Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

HHS Public Access

Author manuscript

Psychiatr Serv. Author manuscript; available in PMC 2022 October 01.

Published in final edited form as:

Psychiatr Serv. 2021 October 01; 72(10): 1134–1138. doi:10.1176/appi.ps.202000710.

Financing Early Psychosis Intervention Programs: Provider Organization Perspectives

Yuhua Bao, Ph.D., **Michelle A. Papp**, **Rufina Lee, Ph.D.**, **David Shern, Ph.D.**, **Lisa B. Dixon, M.D., M.P.H.**

Department of Population Health Sciences (Bao, Papp) and Department of Psychiatry (Bao), Weill Cornell Medical College, New York City; Silberman School of Social Work at Hunter College, City University of New York, New York City (Lee); National Association of State Mental Health Program Directors, Alexandria, Virginia (Shern); Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore (Shern); Department of Psychiatry, Columbia University Vagelos College of Physicians and Surgeons, New York City (Dixon); New York State Psychiatric Institute, New York City (Dixon).

Abstract

Objective: The authors aimed to identify prominent financing approaches for coordinated specialty care (CSC) of patients with first-episode psychosis, alignment or misalignment of such approaches with sustained CSC implementation, and CSC provider perspectives on ideal payment models.

Methods: Semistructured interviews were conducted with informants from CSC provider organizations. Purposeful sampling of CSC program directors, team leaders, and other administrators from a national e-mail Listserv was supplemented by snowball sampling via participant recommendations. Interview data from 19 CSC programs in 14 states were analyzed by using an integrated (inductive and deductive) approach to derive themes.

Results: The results indicated that financing approaches to CSC were patchwork and highly varied. Three major sources of funding were cited: insurance billing (largely fee for service [FFS] to Medicaid and private insurance), set-aside funding from the federal Mental Health Block Grant (MHBG) program, and state funding. The findings revealed limited coverage and restrictive rules associated with FFS insurance billing that were misaligned with CSC implementation. The grant nature of MHBG and other public funding was seen as a threat to long-term CSC sustainability and deployment. CSC stakeholders endorsed a bundled-payment approach by public and private payers and supported tying payment to client outcomes to reflect CSC's recovery orientation.

Conclusions: Reliance on FFS insurance billing and public funding is likely to be unsustainable. Additionally, FFS billing is misaligned with CSC goals. Because of the diversity in CSC programs, populations, and existing funding mechanisms and rules, payer-provider collaboration will be essential in designing a bundled-payment model that meets local needs.

Send correspondence to Dr. Bao (yub2003@med.cornell.edu).

This study was presented in part as a podium presentation at the virtual AcademyHealth Annual Research Meeting, July 28–August 6, 2020.

The authors report no financial relationships with commercial interests.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Achieving sustainable financing for intensive, team-based interventions is challenging. This challenge is especially true in the treatment of patients with serious mental illness, where outreach, engagement and extensive contact with patients and families, and elaborate team staffing are particularly important.

Psychosis is one of the most serious and disabling mental health conditions. The onset of psychosis, typically in late adolescence or early adulthood, often derails individuals' lives just as they are beginning employment or college and puts them at high risk for ongoing disability. The economic burden of schizophrenia, a serious mental illness that often causes psychotic symptoms, was estimated at $155.7 billion in 2013 in the United States alone (1). The state-of-the-art treatment for people experiencing early stages of psychosis is known as coordinated specialty care (CSC) (2). This care is delivered by a multidisciplinary team of clinicians and non-clinical specialists, based on the principles of shared decision making, and aimed at maximizing recovery, including improving social and occupational functioning and managing psychiatric symptoms. Community outreach is an integral CSC component because of the program's emphasis on reaching individuals in the early phases of illness. Strong research evidence is accumulating that supports the effectiveness and feasibility of community implementation of CSC (3, 4).

In 2014, Congress increased the federal Mental Health Block Grant (MHBG) by 5% and earmarked these funds to states for implementation of early interventions for people with serious mental health conditions. This set-aside funding, later doubled to 10% starting in 2015, spurred national CSC implementation. In 2018, about 215 early intervention programs nationwide received MHBG set-aside funding (5).

Continued expansion of CSC calls into question the sustainability of current financing mechanisms. MHBG set-aside and other state funding are subject to legislative renewal and annual appropriations and can be eliminated or diverted to other purposes. Moreover, because the earmarked funding is determined as a percentage of total MHBG funding to a state, as CSC capacities increase, the relatively fixed funding is divided among an increasing number of programs and client caseloads throughout the state, effectively reducing funding received by each program and compromising a program's ability to deliver high-fidelity CSC services. Insurance billing, on the other hand, is likely to cover only a small fraction of the operating costs of CSC programs (6), even under optimal billing as seen in New York State (7), where Medicaid provides coverage for supported employment and education (SEE) and peer services through the home and community-based services provision, case or care management services, and clinical services, yet covers only 48% of CSC program costs. In addition to concern about financial viability, the patchwork approach seen in CSC financing (8, 9) raises concerns about program fidelity, because the process of maximizing revenue from existing financing streams may not be aligned with best meeting client goals and needs.

In this study, we sought to explore the following questions: What are the prominent approaches to CSC financing as observed in community-based implementation 5 years after the start of the MHBG set-aside? How sustainable are these approaches (and therefore the population deployment of CSC)? What do CSC program directors or leaders envision as

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

viable payment models that would allow them to continue to deliver and expand evidence-based CSC? To answer these questions, we conducted a qualitative interview study to systematically solicit CSC provider perspectives from a diverse set of CSC programs around the country.

METHODS

Participant Recruitment

We used purposeful sampling to recruit professionals (program directors, team leaders, and other administrators) from CSC provider organizations across the United States. We initially sent a recruitment e-mail in June 2019 to recipients of a national e-mail Listserv (from the Prodrome and Early Psychosis Program Network) serving the CSC provider community. We subsequently supplemented such recruitment with snowball sampling on the basis of recommendations from the informants. Participants provided oral consent before beginning the interview. Each CSC program participating in the study received a $50 American Express gift card. This study was conducted in accordance with a protocol approved by the institutional review board of Weill Cornell Medicine.

Interview Guide

We developed a semistructured interview guide to cover three major domains: current financing approaches adopted by the CSC program, perceived sustainability of the current approaches, and perceived ideal payment models. Open-ended questions allowed informants to elaborate on issues they considered most salient. Additionally, we collected information on each CSC program, including organizational affiliation, client eligibility criteria, referral sources, team caseload, and CSC team staffing. The interview guide is available in an online supplement to this article.

Interviews

Two investigators (Y.B. and M.A.P.) conducted the interviews via Zoom teleconferencing software between July 2019 and February 2020. Interviews typically were held with the program director or team lead of the CSC program and occasionally with an additional staff member. Three of the interviews were with individuals who had spearheaded CSC implementation in their state and who now had consulting and other leadership roles. Two informants held dual roles as program directors at their own site and trainers or coordinators for CSC implementation at multiple sites in their state. Interviews lasted on average 1 hour. The interviews were audio recorded and were transcribed verbatim by one investigator (M.A.P.). Notes taken during and immediately after the interview were incorporated into the data analysis (10).

Qualitative Data Analyses

The qualitative data were analyzed by using an integrated approach, which included the principles of inductive reasoning and grounded theory (11) and a deductive framework for code organization (12). In this approach, researchers begin with and iteratively revise an organizing framework, attributing labels (codes) to salient text within transcripts and documenting recurring themes that emerge. In following accepted, qualitative data-coding

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

approaches (13, 14), two investigators (Y.B. and M.A.P.) independently coded each transcript and met to discuss the code definitions and negotiate a consensus. A third investigator (R.L.) independently coded two transcripts and participated in coding meetings to provide an outside perspective and to help in reaching consensus. The codebook and themes were iteratively developed throughout this process. (The final codebook is available from the authors on request.) The qualitative analysis software NVivo, version 12, was used to facilitate text and code management and development of themes.

RESULTS

We interviewed 23 individuals, representing 19 CSC programs (six from the Northeast, four from the South, five from the West, four from the Midwest) in 14 states. Of the 19 programs, nine (47%) were located at independent behavioral health organizations, four (21%) were affiliated with integrated health care systems, and six (32%) were affiliated with academic medical centers. Years of operation (median=5 and range=1–19), number of CSC clients served (mean6SD was 62642), and eligibility criteria and referral sources all varied among the 19 programs. Eleven (58%) of the programs reported adopting a CSC model that had strong research evidence (e.g., OnTrack, NAVIGATE, Early Assessment and Support Alliance, and Portland Identification and Early Referral) or a hybrid model that drew components from multiple major models. Compared with the 215 programs participating in a 2018 national survey of CSC programs receiving MHBG set-aside funding (15), the 19 programs in our study were larger in terms of team caseload and had been in operation for a longer time but were comparable on other dimensions. Below, we summarize the major themes that emerged from the interviews.

Patchwork Approach to CSC Financing

All 19 programs reported a mix of funding sources. Eight (42%) of the programs reported insurance billing as their primary source of funding, supplemented by MHBG, other federal and state funding, or research funding. Of these eight programs, four had robust Medicaid fee-for-service (FFS) coverage for SEE, peer specialist, or care or case management services (in addition to the clinical services typically covered by Medicaid). These four programs also billed private insurance, which provided much more limited coverage of CSC activities, especially for services delivered by non-clinical staff or in the community. Three programs received bundled payments from Medicaid. One of these three programs received a cost-based daily rate through participation in the Certified Community Behavioral Health Clinics demonstration program that comprehensively covers CSC costs. The daily rate was determined by dividing actual annual CSC program operation costs by the total volume of visits to the program. The other two programs received a cost-based, monthly bundled payment from the local Medicaid-managed care organization, which used the “in lieu of services” provision (i.e., that CSC, because of its medical necessity and cost effectiveness, is provided in lieu of other covered services) (16). For both of these programs, actuarial studies of costs of bundled CSC services provided the basis for the monthly rate, although the bundled payment received by one of the programs did not cover SEE services. One of the 19 programs (5%) derived its revenue entirely from billable services to Medicaid and private insurance; the program was not eligible for MHBG, according to rules of its state,

Author Manuscript

and had to refer patients to a nearby community mental health center for CSC services that were not reimbursable. For 10 of the 19 programs (53%), MHBG, state funding, and other federal funding (e.g., grants from the Substance Abuse and Mental Health Services Administration [SAMHSA]) were primary funding sources. Of these 10 programs, three did not bill insurance (public or private) at all. Abundance of non-MHBG state funding varied substantially across states, ranging from no funding to 4–5 times the amount of the MHBG set-aside. When distributing funding to CSC programs, states typically combined MHBG and any state funding. However, how CSC programs could tap into funding varied substantially, ranging from a lumpsum grant based on estimated population needs in the program's catchment area, to "net-deficit" funding where state grant funds supplemented program costs not covered by insurance billing, to staff time–based billing to the state for services than could not be reimbursed by other sources.

Misalignment of Existing Financing Approaches With Sustained CSC Implementation

Existing payment mechanisms involving insurance billing typically do not cover several essential and integral CSC elements, such as SEE services, peer services, and care or case management. Team meetings, supervision, and community outreach activities are CSC linchpins, but because they do not directly involve enrolled clients, they are not covered by insurance. As a result, teams that were ineligible for MHBG or state funding, or whose state contract required service-by-service billing, heavily staffed their teams with licensed professionals eligible to bill. They also sometimes chose not to provide the uncovered services and instead referred clients to partner organizations that had the means to provide them, leading to potential care fragmentation. In addition, several teams we interviewed expressed concerns that the limited insurance coverage of CSC services encouraged insured clients and families to pick and choose what services they wanted to receive and to refuse services that were not covered or were inadequately reimbursed by their insurance, thus compromising fidelity to CSC.

For covered services (e.g., medication management and individual and group therapies), the standard insurance billing rate was deemed inadequate for the intensity of services required for CSC. Several informants expressed concern that, if they had to rely on insurance billing, they could not deliver the program effectively. In addition to forgoing critical services like SEE, they would have to increase provider caseload to meet productivity targets. One CSC program was grateful for receiving enhanced FFS rates from a managed care plan in recognition of the high intensity of the services provided.

The restrictive conditions associated with FFS insurance billing were further misaligned with CSC goals. With a few exceptions in Medicaid, FFS coverage applies to in-clinic service delivery only. Several informants emphasized how meeting the needs of CSC clients required flexible and innovative service delivery, for example, by meeting at a coffee shop in the community or by addressing a crisis over the phone. However, by doing so, CSC programs risked not being reimbursed for such services, including travel time. Another prominent issue was reimbursement for services involving multiple providers (e.g., a therapy session where multiple therapists are present or receipt of services from multiple providers during a single client visit to the clinic). Because of restrictive payment rules in such

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

circumstances, several provider teams reported having to devise strategies to maximize the billing yield.

Finally, FFS insurance billing consumed substantial staff time and resources. CSC programs engaged in insurance billing expressed frustration with claim submission, rejection, resubmission, and required paperwork. One informant indicated that, although insurance was estimated to cover 40% of the operating costs of their program, they could recover only about 10%. A staff member from another CSC program estimated that they "bring in about 30 cents on the dollar of what's billed out." The high cost of billing and low capture rate is especially unsustainable for small, independent provider organizations that neither benefit from the billing infrastructure of large organizations nor receive intraorganization subsidies.

Overall, CSC programs in our study considered MHBG and state funding relatively stable funding sources, especially if the funding was legislatively earmarked and if a few years remained in the legislative cycle. However, several CSC informants expressed concern about the grant nature of these sources and the inherent unsustainability, as in the following quote: "I have a fear every day as we get closer to June that if the grant funding goes away, we simply are not sustainable."

Perceived Ideal Payment Models

When asked what would be an ideal way of paying for CSC, informants from 15 of the 19 programs (79%) endorsed the idea of a cost-based bundled payment and used terms such as "program fee," "per diem," "per month," and "capitated arrangements." The informants believed that such a payment model would shift the focus from productivity (in terms of billable encounters) to holistic problem-solving and innovation, with the explicit goal of improving client engagement, outcomes, and experience. A staff member from one program already receiving a Medicaid bundled payment for CSC said that the bundled payment "shifts the focus … to the actual participants and what their experience is" with respect to the services that can be delivered under a bundled-payment model.

In addition to a bundled payment, the vast majority of informants also endorsed holding CSC programs accountable for client outcomes in the form of a value-based payment. There was high consensus opinion regarding the types of client outcomes to incentivize, including engagement in employment or school and stable housing and avoidance of criminal justice involvement and hospitalization or emergency department visits for behavioral health issues. Although none of the 19 programs had their funding or payment explicitly tied to client outcomes at the time of the interview, nearly half (N=9, 47%) routinely collected client outcomes data and reported them regularly. Staff from several CSC programs expressed concern, however, about having hospitalization or emergency department visits as a performance measure, citing perverse incentives for denying clients hospitalization when they need it.

DISCUSSION

Conducting interviews with leaders from 19 CSC programs around the United States, we found that financing approaches to CSC are insufficient, patchwork, and highly varied.

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

The CSC programs in our study tapped into three major funding sources: FFS insurance billing to Medicaid and private insurance, MHBG, and state general funds. Study informants described limited benefits and restrictive rules associated with FFS insurance billing and believed that these were misaligned with the CSC model. Informants also believed that the grant nature of MHBG and other public funding threatened the long-term sustainability and population deployment of CSC. CSC stakeholders in our study endorsed a bundled-payment approach and supported the idea of tying payment to client outcomes reflecting CSC's recovery goals.

Reliance on MHBG and other public funding sources to support daily operation of CSC programs was seen as cause for concern, because these funds may not be reappropriated in future legislative or fiscal cycles. More importantly, even if overall appropriations for mental health services remain constant, funding for any specific program, such as CSC, would likely decrease as new programs are implemented. These concerns loom as the COVID-19 pandemic takes its toll on economic activities and government tax revenues.

Interviewed staff in our study endorsed an approach of bundled payment by public and private insurers. For Medicaid, several existing legislative or program mechanisms exist to operationalize a cost-based bundled payment. They include a state Medicaid plan amendment to obtain a rehabilitation option coupled with home- and community-based services coverage for SEE and other services, a 1115 demonstration waiver to meet the needs of Medicaid enrollees with serious mental illness, the "in lieu of services" option in Medicaid-managed care, and the Certified Community Behavioral Health Clinics demonstration and expansion grants from SAMHSA (16), the latter two of which were represented in our study. The current patchwork approach in CSC financing, however, poses challenges for operationalizing a bundled payment across multiple funding sources. Program sustainability would be greatly enhanced if a bundled payment through public or private insurance sources closely covered all costs of program operation. Block grant and state funds could then be freed up to support program start-up, capacity building, network learning, and expansion.

Fulfilling the promise of a bundled-payment model may hinge on the model's specific design and implementation. Credentialing and certification of CSC programs and ongoing monitoring and reporting requirements are needed to ensure fidelity to CSC. These measures, when used as conditions for payment, will also counteract the perverse incentives for skimping that are intrinsic to any bundled payment. Whether risk adjustment is warranted for a bundled payment for CSC and how to risk-adjust remain areas to be tackled by future research and practice. Moreover, what services are to be bundled and how much the case rate should be will need to be determined locally. We are currently developing a decision-support tool to assist CSC stakeholders in making such decisions (17).

This study had a few limitations. We sought to achieve in-depth understanding of CSC financing in the diverse context of state implementation of CSC. The purposeful sampling design of this study did not allow us (and was not meant) to provide nationally representative estimates. Our findings were based on interviews with CSC program leaders and reflected the perspectives of CSC provider organizations. Although such perspectives

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

are appropriate for understanding current financing approaches and alignment with CSC service delivery, future studies should assess perspectives of other stakeholders and, in particular, public and private payers, regarding the design and operation of CSC payment models.

CONCLUSIONS

CSC programs represent an example of a multidisciplinary team providing care coordination and clinical, educational, family, and vocational interventions. This approach has been shown to be both clinically effective and cost-effective for multiple types of serious behavioral health conditions. Our study provides qualitative evidence on the patchwork approach to CSC financing currently used around the country, with programs relying heavily on insurance billing and MHBG set-aside or state funding. These approaches may be inadequate, unsustainable, or misaligned with deployment and the public health and recovery orientation of CSC. Given that bundled payment was highly endorsed by CSC programs in our study, stakeholders should consider moving toward bundled-payment approaches tailored to local circumstances.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Acknowledgments

This study was supported by the Robert Wood Johnson Foundation's Systems for Action Program (grant 74947) and the Early Psychosis Intervention Network (National Institute of Mental Health Cooperative Agreement 1U24-MH-120591).

REFERENCES

1. Cloutier M, Aigbogun MS, Guerin A, et al. : The economic burden of schizophrenia in the United States in 2013. J Clin Psychiatry2016; 77:764–771 [PubMed: 27135986]
2. Heinssen RK, Goldstein AB, Azrin ST: Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care. Bethesda, MD, National Institute of Mental Health, 2014. https://www.nimh.nih.gov/health/topics/schizophrenia/raise/evidence-based-treatments-for-first-episode-psychosis-components-of-coordinated-specialty-care.shtml.AccessedSeptember 24, 2020
3. Kane JM, Robinson DG, Schooler NR, et al. : Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. Am J Psychiatry2016; 173:362–372 [PubMed: 26481174]
4. Dixon LB, Goldman HH, Bennett ME, et al. : Implementing coordinated specialty care for early psychosis: the RAISE connection program. Psychiatr Serv2015; 66:691–698 [PubMed: 25772764]
5. The Mental Health Block Grant Ten Percent Set Aside Study Brief Report: National Overview of CSC Programs. Falls Church, VA, Westat, 2019. https://www.nri-inc.org/our-work/nri-reports/brief-report-national-overview-of-csc-programs.AccessedSeptember 24, 2020
6. The Mental Health Block Grant Ten Percent Set Aside Study Brief Report: Financing and Funding for CSC Programs. Falls Church, VA, Westat, 2019. https://www.nri-inc.org/our-work/nri-reports/brief-report-financing-and-funding-for-csc-programs.AccessedSeptember 24, 2020
7. Smith TE, Kurk M, Sawhney R, et al. : Estimated staff time effort, costs, and Medicaid revenues for coordinated specialty care clinics serving clients with first-episode psychosis. Psychiatr Serv2019; 70:425–427 [PubMed: 30914002]

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

8. Goldman HH, Karakus M, Frey W, et al. : Economic grand rounds: financing first-episode psychosis services in the United States. Psychiatr Serv2013; 64:506–508 [PubMed: 23728599]

9. Shern D, Neylon K, Kazandjian M, et al.: Use of Medicaid to Finance Coordinated Specialty Care Services for First Episode Psychosis. Alexandria, VA, National Association of State Mental Health Program Directors, 2017. https://www.nasmhpd.org/sites/default/files/Medicaid_brief_1.pdf

10. Miles MB, Huberman AM: Qualitative Data Analysis: An Expanded Sourcebook. Thousand Oaks, CA, SAGE Publications, 1994

11. Glaser BG, Strauss AL: The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago, Aldine De Gruyter, 1967

12. Bradley EH, Curry LA, Devers KJ: Qualitative data analysis for health services research: developing taxonomy, themes, and theory. Health Serv Res2007; 42:1758–1772 [PubMed: 17286625]

13. Armstrong D, Gosling A, Weinman J, et al. : The place of inter-rater reliability in qualitative research: an empirical study. Sociology1997; 31:597–606

14. Hill CE, Knox S, Thompson BJ, et al. : Consensual qualitative research: an update. J Couns Psychol2005; 52:196–205

15. The Mental Health Block Grant Ten Percent Set Aside Study Final Report: Substance Abuse and Mental Health Services Administration. Falls Church, VA, Westat, 2019

16. Shern D: Financing Coordinated Specialty Care for First Episode Psychosis. SMI Advisor: National Association of State Mental Health Program Directors. Alexandria, VA, National Association of State Mental Health Program Directors, 2020. https://smiadviser.org/wp-content/uploads/2020/08/CSC-Issue-Brief_v2-081320.pdf

17. Bao Y, Li Y, Jeng PJ, et al. : Design of a payment decision-support tool for coordinated specialty care for early psychosis. Psychiatr Serv2021; 72:180–185 [PubMed: 33267653]

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

HIGHLIGHTS

- Additional earmarked federal Mental Health Block Grant (MHBG) funding to U.S. states has spurred national implementation of coordinated specialty care (CSC) for psychosis.
- Qualitative interviews with informants from 19 CSC programs in 14 states were conducted to gain an understanding of current financing approaches, alignment or misalignment of these approaches with CSC goals, and CSC provider perspectives on ideal payment models.
- Financing approaches for CSC remain insufficient, patchwork, and highly varied, with programs relying heavily on insurance billing and MHBG set-aside or state funding.
- CSC provider stakeholders endorsed a cost-based bundled-payment approach to CSC financing.