WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH

2SSB 5903 (2019): STATEWIDE IMPLEMENTATION PLAN OF COORDINATED SPECIALTY CARE FOR EARLY PSYCHOSIS

November 2, 2020

Table of Contents

Executive Summary **2**

I. Introduction **6**

a. Specialized Coordinated Care Specialty Model in Washington 6

b. Scope of Need for FEP Treatment Services in Washington 7

c. Benefits of Early Intervention 7

II. Existing Benefit Packages, Payment Rates, and Resource Gaps **8**

III. Development of Discrete Benefit Package and Case Rate Prototype **11**

IV. Number of Coordinated Specialty Care Teams Required in Washington **13**

V. Costs of Statewide Implementation **17**

VI. Consideration of Future Expansion to the Clinical High-Risk Population **19**

VII. Conclusions, Recommendations, and Action Steps **21**

ATTACHMENTS

a. First Episode Psychosis Estimator Tool

b. CPT-HCPCS Code Coverage Detail

Executive Summary
Statewide Implementation of Coordinated Specialty Care for Early Psychosis

The initial onset of symptoms of a psychotic disorder, also known as First-Episode Psychosis (FEP), typically occurs within transition-age youth or young adults aged 15–25 years of age and can significantly disrupt the social, academic, and vocational development of a young person, while initiating a trajectory of accumulating disability. In recognition that delaying treatment can result in loss of family and social supports, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery, the United States Congress directed in 2014 that set-aside funding from the federal Mental Health Block Grant be directed to help states develop FEP treatment programs. With this funding, Washington initiated a pilot program for early identification and intervention for FEP, called the **New Journeys** program. New Journeys uses an evidence-based **Coordinated Specialty Care (CSC)** model to provide early intervention and treatment for FEP. As of October 2020, there are 9 New Journeys teams operating in 7 of 10 regional service areas across Washington.

Individuals experiencing psychosis generate significant costs, including direct healthcare costs (e.g., psychiatric inpatient and emergency department usage) as well as costs to the state through unemployment, caretaking needs and lack of ability to live independently, involvement with the criminal justice system, and premature mortality. Research indicates that the CSC model for early intervention and treatment is successful and cost-efficient, resulting in both improved health outcomes as well as cost savings: an average total cost per patient engaged in early intervention for healthcare services alone is $2,991 lower per patient than those engaged in usual treatment; and those engaged in early intervention realize $3,778 in reduced inpatient costs during a 6-month period after treatment compared to those with longer durations of untreated psychosis. Long-term outcomes indicate farther reaching cost-savings and societal benefits, including increased employment and reduced dispensation of antipsychotic medications more than ten years after inclusion in an early-intervention treatment program. However, these life-changing and in some cases life-saving interventions are not yet broadly known by healthcare providers or effectively implemented across our state.

2SSB 5903 (2019) directed the Health Care Authority to implement the New Journeys early identification and intervention program statewide by 2023 and called for creation of a Statewide Implementation Plan to inform this process by identifying the level of unmet need, developing a discrete benefit package and case rate prototype, analyzing existing health benefits (Medicaid and commercial) to support these medically necessary services, and determining funding resources needed to ensure that individuals across the state of Washington will be able to access these critical services regardless of their geographic area of residence or insurance enrollment status. In response to legislative direction, HCA has worked in collaboration with the Washington Council for Behavioral Health, the University of Washington, and Washington State University to develop the Statewide Implementation Plan and roll out additional New Journeys teams. This report outlines needs and priorities for successful statewide implementation of the New Journeys program, which will result in both improved outcomes for those experiencing psychosis and cost savings to the state; it also offers recommendations for sustainable statewide implementation through establishing a cost-based reimbursement solution that encompasses commercial and public payers.

Based on the most recent census data available and population-based incidence rates, and validated by retrospective analysis of administrative data by the Washington State Department of Social and Health Services Research and Data Analysis Division (RDA), approximately 1,800 new incidences of First Episode Psychosis arise each year within Washington. Using an evidence-based decision support tool that incorporates team capacity and engagement rates, Washington requires an addition of six (6) teams from current levels to meet a minimum threshold of regional needs based on incidence and population, and which will also fulfill the requirement to establish a care team in each regional service area. Immediate priorities to address this include:

- Establishing a team in the Salish and Spokane Service Areas and two teams in the North Sound Service Area, all of which currently have none, and;
- Increasing teams in King County by two and in the Pierce County Service area by half.

A population-based need approach, however, would support the eventual roll-out of up to 45 teams statewide to offer sufficient capacity to treat annual emerging FEP cases statewide, even assuming that only half of all annual cases were identified but that the majority of those identified could be successfully engaged in treatment.

To support statewide implementation, there are several key areas that the Washington State Legislature can address to minimize cost burden on the state and ensure ongoing financial sustainability of the teams. Many critical components of the evidence-based CSC model are not supported by current third-party reimbursement structures, including the team-based care and coordination structure, supported employment and education services, case management, and peer support. HCA contracted with Mercer Government Human Service Consulting (Mercer) to develop a comprehensive Medicaid case rate for the New Journeys program model. Preliminary actuarial analysis resulted in a two-tiered case rate structure for an average treatment duration of 24 months, aligned with the CSC treatment model and utilization data.

- Using the preliminary Medicaid case rate estimate, if adopted it is anticipated that teams could generate approximately $415,584 annually based on a full caseload, which would cover 76% of the average annual New Journeys team cost.
- If a commercial parity mandate were enacted, a best practice pursued by other states in supporting CSC models, it is anticipated that teams could generate approximately $79,920 in additional annual revenue, which along with Medicaid reimbursement, could support up to 90% of annual New Journeys team cost.

These solutions would reduce the current burden on federal grant and/or state budget support from approximately 71% of annual team costs down to 10%, significantly freeing up funds to support ongoing unfunded costs, including the cost of treatment of uninsured individuals and critical non-benefit and non-reimbursable components of the CSC model.

While the recommendations above will significantly impact teams once they are established and enrolling patients, one-time costs remain that will continue to require federal grant and/or state support. CSC teams are highly specialized and require intensive training to provide the evidence-based model of care. Recruitment for new teams typically require at least a six-month period during which patients are not yet enrolled and thus third-party reimbursement opportunities are not yet present. In addition, a strong referral network must be established within the community to provide a steady caseload, and this requires significant early team effort throughout the first year to educate community resources, such as schools, universities, local primary care and mental health providers, hospitals, and community-based organizations in recognizing early psychosis and the availability of CSC services. Given the intense level of effort required to establish the team and

referral network and slow ramp-up to full caseload, new teams require an estimated average of $995,686 in federal grant and/or state support over a two-year implementation period. Adoption of the proposed Medicaid case rate would offset this by approximately $329,004, reducing the implementation cost to approximately $666,682 over two years. However, once teams are in place and able to reach a full case load, adoption of the proposed Medicaid case rate and commercial parity will cause ongoing federal grant and/or state support to drop significantly. Support could then be reallocated to one-time implementation costs for establishing new teams.

In addition to continued expansion of the New Journeys teams, Washington should also pursue expanding the reach of the teams to the clinical high-risk population. Cost savings and improved health outcomes increase as duration of untreated psychosis decreases; thus, early identification methods that include the high-risk population can further contribute to the statewide benefit of CSC treatment. A further consideration is to ensure continuity of care for those that have completed the CSC program. Additional analysis is required to determine future team capacity needs as well as the incremental cost requirements of roll-out and implementation to support these additions.

Action Steps for Statewide Implementation

1.	***Adopt a Medicaid Case Rate for Coordinated Specialty Care***
a.	Adoption of a comprehensive Medicaid Case Rate is crucial to financial sustainability
b.	With implementation of the preliminary rate, an estimated 76% of annual team costs could be supported by Medicaid reimbursement once teams reach a full caseload
2.	***Continue to Expand New Journeys Teams to Meet Population Health Needs Statewide***
a.	Coordinated Specialty Care should be available regardless of county or region of residence
b.	2SSB 5903 requires a minimum of one team per regional service area by 2020; statewide expansion necessary to meet population health needs must be completed by 2023
3.	***Implement a Commercial Parity Requirement to Cover Coordinated Specialty Care***
a.	Commercial insurance typically does not cover most services in the CSC model; addressing this gap is likewise critical to continued financial sustainability of teams
b.	With addition of a commercial parity requirement, along with adoption of the Medicaid Case Rate, unfunded team costs could be further reduced to 10% of annual costs
4.	***Include the Clinical High-Risk Population as Eligible for Treatment***
a.	RDA has identified risk factors that strongly correlate to future experience of First Episode Psychosis, which New Journeys teams could incorporate into outreach and engagement
b.	Incorporating the clinical high-risk population will reduce duration of untreated psychosis, improving outcomes of those experiencing psychosis and realizing additional cost savings
5.	***Maintain Continuity of Care through Step-Down Services***
a.	Following the 24-month New Journeys intervention, research indicates participants benefit greatly from continued step-down services to maintain and cement treatment gains
b.	Additional New Journeys team planning should include capacity and reimbursement strategies to support continued engagement with those who have completed CSC treatment
c.	These services may be adequately supported by current Medicaid and/or commercial insurance coverage; additional analysis should assess strategies to support this component

In sum, early intervention and treatment through the CSC model is cost effective and highly beneficial to those experiencing psychosis, and can impact a lifelong trajectory of accumulating

disability, dependence, and negative health outcomes. Support of this model is aligned with value-based care delivery, redirecting usage of costly inpatient care to lower-cost outpatient clinical and supportive services. With proposed implementation of a sustainable Medicaid case rate and commercial parity mandate, federal and state resources can be reallocated to support a broad statewide implementation strategy that meets population-based incidence of psychosis, and ensures that those at risk of or experiencing these debilitating symptoms can access high-quality, evidence-based care regardless of their insurance status or geographic area of residence.

Statewide Implementation of Coordinated Specialty Care for Early Psychosis

I. Introduction

The initial onset of symptoms of a psychotic disorder, also known as First-Episode Psychosis (FEP), typically occurs within transition-age youth or young adults aged 15–25 years of age and can significantly disrupt the social, academic, and vocational development of a young person, while initiating a trajectory of accumulating disability.[1] In recognition that delaying treatment can result in loss of family and social supports, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery, the United States Congress directed in 2014 that set-aside funding from the federal Mental Health Block Grant be used to help states develop FEP treatment programs based on models currently being used in Canada, the United Kingdom, and Australia.[2] With set-aside funding received from the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2015, Washington initiated a pilot of the evidence-based early identification and intervention program for FEP. Since 2015, additional pilot sites were established, and the FEP program in Washington State was named **New Journeys**. The subsequent Washington State Legislature Senate Bill 5903 (2SSB5903) required HCA to implement the New Journeys program statewide by 2023. This report outlines a Statewide Implementation Plan to inform this process and present strategy to ensure that individuals across the state of Washington will be able to access these critical services regardless of their geographic area of residence or insurance enrollment status.

a. Specialized Coordinated Specialty Care Model in Washington

Developed in partnership with the University of Washington (UW) and Washington State University (WSU), the New Journeys program provides an evidence-based outreach and intervention program for transition-aged youth and young adults first diagnosed with psychosis (FEP). The program targets individuals aged 15–40, aligned with the age ranges most likely to experience a first episode of psychosis, who have experienced symptoms of psychosis for less than 2 years[3] and had less than 18 months of treatment with antipsychotic medications. The program offers specialized early intervention services following a Coordinated Specialty Care (CSC) model that utilizes a team-based, multi-element approach to integrate individualized medical treatment, family and patient education, resiliency training, supported employment/education, and peer support services. This CSC model has been shown to produce significantly improved outcomes among those with early onset of psychosis.[4] The Washington New Journeys program is required to serve eligible individuals regardless of payer type, including those who are Medicaid-enrolled, those enrolled in private insurance, and those without insurance. Under direction of 2SSB 5903, the Washington Council for Behavioral Health has worked with HCA, UW, WSU, and others to develop a standardized benefit package for CSC services and corresponding case rate; identify

[1] Heinssen et al., *Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care (RA1SE)*, National Institute of Mental Health, *available at* https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf.

[2] Senate Report 113-71 Calendar No. 128, 113th Congress, 1st Session, Departments of Labor, Health and Human Services and Education, and Related Agencies Appropriation Bill (Washington 2014) *available at* https://www.govinfo.gov/content/pkg/CRPT-113srpt71/pdf/CRPT-113srpt71.pdf.

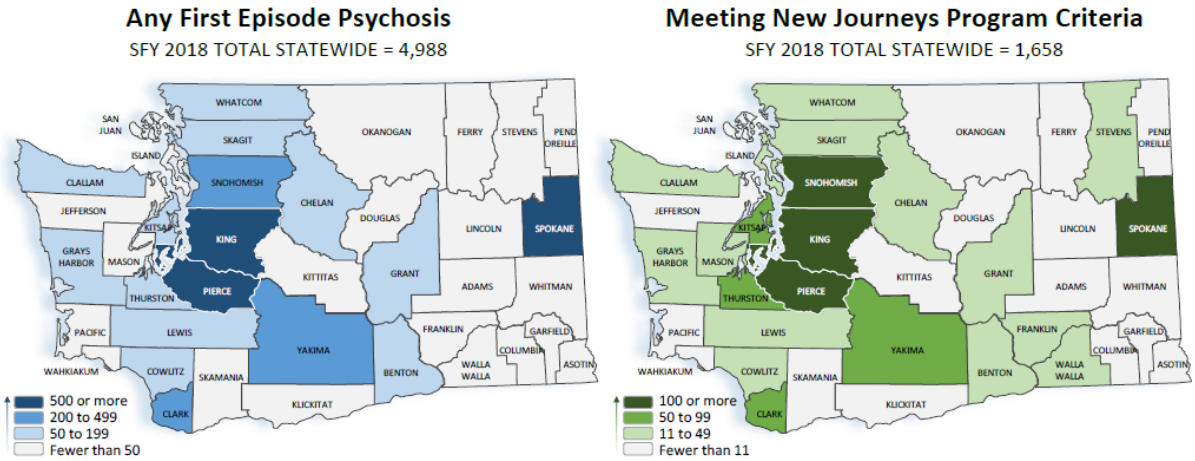
[3] Eligible diagnosis includes: schizophrenia, schizoaffective disorder, schizophreniform disorder, brief psychotic disorder, and psychotic disorder not otherwise specified which are not known to be caused by the temporary effects of substance use or medication (New Journeys Manual).

[4] *See notes 8–10 below.*

costs for start-up, training, and community outreach; and determine statewide needs and a timeline for implementation across the state of Washington.

b. Scope of Need for FEP Treatment Services in Washington

The Washington State Department of Social and Health Services (DSHS) Research and Data Analysis (RDA) division identified 4,988 Medicaid enrollees statewide who received their first psychotic diagnosis in State Fiscal Year (SFY) 2018; of these, 1,658 were within New Journeys qualifying age range (ages 15–40).[5] Expanding its analysis to include Dually Enrolled patients, or those who qualify for both Medicare and Medicaid benefits, RDA estimates that 1,756 new cases arise statewide per year within the target age range. This analysis, however, was limited to the Medicaid-enrolled and Dually Enrolled population; yet psychosis occurs in all populations regardless of payer type. National research on general population-based incidence over a broader spectrum of individuals across all payer sources estimates 86 new cases per 100,000 individuals per year among those aged 15–29, and 46 per 100,000 among those aged 30–59.[6] Based on the most recent census data available, it can be reasonably estimated that approximately 1,800 new incidences of FEP arise each year within Washington alone.[7] RDA data supports this assertion as a low-threshold estimate, although there are likely additional cases that research data is unable to account for among the uninsured, commercially insured, and/or those who are disengaged from healthcare services.



c. Benefits of Early Intervention

The cost of untreated psychosis is significant. In 2013, a study of costs in the U.S. associated with schizophrenia spectrum disorders included $37.7 billion in direct healthcare costs, $59.2 billion in unemployment, and $52.9 billion in productivity losses resulting from caregiving, as well as costs in loss of workplace productivity, increased use of criminal justice related resources, and premature mortality.[8] Comparing per-patient costs of individuals enrolled in an early intervention CSC program versus those following usual treatment protocols, average total costs per patient

[5] Hong et al., *First Episode Psychosis: Estimating Annual Incidence for Washington State Counties using Administrative Data*, Washington DSHS, Research and Data Analysis (RDA) Division.
[6] Simon et al., *Incidence and Presentation of First-Episode Psychosis in a Population-Based Sample* (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/.
[7] 2018 ACS 5-Year Estimates: Table S0101 Population by Age and Sex; see Section IV for further discussion.
[8] Murphy et al., *An Economic Evaluation of Coordinated Specialty Care (CSC) Services for First-Episode Psychosis in the U.S. Public Sector*, J. Ment. Health Policy Econ. 21(3): 123–130 (Sept. 2019).

engaged in early intervention *for healthcare services alone* were $2,991 lower per patient than those engaged in usual treatment.[9] Research shows decreased inpatient costs over a two-year follow-up period after CSC treatment, with the greatest cost benefits realized the earlier an individual is engaged in care after experiencing FEP, thus shortening the duration of untreated psychosis (DUP), with fewer mental health inpatient days per 6-month period and $3,778 lower inpatient costs among the lower-DUP cohort.[10] Long-term outcomes indicate farther reaching cost-savings and benefits, including increased employment and reduced dispensation of antipsychotic medications more than ten years after completion of CSC intervention.[11] With an annual cost per patient of approximately $18,000, this is well below the cost of other common medical procedures (e.g., the average cost of an angioplasty at $32,300, a knee replacement $29,000, and hip replacement $32,500, all of which are routine interventions covered across payer types).[12] The New Journeys program, while still in its early stages, has already garnered considerable success in decreasing symptoms of anxiety and psychotic experience and symptoms during treatment. Participants have likewise reported improved quality of life and engagement in school, while reducing psychiatric-related emergency department and inpatient usage and public assistance.[13]

II. Existing Benefit Packages, Payment Rates, and Resource Gaps

Coordinated Specialty Care (CSC) is a general term used to describe the specialized, team-based treatment model for FEP, but there are several different programs that utilize this model.[14] **New Journeys** is based on the NAVIGATE model, which was tested by RAISE (Recovery After an Initial Schizophrenia Episode), a large-scale NIMH-funded research initiative to test efficacy of the treatment model. Analysis across models demonstrates that the New Journeys benefit package is largely aligned with other CSC models in services offered and length of treatment:

[9] *Id*.
[10] Rosenheck et al., *Cost-Effectiveness of Comprehensive, Integrated Caser for First Episode Psychosis in the NIMH RAISE Early Treatment Program*, 42(4): 896-906 Schizophrenia Bulletin (2016).
[11] Stralin et al., *Early Recovery and Employment Outcome 13 Years After First Episode Psychosis*, Psychiatry Research 271 (2019) 374–380.
[12] Shern, D., Issue Brief- Financing Coordinated Specialty Care for First Episode Psychosis: A Clinician/Advocate's Guide, SMI Advisor (July 2020), *available at* https://smiadviser.org/wp-content/uploads/2020/08/CSC-Issue-Brief_v2-081320.pdf.
[13] Oluwoye et al*., Preliminary Evaluation of Washington State's Early Intervention Program for First-Episode Psychosis*, Psychiatric Services in Advance (2019), *available at* https://doi.org/10.1176/appi.ps.201900199.
[14] In the U.S., models include NAVIGATE, the Connection Program, OnTrackNY, Specialized Treatment Early in Psychosis (STEP) and the Early Assessment and Support Alliance (EASA), etc.

State	Washington (New Journeys)	New York (OnTrack)	Oregon (EASA)	Illinois (First.IL)	Portland, Maine PIER Program
Length of Service	• Up to two years (24 months)	• Up to two years (24 months)	• Up to two years (24 months)	• Three-five years, pending client needs	• Up to two years (24 months)
Services	• Pharmacological Treatment • Individual and Group Psychotherapy • Case Management • Individual Resiliency Training (IRT) • Supported Employment and Education • Peer Support Services • Family Education	• Medication management • Individual & Group Psychotherapy • Family and Individual Psychoeducation • Peer Support • Caregiver/Family Supports and Services • Educational & Employment Support • Case Management • Structured Behavioral Interventions (e.g. social and coping skills) • Individualized safety planning	• Outreach and engagement • Assessment, diagnosis, and treatment planning • Group and individual counseling • Medication support • Education and support for individuals, families/primary support systems • Crisis/relapse planning • Navigating rights and available benefits • Mentoring/peer connections • Independent living skill development • Occupational therapy • Educational and Vocational Support	• Psychiatric care (medications and interventions) • Individual resiliency training (coping and problem-solving abilities) • Supported employment/education • Family psychoeducation • Case management (care coordination, education on community resources, crisis management).	• Community outreach and education • Comprehensive assessment • Individual and family counseling • Multifamily group • Medication management • Employment and education support • Care management • Care Coordination • Psychiatric Consultation & Medication • Peer mentoring/ support

Current CSC programs are supported by a combination of federal Mental Health Block Grant set-aside funding and Medicaid and other third-party fee-for-service payments for certain covered services to receive reimbursement where available. The traditional fee schedule, however, not only does not cover all essential services within the model of care, but also does not reimburse for the team-based care model or off-site flexibility that is essential to the CSC evidence-based models noted above. In addition, a fundamental component of CSC or any early intervention program, is the up-front and ongoing community education and case-finding effort. These additional costs will be discussed later in the document. Below is a summary on how individual components of the CSC model may be supported by a patchwork of fee-for-service coverage; a more detailed list of CPT and HCPCS codes associated with the New Journeys care model is included on page XX in the New Journeys Manual for providers, included as Appendix X of this report:

CSC Model Component	Current Coverage
Team-Based Care and Coordination	Not Covered
Community Education & Outreach	Not Covered
Specialty Screening & Assessment	Not Covered
Pharmacotherapy	Medicaid – covered Medicare – covered Commercial – typically covered
Individual and Group Psychotherapy	Medicaid – covered Medicare – covered Commercial – typically covered
Supported Employment and Education (SEE)	Medicaid – covered in certain circumstances Medicare – not covered Commercial – typically not covered
Case Management	Medicaid – covered in certain circumstances Medicare – not covered Commercial – typically not covered
Peer Support	Medicaid – covered in certain circumstances Medicare – not covered Commercial – typically not covered

See New Journeys Manual for a detailed list of CPT and HCPCS codes and current coverage under current Service Encounter Reporting Instructions (SERI) guidance. See also attachment to this report for detail on the CPT and HCPCS code level for examples of typical commercial coverage.

To ensure a sustainable CSC program, it is crucial to implement a strategy that involves multiple payer sources. Data from current New Journeys sites indicates that in 2019, 78% of patients served were actively enrolled in public insurance, primarily Medicaid, 15% of patients were enrolled in private/commercial insurance, and 7% of patients were uninsured.[15] The proportion of Medicaid-enrolled participants remained fairly stable from prior year data in 2018 (77%), but the proportion of individuals in 2018 with private/commercial insurance was higher (20%) while uninsured were lower (3%).[16] The disproportionate share of Medicaid patients enrolled in treatment, however, is less likely to reflect the actual distribution of need across payer types than of access to care, in that individuals at risk of developing FEP may be more likely to access mental health services and qualify for enrollment in Medicaid prior to or during the course of FEP treatment and may have been more likely to be referred for services in the program.

In addition, established local referral patterns and relationships for the New Journeys sites are likely to focus on other safety-net providers and low-income populations than the broader healthcare system and network of private mental health professionals providing care under commercial health plans. Data from other more established programs with a longer history have demonstrated a more robust payer mix distribution. In New York, data from the OnTrack CSC program in 2017, five years after implementation of the program in 2013, indicated that of 13 existing FEP treatment programs statewide, percentages of clients enrolled in Medicaid ranged from 33% to 77%, with an average rate across all sites of 53% of patients enrolled in Medicaid.[17] A similar survey of patients enrolled in CSC programs in North Carolina in 2016 indicated that approximately 40% of patients were enrolled in Medicaid, approximately 38% of patients were privately/commercially insured, and approximately 22% of patients were uninsured. Rates of Medicaid-enrolled CSC patients increased over the duration of treatment in the North Carolina programs; at admission, most patients were privately insured (57%) or uninsured (25%) and became eligible for and/or enrolled in Medicaid during the course of treatment.[18]

Average payer rates vary significantly for the patchwork of insurance reimbursement options that are currently available. An analysis of average reimbursement by payer type for New Journeys programs operational in 2019 indicates that on average, the programs received approximately $96 per visit from Medicaid, while the average reimbursement rate for private/commercial insurance was $21 per visit.[19] Services for uninsured patients were fully supported through federal Mental Health Block Grant funding, which on average comprised over 70% of total program funding.[20] Based on available data, it is anticipated that as the New Journeys program becomes more established and expansive it will incorporate a wider population and payer mix, and increased level

[15] New Journeys 2019 Evaluation, Washington State University – Spokane.
[16] New Journeys 2018 Evaluation, Washington State University – Spokane.
[17] Smith et al., Estimated Staff Time Effort, Costs, and Medicaid Revenues for Coordinated Specialty Care Clinics Serving Clients with First Episode Psychosis, Psychiatric Service 70:5, May (2019).
[18] North Carolina Coordinated Specialty Care Services for Early Psychosis, Early Psychosis Interventions North Carolina Advisors (2017), *available at https://www.med.unc.edu/psych/epi-nc/files/2018/06/2017_10_23-revised-2016-2017-combined-sxs.pdf.*
[19] Data collected from New Journeys programs includes: BHR-Thurston, BHR-Grays Harbor, and Valley Cities Behavioral Health Care. Data collection on patient services revenue was limited as few teams have sufficient history to establish and implement robust billing and collection for services. Average reimbursement rates may increase as teams implement proper billing protocols.
[20] Id.

of insurance income. However, given the disparity in coverage of services and available reimbursement, a sustainable financial support system must both maximize insurance billings, including adoption of the newly developed Medicaid case rate and a commercial coverage mandate for CSC services, **and** provide ongoing support through federal Mental Health Block Grant and/or state general funds to cover the costs of the model that do not fall within a health benefit, including start-up costs, initial training, community education, and outreach and engagement.

III. Development of Discrete Benefit Package and Case Rate Prototype

In response to request by the Washington State Legislature in 2SSB 5903, HCA contracted with Mercer Government Human Services Consulting (Mercer) to develop an expected Medicaid case rate payment for the statewide implementation of the New Journeys program. As part of this work, Mercer performed an analysis based on current programmatic operations to determine potential Medicaid-allowable reimbursement levels under a uniform case rate. Services included in the preliminary case rate development were limited to Medicaid benefits currently covered under the State Plan, and anticipated a service duration of 24 months during which time the case rate will be issued on a monthly basis for each individual who utilized services (a per user per month (PUPM) payment methodology). Services included in the analysis were aligned with those included in the New Journeys Manual, attached to this report as [Appendix X].

Case rate development also included anticipated non-billable time required to deliver the CSC model of care, including training and fidelity monitoring, supervision, consultation, team meetings, research, and time spent traveling to community-based appointments. Additional adjustments were made to account for lower productivity due to greater documentation needs, medication management, and concurrent delivery of services (i.e., multiple providers present for certain services) in a team-based model.[21] Utilization data and research from other CSC programs demonstrates that individuals with FEP, on average, tend to require a higher intensity of services for an initial period, followed by a reduced level of services for the remainder of the treatment duration. Accordingly, Mercer developed a tiered rate using a durational analysis of utilization data over 24 months to arrive at a projected case rate for two phases—a Tier 1 phase for the first 6 months of services, followed by a Tier 2 phase for months 7–24 of services.

After summary of utilization data by month, Mercer arrived at the resulting case rate projection for CY 2021, per user per month (PUPM):

Tier	Projected Case Rate
Tier 1 (first 6 months)	$1,980
Tier 2 (months 7–24)	$1,310
Average (for illustrative purposes)	$1,480

Note that this is a preliminary case rate projection and not an actuarially certified payment rate. This rate may be used for budgeting estimates but is subject to refinement upon collection and analysis of additional data and information.

[21] New Journeys – Pricing Considerations and Case Rate Development. Mercer Report (June 30, 2020). A full copy of the Mercer report and the utilization data used in rate development is included in the Appendix of the legislative report.

Based on the projected case rate and the average proportion of Medicaid-enrolled clients within the New Journeys program, it is anticipated that once programs are able to reach a full caseload capacity of 30 participants and are billing at maximum efficiency, programs will be able to generate approximately 76% of the cost of annual operations. Realization of this level of patient services reimbursement will require a fully established team at full capacity; additional federal grant and/or state funding will be needed as teams are starting up, which will be discussed more fully below.

Average Annual Cost per New Journeys Team	Estimated % of Medicaid Enrolled Users	Avg. Blended Preliminary Case Rate	Total Projected Annual Medicaid Reimbursement	% of Team Costs Covered by Proposed Medicaid Rate
$ 548,228	78%	$ 1,480	$ 415,584	**76%**

While final development of an actuarial-certified rate is currently underway, there are several limitations to the rate-setting process that must also be considered and will need to be adjusted as the New Journeys program continues to expand and additional utilization data becomes available.

- Mercer's rate-setting methodology included certain non-billable and non-direct patient service-related components, as permitted under CMS managed care rules and listed above. However, there are additional components to the ongoing success of an established team that may impact the financial support required, including providing ongoing education to the public and healthcare providers to establish strong referral networks, and providing outreach and engagement to those that have been referred to the program, and their families, to engage in treatment. ***These costs will be detailed further in Section V below.***
- Because of the limited availability of data from rural and frontier areas, most of the data underlying non-billable time spent was limited to urban assumptions. Future updates will need to account for and verify differentials in time required for certain activities (e.g., travel) for rural/frontier regions.

Additionally, as the program continues to expand statewide, private/commercial insurance is anticipated to become an increasingly significant payer source for New Journeys participants, particularly given the younger demographic served (in 2019, the average age of entry into the New Journeys program was 20 years old)[22] and since passage of the Patient Protection and Affordable Care Act (ACA), young adults are able to remain on their parents' health insurance plans until age 26. Within continued statewide rollout and expansion, the proportion of enrolled individuals with private/commercial insurance may increase from the current average rate of 15% to levels seen in other states as high as 40–50%. A first step would be for HCA to provide the New Journeys teams with training and technical assistance related to billing all third-party payers. Without addressing parity in mental health coverage by private/commercial insurance plans, however, teams will be at risk of facing financial instability as private/commercial insurance typically focuses exclusively on fee-for-service payments that generally do not cover supported employment/education, case management, home or community-based care, and other components of the benefit package that are crucial to successful treatment.[23]

[22] New Journeys 2019 Evaluation, Washington State University – Spokane.

[23] See Dixon, L. B. (2017). What it will take to make coordinated specialty care available to anyone experiencing early schizophrenia: getting over the hump. JAMA Psychiatry, 74(1), 7-8, *available at* http://www.

It is imperative that the state engage the leadership of commercial insurers and Medicaid managed care organizations to support CSC as a benefit available to those with FEP. State insurance commissioners could mandate CSC as a covered service for policies written in the state. For example, the state of Illinois, to address this issue, has passed legislation that amends the state Insurance Code to mandate that for group or individual health insurance policies, coverage will be provided for FEP services provided through certified CSC teams in the state using a bundled payment that does not deconstruct the treatment model.[24] As of the time of this report, a workgroup in Illinois is developing selection of billing codes and determination of the rate as well as the credentialing requirements, but this is a promising practice to ensure that these important services are available to youth and young adults regardless of payer enrollment in Washington. Other states, including Maine and Connecticut, are likewise working to negotiate with commercial payers to establish coverage and inclusion of CSC in their benefit packages. Continued training and support currently provided by UW and WSU to the New Journeys teams would assure commercial payers that members are receiving services from providers with fidelity to the evidence-based model and may increase support of commercial payers who may have concerns about the potential cost of coverage and resultant cost savings and benefits to enrolled members.

naminycmetro.org/wp-content/uploads/2016/11/ WhatItWillTaketoMakeCoordinated-SpecialtyCareAvailabletoAnyoneExperiencingEarlySchizophre niaJAMACommentary.pdf.

[24] *See* 215 ILCS Sec. 356z.33 (a), requiring commercial insurance coverage of coordinated specialty care for first episode psychosis for those under age 26; requiring adherence to clinical models and contract with FIRST.IL through Dept. Human Services' Division of Mental Health to receive rate; requiring payment of bundled rate under one billing code or bundled set of billing codes; coverage will begin as of December 31, 2020 for all plans amended, delivered, issued, or renewed after that date, *available at* http://www.ilga.gov/legislation/publicacts/101/101-0461.htm. Workgroup to convene by June 30, 2020 to determine criteria for enrollment, code for billing. See Children & Young Adult Mental Health Crisis Act Implementation Timeline and Summary, *available at* https://1bo8dy15n7cz1sjbz5hoj5lt-wpengine.netdna-ssl.com/wp-content/uploads/sites/122/2019/10/Implementation-Timeline-for-Childrens-MH-Crisis-Act_Final1.pdf.

IV. Number of Coordinated Specialty Care Teams Required in Washington

The New Journeys Program currently has nine (9) sites operating across Washington, with sites in seven (7) of the ten (10) regional Medicaid service areas. Contracting processes to add sites in the Salish, Spokane, and North Sound regions are currently underway. Below is a list of existing sites at time of this report, as well as a map indicating the location of each site across the state.

Regional Service Area	Sites
Great Rivers	• Gray's Harbor County: Behavioral Health Resources in Hoquiam, WA
Thurston-Mason	• Behavioral Health Resources in Olympia, WA
Pierce County	• Comprehensive Life Resources in Tacoma, WA
King County	• Ryther in Seattle, WA • Valley Cities Behavioral Health Care in Kent, WA
Southwest Washington	• Clark County: Sea-Mar in Vancouver, WA
North Central	• Chelan County: Catholic Charities in Wenatchee, WA
Greater Columbia	• Franklin County: Comprehensive Healthcare in Pasco, WA • Yakima County: Comprehensive Healthcare in Yakima, WA
Spokane	• Frontier Behavioral Health, Spokane (Scheduled to open Winter 2021)
Salish	• Kitsap Mental Health, Bremerton (Scheduled to open Winter 2021)
North Sound	• Compass Health (Scheduled to open Spring 2021)

To determine the number of New Journey teams needed per region, an adaptation of a modeling tool developed by the New York State Office of Mental Health (OMH), in partnership with the RAISE Connection Program, was used.[25] This tool was the first decision support tool developed

[25] Humensky, J.L., et al., State Mental Health Policy: An Interactive Tool to Estimate Costs and Resources for a First-Episode Psychosis Initiative in New York State, Psychiatry Online (2013), available at https://doi.org/10.1176/appi.ps.201300186

for early intervention in psychosis in the United States, and was adapted to provide estimates for the number of teams needed in each Washington Regional Service Area based on the incidence data outlined below. Below is the estimate of team needs statewide based on population:[26]

Estimates for Number of New Journeys Teams Needed in Statewide Rollout

		Low Estimate	Medium Estimate #1	Medium Estimate #2	High Estimate
1	Total population size - Washington State (V)[1]	7,294,336	7,294,336	7,294,336	7,294,336
2	**Total Population - Ages 15-29**	1,480,193	1,480,193	1,480,193	1,480,193
	Number of new individuals in this age cohort with FEP per 100,000 population/year[2] (V)	86	86	86	86
	Rate of new cases of FEP per year (# new individuals/100,000) in this age cohort	0.00086	0.00086	0.00086	0.00086
	Incident cases of FEP/year	1,273	1,273	1,273	1,273
3	**Total Population - Ages 30-40**	1,126,570	1,126,570	1,126,570	1,126,570
	Number of new individuals in this age cohort with FEP per 100,000 population/year[2] (V)	46	46	46	46
	Rate of new cases of FEP per year (# new individuals/100,000) in this age cohort	0.00046	0.00046	0.00046	0.00046
	Incident cases of FEP/year	518	518	518	518
4	Number of incident cases of FEP per year within the target age population (Population size*Rate of new cases of FEP per year)	1,791	1,791	1,791	1,791
5	Fraction of incident cases approached (V)	20%	25%	33%	50%
6	Number of incident cases approached (Cases*Fraction approached)	358	448	596	896
7	Fraction of those approached agreeing to enter services (V)	50%	50%	60%	75%
8	Number of total new active individuals receiving services per year (Cases approached * Fraction agreeing to enter services)	179	224	358	672
9	Maximum # active individuals served per team (V)	30	30	30	30
10	Average # months in treatment (V)	24	24	24	24
11	Number of new individuals each team can take/month (active cases per team/months in treatment)	1.250	1.250	1.250	1.250
12	Number of new individuals each team can take/year (new individuals per month*12)	15	15	15	15
13	**Number of teams needed for population (# new active individuals per year/new individuals per team per year)**	**11.94**	**14.93**	**23.86**	**44.78**

As even under ideal conditions, outreach efforts would be unable to reach all incident cases, estimates of the ability of the CSC teams to contact and engage eligible participants in the program are presented as variables (lines 5 and 7), which combine to generate an anticipated range of active individuals requiring services per year (line 8) and the number of teams needed to meet that demand (line 13). These outreach and engagement levels are adjusted to present a series of low, medium-low, medium-high, and high estimates of the number of teams needed per area, depending on the level of success that teams are able to achieve in approaching and engaging the population with FEP. Variables in line 9 (maximum caseload per team) and line 10 (anticipated months in treatment) are static to reflect New Journeys program guidelines on team caseload and treatment times.[27] Based on this Tool, Washington requires at least 12 teams across the state, at a minimum, to identify and engage the population with FEP needs in each region and enroll them in care. To reach sufficient capacity to provide services based on need, however, incidence data supports a total of 45 teams statewide assuming New Journeys teams can achieve identification of only half of annual incident cases, and of those identified, engage 75% in treatment services. Thus, while immediate priorities should focus on establishing the minimum required number of teams, the goal over time should be to continue expansion of teams across the state to reach a level sufficient to address emergence of psychosis on a population-needs basis by 2023.

[26] A full-size image of the tool is included as an Attachment with this report.
[27] *See* New Journeys Manual, Appendix X.

Applying general population-based incidence rates per region[28] we can determine more precisely the number of New Journeys teams needed regionally. Below are estimates on the annual occurrence of FEP per year based on the population of each Regional Service Area that is within the New Journeys target age range (ages 15–40). Team needs based on regional service areas are rounded to the nearest 0.5 for ease in administrative planning. In addition to identifying the number of teams required per region, this Tool will also allow entities contracting to provide such services to estimate the number of individuals with FEP for which it would be responsible.

Regional Service Area	Total Population	Total Target Age	Annual Incidence of FEP
Statewide	**7,294,336**	**2,606,763**	**1,791**
Salish	367,818	117,832	82
Thurston-Mason	337,311	113,281	77
Great Rivers	279,496	82,992	57
Pierce	859,840	314,517	217
King	2,163,257	833,864	561
North Sound	1,225,448	427,280	294
North Central	253,626	82,306	57
Spokane	592,771	203,191	142
Southwest	498,400	164,763	113
Greater Columbia	716,369	266,737	189

Estimated Number of Teams Needed per Area

Regional Service Area	Low Estimate	Medium Estimate #1	Medium Estimate #2	High Estimate	Existing/2020 Planned Teams	Gap to Estimated Need - Low	Gap to Estimated Need - High
Statewide	**11.94**	**14.93**	**23.86**	**44.78**	**9.00**	**6.00**	**36.50**
Salish	0.54	0.67	1.08	2.02	-	0.5	2.0
Thurston-Mason	0.52	0.65	1.04	1.95	1.0	-	1.0
Great Rivers	0.38	0.48	0.76	1.43	1.0	-	0.5
Pierce	1.44	1.80	2.88	5.40	1.0	0.5	4.5
King	3.82	4.77	7.63	14.32	2.0	2.0	12.5
North Sound	1.96	2.45	3.91	7.34	-	2.0	7.5
North Central	0.38	0.47	0.75	1.41	1.0	-	0.5
Spokane	0.93	1.16	1.86	3.49	-	1.0	3.5
Southwest	0.75	0.94	1.51	2.83	1.0	-	2.0
Greater Columbia	1.22	1.53	2.44	4.58	2.0	-	2.5

Immediate priorities for adequate statewide implementation thus include:

- Establishing one team in the Salish Service Area, which currently has none
- Establishing one team in the Spokane Service Area, which currently has none

[28] Simon et al., Incidence and Presentation of First-Episode Psychosis in a Population-Based Sample (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5811263/ (estimating 86 new cases per 100,000 individuals per year among those aged 15–29, and 46 per 100,000 in those aged 30–59).

- Establishing at least one team in the North Sound Service Area, which currently has none, but also requires a minimum of at least 2 teams based on incidence data
- Increasing the teams in King County from two to four, to meet the minimum service capacity based on population incidence data
- Increasing the team capacity in Pierce County from one team to 1.5, to meet the minimum service capacity based on population incidence data

Although addressing these five priority areas will fulfill the 2SSB 5903 Section 6(2)(a) mandate of establishing a team in each Regional Service Area, the population incidence data indicates that continued team expansion in all service areas is necessary to meet the needs of the population experiencing FEP per Section 6(2)(b) in the bill. HCA is in negotiations and/or in the contracting process with a provider in each of the Salish, Spokane, and North Sound regions, and anticipates the start-up process for teams in Spokane and Salish will begin in January 2021. As existing team experience indicates that at least 6 months may be required to recruit a team in place, and approximately 9–24 months to ramp up to a full caseload, it is anticipated that these teams will be fully operational and at capacity serving their respective regions by the end of 2022. Again, however, these contracts underway will only meet the minimum mandate in 2SSB 5903 of having at least one CSC team available in each Regional Service Area, and as were funded in the 2019–20 state budget. As teams begin to develop stronger community awareness of early identification of FEP and robust referral sources are in place, identification and engagement of the annual number of emerging FEP cases will grow, and subsequent addition of teams should continue up to a level of 45 teams statewide (an addition of 36 teams from the current 9 existing statewide) to meet population-based needs and a goal of community engagement such that half of all annual cases can be identified and referred and/or approached by a team, and that of those identified, that the majority can be successfully engaged in treatment.

V. Costs of Statewide Implementation

Currently, New Journeys is primarily funded through federal Mental Health Block Grant funding; analysis of payer sources across teams in 2019 show that block grant funding comprised over 70% of funding to support team costs. While implementation of a Medicaid case rate will significantly impact financial support for the teams, as would commercial parity legislation, there are two additional categories of costs that will not be covered by third-party reimbursement and will impact the cost of statewide implementation and sustainability:

- One-time start-up costs required for statewide implementation of teams; and
- Ongoing costs unsupported by potential patient services revenue

One-time start-up and implementation costs for new programs include supporting the program during the recruitment of a full or partial team able to provide the evidence-based model of care to patients and thus begin generating patient revenue, time required to enroll a full caseload and thus begin generating more self-sustaining levels of patient services revenue, and time required to implement successful billing protocols.

Finally, a crucial component of start-up costs related to establishing new teams is a time-intensive requirement during the first year to establish a network of early referrers including local schools, universities, medical providers, mental health care professionals, community-based organizations, and members of the community to educate them about the availability of CSC for FEP and early risk signs that may merit referral for evaluation of eligibility for services. Other FEP programs

have reported that this initial engagement and education to the public and healthcare providers is a critical component to ensuring a strong source of early identification of community members that may benefit from the program, thus reducing the duration of untreated psychosis and contributing to improved health outcomes by promptly referring and connecting community members to care, but also contributing to a steady full caseload for teams, ensuring they are able to leverage their full staffing capacity in serving the community and take advantage of the optimal levels of third-party payor revenue that may be accessible to support the program.[29]

Based on the estimated cost per month per team, the average new team would continue to require approximately $666,682 in non-patient revenue-based support over a two-year period, even with implementation of a comprehensive Medicaid case rate for FEP. These costs would support a 6-month recruitment period, during which the team must recruit staff for a highly specialized set of services, and an 18-month ramp-up to a full caseload, which requires significant time, effort, and engagement with the local community to establish.

Implementation Cost Timeline Over Two Years

Cost During Recruitment		*Months 1-6*
Avg. Monthly Team Cost	$	47,077
Sub-Total - Estimated Team Costs During Recruitment Period	**$**	**148,294**
Team Cost during Case Load Ramp-Up		*Months 7-24*
Avg. Monthly Team Cost	$	47,077
Avg. Number of Months to Full Caseload		18
Avg. Team Cost During Ramp-Up	$	847,393
Sub-Total - Team Costs During Ramp-Up Period	**$**	**847,393**
Potential Reimbursement Off-Sets during Ramp-Up		
Avg. # Months to Full Caseload		18
Total Full New Journeys Caseload		30
Avg. Patient Enrollment per Month		1.67
Avg. Anticipated Medicaid Reimbursement during 2-Year Start-up Period	**$**	**329,004**
Anticipated Total 2-Year Implementation Costs	**$**	**995,686**
Anticipated Total 2-Year Patient Services Revenue	**$**	**329,004**
Anticipated Total 2-Year Costs Requiring Grant/State Funding	**$**	**666,682**

Once teams are fully established and operating at full capacity, there will remain continued ongoing costs that are unsupported by potential patient services revenue. Not all patients will be enrolled in public or private/commercial insurance, and it is critical that services be available for uninsured and underinsured members of the population. In addition, not included in the proposed Medicaid case rate are certain non-reimbursable activities crucial to the success of the program. While not as intensive as the time required in the first year of the program, ongoing education to the public and healthcare providers is essential to maintain the early referral network put into place

[29] E.g. PIER staff in Maine spent much of the first year of operations making onsite visits with professional groups, public school professionals, etc. EDIPPP PIER replication program provided approx. 300 formal presentations/year (avg. 22 attendees per presentation) and approx. 50 informal presentations/year (avg. 80 attendees per presentation). Guidance Manual: Educating Communities to Identify and Engage Youth in the Early Phases of Initial Psychosis (https://www.nasmhpd.org/sites/default/files/DH-Community_Outreach_Guidance_Manual__1.pdf);

during the first year and maintain a robust community knowledge of the program and steady maintenance of referral sources.

Additionally, New Journeys teams and similar CSC providers nationwide report that there is often a significant gap in time from when an eligible client is identified and referred for treatment, and when the individual completes intake and commits to engaging in treatment. Eligible clients are often reluctant to engage in treatment due to stigma as well as complications related to symptoms of FEP itself, including delusions, fears, and feeling unsettled.[30] Accordingly, there is additional time required by team members to educate and encourage individuals and their families to engage in treatment, during which time such activities would not be supported by any potential case rate or other third-party reimbursement as clinical treatment and service delivery has not yet begun. Yet, this time spent by the teams is also crucial because engaging in early treatment provides the best hope of recovery and achieving medical cost offsets. Implementation of the proposed Medicaid case rate and a commercial parity solution will greatly reduce the proportion of team costs supported by federal grant and/or state budget funds, thus improving ongoing support of these unfunded activities:

Average Current Proportion of Annual Team Cost Requiring Grant/State Support		*71%*
If Proposed Medicaid Preliminary Case Rate is Implemented:		
Potential Annual Medicaid Reimbursement at Full Capacity	**$**	**415,584**
Projected New Proportion of Unfunded Team Cost Requiring Grant/State Support		*24%*
If Commercial Parity is Required at Proposed Medicaid Case Rate:		
Potential Annual Commercial Reimbursement at Full Capacity	**$**	**79,920**
Projected New Proportion of Unfunded Team Cost Requiring Grant/State Support		*10%*
Annual unfunded Direct Patient Services (e.g. supporting Uninsured Patients)	$	41,972
Annual Cost of Time Spent providing Education to Public and Healthcare Providers	$	3,840
Annual Cost of Time Spent in Outreach and Engagement to Referred Patients/Families	$	6,912
Total Annual Average Costs Remaining per Team Requiring Grant/State Budget Support	**$**	**52,724**

Thus, it is anticipated that if the proposed Medicaid case rate were implemented and parity were required of commercial/private insurers, the proportion of costs required to be supported by federal Mental Health Block Grant funding would reduce from 71% to 10% annually. This diversification of funding sources would in turn allow block grant funds to be reallocated to support a greater number of teams across expanded geographic areas in Washington, reaching greater numbers of individuals experiencing FEP and reducing the overall ongoing burden to the state.

VI. Consideration of Future Expansion to the Clinical High-Risk Population

While the current focus of the Statewide Implementation Plan centers on expanding CSC teams for FEP, which by definition includes those who are already experiencing schizophrenia, schizoaffective disorder, and/or other psychotic disorders not caused by substance use or medication, there is significant value in expanding the program and eligibility criteria to include those at high risk for psychosis. Expanding program reach to the at-risk population will allow for

[30] National Alliance on Mental Illness, First-Episode Psychosis, https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions/Psychosis

earlier identification of those with FEP, which will result in significant cost benefit. There is a strong association between the duration of untreated psychosis (DUP) and short- and long-term outcomes.[31] Up to two-thirds of patients pass through a clinical high-risk state prior to their FEP, but few seek or reach treatment during this clinical high-risk phase.[32] Research demonstrates that the trajectories of long-term outcomes are established by treatment during the first two years.[33] Thus, expanding program reach and eligibility to the high-risk population could have significant gains not only in earlier identification of those that will experience FEP, but also ensuring that they are engaged in treatment during the earliest stage of the disease, shortening the length of this critical DUP period. The Research and Data Analysis Division (RDA) of DSHS has identified key risk indicators through administrative data collected on Medicaid-enrolled individuals who were diagnosed with FEP, which could facilitate identification and outreach to this population, including:

- Prior mental health diagnoses among young and young adults, including depression, mania, anxiety, and ADHD;
- Receipt of crises mental health services within the past six months was heightened for those with FEP;
- Youth and young adults at the highest risk for FEP had health, child welfare, and criminal justice system involvement prior within a recent six-month period. History of reported neglect and abuse was prevalent among members of this group.[34]

RDA's research indicates that it is feasible to assess the risks of FEP and identify high-risk individuals. Using its predictive model, RDA was able to identify 350–400 youth and young adults per year with a 10% or higher change of receiving a psychosis diagnosis in the subsequent year. Integrating child welfare, criminal justice, social service agencies, and acute behavioral health treatment facilities, and/or hospital emergency departments as part of a New Journeys identification and referral network for the clinical at-risk population would aid in prevention of FEP as well as facilitate more expedient connection to care should these at-risk populations develop psychosis. Additional factors will need to be analyzed to determine regional team needs and resulting costs, as well as the cost savings and benefits to the state:

- With an added potential 350–400 eligible youth and young adults per year, team capacity needs would increase by approximately 20–50% depending on the success and ability to identify and engage participants.
- Additional analysis would be needed to determine service utilization needs of the clinical high-risk population and reimbursement opportunity to support the sustainability of team expansion to serve this population.
- However, given the benefits that reaching this population would provide in early identification and intervention and the increased cost benefits and return on investment achieved by reducing DUP, expansion of programs to include and serve this population should continue to be a goal.

[31] Malla et al., Early Intervention in Psychosis in Young People, AJPH Perspectives Supplement 3, Vol. 109, No. S3 (2019).
[32] *Id*; citing Shah, J.L., et al., Is the Clinical High-Risk State a Valid Concept? Retrospective Examination in a First-Episode Psychosis Sample. Psychiatr. Serv. (2017); 68(10): 106-1052.
[33] Harrison G., et al., Recovery from Psychotic Illness: a 15- and 25-year international follow-up study. Br. J. Psychiatry (2001); 178(6): 506-517.
[34] Hong et al., First Episode Psychosis: Predicting the Risks of Psychosis Using Administrative Data, Washington State Department of Social and Health Services, Research and Data Analysis (RDA) Division (Feb. 2019).

- The PIER Program in Maine serves as a long-running successful model and example of evidence-based pharmacologic and psychosocial interventions to identify and treat the early warning signs of mental illness in youth ages 12–25 to prevent onset of psychosis, and can provide a model for how to expand the New Journeys program to meet the needs of this additional cohort.[35] Through inclusion of the at-risk population, the PIER program has been able to reduce first hospitalizations for psychosis by 34%, and impact trajectory of disability, dependence, and future cost of this population; including this population could result in similar benefits in Washington.

VII. Conclusions, Recommendations, and Action Steps

In conclusion, provision of Coordinated Specialty Care under the New Journeys team model provides a cost-effective array of services that research indicates not only results in improved outcomes (e.g., decreased symptoms, and improved quality of life and engagement in school), but reduced cost burden to the state in the form of decreased inpatient and emergency department utilization, dependence on public benefits, and engagement in the criminal justice system. Statewide incidence data indicates that Washington requires substantially more teams in place to meet population needs:

- In the immediate, at least six additional teams must be established to meet a **minimum** threshold across Regional Service Areas, including adding a team in the Salish and Spokane regions, increasing team capacity in Pierce County, and adding two additional teams each in the North Sound and King County regions.
- Expansion of teams should continue beyond this minimum threshold, however, to meet population health needs statewide, which indicate that at modest levels of patient identification and engagement up to 45 teams (an increase of 36 teams from current levels) are required to sufficiently address FEP based on a population-needs basis.

Teams currently rely on substantial support from federal grant and/or state budget funding, limiting financial feasibility of team expansion, but adoption of a case rate inclusive of the evidence-based components of the CSC care model would substantially decrease the cost burden to the state and allow reallocation of funds to support a significantly increased number of teams:

- Adoption of a Medicaid case rate inclusive of the model benefit package components delivered by the New Journeys teams is crucial to sustainability. With implementation of the preliminary Medicaid case rate, up to 76% of team costs could be supported by Medicaid reimbursement once teams are at full caseload capacity.
- As most commercial payers do not cover several of the critical components of the CSC model, addressing this coverage gap is also crucial to financial sustainability. With implementation of a commercial parity requirement to cover the CSC benefit package at a similar rate, the proportion of unfunded team costs requiring grant and/or state budget support could be further reduced to approximately 10% of annual costs.
- Thus, state cost burden could be minimized to focus support on unfunded direct patient services for uninsured patients and cost of essential non-reimbursable service, and could be spread across a substantially greater number of teams.

[35] National Association of State Mental Health Program Directors (NASMHPD), About Early Detection and Intervention of the Prevention of Psychosis Program, available at https://nasmhpd.org/content/about-edippp.

Future New Journeys team planning and anticipated capacity should also consider the need to maintain continuity of care after the 24-month treatment period. Following the durational CSC intervention, engaged participants will continue to need stepped down services (which may be more adequately supported based on current Medicaid and/or commercial coverage) to maintain early treatment gains. Additionally, given the benefits of minimizing the duration of untreated psychosis and the increased cost savings realized by engaging individuals in care as early as possible, Washington should continue to pursue inclusion of the clinical high-risk population that have not yet experienced FEP as part of the New Journeys treatment-eligible population. Incorporation of this critical population was originally intended as part of this scope of work but was moved to a subsequent phase as a result of delays in contract start-up and resource impacts of COVID-19, but continues to remain an important component of a population health-based strategy to address psychosis that integrates prevention, education, and early intervention. Leveraging the risk factors identified by RDA that strongly correlate to future experience of FEP, teams could incorporate this group into outreach and engagement strategies and the state would continue to realize cost savings and improved health outcomes by future inclusion of this cohort into treatment. Further analysis will be required to determine estimated cost impact and capacity needs and should be included in future implementation planning.

Action Steps for Statewide Implementation

1.	***Adopt a Medicaid Case Rate for Coordinated Specialty Care***
a.	Adoption of a comprehensive Medicaid Case Rate is crucial to financial sustainability
b.	With implementation of the preliminary rate, an estimated 76% of annual team costs could be supported by Medicaid reimbursement once teams reach a full caseload
2.	***Continue to Expand New Journeys Teams to Meet Population Health Needs Statewide***
a.	Coordinated Specialty Care should be available regardless of county or region of residence
b.	2SSB 5903 requires a minimum of one team per regional service area by 2020; statewide expansion necessary to meet population health needs must be completed by 2023
3.	***Implement a Commercial Parity Requirement to Cover Coordinated Specialty Care***
a.	Commercial insurance typically does not cover most services in the CSC model; addressing this gap is likewise critical to continued financial sustainability of teams
b.	With addition of a commercial parity requirement, along with adoption of the Medicaid Case Rate, unfunded team costs could be further reduced to 10% of annual costs
4.	***Include the Clinical High-Risk Population as Eligible for Treatment***
a.	RDA has identified risk factors that strongly correlate to future experience of First Episode Psychosis, which New Journeys teams could incorporate into outreach and engagement
b.	Incorporating the clinical high-risk population will reduce duration of untreated psychosis, improving outcomes of those experiencing psychosis and realizing additional cost savings
5.	***Maintain Continuity of Care through Step-Down Services***
a.	Following the 24-month New Journeys intervention, research indicates participants benefit greatly from continued step-down services to maintain and cement treatment gains
b.	Additional New Journeys team planning should include capacity and reimbursement strategies to support continued engagement with those who have completed CSC treatment
c.	These services may be adequately supported by current Medicaid and/or commercial insurance coverage; additional analysis should assess strategies to support this component