

Payment Strategies for Coordinated Specialty Care (CSC)

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Payment Strategies for Coordinated Specialty Care

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Overview

The goal of this paper is to highlight the need for coordinated specialty care (CSC), an evidence-based practice (EBP) for the treatment of early psychosis, and to recommend the use of existing billing codes that offer a consistent national, multi-payer reimbursement method so people experiencing a first episode of psychosis, and who have Medicaid and/or commercial insurance, can access these services. The delivery of coordinated specialty care (CSC) in early psychosis programs transforms lives by changing the trajectory of schizophrenia for youth and young adults.

This highly effective, evidence-based intervention helps young people successfully manage their conditions and get their lives on track.¹ When people do not have access to CSC at the time of their first episode of psychosis, the typical course of illness involves multiple episodes of acute mental illness, with accumulating disability between periods of active psychosis and increases in long-term health care costs. Unfortunately, the future of early psychosis programs – and their ability to help the nearly 100,000 young people who experience psychosis every yearⁱ – is at risk because current reimbursement models do not sustainably support the provision of CSC services. To eliminate this risk, it is vital that health plans and providers develop and implement coding and billing practices specific to evidence-based practices that sustain the delivery of the CSC model in early psychosis programs.

Evidence-based services such as the integrated, team-based mental health services described in this document support clinical and functional recovery by reducing the severity of first episode psychotic symptoms, keeping individuals in school or at work, and putting them on a path to better health. CMS, NIH, and SAMHSA Joint Bulletin on the Coverage of Early Intervention Services for First Episode Psychosis, October 16, 2015

This paper outlines the business case for cost-effective CSC care models not commonly used for behavioral health care services to reimburse the total range of services and costs of the model. It offers existing coding structures that payers can use to begin immediate reimbursement for this EBP. In support of the business case for CSC, we also provide a high-level summary in Appendix 1 of the research supporting CSC as an evidence-based practice. Appendix 2 provides sample admission and continued stay guidelines for health plans to consider in determining eligibility for CSC. The authors of this paper will be working with experts in the field to develop more detailed guidance on medical/clinical necessity requirements for admissions and continued stays, documentation in the medical record, and fidelity monitoring.

¹ See Appendix 1 for a brief summary of the research on early psychosis treatment.

The Business Case for Early Psychosis Intervention

The goal of early psychosis intervention is to identify young people in the early stages of psychosis, minimize barriers to treatment, and facilitate successful engagement in treatment while fostering resilience.ⁱⁱ Early psychosis interventions are individualized to meet the specific needs of youth and young adults who are experiencing symptoms of psychosis. Early psychosis programs provide treatment, rehabilitation, and support, and help young people transition to lower intensity long-term services and supports.ⁱⁱⁱ The National Institute of Mental Health (NIMH), Centers for Medicare & Medicaid Services' Center for Medicaid and CHIP Services (CMCS), and the Substance Abuse and Mental Health Services Administration (SAMHSA) have been engaged in an ongoing partnership (since October 2015) to advance efforts to support early intervention services for youth and young adults who experience first episode psychosis.^{iv}

As noted in the October 2015 CMCS-SAMHSA joint guidance, people experiencing a first episode of psychosis receive services from numerous systems through a variety of funding sources. These people are best served when services meet individual needs, gaps and duplication are eliminated, and payers communicate effectively to coordinate and reimburse providers for the right services and treatments. Among people who experienced a first episode of psychosis, 20% had private or both public and private insurance, 28% had Medicaid, 5% had Children's Health Insurance Program (CHIP), 2% had Medicare, and 43% had no insurance; the insurance status was not known for 5% of this group.^v

The Coordinated Specialty Care Model

Coordinated specialty care (CSC) is an intensive, team-based, multi-intervention approach to treating youth and young adults who are experiencing the onset of psychosis.

The CSC approach involves multiple services, including:^{vi, vii}

- Individual and group psychotherapy;
- Pharmacotherapy;
- Family psychoeducation and support;
- Case management;
- Individualized assessments, training and supports integrated with treatment to achieve and maintain educational or vocational success; and
- Primary care coordination.

Regardless of the amount of investment, and leveraging inclusion of services reimbursed by Medicaid or private insurance, every state and territory has begun to move their system toward earlier intervention, or to enhance such services already being implemented. The Medicaid program is one of several sources of reimbursement to states for mental health and related services and supports.
CMS, NIH, and SAMHSA Joint Bulletin on the Coverage of Early Intervention Services for First Episode Psychosis, October 16, 2015

Figure 1. The CSC Approach



CSC services are individualized – the intensity and duration of services are based on each participant’s needs and goals. The typical CSC program provides services for 24 months, if needed by the program participant; however, some programs provide care for up to 36 months. The evidence from multiple studies and clinical experience shows that most patients need as much as two years of treatment to achieve success. However, these programs are individualized and will document the need for continued care for each patient based on their progress and participation in treatment.

There are several challenges to funding CSC programs in a financially sustainable manner. CSC programs need consistent and reliable reimbursement for sustainability. The intensity of these services and the need for assertive outreach with patients is a key to a program’s success since the risks are high that, without significant care management support in the community, some of these patients will not continue ongoing treatment and could relapse and need higher levels of more costly and less effective interventions such as hospitalization.

The key to expanding these programs to eligible patients is to standardize reimbursement that funds all essential elements of this evidenced-based model. Some current fee schedules are typically based on assumptions that individual practitioners provide office-based services,

which is not the case with many CSC services. CSC is a multi-disciplinary team-based intensive intervention that requires higher staff-to-patient caseload ratios and incurs costs associated with coordination, oversight of the team, training, supervision, and certification. CSC programs also have non-billable, indirect, and overhead costs that cannot be directly billed under some traditional reimbursement models, including costs for non-face-to-face professional services, collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and documentation. Fortunately, Medicaid and Mental Health Block Grants in multiple states are funding all essential services for low-income and uninsured populations.

However, most current billing practices do not reimburse the totality of the team staffing structure, which includes unlicensed practitioners under the supervision of a licensed practitioner, who serves as the team leader, and a physician who provides consultation to the team. Because of these challenges with the current fee schedule for individual practitioner services, CSC requires a new standard, comprehensive approach to billing that uses existing Healthcare Common Procedure Coding System (HCPCS) codes and includes appropriate overhead costs for the reimbursement issues identified above.

While Medicaid covers the majority of services in some states, most current ad-hoc financing mechanisms are complex, unique to each state, and unstable, undermining the ability to develop, expand, and sustain CSC programs. Many, if not most, CSC programs that are reimbursed through fee-for-service models must supplement their insurance revenues with community mental health block grants, state or local general funds, or other grant funding.

These financing mechanisms make it difficult to sustain CSC programs over time and create particular challenges for commercial insurers that cover youth with early stages of psychosis. Often these youth are institutionalized to ensure their safety because of the lack of access to CSC. Although there are a few state Medicaid programs that offer alternatives such as CSC to institutionalization (and that disregard parental income) for youth with severe emotional disturbances, many Medicaid programs do not provide enhanced services for people older than 21 years, and most do not reimburse for CSC models.^{viii} An exception is Assertive Community Treatment (ACT), which is reimbursed by many Medicaid programs but typically requires program participants to have experienced severe mental illness for a duration of time. The typical candidate for CSC has not been ill long enough, severely enough, or consistently enough to qualify for ACT. Commercial insurers typically do not reimburse for ACT because most people who receive ACT services are no longer on commercial insurance. The bottom line is that many people with early stages of psychosis who have commercial insurance are admitted to hospitals. If they are fortunate enough to receive care through a program that implements the CSC model, the program most likely relies on public funding through block grants to subsidize

the shortfall in commercial and Medicaid funding, or the program participant has to pay out-of-pocket for the totality of CSC services.

Current Fee-for-Service Reimbursement Utilizes a Combination of Codes That Do Not Cover CSC Program Costs

Today, CSC programs are being reimbursed through braided funding streams comprising a combination of Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and Medicaid waiver codes. Most commercial insurers and Medicaid programs use traditional fee-for-service payment methods as their current default method of reimbursement for some behavioral health services. However, there are a number of behavioral health and medical team-based treatment programs that use HCPCS billing as a standard reimbursement mechanism (e.g., intensive outpatient programs, cardiac and stroke rehabilitation programs) to receive reimbursement from Medicaid, Medicare, and commercial payers. CSC programs are similar to these service packages. A few state Medicaid programs, such as in Oregon, for example, are reimbursing for CSC team-based models, but the majority of states do not reimburse for the entire package of CSC services under their standard Medicaid programs.

The current reimbursement methodology – using multiple billing codes – pays for each service individually under the existing fee schedule for an individual practitioner/clinic model. Although this option does allow flexibility for the provision of some office-based services, the current reimbursement rates are set using office-based assumptions that all services are being provided face to face, which excludes essential elements of the CSC evidence-based model that are noted above. As a result, the traditional fee schedule does not reimburse adequately for the CSC model. This, in effect, under-compensates the model that provides the most efficient and cost-effective interventions for a condition that can be quite costly to treat.

Fee-For-Service Models		
Practitioner	Service	Fee-for-Service Bill Code and Description*
Team Leader	<ul style="list-style-type: none"> • Team leader • Indirect costs of coordinating multi-disciplinary team • Team staffing, including unlicensed practitioners • Extraordinary training, supervision, and certification costs • Non-billable face-to-face professional services, including collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and extraordinary documentation related to certification 	<ul style="list-style-type: none"> • N/A – Not reimbursed by typical office-based individual practitioner fee schedule rates
Psychiatrist / Prescriber	<ul style="list-style-type: none"> • Pharmacotherapy • Primary care coordination 	<ul style="list-style-type: none"> • 99214 – Level 4 established office visit
Licensed Certified Social Worker (LCSW) / Certified Drug and Alcohol Counselor (CDAC)	<ul style="list-style-type: none"> • Individual and group psychotherapy 	<ul style="list-style-type: none"> • 90837 – Psychotherapy, per 60 minutes • 90853 – Group therapy, per session • 90846 – Family therapy, per 60 minutes
Master’s / Bachelor’s Level Professional / Nurse / Peer	<ul style="list-style-type: none"> • Psychoeducation and support • Case management 	<ul style="list-style-type: none"> • H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes • T1016 – Case management, per 15 minutes • H0038 – Self-help/peer services, per 15 minutes

Fee-For-Service Models		
Practitioner	Service	Fee-for-Service Bill Code and Description*
Educational or Vocational Specialist	<ul style="list-style-type: none"> Individualized assessments, training, and supports integrated with treatment to achieve or maintain educational or vocational success 	<ul style="list-style-type: none"> N/A – Typically not reimbursed by commercial plans, although existing national codes such as H2024 – Supported Employment per diem, and H2023 –Supported Employment per 15 minutes, can be utilized. Medicaid and Vocational Rehabilitation have paid for these services in particular situations.
<p>*Note: Outpatient hospital programs such as partial hospitalization utilize revenue codes (e.g., 0513 – Psychiatric clinic and 0900 – 0919 Behavioral Health Treatments/Services) in conjunction with outpatient HCPCS coding.</p>		

Recommendation: Adopt a Single HCPCS Billing Code for the CSC Evidence-Based Model

Using an existing HCPCS standardized code would address the issues outlined above. Specific coding and billing practices should be followed for a CSC team, based on the expected or actual number of encounters necessary to ensure the safety, improved functioning, and recovery of the youth or young adult. A single code would simplify billing and permit insurers to set a valuation of the model that encompasses all key elements of CSC. Valuation is a separate issue, though, and should include indirect cost reimbursement for the delivery of the CSC model, taking into consideration the factors listed above that contribute to under-compensation through traditional payment models. This approach is similar to standard billing practices for other EBPs. For example, billing for Assertive Community Treatment and Multisystemic Therapy includes compensation for:

- Small caseloads;
- Team staffing, including unlicensed practitioners;
- Extraordinary training, supervision, and certification costs; and
- Lost productivity due to collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and documentation.

Coordinated Specialty Care Team Billing		
Practitioner	Service	Potential Bill Code and Description
Team Leader (Licensed Practitioner)	<ul style="list-style-type: none"> • Team leader • Indirect costs of coordinating multi-disciplinary team • Team staffing, including unlicensed practitioners • Extraordinary training, supervision, and certification costs • Non-billable face-to-face professional services, including collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and extraordinary documentation related to certification 	<p>T1024 – Evaluation and treatment by an integrated specialty team to provide coordinated care to multiple or severely handicapped children per encounter.</p> <p>This existing HCPCS code can be utilized per encounter either as a per visit rate or a monthly case rate.</p> <p>In a monthly case rate, the payer is allowed to define an “encounter” with an HK modifier to reimburse using a monthly case rate for the full model.</p>
Psychiatrist / Prescriber	<ul style="list-style-type: none"> • Pharmacotherapy • Primary care coordination 	<p>HCPCS code modifier HK designates specialized mental health programs for high-risk populations.</p>
LCSW / CDAC	<ul style="list-style-type: none"> • Psychotherapy 	
Master’s / Bachelor’s Level Professional / Nurse / Peer	<ul style="list-style-type: none"> • Psychoeducation and support • Case management 	
Educational or Vocational Specialist	<ul style="list-style-type: none"> • Individualized assessments, training, and supports integrated with treatment to achieve or maintain educational or vocational success 	

Flexible Billing

We recommend two separate reimbursement structures based on the intensity of service delivery. Both would be paid through the HCPCS T1024 coding structure, using a monthly case rate and a minimum encounter rate. This code will accomplish the goal of outlining a standardized approach for billing CSC nationwide, using an existing HCPCS code that encompasses all key elements of CSC. However, we encourage payers in different geographic areas to use other billing codes if it would accomplish these same goals of consistency and

standardization and allow for full funding of the key CSC service package. For example, insurers might develop a value-based purchasing (VBP) reimbursement methodology. Because of the time required to develop a VBP model, we recommend using this code during the development period to prevent delays in reimbursement.

Reimbursement Structure 1: Monthly case rate for delivery of full model. A monthly case rate would reimburse a team for the full delivery of the CSC model. This case rate could be billed for any person meeting the target criteria who is receiving services for the full CSC model that month. Some people may require treatment with the full CSC model for as long as two years.

The monthly minimum required services could include:

- Two to three face-to-face visits or HIPAA-compliant telehealth contacts from a team member;
- One collateral contact via an electronic modality (e.g. telephone, e-mail, phone-based app, or telehealth); and
- One team staff meeting discussion with the full team, including the licensed professionals on the team.

Compensation for the full team would be included in the monthly case rates. The team would be required to continue providing medically necessary services beyond the minimum monthly service requirements. Many cases require additional services during early stages of treatment as well as any time a person experiences periods of destabilization. A case rate creates incentives for the team to quickly stabilize the person and provide supports to keep them stabilized. The T1024 code and HK modifier could be used to note when the team provided the full model and used a case rate for billing. A case rate will reimburse the CSC team for the entirety of the delivery of care for that month.

Reimbursement Structure 2: Encounter rate for less intensive service delivery. An encounter rate could be billed for each encounter when a person meeting the target criteria receives team-based services with less intensity than the full CSC model, but still meets the continued stay criteria. (see Appendix 2 for more information on admission and continued stay criteria). This might occur if a person is absent for part of the month because of hospitalization, or is stabilizing and does not require the monthly minimum service provision. Some people may require follow-up care from the CSC team for several months as they transition to other levels of care. This allows the CSC team to be reimbursed according to the intensity of care provided. In this reimbursement structure, T1024 would be billed as fee-for-service per encounter, without a modifier.

If payment is permitted to vary by service intensity, it is important that payers adopt clinically meaningful standards for at least the following areas:

- Admission criteria to the program, including defining the target population clearly;
- Recommendations for care, supervision, and treatment plans that are developed by a licensed practitioner;
- Minimum staffing required for the program;
- The minimum number of encounters that are required to be provided for a case rate to be billed;
- Discharge criteria to ensure that people who should be transitioned to other levels of care do not remain on CSC caseloads; and
- Instances when it is appropriate to maintain a person on a CSC caseload even if the full model is not delivered that month (e.g., hospitalization, transition to step-down levels of care, absence from the geographic area).

As with other evidence-based practices, the CSC model requires oversight and monitoring to maintain fidelity to the model and ensure that people are not underserved (if paid per member per month), discharged prematurely (if the level of their need is difficult to treat), or kept on the caseload when they are not able to engage in treatment or after they should be stepped down to a lower level of care (if paid using an encounter rate because it is easy to generate encounters).

At a minimum, CSC billing would require appropriate documentation in medical records (and provided to payers) that supports the provision of the model, consistent with the fidelity standards of the model and the rate being billed. For example, regardless of the team rate being billed, the team would need documentation for that month of service delivery to support the following:

- The person met the admission criteria to justify the initial months of treatment;
- A treatment plan was developed that outlined the team-based care to be delivered under the direction of the licensed professionals; and
- After no more than 90 days, a continued stay review was conducted to determine if the person met the continued stay criteria.

To bill the full monthly case rate (Reimbursement Structure 1), the team would need to document:

- Two to three face-to-face visits or HIPAA-compliant telehealth contacts from a team member;
- One collateral contact via an electronic modality (e.g. telephone, e-mail, phone-based app, or telehealth);

- One team staff meeting discussion with the full team, including the licensed professionals on the team, and
- Provision of additional services during early stages of treatment as well as any time a person experiences periods of destabilization, as medically necessary.

To bill encounter rates for less intensive service delivery (Reimbursement Structure 2), the team would need to document that the billable activity occurred (e.g., face-to-face visit or telehealth contact, collateral contact, or team staffing) and that no other additional services were medically necessary because the person was hospitalized or stabilizing and did not require the minimum service provision, or there was another reason, as documented in the medical record.

We recommend that qualified CSC teams would be required to maintain fidelity to the CSC model as evidenced by staff maintaining current training and the provider maintaining documentation consistent with the CSC fidelity standards. The provider should also arrange for regular fidelity reviews by an approved center of excellence. The costs of fidelity monitoring would be built into the payment rate. Periodic fidelity monitoring helps assess whether the program is operating in accordance with the model and provides important feedback about areas of improvement.

The Rationale for Financing CSC Programs Using Team-Specific Billing

The well-researched CSC team-based model achieves better outcomes for people with early psychosis and is cost-effective compared to usual care. The National Institute of Mental Health (NIMH) has published CSC implementation and outreach manuals to support implementation and fidelity to the model. Additionally, a tool has been developed to estimate costs and resources for early psychosis programs.^{ix}

Because CSC is designed as a coordinated package of team-based services and embeds measurement-based care, it is well-suited to financing through team-based billing. Ideally, the payment could be adjusted after the initial period of intensive services to support a stepped-down approach that maintains treatment gains.

A CSC program can be effectively implemented with a variety of team configurations and divisions of labor, including the incorporation of tele-mental health, if the team maintains fidelity to the model. With the use of EBP-specific coding and billing practices, a health plan would have the flexibility to work with local providers to develop the most appropriate delivery and payment mechanism based on local provider and plan capacity to implement this coordinated, team-based approach.

CSC programs are improving lives across the country. However, the expansion and sustainability of CSC programs is at a crossroads because of financing limitations. As a result, there is a compelling need to rapidly implement standard coding and billing practices using existing HCPCS codes. Doing so will ensure the financial sustainability of this evidence-based model and improve access to care that puts young people who experience early psychosis on a path of recovery and prevents unnecessarily costly and devastating outcomes.

Appendix 1. Early Psychosis Research

Overall, compared to patients who received usual care, participants in CSC experienced significantly greater improvements in total symptoms, social functioning, work or school involvement, and overall quality of life.^x First episode psychosis programs implemented in the United States, Australia, Canada, the United Kingdom, and Scandinavia have been shown to improve symptoms, reduce relapse and prevent deterioration and disability. An October 2017 inventory of CSC programs found that there were 248 CSC sites across the United States that receive Mental Health Block Grant funds to provide services for people ranging from age 12 to age 40 or older. Ideally, people are connected with CSC programs very soon after they first experience psychosis (the peak ages for psychosis onset is between ages 15 and 25 years).^{xi}

In 2008, the National Institute of Mental Health (NIMH) launched the *Recovery After an Initial Schizophrenia Episode* (RAISE) project, a large, multi-site, randomized controlled trial in 34 community-based mental health clinics in 21 diverse communities.^{xii} The RAISE-Early Treatment Program (ETP) study examined whether youth and young adults experiencing first episode psychosis achieved better outcomes with coordinated specialty care (CSC) than with typical community-based care.

The RAISE-ETP study found that young people who received CSC showed significantly greater gains and improvement in quality of life than those who received usual care. They were also more likely to be attending school, working, and leading lives without disability.^{xiii} Additionally, the RAISE-ETP study demonstrated the cost effectiveness of early treatment with CSC related to reduced psychotic symptoms and improved community functioning over time.^{xiv} Importantly, CSC produced better outcomes and was more cost effective when the duration of untreated psychosis (the period between first symptoms and treatment) was less than 74 weeks (the median for study participants).^{xv} The recommended standard is under three months of untreated psychosis,^{xvi} suggesting even greater results may be possible with a shorter time to treatment.

Clinical research in multiple countries over the course of nearly two decades supports the value of early intervention in reducing symptoms and promoting functional recovery for people with early psychosis. With the RAISE study, the United States added to this body of research and achieved positive outcomes that set a new standard of clinical care for early psychosis.^{xvii}

In 2016, the *Schizophrenia Bulletin*^{xviii} published a study comparing the cost-effectiveness of Navigate (NAV) – a comprehensive, multidisciplinary, team-based treatment approach for first episode psychosis – and usual community care in a cluster randomization trial. This study showed that a comprehensive service package for first episode psychosis can improve quality of life, albeit at increased costs. However, the value of the achieved clinical benefit appears to

justify these additional expenditures, especially for clients with a shorter duration of untreated psychosis (the time from the onset of symptoms of psychosis to the time of first antipsychotic medication treatment), and when generic prices for antipsychotic medication are applied.

Appendix 2: Admission and Continued Stay Guidelines for Coordinated Specialty Care – DRAFT

Admission and continued stay guidelines for coordinated specialty care focus on the need for service intensity that does not meet criteria for hospitalization but exceeds criteria for office-based outpatient care.

Admission criteria: Consider listing diagnostic criteria for schizophrenia; schizoaffective disorder, NOS; and bipolar with psychosis.

Consistent with these diagnoses, people will frequently experience psychotic symptoms, including hallucinations, delusions, or disorganization, that last at least a week, or less if treated with antipsychotic medication. They also frequently suffer from an elevated risk of suicide and violence, cognitive impairments, limited insight into their illness, and so-called “negative” symptoms, including lack of social engagement, poor motivation, and social isolation.

These symptoms generally produce significant impairment in functioning. Examples of functional impairment include non-participation and drop out from developmentally appropriate occupational roles such as school attendance and work. This functional impairment creates school failure, job loss, and social isolation characterized by reduced or absent support of friends and other community agents. Paranoia, loss of reality testing, and bizarre behaviors create these conditions. A lack of social and family supports can exacerbate these symptoms and functional impairments.

Eligibility for Continued Stay

Both clinical and research evidence underscores that optimal program eligibility typically extends at least two years and sometimes longer, if needed, from the date of enrollment, assuming at least one of the following conditions are met:

- Ongoing psychotic symptoms or risk for return of psychotic symptoms if treatment is withdrawn;
- Ongoing risk of bizarre, disorganized, or dangerous behaviors;
- Persistent impaired or inconsistent occupational functioning (e.g., marginal school or work participation, need for extensive supports to maintain adequate functioning);
- Continued outreach by program staff is required to assist in school and work attendance;
- Persistent limitations in social functioning (e.g., social isolation, limited ability to develop peer relationships and connections);
- Lack of insight into illness impacting treatment participation, without intense monitoring and outreach; and

- Significant lack of social and family supports that enable ongoing productive treatment participation.

Circumstances that would limit continued eligibility for CSC services include a person not meeting any of the eligibility criteria outlined above, or a lack of treatment participation such that outreach efforts do not produce face-to-face contact after two months of effort.

Levels of care for coordinated specialty care include:

- High – a person is experiencing psychotic symptoms and/or a risk of relapse or dangerous behavior that requires weekly psychiatric support or appointments with licensed clinicians, and
- Low – a person has mild or no psychotic symptoms and their functional status includes occupational engagement with school or work.

Endnotes

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