

Crisis Stabilization Services

Engrossed Substitute House Bill 1109, Section 215(38); Chapter 415; Laws of 2019

December 1, 2019



Crisis Stabilization Services



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Executive summary

Engrossed Substitute House Bill 1109 (2019) directed the Health Care Authority (HCA) to coordinate with stakeholders to identify appropriate crisis stabilization and triage funding models and estimate the gap in non-Medicaid funding for crisis stabilization and triage facilities statewide.

Information was requested from a broad stakeholder group, including crisis stabilization providers, managed care organizations (MCOs), and behavioral health administrative services organizations (BH-ASOs). In addition, the crisis triage and stabilization information included on revenue and expenditure reports provided by behavioral health organizations was analyzed to determine amounts previously funded and historical expenditure levels for these services.

Review of the fiscal year 2019 revenue and expenditure reports provided by the regions (excluding Southwest Washington) suggests that of the non-Medicaid funding, approximately 1 percent specifically funds crisis triage and stabilization services. Crisis expenditures in those regions total about 14 percent, not including stabilization and triage services. Funding for crisis stabilization and triage services has lagged behind the average provided for other crisis services.

Survey findings indicate four main issues that must be addressed:

- It is challenging to find staff to provide services for high-acuity individuals.
- Crisis services should be available to everyone in the community, including triage and stabilization. A variety of funding streams may make this difficult.
- Alternative placements are more expensive in the long run.
- Payment models must be revised to ensure payment for capacity or at cost due the unpredictability of the required services.

Proviso language

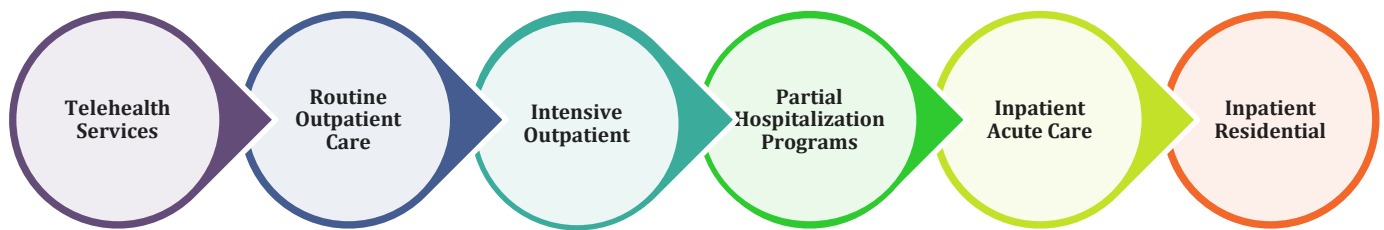
(38) \$500,000 of the general fund—state appropriation for fiscal year 2020 and \$500,000 of the general fund—state appropriation for fiscal year 2021 are provided solely for provision of crisis stabilization services to individuals who are not eligible for medicaid in Whatcom county. The authority must coordinate with crisis stabilization providers, managed care organizations, and behavioral health administrative services organizations throughout the state to identify payment models that reflect the unique needs of crisis stabilization and crisis triage providers. The report must also include an analysis of the estimated gap in nonmedicaid funding for crisis stabilization and triage facilities throughout the state. The authority must provide a report to the office of financial management and the appropriate committees of the legislature on the estimated nonmedicaid funding gap and payment models by December 1, 2019.



Background

Access to the full array of mental health treatment options is vital to recovery for individuals experiencing mental illness. A continuum of treatment is imperative to ensure safe, healthy communities and quality outcomes. Washington State is a leader in providing innovative medical and behavioral health treatment, investing more than \$24 billion annuallyⁱ at all levels of care. Included in the behavioral health treatment modalities are inpatient psychiatric care, hospital diversion programs, peer services, crisis stabilization, housing supports, and many other evidence based practices to promote recovery for people experiencing mental illness.

Figure 1: Cost of care increases from least to most intensive



Telehealth services

- Using electronic devices to provide health care.

Routine outpatient care (ROC)

There are three types of routine outpatient care:

- Individual counseling. This includes one-on-one sessions with a therapist.
- Medication evaluation and management. This includes visits with a psychiatrist or nurse practitioner. They can help decide if medication would be helpful.
- Group therapy. This includes weekly group sessions with other people with mental health issues. Group therapy allows people to learn from one another's experiences.

Intensive outpatient program (IOP)

- A structured treatment that teaches how to manage stress and cope with emotional and behavioral health challenges.
- Can include group, individual, and family therapy.
- Involves frequent visits (usually three to five days per week). Takes about three to four hours of treatment per day. Often lasts four to six weeks.
- Is structured so patients can continue with their normal routines.
- Provides support from the program and social support from other people in the program.



Partial hospitalization

- Is an intense, structured program.
- Involves treatment five to seven days per week for six hours each day.
- Can include group, individual, and family therapy.
- Often includes an evaluation by a psychiatrist. They may prescribe or adjust medications.
- Is often recommended for patients who are still struggling after completing lower levels of care.
- Is helpful for patients who are at risk of hospitalization. Can also work as a step-down for patients who have been hospitalized.

Inpatient acute/crisis care

- Takes place in an inpatient setting.
- Is meant for people who need 24-hour care. Includes daily doctor visits in an inpatient setting.
- Is often recommended for people who aren't able to care for themselves. Inpatient care is also needed for people who may harm themselves or others.
- Can last for a few days.
- Is intended to stabilize a mental health crisis.
- Includes group therapy. Also includes meetings with a team of professionals, including a psychiatrist.
- May require a family session to discuss aftercare plans.

Inpatient residential

- Should only be tried when all available outpatient approaches have failed.
- Is meant to be a short-term placement to stabilize the person.
- Should take place as close to the person's home as possible.
- Is meant for people who don't need medical attention.
- Offers group, individual, and family therapy. Therapy takes place in a supportive environment.
- Should include weekly family therapy.

Perspective

Crisis services should be available to everyone. National statistics attest to the significant need for crisis services. In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health conditionⁱⁱ. Moreover, in any given year, approximately one-fourth of adult Americans will have a mental disorder and about five percent of children aged 4 to 17 years have serious emotional distress.ⁱⁱⁱ



Funding for crisis systems is complex. A variety of services and programs are intended to address a wide range of situations. Eligibility criteria for each of the programs can vary, creating even more difficulty in accessing needed services. Moreover, rural areas may have additional challenges in ensuring care, with staffing issues, financial challenges, and limited populations. Funding that is tied to serving a specifically defined population can limit the financial feasibility of a program, particularly in rural areas or other areas that have a limited population base to draw upon.

Crisis Triage and Stabilization Facilities (CSFs) are a health care alternative to emergency room settings or evaluation and treatment center services for people experiencing a mental health crisis or an acute behavioral health problem. CSFs are designed to provide prompt action, gentle response, and effective support in a respectful environment. CSFs are a part of a healthy continuum of crisis services designed to stabilize and improve symptoms of distress. These programs offer short-term, “sub-acute” care for people who need support and observation, at lower costs and without the overhead of hospital-based acute care. They accept walk-in patients, unless the patient requires medical clearance at a medical/surgical hospital emergency department prior to behavioral health treatment.

While CSFs can be licensed as psychiatric hospitals, they have the floor plan and culture of a residential program. They are clinically staffed with nursing and psychiatric support. Their multidisciplinary care teams also include peer supporters who are often the first and last person a patient may encounter. They also have average lengths of stay for stabilization at or below 5 days for a patient population with acuity levels equivalent to those of an inpatient psychiatric hospital.

Crisis stabilization is defined as “a direct service that assists with deescalating the severity of a person’s level of distress and/or need for urgent care associated with a substance use or mental health disorder. Crisis stabilization services are designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services” (SAMHSA 2012).

Short-term crisis residential stabilization services include a range of community-based resources that can meet the needs of an individual with an acute psychiatric crisis and provide a safe environment for care and recovery. Core attributes of residential crisis services include providing housing during a crisis with services that are short term, serving individuals or small groups of clients, and are used to avoid hospitalization (Stroul, 1988).

Current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning. It also demonstrates that the satisfaction of these services is strong, and the overall costs for residential crisis services is lower than traditional inpatient care.ⁱⁱⁱ



Information gathering

A meeting was held on July 24 with HCA staff to develop an action plan for this report. Key staff in attendance included Keri Waterland, Melodie Pazolt, Michael Langer, Jason McGill, Teresa Claycamp, Christy Vaughn, David Reed, Louise Nieto, Steve Dotson, Kara Panek and Michele Wilsie.

The following is the action plan developed during that meeting:

Work items:

- Invite stakeholders to a workgroup.
- Convene the workgroup with interested parties.
- Identify potential payment methods within the workgroup.

Provide a report that includes the following items:

- Conduct an analysis identifying the unique needs of crisis stabilization and crisis triage providers and how to meet those needs.
- Describe the analysis of the methodology of the gap in funding.
- Estimate the need for non-Medicaid funding.
- Identify potential payment models.

The group determined that the most effective method to gather the data quickly would be to send a questionnaire via email to entities that were willing to provide information. An announcement was made at the BHO/ASO meeting and the MCO meeting in August, during which attendees were informed that HCA would be gathering information for the report. Interested parties were sent an email on September 13, 2019.

Requests for data were made to BH-ASOs, BHOs and MCOs on four occasions. The announcements requesting information were made during the August, September, and October meetings, and stakeholders were encouraged to provide any information. Another follow-up email was sent on October 24, 2019.

Virtual participants

The following people provided detailed responses, which are detailed in the “Data Received” section of this report:

- Joe Valentine, executive director, North Sound ASO
- Jesse Benet Manager, diversion and reentry services, Behavioral Health and Recovery Division, King County
- Jodie Leer, Washington State director, RI International
- Peggy Papsdorf, policy analyst, Pioneer Human Services
- Tom Sabastian, president/CEO, Compass Health

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Snapshot of information received

The questions were intended to gather information regarding the unique needs of providers as well as gaps in funding, per proviso language. We were hopeful answers to the following questions would also be provided, assuming that the information would help guide future prospective payment methods and create an understanding of shortages in the services being offered:

- How many services were needed but not received due to lack of funding?
- What are appropriate payment methods, based on data received?

The following questions were sent out, with general comments condensed by HCA. In depth responses are quoted at the end of the report under the heading “Data Received.”

1. Please indicate the needs that you see as unique to crisis stabilization and triage providers that other providers may not experience.

Crisis stabilization and triage providers have unique operating costs related to a 24/7 facility and the need for adequate staffing to support both 24/7 operation and to ensure the safety and security of staff and clients. Maintaining and filling positions can be difficult. Staff must be compensated at a higher level. Capacity payments or cost reimbursement are necessary to maintain safety, licensing and client requirements of the facilities. Services should be available to everyone in a community. Without sufficient operating support, these facilities will not be financially sustainable over an extended period of time. If they are forced to rely solely on Medicaid funding and receive no reimbursement for non-Medicaid people, and if even Medicaid funding is fee for service rather than capacity payments, then facilities offering these services will not be financially sustainable in the long run.

2. Please indicate how not meeting those needs impacts client care. Please be as descriptive as possible (loss of function, incidence of higher levels of care needed, etc.).

Without adequate funding, these facilities will not be available for services. If this occurs, individuals end up in other places, like jails, emergency departments, and psychiatric facilities. This results in an overall higher cost to the individual and to the system. There could be a higher level of involuntary treatment, due to escalation of the crisis situation and no treatment offered.

3. What payment methods do you utilize when paying for crisis stabilization and crisis triage? For example – hourly rate, daily rate, per diem, contract amount, or other?

Service providers are funded with capacity payments or with cost reimbursement, generally on a per diem rate.

4. Please estimate the number of services provided within your funding (Medicaid and non-Medicaid).



Please see “Data Received” section for full details of information provided. The responses suggest that in excess of 2,500 individuals were offered services, with between 25 percent and 37 percent of those services offered to individuals not enrolled in managed care. This suggests that without the ability to blend funding, somewhere between 625 and 925 people would remain unserved. This estimate only includes the service providers who responded to our questionnaire.

5. Please use the above metric of funding (hourly rate, daily rate, per diem, contract amount or other) to indicate how many services were not provided to your non-Medicaid clients due to lack of funding.

The responses have indicated that they have funded all necessary services despite Medicaid eligibility. The funding is generally provided on a per diem rate.

6. Please indicate other methods of payment that you have employed or would employ that could assist in meeting the needs of the providers as indicated above.

The 1/10 of 1 percent tax is used. In addition, value-based purchasing is used to cover overhead, with performance measures that reduce Involuntary Treatment Act, jail, emergency department, and hospital utilization.

Providers are open to options for per diem payments.

7. Please estimate cost shifts or savings that would occur should the payment method that you are supporting be legislated.

One response included data. See the “Data Received” section of the report.

8. Any additional information you can provide that should be considered?

The general consensus is that these services are beneficial to community members to divert individuals from higher levels of care.

Difficulties outlined by providers

The four challenges most often cited were:

- Individuals not offered crisis stabilization and triage services most often end up in jail or emergency departments, which costs the system more in the long run.
- Staffing issues, including low pay, shift work, and safety, are all concerns that need to be addressed.
- Challenges in the braided funding of Medicaid and non-Medicaid.
- Facilities that accept police drop-offs are necessary and must be funded outside of the managed care arena to allow services for all individuals.

It is apparent from the information gathered that a method of funding crisis stabilization and triage providers must be determined that allows for stabilization services when needed. Capacity or cost



reimbursement payments must be included in the funding mechanisms, as fee for service payments will not allow for appropriate funding for these services.

Potential opportunities provided by additional crisis funding

- Reduction of utilization and lengths of stay in specialized settings.
- Reduced preventable readmissions to acute care hospitals and residential settings.
- Improved access to community-based services to address people’s chronic mental health care needs.
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

In a recent study by Mukherjee and Saxon (2017), the authors reported on the creation of a model of care at a crisis stabilization center in rural Illinois that implemented one of three interventions for deflecting individuals from increased levels of behavioral health care. In this model, clients entering the emergency department would receive a clinical assessment and on the basis of the assessment could be transferred to a community-based crisis center for treatment. The study showed the length of stay in the emergency department decreased from 7.3 hours to 4.12 hours after the introduction of the behavioral health crisis stabilization center intervention. The study also conducted a cost-analysis that showed this intervention saved approximately \$4.1 million in Medicaid costs.

In a separate study by Wilder Research (2013), a crisis stabilization unit in metropolitan Minnesota examined the impact of the unit on the emergency department, outpatient services, and inpatient psychiatric service utilization. The study found the overall cost of providing services in a community-based crisis center was less than providing services in an inpatient unit.^{iv}

A recent systematic review examined the effectiveness of residential alternatives to hospital inpatient services for acute psychiatric conditions (Lloyd-Evans, et al., 2009). This review included randomized control trials or studies that provided specific quantitative comparisons of effectiveness of alternatives to standard acute inpatient care. Based on nine out of the 27 studies reviewed, which were rated as of moderate or high-quality methodological rigor, the authors concluded that there is preliminary evidence to suggest that residential alternatives may be as effective and potentially less costly than standard inpatient units. The authors note, however, that more research is needed given the heterogeneity of the services and patients studied to date, and rigor of the study designs.ⁱⁱⁱ

Revenue and expenditure spending

The far right column of the following extract from the revenue and expenditure reports for non-Medicaid services shows the percentage of funding provided for crisis services in the listed regions during fiscal year 2019.

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Crisis triage and stabilization services are funded at less than 1 percent of all non-Medicaid service funding. HCA did not validate with providers whether this is due to a lack of support for the services or is due to a lack of overall funding in the system.

July 1, 2018 through June 30, 2019	Great Rivers	Greater Columbia	King	North Sound	Optum	Salish	Spokane	Thurston Mason	REPORTED Totals	% Of NonMedicaid Revenues
NON-MEDICAID REVENUE										
Non-Medicaid Revenues (Exhibit F)	\$ 6,245,506	\$ 7,412,491	\$ 20,831,744	\$ 21,422,797	\$ 9,030,472	\$ 8,454,452	\$ 7,555,407	\$ 6,687,213	\$ 87,640,081	
Non-Medicaid State	4,116,317	5,936,206	14,087,225	16,868,606	6,448,872	5,672,942	4,551,280	5,051,975	62,733,423	
Crisis Triage/Stabilization	-	-	-	-	126,231	378,693	-	-	504,924	0.58%
Revenues from Federal	\$ 1,220,854	\$ 1,230,858	\$ 4,636,460	\$ 3,934,394	\$ 2,400,963	\$ 1,220,062	\$ 2,162,793	\$ 1,213,459	\$ 18,019,843	
Total Revenues	\$ 8,718,750	\$ 8,718,323	\$ 27,183,762	\$ 32,940,473	\$ 11,533,013	\$ 9,783,069	\$ 10,080,676	\$ 6,993,696	\$ 115,951,761	
EXPENDITURES - MENTAL HEALTH										
Outpatient Service Costs	\$ 3,002,027	\$ 3,521,048	\$ 3,072,641	\$ 9,934,401	\$ 3,681,179	\$ 3,376,960	\$ 5,596,475	\$ 1,642,755	\$ 33,827,485	
Crisis Services	2,113,913	953,084	706,715	4,513,058	1,001,220	657,880	1,764,417	553,080	12,263,366	13.99%
Freestanding Evaluation and Treatment (E&T)	141,339	-	-	3,848,348	1,078,514	906,108	886,262	836,554	7,697,125	
Other Outpatient Treatment	\$ 454	-	-	\$ 8,622	\$ 446,000	\$ 11,428	\$ 31,075	\$ 35	\$ 497,614	
Crisis Triage/Stabilization	-	-	-	-	446,000	11,428	-	-	457,428	0.52%
Roads to Community Living Grant	454	-	-	8,622	-	-	31,075	35	40,186	
Direct Service Costs (Exclude Outpatient)	\$ 1,295,864	\$ 2,441,515	\$ 19,656,128	\$ 7,717,786	\$ 3,686,933	\$ 1,086,636	\$ 5,659,589	\$ 2,159,144	\$ 43,703,594	
Direct Service Costs (Program/Pilot)	\$ 1,622,487	\$ 2,154,033	\$ 3,088,743	\$ 3,278,786	\$ 1,443,709	\$ 1,652,211	\$ 2,709,793	\$ 1,712,055	\$ 17,661,817	
Total Expenditures - Mental Health	\$ 6,075,841	\$ 8,140,352	\$ 28,028,461	\$ 22,895,510	\$ 10,500,502	\$ 6,259,377	\$ 14,440,764	\$ 5,513,988	\$ 101,854,795	
EXPENDITURES - SUBSTANCE USE DISORDER										
Community Engagement and Referral Services	\$ 36,737	\$ 130,056	\$ 1,349,021	\$ -	\$ -	\$ 21,615	\$ -	\$ 43,768	\$ 1,581,196	
Triage Services	\$ 48,362	\$ 32,890	\$ (685,185)	\$ 993,872	\$ 128,913	\$ 75,426	\$ 13,798	\$ 22,802	\$ 630,878	0.72%
Crisis Stabilization	-	32,890	-	68,347	-	-	-	-	101,237	
Outpatient Treatment Services	\$ 537,264	\$ 748,200	\$ 1,058,410	\$ 1,571,876	\$ 1,021,067	\$ 349,505	\$ 197,094	\$ 376,319	\$ 5,859,735	
Support Services	\$ 155,150	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,046	\$ -	\$ 15,303	
Residential Treatment	\$ 450,651	\$ 460,786	\$ 242,941	\$ 18,500	\$ 90,035	\$ 127,326	\$ 673,369	\$ 352,097	\$ 2,415,705	
Other Services	\$ 1,181,728	\$ 761,630	\$ 2,399,490	\$ 3,253,485	\$ 2,126,833	\$ 1,696,305	\$ 1,024,870	\$ 976,569	\$ 13,420,910	
Other Miscellaneous Services	\$ -	\$ -	\$ -	\$ 66,826	\$ -	\$ -	\$ -	\$ -	\$ 17,323	
Total Expenditures - Substance Use Disorder	\$ 2,409,891	\$ 2,133,562	\$ 4,364,677	\$ 5,904,559	\$ 3,366,848	\$ 2,270,177	\$ 1,914,177	\$ 1,804,181	\$ 24,168,072	
EXPENDITURES - BHO INTEGRATION										
Direct Service Support Costs (BHO only, exclude p	\$ 440,057	\$ 78,310	\$ 1,321,141	\$ 4,482,419	\$ 1,465,697	\$ 192,618	\$ 206,359	\$ 324,472	\$ 8,511,073	
Crisis Telephone (Dedicated Hotline)	-	-	484,900	517,848	59,641	-	43,553	56,000	1,161,942	
Other Direct Service Support Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,046	\$ -	\$ 333,443	
Total BHO Integration	\$ 440,057	\$ 78,310	\$ 1,321,141	\$ 4,482,419	\$ 1,465,697	\$ 192,618	\$ 206,359	\$ 657,916	\$ 8,844,516	
ADMINISTRATION										
Administrative Costs	\$ 102,342	\$ 177,547	\$ 768,977	\$ 413,203	\$ 913,907	\$ 234,030	\$ 164,744	\$ 357,637	\$ 3,132,387	
Other Administrative Costs	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
Capital Projects Expenditures/Acquisitions	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 175,328	\$ 175,328	
Total Administration Costs	\$ 102,342	\$ 177,547	\$ 768,977	\$ 413,203	\$ 913,907	\$ 234,030	\$ 164,744	\$ 532,965	\$ 3,307,715	
Total Expenditures	\$ 9,028,130	\$10,529,771	\$ 34,483,255	\$ 33,695,691	\$ 16,246,955	\$ 8,956,202	\$ 16,726,044	\$ 8,509,051	\$ 138,175,099	

Looking at the row labeled “Expenditures – Mental Health,” overall crisis service expenditures total \$12.3 million. That expenditure divided by the total non-Medicaid revenue of \$87.6 million shows that about 14 percent of all BHO non-Medicaid revenue was spent on crisis services. Analysis of the summary for crisis triage and stabilization service expenditures indicates that BHOs spent a total of just over \$1 million (\$457,428 plus \$630,878) on these services.

Conclusion

Opportunities for earlier intervention are lost without adequate funding for crisis triage and stabilization, which results in higher long-term costs.

More evaluation is necessary to determine facility needs and payment methods for those individuals who need care, regardless of insurance coverage.

As with the health care system overall, there is a continuous need to control costs associated with the delivery of mental health services, while maintaining or improving the quality of care. Several studies have examined the economic impact of various types of crisis services, relative to usual

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mental health care. These studies find that significant cost savings can result from crisis services, due to reduced inpatient utilization, emergency department diversion, and more appropriate use of community-based behavioral health services.

The 2013 study by Wilder Research used claims data to calculate a return on investment of mental health crisis stabilization programs. The authors examined the impact of the program on utilization of health care, including emergency department use, outpatient services, and inpatient psychiatric services. They also investigated the cost of inpatient hospitalization (all-cause and behavioral health only) post-crisis stabilization compared to costs prior to intervention. They compared the value of the resources invested in these programs and the benefits associated with this intervention. Programs served 315 patients at an average cost for mental health crisis stabilization of \$1,085. The study found that the net benefit for mental health crisis stabilization services was approximately \$0.3 million, with a return of \$2.16 dollars for every dollar invested.ⁱⁱⁱ

Recognizing that 2020 will be the first year of integrated managed care for Washington State, the Health Care Authority (HCA) understands that there is a great deal of information to be gathered. Data must be analyzed and community needs assessed to ensure that funding streams provide services for all. HCA will endeavor to ensure that funding is appropriate for the needs of the residents of the state, while providing quality services.

Crisis services, stabilization and triage are a necessary part of the continuum of care for those experiencing mental health challenges.

Data received

The following data and information is exactly what was received by HCA. The different rows indicate different provider responses.

1. Please indicate the needs that you see as unique to crisis stabilization and triage providers that other providers may not experience.
<ul style="list-style-type: none">• Crisis stabilization and triage providers have unique operating costs related to a 24/7 facility and the need for adequate staffing to support both 24/7 operation and to ensure the safety and security of staff and clients.
<ul style="list-style-type: none">• 24/hour staffing is hard to fill, especially in late shifts. Often agencies are unionized, and the positions are functionally similar to other positions in the agency – except the shift work, which in and of its own may not be enough for shift differential salaries to be offered. Also, other shift work at hospitals and with the DCRS often pays better, and when individuals are well trained in crisis work they often get sought after for these more lucrative positions.• Identifying appropriate client-staff ratios can affect capacity to serve/accept new referrals, however is necessary to maintain clinical oversight and safety on the unit.• Capacity limits on diversion options if we want to be able to leverage Medicaid funds. Facilities are limited to 16 beds. We have one diversion facility in all of King County.

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- The laws governing Crisis Stabilization Unit (CSU) and Triage facilities indicate specific requirements due to the potential involuntary nature of these programs, however there is not specific language regarding facilities that are only operating as a voluntary diversion option. This requires facilities to operate under Residential Treatment Facility (RTF) rules, which don't always address the crisis nature of these facilities.
- Leasing facilities that have been specifically designed to serve this population and have been constructed to meet RTF requirements, means that significant increases in facility rent/lease rates are difficult to negotiate due to lack of other feasible/reasonable alternatives for placement

2. Please indicate the needs that you see as unique to crisis stabilization and triage providers that other providers may not experience.

- Crisis stabilization and triage providers have unique operating costs related to a 24/7 facility and the need for adequate staffing to support both 24/7 operation and to ensure the safety and security of staff and clients.

- 24-hour staffing is hard to fill, especially in late shifts. Often agencies are unionized, and the positions are functionally similar to other positions in the agency – except the shift work, which in and of its own may not be enough for shift differential salaries to be offered. Also, other shift work at hospitals and with the DCRS often pays better, and when individuals are well trained in crisis work they often get sought after for these more lucrative positions.
- Identifying appropriate client-staff ratios can affect capacity to serve/accept new referrals, however is necessary to maintain clinical oversight and safety on the unit.
- Capacity limits on diversion options if we want to be able to leverage Medicaid funds. Facilities are limited to 16 beds. We have one diversion facility in all of King County.
- The laws governing Crisis Stabilization Unit (CSU) and Triage facilities indicate specific requirements due to the potential involuntary nature of these programs, however there is not specific language regarding facilities that are only operating as a voluntary diversion option. This requires facilities to operate under Residential Treatment Facility (RTF) rules, which don't always address the crisis nature of these facilities.
- Leasing facilities that have been specifically designed to serve this population and have been constructed to meet RTF requirements, means that significant increases in facility rent/lease rates are difficult to negotiate due to lack of other feasible/reasonable alternatives for placement

- The implementation of the Care Traffic Control Hub statewide will have the ability to stabilize approximately 90% of the crisis calls without further interventions. Assuming that the Hub also is able to dispatch and track mobile crisis teams statewide, another 70% of crises can be resolved in the community with appropriate dispositions in real time to available beds and outpatient treatment slots. This enhanced statewide capability



as the front end of a crisis system continuum of services and supports will be the keystone to a robust crisis system.

- Having a Residential Rehabilitative Center (RRC), without a 23 hour facility that operates as a crisis drop off with recliners, (as opposed to beds), does not allow for the flexibility required to stabilize crises within 7 to 10 hours on average and to maintain a client flow that facilitates maintaining a 100% admission rate for both voluntary and involuntary admissions.
- There is not facility licensure nor a payment mechanism to cover the costs associated with involuntary drop offs to a 23 hour acute observation facility.
- It is critical for immediate crisis service access for “walk-ins” and first responder “drop-offs,” that the RRC operate under a “No Wrong Door” approach. This assures meaningful diversion from Emergency Departments (ED) and incarceration. This results in better outcomes, more police attending to public safety rather than on ED boarding, greatly reduced ED and hospital utilization, and overall system savings.
- In order for the RRC to metaphorically keep the front door open, there has to be an open back door as well; to manage client flow and to support maximizing the facility’s capacity. This means there needs to be sufficient intensive community-based service capacity. A peer operated Crisis Respite facility on the backend of the RRC to accommodate RRC discharges who can further stabilize for up to two weeks while awaiting transitional or permanent housing, or supported education and/or employment. Such programs also are need of state recognized credentialing and financial support.
- In support of an “open backdoor”, there needs to be a strong community treatment and support continuum, such as Assertive Community Treatment (ACT), Program for Assertive Community Treatment (PACT), Forensic Assertive Community Treatment (FACT), open access model outpatient services, that provide same-day appointments, with transportation availability and affordability.
- There needs to be, mutually agreed upon definitions between crisis service providers and MCO’s regarding the Medical Necessity Criteria for behavioral health crisis services. Traditional Medical Necessity Criteria does not accommodate the Crisis Now Model and hence, poses limitations on crisis admissions and lengths of stay. Stabilization services are not a treatment modality per se, aimed at treating diagnosable conditions.
- There needs to be agreements between counties to establish payment mechanisms for crisis services that are clearly defined to financially support out-of-county individuals who have accessed such services and who have no third party insurance coverage.
- Given the nature of crisis work, RI requires a high staff to patient ratio, along with competitive wages to attract those who are most competent and compassionate. Without adequate payment to support such staffing, RI’s ability to hire and retain the staff necessary to maintain safety and high-quality programming is significantly impacted.
- Detox management services, including buprenorphine inductions need to be built into the RRC’s per diem or billed separately and paid as a professional service. Where there are not sufficient Medical Assisted Treatment options and induction supports subsequent to



RRC discharge, Office-Based Opioid Treatment should be encouraged as an RRC add-on program.

- Any prohibitions associated with Emergency Medical Services (EMS) drop-offs at an RRC needs to be overcome to further divert behavioral health crises from EDs.
- Due to the limits of Medicare and commercial payment for crisis services, public safety net dollars need to be able to compensate for these inadequacies so that crisis services can be accessible to all residents.

- Crisis stabilization and triage facilities (comprised of mental health [MH] crisis and substance use disorder [SUD] withdrawal management services) provide care to a very high needs and at-risk population. These clients typically receive care in 16-bed facilities, which have a higher cost to operate and are subject to greater census volatility. As a result, these facilities need a stable cost structure to support the people being served by them, so a per diem structure for reimbursement is not sustainable. The recent closure of the Telecare evaluation and treatment (E&T) in Southwest Washington confirms that operating small, high-intensity services is not financially feasible in the current operating environment.
- In addition, it is more problematic in the North Sound region because the ASO is not run by the county, as in other regions, which means that they don't have access to local discretionary dollars such as 1/10th of 1% tax dollars. We also understand that some former flexible funds, such as Federal Substance Abuse Block Grant dollars, are not available for these services.

- Similar to mobile crisis outreach, crisis stabilization and triage needs to be available to all members of the community regardless of ability to pay or funding source. It is not in the best interests of clients or the community to have to screen for financial eligibility prior to admission, when a law enforcement officer or Emergency Medical Technician (EMT) wants to bring someone to the Triage facility for care. Unlike an outpatient clinic where a provider might complete a financial screening and refer the potential client elsewhere for services, individuals presenting to Triage are in crisis and need immediate assistance.
- Similar to an inpatient unit, the Triage facility must staff for full capacity, but actual referral patterns have peaks and valleys. But a minimum staffing level for safety and good care must be maintained.
- Crisis Stabilization Healthcare Common Procedure Coding System (HCPCS) code is not reimbursed by commercial insurance. So even if individuals come to the facility with commercial insurance, we are not reimbursed for their stay.

3. P What payment methods do you utilize when paying for crisis stabilization and crisis triage? For example – hourly rate, daily rate, per diem, contract amount, or other?



- They were funded with capacity payments with cost reimbursement for the on-site nurse component. The capacity payment was figured using actual costs and 85% occupancy.
- We pay on a cost reimbursement for all services at the Crisis Diversion Facility (CDF) utilizing a combination of Medicaid and local dollars.
- CDF uses a per diem rate for Medicaid covered services, and the rest of the facility costs are covered by local dollars.
- Valued-based purchasing to cover overhead, and meet performance measures that reduce ITA, jail, ED and hospital utilization.
- Services are currently fee-for-service (FFS) and capacity funded depending on the particular MCO.
- We are currently set up to receive some capacity rates (set rate, MCOs pay relative percent of their membership's service provision), with some per diem rates, as well. However, these rates, at best, cover Medicaid members only and do not account for between 15-25% of the individuals we serve who are not Medicaid members.
- MCO contracts for the Medicaid population only are based on a proportional share of a budgeted amount based on costs, divided between the MCOs based on member utilization of the facility.
- Whatcom Triage Contract for the non-Medicaid is designed as a cost reimbursement.

4. Please estimate the number of services provided within your funding. (Medicaid and NonMedicaid)

Stabilization Bed Days in Triage Centers		FY'19	
Count of Services		Eligibility	
County Triage Center		med	state
Skagit	74		46
Snohomish	2,481		1,097
Whatcom	604		294
Grand Total	3,159		1,437
Stabilization Bed Days in Triage Centers		FY'19	
Unduplicated People		Eligibility	
County Triage Center		med	state
Skagit	41		25
Snohomish	384		233
Whatcom	135		82
Grand Total	544		332



- In 2019 between April and September, Medicaid costs cover approximately 24% of all costs at the Crisis Diversion Facility
- Local dollars account for 76% of all costs at the Crisis Diversion Facility

- In the crisis per diem, all RRC services provided are covered with the exception of medically-assisted detox. There are no differences between Medicaid and non-Medicaid.

- Pioneer Human Services Stabilization Program Information:
- Whatcom Community Detox (WCD) is currently an 8-bed subacute withdrawal management program (LOC 3.2) that operates in Bellingham. In Q3 of 2020, Pioneer will transition to operating as a 16-bed acute withdrawal management program (LOC 3.7). Patients at WCD come primarily from Whatcom County, but also from the north sound region at large, broken out as follows (both duplicated and unduplicated services for 2018 and 2019 YTD):

2019 YTD 10.25.19 WCD Duplicated		2019 YTD 10.25.19 WCD Unduplicated	
Grays Harbor	0.7%	Grays Harbor	0.3%
Island	0.7%	Island	0.8%
King	0.2%	King	0.3%
Pierce	0.9%	Pierce	0.8%
Skagit	4.8%	Skagit	4.9%
Snohomish	2.6%	Snohomish	3.3%
Stevens	0.2%	Stevens	0.3%
Thurston	0.2%	Thurston	0.3%
Walla Walla	0.2%	Walla Walla	0.3%
Whatcom	89.5%	Whatcom	88.8%

- Skagit Community Detox (SCD) is a 16-bed subacute withdrawal management program (LOC 3.2) that operates in Burlington. Patients for this program come from all over the region, broken out approximately as follows (both duplicated and unduplicated for 2018 and 2019 YTD):

2019 YTD 10.25.19 SCD Duplicated		2019 YTD 10.25.19 SCD Unduplicated	
Island	6.6%	Island	7.9%
King	1.4%	King	1.9%
Pierce	0.4%	Pierce	0.6%
San Juan	2.0%	San Juan	1.7%
Skagit	55.9%	Skagit	50.9%



Snohomish	16.8%	Snohomish	18.3%
Thurston	0.3%	Thurston	0.4%
Whatcom	16.4%	Whatcom	18.1%
Out of State	0.1%	Out of State	0.2%

- As a result of the number of non-Medicaid patients served in our programs, Pioneer has already absorbed costs and written off revenue since IMC in the North Sound.
- These individuals would have previously been supported through the BHO using non-Medicaid dollars – these data are for the three months since IMC:

WCD	7/1-9/30	SCD	7/1-9/30
Subtotal Clients Served	130	Subtotal Clients Served	260
Subtotal Non-Medicaid Served w/o Pay	48	Subtotal Non-Medicaid Served w/o Pay	65
% of Non-Medicaid Clients Served	37%	% of Non-Medicaid Clients Served	25%
Subtotal of Uncompensated Care	\$64,556	Subtotal of Uncompensated Care	\$166,026
Total Clients Served			390
Total Non-Medicaid Served w/o Pay			113
Avg % of Non-Medicaid Clients Served			31%
Total Uncompensated Care			\$230,582

NOTE: These costs reflect only the first three months of service under managed care. Annualized, we anticipate almost \$1 million in uncompensated care. This is not sustainable and puts these vital services at risk for all members of the community.

- Total Admissions (Both Whatcom and Snohomish Triage) Annualized for 2019: 1,234
- Total Bed Days (Whatcom and Snohomish) Annualized for 2019: 5,226
- Inclusive of all payors/unfunded.
- 25-28% of all admissions are non-Medicaid.

5. Please use the above metric of funding (hourly rate, daily rate, per diem, contract amount or other) to indicate how many services were not provided to your nonMedicaid clients due to lack of funding.



- This is our estimate for the first 6 months as an ASO. It is the estimated number of non-Medicaid persons we have not funded based on extrapolating the annual number of non-Medicaid persons we served as a BHO.

Forecast Unfunded Non Medicaid People 7/1/2019-12/31/2019	
	Unduplicated Non-Medicaid
Skagit	13
Snohomish	117
Whatcom	41
North Sound Region	166

- As long as the contractor stays within their contracted budget, they are able to provide services to individuals regardless of funding source
- However, as costs increase and local funding is unable to keep up with these increasing costs, the agency will struggle to maintain staffing levels to serve this population and it may require reconsideration of criteria for admission to the facility based on Medicaid eligibility

- None, the full constellation of RRC crisis stabilization services are provided to everyone based on what the interdisciplinary team deems appropriate; this however can lead to high uncompensated care, such is the case with detox management and inductions. If 23 hour acute observation stays were in effect, an hourly FFS rate or case rate would be workable.

- We have been providing services to all clients that are referred to or arrive at our doors, despite Medicaid eligibility. As mentioned previously, we see this as a moral issue for our communities and we look to the HCA, MCOs and ASOs to resolve this urgent issue and not require people to go to jail or the ER, or worse.
- As shown above, the current cost structure is not sustainable and does not meet community needs. This issue must be addressed or these vital services are at risk for all members of the community.

- At this point we are continuing to provide unreimbursed services to non-Medicaid individuals. This is not sustainable, and it is our belief that the model does not work if you restrict access based on funding, so without a remedy for the non-Medicaid population, this service will have to be eliminated and will then not be available in our community for ANY clients, Medicaid and non-Medicaid alike.
- That would impact approximately 310-345 non-Medicaid clients and approximately 890-925 Medicaid Clients per year.



6. Please indicate other methods of payment that you have employed or would employ that could assist in meeting the needs of the providers as indicated above.
<ul style="list-style-type: none"> We would pay a daily bed rate for the number of days we authorized.
<ul style="list-style-type: none"> Local funding through the 1/10th of 1% sales tax is the primary funder for this program at this time. Medicaid allocations have recently (in the past 3 years) been implemented to help cover the costs for these program services. Increased funding requests from the contracted provider agency have to date been able to be approved, however competing demands for these local dollars limits the flexibility to continue to address budget shortfalls.
<ul style="list-style-type: none"> Valued-based purchasing to cover overhead, and meet performance measures that reduce ITA, jail, ED, and hospital utilization.
<ul style="list-style-type: none"> As a state, we have an ethical duty to fund these services. The HCA should immediately provide a source of funding such as Substance Abuse Block Grant, Criminal Justice Treatment Account, or other state dollars to meet the full needs of the population. Local funds such as 1/10th of 1% local option funds, where available, are already allocated. Relying on local jurisdictions to fund these services will merely pull these funds from other critical services and is not a feasible or sustainable solution to this critical issue.

7. Please estimate the cost shifts or savings that would occur should the payment method that you are supporting be legislated.																																								
<ul style="list-style-type: none"> This is a rough estimate of savings from diversions to EDs: 																																								
<table border="1"> <thead> <tr> <th rowspan="2">unduplicated people</th> <th rowspan="2">Eligibility</th> <th colspan="4">Annual Non_Medicaid Inpatient Savings at x diversion rate</th> </tr> <tr> <th>50%</th> <th>100%</th> <th>75%</th> <th>25%</th> </tr> </thead> <tbody> <tr> <td>County Triage Center</td> <td>state</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Skagit</td> <td>25</td> <td>\$ 10,588</td> <td>\$ 21,175</td> <td>\$ 15,881</td> <td>\$ 5,294</td> </tr> <tr> <td>Snohomish</td> <td>233</td> <td>\$ 98,676</td> <td>\$ 197,351</td> <td>\$ 148,013</td> <td>\$ 49,338</td> </tr> <tr> <td>Whatcom</td> <td>82</td> <td>\$ 34,727</td> <td>\$ 69,454</td> <td>\$ 52,091</td> <td>\$ 17,364</td> </tr> <tr> <td>Grand Total</td> <td>332</td> <td>\$ 140,602</td> <td>\$ 281,204</td> <td>\$ 210,903</td> <td>\$ 70,301</td> </tr> </tbody> </table>	unduplicated people	Eligibility	Annual Non_Medicaid Inpatient Savings at x diversion rate				50%	100%	75%	25%	County Triage Center	state					Skagit	25	\$ 10,588	\$ 21,175	\$ 15,881	\$ 5,294	Snohomish	233	\$ 98,676	\$ 197,351	\$ 148,013	\$ 49,338	Whatcom	82	\$ 34,727	\$ 69,454	\$ 52,091	\$ 17,364	Grand Total	332	\$ 140,602	\$ 281,204	\$ 210,903	\$ 70,301
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<ul style="list-style-type: none"> I don't know how to answer this since we are leveraging as much Medicaid as possible, unless we are going to be given state non-Medicaid funds to help support the costs 																																								
<ul style="list-style-type: none"> Cross-systems savings re-investment approach is needed that is not simply limited to a payment method. 																																								



8. Any additional information you can provide that should be considered?

- The North Sound BHO built a network of current and planned crisis stabilization facilities that can serve as important alternative to inpatient hospitalization and ED's. If parts of this network began to close it would be even more expensive to have to create replacements in the future.
- Difficulty of determining funding sources during crisis services might preclude using the Triage center at all. If first responders experience being turned away 50% of the time for funding issues, it won't take too long before the ED becomes the correct answer 100% of

	CDF Medicaid Allocation (percent)	APR-2019	MAY-2019	JUN-2019	JUL-2019	AUG-2019	SEP-2019	Grand Total
Amerigroup	0.14	39,973.51	12,941.58	12,423.08	14,028.39	13,470.07	12,981.50	105,818.12
CHPW	0.19	48,539.26	15,714.77	15,085.17	34,068.95	16,356.51	15,763.25	145,527.91
Coordinated Care	0.15	42,828.76	13,865.98	13,310.45	17,034.47	14,432.21	13,908.75	115,380.62
Molina	0.31	97,078.52	31,429.55	30,170.34	15,030.42	32,713.02	31,526.50	237,948.34
United Health Care	0.2	57,105.01	18,487.97	17,747.26	20,040.56	19,242.95	18,545.00	151,168.75
TOTAL		285,525.06	92,439.85	88,736.30	100,202.78	96,214.75	92,724.99	755,843.73

the time.

- Current programs that are no longer financially supported, such as; Community Building participants, need to be sustained. If left unsupported, these participants will likely again be homeless, and presenting to the ED and jail.
- We are experiencing a serious public health crisis in Washington State. More than two people die every day due to opioid overdose – numbers are increasing with the spread of fentanyl – and tens of thousands more struggle with opioid addiction. At the same time, we have seen a resurgence in methamphetamine use, with related deaths last year outpacing deaths at the height of the last meth wave in the early 2000s.
- The current operating environment does not support the continuation of these services. Not working to solve this piece of the solution would be irresponsible, immoral, and ultimately wasteful through the utilization of other high-cost services. The HCA should find a source of funding that is sustainable and pays for the full cost of care.

ⁱ https://www.usgovernmentspending.com/year_spending_2020WAbn_21bs2n_10#usgs302

ⁱⁱ Agency for Healthcare Research and Quality, 2010



iii Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

iv <https://www.mentalhealthjournal.org/articles/behavioral-health-crisis-stabilization-centers-a-new-normal.html>

