THINK **BIGGER** DO **GOOD**
POLICY SERIES

Coordinated Specialty Care for First-Episode Psychosis

AN EXAMPLE OF FINANCING FOR SPECIALTY PROGRAMS

Lisa B. Dixon, M.D., M.P.H.

Spring 2017

Dear Reader,

Now is a time of change in health and human services policy. Many of the changes could have profound implications for behavioral health. This paper is one in a series of papers focused on behavioral health policy, particularly addressing ways to continue to make progress.

The past decade has been a time of steady advances in behavioral health policy. For example, we have met many of the objectives related to expanding health insurance coverage for people with behavioral health conditions. Coverage is now expected to be on a par with that available to individuals with any other health conditions, although parity implementation has encountered roadblocks. Coverage of evidence-based treatments has expanded with insurance, but not all of these services are covered by traditional insurance, necessitating other sources of funding, such as from block grants.

Much has improved; much remains to be accomplished.

As funders, The Thomas Scattergood Behavioral Health Foundation and the Margaret Clark Morgan Foundation believe that now more than ever philanthropic support in the area of policy is critical to improving health outcomes for all. We ask that you share this paper and the others in the series with your programmatic partners, local, state, and federal decision makers, advocacy organizations, and voters.

We believe that these papers analyze important issues in behavioral health policy, can inform policy-making, and improve health outcomes. We hope these papers help to extend progress and avoid losing ground at a time of change in policy.

Sincerely,

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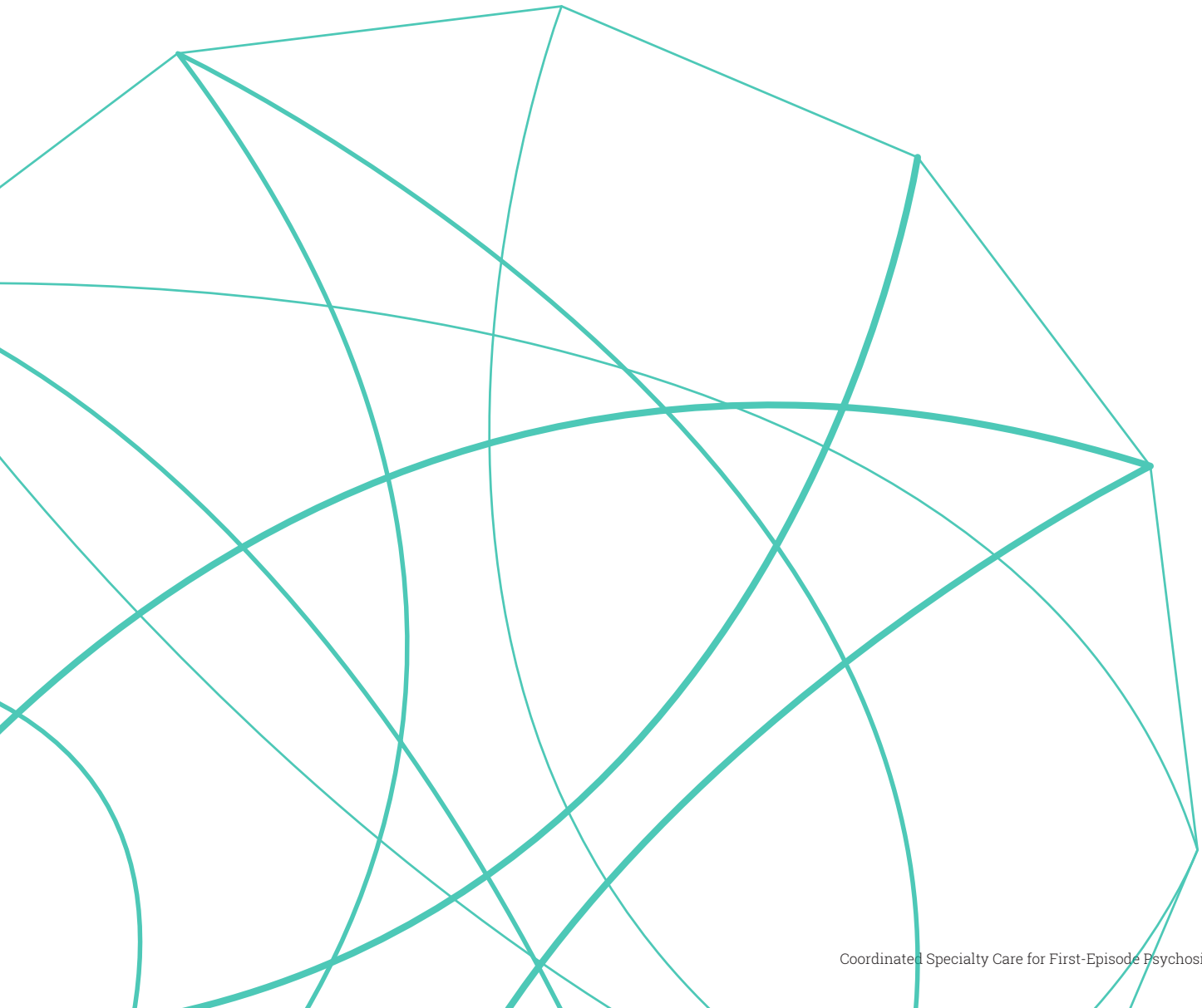

Coordinated Specialty Care for First-Episode Psychosis

AN EXAMPLE OF FINANCING FOR SPECIALTY PROGRAMS

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1 The Challenge

Schizophrenia is a serious mental disorder with a lifetime prevalence near 1% that is associated with high levels of functional impairment. Currently, only 10% to 15% of people with schizophrenia work. The annual cost of schizophrenia in the United States in 2013 was estimated to be $155.7 billion, including significant direct and indirect costs. Delivery of a new treatment approach, called coordinated specialty care (CSC), to every young person experiencing the psychosis of early schizophrenia could change this state of affairs (1).

CSC deploys a new care model developed for young adults with first-episode psychosis that fosters recovery and attempts to prevent disability and may reduce hospitalization and costs. CSC includes evidenced-based psychopharmacologic management, with attention to general health, cognitive and behaviorally oriented individual or group psychotherapy, family support and education, supported education and employment, case management and, more recently, peer support (1,2). Studies of RAISE (Recovery After an Initial Schizophrenia Episode), a project funded by the National Institute of Mental Health, have demonstrated the benefits of CSC programs in the United States and how to implement them (3,4). These studies have also demonstrated that CSC programs are cost-effective.

Coordinated Specialty Care Includes:

1. **Evidenced-based psychopharmacologic management, with attention to general health**
2. **Cognitive and behaviorally oriented individual or group psychotherapy**
3. **Family support and education**
4. **Supported education and employment**
5. **Case management**
6. **Peer Support**

2 The Community Mental Health Block Grant and 21st Century Cures Act

In recognition of the value of CSC programs, in 2014 Congress added 5% to the Community Mental Health Block Grant program. States and federal territories received an additional $25 million to share, with the requirement that the monies be used to develop and support evidence-based programs for individuals experiencing early psychosis. The 5% set-aside for CSC programs continued in 2015, and the allocation was doubled in 2016, providing an additional $50 million for states to share to develop CSC programs (1). In 2008, only two states had such programs. By 2016, 36 states had begun implementing one or more CSC programs. By 2018, that number will grow to 48 states (personal communication, R. Heinssen, National Institute of Mental Health, 2017).

The 21st Century Cures Act continues the allocation to early psychosis treatment, generally requiring states to use at least 10% of their Community Mental Health Block Grant funds on CSC for individuals with early psychosis (5). The good news is that the modest funding allocated through the Block Grant program, which is be maintained in the 21st Century Cures Act, has jump-started a remarkable transformation in the care of individuals with early psychosis that builds on evidence, advocacy, and efficiency.

The continuation of these resources is very promising.

3 Understanding the Problem

The incremental benefits of the Community Mental Health Block Grant and the 21st Century Cures Act will be insufficient to support further implementation of CSC if certain provisions of the Affordable Care Act (ACA) are eliminated and if Medicaid is eroded. The Block Grant funds, because of their limited size, at best build upon provisions of the ACA that have created critical pathways to care for young people who are experiencing the onset of schizophrenia (typically between the ages of 16 and 30).

The ACA and Medicaid provide the foundation of support for early schizophrenia care (6) in the following ways:

The ACA's extension of insurance coverage until age 26 under parental health plans has greatly expanded access to private insurance among young people in the age range of vulnerability to schizophrenia onset. (Before ACA implementation, only full-time students could be covered under parental plans.) In addition, affected individuals with limited means have access to subsidies in state health insurance marketplaces to pay for individual insurance if it is not provided through their workplace or they do not otherwise qualify for Medicaid. Insurance coverage provides access to early intervention services before schizophrenia becomes disabling.

To qualify for health insurance in the Medicaid program, individuals with schizophrenia do not have to first apply for disability benefits in the Social Security Supplemental Security Income (SSI) program, as they did before ACA implementation.

Low levels of employment among people with schizophrenia no longer create a barrier to obtaining health insurance, which was traditionally obtained as a workplace benefit.

If individuals are working full-time, then the ACA creates incentives for many employers to provide insurance for them as a benefit.

Alternatives to the ACA that are being considered for the individual insurance market, such as health savings accounts, do not help people with very low incomes, and tax credits are not helpful for people who do not pay federal taxes. Such individuals will lose coverage, and early psychosis programs will be unable to serve them without a loss of revenue. Efforts to reduce the number of individuals eligible for Medicaid or to cap their benefits will erode the foundation of funding for these programs.

4 Recommended Solution

The key to continued implementation of CSC is its funding base. The Community Mental Health Block Grant and 21st Century Cures Act, which have been important in initiating implementation of CSC programs, are not sufficient to sustain and further expand all of the CSC services needed in the United States. The ability to remain on parental insurance is an important feature of health insurance reform that is an important source of funding. Medicaid has also played a key role as the most flexible source of financing for CSC. Ideally, individuals enter CSC services before they are disabled and before they are on the SSI disability rolls.

If receipt of Temporary Assistance for Needy Families and SSI disability benefits are the sole criteria for determining Medicaid eligibility, which has been recently proposed, then other impoverished individuals will not qualify for appropriate health insurance. This proposed change in Medicaid eligibility will severely limit funding for the very individuals for whom CSC is designed and most hopeful. If policymakers want to keep the SSI rolls from growing, they should encourage policies that make Medicaid available for individuals who are at risk of becoming disabled but who do not yet meet the SSI criteria for disability.

5 Implementation Strategy

Policymakers should continue to support CSC services by expanding its resource base. This requires growing the Block Grant supplement and set-aside for CSC. It is also important to find ways to keep young people at risk of psychosis on some form of appropriate insurance, either private insurance through work or a parent's policy or public insurance, such as Medicaid. Individuals should be eligible for Medicaid before they become disabled. Medicaid coverage may keep them from ever needing SSI—either for its cash benefits or for its pathway to Medicaid.

Policymakers should continue to support Coordinated Specialty Care services by expanding its resource base.

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1 / **Send the paper to your local, state, and federal policy- and decision-makers**

2 / **Share the paper with mental health and substance use advocates and providers**

3 / **Endorse the paper on social media outlets**

4 / **Link to the paper on your organization's website or blog**

5 / **Use the paper in group or classroom presentations**

6 / **Reference the paper in your materials, and cite it as follows:**
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The Scattergood Foundation believes major disruption is needed to build a stronger, more effective, compassionate, and inclusive health care system — one that improves well-being and quality of life as much as it treats illness and disease. At the Foundation, we THINK, DO, and SUPPORT in order to establish a new paradigm for behavioral health, which values the unique spark and basic dignity in every human.

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