Strategies to Achieve Alignment, Collaboration, and Synergy Across Delivery and Financing Systems

Financing Integrated Health and Social Services for Populations with Mental Illness

Research In Progress Webinar
Wednesday, September 11th, 2019
12:00-1:00 pm ET/9:00-10:00am PT

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Agenda

Welcome: Glen Mays

Presenters:
Yuhua Bao, PhD
Thomas Smith, MD
Lisa Dixon, MD, MPH

Commentary:
Cathy Adams, LMSW, ACSW, CAADC is the
Co-owner and Clinical Director of ETCH
(Early Treatment and Cognitive Health)

Q&A: Moderated by Glen Mays

Yuhua Bao, PhD

Yuhua Bao, PhD is a health economist and associate professor at Weill Cornell Medical College in New York City. Her research is concerned with economic and policy strategies to support evidence-based care for mental health and substance use conditions. One current area focuses on innovative payment models for integrated and specialized services for people experiencing early psychosis. Her research has been supported by the National Institute of Mental Health and private foundations such as the Robert Wood Johnson Foundation.

Lisa Dixon, MD, MPH

Lisa Dixon, M.D., M.P.H. is a Professor of Psychiatry at the Columbia University Medical Center and the director of the Division of Behavioral Health Services and Policy Research within the Department of Psychiatry. She also directs the Center for Practice Innovations (CPI) at the New York State Psychiatric Institute. As CPI director, she oversees activities for the New York State Office of Mental Health in implementing evidenced based practices for persons diagnosed with serious mental illness. She is leading the innovative program, OnTrackNY, a statewide initiative designed to improve outcomes and reduce disability for the population of individuals experiencing their first episode of psychosis.

Thomas E. Smith, MD

Thomas E. Smith, MD is Chief Medical Officer, NYS Office of Mental Health (OMH), Medical Director of NYS OMH's Division of Managed Care, and Special Lecturer in the Department of Psychiatry at Columbia University. Dr. Smith has directed behavioral health programs for individuals with serious mental illness in both community and academic settings for over 25 years and has conducted extensive research on the factors that predict recovery from chronic illness in this population.

Cathy Adams, LMSW, ACSW, CAADC

Cathy Adams, LMSW, ACSW, CAADC is the Co-owner and Clinical Director of ETCH (Early Treatment and Cognitive Health) which provides NAVIGATE model interventions to young adults experiencing a first episode of psychosis and their families. Cathy is also the Trainer/Consultant for Michigan's NAVIGATE teams and serves on multiple committees within Michigan, and nationally, targeting the development, implementation and expansion of early intervention programming. Cathy has frequently been a speaker on the early treatment of psychosis.

Research Team

Yuhua
Bao, PhD

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Jennifer
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MPH

Michelle Papp, BA

Rufina Lee, PhD

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Outline of the presentation

- Why do we need a payment design tool for early psychosis programs?

- Our S4A developmental project (2017-2018)

- Our current S4A project (2019-2021)

- Demonstration of payment tool prototype

- Stakeholder feedback

- Q&A

- Peak onset between 15 and 25 y.o.
- It can be years before a formal diagnosis is made
- Onset of condition usually derails an individual, leading to disruption in school or employment
- Without addressing recovery and function, it can lead to life-long disability
- Prior to 2005, many countries started developing early interventions for psychosis, but not US except OR and CA

Coordinated Specialty Care (CSC) changes the paradigm of treating early psychosis

- Principles

  - Recovery orientation

  - Shared decision-making

  - Team of specialists (both clinicians and non-clinicians)

  - Minimize Duration of Untreated Psychosis (DUP)

- Key Service Elements

  - **Case management**

  - **Supported Employment/Education**

  - **Family Education and Support**

  - Psychotherapy
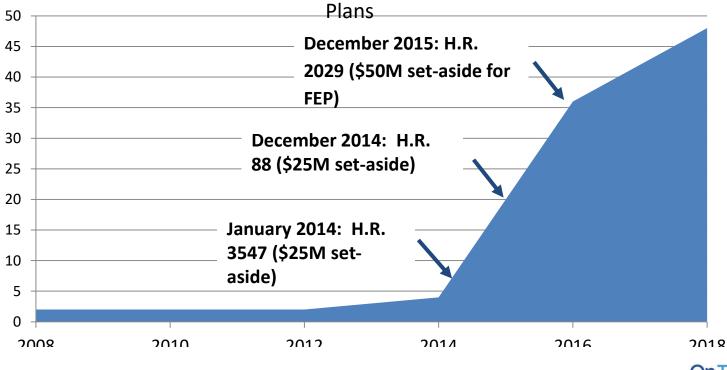
  - Pharmacotherapy

  - **Primary Care Coordination**

https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-coordinated-specialty-care-csc.shtml

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S4A
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Cumulative Number of States with Early Psychosis Intervention Plans

December 2015: H.R. 2029 ($50M set-aside for FEP)

December 2014: H.R. 88 ($25M set-aside)

January 2014: H.R. 3547 ($25M set-aside)

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- Mental Health Block Grant is seriously inadequate for population-wide deployment
- CSC teams typically take a patch-work approach to financing
  - MHBG funding
  - Insurance billing
  - Grants, state/county funding
  - Institutional supplements
- Scaling-up and sustaining CSC calls for a payment system that
  - Adequately covers the cost of CSC – specialized team, small caseload
  - Aligns incentives with patient-centered, recovery-oriented care
  - Tailored to local preferences and practices

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A conceptual model for a multi-part payment system

Frank, Glied, McGuire (2014)

Part I. Per-case payment
covering team leadership, community outreach, case management, supported employment and education (SEE)

Part II. Per-service payment
covering pharmacotherapy, psychotherapy, family psychoeducation, SEE(?)

How will payers operationalize this model?

How much should the payment rate be?

How should they set up the outcome-based payment?

Part III. Outcomes-based payment
rewarding providers for achieving pre-defined target(s)

- **Developed analytical algorithms** of an innovative, multi-part payment model for CSC

- **Developed and pilot tested the prototype of a decision support tool (DST)** that assists CSC payers to tailor payment to local needs and circumstances

Developmental Project: Components and Design Choices of the CSC Payment System

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Part I: Bundled Case-Rate Payment (Must-have)
Covers CSC services that do not have existing or sustained payment mechanisms

DC CSC services to cover
- ❑ Clinical services
  (e.g. pharmacotherapy, psychotherapy)
- ❑ Community-based, non-clinical services
  (e.g. supported employment/education)
- ❑ Case/care management
- ❑ Administrative tasks

DC Type of case-rate payment
- ❑ Fixed case rate
- ❑ Variable case rate

Part II: Outcome-Based Payment (Optional)
Rewards CSC providers for each client achieving a pre-specified outcome

DC Client outcomes to incentivize
- ❑ No psychiatric hospitalization
- ❑ Engagement in employment/education
- ❑ Not involved in legal issues or probation/parole

DC % of case rate payment to devote to outcome-based payment
- ❑ 5%
- ❑ 10%
- ❑ 15%

DC = Design Choice

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- N=4
- One policymaker from NYS, two behavioral health directors (and their colleagues) from Medicaid Managed Care Plans, and one behavioral health director (and colleagues) from a regional, all-payer plan
- Provided valuable feedback on the relevance and usability of tool
- The need to engage CSC provider organizations in designing and implementing a payment system

  "We should be working side by side. …There needs to be buy in from the get go. Otherwise, providers when they see the results of this, they're just going to spend a great deal of time poking holes in why this is not valid … So this has to be a shared tool."

- **Develop a collaborative decision-support tool used by CSC payers and provider organizations** to design a CSC payment system.

- **Conduct user tests of the collaborative decision-support tool with dyads of users** representing payer and provider organizations of CSC.

Current Project: Progress to date

Implementation of computerized tool

- Refine analytical algorithms

- Update tool prototype

- Programming of the real tool

CSC provider team interviews to assess provider perspectives

- Recruit via a national listserv and snowballing

- Current financing approaches

- Financial planning needs

- Feedback on tool prototype

- 13 interviews conducted with informants from 10 states

- Financing approaches run the entire gamut from all or almost all grant-funded to almost all insurance-billing supported
  - State/county funding is, in most circumstances, limited, has restrictive eligibility rules, and is usually paid in lump-sum (i.e., not by clients served)
- Insurance billing is at odds with CSC
  - Regular rates are not adequate to support the specialized, small-caseload nature of CSC
  - Programs devote substantial manpower to getting reimbursement
  - Programs that rely on insurance billing had to forgo essential CSC services (e.g., Supported Employment and Education) that are not reimbursable

- When asked what would be an ideal way of paying for CSC, providers unanimously endorsed the bundled payment idea
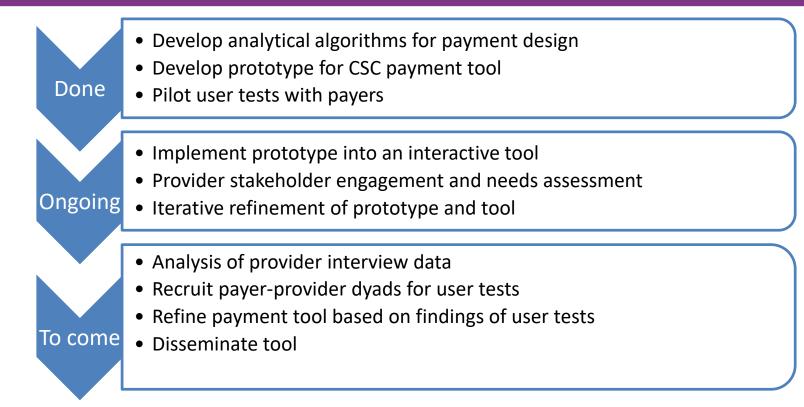
  "bundled rate", "blanket code/fee", "case-rate payment", "program fee", "daily/monthly rate", "per diem"

- Provider stakeholders largely expect current financing model to go on, but were anxious about possible future changes

- Overall, provider stakeholders think our tool is helpful and makes sense

  "In the past when we've kind of talked about doing this… we didn't really know kind of what to base the fee off of, so having these variables actually outlined I think is very helpful."

- They envisioned different ways of making use of the tool

- Their feedback already informed quite a few changes to the prototype

Project Progress and Future Steps

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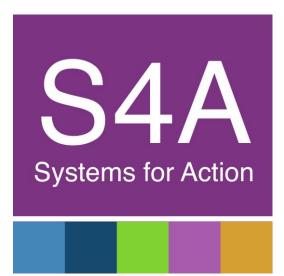
Done
- Develop analytical algorithms for payment design
- Develop prototype for CSC payment tool
- Pilot user tests with payers

Ongoing
- Implement prototype into an interactive tool
- Provider stakeholder engagement and needs assessment
- Iterative refinement of prototype and tool

To come
- Analysis of provider interview data
- Recruit payer-provider dyads for user tests
- Refine payment tool based on findings of user tests
- Disseminate tool

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Thank You!

- Contact: yub2003@med.cornell.edu

Questions?

www.systemsforaction.org

- **October 9th, 2019**

Systems for Action Individual Research Project

Addressing the Health and Social Needs of Justice-Involved Young Adults

George Naufal, PhD, Assistant Research Scientist, Public Policy Research Institute, Texas A&M University and Emily Naiser, PhD, MPH, Project Director, Public Policy Research Institute, Texas A&M University

- **October 23rd, 2019**

Connecting Vulnerable Seniors to Nutrition Assistance Through a Managed Care Plan

Suzanne Kinsky, MPH, PhD, Adjust Assistant Professor, Behavioral and Community Health Sciences, University of Pittsburgh Medical Center and Alex Kalinowski, Benefits Data Trust

Acknowledgements

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