Key Findings

Analysis of California Senate Bill 1337
Coordinated Specialty Care for First-Episode Psychosis

Summary to the 2021–2022 California State Legislature, April 20, 2022

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

The version of California Senate Bill 1337 analyzed[1] by CHBRP would require coverage of coordinated specialty care (CSC) services for the treatment of first-episode psychosis (FEP).

In 2023, of the 22.8 million Californians enrolled in state-regulated health insurance, 14.8 million would have insurance subject to SB 1337.

Benefit Coverage: At baseline, none have benefit coverage compliant with the bill's requirements. Postmandate, 100% would

Medical Effectiveness: Evidence of the effectiveness of CSC, as compared to outpatient treatment-as-usual is varied among the outcomes of interest.

Cost and Health Impacts[2]: In 2024, SB 1337 would result in 5,010 (of 15,029) enrollees with FEP accessing services from CSC teams. Annual expenditures would increase by $69,146,000 (0.04%). This change includes increases in premiums as well as, for enrollees engaged with CSC teams, decreases in cost sharing

SB 1337 would produce limited public health impacts because, although the CSC model is effective in improving some health outcomes (treatment adherence, psychiatric hospital admissions, reductions in hallucinations and delusions, recovery from psychosis and general functioning), it does not appear to be more effective than outpatient treatment-as-usual for other outcomes (relapse rates, psychotic and depressive symptoms, and quality of life).

Long-term impacts would remain limited, due to persistent provider supply limitations and other barriers (e.g., stigma, misdiagnosis of symptoms).

CONTEXT

Psychosis is a symptom of a range of mental health disorders. It is an abnormal state involving significant problems with reality testing. It can include delusions, hallucinations, incoherent or nonsense speech, behavior inappropriate to the situation, paranoia, and/or catatonia. Episodes are sometimes accompanied by violent acts most often self-directed. It may affect a person briefly as an episode, or as a long-term chronic illness that requires mental health treatment. Nationally, three out of 100 people experience psychosis during their lifetime, with most recovering.

First-episode psychosis (FEP) refers to the initial onset of signs and symptoms of loss of contact with reality; it often occurs before a mental health disorder or physical condition is clinically diagnosed. FEP experiences usually occur in adolescence to early adulthood (12–30 years of age) with the peak age of onset for schizophrenia-spectrum/primary psychotic disorders at 20.5 years of age.

BILL SUMMARY

SB 1337 would:

- Require coverage of coordinated specialty care (CSC) services for the treatment of FEP, a team-based service delivery method including but not limited to case management, pharmacotherapy and medication management, psychotherapy, and outreach and recruitment activities.
- Require CSC services to be consistent with the National Institute of Mental Health's (NIMH) *Coordinated Specialty Care for First Episode Psychosis Manual II: Implementation*, and would specify the CSC team membership, training, and supervision requirements.
- Require use of specified billing procedures for bundled CSC team services.

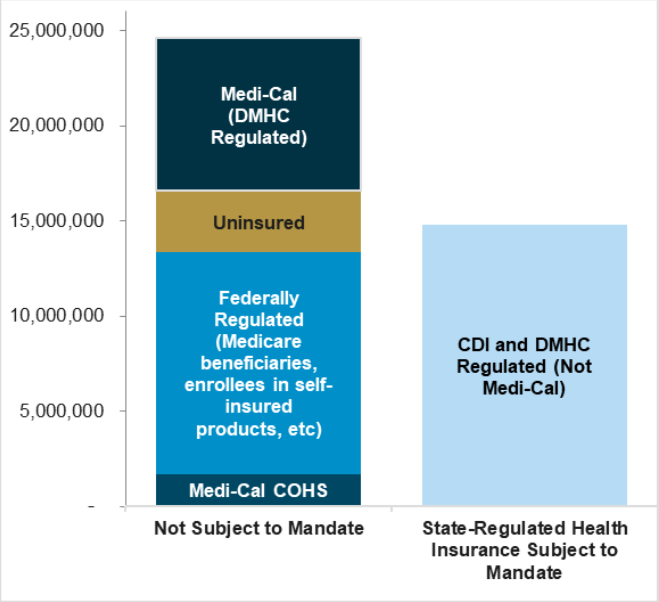
SB 1337 would also require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), in collaboration with Department of

[1] Refer to CHBRP's full report for full citations and references.
[2] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

Health Care Services (DHCS), to create a working group to establish guidelines, including but not limited to inclusion and exclusion criteria for enrollees eligible to receive CSC services, and caseload and geographic boundary parameters for the CSC teams.

As noted in Figure A, SB 1337 would apply to the benefit coverage of commercial enrollees and enrollees in plans and policies regulated by DMHC and CDI — including those associated with the California Public Employees' Retirement System (CalPERS). As Medi-Cal already covers CSC services and as it is unclear how the change in the Health & Safety Code would affect the benefit coverage of beneficiaries enrolled in DMHC-regulated plans, CHBRP has assumed SB 1337 would not apply to the benefit coverage of these Medi-Cal beneficiaries.

Figure A. Health Insurance in CA and SB 1337



Source: California Health Benefits Review Program, 2022.
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care; COHS = County Organized Health System.

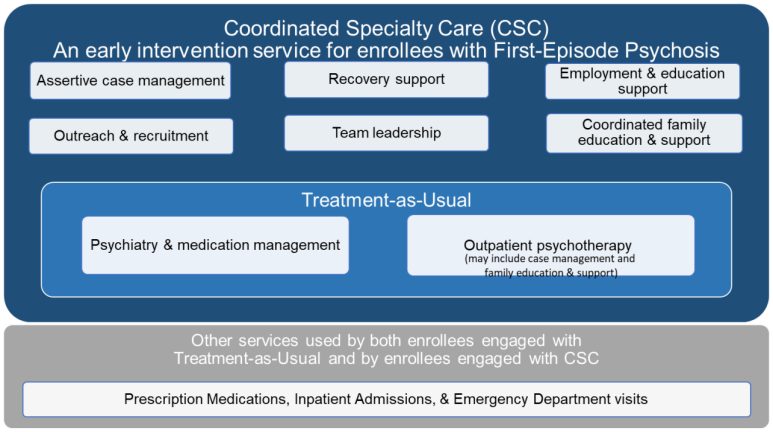
ANALYTIC APPROACH

Figure B shows the relationship between CSC services, outpatient treatment-as-usual, and other services used by people experiencing FEP.

Although SB 1337 does not address coverage for services outside of CSC, this analysis considers the impact of engagement with a CSC team on enrollees' use of psychiatric and nonpsychiatric hospitalizations, emergency room visits, and prescription drugs.

Although SB 1337 would require coverage for employment and education support beyond the 1 to 2 years of an enrollee's engagement with a CSC team, CHBRP has not modeled that additional utilization and cost, which would not begin until some years after the projections included in this analysis.

Figure B. Services Used by Persons Experiencing First-Episode Psychosis



Source: California Health Benefits Review Program, 2022.

IMPACTS

Medical Effectiveness

Evidence of the effectiveness of CSC, as compared to outpatient treatment-as-usual, is varied among the outcomes of interest. Below are the medical effectiveness findings for CSC for an average duration of 2 years compared with outpatient treatment-as-usual.

CHBRP found a *preponderance of evidence*[3] that, compared to outpatient treatment-as-usual, CSC:

- Increases treatment adherence;
- Improves positive and negative psychotic symptoms;
- Improves general functioning; and
- Reduces admissions to a psychiatric hospital.

CHBRP found *limited evidence*[4] that, compared to outpatient treatment-as usual, CSC:

[3] *Preponderance of evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective.

[4] *Limited evidence* indicates that the studies have limited generalizability to the population of interest and/or the studies have a fatal flaw in research design or implementation.

- Reduces mean number of hospital days per year;
- Increases the likelihood that people will recover from psychosis;
- Improves cognitive functioning; and
- Does not affect relapse rates or quality of life.

CHBRP found *inconclusive evidence*[5] that CSC decreased effects on general psychotic symptoms and depressive symptoms.

CHBRP found *insufficient evidence*[6] about the effects of CSC on:

- Emergency room visits;
- Recreational drug use; and
- Incidence of violence.

One study (*insufficient evidence*) found that CSC improves mental health status and quality of life among people in the highest socioeconomic status (SES) quartile but not among people in lower SES quartiles.

CHBRP found *limited evidence* that receiving CSC for up to 5 years, when compared to CSC for an average of 2 years:

- Reduces disengagements from mental health treatment services.
- Increases remission rates.
- Does not reduce psychiatric hospital utilization.
- Does not improve general functioning.

Benefit Coverage, Utilization, and Cost

SB 1337 would require DMHC and CDI, in collaboration with DHCS, to create a working group to establish guidelines, including but not limited to inclusion and exclusion criteria for enrollees eligible to receive CSC services, and caseload and geographic boundary parameters for the treatment team. In 2023, the first postmandate year, the working group would begin and existing CSC programs would begin to expand capacity, but no measurable impact is expected. The impact figures in this report would be for the following year, 2024.

CHBRP has assumed that the diagnoses that would most commonly be associated with engagement with CSC teams would include those reported in the NIMH manual for implementation of CSC teams: schizophrenia, schizoaffective and schizophreniform disorders, delusional disorder, and psychosis not otherwise specified (NOS). This report presents changes in utilization for enrollees with these diagnoses, some of whom, postmandate, would become engaged with CSC teams while others continued with outpatient treatment-as-usual.

Benefit Coverage

Of the14,776,000 enrollees with health insurance that would be subject to SB 1337, none have benefit coverage compliant with the bill's requirements. Postmandate, 100% would.

Utilization

In 2024, when the DMHC-CDI-DHCS working group will have provided guidance and by when CSC teams will have had time to expand capacity, CHBRP estimates that one-third of eligible commercial/CalPERS enrollees (i.e., those aged 15–35 years experiencing FEP) would engage with a CSC team.

For those enrollees engaged with a CSC team, CHBRP estimates:

- A 5% reduction in inpatient psychiatric hospitalizations; and
- An end to use of outpatient treatment-as-usual (psychotherapy and medication management visits) with a concomitant increase in use of the CSC team for those services.

Unit Costs

Postmandate, per-unit costs for CSC team services would be monthly payments for bundled services. CHBRP estimates a monthly CSC team cost per enrollee of $1,551, so $18,606 for an enrollee engaged with a CSC team for a full year.

CHBRP projects no change in per-unit costs for other services used by enrollees with FEP.

Expenditures

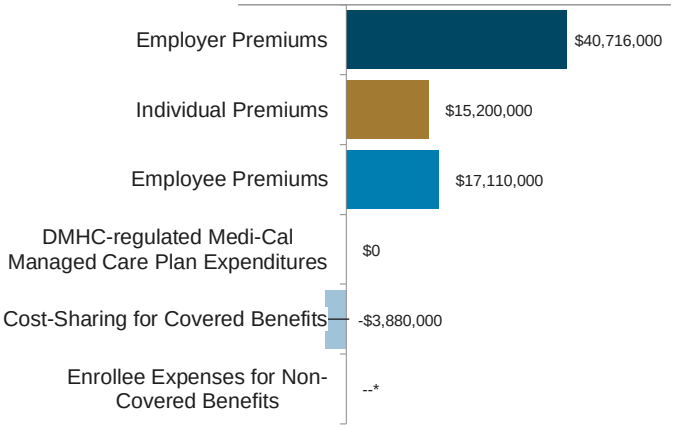
SB 1337 would increase total net annual expenditures by $69,146,000 (0.04%). This change includes increases in premiums as well as — for enrollees engaged with

[5] *Inconclusive evidence* indicates that although some studies included in the medical effectiveness review find that a treatment is effective, a similar number of studies of equal quality suggest the treatment is not effective.

[6] *Insufficient evidence* indicates that there is not enough evidence available to know whether or not a treatment is effective, either because there are too few studies of the treatment or because the available studies are not of high quality. It does not indicate that a treatment is not effective.

CSC teams — decreases in cost sharing (which are not expected to be applicable for CSC team services).

Figure C. Expenditure Impacts of SB 1337



Source: California Health Benefits Review Program, 2022.

Notes: *Although it is possible, CHBRP is unaware of any commercial enrollees self-paying for CSC services.

Medi-Cal

No impact would be expected for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

CalPERS

Premiums for CalPERS enrollees in DMHC-regulated plans would increase by 0.06%.

Covered California – Individually Purchased

Premiums for individually purchased Covered California plans/policies would increase by 0.06%.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 1337

Public Health

In the short term, SB 1337 would produce a limited public health impact with 5,010 (of 15,029) eligible enrollees with FEP accessing CSC programs. This projection is supported by evidence that the CSC model is effective in improving some health outcomes, including treatment adherence, psychiatric hospital admissions, reductions in hallucinations and delusions, recovery from psychosis, and general functioning. However, CSC programs do not appear to be more effective than outpatient treatment-as-usual for other outcomes, including relapse rates, psychotic and depressive symptoms, and quality of life. Moreover, although some barriers to care would be removed, such as insurance coverage/cost, coordinated care, outreach and intake, other barriers to care would remain, including limited provider supply, misdiagnosis of symptoms, and patient concerns with stigma.

Long-Term Impacts

The long-term impacts from SB 1337 would remain limited, similar to the short-term impacts projected in this analysis, due to persistent provider supply limitations and other barriers (e.g., stigma, misdiagnosis of symptoms). CHBRP estimates about 5,000 enrollees per year would receive treatment through a CSC team.

Essential Health Benefits and the Affordable Care Act

Two components of CSC team service (as defined by SB 1337) could exceed essential health benefits (EHBs): outreach and recruitment activities and educational and employment support. As the two services would be only a limited portion of the bundled set of services for which a CSC team would bill on a monthly basis, CHBRP cannot estimate the potential cost of SB 1337 exceeding EHBs.