



“Financing CSC services through Medicaid and commercial insurance presents a unique challenge to states and providers due to both the types of services that compose CSC and the intensity of service provision required (in terms of time and frequency).”

INFORMATION BRIEF

Use of Medicaid to Finance Coordinated Specialty Care Services for First Episode Psychosis

AUTHORS: DAVID SHERN, PH.D., KRISTIN NEYLON, M.A., MIHRAN KAZANDJIAN, M.A., AND TED LUTTERMAN



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List of Acronyms

The following is a list of acronyms used throughout this report:

- **ACO:** Accountable Care Organization
- **ACT:** Assertive Community Treatment
- **CCBHC:** Certified Community Behavioral Health Clinic
- **CCO:** coordinated care organization
- **CHIP:** Children's Health Insurance Program
- **CMS:** Centers for Medicare and Medicaid Services
- **CSC:** coordinated specialty care
- **DUP:** duration of untreated psychosis
- **EASA:** Early Assessment and Support Alliance
- **EDAPT:** Early Diagnosis and Preventive Treatment
- **EPICenter:** Early Psychosis Intervention Center
- **FEP:** first episode psychosis
- **FMAP:** Federal Medical Assistance Percentages
- **FPL:** federal poverty level
- **HCBS:** home and community-based services
- **HHS:** Department of Health and Human Services
- **HIT:** health information technology
- **MCO:** managed care organization
- **MHBG:** Community Mental Health Services Block Grant
- **MHO:** mental health organization
- **NASMHPD:** National Association of State Mental Health Program Directors
- **NIMH:** National Institute of Mental Health
- **NRI:** NASMHPD Research Institute, Inc.
- **PREP:** Prevention and Recovery in Early Psychosis
- **RAISE:** Recovery After an Initial Schizophrenia Episode
- **RBHA:** Regional Behavioral Health Authority
- **SAMHSA:** Substance Abuse and Mental Health Services Administration
- **SBHA:** state behavioral health authority
- **SMI:** serious mental illness
- **SSI:** Supplemental Security Income



Background and Introduction

Coordinated specialty care (CSC) programs have been serving individuals experiencing first episode psychosis (FEP) worldwide for at least the past 20 years.¹ Programs in Australia, Scandinavia, Canada, and the United Kingdom have led this initiative globally, whereas the Early Assessment and Support Alliance (EASA) program in Oregon and the Early Diagnosis and Preventive Treatment (EDAPT) and the Prevention and Recovery in Early Psychosis (PREP) programs in California have led the way in the United States, beginning in 2001, 2004, and 2006, respectively.

In 2008, through the National Institute of Mental Health's (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) project, the federal government implemented a multi-site clinical trial to assess the effectiveness of a CSC program within the U.S. behavioral health care system. Findings from the RAISE project demonstrated that the CSC approach is more effective at improving clinical and functional outcomes (e.g., improved health-, education-, and work-related goal attainment) than treatment-as-usual for individuals experiencing FEP, especially those between the ages of 15 and 35 within the first two years after a psychotic episode.² The CSC program also was found to be more cost effective than usual care.³ Research from the United Kingdom has identified significant cost savings in both health care and other social costs associated with early intervention programs.⁴ Finally, based on an independent actuarial study completed for a CSC program in Oregon, CSC programs offset costs in residential, emergency, and hospital care for persons served by CSC programs and also reduce the need for more intensive and expensive levels of care in the future. With the combined efforts of NIMH and the Substance Abuse and Mental Health Services Administration (SAMHSA), Congress was apprised of these findings and subsequently appropriated funds to support states in developing new or expanding existing CSC services nationwide.

In fiscal year 2014, Congress directed SAMHSA to require state behavioral health authorities (SBHAs) to dedicate at least 5 percent of their Community Mental Health Services Block Grant (MHBG) funds (referred to as the "Set Aside") "to support programs that address the needs of individuals with early serious mental illness (SMI), including psychotic disorders."⁵ Congress appropriated \$25 million in additional funds to support this directive so states would not have to take funding away from other initiatives. This original directive suggested, but did not require, that states use the funds to support the treatment of FEP through the development and/or expansion of CSC programs. However, in December 2015, when Congress doubled the amount of the Set Aside to 10 percent of the MHBG, it also required that SBHAs use the funds "only for programs showing strong evidence of effectiveness" that exclusively support

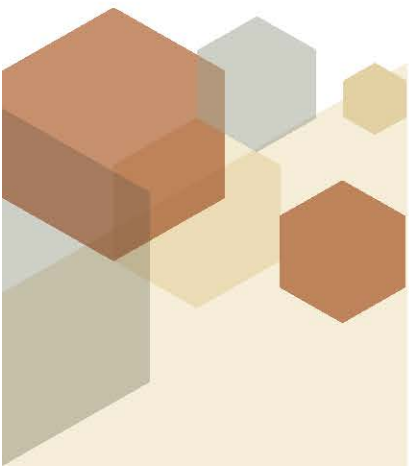
¹ Heinsen, R. K., Goldstein, A. B., & Azrin, S. T. (2014). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care*. Bethesda, MD: National Institute of Mental Health. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

² Ibid.

³ Rosenheck, R., Leslie, D., Sint, K., Lin, H., Robinson, D. G., Schooler, N. R., ... Kane, J. M. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE Early Treatment Program. *Schizophrenia Bulletin*, 42(4): 896–906.

⁴ Tsiachristas, A., Thomas, T., Leal, J., & Lennox, B. R. (2016). Economic impact of early intervention in psychosis services: Results from a longitudinal retrospective controlled study in England. *BMJ Open*. Retrieved from <http://bmjopen.bmj.com/content/bmjopen/6/10/e012611.full.pdf>

⁵ Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). Guidance for the revision of the FY 2014–2015 MHBG Behavioral Health Assessment and Plan. <http://www.samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>



individuals experiencing an FEP.⁶ With the implementation of the Set Aside, SAMHSA and NIMH have worked together to develop guidance for states about the use of evidence-based practices for FEP and strongly encourage the implementation of CSC models using Set Aside funds through guidance, training, and technical assistance.

CSC programs are team-based, recovery-oriented approaches to care that commonly include psychotherapy, medication management, family education and support, case management, supported employment, and supported education.⁷ Increasingly, CSC programs offer primary care coordination, peer support services, and supportive housing services in addition to the traditional core components of the model. Outreach and engagement activities also are essential to effective CSC programming, which is necessary to reduce the duration of untreated psychosis (DUP) through outreach and linkage with the numerous sites, such as schools, hospitals, and primary care providers, where persons experiencing an FEP may first be seen. Education of potential referral sites, coupled with outreach and engagement activities with potential service recipients, may occur prior to formal enrollment in a CSC program. Thorough client assessments to determine eligibility and develop a comprehensive service plan also are required. Financing CSC services through Medicaid and commercial insurance presents a unique challenge to states and providers due to both the types of services that compose CSC and the intensity of service provision required (in terms of time and frequency).

The majority of SBHAs have directed their contracted CSC providers to bill other payer sources, such as Medicaid and commercial insurance, for services whenever possible and to use the MHBG and other state funds to support CSC service components that insurance will not cover. Even though more than 20 years of data support the value of CSC services, providers find that many services required in the CSC model are not covered at all by Medicaid and commercial insurance, or are covered only in a limited number of settings; those services that are covered may not be reimbursed at sustainable rates that fully support the high intensity of services the CSC model requires.⁸ Recognizing that using the MHBG and other state funds to fill gaps in Medicaid and commercial insurance coverage is not a viable long-term strategy, SBHAs and CSC providers are seeking sustainable financing strategies to support their programs.

Although the majority of CSC programs in the United States are relatively new, these challenges are not unique to newly implemented CSC programs. Even mature CSC programs have to re-evaluate their financing strategies constantly to keep up with evolving program components and health care reform.

The purpose of this report is to help states and providers better understand how Medicaid can be used to develop more sustainable financing models that support CSC programs for FEP. It provides examples of strategies currently used by states to

⁶ SAMHSA. (2016). Ten percent Set-Aside narrative instructions for FY 2016. Retrieved from <http://bgas.samhsa.gov>

⁷ National Institute of Mental Health (NIMH). (2015). What is coordinated specialty care? Retrieved from <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml>

⁸ Heinszen, R. K., Goldstein, A. B., and Azrin, S. T. (2014). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care*. Bethesda, MD: National Institute of Mental Health. Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

finance CSC services that other states may consider pursuing and highlights potential mechanisms for further exploration. Issues related to the role of private insurance may be addressed in a later technical assistance document.

Methodology

To help SBHAs and CSC providers better understand potential strategies that may be used to finance CSC services through Medicaid, a team of researchers from the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) conducted a series of interviews with representatives from SBHAs, state Medicaid authorities, and CSC programs in Georgia, New York, Oklahoma, and Oregon. The research team also interviewed experts in behavioral health financing, including John O'Brien, M.S., Senior Consultant at the Technical Assistance Collaborative, Inc., and former Senior Advisor to the Administrator on Health Care Reform at SAMHSA; Kirsten Beronio, J.D., Senior Policy Advisor for Behavioral Health at the Center for Medicaid and Children's Health Insurance Program (CHIP) Services; and Mary Pat Farkas, Technical Director, Health Homes, at the Centers for Medicare and Medicaid Services (CMS). Responses from these interviews, along with supplemental web-based research, inform the content of this report. External sources are cited in footnotes throughout the report.

Since the research team was only able to interview representatives from a few states, the team has attempted to select examples of both representative and innovative uses of Medicaid. Oregon has been a leader both in first episode psychosis programming and innovative funding approaches for several years, so the state is featured more prominently than other states, reflecting the longevity of their efforts and financing innovations that are particularly relevant to supporting the full CSC model with Medicaid.

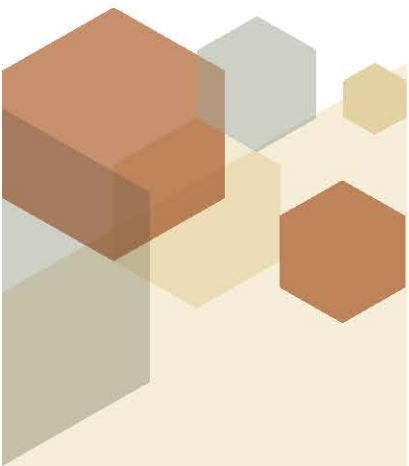
(CAUTION TO THE READER: It is important to note that the way Medicaid systems are designed and the mechanisms through which benefits are delivered vary greatly by state. In addition, this report was developed in the context of the health care environment as of August 2017, during which the Patient Protection and Affordable Care Act ["Affordable Care Act"] was still the legislation governing insurance coverage and enabling Medicaid expansion in 32 states.⁹ All financing strategies discussed in this paper comport with the Affordable Care Act but may change if Congress repeals or amends the law.)



Challenges to Using Medicaid to Finance CSC Programs

As indicated in the introduction, the nature of the population to be served in CSC programs—and the conventional array of services included in Medicaid state plans—do not easily support all aspects of CSC programming. The first challenge that must be addressed involves eligibility to participate in the Medicaid program. Medicaid was designed to serve poor families and persons with disabilities and to provide long-term

⁹ Kaiser Family Foundation. (2017). Status of state action on the Medicaid expansion decision. Retrieved from <http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



care in residential facilities (e.g., nursing homes) for impoverished individuals requiring skilled nursing care. With regard to individuals with SMI, states have traditionally used disability status, as indicated by participation in Supplemental Security Income (SSI), to determine eligibility to participate in Medicaid. Because CSC programs are intended to avoid the development of a disability, the traditional requirements for Medicaid eligibility based on a disabling condition will exclude many individuals enrolled in CSC programs. However, a legitimate argument may be made that individuals with FEP who also meet other eligibility requirements (e.g., income level) should be granted presumptive eligibility for Medicaid since the time for CSC treatment is defined and limited. Second, the conventional array of services funded by Medicaid may not include all of the service elements that compose the CSC programming approach. Supported employment, supported education, and family support services are examples of CSC components that are not generally included in a standard Medicaid benefits package; a 2015 joint information bulletin from CMS, SAMHSA, and NIMH (described later in more detail) acknowledges this limitation, specifically for supported employment.¹⁰ Public education, outreach to potential enrollees, and engagement activities prior to program enrollment also are not covered. Finally, the intensity of services required might not be reimbursed adequately using standard reimbursement rates, and some state requirements regarding which type of agency can provide Medicaid services may also be a barrier. Therefore, sustainable funding of the program involves strategies to address these challenges.

Eligibility to Bill Medicaid



The expansion of Medicaid in 32 states has contributed to expanded coverage for single individuals whose income is below 138 percent of the federal poverty level (FPL). In these states, low-income adults can be enrolled in the Medicaid program and have their services reimbursed through Medicaid. Income requirements in non-expansion states make it more challenging to secure Medicaid benefits for low-income individuals, unless they meet some other eligibility requirement (e.g., pregnant women, families on Temporary Assistance for Needy Families).

Additionally, individuals who continue to be covered by their parents' insurance and who meet the income eligibility requirement (e.g., emancipated minors) may be eligible for third-party liability coverage under Medicaid. For these individuals, services that are denied by commercial insurance but covered by Medicaid can be billed to Medicaid as a secondary payer. Case management, for example, is not likely to be a covered service in a commercial plan, but it may be covered by Medicaid. Following denial of the billing by the commercial service, a claim for such services may be submitted to Medicaid for payment if it is a covered Medicaid service.

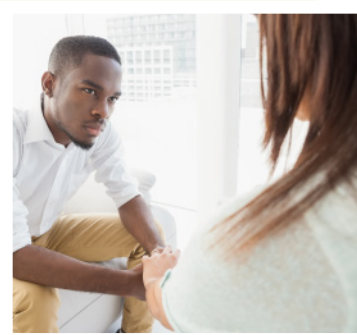
¹⁰ Centers for Medicare and Medicaid Services (CMS), National Institute of Mental Health (NIMH), and Substance Abuse and Mental Health Services Administration (SAMHSA). (2015). Joint informational bulletin: Coverage of early intervention services for first episode psychosis. Retrieved from <https://www.medicare.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf>. "Supported employment is not itself a mandatory or optional section 1905(a) benefit and CMS cannot reimburse for certain supported employment activities under the state plan. However, states may be able to use section 1905(a) state plan services to cover some component services of supported employment that assist or support individuals who are working or desire to work. For example, under section 1905(a) rehabilitative services option, a state may cover services such as individual therapy or behavior modification that help individuals manage their behavior in the work environment, develop strategies for resolving workplace issues, and address their symptoms while at work. States can implement the full breadth of the supported employment model through 1915(c) and (i) authorities."

Medicaid Financing Options

Many Medicaid financing options that are available to states were summarized in a joint information bulletin from CMS, SAMHSA, and NIMH in 2015.¹¹ These include various options that may be part of Medicaid state plans, as well as waivers that can provide additional flexibility in the provision of services. Several of these will be discussed in greater detail later in this report.

The Medicaid rehabilitation services option (“rehab option”) is the primary vehicle that states use to finance their mental health services. The rehab option allows states to provide services beyond the required set of mandatory services (e.g., inpatient hospital stays and nursing home care), including prescription drug benefits and clinical services. Federal law defines rehab services as those medical or remedial services “recommended by a physician or other licensed practitioner ... for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”¹² By incorporating this option into a Medicaid state plan, states have the flexibility to determine service eligibility, the service array, limitations on services, and which providers can deliver which services.¹³ The Kaiser Family Foundation summarizes the key characteristics of the rehab option as follows:¹⁴

- **Where services can be provided:** Rehab option services can be provided in community settings, including a person’s home or work environment, whereas some other service categories specify the setting in which services can be provided;
- **Types of providers:** Rehab option services can be provided by a broader range of professionals than some other options; the rehab option does not require services to be provided under the direction of a physician; and it permits community paraprofessionals and peer specialists to provide services; and
- **Scope of coverage:** A broader range of services can be covered than only the clinical treatment of a condition, including those that assist individuals in re-acquiring skills essential for everyday functioning such as skills training services that assist individuals in developing interpersonal interaction skills that are necessary to maintaining employment and that may be provided at the individual’s job site.



This description of the rehab option makes it clear that its flexibility in design and emphasis on assisting individuals in re-acquiring skills, as well as its inclusion of off-site services, fit the CSC model well. Also, the use of a broader range of mental health services and case management providers comports with the team-based CSC approach. Peer services, which are increasingly common among CSC programs, also may be reimbursed through the rehab option. While the specific services and reimbursement approaches vary by state, as of 2013, all 50 states and the District of

¹¹ Ibid

¹² Spigel, S. (2005). Rehabilitation option services. Retrieved from <https://www.cga.ct.gov/2005/rpt/2005-R-0687.htm>

¹³ Ibid

¹⁴ Kaiser Family Foundation. (2007). Medicaid’s rehabilitation services option: Overview and current policy issues. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7682.pdf>

Columbia have included services under the rehab option in their Medicaid state plans. Given these characteristics of the rehab option and its broad adoption across the states, it is not surprising that each state interviewed for this report identified the rehab option as a common mechanism for providing specific CSC services that are likely not covered under the traditional clinical services option.



GEORGIA'S USE OF THE REHAB OPTION TO FINANCE CSC SERVICES

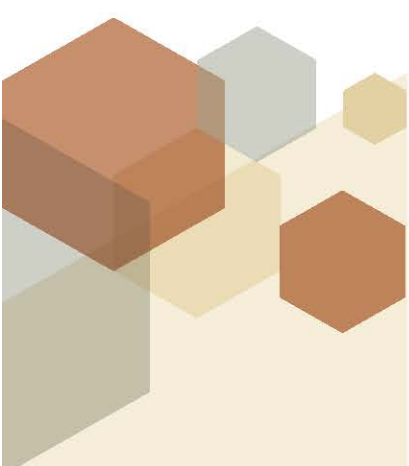
The Georgia Department of Behavioral Health and Developmental Disabilities and the Georgia Department of Community Health have worked together to utilize the Medicaid rehab option to create a package of treatment and rehabilitative services and supports for eligible recipients who have mental health and substance use conditions. The fundamental elements of the package include traditional behavioral health medical supports (physician and nursing services), traditional therapies, targeted skills-building supports, psychosocial rehabilitation, crisis services, and peer support services, including whole-health peer services. Young adults who meet the FEP clinical criteria qualify for these services and can access a range of supports in accordance with an individualized recovery plan and in keeping with the evidence-based practices set forth in the CSC model. Georgia also makes extensive use of peer-delivered services, for primary consumers as well as family members, which are billable through the rehab option. The state reports that the use of peers in CSC programs is significant for the engagement and retention of young adults in care.

Use of Medicaid Waivers to Finance CSC Programs

In the joint information bulletin addressing CSC services for individuals with FEP, CMS, SAMHSA, and NIMH discussed various financing mechanisms that could be used to support CSC programming. The financing mechanisms listed that provide the greatest flexibility involve the use of Medicaid waiver programs, which are discussed in the following excerpts from the information bulletin:¹⁵

- **Home and Community-Based Services** [M]any of the services identified in this informational bulletin can be included in the Home and Community-Based Services Program. This includes the 1915(c) Waiver Authority and the 1915(i) State Plan Authority. 1915(c) waivers allow a state to design a comprehensive package of community-based services for individuals who meet an institutional level of care, so long as there is cost-neutrality between the HCBS and institutional services. 1915(c) waiver services may be made available only to certain groups of people who are at risk of institutionalization. States can propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Services that have been provided under the 1915(c) program for older adolescents and young adults include respite and supported employment. Section 1915(c) waiver programs also require that participants must live and receive services in home and community-based settings.

¹⁵ CMS, NIMH, and SAMHSA. (2015).



The Section 1915(i) state plan amendment provides an opportunity for states to amend their state Medicaid plans to offer intensive home and community-based behavioral health services that were previously provided primarily through 1915(c) HCBS waiver programs. Intensive care coordination, respite, and supported employment can be offered under 1915(i) and serve youth and young adults with significant mental health conditions. Under 1915(i), states may not waive the requirement to provide services statewide, nor can they limit the number of participants in the state who may receive the services if they meet 1915(i) eligibility requirements. Unlike the 1915(c) waiver program, the 1915(i) delinks the provision of services with participants meeting an institutional level of care. In order to target the initiative and limit costs, states may identify a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group, and establish additional needs-based criteria. However, states may find the guidelines associated with the 1915(i) more burdensome, including the requirement to develop an independent evaluation and assessment process for eligibility, and the requirement to establish a quality assurance and monitoring strategy for continuous quality improvement.

- **1115 Authority:** Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that further the objectives of the Medicaid and Children’s Health Insurance Program. These demonstrations give states additional flexibility to design and improve their programs, to demonstrate and evaluate policy approaches, such as providing services not typically covered by Medicaid, and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Some states are considering section 1115 demonstrations to address the needs of individuals experiencing a first episode psychosis.

New York and Oregon provide important examples of how these waiver authorities can be used to finance CSC services more comprehensively and flexibly than would be possible with a standard Medicaid benefit package. Both use the 1115 waiver to authorize managed care organizations (MCOs) in their respective states to deliver innovative behavioral health services to non-traditional populations.

NEW YORK’S USE OF THE 1115 WAIVER

New York uses a 1115 waiver to address many of the problems associated with financing CSC services using traditional Medicaid state plan services (e.g., the rehab option). The waiver enables the state to implement Behavioral Health Home and Community-Based Services. Under the waiver, New York created a Special Needs category, which fully integrates the service needs for persons receiving SSI for a disabling mental health condition. All Medicaid state plan behavioral and physical health services are covered in this service package. In addition, as part of this waiver request, new Behavioral Health Home and Community-Based Services were added to the state’s Medicaid Special Needs benefit package. Behavioral Health Home and Community-Based Service benefits include the following:



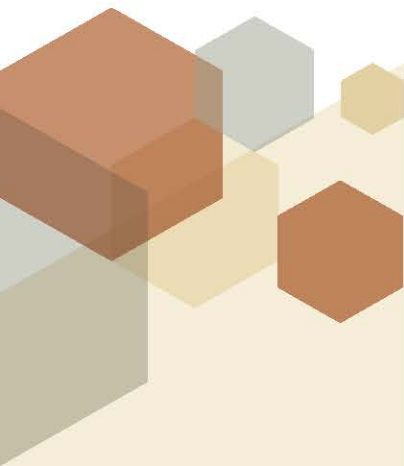
- Rehabilitation
 - Psychosocial rehabilitation
 - Community psychiatric support and treatment
- Crisis intervention
 - Short-term crisis respite
 - Intensive crisis respite
- Habilitation
- Empowerment services and peer supports
- Support services
 - Family support and training
 - Non-medical transportation
- Individual employment support services
 - Pre-vocational services
 - Transitional employment services
 - Intensive supported employment
 - Ongoing supported employment
- Educational support services
- Self-directed services (will be included initially as a demonstration only; not yet available statewide)

As a result of this expansion of services, the state informed their Medicaid MCOs that individuals with FEP who are Medicaid eligible, but not disabled, and who meet criteria for CSC programming for OnTrackNY will be eligible to be served under the Behavioral Health Home and Community-Based Services mechanism established by the 1115 waiver. The MCOs receive a higher premium for these individuals from the state, so these funds can be used to better cover the cost of care for CSC services. Providers will be allowed to bill MCOs for each of the individual CSC services when serving individuals with FEP who are enrolled in a special-needs plan. This strategy, therefore, involves the use of an enhanced rate to better compensate for the intensity of services required by CSC clients and provides flexibility in how these services are delivered in a fee-for-service framework. It relies on the ability to systematically identify individuals who are eligible to receive this higher level of service and provides a financing mechanism that will adequately reimburse the provision of a wider array of services than would be possible through the state's rehab option, including supported education and supported employment. However, the strategy does not fully cover the costs of the program, as outreach and engagement activities are not reimbursable through Medicaid. Funding gaps are addressed through state general funds and MHBG funds.



OREGON'S USE OF THE 1115 WAIVER

Similar to New York, Oregon also uses a 1115 waiver mechanism to establish 16 coordinated care organizations (CCOs) that serve the entire state. The CCOs are composed of networks of providers that offer a full range of health and behavioral health services. Each CCO is accountable to an administrative entity that organizes the service system and reimburses network members for their services. A board composed of community residents, health care professionals, and other stakeholders governs each CCO. CCOs are risk-bearing entities that receive a per-member,



per-month premium, which is intended to cover all services that are needed by their Medicaid enrollees. The CCOs are the Accountable Care Organizations (ACOs) for the Medicaid populations they serve, and they have demonstrated substantial improvements in access and cost savings.

A cardinal feature of Oregon's CCOs is their ability to provide specialty services that are designed to lessen the impact of chronic illnesses and meet the specific needs of their members. The EASA program in Marion County is an excellent example of how the autonomy of the CCO and its flexibility in funding programs can work to sustain the CSC model for Medicaid recipients.

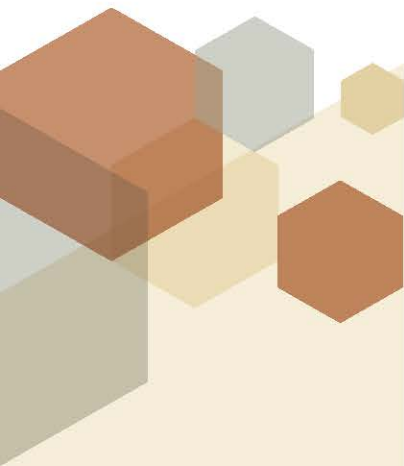
In order to accomplish this, newer financing approaches are needed that can fully cover all the costs of the CSC program. This requires that the CSC program model be understood and sufficiently operationalized for cost and reimbursement purposes. Based on a clear program model, it is possible to specify the staffing composition and a staff-to-client ratio. To the degree to which staff roles and productivity expectations are clear, as well as reasonable expectations for the processes of care and client outcomes, program cost information can be used to develop an enhanced or bundled rate. The rate can then be translated into an all-inclusive rate that is often billed as a monthly or daily charge for individuals who receive a specified level of service. Full coverage of program costs requires client engagement and enrollment at the anticipated levels in order to obtain the revenue needed to cover the costs. Based on this example from Oregon, the problem of deriving a reimbursement rate that covers all program costs involves:

- Specifying the model operationally;
- Developing cost estimates for the full program model;
- Selecting a reimbursement mechanism;
- Determining that appropriate clients are served;
- Assuring that the program, as delivered, has fidelity to the program model; and
- Measuring service quality and/or client outcomes.

MARION COUNTY, OREGON

The CCO in Marion County, Oregon, receives capitated payments from the state to serve the Medicaid population. The county monitors encounter data and compares the data against the capitation rate for outpatient, crisis, and other high-fidelity services. After comparing the actual costs of care with the capitation rates for the CSC program, it was clear that a sizeable gap existed between the capitated payment and the actual cost of services due to the many services included in CSC models that are not billable or, if billable, standard rates may not reflect the actual cost of delivering services to this population.

Once this issue was identified, Marion County approached the CCO and the mental health organization (MHO; part of the CCO network and the entity with which the CCO contracts to provide mental health services) to develop a case rate intended to cover all CSC costs. Marion County then hired a consultant, TriWest Healthcare Alliance ("TriWest"), to calculate the case rate. In developing the rate, TriWest considered



the size of the typical caseload, average occupancy rates, the staffing model used by the program, fidelity requirements, and the number of slots that would likely be occupied by Medicaid enrollees. Productivity and overall capacity also were built into the cost model. However, client incentives, such as transportation vouchers, could not be included in the bundled rate because these are not Medicaid-eligible services. Based on these analyses, a proposed case rate of \$1,371 per member, per month was established. This rate is available to anyone enrolled in Medicaid who receives at least one CSC service within the month. This case rate has been effective since July 1, 2016.

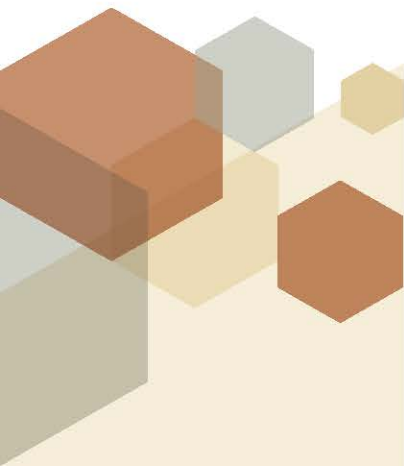
TriWest worked with Marion County, the CCO, and the MHO for nearly a year to develop the per-member, per-month case rates for multiple services, including CSC services. The rates are used by the MHO to contract with Marion County for the delivery of CSC services. In their analysis, TriWest estimated the savings in residential, emergency, and hospital care for persons served by the CSC program and determined that significant cost savings would be associated with CSC programming through a reduced need for more intensive and expensive levels of care in the future. Based on these analyses, the CCO and MHO were supportive of the case-rate approach, which enabled delivery of the full CSC program model.

Marion County collects data to compare the new case rates with fee-for-service billing and has determined that for the first nine months, claims for the bundled case rate were approximately \$333,000, whereas billing for the usual billing codes would have only yielded approximately \$146,000. The difference more closely reflects the true cost of the effective, flexible, person-centered services provided by the CSC program.

OREGON'S PROGRAMMATIC CENTERS OF EXCELLENCE

To use these reimbursement approaches, a clear, operationalized program model with fidelity measures and operational standards is required to ensure that the appropriate clientele are being served and appropriate client outcomes are being achieved. These requirements, in turn, require a process to certify that the programs are performing in accordance with standards.

To address these issues, the Oregon Medicaid Authority has helped develop a series of Centers of Excellence that are charged with developing and updating program standards and supporting, certifying, and providing quality assurance services to the certified programs. In the case of Assertive Community Treatment (ACT), the certification process has allowed the state's Medicaid authority to develop a per-diem bundled rate for ACT services that is restricted to certified programs. The EASA programs also have a Center of Excellence, financed through state general funds and the MHBG, but have not yet developed a statewide bundled payment method for these programs. The state is planning to translate the program and fidelity work of the EASA Center of Excellence into credentialing, which would result in the certification of providers to use special billing codes that earn enhanced rates. The providers are then incentivized to provide EASA services because they can access rates that better match their costs and are easier to code and bill, and they receive reimbursement from the CCO.



The use of Centers of Excellence is illustrative of how Oregon plans to ensure that the coordinated range of services included in CSC programming is adequately reimbursed to help guarantee program sustainability and accountability.

Certified Community Behavioral Health Clinic Demonstration Waiver

In 2017, SAMHSA awarded funding to eight states to participate in a two-year demonstration project to expand access to behavioral health services in community-based settings. Participating states receiving the funding will develop Certified Community Behavioral Health Clinics (CCBHCs), which will receive enhanced Medicaid reimbursement rates to better align with the costs of providing community-based care. CCBHCs are responsible for providing, either directly or through subcontractors, nine types of services, including crisis services; screening, assessment, and diagnosis (including risk assessment); patient-centered treatment and planning; outpatient behavioral health services; outpatient primary care screening and monitoring of certain indicators; targeted case management; psychiatric rehabilitation services; peer support and family support services; and intensive community care for veterans and members of the armed forces. CCBHCs prioritize 24-hour crisis services, evidence-based practices, care coordination, and the integration of physical and behavioral health care. The focus of these demonstration projects aligns well with the goals and strategies of CSC programming. Of the states interviewed for this report, New York and Oregon hope to use the CCBHC demonstration waiver to support their CSC programs, with Oklahoma exploring how the CCBHC approach may be used in one of its rural clinics for CSC. An example from Oregon is included below.

LANE COUNTY, OREGON

A second example of flexible funding in Oregon involves the EASA program operating in Lane County that serves a population of approximately 350,000 individuals and includes the state's third-largest city, Eugene. PeaceHealth, a CSC provider, is participating in the CCBHC demonstration waiver program and uses the cost-based methodology to determine the rates for the provision of CSC services by PeaceHealth. Based on a staffing and productivity model, a cost estimate is derived that covers the full cost of the CSC program, including those services that may not typically be included in a Medicaid state plan. The costing methodology takes into consideration the exact number of qualifying visits the CSC program had over the past year and the cost of delivering the services, including indirect costs such as case review and overhead costs. Across Oregon, the reimbursement rate varies in relation to the unique staffing complements of the CSC programs.

Any day the client is seen, the program is reimbursed a fixed amount, regardless of the number of services that are received during the day. Therefore, in ideal circumstances, and if the program exclusively enrolled Medicaid clients, the full cost of the program would be earned through service to this caseload. Adjustments to the rate may occur annually based on the performance of the program relative to its plan.

However, the PeaceHealth program is also part of the CCO serving Lane County and can bill and receive reimbursement through the CCO. The program, therefore, bills the CCO on a fee-for-service basis for the services that are delivered to the client during any specific visit. The difference between the revenue from this fee-for-service billing and the per-diem rate is paid by the CCBHC. If the fee-for-service rate exceeds the per-diem rate, then no funds are billed to the CCBHC.

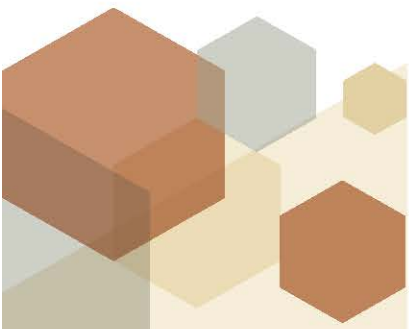
Like all programs, the PeaceHealth CSC program does not exclusively serve Medicaid clients. Therefore, Medicaid is only part of the overall program funding, and the state general funds and MHBG cover the difference between the overall program expenses and the revenue from Medicaid (including the CCBHC and the CCO) and other payers (e.g., commercial insurance, self-pay).

Use of Medicaid Health Homes to Support CSC Services

To better meet the needs of individuals with chronic illnesses, the Affordable Care Act included provisions for the establishment of health homes. Health homes are intended to improve the treatment of chronic conditions, including for individuals with significant mental health disorders, and provide flexibility in both the array and intensity of services provided. States have the flexibility to identify populations to be served and can target the services geographically. Section 2703 health home methodology cannot be used to pay for services that are individual treatment; however, section 2703 health home methodology can be used to pay for services that are not face-to-face, as well as additional program costs that are not actually services, such as information technology, data analytics, training, and administrative oversight. Based on the interview with Oklahoma, the core elements of health homes include:

- **Comprehensive care management:** outreach and engagement; reaching out to a client's providers; conducting comprehensive needs assessment; assessing a client's housing, education, and/or food needs; and constructing a comprehensive care plan.
- **Care coordination:** facilitating and making sure the care plan is being followed across all providers and working as a team to help the client meet goals; continuing monitoring of goal progress; and following treatment regimens.
- **Health promotion:** providing education and engaging the individual for maximal healthy living; promoting wellness; teaching self-management skills; and directly offering or referring the client to exercise.
- **Comprehensive transition care:** facilitating transitions between living arrangements; making sure that the health home has a relationship with hospitals and other institutions; and maintaining ongoing communication with the enrollee.
- **Individual and family supports:** coordinating information and services with family; providing education and guidance to family; and providing caregiver counseling and training.
- **Community and social supports:** making sure clients know where to go in the community; linking clients with other resources; monitoring and following up with clients to make sure they are keeping appointments; and maintaining ongoing engagement with referral sources.





Individuals do not need to have developed a disability to be included in a health home program, but they must meet the state’s eligibility criteria based on the targeted chronic conditions identified in the state’s Medicaid plan and their income level. States can designate the characteristics of persons to be served in the health home as long as they meet the CMS-specified eligibility requirements, one of which specifically references persons with a serious mental illness. Individuals can be served in only one health home at a time, and service provision has to be carefully tracked, optimally with the use of an electronic health record.

Licensed practitioners are required to be included in a health home, but practitioners are not restricted to licensed professionals. Peer specialists can be included in the health home teams and may be particularly beneficial for consumer and family engagement. States are required to collect and report measures of program quality. In a summary of health home features, the Kaiser Family Foundation¹⁶ noted that “states must track avoidable hospital readmissions, calculate savings due to improved care coordination and disease management, and monitor the use of health information technology (HIT); they are also required to track emergency department visits and skilled nursing facility admissions. CMS plans to specify a uniform methodology for tracking avoidable hospital readmissions and calculating savings.” (CMS provides a Resource Center on Health Home Quality Measures, including Resource Manuals.)

The reimbursement rates for health homes are determined by reference to the specific model that is being used in the health home for a specified client group and should cover all health home services provided in the model. Reimbursement methods are flexible and can be reimbursed on a per-member, per-month bundled rate, enabling greater flexibility in service delivery. Some states include the health home rates in an overall capitation rate for existing managed care programs.

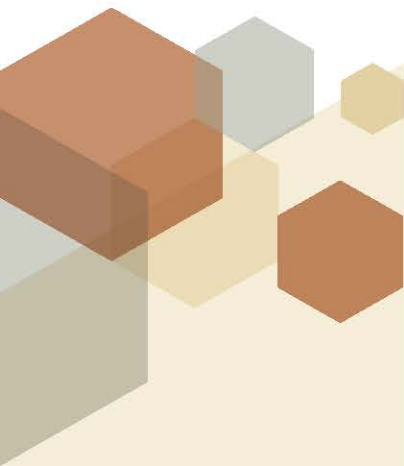
Programs that provide a health home for Medicaid enrollees can also provide health home services to individuals who are not Medicaid enrollees. State Medicaid programs cannot cover the cost or claim of other non-Medicaid populations under the health home benefit. Medicaid, therefore, can be a revenue source for a health home program that serves clients with commercial insurance or who are uninsured. An additional attractive feature of Medicaid financing through the health home involves 90 percent federal participation in the payments for eight quarters, which minimizes the state’s financial liability for the program.



OKLAHOMA’S USE OF HEALTH HOMES

In 2015, Oklahoma initiated two CSC programs with two health home providers in Oklahoma City and Tulsa, out of 22 health home providers statewide. For clients within the health homes, providers are able to bill Medicaid on a per-member, per-month basis to cover care coordination, and they also can bill separately on a fee-for-service basis for direct treatment components, which cannot be included in the health home rate. As a specialty program, the CSC program is organizationally distinct from other services and able to bill the MHBG to cover all remaining costs.

¹⁶ Kaiser Family Foundation. (2011). Focus on health reform: Medicaid’s new “health home” option. Retrieved from <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8136.pdf>



Health home providers delivering services to eligible Medicaid clients can bill a per-member, per-month rate that depends on the acuity of the provided service, as well as the client's age. Providers can bill \$453.96 for adults receiving a high level of service and \$146 for adults receiving a moderate level of service. Health home providers can bill \$1,009.60 for children receiving a high level of service and \$354.34 for children receiving a moderate level of service.

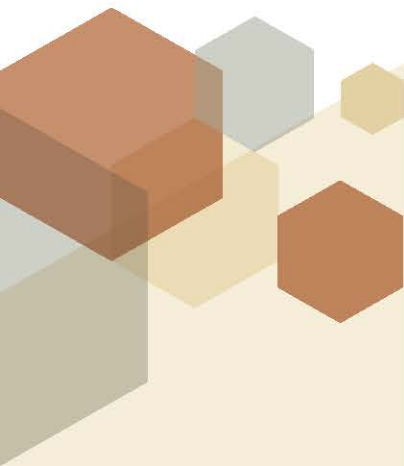
Oklahoma does have specified, targeted minimum service requirements that programs must provide, averaged across their health home clients. Oklahoma requires the collection of health homes shadow claims data from all providers. Through this, all distinct services are reported to monitor the provision of services and assess the degree to which the bundled rates are being used appropriately.

In addition to the standard health home rate to cover care coordination for clients, health home providers in Oklahoma also have an option to bill \$53.98 per client, up to three times per year, to cover outreach and engagement activities. This additional rate must be used for direct-to-client outreach and engagement activities and cannot be used for public presentations or informational campaigns. Currently, this additional rate is not widely used by CSC programs in Oklahoma, as the Set Aside covers outreach and engagement activities. However, providers do have access to a report that shows clients who are eligible for a health home but not currently enrolled.

Summary

Developing sustainable Medicaid financing strategies to support CSC programs is challenging due to the broad array and intensity of services required by the CSC model. However, the demonstrated improvement in client outcomes, as well as the programs' cost effectiveness, make investing in the long-term success of these programs worthwhile. Medicaid financing is an important component of an overall strategy to support CSC programs. This paper explores the various Medicaid strategies that may be used to help finance CSC programs.

Based on interviews with representatives from SBHAs, state Medicaid authorities, and CSC programs in Georgia, New York, Oklahoma, and Oregon, as well as interviews with other experts in behavioral health financing, researchers from NASMHPD and NRI identified the challenges that are involved in financing these programs and explored several strategies states may use to address these challenges. The challenges involve financing the array of services included in the CSC model, many of which may not be included in the covered services that are currently Medicaid reimbursable. Outreach and engagement, family support, and supported education are prominent among these services. Also, CSC services must be flexible in order to accommodate the unique circumstances of each individual and may vary in intensity. Prospective payment systems that use a bundled rate to cover the full array of program costs would seem ideal. Potential strategies identified to meet these challenges include the Medicaid rehab option, Home and Community-Based Service waivers, the CCBHC demonstration waiver, and Medicaid health homes.



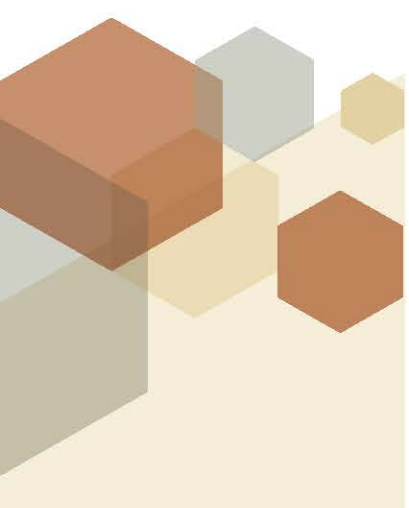
Of these four funding mechanisms, the CCBHC demonstration waiver may be the most promising. The CCBHC demonstration waiver permits the development of cost-based reimbursement that may include all of the CSC program elements. CCBHCs also use a prospective payment model to reimburse these costs for services that provide the flexibility needed to individualize services. However, the CCBHC is a time-limited demonstration waiver that is currently available to only eight states. The future of this promising mechanism is uncertain. If found to be effective, and if CMS and SAMHSA elect to expand the program beyond the demonstration states, it may provide an excellent mechanism for fully covering CSC program costs.

Another promising mechanism is the use of Medicaid health homes to provide CSC services to individuals experiencing FEP. Health homes are an attractive option for CSC programs because they support comprehensive care management, care coordination, health promotion, comprehensive transition care, individual and family supports, and community and social supports, all of which are necessary for a successful CSC program. The health home model provides flexibility to providers in both the array and intensity of services provided, and persons with severe mental health conditions are presumptively eligible for enrollment in health homes so long as they meet Medicaid eligibility requirements. In the Oklahoma implementation featured here, outreach and engagement services are explicitly reimbursed. Clinical and rehabilitation services may be billed separately from health home services depending on the specifics of the health home model.

The use of Medicaid Home and Community-Based Service waivers, such as the 1915(i) and the 1115, allows states to implement Medicaid managed care, which offers them enhanced flexibility and broader service coverage than the rehab option alone can provide. States and providers are able to negotiate enhanced rates with their MCOs that cover the costs of care more fully. Because of these benefits, states without these waivers may find it beneficial to add these waivers to their Medicaid financing strategy. Oregon's use of the 1115 mechanism to create CCOs that may elect to prospectively fund the full CSC program costs is another example of the creativity permitted by the 1115 mechanism. To the degree that ACOs continue to be developed, they may provide the resources and flexibility to support CSC-type programs.

Of the four mechanisms identified in this report, the Medicaid rehab option provides the least flexibility and is the most limited in terms of the services it covers. Typically, the rehabilitation service array does not include all CSC services but, depending on the specific state plan, can cover many of them. The rehab services option is the most commonly used Medicaid funding mechanism, as all 50 states and the District of Columbia have included services under the rehab option in their Medicaid state plans. Each state interviewed for this report currently uses the rehab option to finance several CSC service components.

Third-party liability coverage through Medicaid is another useful tool. Individuals covered through commercial insurance plans who are otherwise eligible for Medicaid (e.g., children covered by their parents' insurance) may be eligible for third-party



liability coverage. In these instances, Medicaid-eligible services must first be denied payment by commercial insurance, then billed to Medicaid as a secondary payer. This strategy can be helpful to fill the gaps in coverage for commercially insured individuals who are Medicaid eligible.

Although a variety of Medicaid financing strategies can help sustain CSC programs, there continues to be a need for supplemental funding through state and federal funds, including the MHBG. Until Medicaid state plans and commercial insurance provide full coverage of essential CSC services, the need for supplemental funds will continue. Pursuing and rigorously evaluating innovative funding options through Medicaid may provide the information necessary to develop accountable and cost-effective insurance mechanisms to cover these important early intervention services.

