Tennessee Department of Mental Health and Substance Abuse Services

KEEPING THE DOOR OPEN:
Building Systems that Sustain Coordinated Specialty Care Programs

Tennessee Statewide Early Psychosis Summit

Tennessee Department of Mental Health and Substance Abuse Services

Dr. Shern joined the National Association of State Mental Health Program Directors in the fall 2012 as a Senior Public Health Advisor. This followed Shern stepping down as President and CEO of Mental Health America, formerly the National Mental Health Association, the country's oldest and largest advocacy group addressing all aspects of mental health and mental illness. Prior to joining MHA in 2006, he was dean and professor at the Louis de la Parte Florida Mental Health Institute (FMHI) at the University of South Florida, at the time one of the nation's largest research and training institutes in behavioral health. Shern also founded and directed the National Center for the Study of Issues in Public Mental Health – a National Institute of Mental Health-funded services research center - located in the New York State Office of Mental Health (OMH).

In addition to advocacy and public education, his research has spanned a variety of mental health services research topics including epidemiological, service system organization and financing issues largely focused on persons with severe mental illnesses. More recently he worked on several projects related to early intervention in psychosis as well as the prevention and promotion in behavioral health with a strong emphasis on reducing traumatic exposure and bolstering resilience.

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Tennessee Statewide Early Psychosis Summit

Keeping the Door Open: Building Systems that Sustain Coordinated Specialty Care

David Shern, PhD

Tennessee Early Psychosis Summit

Virtual Event

September 25, 2025

Agenda

The Legacy of Deinstitutionalization and State Mental Health Programming

The Promise of Prevention and Early Intervention

Coordinated Specialty Care

Financing Challenges and Strategies

Importance of an Insurance Benefit Coverning the Full Cost of the Program

Next Steps to Insure Sustainable Programs

Legacy of Deinstitutionalization

- Cycles of Reform in Mental Health Systems
- Legacy of response to deinstitutionalization
- Since the 1980s, public mental health systems have focused on persons with the most severe illnesses
- Creation of the Mental Health Block Grant in Reagan Administration
- States increased control of federal funding

Increasing Interest in Early Intervention for Potentially Severe Mental Illnesses

- Strong scientific basis for prevention and early intervention
- Increasingly, the federal and state government have shown renewed interest in prevention and early intervention
- Promise of reducing disability
- Improving functioning and well being

Early Intervention is Important

- Mental illnesses are the most disabling medical conditions
- These are Global burden of disease estimates for common mental illnesses
  - Vary from 0 to 1
  - Median estimate .128 for all health conditions
  - Schizophrenia had the greatest burden of disease of any health condition

Schizophrenia
- Acute 0.778
- Residual 0.588

Bipolar Disorder
- Manic Phase 0.492

Anxiety Disorder
- Severe 0.523

Major Depression
- Severe 0.658

Early Intervention Requires Early Identification

- Outreach and Public Education Activities
- Screening and Referral
- Often involves multiple human service systems
  - Educational Settings
  - Primary Care
  - Juvenile Justice
  - Child Welfare
  - Faith Based Settings

Can Involve Multidisciplinary Teams

- Coordination across service systems
- Multiple roles and expertise
- Intensive team activities
- Engagement processes

Financing Can Be a Challenge

- Multiple players across systems may need support
- Full range of treatment and support activities may not have a payment method
- New group 'technologies' should not be deconstructed

Coordinated Specialty Care

CSC 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.

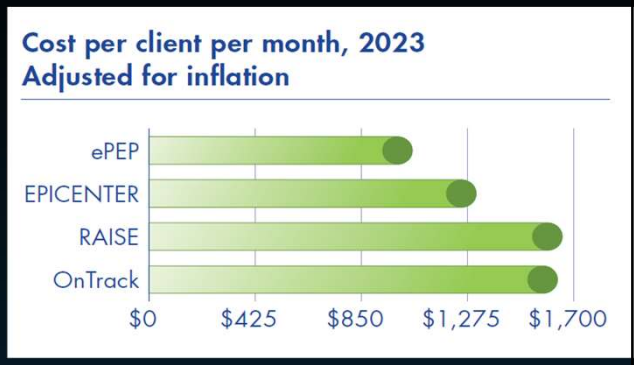
- Psychotherapy
- Medication Management
- Family education and support
- Service coordination and case management
- Supportive employment and education
- Peer Support

In addition to these specific services, CSC involves

- Intensive outreach and engagement
- Services delivered at time and place convenient for patient
- Frequent team meetings to assure coordination
- Frequent collateral contacts
- Small caseloads
- Unlicensed team members
- Specific training requirements for working with younger population in age-appropriate way
- Fidelity monitoring

Benefits of CSC

Costs of CSC Services in the United States



International Early Psychosis Intervention Costs and Outcomes Research

14 of 15 international 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.

Substantial Unmet Population Need for CSC Services

- NIMH Estimates approximately 100,000 new cases of psychosis per year
- In 2021 24,206 individuals were admitted to care for FEP
- 75% of incident cases not treated resulting in substantial unmet need

Event Name or Group Presenting

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Social Cost Savings for Population Access to CSC

Expanding access to CSC from the current baseline of 10-25% to an aspirational target of 90% access could, over the course of 10 years:

- Provide care to an additional ~600-800K individuals
- Generate ~$115-140B in savings

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Over 10 years, a system that addresses 90% of need in United States could generate up to ~$140B in system savings

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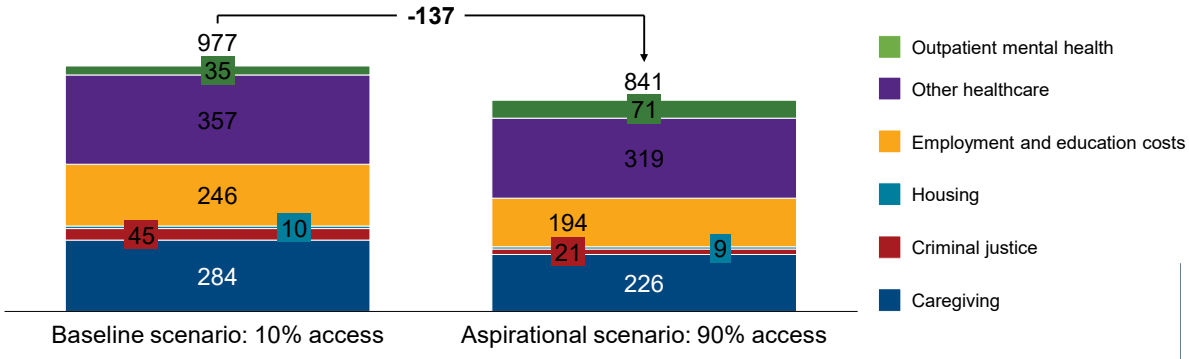
Federal spending on healthcare, social services and lost productivity
Cumulative costs over 10 years, billions of dollars



1. Individuals who receive access within the first year of experiencing psychosis symptoms; Source: FEP National Impact Model, FEP Interactive Calculator Preview

Scaling Coordinated Specialty Care for First Episode Psychosis NAMI 19

CSC Goal - Access for Everyone Experiencing Early Psychosis

In order to have population coverage…

1. Must have a viable funding mechanism that covers the full cost of the program.
2. Current funding relies on a mixture of fee for service insurance payments (mostly Medicaid), federal block grant dollars, and state resources

Current Funding Mechanisms

- Mental Health Block Grant (MHBG) ESMI set-aside helps support initial implementation but is inadequate for meeting the needs of the entire population experiencing early psychosis
- Programs typically use a mixture of block grant funds, state general funds and insurance payments (Medicaid, Medicare, and Commercial) to cover full cost of the program.
- Even in states with expansive Medicaid benefits only half of program costs can be covered.

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Current Funding Mechanisms

- Reliance on discretionary resources threatens long term sustainability.
- Without establishing an insurance benefit **that covers the costs** of the program, the population in need will never be served.
- Lack of a specific billing code for CSC presented an impediment to insurance payment.

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In December 2022 NASMHPD and colleagues applied to CMS for issuance of a HCPCS code specifically for CSC

- Much like the Healthcare Common Procedure Coding System (HCPCS) codes for other team based intensive services
  - Assertive Community Treatment
  - Multisystemic Therapy
- The code should be inclusive of all activities performed by the CSC team
- Will be billed by the team and not individual practitioners
  - No confusion with other services that have existing HCPCS or Current Procedural Terminology (CPT) codes

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Issuance of a HCPCS code by CMS

- The application and response to questions documented that use of existing fee for service (FFS) codes does not result in recovering full cost of the program
  - Current FFS codes are based on office based services – not community based like CSC
  - Several key components of the program (like intensive team interaction, training) are not billable services
- The application was approved, and CMS issued HCPCS codes for team based billing in October 2023
  - H2040, “Coordinated specialty care, team-based, for first episode psychosis, per month”
  - H2041, “Coordinated specialty care, team-based, for first episode psychosis, per encounter”

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Practical implications of having a billing code

- National recognition of legitimacy of CSC services
- Supports efforts to calculate billing rate for team based care
- Facilitates insurance billing – both public and private
- Strengthens legal arguments regarding parity of mental health services

Commercial Insurers are Important Payers for FEP Services

- These are conditions that affect adolescents and young adults
- Young people are more likely to have insurance than traditional public sector clients
  - Either their own or family insurance through the Affordable Care Act
- Estimated 35% of FEP clients have commercial insurance
- Commercial benefits are much more limited than Medicaid

Marginal Increases in Insurance Premium if CSC services were Universally Available

- Based on information from Rosenheck et al's cost effectiveness study, we identified the additional cost per month to provide CSC services rather than usual treatment. Rosenheck et.al., 2016, Shern D, 2020
- Using incident estimates from two recent rigorous studies – one commercial and one Medicaid population, and
- The population structure for New York State in 2010,
- We estimated that the additional cost to an insurance premium of $0.16 per member per month with a two-year length of stay in CSC.
- If only 75% of incident cases are served the costs drop to $0.12 per member per month or an additional premium of $1.44 per year.

Medicaid Financing Strategies

- Amend the State Plan
- Use Medicaid Managed Care 'In lieu of' Provision
- Use Comprehensive Community Behavioral Health Center Financing

Amend the State Plan

To use this option states must

- Request that CMS cover CSC as an evidence-based service under the rehabilitation option
- Calculate a reimbursement rate that anticipates
  - Small caseloads, team staffing, training, and certification
  - Reimbursement rate is calculated by dividing program costs by anticipated number of encounters or members who receive minimum number of contacts.
- Outreach and public education can be reimbursed through a separate contract using Medicaid administrative funds

Medicaid Managed Care

For states that have Medicaid Managed Care Programs (MCOs)

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

Certified Community Behavioral Health Clinic (CCBHC)

- Quite compatible with CSC
  - Core components include care coordination, outreach and public education, relationships with schools, patient engagement, recovery orientation, etc.
- CSC could be required by the state as an evidence based practice
- Addresses many of the problems CSC programs face
  - Includes the full cost of CSC in the per diem rate
  - Training, TA and program evaluation costs included
  - Salaries are set a market rates
  - Services can be delivered on contract to a collaborating specialty program or delivered in house

Summary

- We have a strong research base on the effectiveness of CSC in reducing costs and improving outcomes
- While substantial growth has occurred in CSC programs across the nation, it is estimated that 75% of persons with FEP do not receive CSC
- Assuring population coverage and quick access to CSC is estimated to save approximately $140 billion over a ten year ramp up period
- An insurance benefit that covers the full cost of the program is needed for population coverage
- Several strategies are available to obtain Medicaid funding to cover the full cost of the program.
- Commercial insurance coverage for this young adult population will be a critical part of the payer mix.

Other Issues that Must be Addressed for Sustainability and Program Effectiveness

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Fidelity and Benchmarking

- Assuring Payers that the CSC they are funding meets fundamental aspects of the program model.
  - Fideiliity Measures Employed
- Benchmarking Outcomes Accomodations to Local Circumstances
  - Are the expected outcomes being achieved

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Outreach and Engagement

- Major finding of the RAISE study
  - Reducing Duration of Untreated Psychosis major predictor of outcomes.
- Outreach to referral sources must be continuous
- Public education can be effective
- Rapid contact and engagement is critical
  - Agency barriers
  - Client/Family Barriers

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Workforce

- Recruitment and retention continue to be challenging
- CCBHCs paying market rates may help with compensation
- Support for continuing professional development and career ladders can be helpful
- Potential work with higher education on training for work with people experiencing psychosis

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Rural Services

- Low population density can be challenging for team based services
- Model adaptations may be required
  - Hub and spoke models one potential solution
  - Hybrid models
    - Staff with multiple roles/competencies
    - Shared FTE with other duries/services

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Some Upcoming Resources

- Resolution of the Federal budget
  - Continuing set aside in the MHBG
  - Impact on Medicaid funding/participation
- SAMHSA use of recently convened expert panel findings designed to update the NIMH 2014 paper that defined CSC
- Work of the Kennedy Forum in billing commercial insurers who have incorporated the HCPCS codes
  - Reps from CA, WA, MA, VA, NC, FL, MN, IL, and ME

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Overall Summary

- States are increasingly realizing the importance of prevention and early intervention
- We have a strong scientific base for providing early intervention services in psychosis
- Discretionary block grant resources have been critical in program expansion
- Realizing full population coverage and sustainable programming will require insurance reimbursement for the full program cost
- CMS issuance of billing codes and their incorporation into both public and private payers is an important step toward insurance reimbursement.
- Sustained program integrity and effectiveness requires ongoing quality improvement

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THANK YOU

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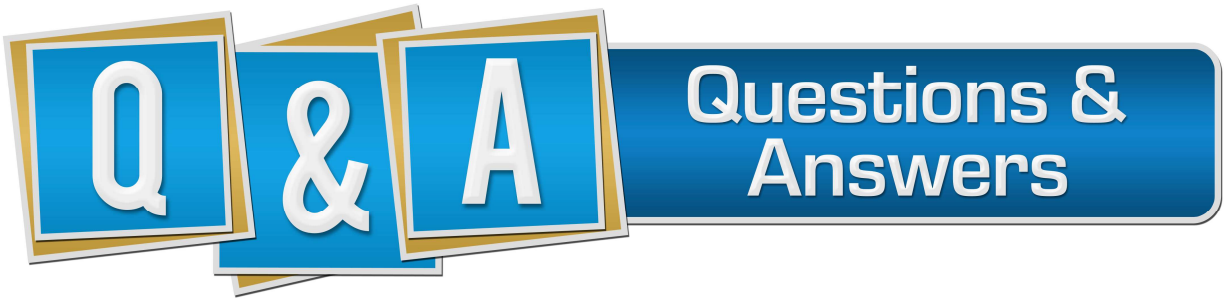

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