Financial Analysis: Crisis Services for Children and Youth in Travis County

Final Report

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Presented By:

TEXAS STATE of MIND

THE MEADOWS MENTAL HEALTH POLICY INSTITUTE FOR TEXAS

Commissioned by:

Integral Care

Table of Contents

Executive Summary

In May 2018, Integral Care asked the Meadows Mental Health Policy Institute (MMHPI) to assess funding for crisis mental health services for children and youth in Travis County. The purpose of this assessment was to support the objectives and recommendations developed by the Children's Crisis Services Task Force (Task Force). Integral Care requested that the assessment include five components:

1. Overview of the current crisis system serving children and youth in Travis County and funding sources used to support crisis services;
2. Analysis of how much is spent on inpatient hospitalizations for Travis County children and youth in psychiatric hospitals, including amounts paid by Medicaid, Medicare, private insurance, and self-pay;
3. Analysis of how Travis County could maximize the use of available public resources;
4. Identification of potential additional mechanisms to support mental health service for children and youth; and
5. Information on potential opportunities to fund recommendations issued by the Task Force.

The information provided in this report is intended to support the overarching mission of the Task Force, which is to improve the quality and availability of community-based crisis services for children and youth. Nationally, the average young person with a mental health concern waits 8–10 years[1] between the onset of symptoms and when he or she obtains care. Without early intervention, symptoms often intensify and reach a point of crisis.

The crisis system for children and youth is a critical entry point for many who need mental health services. In an ideal crisis continuum, a community has the ability to respond to the full range of episodic and intense needs that routinely occur over the course of care. In such a system, crisis events are minimized through integrated care efforts in schools and primary care settings, which include screening and connections to mental health services and supports when appropriate. When children and youth receive crisis care, they are linked to a range of appropriate services that include rapid response to support de-escalation as well as ongoing services and supports for young people and their families to remain stable in the ensuing months and years.

Because of a variety of systematic and financial factors, the current crisis system does not provide the ideal continuum of care. In **Part 1** of this report, we describe key services and service providers that are part of the crisis system, including who they serve and how they are financially supported. In **Part 2,** we provide data on utilization and payments made for emergency hospital services and inpatient care received by children and youth in Travis County. Additional hospital utilization data is also provided in **Appendix 1**. In **Part 3**, we draw from the information presented in Parts 1 and 2 – and our knowledge of healthcare system design,

[1] National Alliance on Mental Illness (2018). *Mental Health Screening*. Retrieved from https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Mental-Health-Screening

delivery, and financing – and summarize opportunities to maximize current and additional resources to strengthen crisis care for children and youth.

While the potential solutions identified in Part 3 are specific to the current system in Texas and address ways to make better use of Medicaid dollars for crisis care, **Appendix 2** focuses more broadly on federally allowable opportunities to use alternative payment mechanisms to support comprehensive crisis care programs. Appendix 2 includes a description of an alternative payment justification developed by the state of Oregon for two crisis providers. **Appendix 3** includes a summary of examples of crisis services and financing systems from other states. **Appendices 4 and 5** includes baseline data provided by two programs that implemented crisis services. To further support discussions with Medicaid managed care organizations (MCOs) on strategies to increase Medicaid supported crisis services, **Appendix 6** includes language from the Florida Medicaid managed care contract, as it pertains to "in lieu of" services. Such allowances are worth considering as they relate to crisis care, enable Medicaid payments for services not included in the Medicaid State Plan, and can provide an effective alternative to inpatient care.

Our findings and recommendations pertaining to Travis County's crisis services array – and its relationship to the broader mental health system for children and youth in the county – are based on the knowledge we have gained from our assessments of children's mental health systems of care in other communities and information we have analyzed for this report that is specific to Travis County. Our findings are summarized below.

- There is a dearth of available home and community-based mental health services. This shortage is likely to contribute to an increase in the number of crises and to lead to overuse of inpatient hospitalization because of limited community-based alternatives.
- Integral Care is the only provider that offers an array of crisis services to the entire population.
- Many components of the child and youth ideal crisis continuum are not offered in Travis County, including crisis respite and short-term residential services.
- Few of the crisis services offered through Integral Care are currently billable through Medicaid. Integral Care must therefore draw from other reserves to cover the cost of services.
- In addition to current barriers by Medicaid payers that limit payment for needed services, many non-profit and community-based services providers frequently choose not to bill Medicaid for services because of the complexity and perceived hassle involved with this process. These challenges are exacerbated by the presence of multiple managed care programs and plans, each with its own contract requirements. This limits both capacity and choice for Medicaid recipients and also puts additional burdens on limited foundation and local funds that could otherwise be used to expand access to other services.
- Medicaid payment rates do not cover the costs or the full array of crisis services that have better outcomes than treatment as usual. Consequently, the current crisis

continuum does not include a MCOT dedicated to serving children, intensive home and community-based crisis stabilization services, and residential crisis respite options.

- Given the rapid increase in the population in Travis County, and a recent rise in youth suicides in the county, demand for crisis services is growing. To keep pace with a growing and diversifying population, Integral Care needs support from partner organizations. Multipronged support for crisis services is especially important to ensure approprioate response times, especially for mobile units that are experiencing an uptick in demand in a broader geographic area.
- There are few formal agreements between providers in the community to facilitate coordination of care or ensure appropriate service bridges to "step-up" or "step-down" care during a crisis event.

Given the challenges and barriers identified in this report, we offer several strategies for community leaders to consider in order to maximize the impact of current funding and improve overall effectiveness of crisis services for children and youth in Travis County. These recommendations include.

- Work with Medicaid managed care organizations (MCOs) to develop a value-based payment arrangement using case rates for crisis services for Medicaid members. This strategy would allow for Medicaid reimbursement for crisis services not currently covered through the program.
- In addition to value-based payment arrangements, develop a value-added service contract with the MCOs. All MCOs are required to provide some type of value-added services, which is an additional type of benefit or service not otherwise included through Medicaid, that is covered by the MCO.
- Coordinate with the Health and Human Services Commission (HHSC) and Medicaid MCOs to establish "in lieu of" service arrangements which would substitute a benefit currently covered by Medicaid for an alternative service. For example, providing short-term residential crisis stabilization instead of inpatient psychiatric care.
- Once Medicaid funding is better integrated to pay for the needs of the many children and youth with Medicaid coverage, expand service offerings further by establishing braided funding arrangements with the county, the city, juvenile justice, and child welfare agencies.
- With Medicaid and other agency funding maximized, redirect limited philanthropic support to service innovation, gap filling, and evaluation of the costs and benefits of current services in order to continue to fill critical gaps in care in a cost-effective and sustainable way.
- Develop a crisis service payment hierarchy agreement among different payors. A payment hierarchy would involve the coordination of multiple potential payers such as Medicaid MCOs, commercial insurers, Travis County, the City of Austin, and the child welfare and juvenile justice system. Through this arrangement a case rate would be developed for specified crisis services and the appropriate payer within the hierarchy would cover the expense for eligible populations. For example, the Medicaid MCO a child or youth with Medicaid would cover the cost of services included for their

members, but juvenile justice might pay on behalf of a young person being served through their system who does not have Medicaid.

We hope the findings and recommendations presented in this report serve as a valuable resource to the community in supporting the work of the Task Force and future efforts to expand and improve crisis services and supports for Travis County children and youth. We are grateful for the support and leadership of Integral Care in improving crisis care.

Introduction

In February 2015, members of the community in Travis County – including providers, community leaders, and schools – jointly released the *Travis County Children's Mental Health Plan* (The Plan) following an extensive community planning process. The Plan was created to address mental health promotion and treatment among children and youth in Travis County and addresses the following goals:

- Promoting wellness and supporting resiliency;
- Providing a continuum of care and effective treatment options for children and youth with a broad range of needs and levels of complexity;
- Responding effectively to children, youth, and families in crisis; and
- Improving outcomes and accountability across the local mental health system.

Since the publication of The Plan, various workgroups and committees have convened to address specific components of The Plan and to implement the recommendations. On October 27, 2017, Integral Care hosted a Leadership Summit that focused on crisis services. Panelists and audience members at the summit agreed on the need to increase and improve the crisis care continuum. In response to the concerns raised at the summit, Integral Care established the Crisis Services Task Force (Task Force).

The Task Force includes 39 people representing 23 organizations, each with unique insights into the current crisis service array. The goal of the Task Force is to identify current needs and services and provide recommendations to strengthen the mental health crisis system for children, youth, and families in Travis County. The Task Force met for the first time on December 18, 2017 and concluded its work in October 2018 with the release of its final recommendations.

To support the work of the Task Force, Integral Care contracted with the Meadows Mental Health Policy Institute (MMHPI) to perform a financial analysis of crisis services for children and youth and provide a report of its findings and recommendations to the Task Force. The purposes of this report are to provide information on how crisis services are currently funded and to identify financing opportunities that can help expand or improve the delivery of crisis care. This report addresses the following components:

- Analysis of how children's mental health crisis services are currently funded in the county, including local, state, and federal sources of such funds;
- Analysis of the amount of funds spent on emergency room use and inpatient hospitalizations for children and youth who were in psychiatric hospitals during the State of Texas Fiscal Year 2015;
- Analysis of how members of the Task Force can maximize the use of available public resources and additional opportunities to best support mental health crisis services for children and youth; and
- Recommendations to fund the implementation of system improvements and new or expanded services recommended by the Task Force.

Methodology and Scope

The analysis conducted for this project was performed by a team at MMHPI with diverse expertise in Medicaid managed care and Medicaid funding; behavioral health services; child welfare and foster care; juvenile justice; mental health delivery systems for children, youth, and their families in communities; and data analysis. The analysis was conducted between May and September 2018.

We obtained information for this report through a series of interviews with key stakeholders, data provided by stakeholders, research on Medicaid financing and best practices, previous experience working on similar mental health analyses in other states, and data pulled from the 2015 Texas Health Care Information Collection (THCIC) and Annual Survey of Hospitals.

For this project, we conducted interviews or collected information from the following organizations:

- Integral Care
- Dell Children's Medical Center
- LifeWorks
- Austin Child Guidance Center
- Austin State Hospital
- Travis County Juvenile Probation Department
- The Children's Partnership

Parallel to the stakeholder interviews, our staff identified specific data points that were necessary for evaluating the crisis system for children and youth. The data we reviewed covered costs/expenditures and utilization of inpatient, emergency room, hotline calls, Mobile Crisis Outreach Team (MCOT), and Psychiatric Service Center services. An in-depth description and discussion of the various data points are presented in the following sections of the report. Utilization and expenditure data were limited to services delivered to children and youth whose county of residence was Travis County; however, expenditure data also included services provided outside Travis County that were paid for by Travis County. For example, if a child or youth resided in Travis County but was hospitalized outside of the county, those costs were attributed to the Travis County system.

Finally, our staff analyzed both the information obtained through interviews and the data/financial reports to provide a comprehensive overview of the Travis County crisis system as it relates to the mental health needs of children and youth and their families.

Part 1: Analysis of Current Crisis Services and Funding Mechanisms

Travis County Children's Taskforce Definition of Crisis

The Texas Administrative Code (TAC) defines "crisis" as a situation in which: (a) a person presents an immediate danger to self or others; (b) a person's mental or physical health is at risk of serious deterioration; (c) a person believes that he or she presents an immediate danger

to self or others or that his or her mental or physical health is at risk of serious deterioration.[2] Integral Care broadly defines crisis based on the TAC definition. Common examples of mental health crisis include (1) thoughts or plans to commit suicide; (2) decompensation as defined by the TAC; (3) someone whose current functioning restricts his or her ability to go school or work, maintain healthy relationships, and/or successfully engage in activities of daily living; or (4) major changes in mood that impact functioning. Integral Care provides a continuum of crisis services, including screening and assessment, to anyone in Travis County who reports or is reported by others to be experiencing a mental health crisis.

The Children's Crisis Services Task Force's (Task Force) definition of crisis aligns with the TAC and Integral Care definitions; is specific to children, youth, and their families; and takes into consideration the fact that a crisis can result from an inability to alleviate distress. The Task Force's definition is as follows:

> *Children or youth are considered to be experiencing a mental health crisis when they are in a state of distress that they are unable to resolve with the skills and resources available to them, thereby impacting their ability to function in their environment and/or creating the potential of danger to themselves or others.*

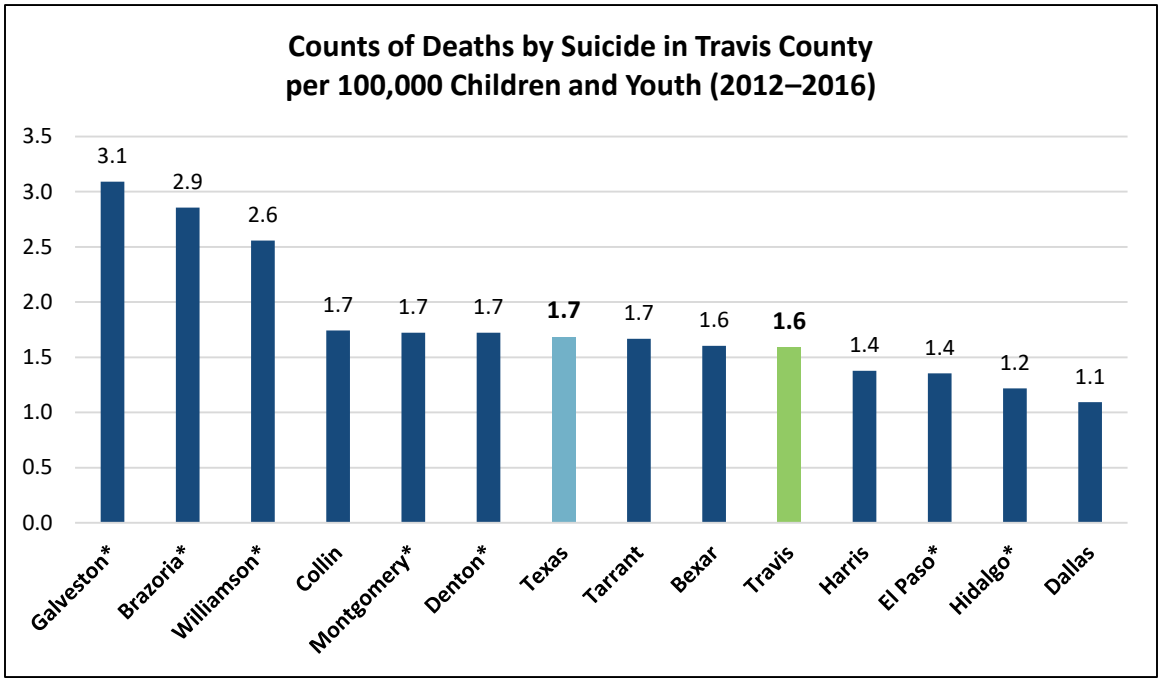
Overview of Need for Child and Youth Mental Health Crisis Services

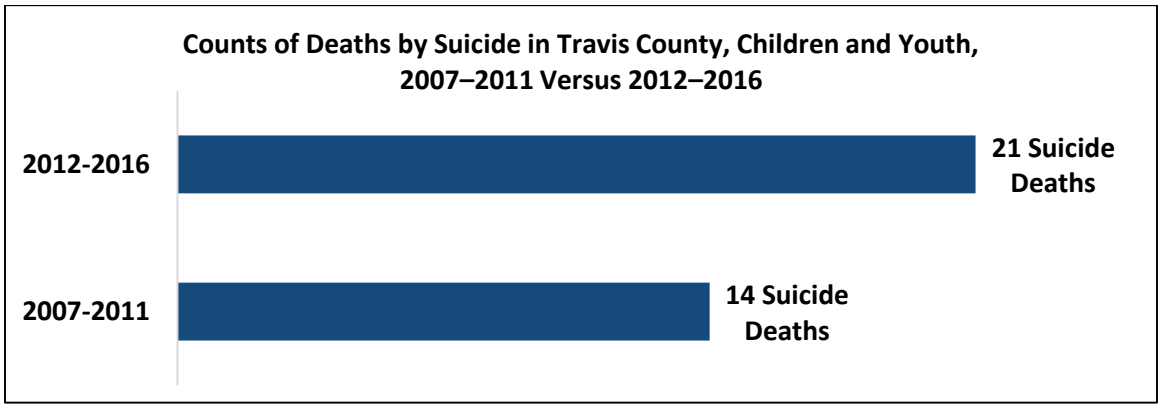
From a system intervention perspective, individual crises exist on a spectrum, with some crises requiring immediate intervention in a safe and secure place, such as an emergency room, while others are best de-escalated and treated in a community-based setting, such as a school, office, or home environment. Both ends of the crisis spectrum require a significant response; however, the challenge lies in ensuring treatment occurs in the most appropriate setting.

Across the crisis spectrum, many members of the Task Force have observed an increase in crisis events involving children and youth. School representatives report an increase in suicide, and attempts occurring at younger ages than previously observed. An analysis of Center for Disease Control (CDC) data on suicide completion rates for children and youth provides a limited picture, but also indicates crisis needs are growing. From 2012 through 2016, the rate of completed suicides for children and youth in Travis County was 1.6 per 100,000. This rate is below the state average of 1.7 but notably higher than rates in Dallas and Harris counties. More significant than the cross-county comparison of the child and youth suicide completion rate is the increase in child and youth death by suicides in Travis County during the last 10 years. There was a total of 35 deaths by suicide for children and youth between 2007 and 2016, a nine-year span. A total of 14 deaths were reported during the four-year span between 2007 and 2011. This number increased by 40% to a total of 21 child or youth deaths by suicide between 2012 and 2016, another four-year span.

[2] Texas Administrative Code (2014). *Title 25, Part 1, Chapter 416, Subchapter a, Rule §416.3.* Retrieved from https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3

Child and Youth Suicide (2012–2016)





Mental Health Crisis Services for Children, Youth, and Their Families

Strong mental health service systems include a crisis management structure that provides support for children and youth affected by a single traumatic event as well as those experiencing the symptoms of developmental trauma or struggling with complex mental health challenges.[3] Crisis service providers work closely with the child or youth and family to decrease distressing symptoms, address risky behaviors, identify potential triggers, and learn skills to effectively deal with future crises. For many children, youth, and their families, crisis services

[3] Pires, S.A. (2010). *Building a system of care: A primer* (2nd edition). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

act as the front door to mental health services, making the availability of a continuum of quality crisis services extremely important.[4]

For most children, youth, and their families, short-term crisis services alone are insufficient and should be fully integrated into a system of care that ensures need-based access to a continuum of services and supports. When meaningful community-based alternatives to inpatient treatment are absent, many children, youth, and families in crisis have nowhere to turn but to the most restrictive, disruptive, and expensive care.

Crisis Continuum Within the Ideal System for Children and Youth

The ideal crisis continuum for children and youth must be partnered with a broader system of care that identifies and responds to the mental and behavioral health needs of children and youth in a community. Without the availability of community-based mental and behavioral health services that address needs ranging from mild to severe, the crisis end of the services spectrum becomes the default point of entry for care. However, in the ideal system, most children and youth would have their mental and behavioral health needs identified prior to reaching a point of crisis. Developing a strong community-based services continuum that people can access prior to being in crisis is a critical factor in preventing crises and maximizing efficient use of the available crisis services.

That said, the ideal crisis continuum is based on the fundamental principle that children and youth have the greatest opportunity for normal, healthy development when they maintain their ties to community and family while receiving help. The Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines provide an overview of the ideal continuum of crisis services and outline essential values for crisis services.[5] These values and guidelines emphasize:

- Rapid response,
- Safety,
- Crisis triage,
- Active engagement of the person in crisis, and
- Reliance on natural supports.

A crisis care continuum for children and youth within an ideal system extends beyond these attributes to include the following service components:

- A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home support, case management, and direct access to out-of-home

[4] Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199–254.

[5] Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Rockville, MD: Office of Consumer Affairs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved on August 31, 2016 from https://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf

crisis supports (for a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team);[6]

- Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate level of services;
- Coordination with emergency medical services;
- Crisis telehealth and phone supports; and
- An array of crisis placements tailored to the needs and resources of the local system of care, including options such as:
  - In-home respite options,
  - Crisis foster care (placements ranging from a few days up to 30 days),
  - Crisis respite (one to 14 days),
  - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision,
  - Acute inpatient care, and
  - Linkages to a full continuum of empirically supported practices;
- First Episode Psychosis (FEP) identification and treatment.

Child and Youth Mental Health Crisis Services Available in Travis County

In Travis County, Integral Care is the primary provider of community-based mental health crisis response services for the general population. Financial support for Integral Care's services comes from a variety of funding streams including the State of Texas, federal funds, 1115 Waiver, City of Austin, Travis County, Central Health, earned income (e.g., billing Medicaid and other insurance for services delivered), and other sources (e.g., grants, foundations, private funds). Through the Health and Human Services Commission (HHSC), Integral Care is appropriated state general revenue and federal block grant funds for the provision of behavioral health crisis services in Travis County; Integral Care is also required to secure local "match" funds to support crisis services.

For fiscal year (FY) 2018, Integral Care budgeted $24,071,142[7] in funds to provide crisis care to people residing in Travis County. In FY 2017, $1,259,914 were spent on crisis services for children and youth. As a stipulation to using these funds, HHSC outlines minimum standards for responding to a behavioral health crisis, including minimum standards around the types of services that must be available. These services and requirements are described in the sections below.

Similar to the 9-1-1 emergency response system, Integral Care is required to provide access to a crisis hotline and mobile crisis outreach 24 hours a day, seven days a week (24/7) to respond to all presenting mental health crises, regardless of a person's insurance status or type. Although Travis County has a number of behavioral health service providers, most medical systems and

[6] For more information, see http://wraparoundmke.com/programs/mutt/.

[7] Integral Care. (2017, August). *Integral Care fiscal year 2018 budget*. Retrieved from http://integralcare.org/wp-content/uploads/2017/09/BudBk-FY-2018.pdf

other health plans do not reimburse for the provision of crisis services. This general lack of reimbursement has resulted in few, if any, providers routinely offering any crisis support services. Therefore, if children or youth experience a crisis while under the care of an outpatient provider, the provider must refer them and their family to Integral Care for crisis intervention services, send them to the nearest emergency room for immediate evaluation, or call 9-1-1.

The only crisis intervention services provided by Integral Care that can be billed to Medicaid are crisis rehabilitation services. These services usually represent a small portion of the overall services provided during a crisis intervention episode. The remaining services provided during a crisis intervention are supplemented by appropriated state funds (General Revenue) and any local funds dedicated to crisis response, regardless of the person's insurance type or whether they are being served primarily by another system (e.g., child welfare or juvenile justice).

In the remainder of this section, we provide information on the crisis services array available through Integral Care as well as crisis-related services provided through other organizations. In summarizing these services, we describe the intervention, provide data on utilization, and, to the extent possible, describe supporting funding mechanisms.

Integral Care Crisis Helpline

A call to Integral Care's Crisis Helpline (472-HELP) is the front door to crisis care. 472-HELP is an entry point for a variety of Integral Care inquiries, but its crisis line is accessible 24 hours a day, seven days a week by dialing "Option 1," otherwise known as the Crisis Line. The Crisis Line provides access to mobile crisis response and stabilization services for children, youth, and adult residents of Travis County. It is staffed by licensed professionals of the healing arts (LPHA) and qualified mental health professionals (QMHPs) who are trained in crisis intervention and available at all times. Crisis Line staff respond to calls from a variety of sources, including parents/caregivers, schools, youth, and law enforcement. They triage calls based on their assessment of risk, designate the need as "emergent" or "urgent," and dispatch the Mobile Crisis Outreach Team (MCOT) when necessary.

MCOT is dispatched to conduct a face-to-face assessment within one hour for children and youth who are determined to have an emergent need for emergency services. Children and youth whose urgent needs put them at risk of serious deterioration are assessed face-to-face within eight hours of their call. Integral Care describes the Crisis Line's most important role as assisting callers in understanding their crisis service options. Crisis Line staff confer with callers, review treatment options, and connect callers with community-providers, their current treatment team, or MCOT. Crisis calls from Travis County residents to the National Suicide Hotline and National Alliance for the Mentally Ill (NAMI) are connected to Integral Care's Crisis Line.

Fifteen percent (15%) of Integral Care's 472-HELP calls are from or made on behalf of a child or youth under the age of 18. In FY 2018, staff for 472-HELP provided 6,226 services to 1,937

unduplicated children, youth, and their families, which represented a 47 percent increase from the previous year. These services included activities such as help identifying Integral Care services and making follow-up appointments. The average length of a Crisis Helpline service was eight (8) minutes.

Table 1. Overview of Integral Care Crisis Helpline Calls for Children and Youth

Calls Received by the Crisis Helpline Regarding Child and Youth in Crisis (Travis County)			
	FY17	**FY18**	**% Increase**
Total Calls	4248	6226	47%
Unduplicated Children Served	1370	1947	42%
Call Resulted in MCOT Dispatch	401	695	42%
Call Resulted in 911 Dispatch	212	272	22%
Source: Integral Care			

Mobile Crisis Outreach (MCOT) and MCOT Expansion (EMCOT)

Health and Human Services Commission (HHSC) Information Item V, Crisis Services Standards,[8] states that the goal of an MCOT response is to ensure:

- Prompt assessment and evaluation in the community,
- Stabilization in the least restrictive environment,
- Crisis resolution,
- Linkage to appropriate services, and
- Reduction of inpatient and law enforcement interventions.

As noted above, when deemed appropriate, MCOT is dispatched by the Crisis Line. MCOT services are delivered in the community where the person is experiencing the crisis. The primary goals of MCOT are to provide crisis services and supports to help the child, youth, or adult return to a more stable level of functioning and to link the person to ongoing services to reduce likelihood of re-occurrence. Mobile crisis interventions include behavioral health and risk assessments to evaluate the potential for self-harm and to identify what triggered the crisis. MCOTs also develop a crisis plan based on the child, youth, or adults' strengths. This plan addresses crisis triggers, community services, crisis resolution strategies, and the creation of a safety plan. MCOT can provide crisis stabilization services for 90 days after its initial crisis response.

Integral Care has four crisis teams that are onsite during high volume times (from 8:00 a.m. to 10:00 p.m. Monday through Friday and 10:00 a.m. to 8:00 p.m. on weekends). Team members are on-call during off hours. MCOT members split their time between responding to urgent and emergent crisis referrals and providing crisis relapse prevention services. Relapse prevention

[8] See "Information Item V – Crisis Service Standards" at https://www.dshs.state.tx.us/mhcontracts/FY17/FY-2017-Performance-Contract.aspx.

services can include phone calls, life skills training, and case management services. Integral Care does not have a specialized children's team. Care is taken when selecting which MCOT will respond to a given crisis; team members' experience and the languages they speak are considered, and MCOT attempts to send the person best matched for the person in crisis. Integral Care also has a specialty team known as Expanded MCOT (EMCOT) that is discharged by 9-1-1 agents or first responders. The goal of this team is to provide first responders with a more efficient means to discharge MCOT. EMCOT serves fewer children and youth than the standard MCOT team.

In FY 2017, Integral Care provided MCOT and EMCOT services to 688 unduplicated children and youth and their families (493 through MCOT and 195 through EMCOT). MCOT delivered 752 episodes of care and EMCOT delivered 257 episodes. A total of 2,170 services were provided by both MCOT and EMCOT. The average length of services for MCOT was shorter than EMCOT: 20 days compared to 25 days.

MCOT is financially supported through General Revenue funds appropriated by HHSC and funds matched by Travis County. During FY 2018 the EMCOT model was supported by $1.8 million dollars in Delivery System Reform Incentive Payment (DSRIP) funding. Because of changes in this funding source, these dollars are no longer available to support the program in FY 2019. The City of Austin and Travis County committed $1.1 million and $800,000 dollars respectively to continue EMCOT services through FY 2019. The Austin City Council's fiscal commitment was made on a one-time basis, whereas the Travis County Commissioner's Court pledged ongoing commitment to sustaining EMCOT. As stated above, only crisis rehabilitation services can be reimbursed through Medicaid, so these appropriations are essential to the provision of ongoing services.

Table 2. Summary of Integral Care MCOT Utilization of Children and Youth (FY 2017)

Crisis Services for Children and Youth				
Program	**Duplicated Count (Episodes)**	**Unduplicated Count**	**Average Length of Service**	**Total Number of Services Provided**
MCOT	752	493	20 days	1,615
E-MCOT	257	195	25 days	555
Total	**1009**	**688**		**2170**

Psychiatric Emergency Services

Psychiatric emergency service centers (PES) provide immediate access to assessment and a continuum of stabilizing treatment for children and youth presenting with behavioral health crises. In FY 2017, Integral Care's PES provided 1,065 episodes of crisis care, hospital triage, and other services to 348 unduplicated children and youth – just 8% of the population served.

Table 3. Summary of Integral Care PES Utilization of Children and Youth (FY 2017)

Crisis Services for Children and Youth				
Program	**Duplicated Count (Episodes)**	**Unduplicated Count**	**Average Length of Service**	**Total Number of Services Provided**
PES	507	348	27 minutes	1,065
Crisis Services	292	268	49 minutes	296

Recovery After an Initial Schizophrenia Episode Program (RA1SE Program)

The Recovery After an Initial Schizophrenia Episode (RA1SE) program is a recovery-focused program that provides intensive community-based services to young adults ages 15 to 30 years who have experienced their first psychotic episode. Often, these first episodes result in an interaction with law enforcement, PES, or MCOT. The RA1SE program is similar to Wraparound, in which a team-based, individualized, strength-based approach to the person's treatment planning includes both formal and natural supports. Youth and young adults who are enrolled in the program can receive services and supports for up to three years. The RA1SE team includes a psychiatrist, LPHA, case manager, Supported Education/Employment specialist, family specialist, and peer support specialists.

Funding for the RA1SE program is provided by HHSC. Since this program provides intensive services, caseloads are small; the program's current capacity is 30. First-year retention rates are 82%. The RA1SE Team is extremely diverse in terms of expertise, background, race, and culture and includes team members who speak Japanese, Spanish, and Arabic.

Table 4. Integral Care RA1SE Utilization

Crisis Services for Children and Youth				
Program	**Duplicated Count (Episodes)**	**Unduplicated Count**	**Average Length of Service**	**Total Number of Services Provided**
RA1SE (through age 21)	86	53	140 days	934

Crisis Stabilization Services

Once the immediate crisis has been resolved, Integral Care can provide community-based crisis stabilization services for up to 90 days to help the child, youth, and family manage a crisis situation and develop skills to identify and minimize crisis triggers, eliminating the need for more restrictive care. These services are provided over a span of a few days to several weeks, depending on the family's need, and can include in-home supports, short-term care coordination, and residential crisis stabilization (e.g., crisis respite beds). Crisis stabilization services can be the gateway to ongoing mental health care for many children, youth, and their families. During FY 2017, 1,429 new[9] children and youth received crisis services through MCOT

[9] New clients are defined as those people who did not receive a non-crisis service within the prior six months.

and PES. Of those served, 457 (32%) were open to ongoing mental health services with Integral Care. The remaining 972 (68%) were not open to Integral Care.

Crisis can occur even when a child, youth, and his or her family is involved in ongoing mental health services. Integral Care provided mental health services and supports to 3,985 children and youth during the fiscal year. Of those children and youth, 37% experienced at least one crisis event during the year. Thirteen percent (13%) of these children or youth required support for more than one crisis episode. Eighty percent (80%) of the children, youth, and their families served by Integral Care did not require crisis services.

School-Based Crisis Services

All school districts in Austin, Travis County, and the surrounding area have written protocols for supporting students who are at risk for suicide or who are experiencing a mental health crisis. These protocols focus on assessing the student's risk of harm to self or others, engaging the student's parents, and making a referral to a community provider for a mental health assessment. If a student is determined by school personnel to be in imminent risk of harming himself, herself, or others, the school may contact 9-1-1 or MCOT and the campus School Resource Officer (SRO) in addition to contacting the parents or guardian. At the time students are released to the custody of a parent or guardian, the family is instructed to seek crisis care from the student's primary care physician, treating psychiatrist, Psychiatric Emergency Services (PES), or a hospital emergency room. The Austin Independent School District (AISD) Reference Guide for Critical Incidence requires a follow up with the family members within 24–48 hours to confirm they have sought recommended follow-up care. School personnel involved in a mental health crisis can include the school counselor, teacher, school administrator, school nurse, and SRO. Schools with a school-based mental health clinic can seek the support of clinic staff to address a mental health crisis on campus. Support provided includes assessing risk, linking to community resources, or facilitating access to MCOT or PES.

An overview of some available school-based mental health services for Austin ISD are provided below. None of the districts or campuses in Austin, Travis County, or the surrounding area have a formal agreement with Integral Care to provide mobile crisis services. As noted above, school-based mental health staff primarily play an advisory role in responding to a student crisis. Availability of crisis support services and mental health personnel varies across districts and campuses and is often provided at the request of school personnel on a student-by-student basis. Therefore, it is difficult to assess the cost of providing school-based crisis care.

Integral Care

In 2013, Integral Care used funds from the Texas Healthcare Transformation and Quality Improvement Program Medicaid Waiver (Medicaid 1115 Waiver) to establish school-based mental health clinics in the Del Valle, Manor, and Pflugerville independent school districts (ISDs). Together, these ISDs and Integral Care provide integrated primary care through partnerships with, People's Community Clinic, and the University of Texas School of Nursing. Austin ISD and Seton/Ascension established school-based mental health services with the

Waiver and Seton contracted with Integral Care to provide the services. However, as of June 2018, Seton Medical Center decided not to continue services under the new Waiver.

The partnership between Austin ISD, Seton, and Integral Care led to the establishment of 16 campus mental health centers across the district. However, recent federal changes affecting Texas' 1115 Waiver and the project it funds led Seton, the administrative agent, to not apply for the next round of funding. In Fall 2018, AISD and Integral Care completed a plan to continue services at all 16 centers, combining $400,000 in Title IV federal funding with $300,000 of projected earned revenue from Integral Care, $430,000 in funding from Central Health, funds from HB13 and the remainder being secured through private funders – St. David's Foundation, Seton Foundation, Michael and Susan Dell Foundation and Austin Community Foundation.

Integral Care has 32 school-based mental health therapists across the four districts. Austin ISD currently has one therapist per school in 16 middle schools. The remaining districts – Manor, Pflugerville, and Del Valle – have a total of 16 therapists across their campuses. Individual campuses within these districts are small, which makes supporting a full caseload difficult. Therefore, most of the therapists support between two and four schools.

Integral Care is moving toward a school-based system of care that includes an on-campus therapist, access to psychiatric assessment and evaluation, school personnel training in de-escalation techniques and crisis triage, and an MCOT liaison. Integral Care's school-based therapists are not crisis responders but can provide support to school counselors and other school personnel in a crisis situation and can act as a link to crisis services such as MCOT. The range of services varies across campuses based on administration, procedures, and district crisis protocol.

The current model of school-based mental health therapeutic interventions and crisis supports requires a fiscal commitment of 50% of each therapist's salary to sustain. Integral Care can fund the remaining costs by billing Medicaid and private insurance for services rendered. Manor, Del Valle, and Pflugerville ISDs have committed to support a portion of the therapists' salaries. Additional funding has also been secured for Manor and Del Valle ISDs through House Bill (HB) 13 funding and a grant from Samsung to support a position that specializes in crisis triage and staff training on crisis de-escalation.

Vida Clinic

Vida Clinic operates 25 school-based mental health clinics at three Austin ISD high schools and 22 elementary school campuses. The three high school mental health clinics are sustained through a combination of district support and revenue. The elementary school clinics are funded by a $4,475,126 Victims of Crime Act (VOCA) grant from the Office of the Governor. The project period ran from October 2017 through September 2018. A renewal proposal for continued funding has been submitted and expands services to an additional five elementary and middle schools.

The goals of the VOCA grant are to (1) identify, evaluate, diagnosis and treat any child who has been a victim of a crime; (2) support families of identified children through therapy and consultation; (3) provide school personnel who work with children and families consultation and support rooted in trauma-informed care; and (4) evaluate the program and share the results. The 22 elementary schools selected for this project all feed into Lyndon B. Johnson, Lanier, and Akins high schools – all schools that are located in high crime areas. Each elementary school has 1.5 FTE licensed mental health clinicians (psychologist, LCSW, LPC). Services are offered year-round and include individual, family, and group therapy; teacher and parent wellness groups; and teacher consultation.

Community-Based Care

Community-based organizations provide unique services often not covered through the large public systems. Although they may bill insurance or Medicaid for specific services provided, they generally support most of their work through private funding sources which allows for more flexibility in terms of population served and types of services provided. Below are examples of community-based organizations in Travis County that help meet mental health needs for children and youth.

LifeWorks Emergency Shelter

LifeWorks provides a range of crisis supports, including walk-in access to counseling services, street outreach, peer support and counseling, and a comprehensive housing continuum for youth in the Austin community. Also, emergency shelter services are included in LifeWorks housing continuum. Lifeworks counseling and other services are not intended for psychiatric crises. In the instance of a psychiatric crisis, Lifeworks refers to PES for crisis care.

The Lifeworks shelter accepts youth between the ages of 16 and 21 for up to 30 days and has the capacity to house up to 20 youth at a time. The daily cost of care is approximately $165 per youth. The emergency shelter is licensed by the Health and Human Services Commission's (HHSC) Child Care Licensing Minimum Standards for General Residential Operations, allowing it to bill a $129 daily rate for shelter services rendered to DFPS youth. The Texas Integrated Funding Initiative (TIFI) and a National Runaway and Homeless Youth grant provide additional funds to cover the cost of shelter care.

Youth Empowerment Services Waiver

The Youth Empowerment Services (YES) Waiver is a community-based Medicaid Waiver program for children and youth ages 3–18 who are living with a serious emotional disturbance (SED) that puts them at risk of out-of-home placement and/or frequent psychiatric hospitalizations. The Health and Human Services Commission (HHSC) contracts with Integral Care to manage the YES Waiver for Travis County. HHSC has capped the capacity for Integral Care's YES Waiver program at 132 children and youth; however, the cap has historically been 160. Integral Care expects the cap to be increased in future years. Additionally, if the need for YES is higher than the cap, Integral Care requests additional spots from HHSC. As of September

2018, Integral Care had 115 children, youth, and their families enrolled in the YES Waiver. While the number enrolled was below the cap at the time this report was written, Integral Care typically maintains enrollment at or near the cap.

Through the YES Waiver, children and youth with SED and their families have access to wraparound case management as well as non-traditional behavioral health services and supports. These non-traditional services may include workforce preparation and training; art, music, or equine therapy; respite or therapeutic services for caregivers, in addition to some of the more traditional counseling and rehabilitative services. This non-traditional and intensive approach to care is intended to prevent out-of-home placement and support healthy living in the family environment.

Of the YES Waiver services, Integral Care delivers the case management and rehabilitative services and subcontracts with community-based providers for the other services. All services delivered through this program are reimbursed by Medicaid. Crisis services, however, are excluded from reimbursement and are supported by the general revenue funds.

The Children's Partnership

The Children's Partnership (TCP) provides community-based services and supports to children and youth with complex mental health needs and their families. Many of the children and youth it serves are at risk of admission or re-admission to a psychiatric hospital or residential treatment facility. TCP coordinates care with key child-serving providers in Travis County through a wraparound approach to providing person-centered, holistic care. Currently, 70 children and youth and their families are receiving services through TCP.

TCP care coordinators are responsible for creating a crisis plan for each family receiving services. The plan addresses natural and community supports. TCP can provide a telephonic response to crisis calls, but this function is not routine. When necessary, TCP care coordinators can also authorize crisis services by partner organizations.

TCP receives funding from Travis County Health and Human Services, the Travis County Juvenile Probation Department, and Integral Care. The amounts of funding and types of services covered through each source is summarized in the following table. Integral Care is the only partner that bills Medicaid for services.

Source	Services and Funding Amounts
Travis County HHS	• Shared database ($12,000) • Six (6) direct-service FTEs • Two (2) administrative system management FTEs • Flexible funding, which varies based on grant funds ($515,000–$600,000)

Travis County Juvenile Probation Department	• Flexible funding restricted to youth with juvenile justice involvement, including therapeutic services ($120,000) • Four (4) direct-service FTEs
Integral Care	• Child and Family Services Care Coordination staff for LOC 4 and YES Waiver are cross-trained as TCP coordinators • Managed service organization (MSO) role for the provider network (TCP pays MSO fees to Integral Care under the contract that manages the flexible funds)

Part 2: Analysis of Travis County Child and Adolescent Psychiatric Hospital Utilization

As previously discussed, hospital emergency departments and inpatient psychiatric departments represent significant components of the crisis care system. Understanding how these services are currently funded provides important insight into key payor sources that support children's mental health care services in Travis County. Using the most recent information available (from 2016) through the Texas Health Care Information Collection (THCIC), we performed an analysis of inpatient, emergency department, and outpatient discharge records for hospitals and ambulatory surgical centers operating in Texas. This analysis allowed us to determine amounts billed in 2015 and 2016 for psychiatric beds for children and youth who reside in Travis County. We also analyzed relevant information from the Annual Survey of Hospitals, which presented related payments hospitals received over the same timeframe.

Child and Youth Psychiatric Emergency Visits

Emergency departments (EDs) have become a critical component of the crisis care continuum for children and youth with mental health concerns. For many children, youth, and their families, EDs are the first point of entry into the mental health system. By design, EDs do not require a referral and are always accessible. A review of the data compiled by the National Hospital Ambulatory Medical Care Survey, which tracked mental health visits to EDs between 2001 and 2011, revealed that emergency room patients (of all ages) with a mental health condition were more likely to be admitted to the hospital than those patients with a medical condition. Children and youth are likely most affected.[10] Taken together, these dynamics have resulted in the frequent overutilization of an expensive component of the crisis care continuum.[11]

Children and youth mental health conditions are often unique and complex in their presentation, and many EDs are not equipped to deal with these complexities. EDs often lack standards for assessing and treating mental health conditions, and many physicians lack mental health training.[12] Many EDs do not have a designated space for crisis services or staff who know how to effectively intervene with children, youth, or families experiencing a crisis. EDs also lack access and connections to available community-based mental health services which can result in increased symptoms, further traumatization, or the use of restraints to ensure the safety of others in the ED.[13] Children, youth, and their families can also wait a long time to be assessed, receive medical clearance for psychiatric hospitalization, or to be placed in an open inpatient

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[10] Luthra, S. (2016). Kaiser Health News. *Scarcity of mental health care means patients – especially kids – land in ER.* Retrieved from *https://khn.org/news/scarcity-of-mental-health-care-means-patients-especially-kids-land-in-er/*

[11] Leon, S. L., Cloutier, P., Polihronis, C., Zemek, R., Newton, A. S., Gray, C., & Cappelli, M. (2017, March). Child and adolescent mental health repeat visits to the emergency department: A systematic review. *Hospital Pediatrics, 7* (3). 177–186. Retrieved from http://hosppeds.aappublications.org/content/7/3/177

[12] Leon et.al. (2017).

[13] Meadows Mental Health Policy Institute (2016, December). *Behavioral health crisis services: A component of the continuum of care*. Retrieved from https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf

psychiatric bed, further exacerbating an already stressful situation. Patients who are determined not to need hospitalization are often sent home without plans or supports for obtaining mental health services in the community, putting them at risk for re-occurring crises and making the ED the only place they receive mental health supports. Dell Children's Medical Center reports that of the 1,900 assessments of children and youth that it conducted in its ED in FY 2017, about half were sent home without any discharge plans. Furthermore, 20–45% of mental health emergency visits by children and youth with mental health conditions are repeat visits, suggesting that their needs continue to go unmet despite referrals to community-based care. This pattern of use by children and youth with mental health conditions and families can result in a significant economic and resource burden on already overloaded EDs.[14]

As noted above, research indicates that once a child/youth shows up at an ED, the likelihood of being hospitalized increases. A review of the THCIC data on Travis County inpatient psychiatric hospital admission from emergency departments is provided below. The data reflect national trends in the use of EDs to treat mental health conditions and the resulting likelihood that an ED visit will end in inpatient hospitalization. In 2015, 267 children under 12 and 1,010 youth ages 12–18 from Travis County – a total of 1,277 children and youth – were admitted to Travis County inpatient psychiatric hospitals from EDs. This number rose to 1,697 – 348 children and 1,49 youth – in 2016, an increase of 420 children and youth (or 33%).

Within Travis County, Dell Children's Medical Center's ED admitted the largest number of children and youth to inpatient psychiatric facilities in both 2015 and 2016: 407 children and youth in 2015 and 451 children and youth in 2016. It was followed by University Medical Center-Brackenridge, which admitted 152 children and youth in 2015 and 180 children and youth in 2016. Children and youth admitted to Travis County inpatient hospitals frequently come from out of county emergency departments. In 2015, approxiately 46 percent of admissions to Travis County hospitals were for children and youth who came from non-Travis County emergency departments and in 2016 the number rose to 55 percent.

A review of the THCIC data revealed that during CY 2016, almost 60% of children seen in Travis County EDs presented with a diagnosis of depression; disruptive, impulse control, and conduct disorders; and panic and anxiety disorder. Approximately 40% of youth seen in EDs presented with a diagnosis of depression and another 25% were diagnosed with anxiety and panic disorders. The primary diagnoses for psychiatric ED visits for children and youth in 2016 is program broken down below in Table 5.

[14] Leon et.al. (2017).

Table 5. Total Psychiatric Emergency Visits by Diagnoses, Children and Youth (2016)[15]

Diagnosis	Child ED Visits	Youth ED Visits	Total ED Visits
ADHD	24	14	38
Adjustment Disorder	15	32	47
Antisocial and Personality Disorders	7	10	17
Anxiety, Phobias, Panic, and Related Disorders	55	241	296
Autism	10	9	19
Bipolar Disorder	4	38	42
Borderline Personality Disorder	2	4	6
Depressive Disorders	40	368	408
Disruptive, Impulse Control, and Conduct Disorders	96	76	172
Dissociative Disorder	2	5	7
Eating Disorders	7	14	21
Elimination Disorders	13	1	14
Family and Relational Problems	2	2	4
Intermittent Explosive Disorder	2	2	4
Neglect, Physical, Sexual or Other Abuse	3	2	5
OCD and related disorders	N/A	1	1
Other Disorders	5	14	19
Other Mood Disorder	N/A	2	2
Other Somatic Disorders	6	12	18
PTSD, Acute Stress, and other Trauma-Related Disorders	8	13	21
Reactive Attachment Disorder	1	N/A	1
Schizophrenia and Psychotic Disorders	13	44	57
Self-Harm	N/A	1	1
Substance Use Disorders	N/A	12	12

[15] See Appendix 1, Table A1-5 for a breakdown of diagnoses by Travis County hospital

Table 1. Travis County Inpatient Psychiatric Hospital Admissions from EDs (2015)

Origin Emergency Department	Children Admitted from ED	Youth Admitted from ED	Total Children and Youth Admitted from ED
Dell Children's Medical Center	102	305	407
North Austin Medical Center	5	22	27
Seton Medical Center	–	12	12
Seton Northwest Hospital	2	22	24
Seton Southwest Hospital	5	8	13
St David's Hospital	–	6	6
St David's South Austin Hospital	2	43	45
University Medical Center-Brackenridge	26	126	152
Westlake Medical Center	–	2	2
Non-Travis County EDs	**125**	**464**	**589**
Total	**267**	**1,010**	**1,277**

Table 2. Travis County Inpatient Psychiatric Hospital Admissions from EDs (2016)

Origin Emergency Department	Children Admitted from ED	Youth Admitted from ED	Total Children and Youth Admitted from ED
Dell Children's Medical Center	106	345	451
Lakeway Regional Medical Center	–	1	1
North Austin Medical Center	6	44	50
Seton Medical Center	–	11	11
Seton Northwest Hospital	3	10	13
Seton Southwest Hospital	1	10	11
St David's Hospital	–	2	2
St David's South Austin Hospital	4	34	38
University Medical Center-Brackenridge	31	149	180
Westlake Medical Center	1	2	3
Non-Travis County EDs	196	741	937
Total	**348**	**1,349**	**1,697**

The cost of psychiatric ED care for children and youth in 2016 exceeded $1.2 million: $291,884 for children and $980,148 for youth (see Table 3, below). Dell Medical Center and University Medical Center-Brackenridge were estimated to receive the highest payments for both children

and youth. The total cost of psychiatric emergency room visits for children and youth during 2015 was unavailable for comparison. National trends in accessing mental health care suggest that improved access to all levels of mental health services and supports prior to a mental health crisis, improved discharge planning, and improved follow-up care could decrease the number children and youth with mental health conditions initially treated and returning to emergency rooms for mental health care. Addressing these trends, therefore, should result in decreasing the cost incurred delivering this level of care.

Table 3. Estimated Payments by Hospital for Child ED Visits (2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay	Hospital Total
University Medical Center-Brackenridge	$33,229	$239	$7,407	$11,654	$1,532	**$54,062**
Seton Medical Center	$139	–	$835	–	–	**$974**
St David's South Austin Hospital	$2,600	–	$152	$683	$2,102	**$5,536**
Seton Southwest Hospital	–	–	$1,433	–	–	**$1,433**
Seton Northwest Hospital	$1,068	–	–	$2,021	$196	**$3,285**
North Austin Medical Center	$2,209	$186	$6,450	$517	$626	**$9,988**
Dell Children's Medical Center	$46,810	$1,213	$114,778	$50,297	$3,507	**$216,605**
Payer Total	**$86,055**	**$1,638**	**$131,055**	**$65,173**	**$7,963**	**$291,884**

Table 4. Estimated Payments by Payer Type by Hospital for Youth ED Visits (2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay	Hospital Total
St David's Hospital	$6,162	$479	$2,872	$2,152	$101	**$11,765**
University Medical Center-Brackenridge	$153,099	$10,605	$96,532	$67,247	$11,134	**$338,617**
Seton Medical Center	$2,947	$2,849	$6,899	$5,185	$553	**$18,432**
St David's South Austin Hospital	$24,153	–	$10,409	$2,435	$18,600	**$55,596**
Seton Southwest Hospital	$3,590	$978	$7,216	–	$13	**$11,798**
Seton Northwest Hospital	$5,660	$3,202	$12,002	$7,013	$254	**$28,131**
Westlake Medical Center	–	$155	–	$643	–	**$798**
Heart Hospital-Austin	$2,136	–	$992	$1,005	–	**$4,133**
North Austin Medical Center	$27,692	$1,338	$20,657	$6,908	$4,995	**$61,591**
Dell Children's Medical Center	$100,372	$3,097	$209,208	$120,957	$15,652	**$449,287**
Payer Total	**$325,810**	**$22,704**	**$366,788**	**$213,544**	**$51,302**	**$980,148**

Estimated Payments by Payer Type for Psychiatric Emergency Department Visits

Table 10 below shows total payments for ED visits of children and youth in CY 2016, broken down by payor source and Table 11 provides a summary of what is included with each identified payor source. Medicaid and third party-managed care providers made the most in mental-illness-related payments in 2016 at $411,865 and $497,834, respectively. Only approximately 5% ($59,265) of the payments were self-pay.

Table 5. Mental-Illness-Related ED Payments for Children and Youth (CY 2016)

Payer	Payments for Child ED Visits	Payments for Youth ED Visits	Total Payments for ED Visits
Medicaid	$86,055	$325,810	$411,865
Other Government	$1,638	$22,704	$24,341
Third Party – Managed Care	$131,055	$366,788	$497,843
Other Third Party	$53,519	$213,544	$267,063
Self-Pay	$7,963	$51,302	$59,265
Total	**$280,229**	**$980,148**	**$1,260,377**

Table 6. Overview of Payers Included in Each Payer Type

Payer Type	Included Payers
Medicaid	Medicaid
Medicare – Fee for Service	Medicare Part A
Other Government	CHAMPUS
	Other Federal Program
	Other Non-Federal Programs
	Veteran Administration Plan
	Workers Compensation Health Claim
Self-Pay	Charity, Indigent, or Unknown
Third Party – Managed Care	Point of Service
	Health Maintenance Organization
	Preferred Provider Organization (PPO)
Third Party Payer - Other	Blue Cross/Blue Shield
	Automobile Medical
	Commercial Insurance
	Indemnity Insurance
	Exclusive Provider Organization (EPO)

Psychiatric Inpatient Utilization

Inpatient psychiatric hospitalization is a critical component of any crisis services system. The inpatient psychiatric facilities that treat children and youth in Travis County include Austin Oaks Hospital, Austin State Hospital, Seton Shoal Creek Hospital, Texas NeuroRehab Center, Cross Creek Hospital, and Austin Lakes Hospital.

However, the use of psychiatric hospitalization as a form of treatment should always be carefully assessed and avoided when there are effective and appropriate community-based alternatives. The American Academy of Child and Adolescent Psychiatrists (AACAP) states that the best place for children and youth is home and that treatment for children and youth with mental health needs should occur in the least-restrictive environment possible with intensive home and community-based services in support.[16] In the absence of sufficient, intensive community-based services, communities will likely see an increase in inpatient hospitalizations and readmissions. For example, in FY 2017, Dell Children's Medical Center saw this level of duplication, with 69 children/youth being served two times, 30 served three times, and two children/youth served four times.

Psychiatric Inpatient Admissions by County of Origin[17]

In 2015, the primary providers of inpatient psychiatric services for Travis County children and youth where Austin Oaks Hospital (525 children and youth) and Seton Shoal Creek Hospital (450 children and youth). In addition, Austin State Hospital served fewer than 17 children and youth from Travis County. Cross Creek Hospital served 91 youth, and Austin Lakes Hospital served 17. Neither Cross Creek nor Austin Lakes served children in 2016.

Overall child and youth psychiatric inpatient utilization in Travis County increased from CY 2015 to 2016. A significant factor in this increase was that 510 children and youth were served at Cross Creek Hospital in CY 2016 vs. 91 in CY 2015. Seton Shoal Creek Hospital's psychiatric inpatient utilization remained relatively stable in 2016 at 460 children and youth. Austin Oaks Hospital utilization dropped by 95 to 430 children and youth during this time frame. A summary of psychiatric inpatient utilization of Travis County hospitals by children and youth is provided below. The information provided is based on total episodes of care. We expect that the total number of children and youth who were hospitalized in this time to be lower since some may have experienced multiple hospitalizations within the year.

[16] American Academy of Child and Adolescent Psychiatry. (2010). P*rinciples of care for treatment of children and adolescents with mental illness in residential treatment centers*. Retrieved from https://www.aacap.org

[17] Hospital admissions are calculated based on hospital discharge data. This may exclude some admissions of people who were not discharged by the end of CY 2015, particularly in hospitals with longer stays, such as Austin State Hospital.

Table 7. Summary of Travis County Psychiatric Inpatient Admissions by County of Origin (CY 2015)

Psychiatric Hospital Name	Travis County Residents		Non-Travis County Residents	
	Children	Youth	Children	Youth
Austin Oaks Hospital	108	417	79	291
Austin State Hospital	<6	11	16	114
Seton Shoal Creek Hospital	84	366	49	200
Texas NeuroRehab Center	–	<6	–	6
Cross Creek Hospital	–	91	–	<6
Austin Lakes	–	17	–	7

Table 8. Summary of Travis Psychiatric Inpatient Admissions by County of Origin (CY 2016)

Psychiatric Hospital Name	Travis County Residents		Non-Travis County Residents	
	Children	Youth	Children	Youth
Austin Oaks Hospital	112	318	99	318
Austin State Hospital	<6	8	26	104
Seton Shoal Creek Hospital	63	397	46	247
Texas NeuroRehab Center	–	–	<6	<6
Cross Creek Hospital	109	401	–	–
Austin Lakes	–	17	–	10

Table 9. Summary of All Child and Youth Travis County Resident Admissions (CY 2015 vs. CY 2016)

Psychiatric Hospital Name	2015	2016
Austin Oaks Hospital	525	430
Austin State Hospital	<17	<14
Seton Shoal Creek Hospital	450	460
Texas NeuroRehab Center	<6	–
Cross Creek Hospital	91	510
Austin Lakes	17	17

The tables below provide a comparison of the 2015 and 2016 estimated payments to Travis County inpatient psychiatric hospitals by payor source for children and youth within and outside of Travis County. The total payments for Travis County children and youth who were placed in inpatient psychiatric hospitals in 2015 is estimated at $5,135,396. The estimated total for children and youth residing outside of Travis County was $5,464,987. Total estimated payments for Travis County child and youth admission in 2016 increased by a little over $ 1 million to $6,183,880. This increase in payments reflects the increase in the number of children

and youth who received inpatient psychiatric care between 2015 and 2016. Payments for services rendered to youth outside the county showed similar growth, increasing to $6,103,276. Payments made to Travis County hospitals for children and youth who resided outside Travis County support these hospitals' abilities to maintain their current bed capacities and do not cost Travis County.

Payments related to child admissions to psychiatric hospitals in 2015 were estimated at $974,848. Medicaid was the primary payor source and the majority of Medicaid funds were received by Seton Shoal Creek Hospital ($334,659) and Austin Oaks Hospital ($300,546). Austin State Hospital received $103,058 in self-pay and indigent funding. Funding to pay for state hospital services are state general revenue funded. The funding is allocated to Local Mental Health Authorities (LMHAs) to cover the cost of a designated number of state hospital beds.

In 2016, inpatient psychiatric hospitals in Travis County received an increase in total payments for children's care. The increase is due to Cross Creek Hospital beginning to receive payments for children admitted for psychiatric care in 2016. The addition of children receiving services at Cross Creek Hospital increased the total estimated payment amount for services to children to $1,323,258. Seton Shoal Creek Hospital received the most payments in 2016 at $537,058. As in 2015, the majority of payments received were from Medicaid.

Table 10. Estimated Payments by Payer – Child Admissions to Psychiatric Hospitals (CY 2015)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay and Indigent	Hospital Total
Travis County Residents						
Austin State Hospital[18]	–	–	–	–	$103,058	**$103,058**
Seton Shoal Creek Hospital	$334,659	$31,180[19]	$56,185	$24,436	–	**$446,460**
Austin Oaks Hospital[20]	$300,546	–	–	$55,095	$69,689	**$425,330**
Payer Total	**$635,205**	**$31,180**	**$56,185**	**$79,531**	**$172,747**	**$974,848**
Non-Travis County Residents						
Austin State Hospital	–	–	–	–	$325,064	**$325,064**
Seton Shoal Creek Hospital	$195,507	$9,686	$61,785	$26,733	$6,704	**$300,415**
Austin Oaks Hospital[20]	$214,154	–	–	$41,595	$59,236	**$314,985**
Payer Total	**$409,661**	**$9,686**	**$61,785**	**$68,328**	**$391,004**	**$940,464**

[18] Austin State Hospital (ASH) codes patients as indigent. Most of ASH's funding is General Revenue.
[19] The PCR ratio was unavailable, so the average PCR across all hospitals for this payer category was used.
[20] Some charges at Austin Oaks Hospital were determined to be miscategorized. For those payments, we re-categorized them as Medicaid.

Table 11. Estimated Payments by Payer – Child Admissions to Psychiatric Hospitals (CY 2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay and Indigent	Hospital Total
Travis County Residents						
Austin State Hospital	–	–	–	–	$118,494	**$118,494**
Seton Shoal Creek Hospital	$235,227	$22,207[21]	$21,954	$30,618	$4,215	**$537,058**
Austin Oaks Hospital[22]	$378,416	–	–	$35,845	–	**$216,826**
Cross Creek Hospital	$243,085	$35,813	$118,770	$50,670	$2,542	**$450,880**
Payer Total	**$856,729**	**$58,020**	**$140,724**	**$117,133**	**$125,251**	**$1,323,258**
Non-Travis County Residents						
Austin State Hospital	–	–	–	–	$459,902	**$459,902**
Texas NeuroRehab Center	–	–	–	$12,807	–	**$12,807**
Seton Shoal Creek Hospital	$123,284	$12,129[21]	$28,938	$34,517	$24,311	**$223,180**
Austin Oaks Hospital[22]	$468,907	–	–	$21,268	–	**$490,174**
Payer Total	**$592,191**	**$12,129**	**$28,938**	**$68,592**	**$484,213**	**$1,186,064**

Payments for youth admitted to psychiatric services totaled $4,160,548 in 2015 and $4,860,622 in 2016. As with the payments for children's admissions, this increase in the total funds received appears to reflect the large increase in the number of youth who received care from Cross Creek Hospital. As with payment for children's admissions, about 50% were made by Medicaid: $2,329,679 in 2015 and $2,760,462 in 2016.

In 2015, Seton Shoal Creek Hospital received $1,995,532, the most payments of the hospitals. Austin Oaks Hospital received $1,538,391, the second most. More than 60% of Seton's total payments were received from Medicaid ($1,296,634). The remaining payments were received from government, third party-managed care, other third party, and self-pay and indigent payors. In 2016, Seton Shoal Creek payments and source of revenue remained stable at $1,998,392. Because of a significant increase in the number of youth served, Cross Creek Hospital's estimated payments totaled $1,464,129. Austin Oaks Hospital's payments dropped to $1,064,223. As with payment for children's admissions, the dollars to pay for state hospital services are derived from general revenue allocated to Local Mental Health Authorities to cover the cost of a designated number of state hospital beds. Austin State Hospital received $216,588 in 2015 and $202,030 in self-pay and indigent funding.

[21] The PCR ratio was unavailable, so the average PCR across all hospitals for this payer category was used.
[22] Some charges at Austin Oaks Hospital were determined to be miscategorized. For those payments, we re-categorized them as Medicaid.

Table 12. Estimated Payments – Youth Admissions to Psychiatric Hospitals (CY 2015)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay and Indigent	Hospital Total
Travis County Residents						
Austin State Hospital	–	–	–	–	$216,558	**$216,558**
Texas NeuroRehab Center	–	–	–	$3,091	$22,062	**$25,153**
Seton Shoal Creek Hospital	$1,296,634	$181,059[23]	$298,643	$190,507	$28,689	**$1,995,532**
Austin Lakes Hospital	$6,459	–	–	$30,350[23]	$23,928	**$60,737**
Austin Oaks Hospital	$893,120	–	–	$318,167	$327,104	**$1,538,391**
Cross Creek Hospital	$133,466	$23,945	$101,055	$65,711	–	**$324,177**
Payer Total	**$2,329,679**	**$205,004**	**$399,698**	**$607,826**	**$618,341**	**$4,160,548**
Non-Travis County Residents						
Austin State Hospital	–	–	–	–	$2,367,156	**$2,367,156**
Texas NeuroRehab Center	–	–	–	$37,788	$27,781	**$65,569**
Seton Shoal Creek Hospital	$502,872	$24,796[23]	$268,316	$123,473	$19,678	**$939,135**
Austin Lakes Hospital	$2,153	–	–	$19,987[23]	$2,761	**$24,901**
Austin Oaks Hospital	$666,798	–	–	$291,532	$169,432	**$1,127,762**
Payer Total	**$1,171,823**	**$24,796**	**$268,316**	**$472,780**	**$2,586,808**	**$4,524,523**

[23] The PCR ratio was unavailable, so the average PCR across all hospitals for this payer category was used.

Table 13. Estimated Payments – Youth Admissions to Psychiatric Hospitals (CY 2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay and Indigent	Hospital Total
Travis County Residents						
Austin State Hospital	–	–	–	–	$202,030	**$202,030**
Seton Shoal Creek Hospital	$1,286,326	$218,206[24]	$195,466	$281,743	$16,651	**$1,998,392**
Austin Lakes Hospital	–	–	–	$127,050	$4,798	**$131,848**
Austin Oaks Hospital[25]	$858,713	–	–	$205,510	–	**$1,064,223**
Cross Creek Hospital[26]	$615,423	$165,177	$425,251	$230,318	$27,960	**$1,464,129**
Payer Total	**$2,760,462**	**$383,383**	**$620,717**	**$844,621**	**$251,439**	**$4,860,622**
Non-Travis County Residents						
Austin State Hospital	–	–	–	–	$2,297,694	**$2,297,694**
Texas NeuroRehab Center	–	–	–	$22,512	–	**$22,512**
Seton Shoal Creek Hospital	$583,343	$59,527[24]	$158,711	$368,890	$95,641	**$1,266,111**
Austin Lakes Hospital	–	–	–	$61,050	$6,397	**$67,447**
Austin Oaks Hospital[25]	$1,084,623	$3,902	–	$174,923	-	**$1,263,448**
Payer Total	**$1,667,966**	**$63,429**	**$158,711**	**$627,375**	**$2,399,731**	**$4,917,212**

[24] The PCR ratio was unavailable, so the average PCR across all hospitals for this payer category was used.
[25] Some charges at Austin Oaks Hospital were determined to be miscategorized. For those payments, we re-categorized them as Medicaid.
[26] Some charges at Cross Creek Hospital were determined to be miscategorized. For those payments, we re-categorized them as Medicaid.

Part 3: Opportunities to Support Expanded Crisis Care

In Travis County, five managed care organizations (MCOs) provide Medicaid services to children and youth through three separate programs (STAR, STAR Kids, and STAR Health). Complexities inherent in the Medicaid program are exacerbated by the sheer volume of agreements and contracts that must be negotiated by providers to work with each MCO. In the following section, we summarize financing and systematic barriers that impede the expansion and improvement of crisis services for children and youth. Drawing upon allowable Medicaid approaches to support non-traditional or non-billable services, we also provide strategies to overcome these barriers. While these strategies offer opportunities to expand crisis services, they also provide a roadmap to increase access to additional mental health services, which, if more widely used, would also reduce the current strain on the crisis system.

Barriers to Maximizing Resources for Crisis Services

Integral Care and local community-based organizations (CBOs) face several barriers to collecting reimbursements for crisis services. Some of these barriers largely affect CBOs, while others are a challenge for all providers, including Integral Care.

Barrier 1: Complexities of billing insurers. CBOs report they do not bill Medicaid or commercial insurers – even when people have insurance and the insurance covers a service – because of the complexity of billing regulations, poor payment rates, and lack of electronic billing systems. Limited training and technical assistance are available to CBOs on becoming certified Medicaid providers or using billing codes and processes. Many CBOs do not have the administrative resources to support billing multiple Medicaid MCOs and commercial insurers. As an alternative to billing Medicaid and commercial insurance, some CBOs focus on obtaining state general revenue funds, federal grants, and funding through philanthropy. However, reliance on grant funding or state general revenue funds without taking advantage of available insurance (Medicaid and commercial) limits crisis care for people who are uninsured. Many federal grants have time limitations, after which CBOs are expected to obtain other funding, which is not always possible. Also, several providers and philanthropic institutions in Texas report that philanthropy is moving away from financing direct services, especially services covered by Medicaid or commercial insurance.

Barrier 2: Challenges in gaining access to MCO networks. MCOs may have network participation requirements that are difficult for some specialty service providers to meet. CBOs may have challenges completing the network applications for MCOs and meeting the administrative burden associated with required credentialing processes. Also, when MCOs achieve contractually required network standards, they close their networks to new CBOs. They may also be reluctant to contract with CBOs that serve a low volume of their members because of the cost of maintaining provider networks, unless HHSC identifies safety net providers that should be in the network.

Barrier 3: Expectations that "public funding" is available to all people who need crisis services. Based on reports from stakeholders, general expectations are that the local mental

health authority (LMHA) will provide all necessary psychiatric crisis services, regardless of funding. While the current crisis team is responsive, it is limited in the number of crises it can address at any one time. For example, covering psychiatric crises at different schools (because of the high number of school settings) while also covering other county-wide crises presents a challenge. This sort of challenge is common for crisis systems in Texas and across the nation and requires a coordinated response among public and private payors to use crisis resources more efficiently. In a community growing as quickly as Travis County, it is particularly difficult for funding to keep pace with the demands of a growing population. In CY 2017, Integral Care responded to about twice the number of crisis calls it handled in CY 2015.[27]

Barrier 4: Only two providers in Travis County provide intensive ongoing outpatient services such as Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitative Services (MHRS). In Austin, Integral Care is the only provider of TCM and MHRS (identified by MMHPI) that contracts with all the Medicaid MCOs to provide services for all Medicaid managed care programs for all populations. Only one other Travis County provider, Pathways Youth & Family Service's Mosaic program, provides these services, and those services are limited to children and youth in foster care. Under managed care, a few non-LMHA Texas CBOs have successfully billed MCOs for these Medicaid funded services. However, providers (including the LMHA) must pay for the staffing time and costs associated with obtaining all the required training and certification for the provision of TCM prior to delivering any services. These costs are not covered in future Medicaid payments. TCM and MHRS are critical components of research-based service alternatives (e.g., home and school-based interventions that can intervene before a crisis occurs) that prevent crises.

Barrier 5: Only one Mental Health Rehabilitative Service crisis code (H2011) exists for billing Medicaid MCOs for all crisis services. Prior authorization is not required for the initial crisis visit under this code because of the emergency nature of the services. Follow-up care beyond the initial visit requires completion of the Child Adolescent Needs and Strengths (CANS) assessment to determine whether the child or youth meets the level of care (LOC) needed for ongoing services. One billing code is inadequate to cover the entire array of crisis services and associated costs.

Barrier 6: MCOs have limited flexibility to authorize evidence-based practices under the Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG). These guidelines were created to address service utilization under a fee-for-service (FFS) system. With the implementation of managed care, these guidelines are outdated. Reliance on TRRUMG inhibits the provision of evidence-based practices (EBPs) by prescribing the amount and type of services, which is generally inconsistent with empirically-based service models that have guidelines for the services types, intensity, and length. In most states, MCOs are responsible for developing their own utilization management guidelines that must be consistent with state and federal requirements.

[27] Integral Care. (2017). Annual report 2017. Retrieved from http://www.integralcare.org/wp-content/uploads/2018/04/IntegralCare2017AnnualReport.pdf

Barrier 7: Payment rates do not cover the costs or the full array of crisis services that have better outcomes than treatment as usual. The current rates in use by most MCOs are based on the former FFS rates, paired with TRRUMG, to manage utilization. Many of these rates do not cover the cost of training, certification, and ongoing supervision required to deliver services consistent with evidence-based guidelines, nor do the rates cover the information technology and the quality management staff necessary to track outcomes and costs. As a result, providers face significant hurdles implementing community-based crisis service alternatives to using emergency department and psychiatric hospital services.

Barrier 8: Staffing crisis services at a level that makes services available 24 hours a day, seven days a week at the peak volume of crises is challenging. While there are patterns of use for crisis care, predicting when any crisis will occur remains difficult. As a result, payments based on a unit of crisis services (e.g., FFS) do not cover the availability of staff when they are on standby. When there is a crisis, the current Medicaid payment and billing code does not always cover the type of crisis care needed by the individual child/family and may not cover the travel time, need for multiple staff, and length of time for crisis resolution.

Strategies to Maximize the Use of Public Resources

The following strategies address the system barriers described above. First, we discuss the need to clearly articulate a broader array of crisis intervention services aimed at supporting families and caregivers, schools, children, and youth across insurers and child-serving agencies. Next, we identify cost-effective alternative payment arrangements that typically have good outcomes. Finally, we discuss approaches to establishing a payment hierarchy and developing payment strategies for all payers.

Strategy 1: Define a single, unified (across all payers) crisis service array for children, youth, and families using research-based practices as the rationale for delivering crisis services with good client outcomes and cost effectiveness. In 2016, MMHPI and St. David's Foundation collaborated to publish a report that defined the ideal continuum of crisis services[28] and outlined the essential values for crisis services as promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines.[29] These values and guidelines emphasize (1) rapid response, (2) safety, (3) crisis triage, (4) active engagement of the person in crisis, and (5) reliance on natural supports. In 2017, we articulated an ideal crisis continuum for children and youth in a study of Harris County's system for Houston Endowment that goes beyond these five elements to include the following service components:

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[28] Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services. A component of the continuum of care*. Dallas, TX: Author, commissioned by St. David's Foundation.

[29] Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Rockville, MD: Office of Consumer Affairs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from https://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf

- A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team/MUTT);[30]
- Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation resources, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate levels of service;
- Coordination with emergency medical services;
- Crisis telehealth and phone supports; and
- An array of crisis placements tailored to the needs and resources of the local system of care, including an array of options such as:
  - In-home respite options,
  - Crisis foster care (placements ranging from a few days up to 30 days),
  - Crisis respite (one to 14 days),
  - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision,
  - Acute inpatient care, and
  - Linkages to a full continuum of empirically supported practices.

While some critical crisis service components exist in Travis County (a finding similar to discoveries in our study of Harris County), several crisis resources – including those from the mental health, child welfare, and juvenile justice systems – are not well coordinated or conceptualized as a single crisis system. Ideally, the crisis care continuum would be more unified, with a broader array of crisis intervention services aimed at supporting families and caregivers, schools, children, and youth across the child-serving agencies. While there is evidence of collaboration among different partners of the current system, the various crisis programs currently available are designed to help individual target populations (e.g., mental health, juvenile justice, child welfare) within each specific system.

Even with a full continuum of crisis options, children and youth will still need psychiatric inpatient care for acute and complex needs. While inpatient psychiatric care is not a substitute for ongoing, well- coordinated outpatient mental health care, inpatient psychiatric hospitalizations can be helpful for acute stabilization of a child or youth with complex needs, such as safety concerns or adjustments of medications that require close monitoring. These hospitalizations should be available when needed, but generally should be brief and supported by the broader crisis array. For example, short-term placement in crisis foster or residential care can divert children and youth with sub-acute needs from inpatient settings as well as provide support as they transition home. The availability of intensive community-based services and supports for families and foster care providers can also assist children, youth, and their caregivers with the transitions back to their homes following hospitalization. Access to inpatient care should be targeted to children and youth who need this level of care rather than to

[30] For more information, see http://wraparoundmke.com/programs/mutt.

children and youth with serious mental health conditions who are in crisis and simply have no place to go.

Residential treatment represents a component of the continuum of care for children and youth whose behavior cannot be managed safely in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth. As such, it should be reserved for situations where less restrictive placements are ruled out, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who may not respond to intensive, nonresidential service approaches. Across Texas (and the nation), children and youth are too often placed in residential treatment because more appropriate community-based services are not available. When utilized, residential services should be brief, intensive, family-based, and as close to home as possible. In an ideal system of care, intensive home and community-based services and other rehabilitation skill building services would be available earlier to prevent out-of-home placement, except when such services cannot be safely provided in the home or community.

Strategy 2: Develop a value-based payment arrangement using case rates for crisis services with the Medicaid MCOs. Value-based payment arrangements provide a financing mechanism to incentivize efficient and high-quality healthcare services through a payment system involving financial risk or rewards. Integral Care and its community partners could develop case rates that cover the actual costs of various psychiatric crisis services: crisis respite, school-based crisis response, juvenile justice diversion, emergency department and inpatient diversion, child welfare crises, etc. Appendix 2 is a sample value-based payment arrangement (including outcome measures) for crisis services that can be used with MCOs and other payers. This document should be paired with a spreadsheet that displays the true costs of each crisis program, inclusive of staffing, administrative, and other costs, to establish a case rate and provide cost information to MCOs and other payers. This approach would fit with the Medicaid MCO contractual requirements for using value-based purchasing. Other payers could also use the same case rates by developing collaborative arrangements. Integral Care is a federal Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic (CCBHC) and should use this certification as a way to negotiate case rates.[31]

Strategy 3: Develop a value-added service contract with MCOs in addition to value-based payment arrangements. Some crisis services could also be paid for as a value-added service by MCOs. Value-added services are extra services that MCOs are allowed to offer to their members. Every year, each MCO must receive approval from the state to provide and publish information on the extra services they will offer to their members. Superior MCO currently

[31] CCBHCs were established by Section 223 of the Protecting Access to Medicare Act (PAMA) as a demonstration program based on the Excellence in Mental Health Act. CCBHCs provide (or contract with partner organizations to provide) nine required types of services, with an emphasis on crisis care, utilization of evidence-based practices, care coordination, and integration with physical health care. National Council for Behavioral Health. (2018). *What is a CCBHC?* Retrieved from https://www.thenationalcouncil.org/topics/certified-community-behavioral-health-clinics/

offers a value-added service under the STAR Health Medicaid program for children and youth in foster care. The program, Turning Point, is only offered in some STAR Health service areas. Turning Point provides crisis intervention 24 hours a day, seven days a week; access to a crisis information line and linkages to mental health assessment services; in-person crisis support; crisis residential beds; and a variety of mental health services. A program similar to Turning Point could be funded by the MCOs in Travis County.

Strategy 4: Work with HHSC and the Medicaid MCOs to develop "in lieu of" service arrangements under HHSC's Medicaid managed care programs. "In lieu of" services are alternative services or services provided in alternative settings that are delivered "in lieu of" covered state plan services or settings. For example, providing crisis stabilization instead of inpatient psychiatric hospital care is an allowable service alternative. Use of research-based "in lieu of" services would enhance the current crisis service array. Providing "in lieu of" services is optional for MCOs and must be cost effective as defined in federal regulations. HHSC would need to amend the MCO contracts to allow for provision of "in lieu of" services. Appendix 6 provides an example of "in lieu of" services contract language from the state of Florida. Requesting the use of case rates for payment of "in lieu of" services to cover the full cost of evidence-based practices results in cost offsets overall.

Strategy 5: Measure outcomes and cost effectiveness of the crisis service array. MCOs and other payers are more likely to rely on case rates, value-added services, and "in lieu of" services when the crisis services are proven to have good clinical outcomes and are cost effective, especially when compared to frequent emergency department use, residential treatment, and inpatient care. Defining and reporting on specific measures, expected outcomes, and cost offsets is an important component of value-based payment methods. Appendix 2 ("Sample Crisis Services Alternative Payment Mechanism") provides a sample list of outcome measures for crisis services, but these measures are samples only and would need to be tailored to Travis County.

Strategy 6: Start the value-based payment/case rate process with the Medicaid MCOs and then expand to commercial insurers. Meet with MCOs and discuss implementation strategies such as identifying cost-effective crisis services, developing the case rates, or providing value-added services (along with associated outcome measures and reports). Over the long term, other community partners could pay the case rate when referring children and youth who are not Medicaid eligible rather than financing separate crisis programs.

Strategy 7: Use "braided" funding to provide crisis services. To enhance current crisis resources, community partners such as the City of Austin, Travis County, and juvenile justice and child welfare agencies could fund staffing of existing crisis programs to offer a broader array of crisis services, such as behavioral health crisis staff at emergency departments and psychiatric hospitals. The MCOs could also use administrative funding to pay for an LMHA hospital liaison position. Austin Independent School District could fund school-based crisis intervention positions. As part of the braided funding approach, explore the use of Title 4E funds to support the room and board costs for crisis respite services for foster care youth.

Strategy 8: Develop a crisis services payment hierarchy agreement among different payers. Using case rates for specific crisis services provides clarity about the services provided, their costs, and their outcomes. When this payment approach is paired with the concept of a single crisis system that all payors support, rather than having segmented services, a payment hierarchy can be developed among all payers: MCOs, commercial insurers, school systems, Travis County, the City of Austin, and child welfare and juvenile justice systems. For example, Medicaid covered/eligible children and youth would be covered by the MCOs. The same approach can be used for children and youth with commercial insurance. Children and youth involved with the child welfare and juvenile justice systems who are not eligible for Medicaid would receive funding from those systems. This strategy will take time to implement but could start with Medicaid MCOs and then expand. The crisis care continuum would be clearly articulated, unified, and have a broader array of crisis intervention services aimed at supporting families and caregivers, schools, children, and youth across insurers and child-serving agencies.

Strategy 9: Explore partnership models for providers who do not have the administrative resources to bill Medicaid and other insurers. Several collaborative arrangements can support CBOs to help with the administrative requirements for billing Medicaid and other insurers. These arrangements include formal partnerships, in which CBOs would become a part of a larger organization, and contractual arrangements to purchase or exchange services. In our work with Impact Austin and LifeWorks, we described the organizational models listed below.[32]

- **Accountable care organizations (ACOs)**. Typically, ACOs are large hospital and physician practices that form integrated care networks and assume responsibility for the health of their patients, the quality of care, and costs. ACOs first emerged during the discussions about the Affordable Care Act in 2011 and have been supported through the Centers for Medicare & Medicaid Services' (CMS) Medicare program.[33] Providers may "buy in" to the ACO or participate as subcontractors, often sharing financial risk for outcomes. While ACOs originally focused on Medicare, there are ACOs across the country in all states covering Medicare, Medicaid, and commercial health plan members.[34] Seton Health Alliance, Inc., was a pioneer Medicare ACO in Austin.
- **Independent practice associations (IPAs)/provider network organizations (PNOs)**. Physician practices formed IPAs to provide a range of administrative and care coordination services, including quality improvement and shared financial risk for

[32] Meadows Mental Health Policy Institute. (June 7, 2017). Community report: Strategies to obtain Medicaid and other third party mental health services reimbursement. Sponsored by Austin Impact and LifeWorks, with additional support from St. David's Foundation. https://static1.squarespace.com/static/576ad56d29687fae3f8cae47/t/59777421d482e92e49f80d10/1501000739710/Community+Report_Strategies+to+Obtain+Medicaid+and+Other+Third+Party+Reimbursement+672017.pdf

[33] Department of Health and Human Services, Centers for Medicare & Medicaid Services. (2011, November 2). Medicare shared savings program: Accountable care organizations; final rule 76. Fed. Reg. 212.

[34] Muhlestein, D., & McClellan, M. (2016, April 21). Accountable care organizations in 2016. Private and public-sector growth and dispersion. Health Affairs Blog. Retrieved from http://healthaffairs.org/blog/2016/04/21/accountable-care-organizations-in-2016-private-and-public-sector-growth-and-dispersion/

outcomes. IPAs and PNOs have expanded to include behavioral health providers or have been established by behavioral health providers.

- **Accountable communities for health (ACH)**. CMS is administering this initiative, which funds selected communities and organizations to test the impact of identifying health-related social needs and connecting Medicaid beneficiaries to services that address those needs as part of their health care.[35]

These partnership models vary widely. Providers may participate as a formal partner of a corporation or other legal entity, or as a subcontractor to the entity. The simplest model is for a small provider to contract with a larger more experienced Medicaid provider or to engage a specialized firm to perform administrative and quality improvement activities. For example, Integral Care and other LMHAs and CBOs use Tejas Health Management to enhance their operations.[36] For additional information on these models and the administrative requirements necessary to bill insurers, please refer to the Community Report: Strategies to Obtain Medicaid and Other Third Party Mental Health Services Reimbursement.[37]

Strategy 10: Develop and support First Episode Psychosis (FEP) programs. We recommend expanding FEP treatment programs and incorporating these into child and youth mental health systems, rather than delaying services until youth become 18 years old and transition to adult systems. Youth with FEP are often identified through the crisis system, law enforcement, and hospitals. Yet, many youth, while having access to health insurance through their parents (up to age 26), Medicaid, or CHIP, do not typically receive care and treatment until five years after first onset of psychosis.[38] FEP Care, sometimes called Coordinated Specialty Care, starts assertive and intensive treatment as close to the initial psychosis episode as possible. The sooner FEP Care is accessed following the onset of psychotic symptoms, the better the outcomes. One study of FEP Care found that people who began treatment within 17 months of the first onset of symptoms had better outcomes.[39] Early symptoms of psychosis can be detected by law enforcement, in emergency rooms, and in hospitals. Studies show that the longer treatment is delayed, the worse the outcome, both for the person and for society.[40] While most people who

[35] Centers for Medicare and Medicaid Services. (n.d.). *Accountable Health Communities Model.* Retrieved from https://innovation.cms.gov/initiatives/AHCM

[36] For more information about Tejas Health Management, see: https://tejashma.org/.

[37] Meadows Mental Health Policy Institute. (June 2017). *Community report: Strategies to obtain Medicaid and other third party mental health services reimbursement*. Retrieved from https://static1.squarespace.com/static/576ad56d29687fae3f8cae47/t/59777421d482e92e49f80d10/1501000739710/Community+Report_Strategies+to+Obtain+Medicaid+and+Other+Third+Party+Reimbursement+672017.pdf

[38] Wang, P. S., Berglund, P. A., Olfson, M.,& Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2), 393–415.

[39] Kane, J. M., et al. (2015). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, AJP in Advance*, 1–11.

[40] Kane et al. (2015).

experience psychosis are not violent, they are much more likely to be violent or become entangled in our criminal justice system when their conditions go untreated.[41, 42]

[41] Nielssen, O., & Large, M. (2010). Rates of homicide during the first episode of psychosis and after treatment: A systematic review and meta-analysis. *Schizophrenia Bulletin, 36*(4), 702–712.

[42] Randall, J. R., Chateau, D., Smith, M., Taylor, C., Bolton, J., Katz, L., Nickel, N. C., Enns, J., & Brownell, M. (2016). An early intervention for psychosis and its effect on criminal accusations and suicidal behaviour using a matched-cohort design. *Schizophrenia Research*, *176*(2-3), 307–311.

Appendix 1: Hospital Utilization

Table A1- 1. Summary of Admissions to Travis County Psychiatric Hospitals From Emergency Departments (CY 2015)

Hospital Name	Travis County EDs		Non-Travis County EDs		Total		
	Children	Youth	Children	Youth	Children	Youth	Total
Austin Lakes Hospital	–	6	–	11	–	17	17
Austin Oaks Hospital	24	113	57	176	81	289	370
Austin State Hospital	1	1	2	9	3	10	13
Cross Creek Hospital	–	16	–	23	–	39	39
Seton Shoal Creek Hospital	117	410	66	245	183	655	838
Total	**142**	**546**	**125**	**464**	**267**	**1010**	**1277**

Table A1- 2. Summary of Admissions to Travis County Psychiatric Hospitals From Emergency Departments (CY 2016)

Hospital Name	Travis County EDs		Non-Travis County EDs		Total		
	Children	Youth	Children	Youth	Children	Youth	Total
Austin Oaks Hospital	28	95	96	315	124	410	534
Austin State Hospital	–	1	–	7	–	8	8
Cross Creek Hospital	17	84	44	140	61	224	285
Seton Shoal Creek Hospital	107	428	54	278	161	706	867
Texas NeuroRehab Center	–	–	2	1	2	1	3
Total	**152**	**608**	**196**	**741**	**348**	**1349**	**1697**

Estimated Payments by Payer Type for Psychiatric Emergency Department Visits

Table A1- 3. Estimated Payments by Payor Type for Child Psychiatric ED Visits (2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay	Hospital Total
University Medical Center-Brackenridge	$33,229	$239	$7,407	$11,654	$1,532	**$54,062**
Seton Medical Center	$139	–	$835	–	–	**$974**
St David's South Austin Hospital	$2,600	–	$152	$683	$2,102	**$5,536**
Seton Southwest Hospital	–	–	$1,433	–	–	**$1,433**
Seton Northwest Hospital	$1,068	–	–	$2,021	$196	**$3,285**
North Austin Medical Center	$2,209	$186	$6,450	$517	$626	**$9,988**
Dell Children's Medical Center	$46,810	$1,213	$114,778	$50,297	$3,507	**$216,605**
Payer Total	**$86,055**	**$1,638**	**$131,055**	**$65,173**	**$7,963**	**$291,884**

Table A1- 4. Estimated Payments by Payor Type for Youth Psychiatric ED Visits (2016)

Hospital Name	Medicaid	Other Government	Third Party – Managed Care	Other Third Party	Self-Pay	Hospital Total
St David's Hospital	$6,162	$479	$2,872	$2,152	$101	**$11,765**
University Medical Center-Brackenridge	$153,099	$10,605	$96,532	$67,247	$11,134	**$338,617**
Seton Medical Center	$2,947	$2,849	$6,899	$5,185	$553	**$18,432**
St David's South Austin Hospital	$24,153	–	$10,409	$2,435	$18,600	**$55,596**
Seton Southwest Hospital	$3,590	$978	$7,216	–	$13	**$11,798**
Seton Northwest Hospital	$5,660	$3,202	$12,002	$7,013	$254	**$28,131**
Westlake Medical Center	–	$155	–	$643	–	**$798**
Heart Hospital-Austin	$2,136	–	$992	$1,005	–	**$4,133**
North Austin Medical Center	$27,692	$1,338	$20,657	$6,908	$4,995	**$61,591**
Dell Children's Medical Center	$100,372	$3,097	$209,208	$120,957	$15,652	**$449,287**
Payer Total	**$325,810**	**$22,704**	**$366,788**	**$213,544**	**$51,302**	**$980,148**

Table A1-5. Total Psychiatric Emergency Visits by Diagnoses and Hospital (2016)

Diagnosis	Child ED Visits	Youth ED Visits	Total ED Visits
Dell Children's Medical Center			
ADHD	7	4	11
Adjustment Disorder	6	2	8
Antisocial and Personality Disorders	7	8	15
Anxiety, Phobias, Panic, and Related Disorders	34	76	110
Autism	6	5	11
Bipolar Disorder	3	18	21
Borderline Personality Disorder	2	1	3
Depressive Disorders	21	155	176
Disruptive, Impulse Control, and Conduct Disorders	77	48	125
Dissociative Disorder	2	3	5
Eating Disorders	6	10	16
Elimination Disorders	12	1	13
Intermittent Explosive Disorder	1	1	2

Diagnosis	Child ED Visits	Youth ED Visits	Total ED Visits
Neglect, Physical, Sexual, or Other Abuse	2	–	2
Other Disorders	5	9	14
Other Mood Disorder	–	1	1
Other Somatic Disorders	2	3	5
PTSD, Acute Stress, and Other Trauma-Related Disorders	3	4	7
Schizophrenia and Psychotic Disorders	6	11	17
Self-Harm	–	1	1
Substance Use Disorders	–	3	3
Heart Hospital of Austin			
Anxiety, Phobias, Panic, and Related Disorders	–	3	3
Eating Disorders	–	1	1
Neglect, Physical, Sexual, or Other Abuse	–	1	1
North Austin Medical Center			
ADHD	1	1	2
Antisocial and Personality Disorders	–	1	1
Anxiety, Phobias, Panic, and Related Disorders	8	27	35
Autism	2	2	4
Bipolar Disorder	–	2	2
Depressive Disorders	1	22	23
Disruptive, Impulse Control, and Conduct Disorders	9	17	26
Dissociative Disorder	–	2	2
Family and Relational Problems	2	–	2
Intermittent Explosive Disorder	1	–	1
Other Disorders	–	1	1
Other Somatic Disorders	1	–	1
PTSD, Acute Stress, and Other Trauma-Related Disorders	–	2	2
Schizophrenia and Psychotic Disorders	–	1	1
Substance Use Disorders	–	1	1
Seton Medical Center			
Anxiety, Phobias, Panic, and Related Disorders	–	2	2
Depressive Disorders	–	5	5
Disruptive, Impulse Control, and Conduct Disorders	–	1	1
Other Disorders	–	1	1
Other Somatic Disorders	–	1	1

Diagnosis	Child ED Visits	Youth ED Visits	Total ED Visits
PTSD, Acute Stress, and Other Trauma-Related Disorders	1	–	1
Schizophrenia and Psychotic Disorders	1	4	5
Substance Use Disorders	–	1	1
Seton Northwest Hospital			
Anxiety, Phobias, Panic, and Related Disorders	1	11	12
Bipolar Disorder	–	1	1
Depressive Disorders	2	11	13
Disruptive, Impulse Control, and Conduct Disorders	1	–	1
Eating Disorders	–	1	1
Other Somatic Disorders	–	2	2
Schizophrenia and Psychotic Disorders	–	2	2
Seton Southwest Hospital			
Anxiety, Phobias, Panic, and Related Disorders	–	4	4
Depressive Disorders	2	3	5
PTSD, Acute Stress, and Other Trauma-Related Disorders	–	1	1
Schizophrenia and Psychotic Disorders	–	2	2
St. David's Hospital			
ADHD	–	1	1
Anxiety, Phobias, Panic, and Related Disorders	–	12	12
Borderline Personality Disorder	–	1	1
Depressive Disorders	–	6	6
Other Somatic Disorders	–	1	1
St. David's South Austin Hospital			
ADHD	–	1	1
Adjustment Disorder	–	1	1
Anxiety, Phobias, Panic, and Related Disorders	5	55	60
Bipolar Disorder	1	2	3
Depressive Disorders	1	17	18
Disruptive, Impulse Control, and Conduct Disorders	2	6	8
Elimination Disorders	1	–	1
Neglect, Physical, Sexual, or Other Abuse	1	1	2
Other Somatic Disorders	3	5	8
PTSD, Acute Stress, and Other Trauma-Related Disorders	1	1	2
Reactive Attachment Disorder	1	–	1

Diagnosis	Child ED Visits	Youth ED Visits	Total ED Visits
Schizophrenia and Psychotic Disorders	–	5	5
University Medical Center - Brackenridge			
ADHD	16	7	23
Adjustment Disorder	9	29	38
Antisocial and Personality Disorders	–	1	1
Anxiety, Phobias, Panic, and Related Disorders	7	49	56
Autism	2	2	4
Bipolar Disorder	–	15	15
Borderline Personality Disorder	–	2	2
Depressive Disorders	13	149	162
Disruptive, Impulse Control, and Conduct Disorders	7	4	11
Eating Disorders	1	2	3
Family and Relational Problems	–	2	2
Intermittent Explosive Disorder	–	1	1
OCD and Related Disorders	–	1	1
Other Disorders	–	3	3
Other Mood Disorder	–	1	1
PTSD, Acute Stress, and Other Trauma-Related Disorders	3	5	8
Schizophrenia and Psychotic Disorders	6	19	25
Substance Use Disorders	–	7	7
Westlake Medical Center			
Anxiety, Phobias, Panic, and Related Disorders	–	2	2

Appendix 2: Sample Crisis Services Alternative Payment Mechanism (Oregon)

Alternative Payment Arrangements and Value-Based Purchasing Description
42 CFR 438.6(e) and 1115 VBP

1. Service Name and Description: Key Components

Site-Based Crisis Services

Provider "A" Crisis

The crisis center provides crisis intervention services 24 hours a day, seven days a week for residents. It is located on the campus of [hospital] and responds to the three [hospital] emergency departments (EDs) to conduct evaluations as requested. (Note: Medicaid only reimburses for these services when a Medicaid enrollee is involved.)

At least one qualified mental health professional (QMHP) is on duty at all times to provide face-to-face assessments and crisis counseling. The crisis center also provides telephone triage, support, and referral on a first-come, first-served basis. Most of this work is done at the crisis center itself, but a large number of assessments also occur at the emergency room (ER) of a local hospital.

During peak demand times (usually early afternoons and evenings), as many as three QMHP's share the workload. During the work week, the center is able to pull staff from other programs to cover crisis needs. During evenings and overnight, there is a qualified mental health associate (QMHA) to assist with managing the crisis center. The staff help gather information, monitor clients who are waiting to be seen, and provide support and practical assistance to clients who are waiting for evaluation and crisis planning. The QMHA staff provide skills training, crisis supports, and connection to community services.

Crisis center staff are responsible for coordinating services for clients in a mental health crisis, including regional inpatient hospitalization, crisis respite in the community, the use of crisis associates (QMHA paraprofessionals trained to support and give reassurance to people in crisis), and access to support for basic needs such as medications, food, and other assistance. The staff also provide referrals to ongoing mental health services and other community resources.

Other crisis services offered by the crisis center include access to a prescriber for medication evaluations and access to a case manager who can provide temporary assistance to clients who are at risk of hospitalization but are not yet connected to regular outpatient mental health services.

Provider "B" Crisis

The crisis team includes qualified mental health professionals (QMHPs) who have been trained to provide trauma-informed care to people experiencing a mental health crisis. A mental health

services entity offers Provider "B" with 24-hours-a-day, seven-days-a-week crisis services that include:

- Telephone triage,
- Face-to-face assessments and crisis counseling,
- Off-site emergency evaluations,
- Consultation,
- Mobile crisis intervention (the team can travel to the client, but this does not happen often),
- Intensive case management,
- Respite placements, and
- Child and adult threat assessment.

On-site services are available Monday through Friday from 8:00 a.m. to 5:00 p.m. Emergency evaluations and crisis intervention take place in local hospital ERs, the jail,[43] schools, and throughout the community at the request of local law enforcement.

Mobile Crisis Outreach

The Provider "A" Mobile Crisis Response Teams pair a police officer or a deputy sheriff with a QMHP to respond to crises involving people with behavioral health issues. The teams de-escalate situations to prevent institutionalization of the person experiencing the crisis. Seven days a week, from 2:00 p.m. to midnight, the teams respond directly to calls for service involving someone believed to be having a mental health crisis.[44] (Note: Medicaid only reimburses for the mental health professional's time when a Medicaid enrollee is involved. Medicaid does not reimburse for any law enforcement time or equipment expense.)

As part of the mobile team, mental health professionals respond to active mental health crises with a law enforcement officer. Although privacy laws forbid the disclosure of most information, mental health professionals are able to research a person's history to advise the officer on the best way to interact with them based on past encounters and diagnoses, and provide pertinent information for imminent crisis situations.

After the immediate need of a mental health crisis is addressed, the team can refer to follow-up care at the crisis center or with the crisis outreach response team, whose staff are tasked with following up with residents, checking in on their well-being and connecting them to community resources.

According to the sheriff's office, the collaborative efforts between law enforcement and mental health professionals over the past nine years have reduced jail bookings by about 20 to 25 percent each year. In 2015, less than ten percent of the more than 2,500 reported mental health crises incidents led to incarceration.

[43] Care inside the jail is not reimbursed by Medicaid.

[44] Medicaid only reimburses for the mental health professional's time when a Medicaid enrollee is involved. Medicaid does not reimburse for any law enforcement time or equipment expense.

Crisis Outreach Response Team and Brief Resource Enhancement and Support

Crisis Outreach Response Team

Created by Provider "A" in 2010, the crisis outreach response team is a collaboration between law enforcement and mental health providers with the aim to engage people who have repeated contact with law enforcement and are believed to be impaired by a mental illness that has contributed to the contact with law enforcement. At this time, the team is composed of a sheriff's deputy and a QMHP from the crisis center who work together to assist people in getting connected with services in the community, with the goal of engaging them in treatment and decreasing their involvement in the criminal justice system.[45]

Referrals to the crisis outreach response team originate from law enforcement officers and are based on two main criteria: (1) a community member has had repeated contact with law enforcement that is believed to be driven by a mental health component and (2) a community member is believed to be affected by mental illness, has cycled through the jail, and has not followed up on any community referrals. The team works to engage people who have come to the attention of law enforcement in some of the treatment and supports that may be needed before continued infractions result in arrest or re-arrest.

The Brief Resource Enhancement and Support

The Brief Resource Enhancement and Support program is designed to work with a client for up to 90 days to identify barriers to community services and to create a treatment plan to surmount those barriers. It has the goal of referral to and engagement with community resources. The program is designed to serve clients who are frequently accessing acute care resources, which may include multiple contacts in the ER or placement at an acute care hospital. Program staff assist in locating shelter or other housing options as well as connecting clients to outpatient mental health providers, alcohol and drug services, peer supports services, and vocational supports, as appropriate.

Crisis Respite

The crisis respite program works in conjunction with the 24-hour crisis center. The crisis center QMHPs provide mental health evaluations to people who have arrived on their own, have been brought in by family or friends, were referred by other professionals (e.g., family practitioners, therapists, clinics), have been brought in by the police, or have arrived at one of the three local ERs. After determining that the individual does not meet inpatient hospital criteria (i.e., imminent dangerousness to self or others or inability to care for self), crisis center staff may offer crisis respite as an option for working through the immediate mental health crisis the client is facing.

Crisis respite is a voluntary program and has the expectation that the QMHP will work with the client to create a crisis respite treatment plan. The treatment plan is very specific to the presenting crisis and individualized for each person served.

[45] Only the QMHP is reimbursed by the MCO.

Once an individual agrees to respite and a plan has been created, the staff and client decide whether to send staff into the client's home, place the client in a home provider's house, or place the client in one of the three two-bedroom apartments overseen by the crisis respite program. This determination is based on client comfort, availability of crisis associate staff, and safety issues. These placements are considered 23-hour beds, and the client must be re-evaluated each day for ongoing needs and participation in the crisis plan. Crisis staff also provide crisis case management to connect to outpatient or community resources to resolve the crisis.[46]

Home providers are families in the community that open their homes to a person experiencing a mental health crisis. Home providers are not mental health specialists; their role is limited to providing a safe, nurturing environment. They are responsible for meals for the time that the client is in the home and for including that client in any planned family activities (within reason). There is never more than one client in the home at any time, and the client cannot stay in a home provider's residence when the home provider is not there.

The crisis respite program has three two-bedroom apartments where clients can be placed, with the preference of placing no more than one client at a time. However, if the need arises, two clients can be placed in an apartment. There is always a crisis associate present when both clients are there. The philosophy of the apartment program is that not everyone in crisis needs 24-hour supervision. At a minimum, staff check in on every client twice a day; however, each treatment plan is specific to the needs of the consumer. Crisis associates can work in client homes, the crisis respite program apartments, the community, or a home provider's home. They are trained to provide skills training and help with case management needs.

Diversion Programs (Jail and Emergency Department for Adults and Children)

Adult Jail Diversion

The jail diversion team takes referrals from a variety of sources, including EDs, community shelters, and other community sites, to divert people from institutionalization, including hospitalizations and incarceration. This team works with the same resources as the Brief Resource Enhancement and Support program.[47]

Child and Youth ED Diversion

Respite is provided on an emergency basis to divert children and youth receiving care in the ER from more restrictive treatment (e.g., hospitalization). There is no local psychiatric hospital that can admit children and youth who must wait for a resource in [city] or elsewhere to become available. Because of shortages in institutional beds and alternatives to inpatient psychiatric

[46] Normal activities of daily living are considered in the content of the service when providing respite care and are not be billed separately.

[47] If the team must visit the jail, these visits are not financed by Medicaid and are paid through provider or state general fund resources.

care, children and youth were waiting in the ER for extended periods of time for a disposition – or waiting for days for a placement – prior to the inception of this program.

Respite services help to de-escalate stressful situations and provide a therapeutic outlet for the child. The child or youth may be placed into a foster home specially contracted with the program (Medicaid does not reimburse for foster care room and board), or the staff may go to the child or youth's home, with the parents' permission, to provided skills training as determined by the QMHP staff and the case manager. The case manager is located within one of the intensive children's programs. The goal of respite services is to reduce time spent in the ED, when possible, and to divert children and youth from higher levels of care, coordinate outpatient services, and support the family as it navigates the situation. There is a contract with a family support provider to provide the family with peer supports and mentoring on how to navigate the various mental health systems.

2. Information on Population to Be Served

The characteristics of the populations to be served in all situations are outlined in the following tables. This population includes people experiencing a seriously acute psychological/emotional change that results in a marked increase in personal distress and exceeds the abilities and the resources of those involved to effectively resolve it.

Table A2- 1. Site-Based Crisis Services in "A" and "B" Counties

Site-Based Crisis Services	Age Ranges	Projected Numbers	Characteristics
Provider "A" Crisis Center	All	4,300 annually	People in crisis who walk into the crisis center
Provider "B" Crisis Staff	All	500 annually	People in crisis who walk into Provider "B" offices

Table A2- 2. Mobile Crisis Outreach in "A" and "B" Counties

Mobile Crisis Outreach	Age Ranges	Projected Numbers	Characteristics
Provider "A" Mobile Crisis Teams	All	755	People in mental health crisis situations served by clinical staff co-located with law enforcement officers who respond
Provider "B" Mobile Crisis Teams	All	600	People in mental health crisis situations served by clinical staff co-located with law enforcement officers who respond

Table A2- 3. Provider "A" Crisis Outreach Response Team and Brief Resource Enhancement and Support

Crisis Outreach Response Team/Brief Resource Enhancement and Support	Age Ranges	Projected Numbers	Characteristics
Crisis Outreach Response Team Brief Resource Enhancement and Support	18 and over	1,172 encounters	People who have repeated contact with law enforcement and are believed to be impaired by a mental illness that has contributed to the contact with law enforcement People who frequently access acute care resources, which may include multiple contacts in the ER or placement at an acute care hospital

Table A2- 4. Provider "A" Crisis Respite

Crisis Respite	Age Ranges	Projected Numbers	Characteristics
Crisis Respite for Adults	18 and over	65 beds/650 bed days	Adults needing crisis respite for 1–3 days to prevent institutionalization

Table A2- 5. Provider "A" Jail Diversion

Jail Diversion	Age Ranges	Projected Numbers	Characteristics
Jail Diversion Team	18 and over	779 encounters annually	People with a history of contact with law enforcement at risk of institutionalization referred from EDs, community shelters, and other community sites

Table A2- 6. Provider "A" Children's Emergency Department Diversion

Children's ED Diversion	Age Ranges	Projected Numbers	Characteristics
Children's ED Diversion	Under age 18	45 children and youth annually	Children and youth seen in the EDs to divert from more restrictive treatment (e.g., hospitalization)

3. Expected Outcomes

In SAMHSA's comprehensive review of the efficacy and cost effectiveness of crisis services, the expected outcomes of these services include the stabilization and improvement of psychological symptoms of distress and engagement of people in appropriate treatment

services to address the problems that led to the crises.[48] Specific outcomes of crisis services include the following:

- Stabilizing psychiatric symptoms in the least restrictive setting;
- Assisting the person to return to his or her family or other community-based living situation;
- Getting people connected to services;
- Reducing ED boarding and reliance;
- Increasing the person's options for community service alternatives for avoidable inpatient admissions;
- Diverting inpatient admissions and jails entry; and
- Offsetting costs related to decrease in ED use, psychiatric admissions, and justice system costs.

These outcome measures are drawn from the work of Balfour et al. to track outcomes and improve the local crisis system and crisis programs and are selected by the counties to fit their specific crisis service array.[49] To develop crisis measures, Balfour and her colleagues used the framework from the Institute of Medicine's *Six Aims of Improvement: Safe, Patient-Centered, Effective, Timely, Efficient, and Equitable*.[50] As suggested by Balfour and her colleagues, the need to tailor measures to local systems is important because each local system may be at a different developmental stage in terms of the array of community-based service alternatives that support people experiencing psychiatric crises. The providers have selected measures that identify positive outcomes and cost effectiveness *and* provide useful information for system improvements.

4. Staffing Qualifications, Credentialing, and Levels of Supervision (Administrative and Clinical) Required

Table A2- 7. Staffing for Site-Based Crisis Services

Staff	Qualifications in Provider "A" for the Crisis Center	Qualifications in Crisis Staff in Provider "B"
Prescriber	Nurse Practitioner	
Supervisor	QMHP	QMHP
Clinician	QMHP	QMHP
Crisis Associate	QMHA	

[48] Substance Abuse and Mental Health Services Administration (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[49] Balfour, M., Tanner, K., Jurica, P. J., Rhoads, R., & Carson, C. A. (2016). Crisis reliability Indicators Supporting Emergency Services (CRISES): A framework for developing performance measures for behavioral health crisis and psychiatric emergency programs. *Community Mental Health Journal, 52(1),*1–9.

[50] Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press. Retrieved from https://doi.org/10.17226/10027

Table A2- 8. Staffing for Mobile Crisis Outreach

Staff	Mobile Crisis Response Team Qualifications in Provider "A"	Qualifications in Mobile Crisis Response Team in Provider "B"
Supervisor	QMHP	QMHP
Clinician	QMHP	QMHP

Table A2- 9. Staffing for Crisis Outreach Response Team

Staff	Qualifications in Provider "A"
Prescriber	Nurse Practitioner
Supervisor	QMHP
Clinician	QMHP
SUD Specialist	Peer
Peer	Peer

Table A2- 10. Staffing for Crisis Respite

Staff	Qualifications in Provider "A"
Supervisor	QMHP
Clinician	QMHA

Table A2- 11. Staffing for Jail Diversion Programs

Staff	Qualifications in Provider "A"
Supervisor	QMHP
Clinician	QMHP
SUD Specialist	Peer
Crisis Associate	QMHA

Table A2- 12. Staffing for Children's Emergency Department Diversion Programs

Staff	Qualifications in Provider "A"
Supervisor	QMHP
Clinician	QMHP
Crisis Associate	QMHA

5. Units of Service and Procedure Codes

Table A2- 13. Units of Service and Procedure Codes: Provider "A" and Provider "B"

Service	Procedure Code	Modifier	Unit Definition	Units of Service
The Crisis Center	S9485	HT	Crisis intervention mental health services, per diem	Per encounter
Provider "B" Crisis Staff	S9485	HT	Crisis intervention mental health services, per diem	Per encounter
Provider "A" Mobile Crisis Response Team	S9485	TG	Crisis intervention mental health services, per diem	Per encounter
Provider "B" Mobile Crisis Response Team	S9485	TG	Crisis intervention mental health services, per diem	Per encounter
Crisis Respite	S9485	HB	Crisis intervention mental health services, per diem	Per diem
Jail Diversion	S9485	HZ	Crisis intervention mental health services, per diem	Per encounter
Crisis Outreach Response Team/Brief Resource Enhancement and Support	S9485	HE	Crisis intervention mental health services, per diem	Per encounter
ED Diversion (children and youth)	S9485	HA	Crisis intervention mental health services, per diem	Per encounter
Modifiers HA - HA CHILD/ADOLESCENT PROGRAM HCPCS Modifier Code HB - HB ADULT PROGRAM, NON GERIATRIC HCPCS Modifier Code[51] HE - HE MENTAL HEALTH PROGRAM HCPCS Modifier Code[52] HT - HT MULTI-DISCIPLINARY TEAM HCPCS Modifier Code HZ - HZ FUNDED BY CRIMINAL JUSTICE AGENCY HCPCS Modifier Code TG - TG COMPLEX/HIGH TECH LEVEL OF CARE HCPCS Modifier Code				

6. Anticipated Units of Service per Person

Table A2- 14. Anticipated Units of Service

Service	Units (May Vary by Age Group)
Crisis Services in Outpatient Settings	1 per encounter (72 hours)
Mobile Crisis Outreach	1 per encounter (24 hours)
Crisis Outreach Response Team/Brief Resource Enhancement and Support	1 per encounter (90 days)

[51] HB is a pricing modifier: services provided in a licensed adult substance use disorder treatment program.
[52] HE is used for the following currently: HE = Tracking Modifier – Mental Health Residential Program, 5–16 residents when billed with T1020; HE = Tracking Modifier – Supported Education when billed with H2023.

Service	Units (May Vary by Age Group)
Respite Care	Per diem (goal of 1–3 days)
Diversion Programs	1 per encounter (90 days per jail diversion and 30 days per child in ED diversion)

7. Targeted Length of Service

The lengths of service vary among the various crisis services.

Table A2- 15. Targeted Length of Service

Service	Length of Encounter
Provider "A" Crisis Center	Average length of stay (ALOS): 90 minutes for screening and de-escalation, but encounter is open 72 hours
Provider "B" Crisis Staff	ALOS: 1 hour, but encounter is open for 72 hours
Provider "A" Mobile Crisis Response Team	ALOS: 60 minutes, but encounter is open 24 hours
Provider "B" Mobile Crisis Response Team	ALOS: 60 minutes, but encounter is open 24 hours
Crisis Outreach Response Team/Brief Resource Enhancement and Support	Up to 90 days
Crisis Respite	1–3 days on average
Jail Diversion	Up to 90 days
ED Diversion (children and youth)	ALOS: 30 days; up to 60 days, as needed

8. Describe Why This Service Is Needed and Is Different Than Any State Plan or Alternative Service Already Defined. If Implemented in Other States, Describe Successful Outcomes.

Today, the [state] Medicaid State Plan and prioritized list covers some limited crisis services provided by individual licensed practitioners. However, the provision of a continuum of crisis services requires a broader array of services to divert people from institutional placements.

The services provided include a variety of team-based crisis services as well as crisis response in alternative settings that are not reimbursed under traditional Medicaid State Plan codes and funding. These services are necessary because they provide important components of crisis intervention services needed in the counties to address the psychiatric crisis needs of their residents. Additionally, these services are consistent with those defined in SAMHSA's crisis service array and evidenced-based toolkit on crisis services.[53] SAMHSA describes the array of crisis services available in states as "a continuum of services that are provided to individuals experiencing a psychiatric emergency."[54] Core crisis services include 23-hour crisis stabilization/observation beds; short-term crisis residential services; crisis stabilization; mobile

[53] Substance Abuse and Mental Health Services Administration. (n.d.). *Evidence-based practices toolkits*. Retrieved August 31, 2016 from http://store.samhsa.gov/list/series?name=Evidence-Based-Practices-KITs

[54] *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration.

crisis services; 24-hours-a-day, seven-days-a-week crisis hotlines; warm lines; psychiatric advance directive statements; and peer crisis services. Other services include crisis respite and specialized crisis intervention teams.[55]

In its analysis of the crisis literature, SAMHSA found evidence of the effectiveness of crisis programs, particularly related to diversion of people from unnecessary hospitalizations and use of least restrictive services. There is also evidence that a continuum of crisis services can reduce utilization and costs of inpatient care. The clinical outcomes are positive.[56]

The crisis services desired by the counties all fit within the SAMHSA services, described as having good outcomes and cost efficiencies pertaining to cost offsets of more intensive services. Furthermore, many states are funding these types of services with Medicaid funds.

Table A2- 16. Descriptions of Comparable State Plan Service Payment Arrangements

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service[a]	Cost per Person per Stay
Residential Placement	H2013	Per diem	90 days assumed	$350.23 per diem $410.50 per diem	$31,520.70 $36,945
State Hospital[b]		Per diem	256 days	$945 per diem	$241,920
Acute Care Hospital[c]		Per diem	9.4 days	$1,000 per day	$9,400
Psychiatric Residential Treatment Facilities (PFRTs)[d]		Per diem	127 days	$500 (50 days or >) – $570 (49 days or less)	$63,500
Day Treatment[e]		Per diem	109.9 days	Day Treatment – $290 (50 or more days), $351 (49 days or less)	$31,871

[a] OHA Medicaid fee schedule, April 1, 2016. http://www.oregon.gov/oha/healthplan/pages/feeschedule.aspx; email dated 4/7/2016 from Cary Moller.
[b] United States Department of Justice Interim Report to the State of Oregon. January 2, 2014. Integration of Community Mental Health and Compliance with Title II of the Americans with Disabilities Act
[c] Program Analysis and Evaluation Team. (2008, November). Children's Mental Health Utilization Report, April 1, 2007 through March 31, 2008. Oregon Department of Human Services, Addictions and Mental Health Division, p. 17.
[d] Program Analysis and Evaluation Team. (2008, November). Children's Mental Health Utilization Report, April 1, 2007 through March 31, 2008. Oregon Department of Human Services, Addictions and Mental Health Division, p. 15.

[55] Substance Abuse and Mental Health Services Administration (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[56] Substance Abuse and Mental Health Services Administration. (2014), p. 5.

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service[a]	Cost per Person per Stay

[e] Program Analysis and Evaluation Team. (2008, November). Children's Mental Health Utilization Report, April 1.

Table A2- 17. Descriptions of Alternative Service Payment Arrangements (Include Type, Amount, Frequency, Etc.)

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service per Encounter	Length of Encounter
Provider "A" Crisis Center	S9485 HT	Crisis intervention mental health services, per diem	Per encounter	$591.14	ALOS: 90 minutes for screening and de-escalation, but encounter is open 72 hours
Provider "B" Crisis Staff	S9485 HT	Crisis intervention mental health services, per diem	Per encounter	$499.15	ALOS: 1 hour, but encounter is open for 72 hours
Provider "A" Mobile Crisis Response Team	S9485 TG	Crisis intervention mental health services, per diem	Per encounter	$272.43	ALOS: 60 minutes, but encounter is open 24 hours
Provider "B" Mobile Crisis Response Team	S9485 TG	Crisis intervention mental health services, per diem	Per encounter	$461.97	ALOS: 60 minutes, but encounter is open 24 hours
Crisis Respite	S9485 HB	Crisis intervention mental health services, per diem	Per diem	$686 (R&B included)[57]	1–3 days on average
Jail Diversion	S9485 HZ	Crisis intervention mental health services, per diem	Per encounter	$499.36	Up to 90 days
ED Diversion (children and youth)	S9485 HA	Crisis intervention mental health services, per diem	Per encounter	$695 (without R&B)	ALOS: 30 days; up to 60 days as needed
Crisis Outreach Response Team/Brief Resource	S9485 HE	Crisis intervention mental health services, per diem	Per encounter	$632.41	Up to 90 days

[57] Respite care furnished in a facility approved by the state that is not a private residence may include room and board costs.

Service	Procedure Code	Unit Definition	Units of Service	Cost of Service per Encounter	Length of Encounter
Enhancement and Support					

Modifier Key
HA - HA CHILD/ADOLESCENT PROGRAM HCPCS Modifier Code
HB - HB ADULT PROGRAM, NON GERIATRIC HCPCS Modifier Code
HE - HE MENTAL HEALTH PROGRAM HCPCS Modifier Code[58]
HT - HT MULTI-DISCIPLINARY TEAM HCPCS Modifier Code
HZ - HZ FUNDED BY CRIMINAL JUSTICE AGENCY HCPCS Modifier Code
TG - TG COMPLEX/HIGH TECH LEVEL OF CARE HCPCS Modifier Code

Table A2- 18. Examples of Crisis Rates Utilized by Other States[59,60,61]

State	Procedure Code	Modifier	Description	Unit	Cost of Service
Delaware	S9485		Crisis intervention mental health services – site-based	Per diem	$766.52
	H2011		Mobile crisis	15 min unit	$146.99 (limit 5 or the per diem rate)
Louisiana	H0045		Respite for adults/children	Per diem	$180
	S9485	HM	Mobile Crisis/Crisis Care Center by high school diploma (HSD) credential	Per diem	$278.05
	H2011	HM	Follow-up crisis intervention (HSD)	15 min unit	$23.16
	S9485	HN/HO	Crisis intervention mental health services (BA/MA)	Per diem	$352.65
	H2011	HN/HO	Follow-up crisis intervention (BA/MA)	15 min unit	$31.69
	90839	GC	Psychotherapy for crisis	1st 60 min	$123.60 (MD) $98.88 (APRN/Psych) $85.52 – (LCSW/LPC)

[58] HE is used for the following currently: HE = Tracking Modifier – Mental Health Residential Program, 5–16 residents when billed with T1020; HE = Tracking Modifier – Supported Education when billed with H2023.
[59] https://medicaid.dhss.delaware.gov
[60] Louisiana Department of Health. (n.d.). *Behavioral health managed care: Managed care document library and resources.* Retrieved from http://ldh.la.gov/index.cfm/page/538
[61] https://www2.njmmis.com/downloadDocuments/CPTHCPCSCODES.pdf

State	Procedure Code	Modifier	Description	Unit	Cost of Service
	90840	GC	Psychotherapy for crisis	Each additional 60 min	$61.50 (MD) $49.20 (APRN/Psych) $43.05 (LCSW/LPC)
New Jersey	H2011		Psychiatric Emergency Rehabilitation Services (PERS)	Per diem (1–24 hrs.)	$820.80
			Follow-up PERS	Hour unit	$92.82 (limit 2)
			Follow-up PERS	Additional per diem beyond 24 hrs.	$653.40
			Outreach	Per episode	$862.19
			Crisis Intervention	15 min unit	$11.26
Modifier Key HA - HA CHILD/ADOLESCENT PROGRAM HCPCS Modifier Code HB - HB ADULT PROGRAM, NON GERIATRIC HCPCS Modifier Code HE - HE MENTAL HEALTH PROGRAM HCPCS Modifier Code[62] HT - HT MULTI-DISCIPLINARY TEAM HCPCS Modifier Code HZ - HZ FUNDED BY CRIMINAL JUSTICE AGENCY HCPCS Modifier Code TG - TG COMPLEX/HIGH TECH LEVEL OF CARE HCPCS Modifier Code					

Description of Process for Reporting Encounter Data (Include Record Type, Codes To Be Used, Etc.)

Each provider will submit an encounter (or per diem for crisis respite).

Description of Monitoring Activities

Unlike other alternative payment methodologies, there is no national model of fidelity to which each crisis team/provider must adhere. Instead, each crisis team/provider must maintain documentation on the effectiveness of the crisis intervention from a clinical perspective. The indicators that have been selected for monitoring purposes by Provider "A" and Provider "B" are in the following two tables.

[62] HE is used for the following currently: HE = Tracking Modifier – Mental Health Residential Program, 5–16 residents when billed with T1020; HE = Tracking Modifier – Supported Education when billed with H2023.

Table A2- 19. Provider "A" Indicators

Primary Domain	Secondary Domain	Metric/Definition	Rationale	Standard Quality Measure
Resolve Crisis in the Least-Restrictive Setting	Community Disposition	Percentage of mobile team visits resulting in community disposition	Allows continued recovery in the least-restrictive setting	Monthly and annual percentages of crisis encounters resulting in community disposition
	Crisis in the Outpatient Setting	Number of crisis encounters in the outpatient setting	Can be an indicator of gaps in the continuum of care	Total monthly and annual crisis and community crisis outreach team screenings, and in specific screening settings (e.g., mobile team, office, phone call)
	Emergency Room (ER) Utilization	Number of mental health or substance abuse ER presentations	Can be an indicator of gaps in the continuum of care	Monthly and annual reports indicating number of mental health or substance abuse ER presentations
	Emergency Department (ED) and/or Psychiatric ED Admissions to the Hospital	Percentage of psychiatric crisis encounters in the ED that result in an admission to an inpatient facility	Promotes focused attention on disposition to the-least restrictive setting	Monthly and annual percentages for ED psychiatric crisis encounters resulting in inpatient admit
Minimize ED Boarding	Diversion from ED	Number of children and youth diverted from the ED annually Number of children and youth successfully diverted from the ED and not into a higher level of care	Medical ED boarding delays access to appropriate care; can be an indicator of gaps in the continuum of care	Percentage of child/youth encounters diverted from ED annually Percentage of child/youth encounters diverted from ED to lower level of care

Primary Domain	Secondary Domain	Metric/Definition	Rationale	Standard Quality Measure
Get People Connected	Follow Up After Crisis Encounter	Percentage of crisis encounters followed up with a phone call within 72 hours	Active engagement post crisis encounter increases likelihood of recovery in the least-restrictive setting	Monthly and annual percentages for crisis encounters receiving phone call within 72 hours
Minimize School-Based Crisis Episodes	School-Based Crisis Response Follow Up	Percentage of crisis encounters followed up with a phone call within 72 hours	Active engagement post crisis encounter increases likelihood of recovery in the least-restrictive setting	Monthly and annual percentages for crisis encounters receiving phone call within 72 hours

Table A2- 20. Provider "B" Indicators

Primary Domain	Secondary Domain	Metric/Definition	Rationale	Standard Quality Measure
Resolve Crisis in the Least-Restrictive Setting	Community Disposition	Percentage of mobile team visits resulting in community disposition	Allows continued recovery in the least-restrictive setting	Monthly and annual percentages of crisis encounters resulting in community disposition
	Crisis in the Outpatient Setting	Number of crisis encounters in the outpatient setting	Can be an indicator of gaps in the continuum of care	Total monthly and annual screenings, and in specific screening settings (e.g., mobile team, office, phone call)
	ED and/or Psychiatric ED Admissions to the Hospital	Percentage of psychiatric crisis encounters in the ED that result in an admission to an inpatient facility	Promotes focused attention on disposition to the least-restrictive setting	Monthly and annual percentages for ED psychiatric crisis encounter resulting in inpatient admit

Primary Domain	Secondary Domain	Metric/Definition	Rationale	Standard Quality Measure
Meet Needs of Complex Patients	People using a high volume of services	Number using a high amount of services and percentage of total population served in crisis system	Extremely high utilization patterns indicate that traditional approaches to care are not successful and should be reevaluated for these people	Annual percentage of people with high utilization based on population served in crisis system
Get People Connected	Follow Up After Crisis Encounter	Percentage of crisis encounters followed up with a face-to-face encounter within seven (7) days	Active engagement post crisis encounter increases likelihood of recovery in the least-restrictive setting	Monthly and annual percentages for crisis encounters receiving face-to-face encounters within seven (7) days

Appendix 3: Examples of Crisis Services Provided in Other States[63]

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Illinois	• Residential Care Services, Emergency Disposition and Assessment (EDA) Services • Acute Community Services (ACS) • Mobile Crisis Teams, Community Support Teams, Hotlines	Illinois contracts with a limited number of hospitals for short-term acute treatment and funds community support and Mobile Crisis Teams. Crisis residential services are funded by the state but operated by community mental health agencies. Each crisis residential center was developed according to the community's needs rather than using a single, predefined service model.	• State General Funds • Medicaid Funds – Medicaid Rehabilitation Option • Local Government Funds • Grant Funding
Maine	• Crisis Stabilization Units: Contain 81 crisis stabilization beds, 54 for adults and 27 for children • Mobile Crisis Teams • Office and Outreach Based • Ambulatory Services • Hotlines • Warm Lines	Crisis services are purchased from private behavioral health organizations through an RFP process. Provides web-based training for emergency staff as well as ER visit reduction projects targeting people with multiple chronic conditions.	• State General Funds • Medicaid Funds – Medicaid Clinic Option – Medicaid Rehabilitation Option • Mental Health Block Grant

[63] Substance Abuse and Mental Health Services Administration (2014). *Crisis services: Effectiveness, cost-effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration.

State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Massachusetts	• Residential Services: Include respite care (including one peer-run respite program) and crisis stabilization care • Ambulatory Care: Includes 21 24-hour emergency service programs (ESPs) and mobile crisis services • Warm Lines • Jail Diversion Programs	Uses an Interagency Service Agreement between the state mental health agency and the state Medicaid agency to provide crisis services through MassHealth's mental health and substance abuse vendor, Massachusetts Behavioral Health Partnership. The state mental health agency, public health agency, ED staff, and consumers have collaborated to develop ED alternatives for those in crisis. Convened workgroups to address ED wait times and access to acute care services.	• State General Funds Medicaid Funds • 1115 Waiver Funds Available under the Medicaid State Plan • Substance Abuse Block Grant • Kids Planning Grant • SMHA Funds
Michigan	• Crisis Residential Units • Intensive Crisis Stabilization Services • Mobile Crisis Teams • Ambulatory • 24/7 Telephone Lines and Walk-Ins	State mental health agency contracts with the Prepaid Inpatient Health Plans (PIHPs) to provide Medicaid managed behavioral health services and with Community Mental Health Service Providers (CMHSPs) to provide crisis services to people who are not eligible for Medicaid.	• State General Funds • Medicaid Funds – 1915(b) Waiver – 1915(c) Waiver
Missouri	• Access Crisis Intervention (ACI) Services – Residential Crisis Services – Residential Respite Beds – 23-Hour Observation Beds – Mobile Response Services – Ambulatory Crisis Services – 24-Hour Crisis Hotline	Missouri is developing partnerships in providing crisis services where possible. The state is improving the links between regional Community Mental Health Centers (CMHCs) and the crisis system and Missouri's hospital association.	• State General Funds • Medicaid Funds – Medicaid Rehabilitation Option • Mental Health Block Grant

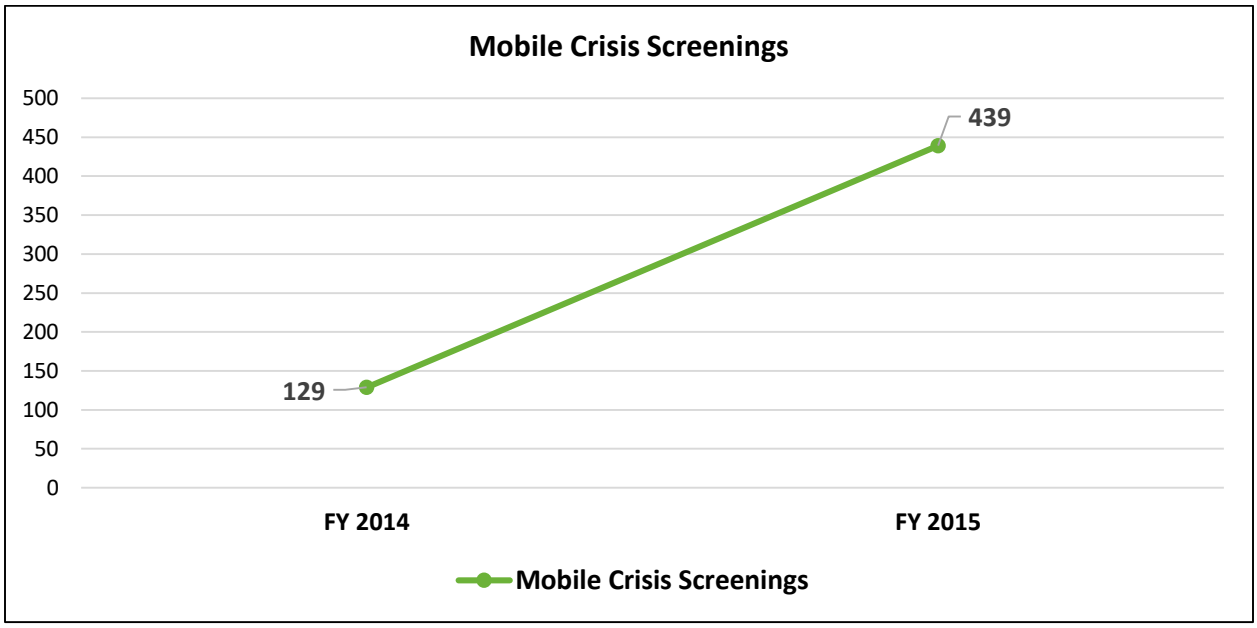
State	Crisis Services Provided	Services Infrastructure and Collaboration	Funding Sources Reported
Tennessee	• Crisis Stabilization Units: Includes seven units with walk-in centers, three respite units, and five medically monitored detoxification units • Mobile Crisis Teams • Crisis Intervention Teams	Provides all publicly funded crisis mental health and substance abuse services through a managed care system. Has partnered with the state's largest employer of ED staff to provide updates on available crisis and non-crisis services; and has partnered with the Tennessee Hospital Association in crisis workgroups. Collaborates with law enforcement through crisis intervention teams and with schools through school-based mental health liaisons.	• State General Funds Medicaid Funds – 1115 Waiver Funds • Mental Health Block Grant • Local Government Grants • Private Insurance • Self-Pay
Wisconsin	• Residential Crisis Services Programs Combining Social Detoxification with Crisis • Stabilization • Walk-In Services • Mobile Crisis Teams • 24/7 Telephone Services	Counties are responsible for the development and delivery of crisis services. The state provides supervision, regulations, and funding along with optional provider support.	• State General Funds • Medicaid Funds – Medicaid Clinic Option – Medicaid Rehabilitation Option – Medicaid 1915(a) Waiver • Mental Health Block Grant • Local Government Funds • Private Insurance • Self-Pay

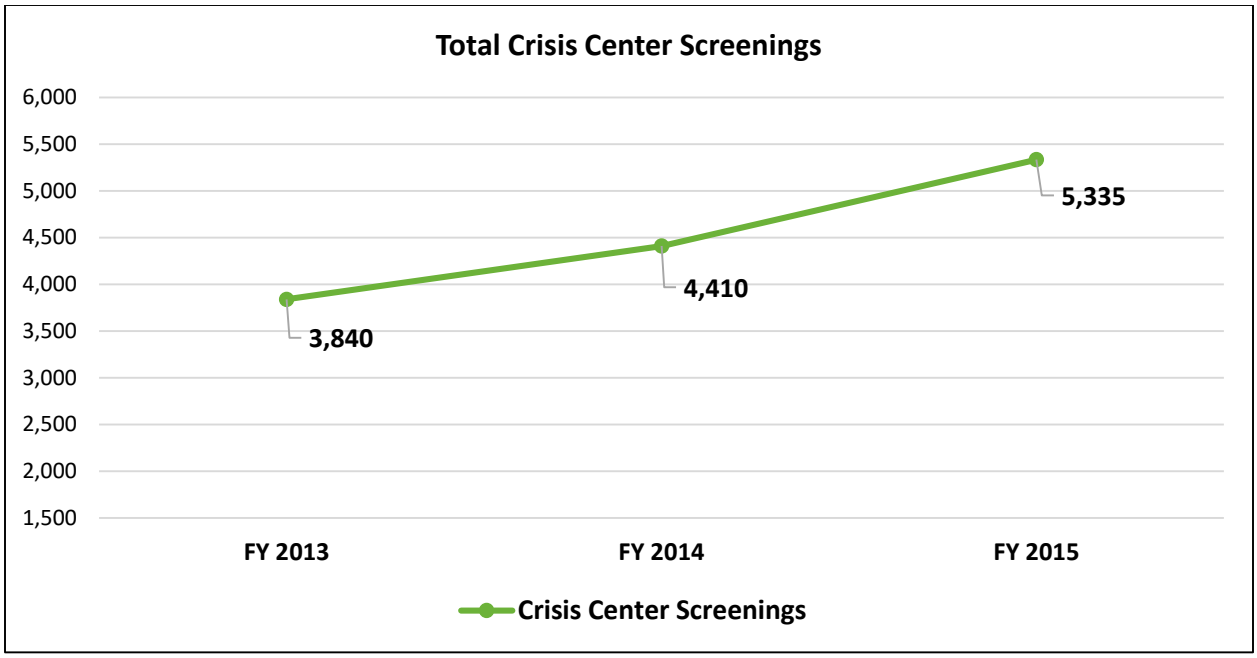
Appendix 4: Provider "A" Crisis Baseline Measures

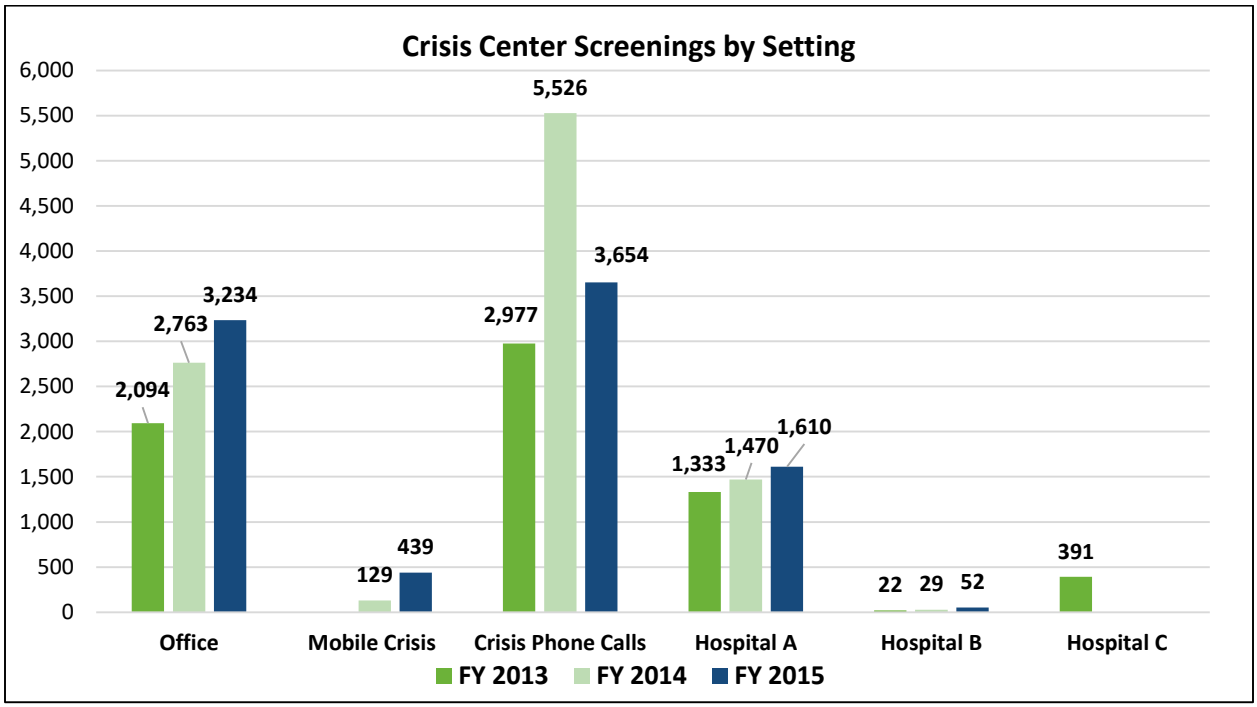
The following analysis was derived from data collected by Provider "A" related to crisis services between fiscal year (FY) 2013 and FY 2015. Data included the total number of crisis screenings, respite placements, and numbers of clients served in diversion programs and pre-commitment services as well as the total number of inmates served, mental health contacts, and referrals made within jail mental health services.

Crisis in the Outpatient Setting

Provider "A" initiated mobile crisis services in FY 2014 and saw a 240% increase in mobile crisis screenings for FY 2015. This increase in mobile screenings paired with a 39% increase in crisis screenings through the crisis center overall from FY 2013 to FY 2015. The majority of crisis center screenings occurred in the office or via telephone.

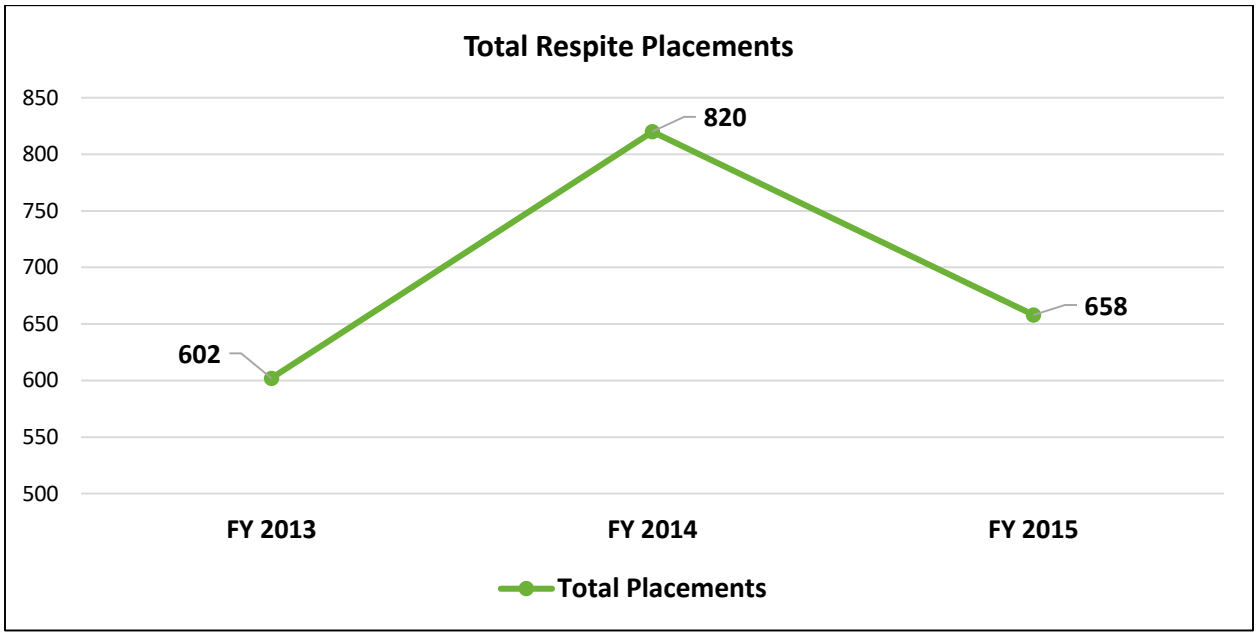


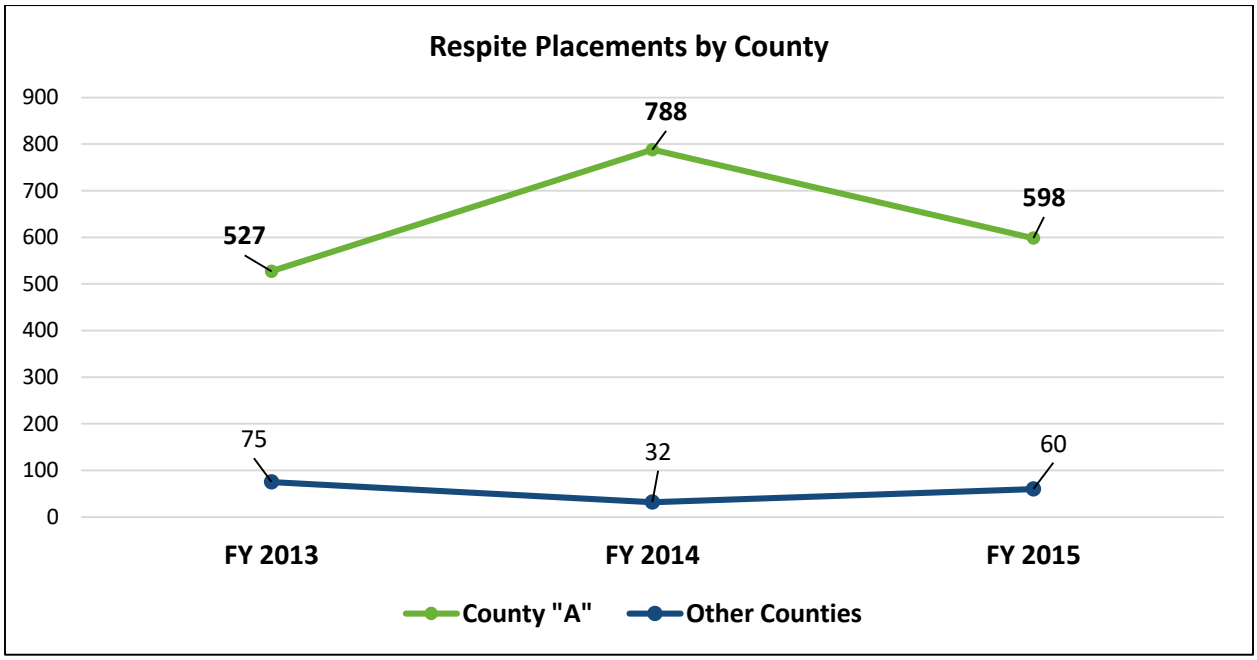

Total Crisis Center Screenings
6,000
5,500
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
3,840
4,410
5,335
FY 2013
FY 2014
FY 2015
Crisis Center Screenings

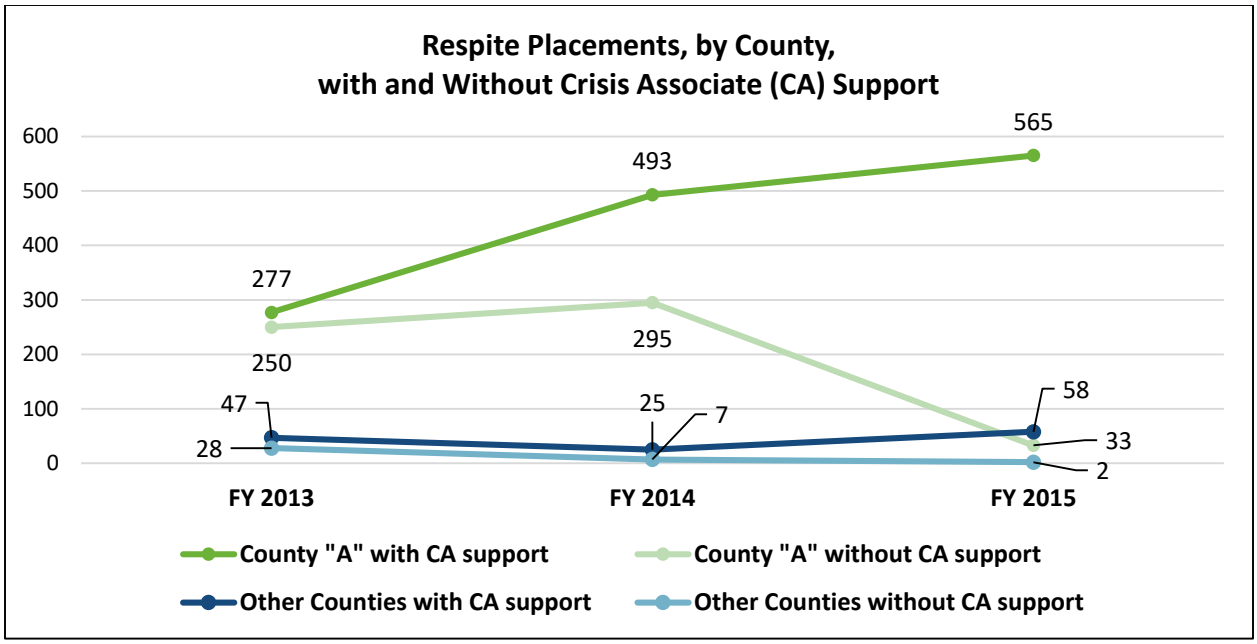

Crisis Center Screenings by Setting
6,000
5,500
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
2,094
2,763
3,234
129
439
2,977
5,526
3,654
1,333
1,470
1,610
22
29
52
391
Office
Mobile Crisis
Crisis Phone Calls
Hospital A
Hospital B
Hospital C
FY 2013
FY 2014
FY 2015

Respite

While respite placements saw an uptick in FY 2014, the numbers did not vary greatly from FY 2013 to FY 2015. The overwhelming majority of respite placement referrals were made by Provider "A."



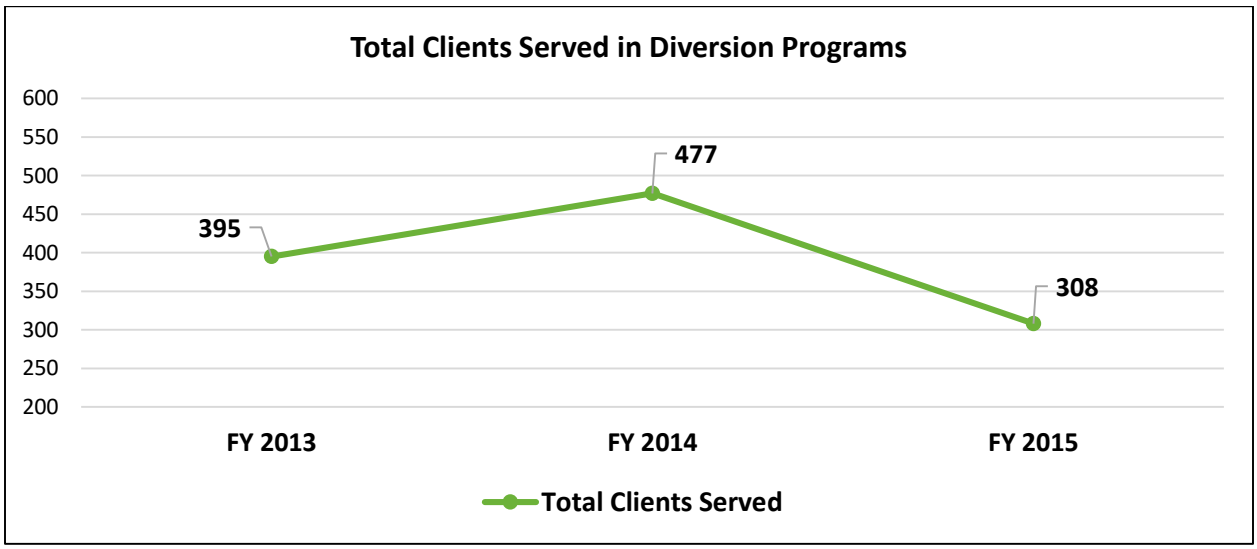


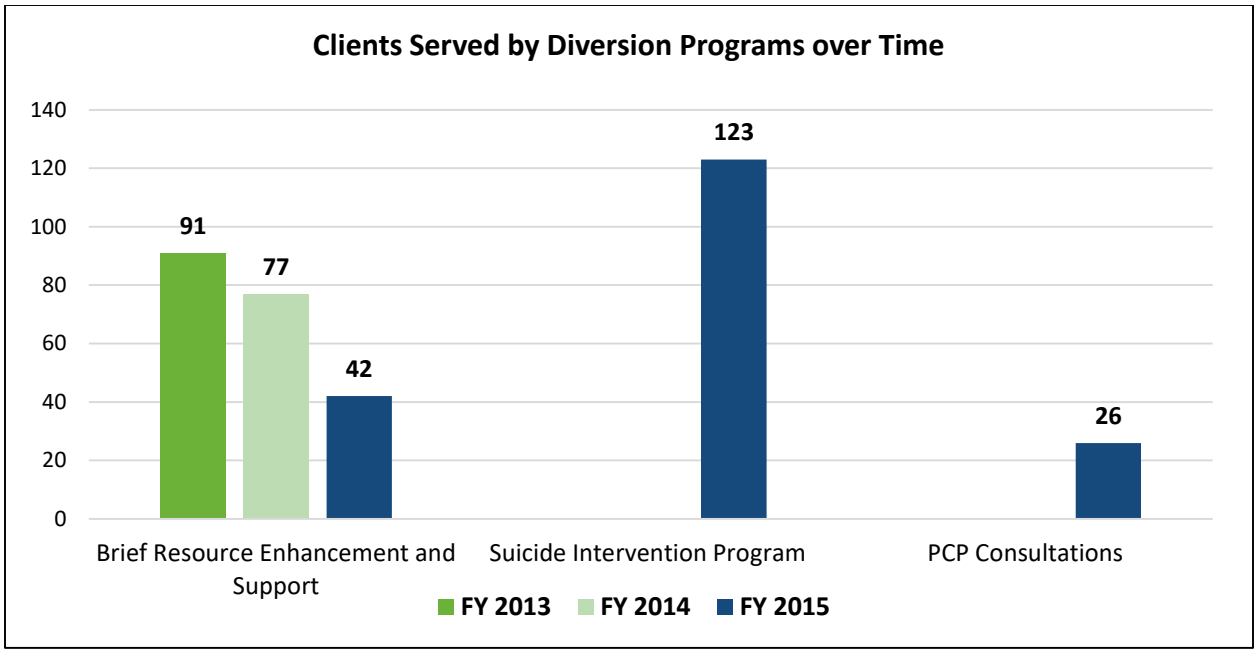


Diversion Programs

In FY 2015, 15% of the children seen in the emergency department (ED) were diverted from hospitalization. Out of the 43 children that met the criteria for hospitalization in the first year of the pilot program, 11 were diverted to sub-acute facilities and only eight children ultimately had to be hospitalized, with an average length of stay of 2.5 days.

The total number of clients served by any diversion program declined by 22% from FY 2013 to FY 2015. The majority of clients were served within the Brief Resource Enhancement and Support program. The suicide intervention program was not initiated until FY 2015, but it served more clients than any other diversion program in its inaugural year.




Clients Served by Diversion Programs over Time
140
120
100
80
60
40
20
0
91
77
42
123
26
Brief Resource Enhancement and Support
Suicide Intervention Program
PCP Consultations
FY 2013
FY 2014
FY 2015

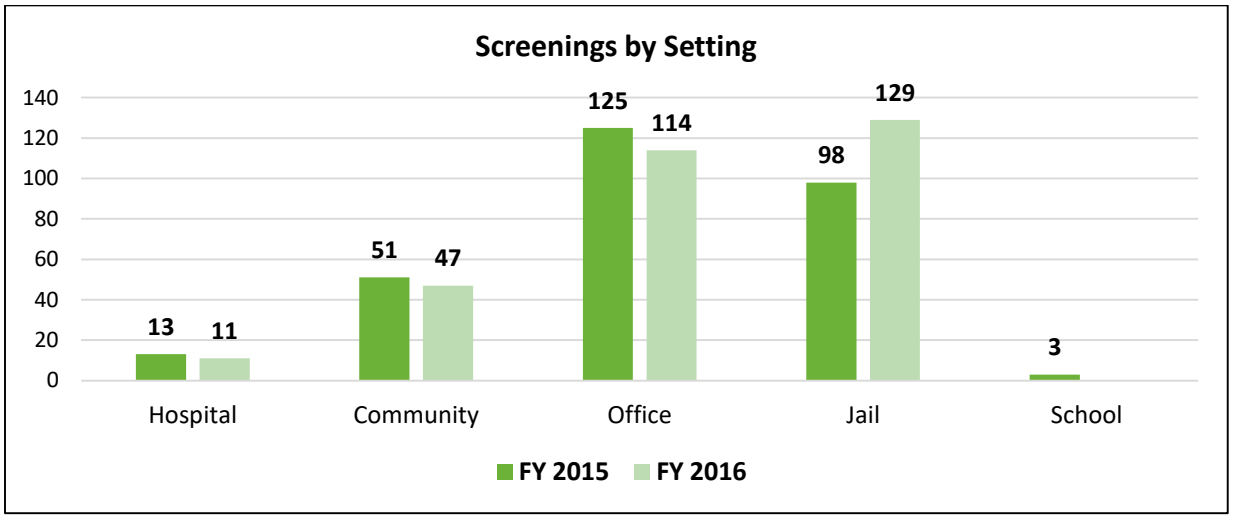
Appendix 5: Provider "B" Crisis Baseline Measures

The following analysis was derived from data collected by Provider "B" related to crisis services provided between fiscal year (FY) 2015 and FY 2016. Data included the total number of crisis screenings, respite placements, services provided to clients with complex needs, and the percentage of clients seen face-to-face within seven days of discharge.

Crisis in the Outpatient Setting

The mobile crisis response team was implemented in September 2016. Prior to this, the crisis team responded to the community to meet the needs of their partners. During FY 2015, a total of 292 screenings were conducted, most of which occurred in an office setting (43%) or in the jail (34%). There were an additional 229 services provided to people in crisis, including case management, consultation, consultation with agency, and support and stabilization.

During FY 2016, at total of 313 screenings were conducted, with a 7% increase in screenings from FY 2015. Again, most screenings occurred in an office setting (36%) or in the jail (41%). There were an additional 880 services provided to people in crisis; these services included case management, consultation, consultation with agency, and support and stabilization, resulting in a 284% increase in other related crisis services.



Respite

Provider "B" placed a total of 55 clients in respite services in FY 2016.

Meeting the Needs of Complex Clients

During FY 2015, 3,169 clients were served by Provider "B" for behavioral health needs. Of those clients, 282 (9%) were seen in crisis services. During FY 2016, 3,573 clients were served by Provider "B" for behavioral health needs, of which 537 (13%) were seen in crisis services. This increase is believed to be a result of adding a case manager position to provide follow up and additional case management services that were not previously being provided.

Get People Connected

In FY 2016, Provider "B" connected with 90% of hospital discharges within seven days of discharge.

Appendix 6: State of Florida Medicaid Managed Care Contract Excerpt

(Attachment II, page 92 excerpt)

Core Contract Provisions – Effective June 1, 2017

1. In Lieu of Services
   a. The Managed Care Plan may cover services or settings that are in lieu of services or settings covered under the State plan (i.e., "in lieu of services"), as specified in this Contract and in accordance with 42 CFR 438.3(e)(2)
   b. The Managed Care Plan shall use a clinical rationale for determining the benefit of the in lieu of service for the enrollee.
   c. The Managed Care Plan shall ensure that the enrollee has a choice of whether to receive the Medicaid covered service or an in lieu of service, and shall ensure that the choice is documented in the enrollee record.
   d. The Managed Care Plan shall submit a copy of its procedures for in lieu of services to the Agency for approval in advance of implementation.
2. The Managed Care Plan may provide any of the following in lieu of services to enrollees when determined medically appropriate, in accordance with the requirements specified in Attachment B., Section VI., Coverage and Authorization of Services, after obtaining approval from the Agency.
   a. The Managed Care Plan may provide services in a nursing facility in lieu of inpatient hospital services. Such services shall not be counted as inpatient hospital days.
   b. Crisis stabilization units (CSU) and Class III and Class IV freestanding psychiatric specialty hospitals may be used in lieu of inpatient psychiatric hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If CSU beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for psychiatric inpatient hospital care in anticipation of such transfers.
   c. Detoxification or addictions receiving facilities licensed under s. 397, F.S. may be used in lieu of inpatient detoxification hospital care. Notwithstanding network adequacy standards, when reporting inpatient days used, these bed days are calculated on a one-to-one basis. If detoxification or addictions receiving facility beds are at capacity, and some of the beds are occupied by enrollees, and a non-funded client presents in need of services, the enrollees must be transferred to an appropriate facility to allow the admission of the non-funded client. Therefore, the Managed Care Plan shall demonstrate adequate capacity for inpatient detoxification hospital care in anticipation of such transfers.
   d. Partial hospitalization services in a hospital may be provided in lieu of inpatient psychiatric hospital care for up to ninety (90) days annually for adults ages twenty-one (21) and older; there is no annual limit for children under the age of twenty-one (21).

e. Mobile crisis assessment and intervention for enrollees in the community may be provided in lieu of emergency behavioral health care.
f. Ambulatory detoxification services may be provided in lieu of inpatient detoxification hospital care when determined medically appropriate.
g. The following services and corresponding HCPCS or Revenue codes may be used in lieu of community behavioral health services:
   (1) Self-Help/Peer Services in lieu of Psychosocial Rehabilitation services.
   (2) Respite Care Services in lieu of Specialized Therapeutic Foster Care services.
   (3) Drop-In Center in lieu of Clubhouse services.
   (4) Infant Mental Health Pre and Post Testing Services in lieu of Psychological Testing services.
   (5) Family Training and Counseling for Child Development in lieu of Therapeutic Behavioral On-Site Services.
   (6) Community-Based Wrap-Around Services in lieu of Therapeutic Group Care services or Statewide Inpatient Psychiatric Program services.
   (7) Structured Family Caregiving - A service for plan members residing in nursing facilities who can be transitioned safely in a community setting but for whom more intensive in-home assistance/support is needed.