approaches can allow states to implement CSC on a broader and more equitable basis.

This report examines the costs of providing CSC services in the United States and strategies for financing them. Chapter 1 provides background about CSC and its service components. As demonstrated in this chapter, the availability of CSC has seen substantial growth in recent years, thanks in large part to the MHBG. However, there is still far from enough capacity to fill the need for these services. Funding to support further expansion in the availability of CSC is necessary.

This report on CSC financing discusses four principal funding sources for these services:

- Mental Health Block Grant funds
- Medicaid reimbursement
- Commercial insurance reimbursement
- State and local funds

Innovative strategies for funding CSC adopted by five states included as case studies in this report include:

- Mandating team-based rates through Medicaid or commercial insurance
- Braiding different funding streams
- Leveraging Medicaid's *in lieu of services* provision

Chapter 2 summarizes findings from a systematic review of studies estimating the costs and associated outcomes of CSC. Estimates of costs of CSC in the United States in 2019 ranged from \$887 per participant per month in Texas to \$1,375 in New York. Adjusted for inflation for 2023, the range is \$1,054 to \$1,653. Fourteen of 15 international studies concluded that early psychosis interventions are cost effective. Most often, the cost advantages stem from reductions in the use of expensive services, particularly inpatient hospital care.

Chapter 3 describes how CSC is financed in the United States and includes five case studies summarizing state financing strategies. The four main sources of funding are the MHBG, Medicaid, commercial insurance, and state and local funding from both the public and some private sector sources. The principal approaches to financing CSC include traditional fee-for-service reimbursement, billing at a team-based rate, and combining or “braiding” different funding streams. The five state case studies demonstrate varied approaches to using Medicaid, block grant funds, state funds, and private insurance to finance CSC services. For example, Texas can provide CSC for Medicaid clients under the Centers for Medicare and Medicaid Services (CMS) in lieu of services (ILOS) authority. The ILOS authority allows Medicaid managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) to offer services or settings that the state has determined to be medically appropriate and cost effective alternatives to covered Medicaid state plan services

or settings. Illinois mandates that commercial insurers cover CSC service costs at a case rate. Washington has mandated a Medicaid team-based rate for CSC. New York and Ohio bill both Medicaid and commercial insurers fee for service. The case studies also illustrate the continued role for the MHBG in supplementing and complementing insurance sources to pay for services and other costs that are not covered by insurance.

Last, Chapter 4 of this report discusses innovative steps that have been taken to fund other team-based behavioral health care services. It shows that behavioral health organizations have discovered creative ways to fund well-established evidence-based interventions, such as Assertive Community Treatment, Multisystemic Therapy, and Collaborative Care, using Medicaid, Medicare, and private insurance. These lessons in financing sustainability could be adapted and applied to CSC for FEP. The precedent that other team-based services have established should hasten appropriate funding for CSC.



CHAPTER 1

Introduction

The word **psychosis** is used to describe conditions that affect the mind, where there has been some loss of contact with reality.¹

First-episode psychosis is generally regarded as the early period (up to five years) after the onset of psychotic symptoms.^{3,4}

Coordinated Specialty Care is an evidence-based, recovery-oriented, team approach to treating early psychosis that promotes easy access to care and shared decision making among specialists, the person experiencing psychosis, and family members.⁵

About 100,000 people experience a first episode of psychosis every year in the United States.^{1,2} The word **psychosis** is used to describe conditions that affect the mind, where there has been some loss of contact with reality.¹ During an episode of psychosis, a person's thoughts and perceptions are disrupted, and they may have difficulty recognizing what is real and what is not.¹ Although the specific definition varies across clinical and research settings, first-episode psychosis (FEP) is generally regarded as the early period (up to five years) after the onset of psychotic symptoms due to a serious mental illness (SMI) and unrelated to substance use, brain injury, or other non-SMI medical issues (e.g., dementia).^{3,4} People usually first experience FEP when they are in their teens to mid-20s.² Studies indicate that people experiencing FEP often go untreated for a year or longer.⁵ Untreated symptoms increase the risk that individuals with FEP will develop a substance use disorder, engage in self-injury, or become homeless or unemployed.⁵

Over the past several decades, doctors and researchers have developed evidence-based, team services for treating FEP, known as early psychosis intervention. Early psychosis intervention services provide intensive and personalized team-based care for individuals experiencing FEP for a period of about two years, but sometimes longer. Programs may also focus on outreach to identify young adults with an early serious mental illness with psychosis. These services are provided in different countries. In the United States they are usually known as **Coordinated Specialty Care** (CSC). Eligibility varies, but CSC programs sometimes serve individuals up to age 40. A key aim of CSC is to provide treatment and recovery support so that individuals have the best chance possible to live their lives and not be disabled by a mental illness as they transition into adult roles. Evidence shows that receiving CSC services can greatly improve quality of life and outcomes for individuals who experience psychosis.²

Purpose of This Report

This report provides an overview of the costs and outcomes of CSC services and summarizes strategies for financing them in different states. The aim is to provide an understanding of the challenges associated with financing CSC and a summary of approaches that have been taken to improve funding for this critical mental illness treatment service.

Financing these important services can be a difficult task. Several activities included in CSC, such as case management and vocational supports, are rarely covered by private insurance, but are more commonly covered under state Medicaid programs.⁶ Many CSC services in the United States rely on funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grant (MHBG). Since 2014, the MHBG has included a set aside for early serious mental illness (ESMI), including FEP, which has provided states with millions in dedicated funds that they can use to establish and run CSC programs.^{7,8} However, the MHBG is not a sufficient source of funds to sustain and support CSC services on a broad basis to meet the need across states.

Coordinated Specialty Care Service Components and Coverage

The National Institute on Mental Health (NIMH), National Institute of Health, recommends that CSC include five core activities: cognitive or behavioral psychotherapy, medication management, family education and support, service coordination, case management, and supported employment and education (SEE).^{2,4,5} To remain consistent with their coverage policies, public and private insurers often refer to SEE with language emphasizing that these are therapeutic, evidence-based behavioral health and medical services that enable functioning in the workplace or post-secondary educational settings. When talking about coverage policy, this report refers to employment and educational services included in CSC as “treatment-integrated services to promote educational or vocational success.” This editorial convention aims for consistency with coverage policy and emphasizes the centrality of SEE as part of the CSC evidence-based team model.

In addition to the five core service components, CSC requires training, small caseloads, a team leader, team meetings, assertive outreach for individual engagement, and community-based care. Without these key elements, the CSC service is not being provided in accordance with the evidence base. Other services that CSC programs may provide include peer support, crisis intervention, recreational therapy groups, and substance use services.⁹

Case management and treatment-integrated services to promote educational or vocational success are usually not covered by private insurance. Medicaid and the Children’s Health Insurance Program (CHIP) programs can reimburse certain services that support employment and educational functioning, such as case management linking individuals to vocational services or individual therapy to help manage behavior in work or school environments.^{10,11,12} Other Medicaid authorities, such as 1915(c) Home and Community-Based Service Waivers and 1915(i) State Plan Amendments offer further flexibility to fund educational and employment services. Programs affiliated with Federally Qualified Health Clinics may receive higher Medicaid reimbursement rates for CSC services.¹³ MHBG or other funds may be used to cover or supplement otherwise uncovered CSC activities.

Different team-based FEP models are used across the U.S. states and territories, as well as internationally. However, it is estimated that 90 percent of FEP services in the United States include the five recommended evidence-based service components.⁹ Research on the effectiveness of FEP interventions shows that the inclusion of the five core CSC service components is the best predictor of improved outcomes for individuals experiencing FEP.¹⁴

NIMH-Recommended Evidence-Based CSC Service Components



Psychotherapy

Evidence-based cognitive or behavioral therapy to help reduce symptoms and improve functioning.



Medication management

Prescribing and monitoring medications to help manage symptoms and improve functioning.



Family education and support

Outreach and education to help families support members with FEP. Families are involved regardless of client age, with consent of the client.



Service coordination and case management

Coordination with other medical and behavioral health services to support individuals' access to needed medical, social, educational, and other services.



Supported employment and education

(or treatment-integrated services to promote educational or vocational success) – Skill-building and supports to achieve and maintain educational or vocational functioning, which may include services such as educational coaching and tutoring, assistance with finding and applying to schools, and job training, development and placements.



Reduced preventable hospitalizations^{15,17}



Improved education and employment rates^{15,17}



Reduced symptoms of psychosis¹⁶



Fewer depressive symptoms¹⁸



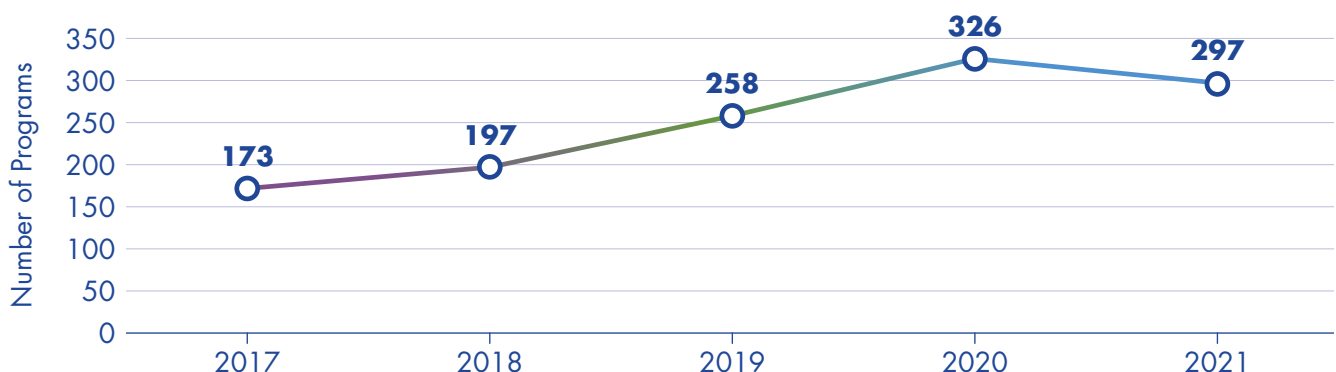
Higher quality of life¹⁸

Benefits and Growth of Coordinated Specialty Care

Highlighting the importance of funding these services, research shows that receiving CSC improves the outcomes of individuals who experience psychosis. Individuals with FEP who participated in CSC services experienced reduced hospitalizations, improvements in education and employment rates, and reduced symptoms of psychosis.^{15,16} Individuals with FEP who received CSC services also experienced fewer hospitalizations, better vocational engagement, and reported greater improvements in quality of life and depressive symptoms than those receiving standard community treatment.^{17,18} These improvements are important not just for quality of care during CSC, but for helping individuals regain and maintain positive life trajectories despite the many challenges that a diagnosis of SMI brings with it.

SAMHSA, states, health care advocates, and policy makers have made great strides toward improving the availability of CSC services for persons experiencing FEP in the United States. Most of this growth occurred after 2014, when the federal government mandated that states use 5 percent of the funds provided to them through MHBG, administered by SAMHSA, for CSC services for FEP.^{8,9} Congress then increased the MHBG set aside to 10 percent in 2016 and added funds to the MHBG to pay for the increase. As of 2022, there were an estimated 381 programs providing CSC services to FEP clients in the United States. However, there are still not enough programs to meet the need for CSC services. In 2021, 24,206 clients were admitted to CSC programs in the U.S.¹⁹ Based on estimates that there are 100,000 new cases of FEP a year,^{1,2} this translates to an unmet need for CSC services for 75,794 individuals with FEP.

Growth of CSC Over Time¹⁹



NOTE: The decrease in the number of programs from 2020 to 2021 is a result of some states' inability to submit data due to the impact of COVID-19 as well as reduced staffing and focus of care during this time frame.

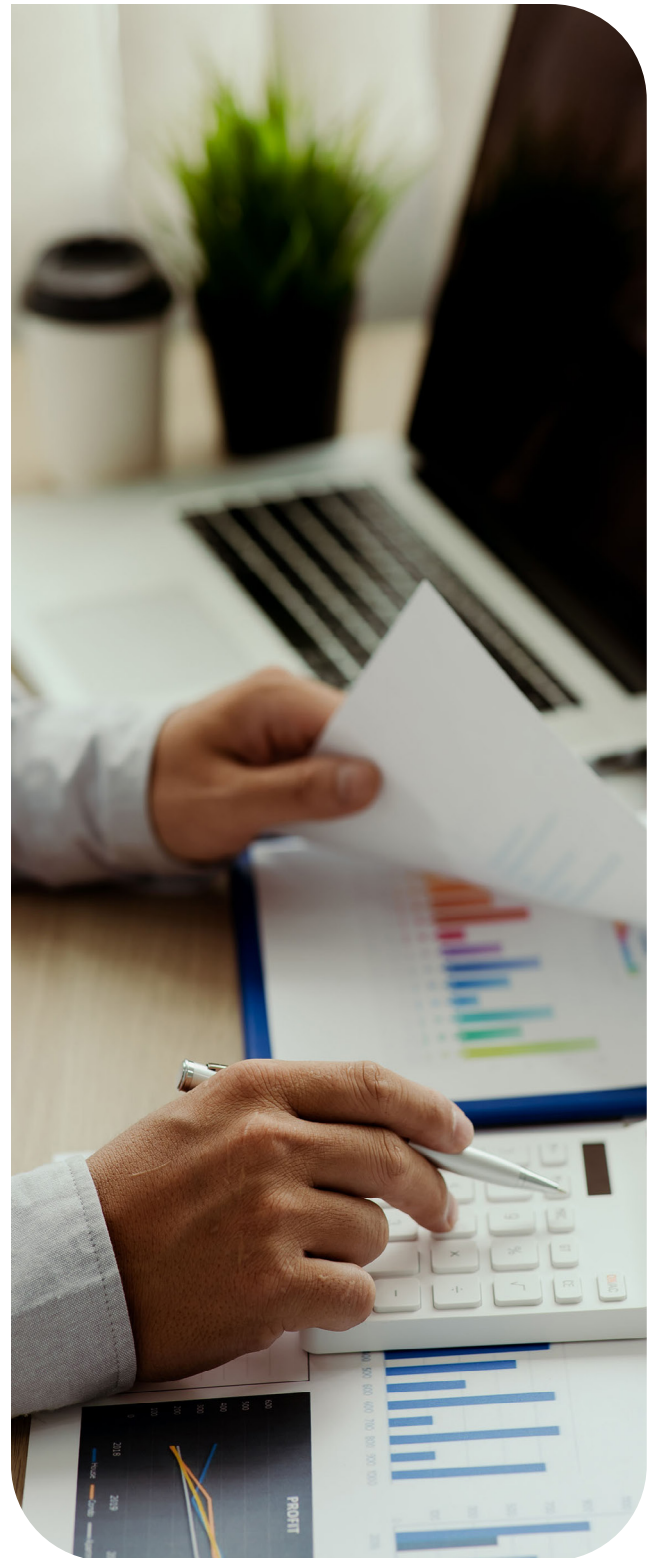
Coordinated Specialty Care Costs and Financing Strategies

While the availability of CSC services for persons experiencing FEP is growing, the United States is still a long way from being able to meet the needs of the estimated 100,000 new individuals experiencing FEP each year.^{1,2} State policy makers, SAMHSA, NIMH, and mental health advocates continue to dedicate efforts towards expanding the availability of CSC for FEP. However, there are major challenges in financing CSC to serve all individuals with first episode psychosis.

To highlight the importance of sustainable CSC financing, the remainder of this report summarizes information about the costs of these programs and their relationships to outcomes. It also details approaches to financing CSC services in five case study states: Illinois, New York, Ohio, Texas, and Washington. Finally, it discusses approaches to financing other team-based behavioral healthcare services and how they may inform future funding mechanisms for CSC.

Research Questions

- What does Coordinated Specialty Care **cost**?
- How are Coordinated Specialty Care **costs** related to **outcomes**?
- How are Coordinated Specialty Care services being funded in **IL, NY, OH, TX** and **WA**?
- What can the financing of **other team-based healthcare services** teach us?



CHAPTER 2

Considering Costs and Outcomes of Coordinated Specialty Care

To better understand why it is important to find sustainable ways to finance CSC, it is helpful to know what CSC services cost and the value of outcomes associated with receiving these services. This chapter provides estimates of the costs of providing CSC for FEP in the United States. It also reviews international research on the cost savings, benefits, and effectiveness of early psychosis intervention services. The term *early psychosis intervention* is used to refer to all evidence-based practices (EBPs) providing intensive, team-based care for early psychosis, including CSC. These services are known by different names in different countries, but provide similar evidence-based, recovery-oriented services during the critical first years after an individual experiences an initial episode of psychosis.

Early psychosis intervention service costs may include costs to train staff, obtain certification, and maintain fidelity to the chosen CSC model. Costs also include staff salaries and benefits, other program overhead costs, and the direct costs of the services provided, such as medications. There are different ways to assess whether CSC and other early psychosis intervention services are thought to be worth the expense, expressed in terms such as cost-effectiveness, cost-benefit, or cost savings. Some studies directly compare the costs of early intervention services to the costs of standard psychosis treatment services. Others use statistical methods to calculate the cost-effectiveness or cost-benefits of early psychosis intervention. Cost-effectiveness analysis is a way to examine both

the costs and health outcomes of one or more interventions. It compares an intervention to another intervention (or the status quo) by estimating how much it costs to gain a unit of a health outcome, like a life year gained or a death prevented.²⁰ Cost-benefit analysis compares the costs and benefits of an intervention, where both are expressed in monetary units.²⁰ These methods focus on different outcomes, but each provides an estimate of the value to be gained from early psychosis interventions.

Through a systematic literature review (see detailed methodology in Appendix A), we identified four studies that estimate the costs of CSC in the United States as well as 15 international studies from the past decade that estimate both the costs and outcomes of early psychosis intervention services.



Early psychosis intervention

refers to all EBPs providing intensive, team-based care for early psychosis, including CSC.



Costs of early psychosis intervention services include staff training and program start-up, staff salaries and benefits, overhead costs, and the direct costs of services.



Cost outcomes

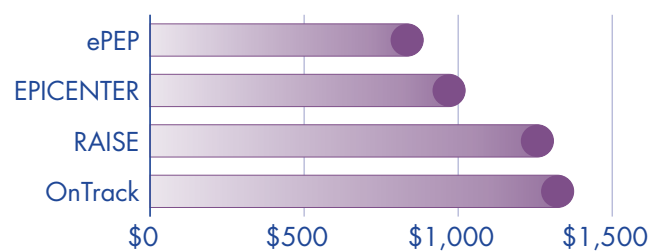
can be estimated by comparing early psychosis intervention costs to costs of standard psychosis treatment or through cost-benefit or cost-effectiveness analyses.

Costs of Coordinated Specialty Care in the United States

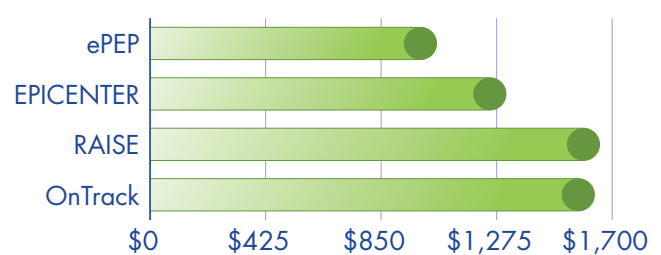
Four studies published between 2013 and 2023 provide estimates of the costs of CSC for FEP services in the United States. The CSC services represented were EPICENTER (Early Psychosis Intervention Center) in Arizona;¹⁶ ePEP (Enhanced Program for Early Psychosis) in Texas;²¹ RAISE (Recovery After an Initial Schizophrenia Episode),²² supported by NIMH and conducted by the Early Psychosis Team in clinics across 21 states; and OnTrackNY in New York.²³

While the methods used to produce cost estimates varied across the studies, all included measures of staff and service costs. Total service cost estimates ranged from \$887 to \$1,375 per client with FEP per month. When adjusted for inflation from the year of publication to January 2023, these per client per month estimates range from \$1,054 to \$1,653.

Cost per client per month



Cost per client per month, 2023 Adjusted for inflation



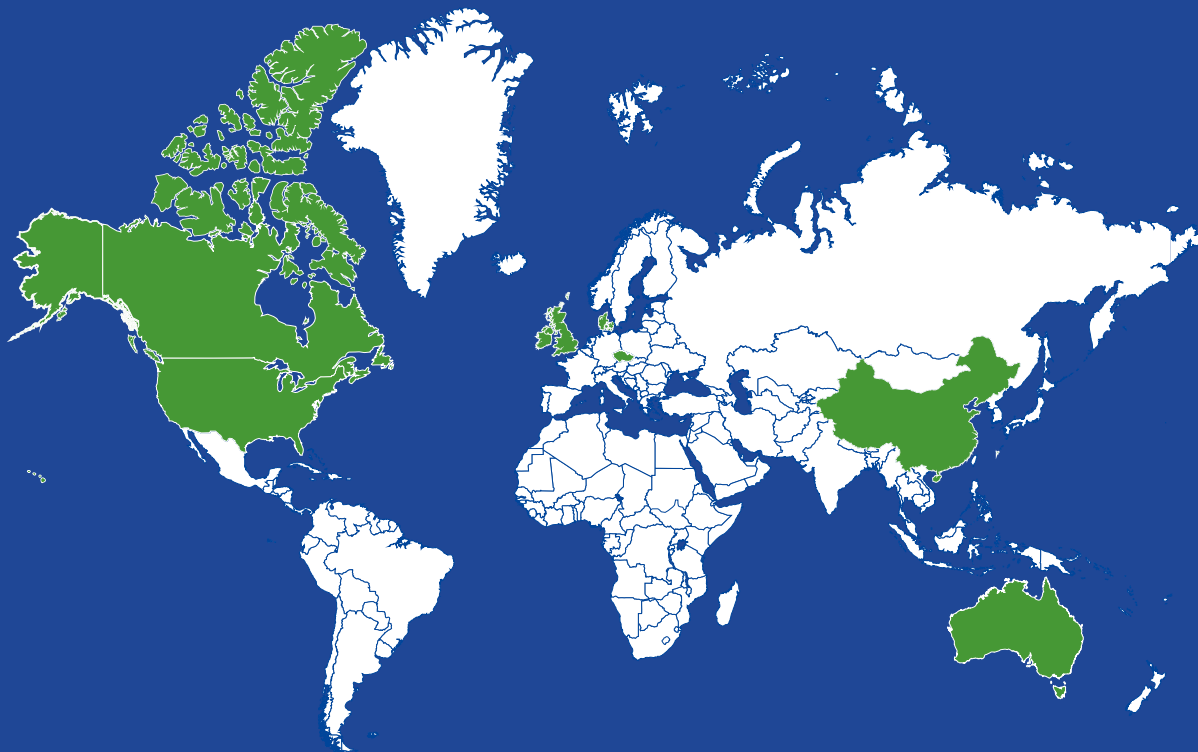
Studies Estimating the Costs of CSC Services in the United States, 2013–2023

Author	Year	Service and state	Cost estimate components	Cost estimate	Cost per client per month	Cost adjusted for 2023 inflation
Breitborde et al. ¹⁶	2015	EPICENTER, Arizona	Salary and benefits for clinical staff, indirect costs for the hospital in which the program was located	\$6,136 per person for the first 6 months of care	\$1,022.67	\$1,309.13
North et al. ²¹	2019	ePEP, Texas	Provision of all CSC services	\$10,639 per client for 12 months of care	\$886.58	\$1,053.74
Rosenheck et al. ²²	2016	RAISE, clinics across 21 states	Inpatient and outpatient care, medication, and staff training	\$7,856 per client for 6 months of care	\$1,309.33	\$1,653.38
Smith et al. ²³	2019	OnTrackNY, New York	All clinic activities provided to 75 Medicaid patients during a two-week period and staff time spent on each activity	\$1,375 per client per month	\$1,375.00	\$1,634.24

International Evidence for the Costs and Outcomes of Early Psychosis Intervention Services

The literature review identified 15 international studies that examined the costs and outcomes associated with early psychosis intervention services that have been published since 2013.^{16,22,24-36} Studies focusing on specific service components that are included in early psychosis intervention EBP services, such as cognitive behavioral therapy, were excluded. Eight countries were represented among the 15 studies: Australia,²⁷ Canada,³³ China,³⁶ Czechia,³⁵ Denmark,²⁸ Ireland,^{24,25} the United Kingdom,^{26,31,34} and the United States.^{16,22,29,30,32}

Countries represented in literature review



Study Design (Total Number of Studies = 15)

The studies used diverse methodologies to calculate and assess costs and outcomes. Most of the studies used quasi-experimental methods (e.g., pre-post design) and five of them computed costs and outcomes using extant data. Only four studies used data from randomized controlled trials (RCTs) that randomly assigned individuals with FEP to receive early psychosis intervention services or standard psychosis care.





14 of 15 studies concluded that early psychosis intervention resulted in reductions in total costs or were cost effective based on decreases in high cost adverse outcomes.



Reduced inpatient **hospitalization costs**, emergency department visits, and potential improvements in **quality of life** were the most frequently cited sources of savings.

The specific cost data computed in each study varied. All but one study explored costs associated with inpatient or outpatient service use. Seven studies considered costs associated with lost or gained time in employment. Some studies included costs associated with outcomes such as the use of other social programs in their estimates, including legal and housing services. Several studies placed monetary values on improvements in quality of life, using established techniques for assigning such values.

The studies also covered a broad range of time spans, from 6 months after beginning early psychosis intervention services to projections of costs and savings over an individual's remaining life.

The findings indicate that the costs of implementing FEP intervention services can be significant. In fact, the RCT studies, which are more rigorous because they use a comparison group, showed that total treatment costs for those assigned to the early psychosis intervention did not significantly differ from those in standard psychosis care. Findings of two studies indicated that early psychosis intervention services led to increases in outpatient treatment costs associated with receiving intensive, team-based services.

The main sources of savings with FEP interventions are typically associated with reduced hospitalizations and emergency room visits, and other health care costs. Hospitalizations are a significant cost associated with FEP, as people with untreated FEP often require hospitalization due to the severity of their symptoms. However, early psychosis intervention services, such as CSC, have been shown to reduce hospitalizations among people with FEP. Of the 15 studies reviewed, one concluded that the intervention did not result in a significant reduction in treatment costs.³⁰ However, the intervention was linked to reduced inpatient and emergency visits, underscoring the benefits of these services.

Each of the countries represented in the literature review has different social welfare and health care systems as well as different cultures and values, all of which shape the provision of early psychosis intervention services. Thus, together, these studies provide consistent and compelling evidence that while early psychosis intervention service costs are generally comparable to the standard care, there is a high probability that the interventions are more cost-effective than usual care based on decreases in high cost adverse outcomes.

International Studies Estimating Costs and Outcomes of Early Psychosis Intervention, 2013–2023

Author	Year	Country	Study Design	Cost Outcomes	Time Span	Findings
Behan et al. ²⁴	2015	Ireland	Cohort comparison	Inpatient hospitalization	N/A	Individuals with FEP who received early intervention services had lower hospital admission rates and shorter hospital stays compared to an earlier cohort not receiving early intervention services; average costs of admission declined.
Behan et al. ²⁵	2020	Ireland	Cohort comparison	Inpatient hospitalization, home-based care	1 year	Psychosis relapses requiring inpatient hospitalization or home-based care were lower in a cohort of individuals with FEP receiving early intervention services than a contemporaneous cohort not receiving early intervention services, resulting in a net benefit of €2,465 per person.
Breitborde et al. ¹⁶	2015	United States	Pre-post comparison	Psychiatric service, legal service, costs associated with unemployment and non-participation in education	6 mo.	Total costs of service utilization were \$17,101 less per individual with FEP 6 months after enrolling in an early psychosis intervention compared to 6 months before, primarily due to reductions in hospitalization costs and contacts with the legal system.
Campion et al. ²⁶	2019	United Kingdom	Predictive model	Health care service, lost employment, and costs associated with quality of life, suicide, and homicide	10 years	Results of economic models based on administrative data from south London boroughs and service costs from other studies found that providing early intervention services to all new FEP cases each year would produce an estimated £13.1 million in savings in the area over 10 years, or £22,880 per person.
Gore-Jones and Dark ²⁷	2019	Australia	Pre-post comparison	Inpatient hospitalization, emergency room visits	4 years	Reductions in emergency room visits and inpatient hospitalizations 1 year after compared to 1 year before enrolling in an early psychosis intervention program resulted in total savings of \$1,716,058 AUD over 4 years.

Author	Year	Country	Study Design	Cost Outcomes	Time Span	Findings
Hastrup et al. ²⁸	2013	Denmark	RCT	Inpatient hospitalization, outpatient services, supported housing, medication, staff costs, quality of life	5 years	Mean total costs for those assigned to the early psychosis intervention did not significantly differ from those in standard psychosis care, but analyses showed a high probability that the intervention was cost effective based on improvements in outcomes.
Liffick et al. ²⁹	2017	United States	Cohort comparison	Inpatient hospitalization, emergency room visits, outpatient services	Up to 717 days (about 2 years)	Early psychosis intervention patients had higher physician and nurse visit costs than a contemporaneous cohort of individuals with FEP at a different clinic, but lower hospital and emergency room costs, resulting in estimated savings of \$6,900 per patient.
Murphy et al. ³⁰	2018	United States	RCT	Inpatient hospitalization, emergency room visits, outpatient services	1 year	Patients with FEP randomly assigned to early intervention had fewer inpatient and emergency room visits than those in standard psychosis care, although the cost difference was not statistically significant.
Park et al. ³¹	2016	United Kingdom	Predictive model	Employment, education, homicide, and suicide rate cost estimates	3 years	Predictive models suggested that early intervention for FEP could result in savings of £2,087 per person relative to standard care over 3 years due to improved employment and education outcomes. Reductions in homicide and suicide rates were predicted to result in savings of £80 and £957 per person per year.
Rosenheck et al. ²²	2016	United States	RCT	Inpatient and outpatient services, medication, staff training, quality of life	2 years	FEP patients receiving CSC had higher outpatient service and medication costs than those receiving community care, but higher quality of life. Cost-effectiveness analyses monetizing quality of life suggest that the intervention is likely to be cost effective.

Author	Year	Country	Study Design	Cost Outcomes	Time Span	Findings
Sediqzah et al. ³²	2022	United States	Predictive model	Inpatient hospitalization, employment rates, lifetime health care costs, quality of life	Lifetime	Early intervention patients were predicted to have 3.2 fewer hospitalizations and 2.7 more years of employment over their remaining lives than non-intervention patients. Analyses suggest that early psychosis intervention is cost-effective and results in cost savings.
Tarride et al. ³³	2022	Canada	Predictive model	Inpatient hospitalizations, days of employment, days in assisted living	5 years	Early intervention services were predicted to result in a net benefit of CAN \$85,441 over 5 years compared to standard psychosis care.
Tsiachristas et al. ³⁴	2022	United Kingdom	Cohort comparison	Inpatient hospitalization, outpatient services, employment, housing	3 years	Early intervention patients' annual health care service costs were £4,031 lower over the 3-year period due to lower inpatient costs, followed by lower outpatient, accident, and emergency costs. Providing early intervention services to all individuals with FEP in England could result in annual savings of £63.3 million.
Winkler et al. ³⁵	2018	Czechia	Predictive model	Inpatient and outpatient services, employment	1 year	Predictive models suggested that providing early intervention services could reduce annual national costs for care by 33%, primarily due to decreases in hospitalizations and improved employment outcomes.
Zhang et al. ³⁶	2014	China	RCT	Medical and indirect services, quality of life	1 year	FEP patients randomly assigned to receive combined medication and psychosocial treatment did not have lower treatment costs than those assigned to standard care over 1 year, but analyses suggest combined treatment was cost-effective.

CHAPTER 3

Financing Coordinated Specialty Care

This chapter provides an overview of how CSC services are financed in the United States, including principal sources of funding and financing strategies. To illustrate different approaches and innovative steps being taken to finance CSC, it also presents case studies summarizing CSC program financing strategies in five states.

Principal Coordinated Specialty Care Funding Sources

There are **four principal sources of funding for CSC services**.^{6,11} Each source is essential to the functioning, success, and expansion of these services. States tend to use a combination of some or all these sources to support CSC services. In addition to these four principal sources, state Vocational Rehabilitation services can provide funding for employment assessments and placements for eligible individuals.



Mental Health Block Grant

Federal funds that can be used to cover any CSC program cost, including specific services, program start-up, and staff training



Medicaid

States can cover most CSC services, depending on state Medicaid plan and statutory parameters



Commercial Insurance

Usually only covers specific CSC services allowed in contract, such as psychotherapy and medication



State and Local Funds

Often used to supplement MHBG funds, but availability greatly varies across states

Principal Coordinated Specialty Care Funding Sources, continued



Mental Health Block Grant

A block grant is a noncompetitive, formula grant mandated by the U.S. Congress.³⁷ The Community Mental Health Services Block Grant (MHBG) program, administered by SAMHSA, makes funds available to all U.S. states and territories to provide community mental health services.³⁸ The MHBG provides funding specific to the development and support of services for individuals with ESMI, including FEP. At least 10 percent of the total MHBG funds a state or territory receives must be used for evidence-based services for individuals with FEP or ESMI. MHBG funds may be used for any component of CSC services as well as training and overhead costs. The MHBG provides supplemental funding to make sure that CSC teams can offer the full complement of evidence-based services, including for participants who have no health insurance. While the MHBG ESMI set aside has been very successful in supporting the expansion and improvement of CSC nationwide, funding is insufficient to sustainably support needed services on a national level.



Medicaid

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.^{39,40} Medicaid can potentially fund most components of CSC services through mechanisms such as a Medicaid State Plan amendment, Managed Care Organization, SMI/Serious Emotional Disturbance (SED) 1115 waivers, ILOS in Medicaid managed care, and Certified Community Behavioral Health Clinics (CCBHCs).⁶ In addition, Medicaid's Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit can cover all costs of CSC services for individuals with FEP under age 21, except the premium, which is generally low.⁴¹ CHIP can also potentially cover CSC services for Medicaid-eligible children under age 19 (about 5% of individuals with FEP).

Several states have had Medicaid state plan amendments or SMI/SED 1115 waivers for providing CSC services approved by the federal Centers for Medicare and Medicaid Services (CMS). In these states, there is a reliable funding stream for CSC services for individuals with Medicaid coverage who experience FEP. Medicaid can pay for all CSC components in these states, including activities to integrate medical services, rehabilitation service coordination with other Medicaid-services, therapy, and counseling. It will also cover care coordination to assist Medicaid-eligible individuals to gain access to needed medical, social, educational, and other services. However, some elements of supported employment and outreach and engagement services are not covered under regular Medicaid state plan authority.^{11,12}

Principal Coordinated Specialty Care Funding Sources, continued



Commercial Insurance

Commercial insurance provides funding for components of CSC services covered under each plan, such as counseling, medications, physicians, and laboratory costs.⁶ Individuals who experience FEP may have access to commercial insurance through their employer or a family member, often a parent. However, it is extremely rare for commercial insurance to fully fund CSC services or to utilize a fee schedule that compensates for CSC training and overhead. Some CSC providers do not bill commercial insurers because of difficulties with receiving payment from these entities, such as when a CSC team is not enrolled in an insurer's network.⁶



State and Local Funding

Specialized grants, charitable giving, and other forms of state general revenue and local funding are used throughout the nation to support CSC services.⁶ Some of this funding is used to supplement MHBG funds, to fill in coverage gaps from billing Medicaid or commercial insurers, or to support services for individuals without insurance. State and local funding varies widely between states.

Coordinated Specialty Care Financing Strategies

There is no uniform national payment methodology that supports comprehensive CSC services for all individuals. However, many states and localities have used a variety of funding sources to establish a significant number of CSC teams throughout the nation. In 2014, the first year of the MHBG FEP funding, there were about 59 CSC teams nationally.⁹ As of 2022, there were an estimated 381 programs. This growth has been made possible by “braiding” or coordinating funds from a variety of sources, including the MHBG, Medicaid, state and local funding, and commercial insurance.

While the expansion of CSC services nationally is a success in terms of access to and support of services for individuals with FEP, funding remains highly variable by location, complex to use, and insufficient to meet the projected need. Even when public and private insurers do provide reimbursement for services, the funds may not fully cover their costs. However, some states have made use of all available funding resources in creative ways to expand CSC services and provide needed and evidence-based services to those individuals experiencing FEP.

Ways to Finance



Fee-for-service is a payment method by which health care providers are paid for each service they perform.⁴² Several services in the CSC model are usually not paid by commercial insurance when fee-for-service is the only payment source. An increasing number of Medicaid programs are covering all service components of CSC. However, assertive outreach and certain components of supported employment are not generally covered through fee-for-service billing in Medicaid.^{11,12} Fee-for-service billing also seldom covers CSC program overhead, outreach, training, and costs to support certification and model fidelity. This is because behavioral health clinic fee schedules rarely cover the costs of the trained team delivering community-based care for a small caseload of individuals with intensive needs, which is required to deliver CSC in accordance with the evidence base.



A **team-based rate** is payment for a pre-defined set of services for an EBP typically provided by a team of health care professionals. Team-based rates emphasize the needs of the individual rather than the volume of services provided. Because the CSC model is team based, this financing strategy can provide coverage for CSC team activities that are usually not funded by the more traditional fee-for-service model. The team-based rate can be a daily or monthly payment for all approved services provided through the team for eligible individuals.



Braided funding is where two or more funding sources are coordinated to support the total cost of a service.⁴³ Medicaid, commercial insurance, the MHBG, and state funds can all fund CSC services for a group of individuals with FEP. By “braiding” the funding, the provider has access to more funds to support an array of services that any one source provides alone. The challenge of using braided funding is that each of the funding sources may have different rules for providing services and different reporting requirements, which increases burden on the provider.

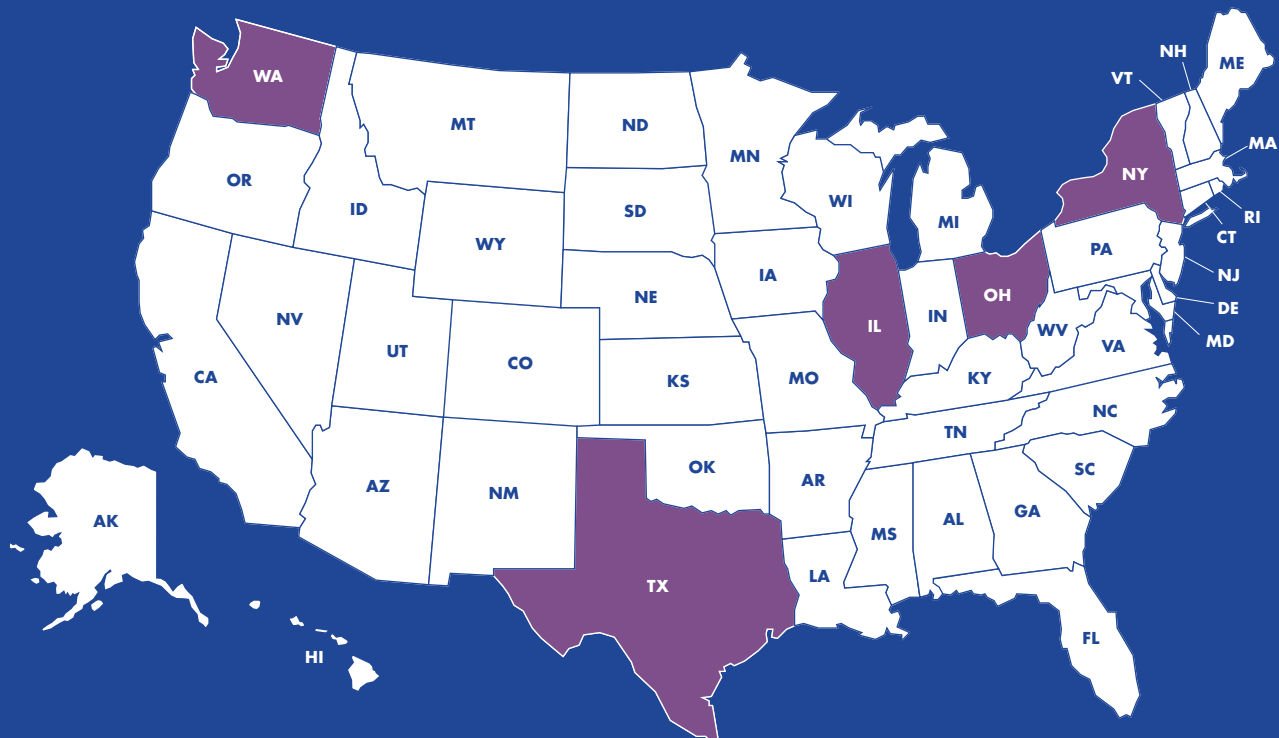
Introduction to State Case Studies

The following pages summarize CSC financing strategies in Illinois, Ohio, New York, Texas, and Washington as of April 2023. The case studies include an overview of CSC services within the state and sections detailing background, information about CSC service funds and cost coverage, innovative approaches to financing CSC, and steps being taken to achieve broader coverage. Content for the case studies was compiled through a review of literature, scans of publicly available background data, and discussions with individuals at the different states (acknowledged in Appendix B).

The five states included as case studies were chosen to represent different CSC financing strategies and innovations. While efforts were made to choose both Medicaid expansion and non-expansion states, Medicaid expansion states have more options

for diversifying their funding streams. They are overrepresented in our case studies. In addition, not all innovative steps to fund CSC are fully represented in the selected states.

The approach to collecting and tracking data on the costs and financing of CSC services differs in each state. The specific content of each case study reflects this diversity. For example, some states collect data on staff, caseloads, and revenue sources including Medicaid and commercial insurance across CSC teams in the state. Others were not able to report these data. The way that CSC budgets and costs are estimated also varies across states. Estimates of the costs to provide CSC services per team or individual served were not available in every state.



Overview of State Case Study Findings

The case studies highlight different CSC service financing strategies, innovations, and steps being taken to improve coverage of CSC services and their costs in each state.

- **All case study states** combine MHBG funds with reimbursements from public and private insurers and other sources to cover costs of their CSC programs.
- Fee-for-service billing of public and private insurance does not cover some CSC components or costs in **every state**.
 - > Commercial insurers rarely cover some services, including treatment-integrated services to promote educational or vocational success, peer support, case management, and program outreach and engagement.
 - > Medicaid programs often do not cover the training and overhead associated with CSC. In addition, outreach and engagement, some components of supported employment, and care coordination are often not directly covered through fee-for-service billing of Medicaid.
 - > Fee-for-service rates based on office-based practices are insufficient to cover costs for many CSC services.
- **New York** and **Ohio** use fee-for-service billing to obtain reimbursement for CSC services from both Medicaid and commercial insurers.
- **Texas** can provide CSC for Medicaid clients as a cost-effective and medically appropriate alternative to other treatment under the CMS ILOS provision.
- **Washington** has mandated a Medicaid team-based rate for CSC.
- Stakeholders in **New York** and **Texas** are working toward a Medicaid case rate.
- **Illinois** has passed legislation mandating that commercial insurers cover CSC service costs at a bundled payment rate. Components of CSC related to education and employment support are not mandated in the rate.
- In **Illinois**, Vocational Rehabilitation services include job development, placements, and supports for eligible individuals receiving CSC services.
- States are working to expand rural coverage of CSC.
 - > **Ohio** has used funds from the American Rescue Plan Act (ARPA) and the Coronavirus Response & Relief Supplemental Appropriation set aside (CRRSA) to expand the coverage of their programs to rural counties through the development of teams offering a hybrid of telehealth and in-person care.
 - > **Washington** is also focused on rural team expansion following legislation calling for the statewide expansion of CSC.



State Case Study: Illinois

CSC Service Background

With the support of MHBG funding, Illinois has been operating FIRST.IL since 2016. FIRST.IL offers evidence-based CSC services to individuals aged 14 to 40 experiencing FEP.⁴⁴ It is modeled after the FIRST program at the Northeast Ohio Medical University's Best Practices in Schizophrenia Treatment (BeST) Center. There are currently 18 providers and 20 teams offering FIRST.IL services. Illinois contracts with the BeST Center as a Center for Excellence for program support services and training. FIRST.IL uses both the Addington Fidelity Scale as well as Columbia University CSC Fidelity Scales as guidance for operation. Formal CSC fidelity reviews have not yet been implemented, but each team receives fidelity scales.

Funds and Cost Coverage

FIRST.IL uses MHBG funds administered by the Division of Mental Health (DMH), state funds, and Medicaid and commercial insurance billing to finance CSC teams. DMH contributes \$2.5 million in block grant funds to CSC providers. The average DMH grant per CSC provider site is \$250,599 and includes funds for training and some direct services not covered by Medicaid. DMH allocates \$225,650 per program for start-up costs.

Providers bill state Medicaid for FIRST.IL services deemed medically necessary through a fee-for-service payment method. Medicaid reimbursable CSC activities include counseling and psychotherapy, case management, crisis services, and medication prescriber services including medication education. State Vocational Rehabilitation services pays providers with Individual Placement and Support contracts for job development, placements, and supports for eligible individuals. Four CSC providers do not have such contracts with Vocational

CSC Service Overview



Medicaid Expansion State

Model of care: FIRST.IL

Clients served: 276

Average team caseload: 17

Team staff: Not available

Rehabilitation providers and are provided \$20,000 in MHBG funds from DMH to pay for Individual Placement and Support services and education supports. Teams accept clients regardless of insurance coverage, and providers are told not to bill CSC clients for co-pays or deductibles. DMH provides additional MHBG funds of up to \$17,500 for FIRST.IL services that are not covered through Medicaid, commercial insurance, or Vocational Rehabilitation billing, such as outreach and otherwise uncovered employment supports.

State Case Study: Illinois, continued

Financing Innovations

Illinois enacted the Child and Young Adult Mental Health Crisis Act (PA 101-0461, Sec. 30) in 2019, which mandates commercial insurance coverage of CSC, Assertive Community Treatment, and Community Support Team treatment for people under the age of 26 through a bundled payment.⁴⁵ The law requires that most components of the CSC model be reimbursable through a bundled rate, including treatment planning, medication management and monitoring, crisis intervention services, peer support, case management, family psychoeducation, resiliency training, substance use treatment support, care coordination, public outreach and education, and individual and group psychotherapy. Commercial insurers are not required to cover treatment-integrated services to promote educational or vocational success, although these services are necessary for model fidelity. They will be financed through other sources. Note that state policy refers to “bundled payments,” although a preference is emerging nationally to refer to these as “team-based rates.”

This transition to commercial insurance reimbursement through the bundled payment is ongoing, led by Thresholds.* After the law’s passage, Thresholds contacted insurers throughout Illinois to discuss the new requirements and determine how best to comply with the law. They discussed rates for services, payment methodologies, and services to be reimbursed. Two prominent insurance carriers responded that they would like to pursue discussions. One agreed to provide a bundled rate for services mandated by the law. The payments will be a per diem rate based on a bundle of existing billing codes. Thresholds and this carrier have worked through the terms of this agreement, and it is now in place. The second

* Highlight on Thresholds

Thresholds is the largest Community Mental Health Center in Illinois, with more than 90 facilities in 5 counties. It provides health care, housing, and support services to individuals with mental illness and substance use disorders.

Thresholds had been providing CSC services before the passage of the Child and Young Adult Mental Health Crisis Act. When the new law was passed, Thresholds reached out to insurance carriers throughout the state to discuss the new requirements and determine how best to comply with the law, and has negotiated a cost-based rate with commercial payers.

interested carrier has agreed, in principle, on a per person per month bundled rate that includes all components of the CSC FEP model, not only those mandated in the new legislation. The final contract with this insurance carrier is not yet in place.

Steps to Achieve Broader Coverage

Thresholds and other providers continue to work with insurance carriers to contract reimbursement for the bundled rate. In their work with insurance providers, Thresholds notes that while the state mandate provides an important foundation to negotiations, it is also essential to provide carriers with additional pertinent information. This includes expressing the financial costs and individual, family, and community impacts of not providing care, and that a relatively small number of clients will require team-based care.

State Case Study: New York

CSC Service Background

OnTrackNY is an innovative, evidence-based team approach to providing recovery-oriented CSC treatment to young people ages 16 to 30 experiencing FEP. Funded by the New York State Office of Mental Health, OnTrackNY has been providing CSC in New York State since 2013. With the support of MHBG in addition to state funds, OnTrackNY has expanded from four initial teams that transitioned from the NIMH RAISE Connection program after it ended to 29 teams within 27 clinics across the state. OnTrackNY multidisciplinary teams provide a variety of CSC services, including psychopharmacology, primary care coordination, cognitive behavioral therapy, crisis intervention and suicide prevention, case management, family education and support, supported employment and education, and peer support.

New York relies upon the Center of Excellence OnTrackCentral team to provide programmatic oversight, training, and technical support, and assist with quality improvement efforts. OnTrackCentral is part of the Center for Practice Innovations at the New York State Psychiatric Institute and New York State Research Foundation for Mental Hygiene. Sites share a common data platform for monitoring performance and the elements of fidelity.

Funds and Cost Coverage

OnTrackNY teams are currently supported through a combination of MHBG, state, and SAMHSA funds along with revenue from commercial insurance and Medicaid billing. The estimated OnTrackNY clinical budget for 2022 was \$11.5 million, including \$4 million in MHBG funds, \$4 million in state funds, \$2.9 million in ARPA and CRRSA funds, and a \$700,000 grant from SAMHSA to support two teams. Note that this estimate only reflects the clinical budget for providing CSC services in 2022, and does not represent the full OnTrackNY network budget.

CSC Service Overview



Medicaid Expansion State

Model of care: OnTrackNY

Clients served: 901

Average team caseload: Standard of 35–40, with exceptions for teams with expanded care loads

Team staff: Standard of 4.5 FTEs

Average annual team operating costs range from \$600,000–\$700,000.

Teams are required to bill Medicaid and commercial insurance plans for all eligible services on a fee-for-service basis. Some of the services in the model, such as psychiatric assessment, medication management, and individual and family psychotherapy, are covered by commercial insurers as well as Medicaid. Case management and education and employment services are typically not covered by commercial insurers or Medicaid.

State Case Study: New York, continued

To support successful implementation of CSC, the Office of Mental Health currently offers supplemental funds via direct contracts to OnTrackNY teams, typically a blend of MHBG and State Aid funds.

A 2019 study estimated that 51 percent of OnTrackNY clients were Medicaid enrollees.²³ The study found that New York Medicaid decided to reimburse OnTrackNY teams for up to 48 percent of total service costs for Medicaid clients, or approximately \$662 of the total average monthly costs of \$1,375 per client. Coverage of OnTrackNY services for individuals with commercial insurance varies across teams but is typically less than Medicaid reimbursements. MHBG and state funds are used to fill in gaps from Medicaid and commercial reimbursement.

Financing Innovations

The State of New York has shown a strong commitment to supporting the availability of CSC services for New Yorkers with FEP. The Office

of Mental Health has earmarked state funds to expand OnTrackNY services since its inception in 2013.⁴⁶ State funds cover an estimated 35 percent of OnTrackNY service costs through its program budget of \$4 million, as shown in the graph estimating total program cost coverage for 2022. The other figures in the stacked bar graph show estimated total program costs covered by Medicaid, MHBG, commercial insurance, temporary COVID-19 relief funds, and other sources.

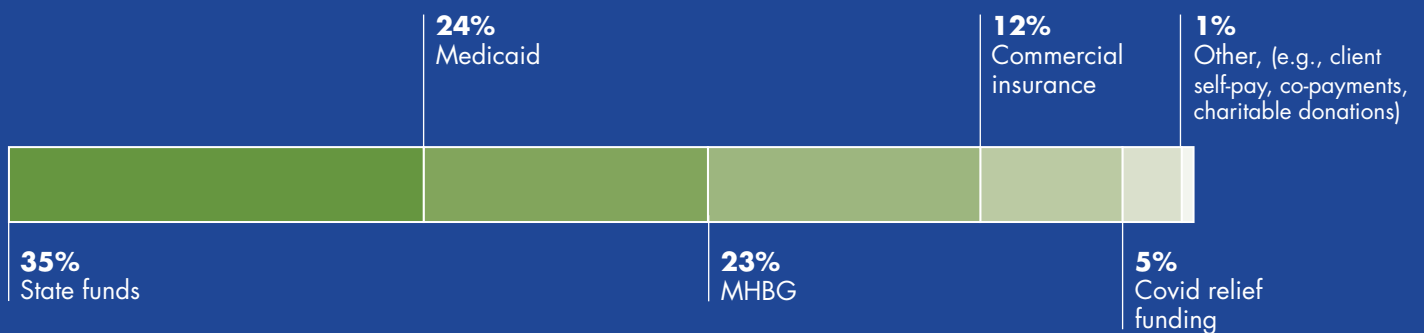
Steps to Achieve Broader Coverage

OnTrackNY is in the process of developing a Medicaid team-based rate based on a cost-based rate developed from all OnTrackNY sites. They aim to have the case rate approved in a state plan amendment.

Temporary funding increases from ARPA and CRRSA funds are being used to improve the quality of OnTrackNY services, expand established teams, and establish new teams.

OnTrackNY plans to expand the number of teams to between 30 and 45 CSC statewide, so that any individual with FEP in the state would have access to CSC services.

Estimated Breakdown of OnTrackNY Site Revenue Sources, 2022



The figures in this graph represent estimates of total service costs covered by different payers in addition to federal and state funds.

State Case Study: Ohio

CSC Service Background

Ohio has been providing CSC services since 2009, when the Best Practices in Schizophrenia Treatment (BeST) Center of Northeastern Ohio Medical University staff were invited to join the RAISE team as one of the pilot sites prior to the randomized controlled trial.⁴⁷ There are currently 20 CSC teams in Ohio. Teams follow either the FIRST model of care developed by the BeST Center or The Ohio State University's EPICENTER model. Nineteen CSC programs in Ohio are based in Community Mental Health Centers. One team is housed at The Ohio State University Wexner Medical Center Department of Psychiatry and Behavioral Health, an academic medical center-based CSC program that serves individuals from all Ohio counties. Both EPICENTER and the BeST Center operate as Centers of Excellence for CSC providers in Ohio, tracking model fidelity and providing ongoing training and support.

Funds and Cost Coverage

Revenue sources for CSC programs in Ohio include but are not limited to MHBG funds, funds from local Alcohol, Drug Addiction and Mental Health Services (ADAMH) Boards, and Medicaid, Medicare, and commercial insurance reimbursements. Not every program receives MHBG or ADAMH funds. Since 2022, additional time-limited funds to support CSC programs have been available from ARPA and CRRSA funds. MHBG funds to support FEP services in 2023 were \$2,576,767.

Medicaid, Medicare, and commercial insurance payers are all billed for CSC services through fee-for-service payment methods. Ohio Medicaid does not cover peer support or some elements of employment support. Commercial insurers additionally do not provide coverage for case management, family psychoeducation, or education and employment supports. All programs, with the exception of the program housed at The Ohio State University, accept uninsured clients.

CSC Service Overview



Medicaid Expansion State

Model of care: FIRST, EPICENTER

Clients served: 694

Average team caseload: Not available

Team staff: Not available

State Case Study: Ohio, continued

Financing Innovations

Ohio has made use of recent funding increases from ARPA and CRRSA funds to create new opportunities to promote the sustainability, reach, and performance of their CSC programs.^{48,49} The 10 percent set aside for ARPA funds for fiscal year (FY)22-FY25 was an additional 4.4 million. These funds include \$2.3 million for CSC virtual team pilot programs, \$1.8 million to fill CSC funding gaps in specific counties, and \$307,926 to improve FEP outcome data using the Healthcare, Outcomes, Network and Education approach.

Using ARPA funds to overcome challenges establishing CSC programs in rural counties, the Ohio Department of Mental Health and Addiction Services has collaborated with The Ohio State University to develop hybrid CSC teams that

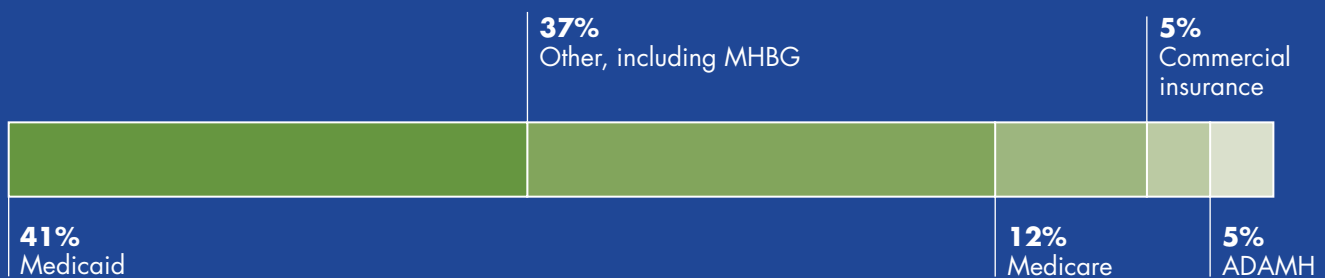
provide telehealth and local community mental health center care to serve Ohio counties that lack CSC teams. One of the pilot hybrid teams is currently accepting clients, and one is preparing to accept clients.

Steps to Achieve Broader Coverage

Ohio continues to work to expand the availability of CSC services throughout the state, including rural counties. A learning health network with bidirectional information exchange is also in development, which will allow the state to benchmark, compare, and monitor program data across time.

Researchers at The Ohio State University are currently analyzing public Medicaid and private insurance claims databases to identify the true cost of care of FEP programs to assist with further program expansion and development.

Estimated CSC Revenue Sources



State Case Study: Texas

CSC Service Background

Texas Health and Human Services Commission (HHSC) established two pilot CSC teams providing outpatient behavioral health services to Texans experiencing FEP with the support of MHBG funding in 2014. When MHBG set aside funding was increased in 2016, the state reimbursed eight additional CSC teams. In 2019, the state provided additional MHBG funds to support a cohort of rural CSC teams. There are currently 29 CSC providers operating 42 teams throughout the state of Texas. CSC models are diverse, and include NAVIGATE, COMPASS, and RAISE. Programs provide team-based services for up to three years. Each CSC provider provides the five key service components recommended by NIMH. CSC programs in Texas include a Certified Family Partner in their treatment model. Other team members include a psychiatrist, a licensed professional of the healing arts, a specialist for integrated employment and education services, and a certified peer specialist.

Training for the various providers is provided by Centralized Training Infrastructure for Evidence Based Practices, the SAMHSA-funded Texas Institute for Excellence in Mental Health, as well as trainers from OnTrackNY and NAVIGATE. Each provider conducts an annual OnTrackNY Fidelity Assessment to meet fidelity requirements. HHSC monitors provider fidelity through monthly technical assistance calls. Additionally, Early Psychosis Intervention Network (EPINET) outcome researchers complete fidelity assessments during onsite visits to providers.

Funds and Cost Coverage

Like other states, Texas CSC providers use a combination of MHBG funds, commercial insurance, and Medicaid reimbursements to cover the costs of CSC services. Texas is a non-Medicaid expansion state, meaning that income qualifications for state Medicaid for adults are more restrictive than Medicaid expansion states. In FY23, funds available

CSC Service Overview



Non-Medicaid Expansion State

Model of care: NAVIGATE, COMPASS, RAISE, STEP, HOPE, EPIC

Clients served: 1,366

Average team caseload: 20–30

Team staff: Minimum 1 FTE

to support CSC services in the state totaled about \$17.6 million. Federal funds including the MHBG, ARPA, and CRRSA provided 95 percent of these funds, and 5 percent came from state general revenue. HHSC allocates \$350,000 to each CSC provider annually to cover start-up costs for training, operations, salaries, travel, and other costs.

State Case Study: Texas, continued

When billed to Medicaid fee-for-service, Texas Medicaid does not cover integrated supported housing, services to promote educational or vocational success, or flexible funding for other non-clinical supports a person may need. Private insurers occasionally pay team-based case rates, but usually reimburse the same as fee-for-service for allowable services.

HHSC contracts with local mental health authorities and local behavioral health authorities to fund their CSC services, enabling them to serve people who are uninsured. Per Texas rules, local authorities must provide services regardless of ability to pay.

Financing Innovations

As of late 2022, Texas Medicaid authorizes MCOs to cover CSC as a medically appropriate and cost effective ILOS to inpatient hospitalizations (Senate Bill 1177, 86th Legislature, Regular Session, 2019).⁵⁰ Through this provision, CSC services can be provided to persons ages 15–30 who have a psychotic disorder diagnosed within the past two

years and who live in the service area of a CSC provider. MCOs opting to provide CSC in lieu of inpatient hospitalization services must use CSC providers that are

- Medicaid-enrolled local mental health authorities or are providers in local mental health authority networks; and
- Part of the Advancing an Early Psychosis Intervention Network in Texas.

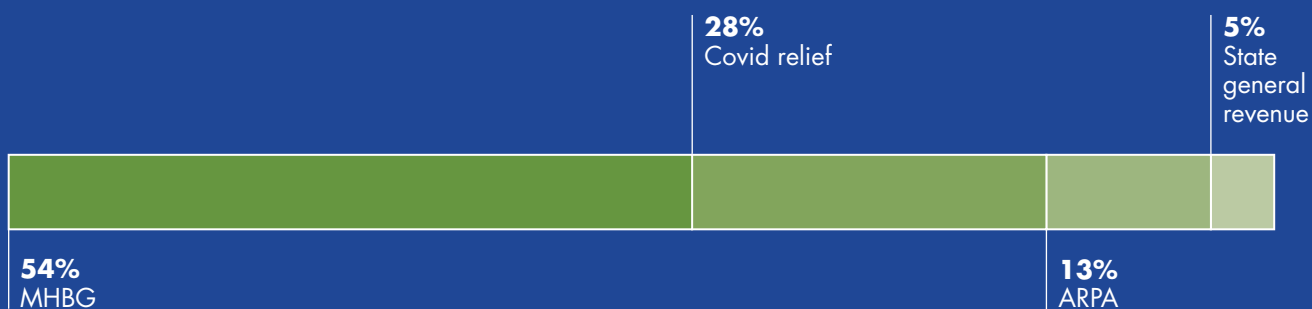
In July 2022, HHSC received \$950,000 allocated through state funding to establish three new CSC providers.

Steps to Achieve Broader Coverage

The National Alliance on Mental Illness (NAMI) and partners have been advocating for \$16 million in additional state funding for CSC in state legislative sessions. If approved, the additional funding would add \$475,000 to each CSC team’s annual budget.⁵¹

A proposal for Medicaid to cover CSC services using a team-based rate is in committee.⁵¹

CSC Budget, FY 2023



State Case Study: Washington

CSC Service Background

Washington launched New Journeys at a pilot site in Yakima with the support of MHBG funding in 2015. New Journeys is an evidence-based, multidisciplinary CSC model based on NAVIGATE. It was developed through the State Division of Behavioral Health and Recovery in partnership with the University of Washington and Washington State University to meet the needs of individuals aged 15–40 experiencing FEP in Washington. In 2019, Washington passed Second Substitute Senate Bill 5903 (sec. 6) which called for the statewide expansion of New Journeys and the development of a Medicaid financing strategy for FEP services. There are currently 17 New Journeys teams across the state. Eleven teams are fully operational, and six are in the start-up process. New Journeys teams become certified by the New Journeys network after completing training, staffing, and fidelity requirements. Fidelity monitoring occurs through monthly consultation calls. The University of Washington is in the process of implementing an annual fidelity review process.

Funds and Cost Coverage

New Journeys has used a combination of MHBG funds, state and local funds, and Medicaid and commercial insurance billing to finance teams since its launch. The New Journeys 2023 budget includes \$4,502,567 in MHBG funds, \$2,307,000 from CRRSA funds, and \$1,895,000 from state and federal provisional funds. The estimated average annual cost of each team is \$548,228.

It is difficult to bill public or commercial insurance for several services through traditional fee-for-service methods. These services include care coordination, community outreach, and specialty screening.⁵² Commercial insurance often only covers psychotherapy, medication and medication management, and family therapy using a fee schedule based on clinic rates. Furthermore, some providers do not have the infrastructure to seek commercial insurance payments.

CSC Service Overview



Medicaid Expansion State

Model of care: New Journeys, based on NAVIGATE

Clients served: 300

Average team caseload: 30

Team staff: Minimum 4.25 FTEs

Currently, these gaps in reimbursement are covered by either state general funds or federal block grant funds. In 2019, programs received reimbursements of about \$96 per visit from Medicaid and \$21 per visit from commercial insurance. An estimated 71 percent of team costs were covered by the MHBG and state funds.⁵³

In July 2022, Washington implemented a team-based rate for Medicaid eligible individuals. Billing through the Medicaid team-based rate is projected to result in reimbursements of \$415,584 per team annually, covering an estimated 76 percent of New Journeys team costs.⁵³

State Case Study: Washington, continued

Financing Innovations

Washington’s implementation of a Medicaid team-based rate will greatly expand the funding available to the New Journeys network. Since launching the Medicaid team-based rate, New Journeys has been able to transition seven teams from MHBG funding, freeing up \$1,950,000 in funding for team expansion and start-up costs. Establishing new teams requires close to \$1 million in federal or state funds per team over a 2-year start-up period. The Medicaid team-based rate is predicted to offset these costs by \$329,004.⁵³

The New Journeys Medicaid team-based rate is determined through actuarial analysis of service utilization data and unique CSC team-based costs such as small caseloads, specialized training, team meetings, and team leader wages. It is reimbursed monthly through MCOs and includes a per member per month case rate that is not a directed payment.

An array of Medicaid allowable services is paid through the team-based rate, including clinical services, family therapy, case management, and peer support. Activities not reimbursed by the Washington State Medicaid program are paid for with state Managed Care Organization Wrap Contracts.

Steps to Achieve Broader Coverage

Washington Health Care Authority is currently partnering with the Mercer actuarial group to develop an additional encounter rate for New Journeys teams to be used in conjunction with the monthly case rate when individuals need services in special circumstances. The updated financing will help expand Medicaid funding and cover team costs more fully.

Washington Health Care Authority also supports the need for mental health parity in commercial plans for New Journeys services. Commercial insurance adoption of the Medicaid team-based rate would result in coverage of 90 percent of New Journeys team costs.⁵³

New Journeys Clients by Payer Type, 2020



New Journeys accepts clients regardless of insurance coverage. State funds support two non-Medicaid clients per team. If the two slots are full, teams may negotiate single case rates with commercial insurance companies.

CHAPTER 4

Insights from Financing Other Team-Based Services

Successful and sustainable approaches to fully funding other team-based behavioral health services offer valuable lessons for financing CSC.⁵⁴ This chapter provides an overview of methods for financing three other team-based EBPs: Assertive Community Treatment (ACT), Multisystemic Therapy (MST), and the Collaborative Care Model (CoCM). The ACT EBP is an especially close parallel to CSC, and over the last decade states have adopted several strategies to fully fund it. Each of these EBP models differ from CSC and cannot be funded through states' MHBG set aside funding to support FEP unless they meet all aspects of the CSC model, but are complementary to CSC services. Some of the strategies used to fund ACT, MST, and CoCM are currently being used in select cases to finance CSC, while others could potentially be adapted for CSC use.

Assertive Community Treatment

ACT is an effective team-based approach to help people with serious mental illness recover and live fulfilling lives in their communities.⁵⁵ The program addresses the needs of people who are having a difficult time living successfully in the community as evidenced by multiple hospitalizations, frequent emergency room use, or repeated criminal justice involvement. The core components of the model are assertive outreach, multidisciplinary teams, small caseloads, and 24/7 availability. ACT has evolved to incorporate new features such as dual diagnosis treatment, shared decision making, supported employment, peer support, and a recovery orientation. Initially, the lack of a sustainable finance model as well as the lack of available community-based services slowed the adoption of ACT nationally.⁵⁶ Fortunately, the availability of ACT and mechanisms for financing it have improved in the last decade. As of 2022, 39 states cover ACT in Medicaid.⁵⁷ While ACT eligibility criteria limit the program's suitability for FEP patients,⁵⁸ it can be adapted for FEP through the ACT for Transition Aged Youth programs.

Multisystemic Therapy

MST is an EBP that involves intensive engagement with families and youth. It is similar to ACT, but was developed for children and adolescents ages 12–17.⁵⁹ MST addresses antisocial behavior through engagement with a youth's network of family, peers, school, and neighborhood. Therapists have small caseloads, are on call 24/7, and provide all care in the home and community. The average length of treatment is three to five months. Approximately 34 states cover MST under Medicaid as a team-based service.

Collaborative Care Model

CoCM is a team-based health care delivery approach that provides comprehensive and coordinated care in primary care settings to patients who are experiencing mental health conditions.⁶⁰ CoCM services employ a multidisciplinary team made up of a primary care provider, a behavioral health case manager, and a consulting psychiatrist. While CoCM does not require small caseloads, community-based interventions, and other extraordinary costs, it does cover information technology and team-based consultation costs. Unlike ACT or MST, CoCM is covered by Medicare and commercial insurance in addition to Medicaid. Providers are reimbursed for mental health screenings that occur in the primary care setting and use a registry to track progress of the treated population toward a set target.

Other Team-Based Service Financing Approaches

In Lieu of Services

States that have Medicaid managed care programs may choose to authorize in lieu of services and settings (ILOSs) that a state determines are medically appropriate and cost effective substitutes for state plan-covered services and settings.⁶¹ ILOSs are also provided at the option of the MCO, PIHP or PAHP, and at the option of the Medicaid managed care enrollee. Pennsylvania authorizes ACT services through the ILOS authority, and Texas has authorized CSC services through the authority.

CMS recently issued new policy guidance for the use of the ILOS authority (SMD 23-001) to ensure appropriate and efficient use of Medicaid resources. For example, CMS now limits ILOS expenses to 5 percent of the per member per month payments or overall capitated rate setting revenues that are received by Medicaid MCOs, PIHPs and PAHPs in a Medicaid managed care program.⁶²

The ILOS authority allows Medicaid MCOs, PIHPs and PAHPs to offer services or settings that the state has determined to be medically appropriate and cost effective alternatives to Medicaid state plan services and settings.



Medicaid State Plan Rehabilitative Option

States can also cover the cost of ACT team services using Medicaid state plan amendments that list ACT as a covered service under the Rehabilitative Option.⁶³ In the state plan amendment that is submitted to and approved by CMS, the state must describe the coverable services and the provider qualifications.

In the case of ACT, the eligible population is individuals with serious mental illness whose patterns of service utilization or clinical or functional status indicates a need for assertive outreach, engagement, services, and support. States can use various reimbursement methodologies to cover the full cost of Rehabilitative Option services for Medicaid enrollees. The availability of a widely accepted fidelity instrument further strengthens the case for the quality and integrity of the services delivered. North Carolina, Ohio, and New York all currently list ACT as an EBP service provided under the Rehabilitative Option in their state plans. Following a similar path, the Rehabilitative Option could also be used to cover CSC services.

Certified Community Behavioral Health Clinic Authority

Certified Community Behavioral Health Clinics (CCBHCs) provide integrated, accessible services to those in need, regardless of ability to pay.⁶⁴ Some CCBHCs are funded through a Medicaid demonstration authorized in 2014, and states can receive a federal match for the costs of operating CCBHCs. A recent report on CSC transitions from the Office of the Assistant Secretary for Planning and Evaluation identified CCBHCs as one of the most promising mechanisms for financing CSC.⁶⁵

Kansas funds ACT using the CCBHC financing mechanism under the Rehabilitative Option.⁶⁶ Although Kansas was not approved as one of the original CCBHC demonstration states, it used the state plan amendment procedure to obtain consent from CMS to establish CCBHCs around the state. Each CCBHC in Kansas is provisionally approved to meet CCBHC criteria and required to include ACT as a core service. The cost of the ACT program is included in the CCBHC cost report and the per diem rate for the clinic. The state oversees fidelity and quality assurance activities to ensure program fidelity.

As with ACT, MST can be funded through CCBHC prospective payment rates. This approach to funding team-based EBPs is likely to increase in importance as more state Medicaid programs become eligible to create CCBHCs, and is an option that CSC providers may consider.

Centers of Excellence

States can use Medicaid administrative match to fund Centers of Excellence. These centers provide training and fidelity monitoring for EBPs, including ACT and CSC, as seen in the CSC financing case studies. The amount of Medicaid funds used for the Centers of Excellence is determined by the proportion of Medicaid clients enrolled in the related program.

In Oregon, Centers of Excellence are funded with Medicaid administrative funds to the extent that they provide functions necessary to implement the Medicaid program. Oregon uses Centers of Excellence to provide training for new staff and ongoing quality improvement activities to ensure that ACT, CSC, and Individual Placement and Support programs are delivered with fidelity. In addition to the use of Centers of Excellence for administrative functions, state-funded Vocational Rehabilitation services and the Medicaid State Plan authority fully cover the cost of these three services for Medicaid beneficiaries in Oregon.

Early Periodic Screening Diagnostic and Treatment Mechanism

Medicaid's EPSDT mechanism⁴¹ for individuals under 21 years of age can fully fund MST. EPSDT requires that a child or adolescent is provided any 1905(c) service that is medically necessary. It is mandatory for states to provide screenings under EPSDT, including for mental health.⁶⁷ Louisiana, Delaware, Missouri, and Nebraska explicitly include MST in their state plans as a reimbursable service under the EPSDT Rehabilitative Option. Coverage of CSC under this mechanism may be possible for individuals with FEP who are under age 21.

Team-Based Billing Codes

Team-based billing codes are an important method to facilitate financing team-based EBP, since billing separate codes does not cover the costs of team training and overhead necessary to effectively deliver these services.

In 2005, CMS defined Healthcare Common Procedure Coding System (HCPCS)⁶⁸ billing codes for team-based billing for ACT. Similarly, MST has had its own HCPCS procedure code since at least 2005. Use of these codes assists providers' ability to bill Medicaid and makes it simpler for Medicaid programs to cover these EBPs.

Current Procedural Terminology codes have been developed for CoCM that separately cover the initial assessment and the subsequent work of the behavioral case manager. These codes simplify coverage decisions because there is a standard definition that insurers may utilize.⁶⁹ However, the codes require a minimum number of contact minutes with the patient during the month, which can be burdensome to track across multiple encounters and has slowed widespread adoption of CoCM.

Development of team-based billing codes for CSC would significantly improve the ability to fully cover these services.

Opportunities and Challenges to Adopting these Team-Based Financing Approaches for CSC

The fact that Medicaid and other insurers provide team-based funding to support ACT, MST, and CoCM establishes a clear precedent for the funding of CSC. Several of the strategies for funding these other EBP models are already being used to help finance CSC in select states. For example, Texas uses ILOS to help fund CSC for Medicaid beneficiaries, and several states use Centers of Excellence Medicaid reimbursement to finance efforts to ensure CSC model fidelity.

However, unlike these other programs, there are neither HCPCS nor Current Procedural Terminology codes for CSC. These codes are an important mechanism to support widespread billing for CSC at a team-based rate. No CMS-endorsed code is currently available for CSC. As of this writing (April 2023), CMS is currently reviewing an application to create a specific code for CSC. The approval of a CSC HCPCS code would remove one significant barrier to funding.



Like CSC, ACT, MST, and CoCM are innovative evidence-based interventions providing multidisciplinary, team-based care. Team-based reimbursement is routinely available for each of these services except CSC. The methods used to fund ACT, MST and CoCM services represent promising strategies for financing CSC.

Like CSC, ACT and MST are primarily billed to Medicaid and funded in a supplementary way under MHBG, with commercial insurance billed when available. However, CoCM can be billed to Medicare as well as Medicaid and commercial insurance. Many individuals with FEP who receive CSC services do have commercial insurance coverage, often under their parents' plans, so this sets an important precedent for coverage of CSC. Illinois has mandated commercial coverage of CSC, and other states are seeking legislation to require coverage.

Services such as MST, ACT, CoCM, and CSC are innovative interventions that have been developed and tested on specific populations and found to be effective in improving important clinical and functional outcomes. All involve multidisciplinary teams using tailored interventions proven to address the specific needs of their clientele, and reimbursing providers for the totality of team efforts is integral to the financial sustainability of these programs. CSC service components are an especially close parallel to ACT services. As noted in the first section of this report, simply providing a subset of services or services by untrained disparate providers in a clinic setting is not CSC and will not result in the outcomes CSC teams produce. Team-based reimbursement is routinely available for each of these EBPs, but not CSC.

The methods used to fund cost-effective, team-based care for the three EBPs reviewed in this chapter are also promising strategies for funding CSC.

However, finding the best coverage and reimbursement strategy among these possibilities depends upon each state's delivery system and Medicaid state plan, as well as the ability of states and providers to collaborate with commercial insurers. Encouragingly, one major commercial behavioral health insurer has expressed an interest in funding the service.

Although it took decades for ACT to be appropriately funded and generally available, the precedent that it and other team-based EBPs have established should hasten appropriate funding for CSC, especially if CMS establishes an EBP code for this service. In fact, the joint NIMH and SAMHSA effort following the RAISE trial⁵—in which block grant funds were appropriated and earmarked to underwrite the development of CSC programs across the nation—shows how rapidly research can move into action.



Conclusion

Psychosis and other symptoms of SMI can be confusing and alarming both for individuals experiencing a first episode and their loved ones. Fortunately, receiving treatment early through evidence-based, recovery-oriented services such as CSC can improve the outcomes of individuals who experience psychosis. The systematic literature review in this report found that early psychosis intervention services are cost-effective across diverse national contexts.

The availability of CSC has seen recent broad expansion in the United States thanks to the efforts of state and federal policy makers, mental health advocates, and other stakeholders. This growth is largely linked to the mandate that states use 10 percent of the federal MHBG funds administered by SAMHSA for ESMI, including FEP programs. SAMHSA is committed to equity in access to behavioral health services such as CSC, evidenced by the agency's support of growth in the availability of these programs. However, funding CSC services is often challenging, as the traditional fee-for-service reimbursement model does not cover all evidence-based service components necessary for treatment effectiveness, and office-based rates are inadequate for the services covered. In addition, while it has been essential for CSC development and expansion, MHBG funds are not sufficient to fully finance the need for these services nationally. Other sources of sustainable funding are necessary.

Findings of this report show that states adopt different strategies to fund CSC. All five states included here as case studies combine funds from the MHBG, commercial and public insurance reimbursement, and other sources. The availability of other funds to support CSC services varies. With the help of MHBG and other recent, time-limited increases in federal funding that can be used to support FEP interventions, including ARPA and CRRSA funds, states are taking different steps to improve the long-term sustainability of their CSC services. One approach is to mandate reimbursement for team-based or case rates to provide coverage of services that are difficult to fund through fee-for-service methods. Several states are using or developing team-based rates for Medicaid. Negotiating team-based payments with private insurers may prove more challenging for states and providers, as illustrated by the case of Illinois.

Insights from approaches to funding other team-based services highlight that additional strategies are available to improve financing for CSC. For example, the development of billing codes specific to CSC would greatly improve providers' ability to track and request reimbursement for full coverage of CSC services, as it does for other team-based behavioral health services. Other strategies that states may leverage for fuller coverage of CSC include utilizing the Medicaid ILOS provision, as Texas currently does, CCBHCs, and the Medicaid state plan Rehabilitative Option.

With continued support and guidance from federal and state agencies, there is potential for states to find sustainable CSC financing strategies that enable further program expansion to meet the public need for these crucial and cost-effective early psychosis treatment programs.

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APPENDIX A

Literature Review Methodology

ERIC, PsycInfo, and PubMed were searched for English-language journal articles, review articles, books or chapters, reports, and gray literature published between 2013 and 2023 that included “coordinated specialty care” or “first episode psychosis services” or “early psychosis interventions” and any of the following terms: program costs, training costs, cost-benefit, cost-effectiveness, cost offset, and cost savings. These searches produced 148 results. After accounting for duplicate entries, there were 139 total results.

A review of search results for inclusion criteria produced a sample of four studies providing data on program costs in the United States and fifteen U.S.-based and international analyses of cost savings, benefits, or effectiveness of early psychosis intervention programs. Cross-references of review articles confirmed that relevant sources were captured.

Costs of CSC in the United States inclusion criteria

- Published between 2013 and 2023
- English language
- U.S.-based
- Provided estimates of CSC program costs in USD

International evidence for costs and outcomes of early psychosis intervention inclusion criteria

- Published between 2013 and 2023
- English language
- U.S.-based or international
- Provided estimates of the cost-effectiveness, cost-benefits, or cost savings associated with early psychosis intervention programs

APPENDIX B

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This publication was developed through significant contributions from the following individuals:

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SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

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