Financing First-Episode Psychosis Services in the United States

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Adequate financing is essential to implementing services for individuals experiencing a first episode of a psychotic illness. Recovery After an Initial Schizophrenia Episode (RAISE), a project sponsored by the National Institute of Mental Health, is providing a practical test of the implementation and effectiveness of first-episode services in real-world settings. This column describes approaches to financing early intervention services that are being used at five of 18 U.S. sites participating in a clinical trial of a team-based, multielement RAISE intervention. The authors also describe new options for financing that will become available as the Affordable Care Act (ACA) is implemented more fully. The ACA will rationalize coverage of first-episode services, but the all-important Medicaid provisions will also require individual state action to implement services optimally.
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Services for individuals experiencing a first episode of psychosis are being implemented in Australia, Europe, Canada, and Asia (1), at a pace that outstrips initial efforts in the United States. An important reason for the slow U.S. growth is a lack of financing. Health insurance does not pay for some services recommended for individuals in the earliest stages of psychosis, and many individuals in the United States who are at this stage of illness do not even have health insurance. Furthermore, funding and service delivery priorities for the public mental health system, designed to serve those without health insurance and to provide services not covered by insurance, favor individuals who have already become disabled by mental illness. As a result, first-episode psychosis services have not been implemented widely.

In 2009, the National Institute of Mental Health (NIMH) launched Recovery After an Initial Schizophrenia Episode (RAISE) to establish the effectiveness of early intervention services in real-world settings. The hope is that a practical test of a package of evidence-based services will lead to more widespread implementation of effective services early in the course of psychosis. The RAISE Early Treatment Program (ETP) (John Kane, M.D., principal investigator) is testing the effectiveness of a team-based, multielement intervention in a clinical trial at 18 U.S. sites. The intervention, called NAVIGATE, is offered to eligible individuals on their regular caseloads. Individuals are eligible if they are 15 to 40 years old and experiencing a first psychotic episode of any duration but have not taken antipsychotic medication for a cumulative period of six months. Services include individual resilience training, supported employment and education (SEE), family psychoeducation, and medication management (2).

From the outset, NIMH wanted RAISE services to be tested outside academic settings and wanted services to be covered by health insurance when possible (2). Medicaid is the insurance program most likely to cover most NAVIGATE components; however, most individuals in the first episode of psychosis are not expected to be enrolled in Medicaid. Some will have private insurance, and some will be uninsured, but very few are expected to meet the disability criterion for Supplemental Security Income (SSI), the most common basis of Medicaid eligibility for single adults. In fact, a main objective of RAISE is to change the trajectory of psychosis and prevent individuals from becoming disabled and needing income supports.

At about the same time that NIMH was developing the RAISE initiative, the Office of the Assistant Secretary for Planning and Evaluation (ASPE), within the U.S. Department of Health and Human Services, began examining a range of policy questions related to early intervention in mental disorders. ASPE supported several studies (3–6), including the study described in this column. The passage of the Affordable Care Act (ACA) changed the policy dynamic for thinking about RAISE. The ACA is expected to improve the care of individuals with

psychotic illnesses, such as schizophrenia (7), and also to affect the coverage of services for first-episode psychosis. The ASPE study described below focused on understanding the financing of early-psychosis services at RAISE sites before full ACA implementation and then looking ahead to the likely full impact of health reform, particularly in regard to changes in financing for these services.

Visits to RAISE ETP sites

Two members of the ASPE project team visited five RAISE sites in the spring and summer of 2012. The programs were chosen to reflect a range of types of service organizations in different U.S. regions in and outside urban areas. Each selected site was implementing the NAVIGATE intervention. Before arriving at each site, the visitors reviewed written documents provided by site staff. They then interviewed several key informants with a semistructured protocol, which was approved by the Westat Institutional Review Board. Details of the methods are available in the final report to ASPE (6).

Each of the five sites has developed a creative financing solution. Details are included in the full report (6), and the main observations are presented below. Although the five sites' funding approaches are somewhat idiosyncratic, the tactics used can provide lessons for others interested in offering such services.

Site 1

An urban community mental health center (CMHC), which oversees all local mental health services in a large western city, funds most of the NAVIGATE services through a capitated Medicaid arrangement. This financing plan, in place since the 1990s, applies to all mental health care for all Medicaid beneficiaries in the state. The capitation amount covers many services not covered by most insurance plans, such as non–face-to-face time in case management and team meetings and some aspects of SEE. The financing strategy applies only to Medicaid beneficiaries, and thus it has created an incentive to enroll individuals in Medicaid, including having participants apply for SSI.

Site 2

A large, not-for-profit, multiservice mental health provider in a small city in the Pacific Northwest is affiliated with a Federally Qualified Health Center (FQHC), which enables it to receive a higher reimbursement for each of its first-episode psychosis services. The fees for Medicaid are generous enough that they help cross-subsidize care for individuals who have no insurance.

Site 3

A complex, multiservice CMHC, the major mental health services provider in a suburban catchment area in the East, subsidizes all NAVIGATE services with state and local mental health resources. The center has only a few RAISE participants and is able to cover all the care from its public allocations for uninsured or underinsured clients. Many NAVIGATE services are not covered by insurance plans available to its clients, so it chooses not to bill for any of the services and uses public funding instead.

Site 4

A CMHC serving ten counties in a state in the central United States uses a mix of Medicaid and state mental health funds to finance NAVIGATE services. The center receives a purchase-of-service agreement from the state mental health authority (SMHA) that blends its funding to serve a mix of Medicaid beneficiaries and uninsured participants.

Site 5

A nonprofit mental health center for a three-county area surrounding a small city in the Midwest finances NAVIGATE services with a combination of private insurance, a capitated Medicaid contract from the SMHA, and categorical mental health dollars from the SMHA and the local mental health authority to cover "bad debt." The private insurance covers some, but not all, NAVIGATE services.

In summary, some insurance benefits cover NAVIGATE services; however, supplementation with various types of public resources is needed to make first-episode services viable. In recognition of that need, NIMH provided each site with resources to pay for the services of an employment specialist to deliver SEE services for five hours a week. Although Medicaid is the most frequently used insurance model, it is most successful when special, non–fee-for-service features are used to cover NAVIGATE services. For example, three sites use some form of capitated Medicaid funding, and another site covers the cost of care by billing through its affiliated FQHC and receiving higher rates. Care for individuals without insurance is covered by various other public funding sources, such as grants or purchase-of-service agreements.

Policy lessons

The RAISE ETP sites have developed adaptive, if somewhat idiosyncratic, solutions to the challenge of financing NAVIGATE services. They have been opportunistic in taking advantage of local funding mechanisms and tactics for covering services for uninsured individuals or for services, such as SEE, that are often excluded from traditional insurance benefits. Some of these strategies can be emulated or adapted by other communities that wish to implement first-episode services during the current period of early health insurance reform.

New opportunities will present themselves as the ACA is implemented (7). The impact of some ACA provisions, however, was already in evidence at the sites in 2012. Some youths in the project were able to remain on their parents' insurance even after they no longer were full-time students, taking advantage of an ACA provision already in effect. In addition, they will not become uninsurable in the future due to a preexisting condition thanks to another ACA provision.

Site visits revealed Medicaid as the dominant funding source for individuals with first-episode psychosis. It was particularly important for funding case management and some elements of SEE, in addition to more conventionally reimbursed services, such as individual resilience training and family psychoeducation (both as psychotherapy), medications, and office visits for medication management.

Several ACA provisions affect various aspects of the Medicaid program. For example, before 2014, the ACA makes it easier for states to cover many home- and community-based services, such as SEE. Before the ACA, these services could be offered through a so-called 1915c waiver, which required that the services be budget neutral—that is, that they reduce costs of other Medicaid services so as not to add costs to the overall Medicaid budget. This was a difficult test for mental health services to meet, because some of the most costly services, such as in freestanding psychiatric hospitals and some nursing homes, are excluded from Medicaid coverage, and expected reductions in those services would not have saved Medicaid dollars. Medicaid policy also requires these services to be offered to all beneficiaries, although they can be restricted to a substate region. The ACA now allows a state to offer home- and community-based services through a state plan amendment under section 1915i of the Social Security Act. This amendment does not require budget neutrality. Services must be offered statewide, but they can be targeted to a population, such as individuals experiencing a first episode of psychosis. A state plan amendment, however, still requires a state to expand its Medicaid program to include these services, which could be costly even when targeted to individuals in a first episode of illness. (More details on 1915i are available in the ASPE report [6].)

The ACA Medicaid expansion is perhaps the most significant reform for the financing of first-episode services. Individuals will now be able to qualify for Medicaid benefits on the basis of income rather than qualifying for SSI on the basis of disability. This will bring millions of currently uninsured single adults into the Medicaid program, where they may find coverage for an array of home- and community-based services that are appropriate for treating psychosis in its early stages. Availability of these services, however, will still be up to the discretion of individual states to include them in their Medicaid plans. The Centers for Medicare and Medicaid Services has also clarified that states may develop targeted benefit plans for subpopulations newly eligible for Medicaid under the ACA, creating additional avenues for states to provide early intervention.

There is now hope that individuals may be prevented from becoming disabled—or the time to becoming disabled by psychosis will be prolonged—with more effective, early intervention. Rather than enrolling individuals in SSI at the outset of community services in order to qualify them for Medicaid, programs may now no longer view disability and dependence on SSI as the inevitable outcome and focus instead on supporting these individuals to recover to their full potential, with SSI enrollment as an outcome to be avoided unless absolutely necessary.

As a side benefit, more widespread use of health insurance, such as Medicaid, is likely to improve the capacity of community programs to bill for services. Programs may no longer forgo reimbursement, which they have done in the past, because of the difficulty and expense of filing a relatively small number of claims.

Taken together, the ACA's reforms and new knowledge about implementing effective first-episode services will create opportunities for community mental health programs. The ACA rationalizes the financing and eligibility for benefits for individuals experiencing a first episode of psychosis. Young people are able to stay on their parents' insurance and will not be prevented from obtaining their own coverage because of a preexisting condition. The Medicaid expansion will bring the appropriate services to the right individuals, before they become disabled and join the SSI rolls.

Since the Supreme Court decision on the ACA, the Medicaid expansion, however, has become a state option. So with respect to the expansion, as well as to the 1915i state Medicaid plan amendment options, the full benefits of the ACA will require the cooperation of individual states. It will be instructive to evaluate the state-by-state implementation of the ACA's Medicaid provisions—both in terms of first-episode psychosis services and of health insurance and health care reform more broadly.

Programs such as RAISE are providing lessons to guide the field into a new era of mental health financing, with more widespread use of health insurance, particularly Medicaid. The current experience with first-episode psychosis services, however, also demonstrates continued need for public funding for some services not covered by most traditional health insurance benefits.

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